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Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Annual Plan 2015/16

Incorporating

Statement of Intent and

Statement of Performance Expectations

2015/16-2018/19

Annual Plan 2015/16 & Statement of Intent 2015-2019

Pursuant to Section 38 of the New Zealand Public Health and Disability Act 2000; Section 139 of the Crown Entities Act 2004; Section 49 of the Crown Entities Amendment Act 2013; New CE Act s149C.
Capital & Coast District Health Board, Wellington Hospital. Private Bag 7902, Wellington South
Note: This Annual Plan should be read in conjunction with the Capital & Coast District Health Board Māori Health Plan, the Regional Public Health Plan, the Sub-Regional Mental Health and Addictions Plan, the Disability Strategy; and the Central Region Regional Health Services Plan. These plans are available on our website: **http://www.ccdhb.org.nz**
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Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

23 OCT 2015

Dr Virginia Hope
Chairperson
Capital & Coast District Health Board
Private Bag 7902
Newtown
Wellington 6242

Dear Dr Hope

Capital & Coast District Health Board 2015/16 Annual Plan

This letter is to advise you that together with the Minister of Finance, I have approved and signed Capital & Coast District Health Board's (DHB's) 2015/16 Annual Plan for one year.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2015, Vote Health received an additional $1.7 billion in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, a refresh of the New Zealand Health Strategy is currently under way. The Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for the next three to five years for delivery of health services to New Zealanders. Thank you for your involvement to date and your continued input into the refresh.

Living Within our Means
The Government is determined to reach surplus in 2015/16. To assist with this, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning a surplus for 2015/16 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2015/16.

Health Shared Services Programme
DHBs have committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to include cost and benefit impacts for the Finance Procurement and Supply Chain Initiative in Annual Plans where these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

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With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

National Health Targets
Your Annual Plan provides a good range of actions that I am confident will support strong health target performance when implemented in 2015/16. Please ensure all health target actions identified in your Annual Plan are fully implemented to help you to continue to deliver better outcomes for your population.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator became the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. I am concerned that the pace of progress needs to improve if the 85 percent target is to be achieved by July 2016. Please ensure delivery of this target remains a key priority for your teams.

System Integration
As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2015/16. Shifting services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Capital & Coast DHB intends to continue its contract for the management of community referred radiology with Compass Health. It is encouraging to see that the DHB will continue to strengthen integration in 2015/16 by:

- shifting four gynaecological procedures into primary care
- developing an acute demand plan
- developing clinical pathways for dementia, frail elderly, orthopaedics and respiratory services
- implementing primary care direct referral for carpal tunnel surgery and colposcopy.

I look forward to being advised of your progress with this throughout the year. Where these services trigger the service change protocols you will need to follow the normal service change process.

Better Public Services (BPS): Results for New Zealanders
Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

It is important that DHBs continue to work closely with other social sector organisations, including non-governmental organisations, to achieve our sector goals in relation to these and other initiatives, such as Whānau Ora, Children's Action Plan and Youth Mental Health.

Tackling Obesity
I am pleased to note that your Annual Plan includes a focus on obesity, and identified a range of activities and initiatives to help tackle obesity. I have asked Ministry officials to look at what actions can be undertaken to help address childhood obesity, including, advice on a possible obesity target that will be meaningful and evidence based. I will be writing to all DHBs in coming months to outline proposed next steps.

Annual Plan Approval
My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. I am aware you have a number of service reviews under way. I have asked the National Health Board to ensure regular updates are provided as these reviews progress. Please ensure that you advise the

National Health Board as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2015/16 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

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‘MODULE 1’ INTRODUCTION & STRATEGIC INTENTIONS

1.1 FORWARD FROM DHB CHAIR, DEPUTY CHAIR, AND CHIEF EXECUTIVE

Our Annual Plan 2015/16

We are pleased to present the Capital & Coast District Health Board Annual Plan for the 2015/2016 financial year. The plan outlines our performance intentions for the next year to Parliament, the Minister of Health, and the public. Our plan focuses on local, regional, and national priorities to improve the health of our population, and sits within the New Zealand Triple Aim of improved quality, safety and experience of care; improved health and equity for all populations and best value for public health system resources.

Working with our neighbours

Significant parts of this document have been shared across the Wairarapa, Hutt Valley, and Capital & Coast DHBs reflecting a co-operative approach to the planning and delivery of health services across the lower North Island sub-region. We are moving towards more streamlined services across the three DHBs. For the past two years, the Sub-regional Clinical Leadership Group has progressed integrated activity in a number of specialties including Ear, Nose, and Throat, Gastroenterology, Child Health, and Palliative Care. We are also creating a single laboratory service across Hutt Valley and Capital & Coast DHBs, and are progressing a single Mental Health, Addictions, and Intellectual Disability directorate for the sub-region. Building upon our efforts to-date, more change will be required in 2015/16 to some service configurations as the DHB considers the most efficient and patient-focussed ways to deliver safe, high quality, and affordable health services at local and sub-regional levels.

Care closer to home

Integration can be seen not just with our neighbouring DHBs but also with local health providers. We work in partnership with Primary Health Organisations, medical practices, pharmacies, community health providers, support groups, aged residential care, and non-government organisations to promote healthy lifestyles, improve the health of our community and care for those who are unwell. We are also an active partner in cross-agency initiatives such as Whānau Ora, the Wairarapa and Porirua Social Sector Trials, Children’s Action Plan, and the Prime Minister’s Youth Mental Health Project.

This year we intend to build on the success of our partnerships with local primary health organisations to deliver more health services in the community. These include the Nursing Practice Partnership, which provides patients with diabetes care closer to home, and greater collaboration between primary and secondary clinicians through projects like HealthPathways to enable direct surgical referrals from primary health, where possible. Community engagement is also necessary to achieve aspect of the Triple Aim and we intend to capitalise on the success to date of the Porirua Social Sector trial, a cross-agency initiative designed to reduce the number of Ambulatory Sensitive Hospitalisations and Emergency Department attendances among Porirua residents aged 0 – 74. Practical steps to achieve this have included tissues and hand sanitiser being distributed in local schools, ensuring all children are enrolled in dental and medical services and the simplification of key health messages for parents. We are also strengthening our relationship with Wellington Free Ambulance, specifically around the Urgent Community Care system in Kāpiti and Porirua, where mobile paramedics attend the needs of people who unexpectedly require medical care, but not necessarily a trip to the emergency department.

Delivering high quality health services

The gains we seek in efficiency, purchasing, productivity, and quality in our operation and service delivery rely on an engaged and enthusiastic workforce that understands both their own business and the bigger picture of health service delivery. Clinical engagement is critical. Regular clinical forums and clinical input into service development is an essential part of our engagement strategy. Our professional heads, clinical directors and clinical leaders play a key role in decision making and service development. We encourage innovation and practice improvement to

benefit our combined populations. Our annual local Nursing and Midwifery Awards, the Allied Health, Technical & Scientific Awards the Quality Awards, celebrate innovation and recognise the achievements of staff across the DHBs.

Our Service Integration and Development Unit (SIDU) is supporting our clinical teams to gather and analyse data about the changing make-up and needs of our population, to inform planning for sustainable services that predict and responds to future needs.

This Annual Plan demonstrates that our DHB is committed to the delivery of national and regional programmes. We remain focused on improving our performance, meeting national targets, living within our means, and, most importantly, ensuring the on-going delivery of effective and integrated health services for our communities.

Virginia Hope
Board Chair
Capital & Coast District Health Board

Derek Milne
Board Deputy Chair
Capital & Coast District Health Board

Debbie Chin
Chief Executive
Capital & Coast District Health Board

The Capital & Coast District Health Board Annual Plan and Statement of Intent/Statement of Performance Expectations is approved for 2015/16

Hon. Jonathan Coleman

Minister of Health

Date 15.10.15

Hon. Bill English

Minister of Finance

Date 19.10.15

Dr Virginia Hope

Chairperson

Capital & Coast District Health Board

Dr Derek Milne

Deputy Chairperson

Capital & Coast District Health Board

Debbie Chin

Chief Executive

Capital & Coast District Health Board

1.2 CONTEXT

Our District Health Board (DHB) is one of 20 DHBs across New Zealand, established under the NZ Public Health and Disability Act, 2000 (NZPHD Act). As Crown Entities, DHBs are accountable to the Minister of Health and the Minister of Finance for ensuring the populations health and independence, improvement of health system sustainability and quality, and to eliminate health inequities. Our accountability is demonstrated primarily through the annual planning and reporting process (see Appendix 1 for DHB objectives and accountability under the Act).

1.2.1 Background

This Annual Plan 2015/16 (and Statement of Intent 2015-19), describes to Parliament and the public what we intend to achieve during July 2015 to June 2016, and why; setting out activities for the coming year that address national, regional, sub-regional, and local priorities; and, our broader intentions through to 2019. This document comprises our Statement of Intent (Modules 1 and 5), Statement of Performance Expectations covering what we produce (outputs) and financial inputs (Modules 3 and 4), operational actions (Module 2), proposed changes in service configuration (Module 6), and how we will measure our performance in key areas (Module 7). The funding we receive from Government to undertake this work is largely determined by complex formulae that take into account our population's size, age, gender, ethnicity, and socio-economic status (see Module 4 for details).

Our DHB is part of a sub-regional approach to delivering services to our populations; the Wairarapa, Hutt Valley, and Capital & Coast DHBs work together as one to benefit our combined population as a whole. Our sub-regional group is responsible for a total population of around 485,263; geographically defined as 43,233 in Wairarapa DHB district, 143,775 for Hutt Valley DHB, and 298,255 for Capital & Coast DHB[1]. Our individual DHB Annual Plan includes sub-regional projects that we will work on together to improve the patient journey, access to services, clinical safety, and how we will utilise our individual resources.

1.2.1.1 Te Tiriti o Waitangi

We recognise and respect Te Tiriti o Waitangi as the founding document of Aotearoa/New Zealand; it encapsulates the fundamental relationship between the Crown and Iwi and responsibility to its Treaty partners (see Appendix 2). It provides a framework for Māori development, health, and wellbeing. The NZPHD Act supports this by requiring DHBs to establish and maintain processes to enable Māori to participate in, and contribute towards, strategies to improve Māori health outcomes.

The Māori Health Strategy He Korowai Oranga (the cloak of wellness) sets the overarching framework to guide the Government, the health and disability sector, and our DHB to achieve the best health outcomes for Māori. Implementing He Korowai Oranga is the responsibility of the whole of the health and disability sector. He Korowai Oranga has recently been refreshed and takes a broader view of health[2] - Pae ora (healthy futures), is the vision and provides a platform for Māori to live with good health and wellbeing in an environment that supports a good quality of life. Pae ora encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high-quality and effective services. As an interconnection of elements, it unites Mauri ora (healthy individuals), whānau ora (healthy families), and wai ora (healthy environments). We promote development of these elements through our work in the action areas demonstrated in Module 2 of this Plan - specifically Primary Care and Integration, Healthy Families, Social Sector trials, Equity and Māori Health, Whānau Ora, and the work of Regional Public Health in promoting and enabling resilient communities and healthy environments.

Capital & Coast DHB considers our current and future generations as a 'taonga' and therefore health and well-being is a shared responsibility, in which implementing health improvement strategies for Māori are a priority. Our DHB continues to support and prioritise Māori provider services in the hospital and community settings. Our Māori Partnership Board provides governance, strategic planning, and development support to the DHB, representing local iwi including, Te Ātiawa (Wellington), Ngāti Toa Rangatira (Porirua), and Te Ātiawa ki Whakarongotai (Kāpiti).

[1] Statistics NZ data for 2014/15

[2] He Korowai Oranga is a high-level strategy that supports the Ministry of Health and district health boards (DHBs) to improve Māori health by addressing the New Zealand Health Strategy, New Zealand Disability Strategy, New Zealand Public Health and Disability Act 2000.

Nationally, Māori continue to have poorer access to, and health outcomes. This includes higher rates of cancer, diabetes, and cardiovascular disease, resulting in lower life expectancy and higher infant mortality. This plan identifies specific actions (Table 3) our organisation is taking to support infrastructure development and provide programmes that support staff in reducing inequity in health-related outcomes for Māori. Our DHB also has a Māori Health Plan that describes actions towards improving outcomes related to the national Māori Health Indicators (see Appendix 2 for an overview of the Plan). The Māori Health Plan addresses key national health indicators for Māori: enrolment in PHOs, fully immunised at 8 months old and at 65 years for influenza, screening for breast and cervical cancers, mothers smoking at 2 weeks post-natal, cardiovascular assessments, rheumatic fever, oral health, mental health, and SUDI.

In 2010 a new public policy approach to health and social service delivery was announced because despite Māori being entitled to the same level of well-being experienced by non-Māori citizens, disparities between the two populations persist. Underpinned by Māori values, it provided the Crown with another mechanism to reduce health and social well-being disparities; the whānau (family) centred approach seeks to achieve the goal of 'whānau- ora- (well- being of the extended family) and requires health services to work across traditional sector boundaries to improve client health. We have described our work towards this in Module 2, 2.2.3, Whānau Ora.

1.2.1.2 Health Profile of Our Sub-Regional Populations

Our People

The three DHB sub-region is home to nearly 11% of the national population; 463,194 'usually resident population' at the last census in 2013[3]. The largest change from the previous census was in the Wairarapa population (6.5% increase) and the Capital & Coast population (6.4%). The Wairarapa and Capital & Coast populations are also expected to grow by 6% and 8% respectively over the next ten years, with 3% growth predicted in the Hutt Valley; the sub-regions population as a whole is projected to reach over 500,000 by 2033.

Wairarapa DHB

- has a population of 41,100, 9% of sub-region
- is covered by the local authorities of South Wairarapa District, Carterton District (population 8,232), and Masterton District (23,350)
- is spread across a large geographic area of 5,936 square kilometres

Hutt Valley DHB

- has a population of 138,370, 30% of sub-region
- covers two local authorities Lower Hutt City (98,200) and Upper Hutt City and (40,180)
- covers 916 square kilometres

Capital & Coast DHB

- has a population of 283,700, 61% of sub-region
- covers three local authorities Wellington City (190,960), Porirua City (51,700), and the Kapiti Coast District south of Te Horo (41,000)
- covers 739 square kilometres.

Ethnicity is a strong indicator of need and demand for our health services and we consider the unique health needs of each of these population groups in our planning for the future. Reducing disparity based on ethnicity is essential for creating a fair health system, in which individuals have equity of outcomes[4]; equity also reduces unnecessary costs in health expenditure. Ethnic groups are distributed differently across our sub-region; 17%, 17%, and 11% Māori of the population in Wairarapa, Hutt Valley, and Capital & Coast DHBs respectively, and Pacific 2%, 7%, and 7%. Both these populations are younger and have higher fertility rates. Our Asian population averages 10% across the sub-region.

Over the sub-region, Māori makes up 12% of our population:

- Wairarapa is young, with 53% of the Māori population under 25 years old ; projected to increase by 16% (1,120 people) over the next ten years; across most age groups, with the greatest growth in the Māori population over 65, which is expected to increase by 70% (305 people)
- Hutt Valley comprises around 24,060 Māori; it is young, with 51% of the population under 24 years old, compared with 34% of the total Hutt Valley population under 25. The population is projected to increase

[3] Statistics New Zealand, Census 2013 'usually resident population', 2013

[4] Inequity and inequality- Health inequality is the generic term used to describe differences, variations, and disparities in the health outcomes of individuals, populations or groups; Health inequity is the presence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically.

by 5% (1,200 people) over the next ten years, which is largely driven by an increase in older people. The number of Māori people over 65 is expected to increase by 97% (1,060 people)

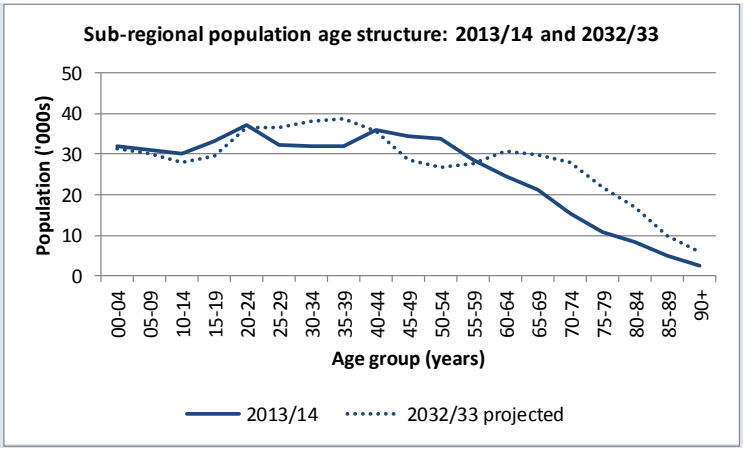
- Capital & Coast comprises around 33,420 Māori; it is young, with 51% of the population under 24 years old, compared with 34% of the total Capital & Coast population under 25. The population is projected to increase by 11% (3,570 people) over the next ten years, which is largely driven by an increase in middle-aged and older people. The number of Māori people between 25 and 64 is expected to increase by 19% (2,780 people) and the number over 65 is expected to increase by 66% (1,000 people).

Our Pacific population comprises 6% of the sub-region:

- 2% (885 people) of the total population in Wairarapa; 51% of the Pacific population is under 24 compared with 30% of the total Wairarapa population under 24; the population is projected to increase by 23% (208 people) over the next ten years, largely driven by an increase in older people, with the number of Pacific people over 65 expected to increase by 63 people over the next ten years.
- Hutt Valley the population comprises 8% (11,190 people) of the DHBs total population; it is young, 46% of the Pacific population is under 24 years old, compared to 33% of the total Hutt Valley population under 24. The population is projected to increase by 1.2% (130 people) over the next ten years, largely driven by an increase in older people, but offset by a decrease in the number of young people; over the next ten years, the number of Pacific people over 65 is expected to increase by 61% (430 people), while the number of people under 24 is expected to decrease by 11% (555 people)
- Capital & Coast Pacific population is 8% (around 22,000 people); 36% of Pacific people in the sub-region live in Porirua City; it is also young, with 46% of the Pacific population under 24 years old, compared with 33% of the total under 24s. The population is projected to increase by 2.4% (520 people) over the next ten years, is largely driven by an increase in older people, but is offset by a decrease in the number of young people. Over the next ten years, number of Pacific people over 65 is expected to increase by 31% (485 people); number of people under 24 is expected to decrease by 6% (635 people).

The Asian population comprises around 10% of the sub-regions population:

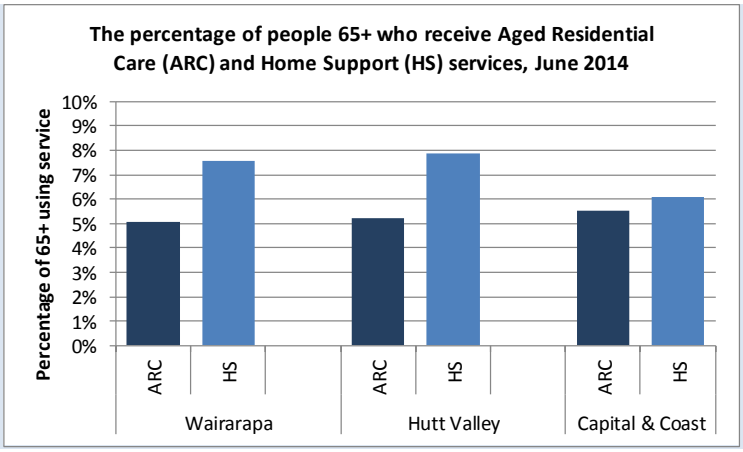
- 2% of the population in the Wairarapa
- 9% in Hutt Valley
- 11% in Capital & Coast
- It is the fastest growing ethnic population, and is expected to increase 50% by 2033. The greatest proportion of Asians is in the 25-35 year age group, and has a greater proportion of children and young people (15-24 years).



The sub-region's ageing population presents a significant challenge to our health system. Wairarapa has one of the highest concentrations of people aged over 75 of any DHB (19% of its population). Hutt Valley has a large population of over 15 year olds (20%); and Capital & Coast is characterised by a large population of working-age adults, 50% of the population are aged 25-64 years. By 2033 we anticipate that at least 20% of the sub-regional population will be aged over 65, and the population over 85 will have doubled, at the same time the number of children and young people will decline. We need to plan ahead for this older population because as people age, they develop more complicated health needs and multiple health conditions; they will continue to consume more of our increasingly pressured health resources which in turn stretch our workforce, capacity, and finances.

Many long-term conditions become more common with age, including heart disease, stroke, cancer, respiratory disease, and dementia. In 2013/14, hospital discharges for people aged over 65 made up 29% (23,074) of all

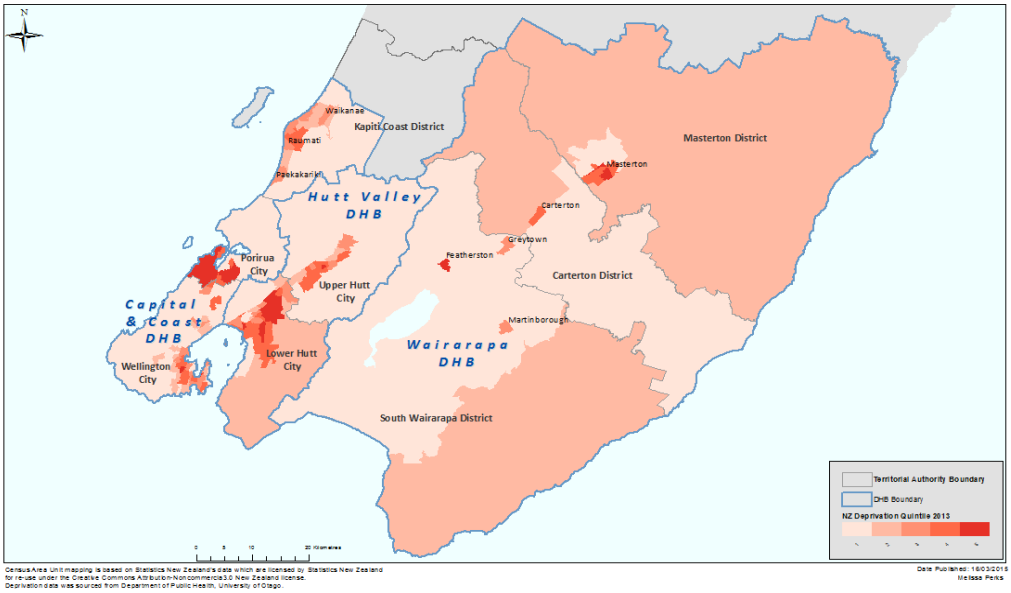
discharges for people living in the sub-region[5]; discharges for residents aged over 65 made up 36% of discharges (2,951) in Wairarapa, 28% (7,241) in Hutt Valley, 29% (12,882) in Capital & Coast. Older people also stayed longer in hospital than younger people, with an average of 3.7 days. Although the number of older people is increasing, most people are staying healthy and active for longer. The goal of health services is to support older people, and especially frail elderly, to manage their long-term conditions and to remain independent for longer, and as people become frailer, ensure there are services to support them to stay safely at home. In 2013/14 the average age for people entering residential care was 83.



Our Health

Overall, most New Zealanders are now living longer than ever before, but some of these extra years are lived in poor health, particularly due to long-term conditions. There is a diversity of health needs in our society, with Māori, Pacific people, and people living in more deprived neighbourhoods having worse health outcomes. There are some positive trends in lifestyle factors that influence our health, including reduced adult and youth daily smoking rates, and reduced hazardous drinking rates among young adults. However, obesity rates continue to worsen; an estimated 1.2 million New Zealand children and adults are obese.

Social and material factors, such as housing, employment, transport, communication, support, education, and income, contribute greatly to a person's health. The New Zealand Index of Deprivation is a summary measure of neighbourhood socioeconomic deprivation, from 1 to 10 – 1 for the least deprived 10% of areas, and 10 for the most deprived 10%; it has been shown to be strongly correlated with smoking prevalence, mortality rates, and infant hospitalisation rates[6].

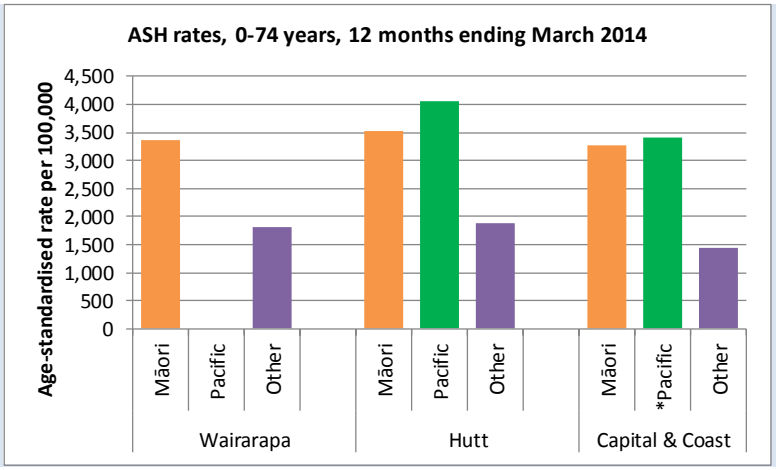


[5] Acute and elective casemix discharges from any hospital including births and excluding ED >3 hours and ATR discharges
* Unavailable as population is too small to calculate a reliable rate
[6] 2015: Health Needs Assessment. Service Integration & Development Unit. http://www.ccdhb.org.nz/

Although Wellington city has one of the least deprived populations in the country, across the sub-region there are pockets of significant deprivation in parts of Porirua, Naenae, Taita, Wainuiomata, and Masterton. Māori and Pacific are more likely to live in deprived areas than other ethnicities (29% of Māori and ~50% of Pacific live in the most deprived quintile across the three districts). Intersectoral work has a key part to play in addressing the impact of deprivation (see Module 2, 2.2.1, 2.2.5, 2.2.10; and Regional Public Health Annual Plan[7]).

Demand for secondary care services can be impacted by many health conditions for which earlier identification and treatment can prevent hospital admissions. The sub-region's leading causes of these types of admissions (called Ambulatory Sensitive Hospitalisations - **ASH**) are cellulitis, dental conditions, gastroenteritis, angina and chest pain, and pneumonia. We aim to reduce these 'potentially avoidable' ASH admissions, and thereby reduce hospital demand, through a variety of primary care initiatives and our two Social Sector Trials.

Hutt Valley DHB has higher than national ASH rates, while Capital & Coast DHB is slightly lower, and Wairarapa DHB is very close to the national level. ASH rates for Māori and Pacific across the sub-region are twice that of 'other' ethnic groups, therefore ASH is a key Māori Health Indicator[8].



Although ASH provides a useful measure of potentially avoidable admissions, it excludes people aged over 75 and only accounts for 17% of all acute admissions. While the rate of ASH admissions has decreased slightly over the last five years, the overall volume of acute admissions has grown, particularly for Capital & Coast (6% per year on average) and Hutt Valley (3% per year).

Much of this is driven by population growth and ageing, however there is an underlying increase in acute admission rates for some groups such as people aged over 75 years in Hutt Valley. Older people also have longer lengths of stay than younger people: 3.5 days for people in Wairarapa, 4.4 days for Hutt Valley and 3.9 days for Capital & Coast, compared to around 2.5 days for people aged under-75 years; people identified as having significant disabilities spend a minimum of three days in both Capital & Coast and Hutt Valley.

Acute admissions are the most significant source of pressure on hospital resources; we are pursuing opportunities to provide acute care in alternative community settings and to reduce overall length of stay by improving patient pathways. Many acute hospital admissions are due to exacerbated or poorly-managed long-term conditions including cardiovascular disease (CVD) and tobacco-related illness: CVD risk assessment and smoking cessation are two of our key Māori Health Indicators. Nationally there is also an acknowledgement that the health outcomes for people with intellectual disabilities are poor in comparison to the rest of the population, irrespective of ethnicity, and this population group are also more likely to die prematurely.

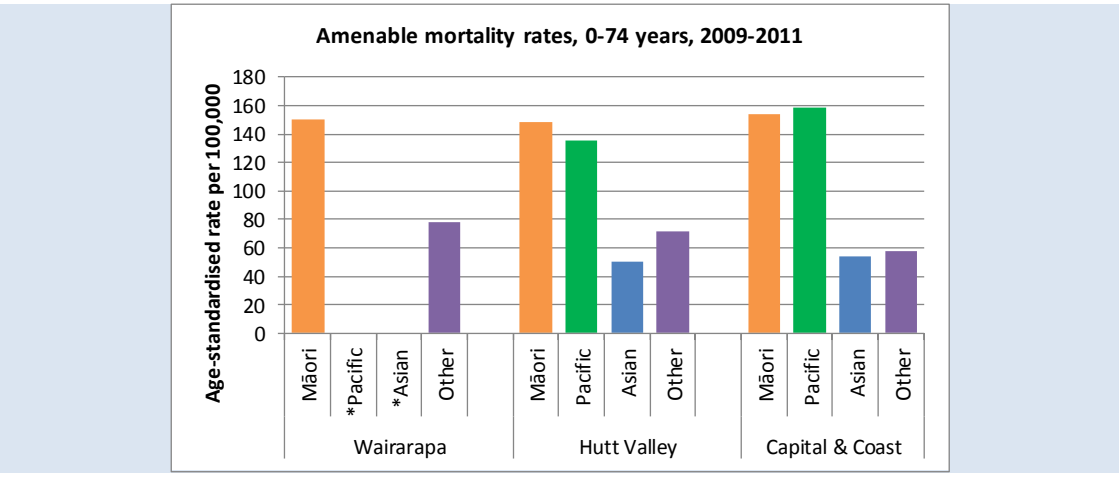
Demand for acute hospital services has increased in Hutt Valley and Capital & Coast DHBs. From 2010 to 2015 the Emergency Department (ED) attendance rate for Wairarapa residents has declined (24%) while attendances to Hutt Valley and Capital & Coast have increased by around 20% (compared to a five % increase nationally). Acute demand rates are highest amongst older adults and young children and growth has been fastest amongst children. Māori and Pacific people have higher rates than people of Asian or other ethnicity.

[7] http://www.rph.org.nz/
[8] Māori Health Indicators, national indicators as described by Ministry of Health for Māori Health Plans 2015/16: these are priority health issues for Māori at a national level.

Gout is the most common inflammatory arthritis; it affects around 4% of the adult population; in elderly Māori and Pacific Islanders the prevalence is over 25%; this is also a significant health issue for Māori males. The development of gout is strongly influenced by hereditary factors and is associated with the metabolic syndrome, renal impairment, diabetes and heart disease. Gout is a curable condition that needs urgent attention, as despite effective treatment being available, a large number of patients continue to suffer attacks of gout severe enough to require hospital admission.

Amenable mortality is one of the ways that we measure the current health of our population, and the quality and coverage of health services that they are receiving. Amenable mortality is defined as premature deaths from conditions that were potentially avoidable through good health care; 'premature' is defined as death under 75 years.

Differences in amenable mortality rates for different population groups reflect variation in the coverage of services across the population and the quality of health care. We can use amenable mortality to investigate the effect that unequal access and quality of care has on social inequity. While amenable mortality rates have declined in the sub-region since 2002 and are similar to the national average, ethnic inequalities are glaring; Māori and Pacific rates in all three DHBs are more than twice that of 'other' ethnic groups. Addressing amenable mortality rates is a key area in our Māori Health Plan (see Appendix 2 for summary).

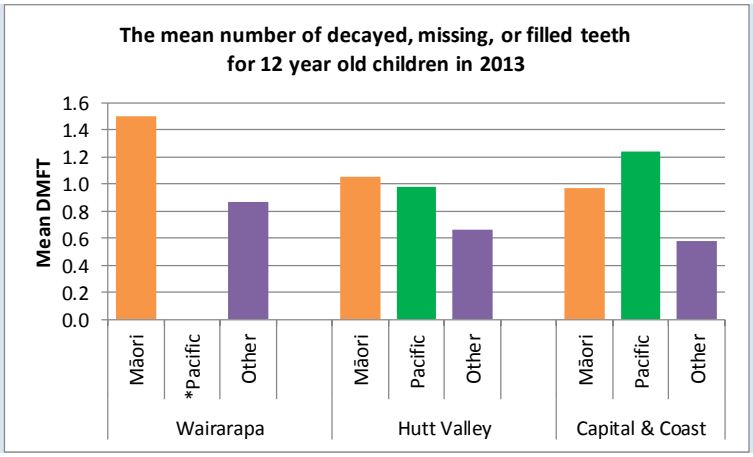


Amenable mortality rates measure deaths from diseases that should be preventable given effective and timely healthcare. Avoidable hospital admissions provide a broad measure of the accessibility and quality of primary care provision. Both indicators show marked and persistent ethnic disparities. There is evidence of barriers to accessing health care for Māori and Pacific people and those on low incomes.

Key health issues impacting on amenable mortality include obesity, smoking, cardiovascular disease, and diabetes and related illnesses. These issues can be associated with unhealthy lifestyles and environments and poor health literacy, and contributed to by inadequate nutrition, stress, and lack of appropriate physical activity. The leading causes of death in our sub-region are mostly related to long term conditions: cardiovascular diseases (37%), cancer (30%), and respiratory conditions (9%); diabetes is an underlying factor for many cardiovascular diseases and prevalence is rapidly increasing.

The current level of amenable mortality can be thought of as potential for population health gain through improvements in the health system. Amenable mortality cannot realistically be eliminated; however, by definition over nearly a third of these deaths should not have occurred, given access to currently available health technologies and interventions. From an equity perspective it is possible to use amenable mortality to ask what contribution to social inequality in health is currently being made by inequality in access to and quality of health care.

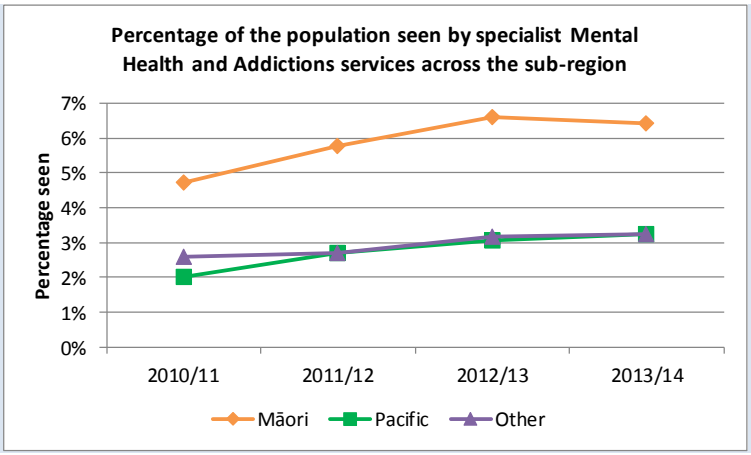
Child health is a focus area for our DHBs because although some good gains have been made in areas such as immunisation, more work is required to improve health outcomes, especially for vulnerable children. Ante-natal smoking rates are high amongst Māori mothers, and breastfeeding rates remain comparatively low for Māori and Pacific infants. Pre-school aged children have the highest ASH rates compared to other age-groups.



Dental conditions are the top cause of avoidable admission for children, which accounts for 24% of ASH in the sub-region. Children's oral health is a particular issue for Hutt Valley and Capital & Coast DHBs, which have higher admission rates than national; additionally, all three DHBs have persistent ethnic inequalities in oral health indicators such as 'decayed, missing or filled teeth', and 'caries-free' (Module 7). This health issue is represented in the Māori Health Indicators, and our Māori Health Plan.

Despite notable overall improvements in oral health over the last half century, tooth decay also remains a significant chronic disease in adults, with consequences including pain, infection, impaired chewing ability (and subsequent nutritional deficiencies), and tooth loss. Tooth decay is an irreversible disease, if untreated it is cumulative through the lifespan; children with tooth decay tend to have pervasive decay by adulthood, and are likely to suffer extensive tooth loss later in life. Māori are 1.6 times more likely to have had teeth removed due to poorer oral health.

Early access to health advice, information, and oral health service can improve outcomes for children. Sub-regionally, the oral health clinical care of our children is attended to by the 'Bee Healthy Regional Dental Service', a community-based dental service for all children aged under-18 years that examines around 43,000 children per year. We continue to work towards improving oral health outcomes through promoting early access to services, oral health and nutrition education, timely treatment, and more engagement with communities. See Modules 3 and 7 for our outputs and measures around oral health.



Good mental health is an essential part of a person's overall health and well-being, unfortunately mental illness remains one of the leading causes of disability throughout in this country. Effects are most often of a relatively mild and short-term nature, but if left untreated an illness can become more serious with significant long-term impacts on a person's life. In 2013/14 a total of 17,781 people (3.7% of the sub-region population), were seen for severe conditions by DHB or NGO providers of secondary mental health and addiction (MH&A) services.

The NZ Mental Health Survey[9] estimates that in our sub-region, 60,000 adults aged 16 years or over (15%) will experience MH&A issues during the 2015/16 year. This estimate takes into account factors such as age, ethnicity and deprivation. The disproportionately high percentage of Māori using specialist MH&A services in the three DHBs reflects the particularly high and complex needs of this population.

Suicide and suicidal behaviours continue to be a major public health issue in New Zealand. Every year more than 500 New Zealanders take their lives and there are over 2,500 admissions to hospital for serious self-harm. Suicide prevention in New Zealand is guided by the New Zealand Suicide Prevention Strategy 2006–2016 and the New Zealand Suicide Prevention Action Plan 2013–2016. The local quantitative impact of death by suicide is shown in the table below, the qualitative impact is significant yet difficult to measure.

Suicide age-standardised deaths, by DHB, for the period 2008 to 2012[10]

DHB	Total rate[11]	Youth rate[12]
Capital & Coast	7.8	12.2
Hutt Valley	10.8	18.6
Wairarapa	20.0	38.9
National	11.6	19.8

Our sub-region funds and delivers a range of mental health and addiction services that support people to recover and live well in the presence of their illness; including services focusing on suicide prevention and post-vention. Our services work in partnership with individuals and their whānau to maintain their health and independence, providing initiatives that promote mental health, identify issues, and intervene as early possible in the life-course. Services also work to build resilience within our communities over time, so that adverse outcomes later on in life are be reduced or avoided altogether.

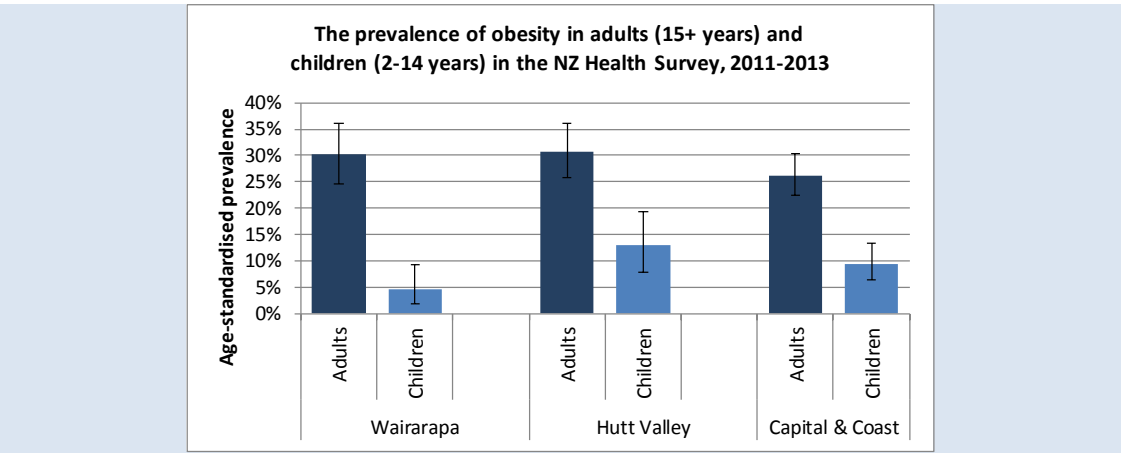
In 2014 a consultation began on a proposal to integrate DHB Mental Health, Addictions, and Intellectual Disability (MHAID) Services across the three DHBs. The new single sub-regional structure for inpatient and community services has been in place since early 2015 (see 1.3.3.1 for expected outcomes).

Risk Factors

A risk factor is anything that increases the probability of a disease or injury occurring. To prevent diseases and injuries it is important to understand the risks to health. Lifestyle factors have a significant impact on overall health and well-being and are key contributors to cancer, cardiovascular disease and diabetes, which are major causes of death and poor health in our population. The Ministry of Health has estimated the burden of disease across New Zealand; four lifestyle factors have a major impact: smoking (9.1% of health loss), obesity (7.9%), physical inactivity (4.2%) and poor diet (3.3%). Major physiological risk factors include high blood pressure (6.4% of health loss) and high blood cholesterol (3.2%); the key finding was the change in ranking from tobacco to obesity as the leading risk factor cause of health loss by 2016.

Obesity prevalence is one of our most significant non-communicable diseases (NCD) and a leading cause of health loss, causing early death, illness, and disability[13]; three groups of NCD - CVD, cancer, mental disorders account for 46% of all health loss in NZ[14]. In 2012 New Zealand adults ranked third highest out of 15 OECD countries for measures of obesity; in 2010 New Zealand children (aged 5–17 years) ranked third highest out of 40 countries for overweight (including obesity)[15]. It is projected that excessive body weight will overtake tobacco use as the leading risk to health in the near future, making obesity a significant issue for New Zealand.

[9] Te Rau Hinengaro 2006
[10] New Zealand Mortality Collection
[11] per 100,000 population and age-standardised to the WHO World Standard population
[12] per 100,000 population, age-specific
[13] Murray, CJL.,Vos T., Lozano R., et al., 2012. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 380: 2197-223.
[14] Ministry of Health. 2013. Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016. Wellington: Ministry of Health.
[15] Ministry of Health. 2015. Understanding Excess Body Weight: New Zealand Health Survey. Wellington: Ministry of Health



The New Zealand Health Survey 2011-13 estimated that 28% of adults aged 15+ years and 10% of children aged 2-14 years in the sub-region were obese. These rates were not significantly different from the New Zealand average. National estimates demonstrate the ethnic differences and social gradient associated with obesity[16]; obesity prevalence was 1.7 times higher for Māori adults compared to non-Māori and 2.5 times higher for Pacific compared to non-Pacific; adults living in the most deprived areas were 1.5 times more likely to be obese than those living in the least deprived areas. These ethnic and socioeconomic disparities in obesity were greater amongst children, with Māori twice as likely as non-Māori, and Pacific three times more likely than non-Pacific, to be obese. Children living in the most deprived areas were three times more likely to be obese than those living in the least deprived areas.

Good food choices and opportunities for physical activity is imperative - Peter Gluckman recently stated in a World Health Organization report on ending childhood obesity "There is an understandable tendency to see obesity as a problem for the health sector, but preventing childhood obesity demands the coordinated contributions of government ministries and institutions responsible for policies on education, food, agriculture, commerce and industry, finance/revenue, sport and recreation, media and communication, environmental and urban planning, transport and social affairs"[17]. The Child Obesity and Type 2 Diabetes Prevention Network (CODPN) was formed in 2012 out of concern for the high prevalence of obesity and increasing incidence of type 2 diabetes locally, and need to better of co-ordinate individuals and organisations undertaking relevant activities (Module 5).

Eating plenty of vegetables and fruit can help protect against major diseases like heart disease, stroke, high blood pressure and some cancers. Ministry of Health nutrition guidelines recommend eating at least three servings of vegetables and at least two servings of fruit per day for good health. Nationally, Māori adults had similar levels to non-Māori adults for being physically active (53%); however, Māori adults were less likely to eat at least three servings of vegetables (62%) or at least two servings of fruit (49%) each day than non-Māori[18].

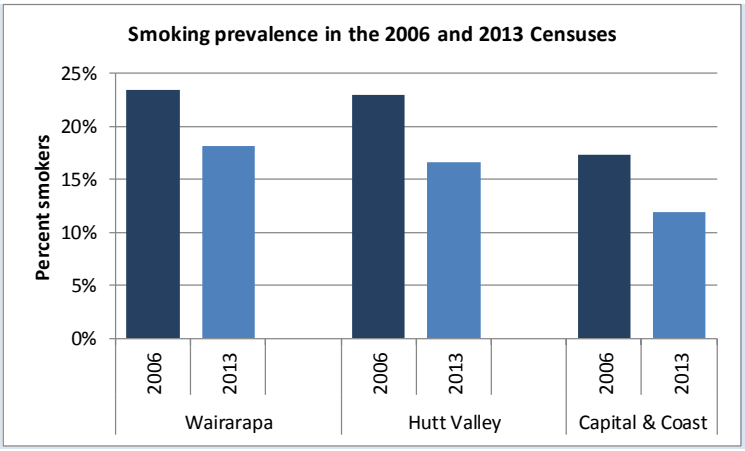
Across the DHBs, we have been supporting primary care to provide education programmes on healthy food and exercise for people with long-term conditions; the primary school curriculum carries a strong emphasis on health eating and exercise and sport; and the B4 School Check programme identifies children at risk regarding weight. Healthy Families NZ is a new initiative that aims to improve people's health 'where they live, learn, work, and play' in order to prevent chronic disease including obesity; the most visible aspect of Healthy Families NZ is the establishment of 10 Healthy Families communities across New Zealand; in our sub-region this is based at Hutt Valley (see Module 2, 2.2.6).

Policy and environmental change have been identified as the foundation of obesity prevention in an environment that promotes eating too much and moving to little. Our Regional Public Health service is supporting City Council work in prioritising cycle ways and pedestrian walkways, to create an environment that supports easy access to healthy affordable food in communities, including fruit and vegetable co-operatives, community gardens and markets, opportunities for cooking and nutrition literacy, food policy for council owned facilities and events (and DHBs), implementing good urban design principles and reviewing food retail zoning conditions. Regional Public Health supports delivery of health promotion and prevention work on behalf of the sub-regional DHBs.

[16] Obesity rates by ethnicity unavailable at a sub-regional level due to small sample size.
[17] WHO interim report of the commission on ending childhood obesity. World Health Organization 2015, p.23 http://www.who.int/end-childhood-obesity/commission-ending-childhood-obesity-interim-report.pdf
[18] The Health of Māori Adults and Children 2011–2013, Ministry of Health, June 2014.

The health outcomes associated with smoking places significant burden on the health system. While the proportion of regular smokers dropped substantially in all three DHBs between 2006 and 2013 censuses, rates in Wairarapa (18%) and Hutt Valley (17%) are still higher than national levels (15%). Nationally, daily smoking rates remain high for Māori adults (36%) and adults living in the most deprived areas (28%). If this trend continues, inequities in smoking and related diseases will increase. We are committed to achieving the Government's goal that New Zealand will be Smokefree by 2025; to achieve this we are working with our Alliance Leadership Teams and Māori providers to encourage and support clinical leadership in general practice to achieve the health target which will lead to more people supported to quit, and more quit attempts.

Our Tobacco Control Plan was updated in early 2015, and will deliver a range of clinical training and health promotion initiatives that support and enable the health targets to be met; achievement against which is reported six-monthly to the Ministry (see Module 2, 2.2.12 for actions; and Module 3 for related outputs).



Health impacts of alcohol include disease and injuries; hazardous drinking is defined as behaviour that results in a score of 8 points or more on the Alcohol Use Disorders Identification Test. 'Hazardous drinking' refers to an established drinking pattern that carries a risk of harming the drinker's physical or mental health, or having harmful social effects on the drinker or others. The 2012-13 health survey identified that 19% (1 in 5) adults in the sub-region drink alcohol to a level that is hazardous to their health; similar to the national average (17%): 14% in Hutt Valley DHB, 20% in Wairarapa and Capital & Coast DHBs.

High blood pressure (also called hypertension) can damage the heart and kidneys and can also lead to ischaemic heart disease, stroke, and kidney (renal) failure. Prevalence of high blood pressure (medicated) is similar amongst adults in Wairarapa (12.3%), Hutt Valley (12.6%) and Capital & Coast (11.2%) and comparable to the national average (11.7%). High blood pressure rates increased steeply with age; nearly half of adults aged 65 years and over are affected.

Prevalence of high blood cholesterol (medicated) amongst adults in Wairarapa (9.3%) and Hutt Valley (8.5%) has not been significantly different to the national average (8.0%). Adults in Capital & Coast DHB are significantly less likely to have high blood cholesterol (medicated) than the average for New Zealand. The rate of high cholesterol increases steeply with age, with nearly a third of adults 65+ years affected.

1.2.1.3 Internal and external factors affecting our performance

Clinical factors

1. **Frail elderly** – Demographic factors that affect health spending include population growth and the age distribution of the population. New Zealand's population is ageing as a greater proportion gradually shifting into the older age groups. Population ageing affects health spending, since older people tend to need more health care. Although this ageing effect will become progressively more important through the 2020s and 2030s, it is not usually projected to become the dominant driver of future spending growth.
2. **Acute demand** – on-going increases in acute demand for a wide range of services including acute hospital care, with still only emerging evidence on effective ways to reduce the growth; we have an opportunity to invest in pilots of health care home model of care, with monitoring and evaluation of performance
3. Health outcome disparity – areas of growing disparity are also increasing demand on services; significant contributors to health inequity are long-term conditions, smoking

4. Population profile – relative ageing of the population, obesity and related diseases, long-term conditions and related complex discharges, increasingly younger patients and the challenge of appropriate funding fit.
5. Growing public expectations of the health system – access to and quality of services

Financial factors

We continue to operate in a national environment where financial restraint is driving improvements in efficiency and waste reduction; however we must take care that the health and safety of our patients and consumers is not adversely affected by decisions we make to live within our budgets. In order to grow our services in the areas of need we must continue to review resource allocation and utilisation across our entire system.

Factors affecting health spending include: demographic demand growth (mainly population ageing), non-demographic demand; growth (income and technology-driven demand), and rising costs due to low productivity growth relative to the rest of the economy (typical for labour-intensive sectors like healthcare).

1. Publicly-funded **spending** on health care has more than doubled as a share of GDP over the past 60 years, rising from around 3% in 1950 to 7% in 2010. The main drivers of health spending will continue to be **income growth** and **technological** change - both of which affect the demand for, and the cost of supplying, health care
2. Economy-wide productivity growth drives incomes, and therefore the cost of **workforce** - the major input into health-care services
3. **technology** progressively extends the range of possible treatment options; new treatments provide real benefits to patients but tend to involve new spending with relatively high costs; although technological innovation may lead to a decline in the cost of a service, overall spending can rise if the use of the service increases
6. Wairarapa management **structure** – with the Hutt Valley and Wairarapa Boards agreeing to two separate Chief Executives from mid-2015, Wairarapa DHB will face some additional costs
7. **Laboratory services** - opportunity to release significant savings for new initiatives and to relieve financial pressures in other parts of the system. A specific risk at Hutt that a good proportion of these potential savings may not be realised if the current model of delivery is retained there.

Overall, the success of New Zealand's public health system should be measured in terms of the health outcomes it delivers for New Zealanders, rather than how much new money is invested each year or how many new procedures are performed.[19] At both sub-regional and individual levels we are focussing our efforts on the financial viability of our services and clinical quality and sustainability; which are equally essential for improving the health outcomes of our populations' health and wellbeing indicators, and short term impacts.

1.2.1.4 Our health system risks and opportunities

Key risks and opportunities identified for patient /population outcomes and for our health system performance include:

1. At capacity for Cardiac Surgery; will require a step cost investment to meet higher volumes
2. At capacity for MRI; will require step cost investment with agile transition to increase MRI machine capacity
3. Integration opportunities
    a. primary care and secondary services – seamless journeys and patient pathways
    b. sub-regional integration of appropriate services across the three neighbouring DHBs; necessary for financial and clinical safety reasons, and for providing the best service for the people of the three districts
4. Workforce capacity and capability - insufficient for growing demand in some areas (e.g. Sonography) Shortages in health care workforce is a threat to our ability to deliver services that are timely and safe
5. MECA settlements above funding increase parameters
6. Health and Safety bill additional costs impact
7. National work programmes with cost pressures on DHBs
8. Barriers to moving focus of activity from hospital to community settings to support policy direction and necessary shift in models of care, e.g. doesn't necessary make up-front savings (sunk costs in hospitals), resistance from some unions and professional groups to changes in where and how care is delivered

[19] The Treasury 2014 Briefings to Incoming Ministers Information Release. Release Document November 2014, Updated May 2015 www.treasury.govt.nz/publications/briefings

9. Constrained ability to invest in infrastructure improvements and capital investments

1.2.2 Nature and Scope of Functions

Our DHB is governed by a Board consisting of eleven members who are accountable to the Minister of Health and the public; it is a mix of members elected by the public and appointed by the Minister; the Boards' sole employee is the Chief Executive of the DHB. In early 2015 the Hutt Valley Board with Wairarapa Board decided to appoint Chief Executives dedicated to each DHB. Wairarapa, Hutt Valley, and Capital &Coast DHBs confirmed their intent to work collaboratively together on integrating practices and policies where appropriate.

The structure of our DHB is based on the DHBs three key roles: planning, funding, and providing health and disability services to our communities, as set out in the New Zealand Public Health and Disability Act 2000. The Māori Health Directorate also spans planning and funding functions, and workforce development, across Māori and DHB providers, and is overseen by Māori Governance. We have a sub-regional joint Community and Public Health Advisory Committee (CPHAC)/Disability Services Advisory Committee (DSAC). In addition to this joint committee, each Board operates a committee focussed on finance, risk, and audit (FRAC), and there are two Hospital Advisory Committees (HAC) – for Wairarapa/Hutt Valley and Capital & Coast. Each DHB each has Māori Advisory/Relationship group, and sub-regionally a Pacific Health Collective. Our Sub-Regional Disability Support Advisory Committee ensures people with disabilities have a forum to enable their voices to be heard.

Capital & Coast DHB hospital services are delivered via the Wellington Regional Hospital, a secondary and community facility at Kenepuru (Porirua), a Forensic, Rehabilitation, and Intellectual Disability Hospital at Ratonga Rua-o-Porirua, and Kapiti Community Hospital.

1.2.2.1 We Plan

Our DHB plans the strategic direction of the local and sub-regional health system, in partnership with our Alliance Leadership Teams, clinical leaders, regional DHBs, National Health Board, service providers, and our communities; this informs how we spend the funding provided from the Government to ensure the health of our population. We assess our populations health needs at regular intervals and determine what the optimum mix of services will be with the funding available to us.

1.2.2.2 We Provide

We own and deliver a wide range of health and wellbeing, hospital and specialist services, for our local population. In addition, services are provided for our sub-regional and regional neighbours, for example: Wairarapa DHB provides ophthalmology and urology services, Capital & Coast DHB provides ophthalmology and urology services for Capital & Coast and Hutt Valley, and Capital & Coast DHB provides regional cardiothoracic, neurosurgery, and vascular surgery; Hutt Valley DHB provides regional plastic surgery and rheumatology services; and the sub-regional Mental Health and Additions service provides a regional forensics service and rehabilitation programme, and nationally provides Intellectual Disability Care Agency, and ID offender inpatient unit.

1.2.2.3 We Fund

In addition to our own DHBs hospital and community providers, services across the sub-region include: five Primary Health Organisations (PHOs)[20] who support a primary care provider network of 91 general practices; 100 community pharmacies; 67 age-related residential care providers; five home-based support service providers; 25 contracted dentists in Hutt Valley, eight in Wairarapa, and 41 in Capital & Coast; two hospices; two hospital and private community radiology/imaging services, a community laboratory (Wairarapa also providing a service); 36 mental health providers, and around 10 Māori health providers. Our sub-regional Service Integration and Development Unit (SIDU) manages 700 contracts and service agreements across our health system. All of these healthcare and support care providers are dispersed geographically across the three DHBs to provide care 'closer to home'. The Wairarapa DHB funds population health services provided in the Wairarapa district.

[20] Te Awakairangi Health Network – covers all of Hutt Valley; Cosine Primary Care Network – includes Karori Medical Centre in Capital & Coast DHB and Ropata Medical Centre in Lower Hutt; Ora Toa – Capital & Coast DHB (practices in Porirua & Newtown); Well Health Trust – Capital & Coast DHB (practices in Porirua, Newtown & Wellington youth health service); Compass Health – covers all of Capital & Coast DHB, as well as Wairarapa.

Under the NZPHD Act, 'service agreement' means an agreement under which DHBs agree to provide money to a person in return for the person providing services or arranging for the provision of services. A DHB may, if permitted to do so by a Plan prepared under section 38 of the Act, negotiate and enter into service agreements containing any terms and conditions that may be agreed; and negotiate and enter into agreements to amend service agreements.

The costs of providing services to people living outside of our district are met by the DHB of the patient and are referred to as Inter-District Flows (IDFs). Where we do not provide the service we have funding arrangements in place with other DHBs enabling our districts residents to receive that service outside the district. We also deliver against service delivery contracts with external funders, such as the Accident Compensation Commission (ACC). We continually monitor IDFs and ACC volumes to ensure our ability to provide for our local population is not adversely affected by demand from outside the district. The Ministry of Health and National Health Board also have a role in the planning and funding of services such as mental health and addictions; some services are funded and contracted nationally, for example public health services, breast and cervical screening, as well as the provision of disability support services for people aged less than 65 years.

1.2.2.4 We Promote and Protect

The Regional Public Health unit (RPH) ensures our sub-regional population's health through health promotion, health protection, and evidence-based public health initiatives. The unit is one of twelve public health units in New Zealand and provides services as per the Ministry of Health's service specifications for public health services and contractual agreements with Wairarapa, Hutt Valley and Capital & Coast DHBs, and the College of Public Health Medicine. Regional Public Health ensures statutory responsibilities are met as specified by the Ministry of Health. The Wairarapa DHB shares in the employment of RPH staff.

This plan aligns to the three DHBs' annual plans and Māori health plans, and the Central Regional Services Plan. It describes public health services provided by RPH and funded by the Ministry of Health; RPH's vision is to achieve 'better health for the greater Wellington region' by focusing on communities and the environment, rather than at the individual level. A multidisciplinary workforce at RPH undertakes all five of the core public health functions for New Zealand: Health assessment and surveillance; Public health capacity development; Health promotion; Health protection, and Preventive interventions. These functions are integrated into a population-based approach, meaning staff work within a variety of settings where people live, work, learn and play.

1.2.2.5 We Integrate

Our DHB plans, purchases, and monitors services sub-regionally through our SIDU, with each DHB Board maintaining oversight of its business in respect to services for their own communities. Our Board consists of eleven members; a mix of elected and appointed. We share a sub-regional joint Community and Public Health Advisory Committee (CPHAC)/Disability Services Advisory Committee (DSAC); the key mechanism whereby the work of SIDU, and the monitoring of progress across DHB integration and population health and disability related initiatives, takes place. In addition to this joint committee, each Board operates its own committee focussed on finance, risk and audit (FRAC); there are two Hospital Advisory Committees (HAC) – for Wairarapa/Hutt Valley and Capital & Coast (local HAC issues are discussed at each Board). Each DHB each has Māori Advisory/Relationship group, and sub-regionally share a Pacific Health Collective and a Sub-Regional Disability Support Advisory Committee.

In each DHB there is a local Alliance Leadership Team (ALT) that supports the primary/secondary integration work. At Wairarapa, the integration programme is known as Tihei Wairarapa, at Hutt Valley the group is Hutt INC (Hutt Integrated Network of Care), and Capital & Coast has the Integrated Care Collaborative (ICC). See 1.3.3.1 for areas of DHB sub-regional integration and 1.3.3.2 for areas where we integrate with our primary care partners; 2.2.17 describes actions supporting primary care integration.

We recognise that clinical leadership is a critical success factor in sustainable health service development including integration. To this end we support clinically meaningful improvement projects in which clinicians lead change, working alongside managers, with the focus on achieving best care for patients; we endeavour to make sure that clinicians have access to all the relevant data, and are supported to create solutions; we enable robust dialogue to develop plans that meet competing requirements; embed joint responsibility for costs and outcomes; allow time invested in planning with all stakeholders from the outset; provide senior management and board support; continue to develop trust, respect, and greater mutual understanding of the factors that drive clinical quality and costs.

1.3 STRATEGIC INTENTIONS AND OUTCOMES

1.3.1 National Outcomes

New Zealanders have health outcomes comparable with those of people in other developed economies. Life expectancy is around the OECD average and has risen steadily over the last 50 years in line with international trends. Infant mortality rates have declined over time, but more slowly than in other OECD countries and New Zealand's performance on this measure is now slightly below the OECD average. These indicators reflect economic and social conditions as well as the characteristics and effectiveness of the health system.

New Zealand also performs well by international standards against some important measures of quality of our healthcare. For example, in-hospital mortality rates have decreased steadily over the last decade and are now amongst the best in the OECD, and admission rates for uncontrolled diabetes are around the OECD average despite our higher prevalence rates for this disease. We do less well against some other indicators of performance, with relatively high levels of hospital admissions for asthma and chronic obstructive pulmonary disease (lung disease), and there are clear, persistent, disparities nationally in health outcomes and access to care for particular population groups.

The Ministry of Health has three high-level outcomes that support the achievement of health system outcomes:

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

1.3.1.1 Letter of Expectations from the Minister of Health

The Minister of Health's letter for DHBs and subsidiary entities, received December 2014, sets the expectations for the road map of this Annual Plan and focus areas for activity. The specific areas all DHBs will be addressing for 2015/16 are:

1. Living Within our Means
   a. Budgeting and operating within our allocated funding
   b. Make improvements in purchasing, productivity, and quality of services
2. Clinical Leadership
   a. Ensuring this is utilised in all aspects of DHB business, budgeting, and service design
3. Primary-Secondary Care Integration
   a. Move more services closer to home
   b. Promote earlier intervention and population-based initiatives
   c. Meet the National Health Targets, focussing on improving cancer services, and boosting elective surgeries to target orthopaedic and general
4. Morbidity
   a. Reinforce DHBs role in helping reduce incidence of obesity through cross-agency work with education, social, and justice sectors.
   b. Support and align with Regional Public Health initiatives.

These national expectations are important to our local populations, and have been covered off through our intentions and actions in Module 2, as described for each of the priority areas and Health Targets, and in Module 5, which lays the foundation for a robust organisation which can deliver on our intentions and national and local expectations. Module 4 describes our financial management expectations. These areas to be addressed in 2015/16 also impact on longer term planning and system needs; in 2015/16 we are developing a Health System Plan which will take these areas into account (see 1.3.3.2)

1.3.1.2 System Integration - Better Sooner More Convenient Services

Demands on healthcare are changing, with chronic, long-term conditions increasingly important as sources of ill health. In order to meet this change, the system needs to rebalance towards primary and community-based care, which in turn means good access to, and seamless and integrated care between, these settings is required. Our vision is for an integrated health system with consumers at the centre, where care is delivered closer to home by trusted, motivated health professionals working together. To enable this we need to develop our workforce capacity and skills, composition and flexibility, ensure technology is an enabler not a barrier, and manage funding across the system better. We acknowledge that all parts, and people, of our health system need to jointly develop and implement integrated services; we are working with primary care, NGOs, the community, and other sectors to progress this.

Services may need to be shifted to enable services to be more convenient. Shifting services will be varied based on local need, context and scalability - ranging from co-locating outpatient clinics into the community, through to the redesign of service structures, resourcing and facilities. Our local actions supporting this are detailed in section 2.2.17 – Primary care and Integration.

Effective integration requires us to think in a 'whole of system' context. While whole of system thinking is not a new concept to our local health system, we are growing our commitment (and expected deliverables) to a more effective system integration (see 1.3.3.2). This is demonstrated in the strategic direction and planned activities of our DHB; priority areas important in integrating the health system include (see details in Module 2):

1. Diabetes Care Improvement Packages
2. Long-term Conditions
3. Stroke
4. Cardiac Services
5. Improved Access to Diagnostics
6. Integrating Services into the Community
7. Primary Care and the Integrated Performance and Incentive Framework (IPIF)
8. Health of Older People
9. Rising to the Challenge – Mental Health and Addictions
10. Maternal and Child Health
11. Cancer Services
12. Healthy Families NZ
13. Spinal Cord Impairment Action Plan

1.3.1.3 Better Public Services

A system that provides Better Public Services will see:

1. decreasing incidence of rheumatic fever
2. more responsive mental health services for youth
3. fully immunised children
4. early identification and support for vulnerable children.

Our actions supporting these are described in Module 2. Because factors affecting health are complex and interrelated, system integration work links into and overlaps with our Better Public Services initiatives of Reducing Rheumatic Fever, Children's Action Plan, Whānau Ora, and the Prime Minister's Youth Mental Health Project. Hutt Valley DHB is also supporting the Healthy Families NZ through Regional Public Health's partnership with Lower Hutt City Council, Wairarapa DHB is involved in delivering a Social Sector Trial, and Capital & Coast DHB has a Social Sector Trial based in Porirua.

1.3.1.4 Social Sector Trials

A corner stone to addressing morbidity is strong cross-sector relationships. Social Sector Trial (SST) initiatives involve education, health, justice, social development, and the New Zealand Police working together to change the way that social services are delivered[21]. The 16 SSTs nation-wide have been extended for 2015/16 and Government has signalled that during that time it will be making decisions to further enable community-led integrated social sector services beyond the end of the financial year. Across the sub-region we are supporting two trials, in Porirua and Wairarapa.

[21] see http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/social-sector-trials/

At Capital & Coast DHB the Porirua SST is a cross-agency partnership, between the DHB, PHO, and community agencies, designed to reduce the number of Ambulatory Sensitive Hospitalisations and Emergency Department attendances among Porirua residents aged 0 – 74. The SST's action plan has targeted four areas of activity - improved self-management, resilience and well-being; a well-start to life for children in Porirua; improved access to appropriate primary care in Porirua East and Titahi Bay; an aligned inter-agency response; and supportive environments for well-being. Practical steps have so far included tissues and hand sanitiser being distributed in local schools as part of an integrated campaign to reduce the number of untreated skin infection and upper respiratory infection cases requiring hospital treatment; ensuring all children are enrolled in dental and medical services to reduce the number of untreated dental conditions requiring hospital treatment; and, the simplification of key health messages to improve the health literacy of parents.

1.3.1.5 New Zealand Health Strategy Update and Associated Reviews

Early in 2015 the Ministry of Health started a process to update the New Zealand Health Strategy. The current Health Strategy was published in 2000; much has changed in our national environment in the last 15 years. The updated strategy will set a new vision and a road map for the next 3–5 years for the health sector. The strategy is being developed in conjunction with two external reviews: 1/ a review of health system funding, looking at the arrangements to support a high quality health sector that integrates with the social sector and is sustainable in the long term; 2/ a review of health system capability and capacity to help ensure an adaptable and responsive health and disability sector is developed that can deliver on the updated strategy. The objectives of these pieces of work are to provide:

- a unifying statement of the Government's direction for the health sector
- clear priority areas for the sector to focus their efforts on
- commitment and clarity for the public about what they can expect from their health services, and
- a foundation for a safer and more clinically and financially sustainable health sector.

1.3.1.6 National Issues

Demands on the health systems of developed countries are changing and growing, and New Zealand is no exception. Our health and disability system faces a number of pressures over the foreseeable future that will impact on the way that DHBs plan, fund, and deliver health services across the system.

Population Health systems like ours have evolved to deal best with life threatening conditions in hospitals, with specialist doctors playing the leading role in delivering care. However, about half of all health loss is now accounted for by non-fatal, disabling conditions, and this proportion is projected to increase; we continue to face the growing impact of long-term conditions such as diabetes and obesity, which is increasingly affecting the young population, and still impacts to a greater degree on Māori and Pacific people; these chronic conditions require sustained management over many years and most of this care will occur outside hospital, therefore, the system needs a rebalance towards primary and community-based care and patient self-management. Significant gains will be made by concentrating on people with poorer health outcomes or complex health needs and the greatest areas of disparity, including vulnerable children, frail elderly, people with long-term conditions, people with mental health and addiction problems, and people with disabilities.

Workforce The ageing and unevenly distributed workforce, which does not match anticipated future demand for health and disability services, requires a comprehensive national strategy to advance, and is being developed by Health Workforce New Zealand.

Technology We are seeing the evolution and availability of more expensive health care treatments and increasing treatment costs; the public expectations of services and treatments are also changing with high expectations the system; we need to better utilise digital technologies for improving and streamlining communications between providers and with consumers, and work on improving data collection, verification, and its application.

Information Health systems are complex organisations, with multiple stakeholders and accountability arrangements. Information is necessary for those relationships to function effectively. It is also needed to monitor quality of care, understand patient outcomes, and manage spending. A lack of robust data can lead to false assumptions and poor decision making. The Auditor General observed in 2013 that the quality and management of information across the health sector requires improvement; challenges to overcome include outdated patient management systems and a lack of connectedness between DHBs and the primary and private health sectors.

Access Some people continue to face barriers that make it hard for them to access primary care - an issue if we are looking to rebalance the health system towards primary/preventative care; barriers that prevent people from

accessing care can lead to poor outcomes for individuals and for the health system as a whole - people who do not receive timely treatment may face deterioration in their health status, alternatively, they may refer themselves to the emergency department, which is free and open 24 hours; in both cases, overall costs to the health system may increase. The problem is more pronounced for certain groups, with the New Zealand Health Survey showing that unmet need for primary care is greater for Māori and Pacific people and those on low incomes/most deprived areas are 1.4 times as likely to have unmet need than those living in the least deprived areas. Māori adults are the most likely to have unmet need for primary care (1.5 times more likely than non-Māori). We need to balance resources for primary and secondary care, including promoting wellness models; keeping people well will reduce the increasing demand for health services by the ageing population and those with long-term conditions; promoting Patient Portal and Manage My Health initiatives will help to reduce barriers to access

Financial sustainability With all these challenges we also have to maintain quality, safe, and sustainable services in the face of a constrained funding environment and a growing fiscal sustainability challenge. Health accounts for more than a fifth of government spending; a major investment of public money; it is essential that this limited resource delivers the best possible health outcomes for New Zealanders, this means having a very clear focus on maintaining the quality of services provided and the experience of patients, and ensuring that services are accessible to all population groups. There is scope to improve the way the system is organised and managed to achieve these goals.

1.3.1.6 New Zealand Strategic Priorities[22]

Government's cross-sector priorities

1. **Supporting Vulnerable Children**, including reducing rheumatic fever cases and assaults on children - A substantial reduction in rheumatic fever cases among children. Rheumatic fever primarily affects children and is a complication of a particular type of sore throat (caused by the Group A streptococcal bacteria). It is a preventable disease that can have serious consequences (such as the development of rheumatic heart disease) if not treated early. There are around 140 deaths from rheumatic heart disease in New Zealand each year. Rheumatic fever mainly affects Māori and Pacific peoples
2. **Increasing immunisation rates for infants** (also one of the six health targets) The challenge for 2015 is to ensure that 95 % of infants receive their three primary scheduled vaccinations by the time they are eight months old, and that this is maintained through to 30 June 2017
3. **Reducing the number of assaults on children** The Children's Action Plan is a living document that provides a framework for how health and social services and communities can change the lives of vulnerable children and their families. It includes a summary of required actions, and proposes a five-year timeline (to the end of 2017) that allocates periods to development and implementation. The Government's goal is that by 2017 we will have halted the 10-year rise in the number of children who have suffered physical abuse, and will have reduced current numbers by 5 %
4. **Social Sector Trials** The social sector trials are an innovation involving the Ministries of Social Development, Education, Health and Justice, and the New Zealand Police working together to change the way that social services are delivered, in order to improve social outcomes through community-based solutions. The trials are aimed at reducing youth offending, truancy and levels of alcohol and drug use, and increasing youth participation in education, training and employment.
5. **Youth Mental Health Project** The Ministry is leading the implementation of the Prime Minister's Youth Mental Health Project (YMHP). Launched in 2012, this four-year cross-agency project aims to improve the mental health and wellbeing of young people with, or at risk of developing, mild to moderate mental health issues. The YMHP comprises 26 initiatives designed to reach young people, not just through the health system, but also through their families and communities, their schools and the internet
6. **Health Targets** The health targets are a set of national performance measures specifically designed to improve the performance of key health services of particular concern to patients, in accordance with the Ministry's drive for clear and quantifiable results
7. **Whānau Ora** An innovative approach that supports whānau to identify and achieve their own aspirations. Te Puni Kōkiri is the lead agency for both phase one of this programme – which focuses on supporting Whānau Ora collectives to be more whānau-centred and whānau-driven – and phase two – which explores an approach to commissioning for Whānau outcomes. Te Puni Kōkiri supports commissioning through three entities: Pasifika Futures (focused on Pacific family outcomes), Te Pou Matakana (covering the North Island)

[22] Ministry of Health. 2015. *Statement of Intent 2015 to 2019: Ministry of Health*. Wellington: Ministry of Health

8. **National Drug Policy 2015-20** This new Policy sets out the Government's approach for minimising harm from drugs over the next five years. It also guides decision-making by local services, communities, and non-government organisations.

Health sector priorities

9. **Making core services more accessible**, including providing more services in communities. Central to achieving this is integrating primary care with other parts of the health services to better manage conditions.
10. **Maintaining wellness for longer** because New Zealanders are living longer and are likely to spend a period of their later years managing a long-term condition. Investment is needed to help people stay well and prevent onset of these conditions.
11. **Reduction of obesity**, with a focus on children, as excess body weight is one of the most important modifiable risk factors for a number of diseases, including type 2 diabetes, ischaemic heart disease, ischaemic stroke and common cancers. Any solution will require a multifaceted, cross-government approach, involving a range of interventions.
12. **Long-term conditions** constitute the largest health burden in New Zealand; many people suffer from several such conditions, and they disproportionately affect Māori and Pacific people. Diabetes is one of the most common LTCs, affecting an estimated 257,700 people in New Zealand. The Ministry's five-year Diabetes Plan will be implemented from 2015/16.
13. **Improve quality and safety** of health and disability services through a programme of work across the system. Findings of the review of the breakdown of care at Mid Staffordshire NHS Foundation Trust in the United Kingdom reinforced the importance of and need for an explicit focus on continuous quality improvement.
14. **Prioritise the wellbeing of older New Zealanders**, particularly as our population ages and needs change. This will be supported by providing people-centred health services that promote older people's independence and enable them to age in place for as long as possible
15. **'Rising to the Challenge: The Mental Health and Addiction Service Development Plan** 2012–2017' sets the direction for mental health and addiction service delivery across the health sector. The Plan outlines actions aimed at making service provision more consistent and to improve outcomes for people who use primary and specialist services and for their whānau.
16. **Making New Zealand essentially a smoke-free nation by 2025**, because smoking is the single leading preventable cause of health loss and causes up to 5000 premature deaths each year. The smoking rate remains high in some groups, particularly Māori.
17. **A new therapeutic products regulatory regime** to regulate therapeutic products in New Zealand, following the cessation of the Australia New Zealand Therapeutic Products Agency (ANZTPA) project.
18. **Making the best use of information technology** and ensuring the security of patients' records, because integrated IT solutions allow clinicians – and, increasingly, patients – to share health information and access it when and where they need it, to promote seamless care.
19. **Strengthen the health and disability workforce**. An appropriately trained, motivated, supported and flexible workforce is essential to provide high-quality and sustainable health and disability services. New Zealand has a highly mobile but ageing health and disability workforce. Rising demand in aged care, mental health and rehabilitation services means that the recruitment and retention of staff in these areas is a priority at a national level and for individual employers.
20. **Improve regional and national collaboration** to enable significant gains from DHBs working together in new and innovative ways. The Ministry has commissioned advice on how capability and capacity of the system can be lifted to improve its responsiveness and adaptability to meet future need and support regional and national collaboration. This advice will be reflected in the updated New Zealand Health Strategy.

Details of how our DHB is addressing these priorities are provided in Module 2 of this Annual Plan.

1.3.2 Regional Outcomes

The Central Region is one of the four 'regions' in New Zealand that is a collective of DHBs who work together on regional initiatives for the benefit of their regional population. The Central Region Regional Service plan (RSP) lays the foundation for collaboration between the six DHBs in the central region: Whanganui, MidCentral, Hawke's Bay, Wairarapa, Hutt Valley, and Capital & Coast[23]. The regions' population is 884,000: Capital & Coast District Health

[23] Central Region, Regional Health Services Plan - http://www.centraltas.co.nz/

Board comprises 34% of this, Hawkes Bay 18%, MidCentral 19%, Hutt Valley 17%, Whanganui, 7%, and Wairarapa 5%[24].

The region has 19% of New Zealand's population while it carries ~40% of the national budget deficit. The Central Region is slightly more urban and less rural than the other regions. Projections for growth by 2030 indicate this region will see the lowest growth rate of the four regions, more than half the growth will occur in the Capital & Coast District Health Board area with a 12% increase, Whanganui will decrease by 3%, the remaining DHBs will increase between 2% and 6%.

The RSP 2015/16 remains focused delivering contemporary best practice clinical services that have their roots in clinical and consumer input. Our regional vision is that there will be an integrated system of health service planning and delivery that will lead to on-going improvements in the sustainability, quality, and accessibility of health services.

1.3.2.1 Central Region's Vision and Strategic Direction

'Empowered self-care supported by a fit-for-purpose and interconnected regional network of accessible primary, secondary, and tertiary health care services. The right care for the right person for the right reasons in the right place at the right time'. We are progressing with the following strategy towards achieving this vision:

1. Consolidation - continued focus on key longer-term priorities while addressing emerging priorities
2. Commitment - regional priorities will take precedence over sub-regional/local priorities
3. Collaboration - regional solutions to derive greatest benefit and financial effect

1.3.2.2 Regional Priorities

The six central region DHBs have agreed the following priority action areas for 2015/16

1. Progressing Māori health outcomes
2. Regional ICT
3. Management HBL successor arrangements
4. Strengthening specialist clinical services
5. Cross-agency collaboration

A regional approach will help the sub-region address some of the challenges facing us including more effective resource use. For further information on how we will locally support delivery on our regional priorities, see Table 4 in Module 2 in the appropriate health priority area.

1.3.3 Sub-Regional Outcomes

Our sub-regional DHBs Wairarapa, Hutt Valley, and Capital & Coast District Health Boards share staff and services, and treat each other's populations. It is essential that we work well together for the sake of our patients, consumers, and population, and for clinical safety and system efficiency. We also must work collaboratively with our primary care partners across the region – our annual planning processes are developed with, and endorsed by, our Alliance Leadership Teams.

1.3.3.1 Sub-regional Integration – Our Neighbours

Demands on sub-regional health services are increasing within a tight financial environment, and sub-regionally we are also facing an ageing population, long-term conditions, and the needs of vulnerable populations, all which are placing greater pressures on the health system.

One of the ways to address this individually is through strong collaboration with our neighbouring DHBs. In late 2012, the three DHBs committed to an approach to working together that ensure the sustainability of our collective services, both clinical and financial; we have been maintaining momentum on this and continue to grow integrative activity where feasible. Having joined-up health services ultimately improves patient care and quality; instead of being passed between hospitals, patients receive more co-ordinated care, faster, have greater access to specialist services, and have a better experience.

[24] Statistics NZ, November 2014

Together we are consistent in the review of our plans, short and long term, under the lens of the Triple Aim - an international healthcare improvement policy that outlines a plan for better healthcare systems by pursuing three aims: improving patients' experience of care, improving the overall health of a population and reducing the per-capita cost of health care; and integration that enables delivery of each of these aims. In New Zealand this policy has been adapted by the Health Quality & Safety Commission, and we support the Commission and its initiatives for the 2015/16 year. Our approach to quality improvement is also underpinned with an equity in health outcomes perspective, as equity cuts across all dimensions of high-quality health services.

Our shared focus remains on shorter, safer patient journeys - acute flow (Emergency Departments, Integrated Operations Centres, quality improvement teams) and living within our means (acute volumes, green/sustainability initiatives). Our sub-regional approach towards this includes exploring new and different models of care and to increase our focus on how to bend the acute demand curve including early intervention and integrated services focused on the patient and provided closer to home. Doing this through the use of alliancing principles supports the implementation of the Better Public Service targets through:

1. effective use of data to inform new models of care that eases the pressure on hospitals
2. joint development of the new models of care
3. improving quality through efficiency and effectiveness
4. ensuring sufficient change management capability to undertake this development, and its implementation
5. and putting in place effective clinical leadership

Integration is not a new concept in our sub-region; many services such as cancer, burns and plastic surgery, rheumatology, and public health have been sub-regional for some years - Capital & Coast and Wairarapa DHBs provide ophthalmology and urology services for our three DHBs; Hutt Valley DHB provides plastic surgery and rheumatology services; and mental health & addiction services are streamlined across the sub-region. Having joined-up health services improves patient care; instead of being transferred between hospitals, patients receive more co-ordinated care, faster, have greater access to specialist services, and have a better healthcare experience. Where there is a clear benefit to patients and consumers and clinical practice (in line with the Triple Aim) we will continue to support health services becoming sub-regional and integrated; this is reflected throughout this Plan, and in detail in Module 2 actions.

The three DHB Chief Executives, with the endorsement from the Sub-regional Clinical Leadership Group, support a whole-of-health-system approach for our sub-region, by working towards operating as one organisation, as one team over multiple sites. While the three Boards continue to provide governance, ensuring local accountability to the populations of their district, it is our combined goal to develop integrated service approaches to improve preventative health, provision of relevant services close to home, and quality hospital care – including highly complex care – for those who need it. This requires a strong focus on relationships with primary and community care, with our DHB neighbours, and working closely with staff and communities as we progress service design. Following are examples of areas where we have as three DHBs worked together to create integration of planning and delivery of services, for better sustainability of the service and system, and towards better outcomes for the population.

Laboratory Services

The three DHBs have created a new integrated service with a new provider that will include the Hutt Valley DHB and Capital & Coast DHB (Wairarapa DHB having had an integrated laboratory service for some year). Patient safety and quality of services remains paramount – there will be no reduction in service or quality of services. Integrating hospital and community laboratory services is not a new concept in New Zealand – nearly half of our DHBs have an integrated laboratory service. Our laboratory services will continue to be located in the community and at the four hospital sites – Wairarapa, Hutt, Kenepuru, and Wellington Hospitals. The benefits for patients and health professionals by integrating laboratory services across the three DHBs include avoidance of unnecessary duplication of tests and patient discomfort; one consistent process to request tests and timeframes for getting results back; enable the laboratories and equipment in the region to be upgraded; and, the three DHBs will all save

money which will be reinvested into health services. The new integrated laboratory service commences November 2015.

Gastroenterology service

Our three District Health Boards face challenges in providing sustainable gastroenterology services that meet current and expected future demand; patients have been experiencing unequal levels of access to timely colonoscopy and gastroscopy services, compounded by an increasing demand for services and specific service delivery targets. The demand for urgent colonoscopy procedures is also expected to increase significantly with the implementation of a National Bowel Cancer Screening Programme. Therefore the sub-regional gastroenterology project was initiated in 2015, to create a model of care to reduce inequalities in access. The key objectives are: developing a single production plan for the sub-region ensuring each DHB meets expected volume delivery targets, and wait-time and access targets; developing local services to meet the needs of communities in all three DHBs; streamlining referral process, triage, and booking systems; and, standardising reporting, maximising the opportunity of a sub-regional approach to implementing Global Rating Scale (GRS). Configuration of service delivery will operate as a sub-regional service, supporting efficient use of facilities and capacity on each site and developing a system-wide approach to manage future demand. Current colonoscopy services will be maintained and Wairarapa services enhanced and improved; improvements will be triage and delivery, and in making sure people are seen in timely manner.

Blood and Cancer Services

In June 2014 the Wellington Blood and Cancer Service was successful in receiving funding to progress the design of a sub-regional ambulatory model of care. In submitting the application it was recognised that the current model of service delivery appeared at capacity, in the delivery of both inpatient and day-procedure services. To enable us to provide sustainable high quality care, we needed to consider an integrated service approach in our ambulatory model of care for the delivery of Outpatient Care and Treatment. The 2015/16 project will investigate options for service delivery across the sub-region.

Hospital Imaging Services

Our three DHBs have been working together over the past year to develop a single sub-regional hospital radiology service which is patient focused, high quality, timely, affordable and sustainable. The benefits of this approach include:

- Consistent level of triaging protocols will mean more clinically appropriate access to care
- Patients are more likely to be imaged at the location most convenient to them
- Building and strengthening of workforce opportunities
- Better resource planning around service developments.

A sub-regional Radiology Manager works in partnership with two clinical leadership positions: one in Wairarapa and Hutt Valley DHBs, and one in Capital & Coast DHB.

Ear Nose and Throat Services

Our ENT services have been working together sub-regionally over last several years on improving current service provision and in determining the strategic direction of services, including workforce development and recruitment.

Mental Health and Addictions

The newly integrated sub-regional Mental Health, Addictions, and Intellectual Disability Service / Te-Upoko-me-te-Whata-o-te-Ika, was launched in February, 2015**.** This was the culmination of a year's work that included engagement with staff and formal consultation that generated development of the preferred service model. Integration is enabling the implementation of single acute adult model of care (by June 2016) and a single youth model of care (by August 2015).

An underpinning design principle is that services are located in local communities where they can best respond to local needs. Specific benefits being realised from local system integration include:

- a cohesive Service Leadership Team, and Clinical Governance structure, with clearer accountabilities
- sub-regional DHB services operating seamlessly ('no boundaries') for clients
- standardised practices across DHBs, especially with policies and procedures for consistency of care
- clinical expertise and knowledge shared across the sub-region
- single point of entry, clear pathways, clarity of patient journey through the system, equity of resources
- strengthening of our Improvement and Development systems and capabilities – quality, research, learning, training, information flow, and clinical governance.

The integration is aligned to the priorities of the Health Ministry's Health Framework Blueprint II: How things need to be (which describes how our approach, systems of care and results need to evolve over the next decade) and goals within Rising to the Challenge. The Triple Aim also underpins the integration intent towards a single service.

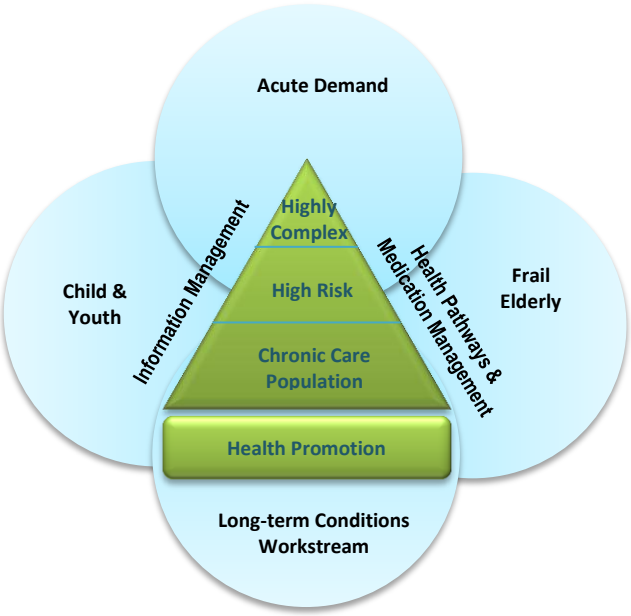
Sustainability – the Environment

As part of our approach to ensuring service sustainability we are also looking at sustainability of our environment. In 2015 the sub-regional Chief Executives endorsed a proposal to create a sub-regional Energy Management Programme aligned to ISO 50001. To facilitate this, two sub-regional roles were formed - an Energy Manager and a Controls Systems Engineer, both of which are critical to the success of an energy management programme of such a large scale. These roles will enable achievement of targeted energy reduction of at least $700,000 (10% of current energy spend) over the next two years. Previous projects have demonstrated that significant savings are possible, with two projects in 2015 delivering $340,000 per annum of sustainable, energy reduction, savings. As part of the Energy Management programme the sub-regional Energy Efficiency Statement of Intent outlines the short and medium term objectives that have the potential to lead the DHBs towards combined energy reductions of greater than 40% by 2021. Having this document as the guiding objective will assist with maintaining support of EECA for the utilisation of Grants and very low interest Crown Loans that are necessary to support a successful Energy Management Programme.

1.3.3.2 System Integration - Primary and Secondary

The people in our sub-region will experience an integrated health system as providing appropriate care closer to them, keeping them well at home, and providing responsive services in times of acuity. System integration will drive efficiencies and support sustainability while we are facing limited resource and escalating demands on services. The Alliance Leadership Teams (ALTs) across the sub-region are key drivers for and enablers of integration. Each ALT membership includes clinical leaders across the health system who are committed to driving change. Our three ALTs are Tihei Wairarapa, Hutt Integrated Network of Care (Hutt INC), and the Integrated Care Collaborative Programme (ICC).

System integration progress will in part be driven through the Integrated Performance and Incentive Framework (IPIF). The aims of the IPIF are to lift performance of the whole health sector, increase the rate of clinical integration, improve quality of health and wellbeing services, and support and improve system sustainability.



The IPIF is closely aligned with the Triple Aim; by using system performance measures, the IPIF addresses equity, safety, quality, and cost of services. The indicators are made up of composite measures, the stepping stones for reaching the overall goal of 'all New Zealanders can access the health service they need in order to be healthy'. ALT clinical leaders and hospital leadership work together to identify areas for improvement, guide clinically-led developments in services, and support the implementation of subsequent change. In support of this leadership, there is significant primary and community stakeholder engagement to ensure that ground-up level input in to service development. The ALTs will be engaged in the process for utilisation of their Flexible Services Pool and other resources available through service review.

Wairarapa DHB is sustaining its provision of quality care in the sub-region and continuing to focus on the Triple Aim, putting the patient at the centre of all service design and delivery actions and initiatives. The Tihei Wairarapa Alliance Leadership Team is supporting health system integration in the Wairarapa, guided by the alliance arrangement between Compass Health PHO and the Wairarapa DHB. The programme seeks to improve health

outcomes for the local population and reduce disparities through improving integration and coordination of health services. The programme is governed by the Tihei Wairarapa ALT, which comprises of clinical leaders from primary care and the hospital, allied health, community, Iwi and health management. The Wairarapa is focussing on improving access to primary care, both for relieving pressure for hospital services and to improve patient and consumer outcomes.

At Capital & Coast District Health Board the Integrated Care Collaborative Programme (ICC) was launched in 2012 and converted to an Alliance in 2013. The ICC has enabled strong linkages to be established with leads from across the sector to work towards improvements for the whole of the Capital & Coast DHB.

ICC aims to:

1. Improve the quality, safety and experience of care
2. Improve health and equity for all populations
3. Gain the best value from the resources made available to the public health system.

The programme is led by the ICC Alliance Leadership Team, which comprises of clinical leaders and key management members from across primary care and the hospital. To date the ICC has delivered a Shared Electronic Health Record, the Diabetes Care Improvement Plan, Frailty Codling, Primary Options for Acute Care, Oxycodone Prescribing Improvements, and free < 6 years old funding and developed a number of Child Health Pathways. These service developments have been delivered in accordance to the ICC Framework, which is based on consensus clinical lead developments and structured programme/project management processes. The ICC ALT has been key in driving improvements and will continue to build on these achievements, as well as through new transformational change opportunities.

The areas of focus for the programme have included acute care, child health, long-term conditions, youth health, frail elderly health, medication, and information management. This collaborative alliancing approach has delivered a number of benefits to Capital & Coast DHB including:

- HealthPathways localisation
- Primary Care Options for Acute Care (POAC) – Practices can deliver acute treatments for adult cellulitis and DVT to people as per the clinical pathways
- Frail Elderly Identification Tool – Primary care are able to identify and code frail elderly to support proactive management and support, helping them to keep well
- Diabetes Care Improvement Plan – Primary care practices can deliver flexible diabetes services with enhanced support from the specialist services, delivering better outcomes for the growing number of people with diabetes across the DHB
- Shared Care Record implementation – Identified hospital clinicians can access the patients' primary care shared electronic health record, improving the quality of information, reducing duplication and ensuring that patients don't have to repeat their stories
- Urgent Community Care – Extended Care Paramedics provide support to people in Kapiti and Porirua to support them within the community
- A number of health pathways have been developed for children and others that are now available on the '3D Health Pathways' website[25]
- Medication management - oxycodone prescribing guidelines, education and audits have appropriately reduced the use of this opioid.

Current projects include introducing patient access to the primary care record, extending acute care packages in primary care, enhancing frail elderly management, developing a Respiratory Care Improvement Plan, Youth service development, and antipsychotic prescribing guidelines.

Sub-regional work of the Alliance Leadership Teams

The three Alliance Leadership Teams (ALTs) are also working to a collective set of outcome measures that reflect the combined performance of services across the systems. The outcomes measures capture the ALT programmes goals to support integrated solutions that streamline acute care, maximise planned care, and support prevention. While maintaining a whole of system view, in order to deliver on improvements in the identified outcomes, the ALT programme has been developed through focusing on the complexity of the populations (Acute Demand & Long-Term Conditions), targeted work specific to particular age groups (Frail Elderly, Youth, Vulnerable Children) and enablers that underpin the system (Health Pathways, Information Management and Medication Management) across the DHBs.

[25] http://3d.healthpathways.org.nz/index.htm

With the complexity of patients' needs and the need for integrated systems there are overlaps across the focus areas, which are managed through the communication across the work streams and also overlap in DHBs with an increasing number of work streams working across the DHBs. For example, the Youth Service Level Alliance (SLA) works alongside the local Porirua and Wairarapa Social Sector Trial leads. The SLA members are clinical leaders and managers appointed by the Alliance Leadership Teams.

Over 2014/15 the sub-regional SLA focussed on: developing a youth needs analysis and intervention logic to inform services planning; initiatives for improving accessibility of health services for young people by making services more youth friendly and responsive to the needs of youth, which required implementing health workforce development strategies and improving care pathways for young people and an integrated\ stepped care approach to meeting the mental health needs of young people, and devising an outcomes framework to measure the impact of service initiatives.

Health Pathways

HealthPathways is also a resource developed sub-regionally with the ALTs, for use in Primary Care in the wider Wellington region. It offers guidelines for clinical staff on almost 600 clinical conditions with regards to assessment, management, and referral. In addition, relevant reference materials for clinicians and educational resources for patients to ensure there is a wealth of information presented in a user friendly format. A team of five Clinical Editors and all local GPs are localising the Canterbury content. To date around 90 Pathways have been localised. One-click access to the website is available to all MedTech practices throughout the sub-region (an average of 700 users access the site monthly). Although written specifically for GPs in consultation with patients, the whole wider medical community can benefit from all the resources and information contained in the pathways. Due to its technical nature and medical vocabulary this site is not intended for public use, but most pathways contain up to date patient resources that can be printed off for patients as required.

Integrated Performance and Incentive Framework

Development of IPIF is an evolutionary process with phased implementation over a number of years; Phase 1 2015/16 is a transitional year. As well as implementation of a new set of performance payment measures, the transition year includes implementing the PHO self-assessment against the Minimum Requirements.

The development of IPIF measures has focussed on those that best demonstrate integration actions and delivery; these have been clustered into age domains - for 2015/16 we will focus on: Healthy Start (antenatal to 12 years) and Healthy Ageing; in December 2015 financial and non-financial incentives to support and enable the achievement in these areas will be introduced. In 2016/17 Healthy Child, Adolescent, and Healthy Adult measures will be introduced. All measures have a focus on equity of health outcome for everyone. Healthy Start intends to measure improved integration of services, equity and health outcomes for pregnant women and new-borns through to the first year of life; measures may include early registration with a Lead Maternity Carer (LMC) and early enrolment with a PHO, and first year of life factors such as breastfeeding. Healthy Ageing measures are categorised into domains that will aid improvement of integration of services, equity and health outcomes for people aged 65 and over: keeping people healthy; identifying people who need car; keeping people in the community; care of frail people; and, supported end of life; measure covers polypharmacy management.

We are also including Health Adult measure of cervical screening, and a Capacity/Capability measure of ePortal implementation. Success at any level within the IPIF structure will be achieved by PHOs, GPs, and DHBs working collaboratively together and effective Alliance relationships. The measures anticipate an environment of high trust, in which effective local relationships set the agenda for quality improvement, and require system wide integration collaboration.

1.3.3.3 Health System Planning

Wairarapa, Hutt Valley and Capital & Coast DHBs are developing a long term health system plan to provide a high level vision of what health service delivery for our region will look like in 15 years' time. The project is focussed on building the sustainability and efficacy of the three organisations, whilst improving health outcomes across our multiple communities. This strategic view will provide a platform for cohesive and effective service planning and change management over the coming years. The planning approach is evidence-based using the best data available, and will enable discussions about what a good system of delivery should look like with both clinical and non-clinical stakeholders across each of the three DHBs.

1.3.3.4 Living within Our Means

Keeping to budget is essential as the increasing demand of illness, chronic disease, and inequity impacts constantly challenges the health sector. Appropriate planning, analysis of robust data, and working better together will allow for resourcing of investment into new and more health initiatives. In order to meet the expectations of our population, we will continue its focus on strategies to constrain cost growth and rebalance our health system. These strategies are reflected throughout this Annual Plan and include: minimising duplication and waste of resource; balancing the Triple Aim objectives; developing our clinical leadership and clinical input into core business (budgeting and service design); developing our workforces capacity, skill sets, and scope of practice; moving towards integrated workforce models; addressing acute demand; and support systems that enable sharing of resource and information and promote timely clinical decision-making and improved quality of care.

Our DHB will budget and operate within our allocated funding whilst ensuring sustainable health services; we are expected to continue to manage our finances prudently, and we will ensure that all financial plans for 2015/16 and out years reflect this (Module 4). Specifically we will work on National Entity Priority Initiatives that will enable better resource management; proactively manage cost growth (including personnel) and improve use of our workforce; provide information on the production plans; and, demonstrate appropriate clinical and executive leadership (see Module 5).

Through 2015/16 we will continue the implementation of Shared Services actions aligned with Health Benefits Limited (HBL) work programmes as agreed (see Module 5); increase theatre utilisation; identify regional[26] and sub-regional activity that collectively improves financial performance (Module 2); and, increase service outputs delivered within a primary care and/or community setting, relative to hospital delivery, and reduction in demand for acute hospital services (Module 2, 2.2.17). We will measure progress in this area through monitoring and reporting on any proposed service change (see Module 6); success in reducing inpatient length of stay (see Module 7, OS3); reducing acute readmissions to our hospitals (see Module 7, OS8); and delivery of the sub-regional Mental Health and Addictions service.

Acute Volumes Growth – Acute Demand Management

Continued growth in acute hospital admissions (urgent or unplanned admissions) is one of the most significant challenges for DHBs to manage, and places intense pressure on our constrained hospital resources. One of our indicators for observing the impact on the system is the Emergency Department health target of 95% of people presenting at ED are admitted, discharged or transferred within six hours.

Many acute admissions are a result of long-term conditions (LTCs) not being well managed; we have a range of initiatives for 2015/16 that will improve services and outcomes for those with LTCs, working with primary care and community services to develop workforce training and IT systems, and risk stratification processes. Our ED services have identified areas for development, and we focus on support services for people when returning home.

Part of managing demand to acute care is also improving access to acute hospital services. Emergency medicine adds value to the care of a great many patients, however, there are some patients for whom it does not, for example: patients who are clinically stable, who do not require further urgent treatment or investigations, who have had any distressing symptoms addressed and for whom the need for admission to an in-patient speciality unit has been determined by a primary health care provider (or an ED clinician). We endeavour to have systems which allow the timely movement of such patients to the in-patient speciality unit, without the need for undue time or duplication of clinical assessment in the ED; this may include use of the in-patient speciality admissions units, such as Medical Admissions and Planning Units. The development of alternative pathways through which patients can access acute services, such as access to diagnostics in the community and to 'acute' specialist outpatient clinics, is also a contributor to managing acute demand, and areas we are working on.

Opportunities to reduce acute demand will also be found in improving the management of long term diseases and the delivery of health care and support services to the elderly; to this end we are working with primary care and the community to support self-care and literacy and supporting the development of a healthy environment, and we are working with aged-care providers and community professionals to improve services and better support people to stay in their home.

Module 2, 2.2.17, Primary Health and Integration, details a number of initiatives that will support the reduction of attendances to our Emergency Departments.

[26] Central Region Regional Services Plan - www.centraltas.co.nz/

Green Initiatives

Our goal is to reduce our energy usage by 40% by 2021 – not only will this contribute to the sustainability of the environment, but it will also generate significant financial savings for the organisation. Specific actions over the next three years toward achieving this goal include:

- Recycling pilot - PVC recycling of IV bags and face masks, into playground safety matting
- Sub-regional Travel Survey in collaboration with Greater Wellington Regional Council – data collected anonymously will provide an overview of how the sub-regional DHBs workforce gets to and from work, as well as travel between DHBs; will inform our own sustainability initiatives, feed in to future transport planning by the Council.
- Building Management System (BMS) upgrade – upgrading the way temperature is controlled will save on gas and electricity bills, and reduce our greenhouse gas emissions by 983 tonnes of carbon dioxide per year

1.3.3.5 Effective Governance and Clinical Leadership

Our DHB continues to work towards enabling and embedding local clinicians in taking a lead role in the establishment of regional clinical networks, local and regional clinical pathways, and towards optimal clinical arrangements for securing specialised hospital capacity between our neighbouring DHBs. Strengthening clinical leadership is assisted through the activity of the three ALTs and active involvement of clinicians in the development of collaborative service models. Each Board has its own Clinical Governance, supported by management, and Clinical Leadership Structure (see Module 5). The Sub-regional Clinical Leadership Group (SRCLG) allows for the initiation of innovative ideas for service provision across the sub-region. When it is deemed desirable for clinical service to be further coordinated to improve the quality of care the SRCLG can initiate and lead the positive change

1.3.3.6 Reducing Health Disparity

Health outcome inequity[27] against some population groups affects all population groups. Under the NZ Public Health and Disability Act, DHBs are charged with the task of reducing health disparities by improving health outcomes for Māori, Pacific people, people with disabilities, and other population groups. The World Health Organization defines equity as: the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically: Health inequities involve more than inequalities – whether in health determinants or outcomes or in access to the resources needed to improve and maintain health – but also a failure to avoid or overcome such inequality that infringes human rights norms, or is otherwise unfair[28].

The Ministry of Health Reducing Disparity framework[29] provides a guide for the development and implementation of comprehensive strategies to reduce health inequalities and improve health. It describes four levels of intervention where health inequalities may be reduced by targeting: Influencing decision-making at a policy level across sectors; Influencing other agencies at a local level in areas that impact on health; Influencing the planning and funding of health services with the aim to improve health status; and, Influencing the effect/impact of disability and illness on an individual's socioeconomic position. Using this framework, we aim to address disparity by developing accountability targets, assessing 'value for money' and effectiveness, and promoting inter-sectoral action and collaboration with families and communities.

We are using the framework 'Equity of Health Care for Māori'[30], which was developed to guide health practitioners, health organisations, and the health system to achieve equitable health care for Māori. The three areas we are applying this are: Leadership - championing the provision of high quality health care that delivers equitable health outcomes for Māori; Knowledge -developing a knowledge base about ways to effectively deliver and monitor high quality health care for Māori; and, Commitment: - to providing high quality health care that meets the health care needs and aspirations of Māori. Our planning activities incorporate the use of the Health Equity Assessment Tool (HEAT).

Capital & Coast DHB is progressing work towards reducing inequity in Māori health outcomes with Whānau Care Services, referrals onwards, ethnicity data collection (project), and the Whare Whānau support services.

[27] Inequity and inequality- Health inequality is the generic term used to describe differences, variations, and disparities in the health outcomes of individuals, populations or groups; Health inequity is the presence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically.
[28] Institute of Medicine: http://www.iom.edu/Reports/2010/Future-Directions-for-the-National-Healthcare-Quality-and-Disparities-Reports.aspx
[29] Ministry of Health (2002) Reducing Inequalities in Health. Wellington: Ministry of Health
[30] Ministry of Health (2014). Equity of Health Care for Māori: A framework. Wellington: Ministry of Health

The sub-regional disability advisory group is progressing work towards reducing inequity in outcomes of people with disabilities through the work of CPHAC/DSAC; Capital &Coast DHB and Hutt Valley DHB now have disability alerts held by 8000 patients, alerts are both a tool to improve access to quality patient care, and for population health planning particularly for people of all ages with the highest support needs.

1.3.3.7 Aligning our Planning

Health system planning is complex with many interrelated parts that attempt to reflect the adaptive system that is health care delivery, including the impact of education, social development, and justice work and policies. Impacting more immediately on hospital services are planned initiatives for Māori and Pacific people health, disability actions from the national strategy, and Regional Public Health Service initiatives; these plans align with the DHB Annual Plan and all are mutually independent for the successful delivery of health outcomes for our population. In our process, we shall be inclusive, open, honest and ethical in the planning and delivery of services. We shall strive for the highest standards in all that we do. We shall collaborate and cooperate with our neighbours to provide equality health care services and support the people of our district to determine and take responsibility for their own health and well-being.

Māori Health Planning

Improving Māori Health outcomes continues to be a priority for the three DHBs; we must provide for the needs of Māori as set out in section 4 of the NZPHD Act 2000 to ensure there are mechanisms to enable Māori to contribute to decision-making on and to participate in the delivery of health and disability services. The DHBs will apply and support a strengths-based approach, recognise the diversity of Māori society, and work beyond a one size fits all view. This will be achieved by understanding the challenge of working with traditional values in modern times and making the best from collective resources and collaborative action aligning with the intent of the national Māori Health Strategy (2014) 'He Korowai Oranga'.

DHBs are required to create a stand-alone Māori Health Plan to improve the health outcomes of Māori in line with the national Operational Policy Framework (Section 6.2). The Māori Health Plans include appropriate activities to improve health equity, and align with national Māori Health Indicators and locally identified health needs. Because primary care sector has a strong role to play in improving health outcomes for Māori, the plans be developed jointly with the PHO, and the PHOs must have actions in place necessary to effect the change they must achieve to implement the DHB Māori Health Plan. In developing the plans, the DHBs work with Māori at both governance and operational levels.

While the current health sector environment is likely to have an impact in 2015/16, it is important that the DHBs make the best use of our existing resources to ensure better, more efficient and more effective care for Māori and their Whānau within our districts whilst reducing existing disparities. This Annual Plan refers to the Māori Health Plan in the relevant indicator areas and also includes annual activities by Māori Health teams of the DHBs; these teams are working to ensure that the organisations are culturally responsive and have systems and policies that enable the reduction of inequity by all staff (see Table 3 for details of indicator areas and location in DHB Annual Plan).

To ensure Māori health remains a focus for the DHB, DHB CEOs nationally endorsed the following Tumu Whakarae recommendations in 2013 that a standardised Māori health performance report be used by DHBs on a monthly basis to monitor performance; DHB CEs in partnership with DHB Māori Directorates support and facilitate Executive and Clinical Leadership roles to be accountable for performance against relevant health achievement areas for Māori, and that the Māori Health Plan priorities have the same prominence and status as national Health Targets in terms of performance improvement and reducing inequalities (see Stewardship Module 5 for detail). From 2014/15, for all performance measures included in the Māori Health Plan, a rating has been applied when the DHB has met the target agreed in its Annual Plan and has achieved significant progress for the Māori population group, and the Pacific population group.

Our Māori Partnership Board have identified health priorities areas for focussing effort on in 2015/16: all national Māori Health Plan indicators, but in particular respiratory health issues affecting 0 to 14 year olds, diabetes, Whānau Ora , Māori Health Development, Māori Mental Health, Māori with disability Did Not Attends, and youth mental health. Support will be given also to iwi towards a Smokefree 2025, and for improving health literacy of staff. See the Capital & Coast DHB Māori Health Plan for details and actions around addressing these on our

Capital & Coast DHB web page[31], an overview in Appendix 2, and the DHB Annual Plan sections in Module 2 'Equity and Māori Health' 2.2.8 and 'Workforce Development' 2.2.27.

Pacific Health Planning

Our sub-regional DHBs are committed to continue to work and develop its partnership with Pacific communities and health professionals to provide services that meet the needs of people at the right time and in the right place, at community, primary, secondary and tertiary health levels. Nationally, the Ala Mo'ui- Pathways to Pacific Health and Wellbeing 2014-2018, and the Pacific Strategic Action Plan II (2007-2012), sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities. The priority actions encourage everyone in the health and disability sector to work collaboratively to improve outcomes for Pacific peoples; key areas of focus include access to primary care, national screening programmes, mental health and addiction services, and working across government to address determinates of health.

Our DHB Health Needs Assessment demonstrate that there are major areas of concern for Pacific within the district such as high ambulatory sensitive/avoidable hospitalisation rates, poor child health particularly in oral health, high child and adult admission rates for respiratory disorders and cellulitis, LTC related conditions including cancer, and low breast and cervical screening uptake for Pacific women. Pacific peoples are also disproportionately exposed to health risks and unhealthy behaviours that contribute to ill-health. In order to improve the health of Pacific peoples and to reduce inequalities, the detrimental levels of health risk factors experienced by Pacific peoples must be addressed urgently. Many hospitalisations are potentially avoidable, and could be prevented through primary health-care interventions and improvement in household conditions.

The factors that affect access to health services and the delivery of quality of care need to be better understood in order to improve the healthcare-related outcomes of Pacific peoples. Empowering communities through health education and information that enforces positive messaging and control of negative influences and the development of skills can improve health measures. Pacific health workforce development is vital in supporting Pacific people and services to be more responsive to the health needs of Pacific people as a better understanding of Pacific perspectives on health and culturally-competent services and workforce can improve responsiveness to Pacific health needs. Failure to improve the health status of Pacific people will perpetuate the current state of Pacific health[32]. See Module 2, 2.2.9 Equity and Pacific Peoples Health for detail around our actions for 2015/16.

Regional Public Health Service Planning (RPH)

RPH is our sub-regional public health service, serving the populations of Wairarapa, Hutt Valley, and Capital & Coast DHBs. RPH provides services to improve, protect and promote the health of communities, and provides all five of the core public health functions for New Zealand: health promotion; health protection; early interventions; health assessment and surveillance; and, public health capacity development. The approach to delivering on these functions is population based, which means working in a variety of settings and communities where people live, work, learn and play. RPH works towards a more equitable distribution of health and well-being so that people can contribute positively to their communities. This takes into account the barriers and enablers to health and well-being such as access to health care services, housing, income, employment and education. Module 2 includes reference to DHB collaboration with RPH.

In 2015/16 RPH is investigating potential options for a more community-focussed approach to its health promotion activity, developing from the traditional setting-focussed approach. It is identifying and focusing on communities which may not be benefitting from other initiatives – school communities are a key component in this approach. See Appendix 2 for an overview of the RPH Business Plan, and the RPH web page for the full plan[33].

Disability Strategy Implementation

The 2013 Disability Survey (Statistics New Zealand 2014) found that about 95,000 children and 967,000 adults in New Zealand reported having a disability. Among people of all ages with disability, most live in households in the community.

The NZ Disability Strategy (NZDS) has 14 key focus areas which give guidance to policy makers on eradication of systemic, attitudinal and structural barriers in all aspects of service delivery and legislation. The Strategy has been hailed globally as the first of its kind. It re-defined disability for the 21st Century; it was further strengthened by the United Nations Convention on the Rights of Persons with Disabilities, 2009 (UNCRPD).

[31] http://www.ccdhb.org.nz/
[32] http://www.stats.govt.nz/browse_for_stats/people_and_communities/pacific_peoples/pacific-progress-health/summary.aspx
[33] http://www.rph.org.nz/

We are working on implementing the National Strategy, and national Disability Action Plan 2014-18, through a sub-regional action plan, 'Valued Lives Full Participation: 'Sub-Regional, NZDS, and UNCRPD Implementation Plan 2013-18'. This will ensure a consistent and equitable planning process across the sub-region, but also aims to enhance local health care practice both at primary and secondary service levels to benefit the whole population. See Module 2, 2.2.7 Equity and Disability, for our actions supporting the delivery of our sub-regional plan and the national strategy.

1.3.4 Our DHB Context

1.3.4.1 Vision for Our Population

Capital & Coast "Better health and independence for people, families and communities – keeping people well and eliminating health inequalities, everyone will enjoy the best possible health throughout life". We understand that we must work with our communities to help reduce disparities in health status and reduce the incidence of chronic conditions amongst our population while increasing the independence of the people in our district. To achieve our health goals, we have developed a range of specific strategies which include:

1. Focusing on people through integrated care
2. Supporting and promoting healthy lifestyles
3. Working with our communities
4. Developing our workforce
5. Updating our hospitals, and
6. Managing our money responsibly.

We aim to meet the Government's objectives, as well as the needs of our population, through the following strategic goals:

1. Improving outcomes for frail elderly through effective pathways, better access to quality services, and quality improvement focus maintained for home and community care services
2. Reduction of health disparities within our population
3. Unnecessary hospital admissions avoided through integrated delivery of services, including more services provided closer to home, integrated care in the community, improved access to mental health and addictions services, and improved access to appropriate information that promotes and enables wellness and good personal health practices.
4. Improving the health of children in vulnerable communities, with a particular focus on rheumatic fever, serious skin infection and respiratory conditions, quality of healthcare provided, integrating child health services, working with schools (developing Health Promoting Schools and School Nurses initiatives), providing rigour around the monitoring and evaluation of child health outcomes
5. On-going quality improvement of planning and reporting processes – monitoring and evaluation of strategic goals and operational targets
6. Enhancing clinical leadership/communication throughout our DHB; increased innovation (telemedicine, telehealth)
7. Ensuring financial and clinical sustainability, and
8. A culture of collaboration with local and regional partners.

1.3.4.2 Our Priorities

As a DHB we face locally all the national issues and associated challenges mentioned in section 1.3.1.6. In addition to our need to address these - as the national fabric of the health system underpins our ability to deliver services to our local population – we must also review our districts unique health needs (as described in section 1.2.1.2) and design, commission, and fund services that best serve our population.

1. Acute demand management and Integrated Care – services can be provided as close to home as possible, and unnecessary hospital admissions can be avoided
2. Empowered self-care – advance care planning; patient experience measurement
3. Better care of our older people – frail elderly pathways; aged care facility overview; home and community support improvement
4. Pathways Closer to Home (managing IDF's) – sub-regional work to ensure patients are cared for closer to home where clinically appropriate. This will include Wairarapa referring for secondary care treatment not able to be completed at Wairarapa Hospital. The critical care network is developing a way of working to maximize the use of the HDU and ICU's. Our operations centers are working together to identify patients early and ensure where possible and clinically appropriate they are moved to DHB of domicile.

1.3.5 Our Populations Health Outcomes

As the major funder of health, wellbeing, and disability services in our district, we work to create, and maintain, positive changes in the health of our population. As our decisions about which services to fund have a significant impact on the health of our population, and contribute to the effectiveness of our entire health system, we must measure the impact of our funded initiatives. Whilst impacts are generally measured in the medium term, progress toward improving the health of our population is measured on three different timescales: long-term outcomes (5-10 years), medium-term impacts (3-5 years), and short-term outputs (1 year).

When we deliver our outputs (Module 3), we can expect to see over time improvement in our medium-term impacts, which in the long-term, will lead to progress toward our outcomes. It is important to note that these outcomes are progressed not just through the work of the District Health Boards, but also through the work of all of those across the health system, social services, and whole of government.

1.3.5.1 Logic Flow

Longer term outcomes can generally expect to be seen 5 to 10 years after the related activity is implemented. Outcomes are often dependent on contributions from other sectors, e.g. ethnic health disparities are affected by the broader determinants of health (e.g. housing, employment, educational attainment, income, and deprivation). Shorter term outcomes are generally seen two to three years after a related activity is implemented. These usually focus on how segments of health sector activity affect the health-related wellbeing of particular segments of the community. For example, obesity is sensitive to the work of health promotion and prevention services; these outcomes are somewhat dependent on other factors, such as the cost and availability of healthy food and the socio-cultural value of obesity in different ethnic communities.

Impacts refer to the immediate effects of specific health sector activity on specific aspects of health; outputs refer to the types and volumes of specific activities delivered by the health sector, i.e. what health services do with the funding and assets available to them. In the following section, we present our intended outcomes and their associated impact measures, with flow from local inputs through to national outcomes.

Trends over time for impact measures indicate to us which areas the health system is making a positive difference and which areas we should seek to improve. The following diagram shows the connection between inputs, outputs, and desired outcomes of our health system, and shows where this work is described in the Annual Plan document under the relevant Module.

Logic flow from local inputs to national outcomes

1.3.5.2 Outcomes and Impacts

As the major funder and provider of health, wellbeing, and disability services in our district, we work to make and maintain positive changes in the health of our population. Our decisions about which services to fund and deliver have a significant impact on the health of our population, and contribute to the effectiveness of our entire health system. In the following section, we present our nine intended outcomes and their associated impact measures. Although we do not have a specific target for our selected impact measures, trends in these measures can indicate in which areas our DHB is making a positive difference and in which areas our DHB should seek to improve. It is important to note that these outcomes are progressed not just through the work of DHBs, but also through the work of all of those across the health system and wider health and social services.

Outcome 1: Reduce ethnic health disparities

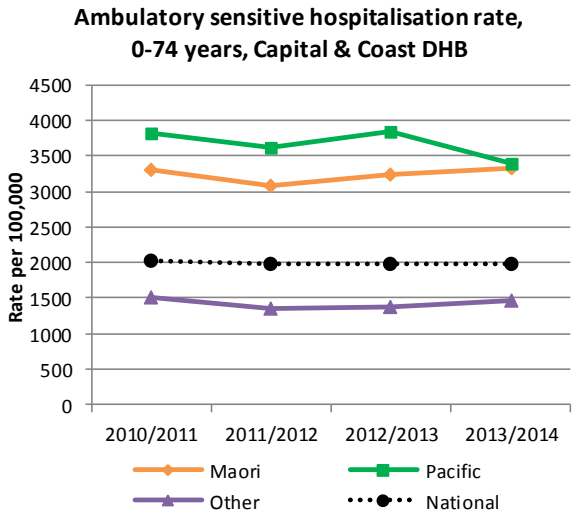
There are recognised health disparities for several population groups due to accessibility, social determinants of health, cultural responsiveness, and current models of care. Patients can find it hard to access services or to know how to manage their health if services are not culturally competent. We acknowledge our responsibility to design and deliver services that are accessible and responsive to our population's needs.

Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. These conditions include skin infections, dental conditions, asthma, pneumonia, cardiovascular disease, and diabetes.

ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

In Capital & Coast DHB, the ASH rate for Maori and Pacific is more than twice the rate for other ethnicities, and this disparity has remained constant over the last four years.

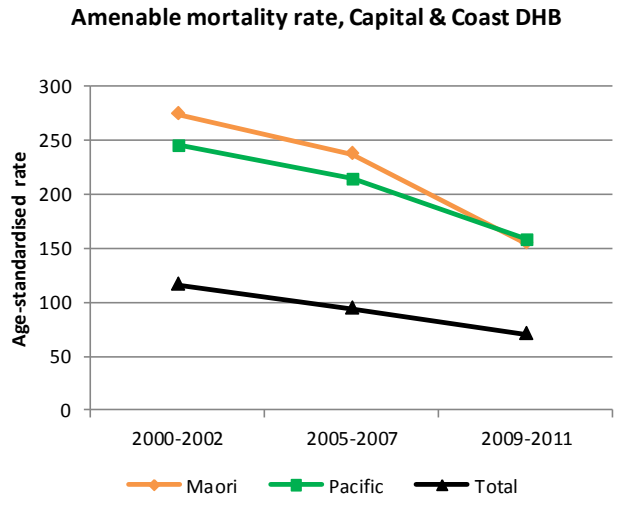


Source: Ministry of Health

Impact measure: A reduction in amenable mortality rates

'Amenable mortality' is defined as premature deaths from conditions that were potentially avoidable through health care. Differences in amenable mortality rates for different population groups reflect variation in the coverage and quality of health care received by them.

Māori and Pacific amenable mortality rates are more than 2.5 times higher than other ethnicities, indicating that these groups are not receiving equitable coverage or quality.



Source: Health Needs Assessment

Outcome 2: Environmental and disease hazards are minimised

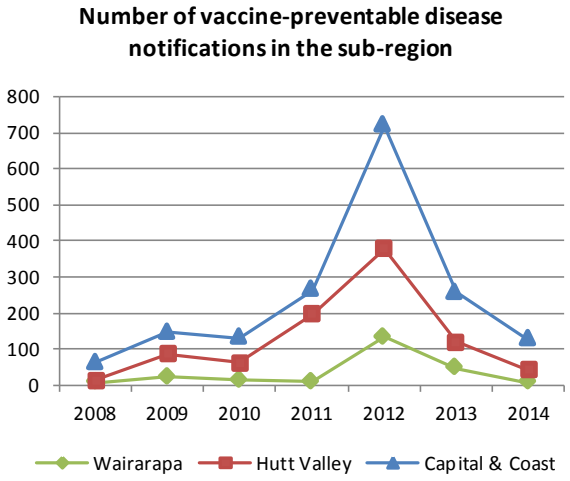
Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised.

Public health actions are aimed at reducing the levels of harm from alcohol and drug use in the greater Wellington region. To achieve this Regional Public Health works with Police, councils, and community agencies to understand and address the issues driving the harmful consumption of alcohol and drug use.

Impact measure: A decrease in vaccine-preventable disease notifications[34]

In addition to protecting an individual from disease, immunisation can also provide population-wide protection by reducing the incidence of infectious diseases and preventing the spread of these diseases to vulnerable people.

The peak in 2012 was due to Pertussis (whooping cough) outbreaks in the region, which caused an increase in vaccine preventable disease notifications. The number of notifications has returned to previous levels in 2014. In the longer term, with increased immunisation, we expect that the number of vaccine-preventable disease notifications will decrease.

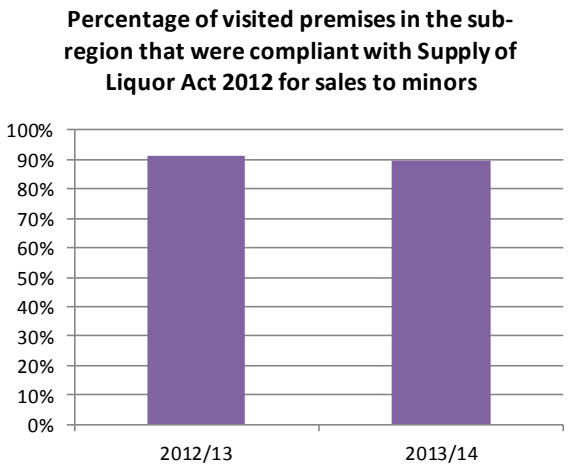


Source: Institute of Environmental Science and Research

Impact measure: An increase in the percentage of premises visited that are compliant with Supply of Liquor Act 2012, for sales to minors (in the sub-region)

Alcohol is a significant contributor to disease and injury for New Zealanders. Alcohol is causally related to more than 60 health conditions and is a significant contributor to injury, road trauma, alcohol poisoning and crime. In 2007 alcohol consumption was attributed to 5.4% of all deaths for those under 80 years old. In 2004 alcohol accounted for 28,403 years of life lost (disability-adjusted life years – DALYs) representing 6.5% of all DALYs for those under 80 years[35]. Young people, Maori, Pacific peoples and those living in areas of higher socioeconomic deprivation are at greater risk of experiencing harms from alcohol. Harm reduction strategies include changing both physical and social environments. Effective interventions include regulating the availability of alcohol through minimum legal age of purchase, hours and days of sale restrictions and restriction on the density of outlets.

Controlled purchase operations (CPOs) have been an effective compliance tool over the last ten years, with the national incidence of premises selling to minors declining during this time. Regional Public Health works with Police, volunteers aged 15-17 and the District Licensing Committee to carry out CPOs.



Source: Regional Public Health

[34] Includes the following notifiable diseases: Haemophilus influenzae type B, Hepatitis B, Invasive pneumoccocal disease, Measles, Mumps, Pertussis, and Rubella.

[35] Ministry of Health (2013). *Health loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016.* Wellington: Ministry of Health.

Outcome 3: Lifestyle factors that affect health are well-managed

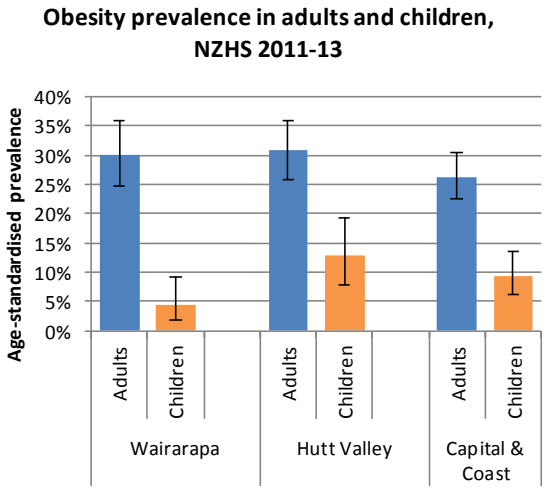
Lifestyle factors have a significant impact on overall health and well-being and are key contributors to cancer, obesity, cardiovascular disease and diabetes, which are major causes of death and poor health in our population. The Ministry of Health has estimated the burden of disease across New Zealand using 'disability-adjusted life years' (DALYs) that include both burden from early death and from lives led with disability. There are four key lifestyle factors that drive health loss: smoking (9.1% of health loss), obesity (7.9%), physical inactivity (4.2%) and poor diet (3.3%). Reducing the incidence of these negative lifestyle factors will improve the health of our population.

Impact measures: A decrease in the obesity prevalence in adults and children (adults 15+ years and children 0-14 years)

Obesity is one of the most important modifiable risk factors for a number of major diseases, including type 2 diabetes, ischaemic heart disease, ischaemic stroke, and several common cancers. In the last two decades, the prevalence of overweight and obesity in developed countries has increased so quickly that is has been described as an epidemic[36].

The most recent NZ Health Survey shows that there is no significant difference in obesity rates between the three DHBs. Adults have a much higher obesity rate than children in all three.

By providing education and support for people to live healthily, we expect that the prevalence of obesity will decrease.

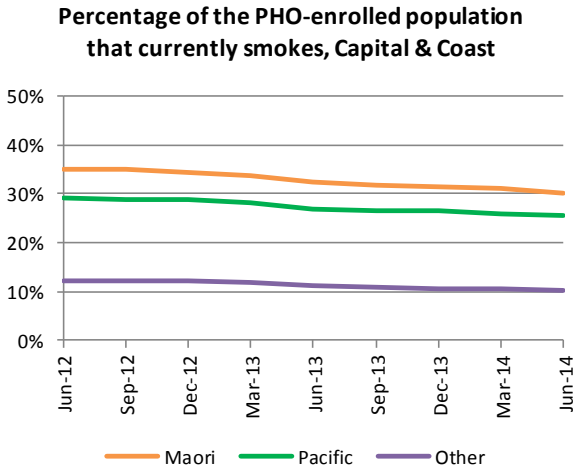


Source: New Zealand Health Survey, 2011-13. Error bars represent 95% confidence interval.

Impact measure: A decrease in the proportion of the PHO-enrolled population that is recorded as a 'current smoker'

Cigarette smoking has serious consequences for health. It is estimated that smoking kills 5,000 New Zealanders a year. Ministry of Health has set a goal that New Zealand will be smokefree by 2025. Our DHB is working towards this goal by providing smoking advice and cessation support to patients when they visit their general practice or visit the hospital.
Despite a drop in the smoking rate across all ethnicities in the last two years, Māori and Pacific continue to have higher smoking rates than other ethnicities.

By continuing to provide smoking cessation advice and support, we expect that the percentage of people who smoke will decrease.



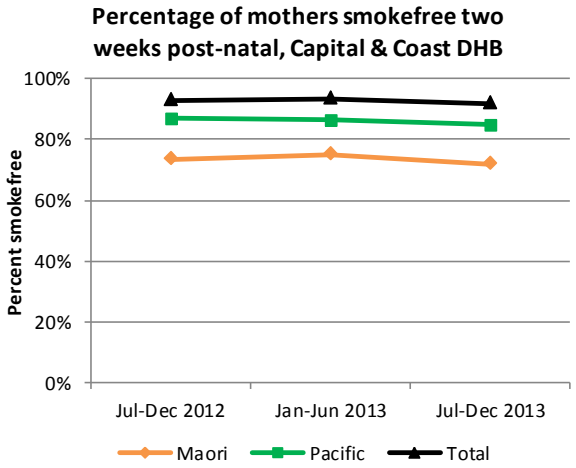
Source: PPP Reports, DHB Shared Services

[36] Ministry of Health. 2004. *Tracking the Obesity Epidemic: New Zealand 1977–2003.* Wellington: Ministry of Health.

Impact measure: An increase in the proportion of mothers who are smokefree two weeks post-natal

Maternal smoking, both during and after pregnancy, can negatively impact a child's health. Infants are more at risk of sudden infant death syndrome, respiratory conditions, and tooth decay if they are exposed to cigarette smoke.
Mothers are given smoking cessation advice in hospital, and lead maternity carers provide information about the risks associated with smoking and referrals to smoking cessation providers. By continuing to provide cessation advice and support, we expect that the percentage of mothers who are smokefree two weeks post-natal will increase.

In Capital & Coast DHB, Māori and Pacific mothers were less likely to be smokefree compared to other ethnicities.



Source: WCTO Quality Indicators, Ministry of Health

Outcome 4: Children have a healthy start in life

A child's circumstances and health can have a lasting effect on their life. Poor health as a child predicts self-rated health and the development of chronic conditions as an adult[37]. For this reason, it important that the DHB provides children and their whānau with high-quality, equitable, and accessible services.

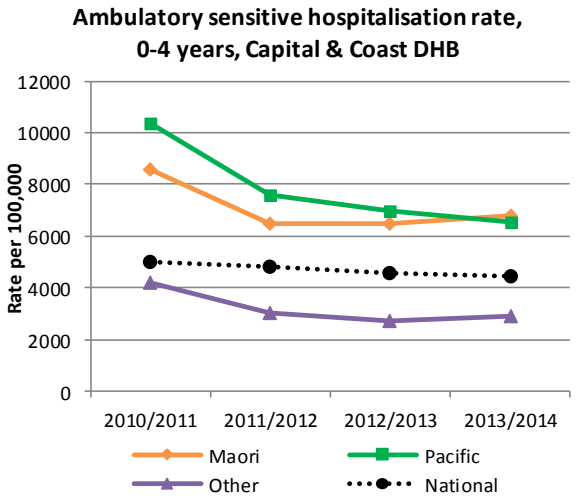
Impact measure: A reduction in Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital for conditions that could have been prevented or treated by appropriate interventions in a primary care or community setting. For children, these conditions include skin infections, dental conditions, asthma, respiratory infections, and gastroenteritis.

ASH rates also highlight opportunities to better support people to seek intervention early and to manage their long-term conditions. A reduction in ASH admissions will reflect better management and treatment across the whole health system.

In Capital & Coast DHB, Māori and Pacific children had higher ASH rates than other ethnicities.

Note that in 2010/11 there was an artificial increase in admissions in the 0-4 age group due to administrative changes. This was remedied in 2011/12. Note that Ministry of Health is revising the methodology for this measure in 2015/16.



Source: Ministry of Health

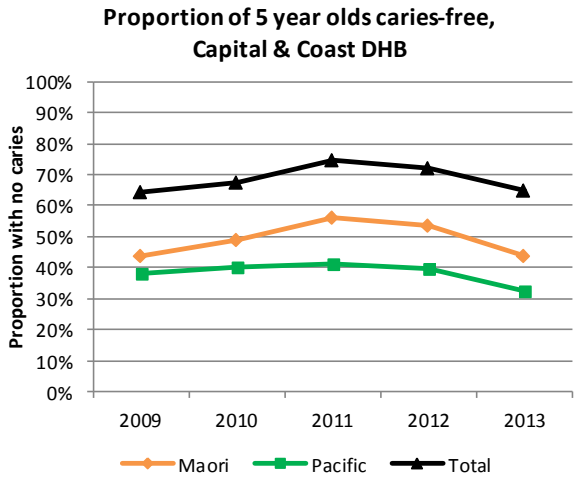
[37] Haas, H. A. (2007). The long-term effects of poor childhood health: An assessment and application of retrospective reports. *Demography, 44*(1), 113-135.

Impact measure: An increase in the proportion of children caries-free at 5 years

Regular dental care has lifelong benefits for health. Improved oral health is also an indicator of the equity of access to services and the effectiveness of mainstream services at targeting those most in need. Māori and Pacific children have worse oral health outcomes than other ethnicities.

The DHB is undertaking a number of activities to improve oral health outcomes for children. A new sub-regional enrolment system has recently been established, and its aim is to enrol every infant with community oral health services. In addition, Before School Checks include a 'Lift the Lip' oral health examination, through which children with poor oral health are referred to community oral health services.

By ensuring that every child has access to and is receiving oral health services, we expect that the proportion of five year olds with no caries will increase.

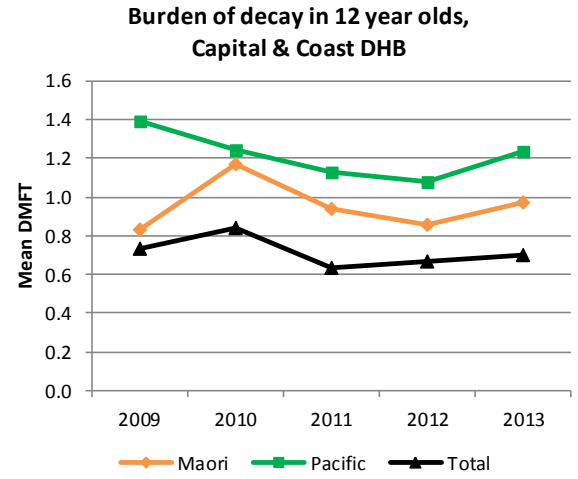


Source: Bee Healthy Dental Service

Impact measure: A decrease in the burden of tooth decay at Year 8

The burden of tooth decay is measured by the mean number of decayed, missing or filled teeth (DMFT) in twelve year old children. Māori and Pacific children have a higher burden of decay than other ethnicities.

By ensuring that every child has access to and is receiving oral health services, we expect that the burden of decay in twelve year olds will decrease.



Source: Bee Healthy Dental Service

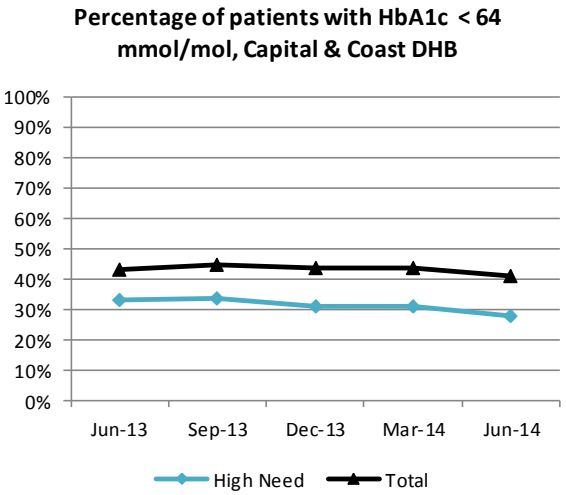
Outcome 5: Long-term conditions are well-managed

The New Zealand Burden of Disease Study[38] suggest that over the next decade people will be living longer with more long-term conditions and consequent disability. In response, our health system needs to increasingly focus on the prevention and on-going management of long-term conditions.

Impact measure: An increase in the proportion of diabetics with satisfactory blood glucose control (HbA1c less than 64 mmol/mol)

Diabetes is a long-term condition that is caused by the body not being able to control its blood sugar levels properly. Diabetes is associated with kidney failure, eyesight problems, foot ulcers, and cardiovascular disease. However, with good diet and exercise, diabetes can be controlled and the risks associated with diabetes minimised. A lower level of HbA1c in the blood indicates that a person's diabetes is being well-managed.

General Practices in our sub-region are required to have a 'Practice Population Plan' that outlines the services and support that they will provide to diabetics. By improving the quality of care and empowering people with diabetes to look after their health, we expect to see an increase in the proportion of diabetics with good blood glucose control.



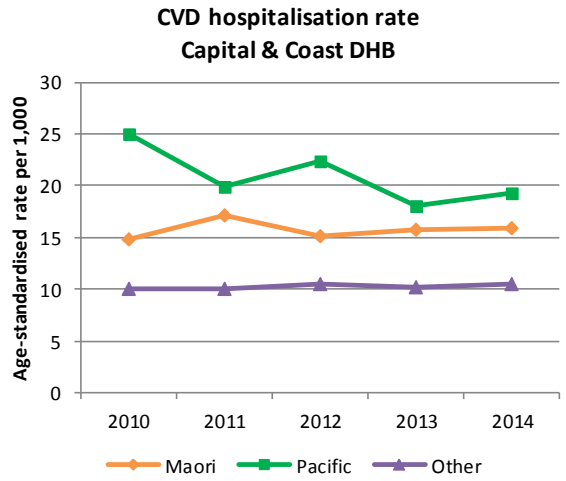
Source: PPP reporting

Impact measure: A decrease in the hospitalisation rate for cardiovascular disease

Cardiovascular diseases (CVD) are diseases that affect the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease. Cardiovascular disease is the leading cause of death in the sub-region. Overall, around 70% of the burden of cardiovascular disease is attributed to modifiable risk factors. CVD is preventable through adopting a healthy lifestyle, and can be managed with lifestyle change, early intervention and effective management.

One of the Health Targets is to provide CVD risk checks for the eligible population (65+ years). By identifying those at risk of CVD early, we can help them to change their lifestyle to improve their health, and reduce the chance that they develop a serious health condition. We expect that this intervention will lead to a decrease in the rate of CVD-related hospitalisations for our population.

In Capital & Coast DHB, Maori and Pacific have a higher rate of CVD hospitalisation than other ethnicities.



Source: National Minimum Dataset, ICD codes I00-I99, 15+ year olds

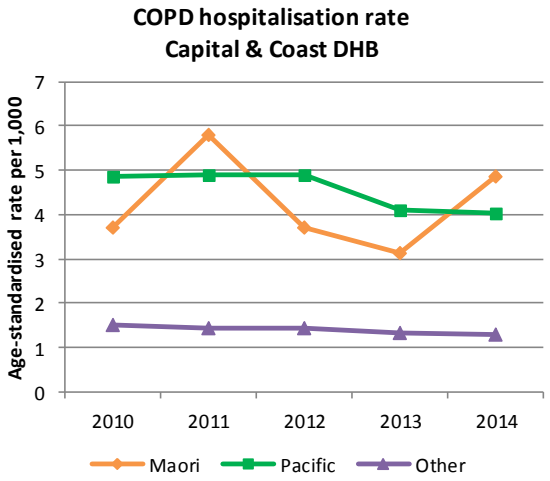
[38] Ministry of Health

Impact measure: A decrease in the hospitalisation rate for chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is the result of damage to the lungs. COPD is most commonly associated with smoking, and although lung damage is permanent, quitting smoking can help to improve COPD symptoms and prevent further damage.

By providing cessation support for people who smoke, improving access to primary care, and helping people to take their medication regularly, we expect that the rate of COPD hospitalisations for our population will decrease.

In Capital & Coast DHB, the rate of COPD hospitalisation for Māori has varied over the last five years. Rates for Māori and Pacific are approximately three times higher than the rate for other ethnicities.

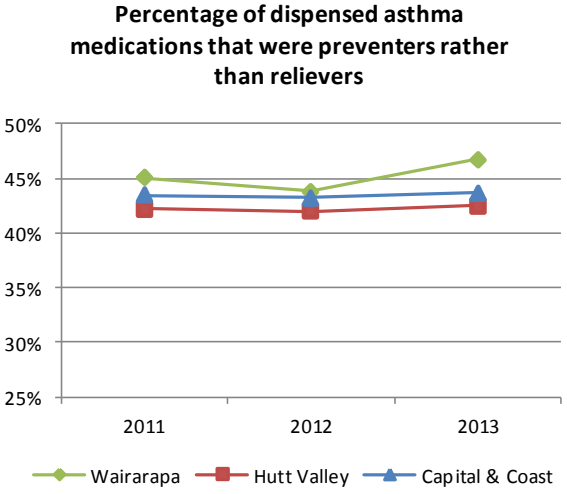


Source: National Minimum Dataset, ICD codes J40-J44, 15+ year olds

Impact measure: An increase in the proportion of dispensed asthma medications that were preventers rather than relievers

Asthma occurs when a person's airways tighten and produce more mucous, making it difficult to breathe. It is often caused by pollen, cold air, or respiratory infections. People with on-going asthma generally use a preventer, which reduces the chance that their asthma will be triggered. They can also use a reliever, which they take to reduce their symptoms if they have trouble breathing.

If a person's asthma is well-managed, they should be using their preventer more frequently than their reliever.
A higher percentage of preventers dispensed indicates that asthma is being well-managed. By improving access to primary care, and supporting people to take their long term medications, we expect that people will use more preventers and less relievers.



Source: Health Quality Safety Commission

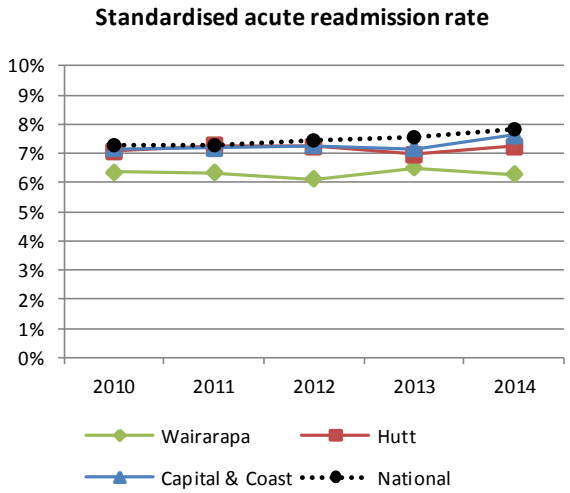
Outcome 6: People receive high quality hospital and specialist health services when they need them

Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention (i.e., removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic, and to reduce the risk of cancer and infection) or through corrective action (i.e., major joint replacements to relieve pain and improve activity). Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services.

Impact measure: A reduction in the standardised[39] rate of acute readmissions to hospital within 28 days

A decrease in the rate of acute readmissions shows that people are receiving high-quality care in hospital, that they are being appropriately discharged (i.e., not leaving hospital too early or too late), and that they are being well-supported by primary and community care once they are out of hospital.
The standardised acute readmission rate has remained at about 6.5% for Wairarapa and 7% for Hutt Valley and Capital & Coast over the last five years. Although the acute readmission rate has remained the same, the average length of stay in our hospital facilities has decreased (see Section 3.3.3), which shows that the effectiveness and efficiency of treatment in hospital has improved.

Note that the methodology for this measure is being revised by Ministry of Health in 2015/16.

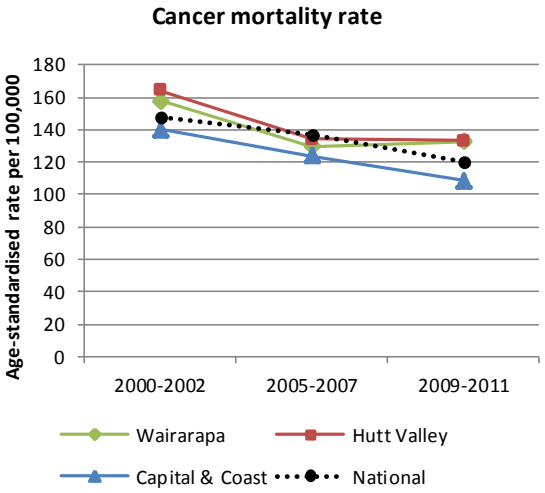


Source: Ministry of Health

Impact measure: Maintain or reduce the age-standardised[40] cancer mortality rate

More people are developing cancer, mainly because the population is growing and getting older.
Many cancers can be cured if they're found and treated in time. It is estimated that in New Zealand, about one person in every three who gets cancer is cured.

By screening women for breast and cervical cancer, and providing timely cancer treatment, we expect that the cancer mortality rate will decrease.



Source: Ministry of Health Mortality dataset

[39] The standardised acute readmission rate accounts for casemix and population differences between DHBs, in order to improve the comparability of the measure across the sector. Refer to the Ministry of Health website (www.moh.govt.nz) for more information on how this measure is calculated.

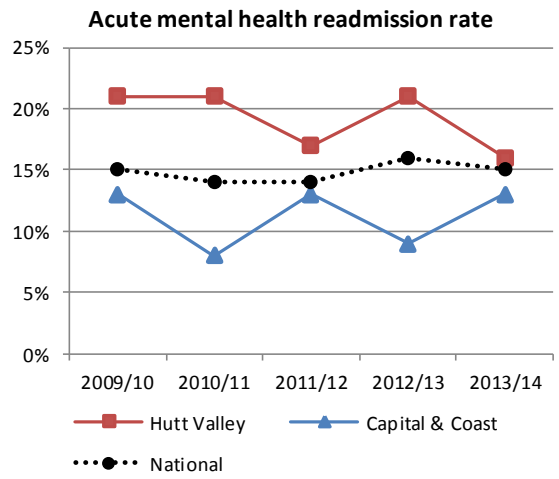
[40] Age-standardisation accounts for differences in the age structure between populations and changes in the age structure over time. The age-standardised rate estimates what the rate would be if the age structures were the same. See also Section 3.2.2.

Outcome 7: People receive high quality mental health services when they need them

Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act.

Impact measure: A reduction in the rate of acute readmissions to inpatient mental health services within 28 days

Inpatient mental health services aim to provide treatment that enables individuals to return to the community as soon as possible. Unplanned readmissions to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to support the person out of hospital. A decrease in the rate of acute mental health readmissions reflects good continuity of care across the health system.

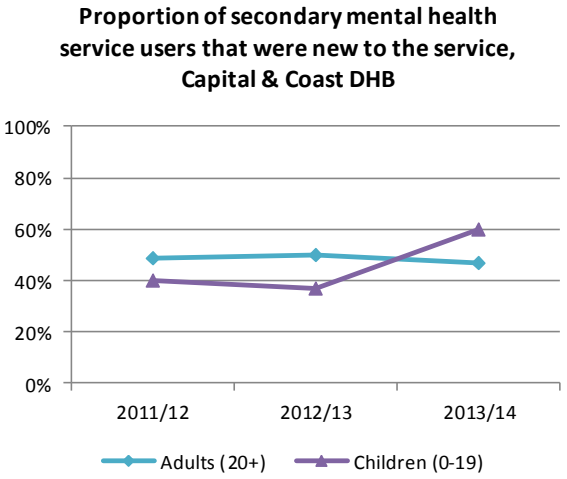


Source: Ministry of Health

Impact measure: An increase in the percentage of new service users accessing secondary mental health services (of all people accessing secondary mental health services. New service users are those who have not used mental health services in the last five years)

This measure indicates the responsiveness of secondary mental health services to people who require secondary mental health care for the first time.

By ensuring that existing users of secondary mental health services only receive these services for as long as they need them, we can increase our capacity and remove access barriers for new service users. As a result, we expect that the proportion of service users that are new will increase.



Source: Ministry of Health

Outcome 8: Responsive health services for people with disabilities Disability is defined as long-term limitation (resulting from impairment) in a person's ability to carry out daily activities. In 2013, an estimated 24% of people living in New Zealand were identified as disabled. National estimates by age and gender applied to the sub-region indicate a disabled population of approximately 109,000 people: 11,000 in Wairarapa (27%), 33,000 in Hutt Valley (24%) and 65,000 in CCDHB (23%). The DHB has a responsibility to provide responsive and appropriate health services to people with disabilities.	
Impact measure: An increase in the proportion of patients and clinicians that found the Health Passport useful (as a percentage of patients and clinicians that responded to an evaluation survey and reported using the Health Passport) The Health Passport is a document that a person takes with them when they use medical services. The Health Passport contains information about the person that they would like hospital staff to know. For example, a Health Passport includes how a person would like to be communicated with, their medical conditions, what medications they are allergic to, and their religious/spiritual preferences. An increase in the proportion of people that find the Health Passport useful will indicate that the Health Passport is achieving its aims and improving the quality of care of patients when they are in hospital.	Measure to be developed during 2015/16

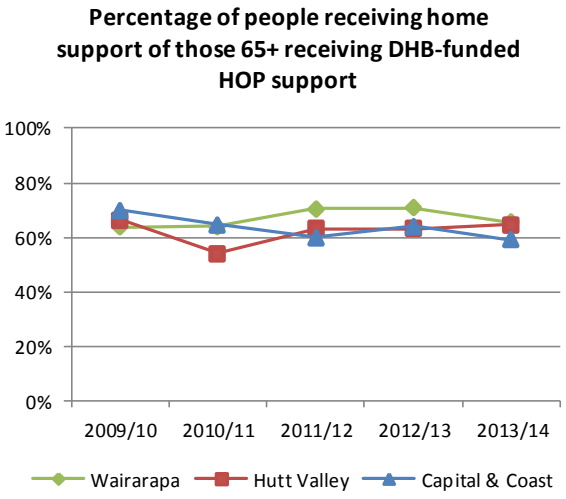
Outcome 9: Improve the health, well-being, and independence of our region's older people

Our ageing population will increase pressure on the health system. National estimates suggest that the increase in health expectancy over the period 2006–2016 will be less than the corresponding increase in life expectancy. In other words, people will live longer, and they will live longer in good health, but they will also live longer in poor health, with multiple comorbidities, functional impairments and frailty. The DHB has a responsibility to provide appropriate services to improve the health, wellbeing, and independence of our older population.

Impact measure: Maintain or increase the proportion of patients receiving home based support services (of those 65+ who receive DHB funded home based support or aged residential care services)

With an ageing population, it is important that services are effective and efficient for people who wish to remain in their own homes. A 2008 study[41] found that "…home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy." This shows the importance of helping older people to maintain their independence.

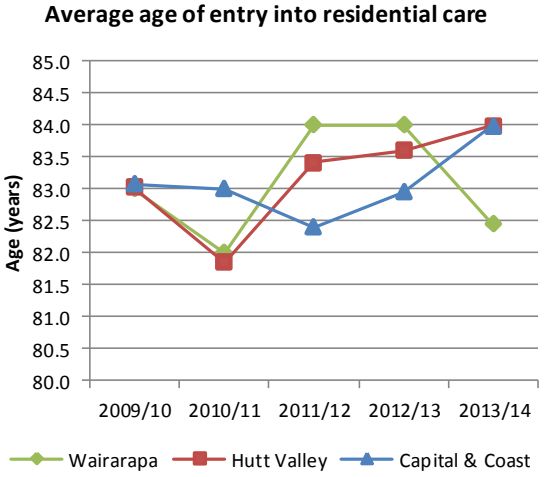
By providing comprehensive and high-quality home-support services, we expect that there will be an increase in the proportion of people receiving home support rather than in residential care.



Source: Health of Older People regional benchmarking

Impact measure: Maintain or increase the average age of entry into residential care

An increase in the average age of entry into residential care would indicate that older people are remaining independent and staying at home for longer. By providing quality home support services to those who need them, and high-quality and timely health services for older people to help them maintain their health, we expect that the average age of entry into residential care will increase.



Source: Health of Older People regional benchmarking

[41] Hambleton, P., Keeling, S., & McKenzie, M. (2008). Quality of life is … : The views of older recipients of low-level home support. *Social Policy Journal of New Zealand, 33*, 146-162.

‘MODULE 2’ DELIVERING ON HEALTH PRIORITIES & TARGETS

2.1 HEALTH TARGETS AND PRIORITIES

This part of our Annual Plan describes the actions that we are taking in 2015/16 to effectively and efficiently deliver on the overarching goal of ‘Better, Sooner, More Convenient Health Services for all New Zealanders’ – in a sustainable and clinically-safe way. It includes what will be delivered through our work in partnership with our Alliance Leadership Team (ALT), and on our Central Region Regional Service Plan. It also describes actions under the responsibility of the ALT, around integrating clinical services and delivering a range of hospital services in community/primary settings; actions that are designed to make better use of available resources; and indicates points of interaction with other planning activities, e.g. Māori Health Plan, Mental Health and Addictions Plan, Disability Action Plan, and Regional Public Health Service Plan.

Priorities in health service delivery have been grouped into the six high level National Health Targets, the Government Priorities, regional priorities, and our local health system priorities. Health targets are a set of national performance measures designed to improve the performance of key health services[42]. The targets provide a focus for action in areas of significant public and government priority. The health targets are reviewed, and adjustments are made to individual health targets annually with Ministerial agreement, as part of each annual planning round.

2.1.1 Priorities for a Better Sooner More Convenient Health System

We will maintain our momentum on those Health Targets where we have shown consistent achievement; we will continue to build on the gains we are making in the other areas to ensure sustainable progress towards achievement. Our DHB and ALT are working to achieve outcomes against the Minister’s Letter of Expectation, December 2014.

Table 1- National Health Targets

NATIONAL HEALTH TARGETS		WHAT WE ARE DOING
Better Public Services	Immunisation	68
System Integration	Emergency Department	70
System Integration	Better Help for Smokers to Quit	72
System Integration	Faster Cancer Treatment	74
System Integration	Electives	77
System Integration	More Heart and Diabetes Checks	79

2.1.1.1 Better Care through Supporting Service Integration

The World Health Organisation describes integration as ‘the organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money’. We intend to integrate services that result in the patient journey through the health system being seamless and as simple as possible, as described by the ‘Better Sooner More Convenient’ policy. ‘Integration’ of services includes primary and secondary care (See 2.2.17), and with our sub-regional DHBs (each priority area describes sub-regional activity).

2.1.1.2 Delivering Better Public Services

There are a number of priorities that can only be delivered with government agencies working together, particularly through Whānau Ora and Social Sector Trials (SST). Locally we are delivering two SSTs - in the Wairarapa and Porirua. The areas in which health has a specific role to play in improving public health are: Immunisation target,

[42] Detailed health targets information is available at www.health.govt.nz/healthtargets

Children's Action Plan; reducing Rheumatic Fever; and the Youth Mental Health Project; our focus will also include reducing the inequity experienced by Pacific people, Māori, and those with disabilities.

Table 2 – Government Priorities and Enablers guiding our work 2015/16

GOVERNMENT PRIORITY AREAS		WHAT WE ARE DOING
Better Public Services	Rheumatic Fever	50
Better Public Services	Children's Action Plan	52
Better Public Services	Whānau Ora	54
Better Public Services	Youth Mental Health Project	58
Better Public Services	Healthy Families NZ	61
Better Public Services	Equity and Disability	62
Better Public Services	Equity and Māori Health	64
Better Public Services	Equity and Pacific People's Health	66
Better Public Services	Social Sector Trials	50, 52, 58, 106
System Integration	Palliative Care	56
System Integration	Diabetes Care Improvement Packages	80
System Integration	Primary Care and Integration	82
System Integration	Health of Older People	88
System Integration	Mental Health and Addictions	93
System Integration	Access to Diagnostics	98
System Integration	Cardiac Services	99
System Integration	Stroke	101
System Integration	Long-Term Conditions	103
System Integration	Spinal Cord Impairment	105
System Integration	Maternal and Child Health	106
System Integration	Major Trauma	110
Enabler	Workforce	111
Enabler	IT	114
Enabler	Quality Improvement	116
Enabler	Living Within Our Means	130

Table 3 – Māori Health priorities for 2015/16

MĀORI HEALTH INDICATOR (Māori Health Plan)	ANNUAL PLAN AREA (DHB Annual Plan)	WHAT WE ARE DOING
Data quality	Equity and Māori Health 2.2.8	64
Ambulatory Sensitive Hospitalisations (ASH) 0-4, 45-64 years	Primary Care and Integration 2.2.17 Social Sector Trials 2.2.5	 50, 52, 58, 106
Māori enrolled in Primary Health Organisations	Primary Care and Integration 2.2.17	82
Immunisation coverage at 8 months old Maternal and Child Health	Equity and Māori Health 2.2.8	64
Immunisation for influenza at 65+ years	Primary Care and Integration 2.2.17	82
Breastfeeding to 6 months old	Equity and Māori Health 2.2.8 Maternal and Child Health 2.2.25	64 106
Screening for breast cancer	Output Classes (Prevention) 3.3.1 Equity and Māori Health 2.2.8	119 64
Screening for cervical cancer	Output Classes (Prevention) 3.3.1 Equity and Māori Health 2.2.8	119 64
CVD risk assessment	More Heart and Diabetes Checks 2.2.15 Output Classes (Early Detection & Management) 3.3.2	79 119
CVD angiograms / data collection	Cardiac Services 2.2.21	99
Rheumatic Fever	Rheumatic Fever 2.2.1	50
Oral health	Equity and Māori Health 2.2.8 Output Classes (Early Detection & Management) 3.3.2 Maternal and Child Health 2.2.25	64 119 106
Mental health	Mental Health and Addictions 2.2.19	93
SUDI	Maternal and Child Health 2.2.25 Better Help For Smokers To Quit 2.2.12	106 72
Mothers Smokefree at 2 weeks postnatal	Better Help For Smokers To Quit 2.2.12	72

2.1.2 National Entities

Our Annual Plan also states our responsibilities towards supporting delivery of initiatives with our six National Entities. Page references are to Module 2, but some have a more appropriate fit in 'Stewardship', Module 5.

Table 4 – Actions supporting National Entity activity for 2015/16

NATIONAL ENTITY PRIORITIES	WHAT WE ARE DOING
Health Workforce NZ	111, 151
National Health IT Board	114, 149
Health Quality & Safety Commission	116, 147
Health Promotion Agency	50, 68, 79, 106
Shared Services Programme	141
PHARMAC	142
National Health Committee	142

2.1.3 Regional Actions

The Central Region Regional Services Plan is a framework for the collaborative activities of the six lower North Island DHBs - Whanganui, MidCentral, Hawke's Bay, Wairarapa, Hutt Valley, and Capital & Coast, and services ~880,000 people. Inputs required for achievement of regional outputs include: development of effective networks – clinical/non-clinical; building workforce and a supportive training hub; focus on Māori health; capital assets; and, shared services between the DHBs. Table below describes the priority area Actions under these priorities intended to improve the quality of services, reduce waste and harm, and improve the patient experience.

Table 5 – Central Region actions we are contributing to for 2015/16

REGIONAL PRIORITIES	OUTPUTS	WHAT WE ARE DOING
Children's Action Plan	Co-Ordinated Services	52
Palliative Care	Improved Services	56
Māori Health	Co-Ordinated Services	64
Cancer Services	Improved Access; Reduced Waiting Times	74
Electives	Improved Access; Reduced Waiting Times	77
Health of Older People	Improved Health Outcomes	88
Mental Health and Addictions	Improved Service Delivery	93
Diagnostic Imaging	Improved Access; Reduced Waiting Times	98
Cardiac Services	Improved Access; Reduced Waiting Times	99
Stroke Services	Improved Services; More Timely Access	101
Maternal and Child Health	Improved Services	106
Major Trauma	Systems Developed	110
Workforce	Enabler For A Sustainable And Fit-For-Purpose Workforce	111
IT	Enabler For Improved Systems	114
Quality Improvement	Enabler	116
Hepatitis C Service	Improved Services	82
Capital	Enabler For Fit-For-Purpose Structures	150

2.1.4 Sub-Regional Actions

Our three sub-regional DHBs serve their own and their neighbouring populations health care needs; they retain their own Boards and Chief Executives that oversee the health needs of the local populations, however they also work together as one in terms of what is best overall for the three populations. Each health priority area and many Stewardship activities include sub-regional activity and initiatives that work to improve the journey for the patient and consumer that support improved service quality and safety and that enables a more effective and efficient health system for the sub-region. During the year new initiatives may be expected that further promote smart sub-regional activity where evidence and experience suggests there is a need.

2.2 PRIORITY AREA DELIVERABLES

The following sections in Module 2 pull the national, regional, sub-regional, and local priorities together for each Health Target and health priority area. Each section sets out the key actions needed to achieve higher-level results our DHB expects to achieve, and identifies accountability measures that provide evidence of progress towards achievement.

DELIVERING BETTER PUBLIC SERVICES

2.2.1 RHEUMATIC FEVER

Rheumatic fever is a serious but preventable illness. It mainly affects Māori and Pacific children and young people (aged 4 and above), especially if they have other family members who have had rheumatic fever. Rheumatic fever can develop after a 'strep throat', a throat infection caused by Group A Streptococcus (GAS) bacteria. Most strep throats get better and don't lead to rheumatic fever. However, in a small number of people an untreated strep throat leads to rheumatic fever one to five weeks after a sore throat. This can cause the heart, joints, brain and skin to become inflamed and swollen. While symptoms of rheumatic fever may disappear on their own, the inflammation can cause rheumatic heart disease, where there is scarring of the heart valves. People with rheumatic heart disease may need heart valve replacement surgery. Rheumatic heart disease can cause premature death in adults.

Sub-Regional

	Action	Measure	Timeframe
1	In 2014 a sub-regional rheumatic fever plan was developed, with the aim to reduce the incidence of Rheumatic Fever through a programme of work focussed on prevention, treatment, and follow-up. The plan is part of the Government's Rheumatic Fever Prevention Programme (RFPP) which is working to improve outcomes for vulnerable children and achieve the goal of reducing the incidence of rheumatic fever in New Zealand by two thirds to a rate of 1.4 cases per 100,000 people by June 2017. The key components of the plan are: 1. Prevent the transmission of Group A Streptococcal throat infections in Wairarapa, Hutt Valley, and Capital & Coast DHB sub-region, through: – Implementation of a pathway, with Regional Public Health, across the sub-region to identify and refer high risk children to comprehensive housing, health assessment and referrals services by June 2016 – Development of the Housing and Health Capability Building Programme with Regional Public Health throughout 2015/16 and implementation of insulation referral process for high-risk patients by June 2016 – Raising community awareness with Regional Public Health throughout 2015/16, and on-going 2. Treat Group A Streptococcal infections quickly and effectively through: – Provision of training and information with Regional Public Health for primary care providers, throughout 2015/16 and on-going – Development and implementation of audit tool for the treatment of sore throats in primary care by June 2016 – On-going sore throat swabbing in schools throughout 2015/16, with Regional Public Health 3. Facilitate effective follow-up of identified rheumatic fever cases through: – Tracking of timeliness of antibiotics through rheumatic fever register with annual audit and stakeholder meetings – Appropriate mechanisms for annual training of hospital medical staff implemented by June 2016 – Implementation of audit process to follow up on all cases of rheumatic fever (root cause analysis process undertaken) with Regional Public Health; for Hutt Valley and Capital & Coast DHBs this will include quarterly reporting on the lessons learned and actions taken, by June 2016 – Development and implementation of a clinical pathway with Regional Public Health from	55% reduction from baseline in rates of rheumatic fever hospitalisations (cases/100,000 population); reduction in rates for Māori Rates at baseline and target rates for rheumatic fever hospitalisations (cases/100,000 population) for Wairarapa, Hutt Valley, and Capital & Coast DHBs: See PP28 (Module 7): Reducing Rheumatic fever	Q4

	2009/10-2011/12	2015/16	
DHB	Baseline year (3-year average rate)	55% reduction from baseline	
		Rate	Numbers
Wairarapa	0.0	0.0	0.0
Hutt	4.9	2.2	3
Capital & Coast	2.9	1.3	4

	diagnosis through to the end of bicillin course, by June 2016 In 2015/16 there will be increased focus on consistent communication messages to the public and health professionals, education of health professionals in primary and secondary care and antibiotic adherence.	
2	– Refinement of the throat management services in primary care in Capital & Coast DHB – Refinement of walk-in sore throat clinics in the Hutt Valley	Q4
3	– Engagement with Pacific Health and Wellbeing Collective – Ensure key messages are reaching Pacific families	Q4
4	– With Regional Public Health, maintain engagement with local providers in Porirua East through Porirua Kids Group and Porirua Social Sector Trial – Refer to 2.2.5, Youth Mental Health Project	Q4

Capital & Coast DHB

	Action	Measure	Timeframe
1	Meet 2015/16 targets for first episode rheumatic fever hospitalisations	Meet targets for first episode rheumatic fever hospitalisations for 2015/16	Q4
2	Review and update sub-regional DHB Rheumatic Fever Prevention Plan	Delivery of updated sub-regional Rheumatic Fever Prevention Plan	Q1
3	Undertake root cause analysis of every rheumatic fever case and identify systems failures.	Provide a report on the lessons learned and actions taken following the root cause analysis	Q1, 2, 3, 4
4	See Māori Health Plan for further details on Rheumatic Fever actions	Reduction in rates for Māori	Q4

National Entities – Health Promotion Agency

	Action	Measure	Timeframe
1	Rheumatic fever public awareness campaign targeted at Pacific and Māori parents of at risk children and young people; raise awareness about: 1. link between sore throats and rheumatic fever 2. importance of getting sore throats in at risk children checked by a health professional 3. importance of completing full antibiotics course for children who have Group A streptococcal bacteria 4. people at-risk of rheumatic fever can keep their children safe in their own homes	Support HPA activities around this campaign; from April 2015 to August 2015	Q4

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2.2.2 CHILDREN'S ACTION PLAN

The Children's Action Plan (CAP) provides a high level programme framework for the Government's White Paper for Vulnerable Children (2012). It outlines a range of cross-government interventions targeting vulnerable children who are at risk of harm now or in the future. It aligns under Better Public Services context, specifically early identification and support for vulnerable children.

Sub-regional

Action	Measure	Timeframe
Perinatal, Maternal and Infant Mental Health Strategy **This strategy will help address the needs of children with mental health and behavioural problems.** Strategy takes into account a cross sector, stepped care approach to working with expectant families and those with young children. The development is informed by a Steering Group with representatives from a variety of services, and a Reference Group with members from over 35 agencies and services (primary care, NGOs, PHOs, various hospital departments including social work, neonates, maternity, women's, children's and mental health; other government departments including Child Youth and Family and Education, etc.) working with expectant mothers, families, and young children.	– Clinical Care Pathway – Training and education regarding the use of screening and assessment tools – Trial and evaluation plan for the strategy implementation developed – Strategy reviewed	Q1 Q2 Q3 Q4

Capital & Coast DHB

	Action	Measure	Timeframe
1	Implement Vulnerable Children's Act requirements across the sub-region including: – completion of Vetting Policy relating to safety checks of all core and non-core workers by HR – update Child Protection Policies to ensure systems in place to identify and report on child neglect and abuse – all DHB funded service providers to sign a variation of service agreement, regarding requirements under the VCA, to adopt and review child protection policies – maintain VCA Working Group chaired by Sub-Regional Quality team, to ensure adherence to VCA requirements across the sub-region – see Module 5 Stewardship - Workforce	– All core workers (someone who is has unsupervised contact or primary responsibility for a child patient) starting in new role are safety checked – All non-core workers (any other person working with children) starting in a new role are safety checked	Q1 Q4
	Complete National Child Protection Alerts System accreditation and align with other child protection information systems	– Implement NCPAS	Q4
	Violence Intervention Programme – Continue rollout and evaluation of VIP training to all DHB professionals, as well as primary and community health workforce, to recognise signs of abuse and maltreatment in designated services: child and maternal health, alcohol and drugs, mental health, sexual health and Emergency Department, and Regional Public Health – Co-ordination of partner and child abuse and neglect programmes with Regional Public Health to support increased identification of vulnerable children	– Reduce deaths from assault neglect or maltreatment of children aged 0-14 years – Reduce hospitalisations for injuries arising from the assault, neglect or maltreatment of children aged 0-14 years by 3%	Q4 Q4
	Continue to support rollout of Shaken Baby Programme	– Achieve audit scores of 80/100 for each of the child and partner abuse components of hospital VIP programmes	Q1
2	Support establishment of Children's Teams: – Work towards engagement processes with primary and community partners regarding future implementation of Children's Teams – Monitor regional DHBs' experiences from pilots		Q4

3	**Services across primary and referred health services** Service planning and development activities work to provide an effective continuum of to meet the needs of: – pregnant women with complex needs – vulnerable children and their families / whānau – children referred to Gateway Programme – Vulnerable Women and Unborn Baby MDTs meets fortnightly in each DHB – Review and re-launch of VIP training (Partner abuse & Child abuse and neglect) – Continue discussions with ED, Allied Health and local Women's Refuges about enhancing referral pathways for partner abuse victims. – Working in local Social Sector Trials (Wairarapa, Porirua), with Regional Public Health, to deliver outcomes for children across a wide range of dimensions – health, education, social and justice, through a locally-integrated approach with other agencies to address issues with the most vulnerable populations in specific communities. – Ensuring Vulnerable Pregnant Women and Children multidisciplinary team (MDT) processes are streamlined across sub-region, to support early identification and referral systems (see also 2.2.5 Youth Mental Health Project) – Support implementation of Rising to the Challenge - e.g., Children of Parents with Mental Illness and / or Addiction (COPMIA) - and Healthy Beginnings: Developing perinatal and Infant Mental Health Services in NZ (see 2.2.19 Mental Health and Addictions)	– 100% of Report of Concern (ROC) to CYF result in an MDT meeting – 100% of children referred by CYF have completed a Gateway Assessment – Vulnerable Pregnant Women & At Risk Unborn Children Pathway completed, and live as part of the 3 DHBs Health Pathways work – A stocktake of referred services for vulnerable pregnant women completed – Increased screening rates within Child Health, Women's Health. – All DHBs' Fortnightly Vulnerable Women and Unborn Baby Groups have adopted the National Maternal Care, Wellbeing and Child Protection Multiagency Group Toolkit – Reduced avoidable presentations to the Wellington Hospital Emergency Department; Reduced avoidable admissions to the Wellington Hospital through a cross-agency response – Uptake of National VPW toolkits within DHB MDTs	Q4

Regional			
	Action	**Measure**	**Timeframe**
1	Support implementation of Regional Children's Teams (when pilot is established in sub-region) – see also actions above		Q4
2	Monitor DHBs' experiences from pilots already established nationally		Q4

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2.2.3 WHĀNAU ORA

Whānau Ora is an inclusive interagency approach to providing health and social services to build the capacity of all New Zealand families in need. It empowers whānau as a whole rather than focusing separately on individual family members and the challenges they face in isolation. The whānau ora philosophy is distinctive because it recognises a collective entity (the whānau); endorses a group capacity for self-determination; has an intergenerational dynamic; is built on a Māori cultural foundation; asserts a positive role for whānau within society; and, can be applied to a wide range of social and economic sectors. As DHBs hold the key relations with health providers, we are well placed to use the opportunity present by the whānau Ora provider collectives programmes and the NGO Commissioning Agencies to improve service delivery and build mature providers. The results expected of whānau-centred initiatives are that whānau will be: self-managing; living healthy lifestyles; participating fully in society; confidently participating in te ao Māori; economically secure and successfully involved in wealth creation; and, cohesive, resilient, and nurturing. Refer to S15 (Module 7) for delivery measures related to Whānau Ora.

Sub-Regional

	Action	Measure	Timeframe
1	Strengthen relationship with local Whānau Ora provider collectives – involve Whānau Ora providers and collectives in strategic planning, support outcome focused, whānau-centred service delivery through its contracts with local Whānau Ora providers and collectives, work with Whānau Ora providers and collectives to maximise their capacity and capability to improve whānau health outcomes	– Participate in processes led by the Ministry to obtain a broader health sector view on Whānau Ora implementation – Support providers using the Whānau Ora Information System	Q4
2	Identify opportunities to collaborate with Whānau Ora Commissioning Agencies – involve local commissioning agencies in planning, working on joint projects/commissioning together, building strong relationships with the Commissiong Agencies for the benefit of families/whānau	– Improved contracting processes through a greater focus on outcomes for Whānau – Further refinement of integrated contracting process within the DHB and the integration of streamlined contracts across Government funders	Q4

Capital & Coast DHB

	Action	Measure	Timeframe
	Capital & Coast DHB have made some positive gains for Māori, nonetheless, inequalities still exist. With a collective approach from across the health system, we are determined to make further progress. We will continue to support the capacity and capability growth Te Runanga O Toa Rangatira Inc., as a Whānau Ora Provider Collective; by ensuring that the organisation is involved in strategic and planning discussions directed at the implementation of Whānau Ora. Because Whānau Ora is a key cross-government work programme, we will also continue to support inter-agency relationships with Te Puni Kōkiri, the Ministry of Health, the Ministry of Social Development and Te Pou Matakana (North Island Commissioning Agency) to ensure that Whānau Ora remains on everyone's agenda. The DHB's Māori Health Action Plan provides more detail on areas of focus for 2015/16		
1	Maintain key links with Māori bodies at local, regional, and national forum where there is a focus on Whānau Ora	– Report learning / achievements of Māori / Māori health at local, regional, national and international levels	Q1, 2, 3, 4
2	Engage with local Whānau Ora collectives to identify and implement planned areas of provider development with a particular focus on workforce initiatives to improve whānau health outcome and accessing Whānau Ora resources	– Continue to support Scholarship programmes and Hauora Māori opportunities to grow local Māori health workforce through tertiary study and training	Q4
3	Re-start the Whānau Ora Integrated Care Collaborative[43] to identify health priorities across planning, services, and programme evaluation opportunities to accelerate improved Māori Health outcome	– A minimum of: – Four meetings per annum – Two reports on Māori Health plan indicators	 Q4 Q1, 3

[43] Whānau Ora Integrated Care Collaborative membership includes current Whānau Ora Collectives, Capital & Coast DHB Māori Partnership Board members, PHOs and Māori Health providers. The purpose of this group is to best utilise the relatively small critical mass of Māori Health intelligence to provide advice and guidance to the Capital & Coast DHB wide Integrated Care Collaborative in the planning, funding and hospital/community level services

		–	Identify MPDS[44] / MPCAT[45] opportunities and options	Q4
4	Engage with local Whānau Ora collectives to identify and implement shared health promotion initiatives. Initiatives will be aimed at supporting whānau to determine their health pathway with a focus on reducing the impact of long term conditions and improving child health	–	A minimum of four meetings per annum	Q1, 2, 3, 4
5	Develop and implement effective contracting, reporting and monitoring processes which enable 'Whānau Ora Outcomes' to be achieved and identifying potential opportunities for joint funding with PHO and/or Primary and Community care providers	–	RBA[46] and MBIE[47] strategies and actions implemented across all service development and contracts to support a focus on Whānau Ora	Q4
		–	Identify MPDS[48] / MPCAT[49] opportunities and options	Q4
6	Where appropriate, engage with local commissioning agencies, in particular Te Pou Matakana (North Island Commissioning Agency) to identify and implement opportunities in planning, service development, and funding of joint programmes	–	Initiate regular engagement with Te Pou Matakana	Q1
		–	Work towards formalising collaboration between South Island DHBs and Te Pūtahitanga	Q4
		–	On-going engagement with government agencies	Q1, 2, 3, 4
7	Engage with local Whānau Ora collectives to ensure the priorities and actions identified within the DHB's Māori Health Plan are aligned with the direction of Whānau Ora	–	A minimum of four meetings per annum	Q1, 2, 3, 4
8	Participate in national processes to obtain a broader sector view on Whānau Ora implementation.	–	Support Te Runanga O Toa Rangatira Inc in the implementation of the Whānau Ora Information System as required	Q4

[44] Māori Provider Development Scheme
[45] Māori Provider Capacity Assessment Tool
[46] Results Based Accountability
[47] Ministry of Business, Innovation & Employment
[48] Māori Provider Development Scheme
[49] Māori Provider Capacity Assessment Tool

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2.2.4 PALLIATIVE CARE

The fundamental challenge facing palliative care in New Zealand is one of systematic inattention at the strategic levels of thinking around person-centred healthcare. We are creating the notion of dying well, which takes its place as a properly conceived life stage. Incorporating 'Healthy Dying' into a continuum which begins with 'Healthy Start' and currently ends with 'Healthy Aging' allows a holistic consideration of palliative care in relation to the wellbeing of the population. Incorporating health promotion principles in Healthy Dying means directing effort towards giving people the skills and information to make a good life for themselves, and recognising that a 'good death' is an essential and natural part of a 'good life'. In addition to benefiting the individual and their carers and Whānau, this approach also has benefits for health system sustainability.

Sub-Regional

	Action	Measure	Timeframe
1	**Managed Clinical Network (MCN)** The intention of the MCN is to converge on a model where primary healthcare providers predominate. Currently Wairarapa has no hospice or hospital service (no inpatient beds), and specialist palliative care is provided by a community nursing team plus a weekly visit from a specialist provided by Te Omanga Hospice; however, ARC facilities have in total three dedicated beds for those who are dying. Hutt Valley specialist services including inpatient beds are provided exclusively by Te Omanga Hospice, which also provides consulting staff at Hutt Hospital; the hospice is moving towards a model of shared care with GPs. Capital & Coast has specialist services at Mary Potter Hospice and Wellington Hospital, with a high degree of interaction between them; District nurses and hospice staff provide community care in people's homes; moving towards a more community-based model.		
2	**Clinical governance**		
	– Governance group developed to ensure membership reflects all facets of the palliative care sector in the sub-region	– Survey of network membership	Q2
	– Network engages with a cohesive set of networks representing particular interests of relevance to palliative care across the sub-region	– Survey of network membership	Q4
	– Network makes funding recommendations to DHB management	– Analysis of network inputs to decision processes	Q4
	– Network makes funding decisions	– Analysis of network inputs to decision processes	December 2016
3	**Models of care**		
	– Create high-level work plan, low-level project plans, detailed plan for on-going work	– Plans created	Q1
	– Maintain connections with Health of Older People and Long-Term Conditions work	– Evidence of palliative care in other parts of the planning process	Q3
	– Create suite of measures to monitor quality improvement; modelled on those developed by Australian Palliative Care Outcomes Collaboration (e.g. '90% of patients spend three days or less in an unstable phase')		2016-17
	– Maintain connections with DHB disability programme of work; progress work on collaboration between all NASCs	– Appropriate and agreed measures created by the Network	Q1 & on-going Q3
4	**Sustainable workforce**		
	– Creation of a detailed project plan for on-going work	– Plan created	2016-17
	– Work with specialist palliative care providers (Hospices and Hospital Palliative Care Teams) to implement the national Specialist Palliative Care Service Specifications	– Implementation complete	Q4
5	**Advance Care Planning**		
	– Contribute to existing, on-going Advance Care Planning project work, with Frail Elderly, Primary Care and Acute Demand teams	– # trainees and business units practicing ACP	Q1, 2, 3, 4
6	**Last Days of Life Pathway**		
	– Contribute to project implementing model of care identified in final report of Last Days of Life Working Group	– # trainees and business units following the pathway	Q1, 2, 3, 4

Regional			
	Action	**Measure**	**Timeframe**
1	Engagement with regional networks - Central Cancer Network, Central Region Palliative Care Network	Participate in the delivery of the Regional Services Plan	Q4

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2.2.5 PRIME MINISTER'S YOUTH MENTAL HEALTH PROJECT

The three sub-regional DHBs have a Youth-Specific Service Level Alliance (SLA) comprising key clinical leaders and managers appointed by the Alliance Leadership Teams, that leads the planning and delivery of youth health services. The SLA oversees the implementation of the 2015/16 DHB Annual Plans for the Youth Services component of the Prime Minister's Youth Mental Health Project, Primary Care, and work closely with the Porirua and Wairarapa Social Sector Trials. Social Sector Trials have been established in 16 locations around New Zealand to test what happens when community leads are given the mandate to co-ordinate social development, health, education, police and justice activities at a local level in order to achieve improved social outcomes. Fourteen of the 16 Trials have specific outcomes around 12 to 16-year-olds to improve engagement with education and work, and decreased consumption of alcohol and drugs.

The SLA focuses on:

- developing a youth needs analysis and intervention logic to inform services planning;
- initiatives for improving accessibility of health services for young people by making services more youth friendly and responsive to the needs of youth, particularly the 20% of young people at risk of poor health outcomes (those engaging in risky behaviour and/or those who may be distressed), by: implementing health workforce development strategies and improving care pathways for young people; and, implementing an integrated\stepped care approach to meeting the mental health needs of young people; and
- devising an outcomes framework to measure the impact of service initiatives.

The SLA is responsible for:

- developing work streams to progress the priorities and targeted actions;
- partnering with young people, in order to set direction, inform decision making, review progress and disseminate information;
- setting direction and outcomes to be achieved and establish how to monitor achievement of those outcomes; and
- providing progress updates to ALTs and stakeholders.

Sub-Regional

	Action	Measure	Timeframe
1	**Youth Service Level Alliance 2015/16 - overseen by the Service Level Alliance -** Primary Mental Health		
	– Improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health issues) – Utilise results of Ministry of Health's evaluation of the Prime Minister's Youth Mental Health Project to identify what works in order to improve: - early identification of mental health issues - equity of access across the district - better access to timely and appropriate treatment and follow up - target Māori, Pacific, and low decile youth populations	– See Module 7, PP25 – Increase average # referrals received for youth aged 12-19 years to Primary Mental health services – BASELINE: 2013/14 average 332 referrals each quarter (Wairarapa 36,Hutt Valley 83,Capital & Coast 213)	Q1, 2, 3, 4
	Implement service initiatives to support Youth Transitioning from adolescence Mental Health Services (12-25 year old) services to Primary Care that best support young people and their recovery beyond specialist service delivery – Assess the gaps, service barriers – Explore potential opportunities to reconfigure and realign services	– See Module 7, PP7 (Child & Youth with a Transition (discharge) Plan)	
	Enhance primary care service – Enhance primary care service to address 'moderate plus' mental health and alcohol and other drug issues within a primary care setting and to meet the needs of those young people with more severe presentations who choose to remain with their primary care provider – Assess opportunities to enhance primary care service for youth by addressing workforce capacity and capability issues – Outreach psychiatric and psychological services within primary care and YOSS Services (more free ranging clinics) – Assess joint training opportunities	– See Module 7, PP26	
2	**Youth Health Workforce Development**		

	Workforce plan – Build on existing training, offer to more health professionals – Build clinical networks e.g. school nurse network – Build network of youth health champion across primary care and hospital services **School-based Health Services (SBHS) clinical network** – Support development of the SBHS clinical network for all secondary schools nurses to build workforce capability to: - support SBHS nursing training - support a framework for continuous quality improvement - Improve and extend SBHS clinical support – Maintain SBHS in decile 1-3 secondary schools, teen parent units, and alternative education facilities **Improved HPV Gardasil coverage** – Improved HPV Gardasil coverage with Regional Public Health – Improved awareness amongst GPs **Continue the roll out of the Youth Health Care in Secondary Schools: A framework for continuous quality improvement**. – Assist those planning, funding, or providing primary health care services in secondary schools to continuously improve the quality of those services	– Improved Sexual Health Literacy – Early intervention and treatment – See Module 7, PP25 – HPV Gardasil coverage rates increase (see Module 7, P21) – Improve awareness and follow of HPV Gardasil coverage within General Practice – Providers report on policies and a quality improvement plan that are developed from self-assessment of quality indicators as per the Framework for CQI	Q1, 2, 3, 4
3	**Pathways Development** – Existing pathways are localised to ensure they are youth relevant – A generic youth pathway is developed: - identify a clinical lead/s for youth health pathways - consult with sub-regional youth health sector about priority pathways - use existing clinical pathway process of development and editing to localise relevant pathways/develop new pathways - communicate with relevant individuals/organisations around NZ e.g. SYHPANZ to be aware of other work which can be adapted locally **Implement a Youth Friendly Service provision process** – Developmentally appropriate for young people in child health hospital and health services – Endorsement of a youth-friendly initiative led by a visible youth health leadership group – Health services using brief audit tool and this results in changes individual practice and service changes	– Health professionals have knowledge and skills to meet the needs of youth – Improved transitions between services for youth – More high risk youth are engaged in appropriate services – More youth participation and feedback on health services	Q3
4	**Review and improve the follow-up care for those discharged from CAMHS and Youth AOD services** – Improve follow-up in primary care of youth aged 12-19 years discharged from secondary mental health and addiction services by providing follow-up care plans to primary care providers **Improve access to CAMHS and Youth AOD services through wait times targets and integrated case management** – Implement actions to meet the waiting time targets	– Follow-up care plans should be provided with the expectation that they are activated by the primary care provider within three weeks of discharge – 80% of youth to access services within 3 weeks – 95% to access services within 8 weeks – See Module 7, PP7	Q4
5	**Prevention of harm from alcohol** Controlled purchase operations to ensure premises' compliance with Sale of Liquor Act for purchase of alcohol to youth under 18 years, by Regional Public Health	– See Module 3, Prevention	Q4
	Capital & Coast DHB		
	Action	**Measure**	**Timeframe**
1	**Continued support of the Porirua Social Sector Trial (PSST) with Regional Public Health to Reduce ASH rates and ED admissions for young people** – Ensure that PSST lead is represented in the Youth Service Level Alliance (sub-regional) for project prioritisation, service	– Reduce fragmentation of AoD services for	Q3

planning, and service development – PSST and Youth Service Level Alliance have community input, ground-up focus, driving work programmes; engagement focus will be enhanced to include vulnerable groups – Youth Service Level Alliance and PSST service priorities will remain aligned in terms of outcomes for young people and in terms of service delivery and service monitoring – Youth Service Level Alliance and PSST are accountable to Capital & Coast Board and ICC Alliance Leadership Team **Increase existing service capacity within three YOSS to work with young people and their families, responding to AOD and youth health issues within YOSS, schools and alternative education settings** – The YOSS, Kapiti Youth Support, Evolve and Vibe working in a range of youth settings – The plan will utilise funding to support and further extend this existing work – Through YOSS, AOD services can be delivered in an integrated way, providing access to a full range of health and social support services that give young people the best chance to succeed with any AOD treatment **Provide follow-up of young people presenting to Capital & Coast DHB ED with AOD issues** – Identify young people at ED who would benefit from brief interventions and further support **Workforce development to support primary care to build skills and knowledge - enable them to recognise and respond effectively to the alcohol issues of young people** – Provide support for primary care and other agencies developing responses to youth (including AOD problems), including training coaching, mentoring, supervision, consultation/liaison – Collaborate with services across sub-region (including PHOs and ED's) and ensuring assertive engagement-focused service provision in settings involved with children and young people – Action Table based on building on the outcomes to date - population health key messages, dental access, population health in primary schools, research for youth access and whānau access to health services and the warm housing support – Referral process between primary and secondary care social and allied health services moved to a shared service model – Link social and allied health services within health and then/with other navigator services across Porirua – Link support for those who directly experience family/domestic violence with support close to home (link with MSD, Police) – Increase engagement opportunities for those most dis-engaged e.g. take health support to those in Family and Youth Court processes, working with youth 18-19 years old who are Work and Income customers, supporting young people identified by Public Health Nurses or Social Worker in School programmes to create engagement in wellness thinking, resilience and treatment for the child and their whānau to reduce their need for hospital admissions – Support creation of community health hubs in primary schools to ensure these communities have easy access to services – Ensure whānau/children are aware of services available to them, e.g. support to stay well while they attend school and play sport – Ensure Māori and Pacific ambulatory sensitive hospitalisations and Emergency Department attenders are identified and a follow up process established in primary care and the community – Health providing leadership for community development given the extensive access to data around the wellbeing of community linked with the Porirua City Council Children and Young People being the focus of city decisions – Link with Compass Health Mental Health Advisory Group workshop on suicide prevention work	youth and better integrate the work of SST sites and YOSS with the health sector – Increase in early identification and intervention for drugs and alcohol Q3 – Reduced ambulatory sensitive hospitalisations (ASH) and emergency department attendances for young people (key goal of the Porirua Social Sector Trial) Q3 – Health professionals have knowledge and skills to meet the needs of youth Q3 – Engagement with youth enhanced Q3 – SLA and PSST report quarterly to DHB and ALT Q1,2,3,4 – Reduction in ASH rates and ED admissions will be monitored and reported on Q1,2,3,4 – Reduction in Māori and Pacific ambulatory sensitive hospitalisations and Emergency Department attendance Q2, 4

DELIVERING BETTER PUBLIC SERVICES

2.2.6 HEALTHY FAMILIES NZ

New Zealand has one of the best health systems in the world, but it is under pressure from increasing rates of preventable chronic diseases. In particular, an increase in people being overweight or obese is associated with higher rates of diabetes, cardiovascular disease, osteoarthritis and some cancers. A new initiative that aims to improve people's health where they live, learn, work and play in order to prevent chronic disease. Encouraging families to live healthy lives (by making good food choices, being physically active, sustaining a healthy weight, being smoke free and drinking alcohol only in moderation) is part of our approach to promoting good health. The most visible aspect of Healthy Families NZ is the establishment of 10 Healthy Families communities across New Zealand. At each location, a locally-based lead provider is responsible for bringing together a partnership of key organisations in the community, and establishing a dedicated health promotion workforce in each community selected to participate in the initiative. The health promotion workforce will work across schools, early childhood education centres, workplaces, and other community settings, such as sports clubs.

Lead by Hutt Valley DHB

	Action	Measure	Timeframe
1	Hutt Valley DHB will support and align closely with several of its providers and hospital based services and the other participating organisations by identifying opportunities to add value to a community-led, dynamic systems approach to preventing chronic disease.		
2	Hutt Valley DHB and Regional Public Health are fully committed and active members of the Prevention Partnership. Regional Public Health (a Hutt Valley DHB based service) has been instrumental to date in bringing the partners together, winning the RFP process and establishing the pathway forward.	Provision of a confirmation/exception report against participation	Q4
3	Continue to commit FTE resource at both a governance and operational level. Development of the Healthy Families Lower Hutt 'roadmap'; with subsequent identification of specific resources required.		
4	The partnering organisations include Hutt City Council (lead agency), Te Runanganui O Taranaki Whanui, Regional Public Health, Te Awakairangi Health Network, Sport Wellington, Takiri Mai Te Ata Trust, Hutt Valley Youth Health Trust, The National Heart Foundation Of New Zealand, Pacific Health Service Hutt Valley, and Te Aroha Hutt Valley Association.		
5	DHB will participate in the development of the Healthy Families Lower Hutt Roadmap, with the Healthy Families NZ local lead provider.		

DELIVERING BETTER PUBLIC SERVICES

2.2.7 EQUITY AND DISABILITY

Disability is not about what people *have* – people live with impairments of many kinds; disability is about the *interaction* of people, services, and systems with the individual and group in a way that *disadvantages* them. While 24% of the population across all communities and age groups now identify with a disability, research suggests an even higher percentage of those are high users of our health-services, although people who experience disability as a result of long-term conditions, and those who have lifelong disability with additional complex health needs, are often invisible in population health data. However we do know that people with learning disabilities are 17 times more likely to be admitted with respiratory disease and psychosis, 4.5 times more like to die prematurely, and the cost of admission is on average 2.5 times that of their peers. All ages are impacted: children transitioning to adult services and their families experience great difficulties, older people are facing barriers due to access issues. We know a more enabling and person-centred system will lead to better quality and more enabling services for all, therefore our sub-regional DHBs have collaborated with our communities and agreed on a five-year plan for improved integration and better health outcomes for people with disabilities. Under the NZ Disability Strategy, we have an obligation to address the health needs of our population; in addition, the United Nation Convention reports have identified continuing disparity and the need for considerable improvement in provision of health services to people with disabilities; our plan aims to improve the health of this important and diverse population.

Sub-Regional

	Action	Measure	Timeframe
1	**Disability Alerts** – Intensive work to be undertaken to ensure administrative and clinical staff understand and support patients to self-identify needs via alerts and the Health Passport	– 3000 more alerts in the patient management system for the unfunded population	Q4
2	**Heath Passport** – Educate staff to ensure Health Passports are asked for, read, and left with the patient – Conduct targeted surveys to get feedback on Health Passport from users – Implement targeted approach with primary care practices to read code Passports; encourage secondary clinicians to use a shared care record (e.g. Manage My Health), for patients with disabilities	– 40% of patients with disability alerts also are identified as Health Passport users identified within the patient management system – % Positive patient feedback on Passports from targeted user surveys shows Passports are being used effectively – 500 Health Passports read coded in primary care practices	Q4
3	**Sub-Regional Disability Forum** – Plan, organise, and coordinate engagement – Participation and/or leadership in at least one local forum each year in each locality – Engagement with Māori and Pacific communities is increased via the formation of a sub-regional Māori disability action group – Engagement with Pacific improved via increased participation/collaboration	– One sub-regional disability forum held	Q4
4	**Improve Consumer Engagement** – Work with Alliance Leadership Teams to engage primary care. – Engage a network of consumer advisors to include Sub-regional Disability Advisory Group - mental health and consumer council	– % Positive and active use on 50% of key projects of consumer consultation	Q4
5	**Intellectual Disabilities Within Primary Care** – Identify and purchase rights for comprehensive health assessments; work with primary care providers to implement – Transitional health pathway developed (see 2.2.17)	– 50 people with intellectual/learning disabilities have access to comprehensive health assessments in primary care	Q4

6	**Disability Responsiveness Workforce Development** – E-Learning – Staff development by educators on use of the alerts and the Health Passport – NZSL review and development of policy to improve workforce responsiveness to deaf	– Disability Responsiveness eLearning established across sub-region – Increased cost effective and efficient access to NZSL interpreters reviewed with participating practices, and considered for wider roll out in 2016/18	Q4
7	**Deaf Responsiveness – link with Mental Health planning** – Develop NZSL in consultation with deaf community and clinicians	– Five-year implementation plan developed	Q4

Capital & Coast DHB			
	Action	**Measure**	**Timeframe**
1	**Child Health** – Target high needs practices to get a named role for referral and communication with child specialist services	– 100% of targeted practices have a named role for referral and communication with child specialist services	Q4

DELIVERING BETTER PUBLIC SERVICES

2.2.8 EQUITY AND MĀORI HEALTH

In New Zealand inequity in health exist between ethnic and socioeconomic groups, people living in different geographic areas, people belonging to different generations, and between males and females. These inequalities are not random: socially disadvantaged and marginalised groups have poorer health, greater exposure to health risks, and lesser access to high-quality health services. In addition, indigenous peoples tend to have poorer health. In New Zealand the extent of these inequalities is unacceptable. Inequalities in access to and decisions over resources are the primary cause of health inequalities. Differential access to health services – and in the quality of care provided to patients – also contribute to unequal health outcomes. These structural inequalities may explain more of ethnic inequalities in health than is often recognised. Existing measures may not fully capture the dimensions and impacts of socioeconomic position relevant for different ethnic groups; cross sectional studies fail to take the effect of cumulative disadvantage over the life course into account. Nevertheless, it appears likely that discrimination makes an independent contribution to ethnic inequalities in health in New Zealand – albeit one that is not currently well quantified or understood. While discrimination may affect health partly through socioeconomic pathways, the experience of personal discrimination or institutional bias may also affect health more directly, through psychosocial stress. See Appendix for summary of our Māori Health Plan. In order to establish our organisation as responsive to inequity, we aim to:

- always engage the use of high-quality health information, for example, population health data and complete and consistent ethnicity data, to inform organisational decision-making
- designate appropriate time, resources and information to enable Māori to have input into the design and implementation of health equity initiatives
- allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving health equity for Māori
- ensure that the Code of Rights is visible and that Māori individuals and whānau understand their rights
- recognise the relevance and importance of te reo and tikanga Māori to high-quality health care
- ensure that all continuing professional development activities undertaken by health practitioners have a robust health equity and cultural competency focus

Sub-Regional

	Action	Measure	Timeframe
1	Regional Public Health's Māori Strategic Plan 2014-2017 – Support Implementation of Plan – Implement activities in four pathways: Te Ara Tuatahi – Relationships; Te Ara Tuarua – Workforce Development; Te Ara Tuatoru = Accountability; and Te Ara Tuawha – Communication	– Strategic relationships established with iwi leaders	Q4
2	Regional Screening services – Identify strategies to improve the uptake of cervical screening by Māori women – Identify strategies to improve the uptake of breast screening by Māori women	– % increase Māori women screened - breast – % increase Māori women screened - cervical – see Module 3, Output Classes, 3.3.1 Prevention Services – see Māori Health Plan for details	Q4

Capital & Coast DHB

	Action	Measure	Timeframe
1	Te Tohu Whakawaiora: Embed Certificate in Health Care Capability *Raising Capability to Accelerate Māori Health Gain* – NZQA approved, will result in a National Certificate in Māori Management – Generic (workplace practices) Level 3 – Support implementation over H&D primary and secondary sectors post evaluation – Designed for non-Māori and Māori with minimal knowledge of Māori paradigms – Support engagement of DHB Boards, ELT and workforce to engage with training	– 8 month pilot Feb 2015 – 2016 facilitated by Māori Health Directorate / Development Unit	Q4
2	Māori Health Plan deliverables – Capital & Coast DHB has a Plan focusing on specific national and local Māori health disparities and actions towards improving these. – National Health Indicators: data quality, PHO enrolment, ASH, breast cardiovascular, cancer screening, smoking,	– Reporting against the indicators to Ministry of Health – Report to DHB governance groups – Report to Māori Partnership Board	Q1, 2, 3, 4

	immunisation, and in particular rheumatic fever, breastfeeding, oral health, and mental health – Local health priorities: respiratory conditions 0 to 14 years, diabetes (including link to breastfeeding), support to iwi towards a Smokefree 2025, and youth mental health. – See Appendix 2 for overview of our Māori Health Plan, and DHB website for the full plan		
3	Health Literacy – Support Child Health Service to implement health literacy Three Step Health Literacy communication 'A.B.C' (Ask – them what they know, Build – on what they have already, Check – back on their understanding) strategies for staff – Implement Health Literacy Project – four work streams – Support organisational service development to promote workforce health literacy capability – Rollout of 'A.B.C' strategies into other directorates (e.g. Medicine and Cancer)	– Staff receive Three Step Health Literacy communication information (resources, e-learning) – Increased awareness of requirements of a health literate organisation	Q4
4	Did Not Attends (DNA) – Work with DHB DNA Steering Group to improve data collection and systems and improve DNA capability including targeted pieces of work with services – Whānau Care Service continue to provide Outpatient Clinics Attendance support to support the reduction in Māori DNA in priority areas	– Reduced Māori did not attend (DNA) rates – Reduced Māori readmission and admission rates	Q4
5	Long-Term Conditions Management (see Long-term conditions, 2.2. 23) – Work with Charge Nurse Managers to ensure Māori patients and whānau who require specialty cultural, social and clinical support are referred to Whānau Care Services in a timely manner – Provide Cardiology Cultural Speciality Nursing Service – Support organisational patient pathway initiatives that support the "shorter safer patient journey" e.g. 6 hour Rule; Frail Elderly / kaumatua; Integration with primary care	– Improved patient satisfaction – Reduction in patient & whānau complaints – Improved management of frail elderly Māori between HHS and primary care	Q4
6	Disability (see Equity and Disability, 2.2.7) – Work with Disability and Patient Administration Service to ensure Māori patients have Disability Alert in patient administration system – Educate staff to ensure Māori patients care is supported by Health Passport use, as appropriate	– Increase in Māori patients with disability alerts in the patient administration system – Number of Māori patients users identified in the patient management system – % positive feedback from Māori patients on Passport in surveys show Passports are being used effectively.	Q4
7	Workforce development - see section 2.2.27 Workforce for details		
	Regional		
	Action	**Measure**	**Timeframe**
1	Te Rau Matatini Promote the Te Rau Matatini Whānau Ora 2014-17 model, and its adoption across Central Region Undertake workforce development, particularly in cultural competence for non-Māori/other ethnic specific services Support implementation of the Māori Health Workforce Development Plan Accelerate performance locally against annual Regional Māori Health Plan indicators.	– Consumers and their families/whānau receive services delivered in integrated ways appropriate to their cultural as well as health and social needs – Implement Te Tohu Whakawaiora. – Produce equity report to support regional reporting; includes immunisation, breastfeeding, ASH rate, oral health.	Regional quarterly

DELIVERING BETTER PUBLIC SERVICES

2.2.9 EQUITY AND PACIFIC PEOPLES HEALTH

'Pacific 'āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāmili experience equitable health outcomes and lead independent lives'. We are building on the foundations that have already been laid across our district with relation to Pacific. Our focus is an ethnic-specific approach for Pacific outcomes that incorporates seven overarching strategic priorities: 1 - Child & Youth Health, 2 - Workforce development, 3 - Chronic Disease Management/Long-term Conditions, 4 – Did Not Attends, 5 - Health Literacy, 6 - Mental Health & Addictions, 7 - Health of Older People.

We acknowledge that some of these strategies have outcomes that are achievable in the short to medium term and some long-term. Addressing health inequalities requires a population health approach that takes account of all the influences on health and how they can be tackled to improve health. This approach requires both inter-sectoral and integrated actions that addresses the social and economic determinants of health and action within health and disability services and tackling the root causes of health issues, particularly the social, economic component.

Sub-Regional

	Action	Measure	Timeframe
1	**Child Health** – Provide timely advice and support to Child Health, Primary Care, Maternity, Plunket, Regional Public Health, and Dental Health Services to improve immunisation, service utilisation and delivery – Monitor enrolments in Community Oral Health Services, referrals to the breastfeeding lactation team, referral from Child Health Services to the Pacific Health Unit, and Pacific Navigation Service, six-month immunisation rates, rheumatic fever screening and number of children enrolled in primary care – Wairarapa DHB & Hutt Valley DHB develop a community education programme to raise awareness on dental health, asthma, skin infection, hygiene, and nutrition using the Parish Nurses model – Work with health providers to ensure a consistent referral system of Pacific families by health providers to housing support service – Support the implementation of the Children's Action Plan (see 2.2.2)	– Increased % of Pacific infants who are enrolled with general practice by 3 months – Increased % of Pacific infants who receive all five Well Child/Tamariki Ora core contacts in their first year of life accordingly to protocols and guidelines – Capital & Coast DHB B4School Check annual target achieved – Six months immunisation target achieved – Increased % of Pacific infants who are breastfed up to 3 months – Target to achieve 90% of Pacific children caries-free and DMGT rates at age 5 and school year 8 – Reduced ASH admissions for Pacific – Decreased acute respiratory admissions (pneumonia and bronchiolitis) for Pacific children – Reduced rheumatic fever incidence	Q4
2	**DNA** – Work with Sub-regional DNA project lead to ensure data collection and systems are improved – Monitor progress by utilising data and information gathered from the disability alerts, Decision Support Unit, and from the Pacific Health Unit Project – Pacific Health Units to continue working on the Pacific DNA Project to support the reduction of DNA rates; Capital & Coast DHB to work with clinics: cardiology, eyes, child health services, ENT, audiology, diabetes, respiratory – Hutt Valley DHB & Wairarapa DHB: rheumatology, fracture, gynaecology, colposcopy, respiratory , ENT, audiology, cardiology, and all under 15 Pacific children	– Reduced admission and readmission rates – Reduced did not attend (DNA) rates for Pacific	Q4
3	**Health Literacy** – Fund Pacific Radio Programme with Regional Public Health, across the sub-region – Work with primary care and NGOs to ensure preventative programmes are working for people with low levels of health literacy and focus on improving awareness and health outcomes – Referrals received by Pacific Health Units are actioned within 12 hours, between 8.30–5.00 daily – Wairarapa DHB & Hutt Valley DHB explore option of funding Parish nurses to provide church-based	– Increase participation in exercise programmes – Reduced ASH and DNA rates – 100% of referrals are actioned by the Pacific Health Units within 12 hours – Pacific people receive health information in their place of gathering	Q4

	health education		
4	**Long-term Conditions Management** – Support the development and implementation of the Diabetes Care Improvement Plan (DCIP) (see 2.2.16 and 2.2.22) – Contribute to the development of clinical pathways and Pacific Models of Care to improve Pacific utilisation of general practice (see 2.2.17 Primary Care and Integration) – Work with Charge Nurse Managers to ensure Pacific patients who require cultural, social, and clinical support are referred to the Pacific Health Unit on a timely manner – Work with Regional Screening services to identify strategies to improve the uptake of cervical and breast screening by Pacific women – Monitor primary care performance against achieving targets for Pacific people (see 2.2.17 Primary Care and Integration)	– Reduced morbidity and mortality associated with LTCs – Improved management of conditions for Pacific Peoples with diabetes and CVD – Cervical and breast screening targets achieved – see Module 3, Output Classes, Prevention Services	Q4
5	**Workforce Development** – Work with relevant directorates (DONM, Allied Health, Mental Health, Child Health, HR) to ensure Pacific workforce capacity in nursing, social work, medicine, midwifery, therapeutic services, is increased to better support the cultural and health need and better reflect the Pacific population – Lead the coordination of the Pacific Nurses fono, and support Pacific Midwives events – Monitor the Pacific nurse PDRP and QLP progress – Work with Whiteria Pacific Nursing Programme and DONM to ensure placement for 3rd year students are in the areas of high Pacific admission (renal, cardiology, ED, paediatrics) – Work with Director of Nursing and Midwifery team to ensure Pacific participation on the NETP recruitment process – Promote the Health Science Academy project to schools with high Pacific enrolment – Disseminate training and funding opportunities for nurses, allied health and health care assistance – Work with the ADON professional development to identify training opportunities and mentoring support for HCA	– 85% Pacific Nurses and Midwives enrolled on the PDRP and QLP programme – Increased in attendance in the nurses fono – Increased % of Pacific workforce capacity – Increased % of graduates offered employment on the NETP and NESP programme – Increased # of secondary schools with high Pacific populations targeted for the delivery of the health science academies – Increased # of placement for 3rd year Social Work students – Increased Pacific Social Worker capacity – Increased number of HCA and support workers attendance in professional development training	Q4
6	**Mental Health & Addictions** – Support development of the sub-regional Mental Health Strategic Framework (see 2.2.19 Mental Health & Addictions) – Support the implementation of 'Rising to the Challenge' – Mental Health & Addiction Service Plan 2012/17 to ensure services are responsive to Pacific people affected by mental health and addiction issues	– Improved health status of Pacific people with severe mental health illness through improved access rates	Q4
7	**Older People** – Monitor Pacific access to NASC and Care-Coordination Services – Support the development and implementation of the Dementia Pathway and Falls Strategy – Work with other services to investigate improvement of the coverage of information for older people and carers – Provide cultural input in the development of health pathways and trainings to ensure cultural responsiveness – Promote access to primary care health services and activities targeting older people	– Increased % of Pacific elderly receiving NASC and Care-Coordination support – Reduction in falls related admissions – Improved access to primary care – Reduction in admission rate for 65+ age group	Q4
8	**Pacific Health Action Plan 2015-2018 (Hutt Valley DHB & Wairarapa DHB)**	– Implementation of the Pacific Health Action Plan	Q4

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2.2.10 HEALTH TARGET – IMMUNISATION

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children, with the outcome of longer and healthier lives. The changes required to reach the target immunisation coverage levels will lead to better health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. It will also require primary and secondary health services for children to be better co-ordinated. These actions support and encourage the implementation of the Primary Health Care Strategy, and strengthening of the primary care workforce.

Sub-Regional

	Action	Measure	Timeframe
1	– Provide narrative report on interagency activities that took place to promote immunisation week – Provide completed events report to demonstrate 85% of six week immunisations are completed – Increase data analysis and stakeholder engagement – Work with B4 School check providers to increase the delivery of 4 year old immunisations – Develop strategies to increase HPV vaccination - include the use of an online learning tool – Promote 100% consent form return for the HPV programme at year 8 – Support primary care to routinely promote HPV immunisation especially when the practice has been notified the 12 year old has declined vaccination through the school based system – Work with primary care on implementing a programme to recall 14-year-old girls not fully HPV immunised such as promoting entering HPV as part of their patients Immunisation Recall settings in MedTech	– Increasing immunisation rates – narrative report on DHB and interagency activities to promote immunisation week – 85% of six week immunisations are completed (measured through the completed events report at eight weeks) – 95% of eight-month-olds and two-year-olds are fully immunised – 90% of four-year-olds are fully immunised by June 2016 – Use on-line learning tool to promote knowledge benefits of the HPV programme – Reduce inequity in immunisation status – see Māori Health Plan for details	Q4

Capital & Coast DHB

	Action	Measure	Timeframe
1	– Immunisation Steering Group will meet three times a year; chaired by Director of Nursing Primary Health Care and Integrated Care; minutes distributed by Capital & Coast DHB Immunisation Team – Monitor and evaluate immunisation coverage through regular NIR/Datamart interrogation and analysis; alerting PHOs/Immunisation Outreach teams of progress achievements or areas of concern; overdue reports are sent to PHO Outreach Teams 6 times a year; on-going education through VT/IMAC training session to optimise use of NIR as a tool to ensure timeliness/completion of immunisation for all children – Daily NIR check on immunisation status on all children who are inpatient in paediatric wards and action as required; list of overdue immunisations sent to ward/unit; education of RNs in paediatric service; immunisation champions established; standing orders developed; once weekly NIR check of immunisation status of all children who are scheduled to attend paediatric outpatient appointments; list of overdue immunisation sent to ward/unit – Table possibility of immunisation project for ED at the Immunisation Steering Group meeting (DHB does not currently monitor children in outpatients or ED due to reaching target without this intervention); project will be considered in regards to cost/benefits; scoping exercise will be undertaken to establish how many children present to ED who are overdue for immunisation – Education of RNs in the paediatric service, including, establishing immunisation champions and developing standing orders – Cold chain accreditation within the hospital will be heavily promoted and encouraged by the immunisation team – The DHB will continue to work with NGOs regarding immunisation education delivered through the DHBs clinics and PHO's who support refugee health and marginalised members of society such as City Mission, supporting them with key messages regarding immunisation for special groups, e.g. HIV positive patients	– 85% of six week immunisations are completed (measured through the completed events report at eight weeks) – 95% of eight-month-olds and two-year-olds are fully immunised (see Māori Health Plan for details) – 90% of four-year-olds are fully immunised by June 2016 – All children attending hospital are up to date with immunisations – Intersectoral collaboration leads to improved immunisation coverage – Actively increasing HPV (12-year-old) immunisation rates – B4SC providers given training regarding immunisation	Q1, 2, 3, 4 Q4

National Entities – Health Promotion Agency				
	Action		**Measure**	**Timeframe**
1	Immunisation is one of the most effective and cost-effective medical interventions to prevent disease. The HPA programme provides critical information for parents of infants, school aged children, teens and adults, to help parents make informed health choices and alerts and prompts New Zealanders to get themselves or their families vaccinated at the appropriate times.	–	Supports meeting the immunisation Health Targets for eight-month olds, 2 year olds, and the HPV target for young girls	Q4

SUPPORTING SYSTEM INTEGRATION

2.2.11 HEALTH TARGET – EMERGENCY DEPARTMENT

Long stays in emergency departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients. Improving our delivery against this measure supports the health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives'. It will also result in a more unified health and disability system, because a coordinated, whole of system response is needed to address the factors across the whole system that influence ED length of stay.

Sub-Regional

	Action	Measure	Timeframe
1	Preventative and proactive care in primary and community care settings to avoid the necessity for ED presentation or acute admission e.g. clinical management of frail elderly in the community, diabetes care improvement plans	– Reduction in growth of ED presentations – Decrease in growth in Acute admission rate – Hospital Occupancy rate – Average LOS for acute admissions – Representations to ED – Readmissions	Q4
2	Alternatives settings for management of patients, e.g. clinical pathways for the management of selected conditions in primary care e.g. cellulitis, DVT and gastroenteritis.		
3	Alternative access to diagnostics e.g. access to radiology in the community		
4	Build on joint appointment of two SMOs across Capital & Coast and Hutt Valley DHBs (rotation between sites to promote consistency)		
5	Acute demand and primary care integration actions that contribute to demand on ED services - see 2.2.17		

Capital & Coast

	Action	Measure	Timeframe
1	Improve efficiency within ED and inpatient areas – Criteria led discharge – early specialist review, expected date of discharge, assertive board rounding – embed in internal medicine and extend to other specialties – Focus on in-patient pathway for the frail elderly to ensure appropriate streaming of patients e.g. assessment, treatment and discharge with support, inpatient or assessment treatment and rehabilitation (e.g. Kenepuru geriatrician at ED front door) – Continued implementation of Trend Care to remaining wards and units within Wellington Regional Hospital; utilisation of Trend Care data to better inform the matching of available resources to demand; embed and collect data on application to fully predict and actualise amount of resource the patient needs – Roll out Integrated Operations Centre; implement dashboards to monitor patient flow and real time utilisation of services through dashboards for occupancy, bed management, and production planning to manage demand and capacity. – Continue to improve discharge processes. e.g. ensuring community support services are in place that respond rapidly for patients not requiring hospital admission or to enable discharge at the appropriate time	– 95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours	Q1, 2, 3, 4
2	Improve efficiency within ED, Short Stay Unit, MAPU, and SAPU including: – Diagnostic/analysis work to identify the main factors continuing to impact on ED length of stay – Optimise use of Short Stay Unit to enable flow out of ED where further observation is required before discharge or admission – Improved access to specialist assessment for surgery		
3	Acute demand initiative in ED to ensure appropriate streaming of patients, e.g. assessment, treatment and discharge with support, inpatient or assessment treatment and rehabilitation (includes winter planning, better bed utilisation/flexi-bed use)		
4	ED Quality Framework implementation • Quality framework for ED expanded; it includes 21 compulsory measures and another 38 non-compulsory • Continued development in this area, aiming to report on all 21 compulsory measures by Q2 • Administrative support to facilitate meaningful usage of data to improve the patient experience and safety	– ED Quality Framework suite of measures reporting on compulsory measures – Improved patient outcomes – Reduced reportable events and complaints	Q2 Q4 Q4

	• Implement non-mandatory measures	– 3 non-mandatory measures identified – Learn from findings from 3 measures and commence identification of future non-mandatory measures for monitoring	Q1 Q3
5	Maintain Acute Patient Flow Programme working group (clinical leads from allied health, medical and surgical, quality, and DON)		Q4
6	On-going improvement in management of SMO and RMO staff rostering - to meet the presentations and complexity at the right time		Q4
7	Acute Demand management See section 2.2.17 Primary Care and Integration for details around the sub-regional and local responses to managing acute demand	See 2.2.17 for measures	Q4
8	Integrated Operations Centre (IOC) IOC was established in late 2014. By August 2015 the IOC will be in place and the platform for realising the desired outcomes will be established. It is fundamental to optimising the DHB's performance and a prerequisite to achieving further service integration with Wairarapa and Hutt Valley DHBs. The programme of work has included implementation of business processes, change management and technology changes required to achieve the objectives: 1. To optimise patient flow and consistently achieve Emergency Department and Elective Surgery targets. 2. To determine Nursing and Midwifery workforce requirements based on patient acuity. 3. To reduce weekend mortality rates and organisational risk exposure relating to visibility of workload and the management of tasks after hours. Technology enablers align with Hutt Valley DHB and include the implementation of an IOC Dashboard, Trendcare (patient acuity and workload measurement), Orion Electronic Whiteboards and the selection of a preferred vendor to implement a Task Management solution. The realisation of the benefits in terms of achieving safe staffing and better patient outcomes is a journey that will take time. The IOC Programme has the commitment and involvement of clinical and operational leaders throughout the organisation and will be supported by a strong change management framework.	– Improved patient outcomes – Reduction in the Relative Stay Index (RSI) – a measurement of length of stay – Reduction in reportable events due to staffing levels – Reduction in casual and overtime costs for Nursing and Midwifery beyond 2015/2016 – Reduction in weekend mortality rates – Increase in Medical Emergency Team (MET) calls after hours (linked to better patient outcomes) – Improved staff satisfaction	Q4
9	**Social Sector Trials** Continue to support the Porirua Social Sector Trial as a way of effecting preventative and proactive care in primary and community care settings, to avoid the necessity for ED presentation or for acute admission. See also 2.2.5 for actions of our Social Sector Trial that seek to have an impact on local ASH rates.	See 2.2.5 for measures	Q4

SUPPORTING SYSTEM INTEGRATION

2.2.12 HEALTH TARGET – BETTER HELP FOR SMOKERS TO QUIT

At present, tobacco smoking places a significant burden on the health of New Zealander's and on the New Zealand health system. Tobacco smoking is related to a number of life-threatening diseases, including cardiovascular disease, chronic obstructive pulmonary disease and lung cancer. It also increases pregnant smokers' risk of miscarriage, premature birth and low birth weight, as well as their children's risk of Asthma and Sudden Unexplained Death in Infants (SUDI).

Delivery against this measure supports the health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives', as well as the intermediate outcome of 'a more unified and improved health and disability system'. The measure also supports the Government's aspirational goal of a Smokefree New Zealand by 2025. Achieving a Smokefree New Zealand will mean that: our children and grandchildren will be free from exposure to tobacco and tobacco use; the prevalence of smoking across all populations will be less than 5 %; and, tobacco will be difficult to sell and supply

Sub-Regional

	Action	Measure	Timeframe
1	Update the Sub-Regional (3DHB) Tobacco Control Plan with Regional Public Health	– Delivery of updated plan to Ministry of Health	Q1
2	ABC, NRT competency training is provided to all hospital based health professionals, with Regional Public Health Health target information is kept up to date and accessible to health professionals Delivery of ABC in clinical practice and other settings Constant improvement of ABC data collection processes and systems, with Regional Public Health	– 95 % of patients who smoke and are seen by a health practitioner in a public hospital will be offered brief advice and support to quit smoking – 90% of PHO-enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months – Advice and support to quit is documented and coded accurately	Q1, 2, 3, 4
3	Make progress towards health target for pregnant women with Regional Public Health	– 90 % of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking – ABC, NRT competency training is provided to all primary health care professionals – Health Target information is kept up to date and accessible to health professionals – Delivery of ABC in clinical practice and other settings – Constant improvement of ABC data collection processes and systems – See Māori Health Plan for measures on Mother's Smokefree at 2 weeks postnatal –	Q1, 2, 3, 4
4	Provide technical advice and support on smoking cessation to primary and secondary care health services, with Regional Public Health	– Support provided	Q4
5	Support development of an holistic model of care to reduce SUDI (Sudden Unexpected Death in Infancy) and address SUDI risk factors See Māori Health Plan for details of focus on support for women from early in pregnancy, and parents/whānau with infants aged less than 6 months	– SUDI decrease for Māori Tamariki	Q2, 4

Capital & Coast DHB

	Action	Measure	Timeframe
1	Improve smoking cessation support service referral processes and systems	Referrals to smoking cessation providers: How much was delivered; How well was it done; Is anyone any better off. Number of referrals; Number of quit attempts; Number of successful quits	Q2, 4

2	Provide a specialist cessation service	Capital & Coast DHB continues to fund Ora Toa Quit Smoking Service	Q4
3	Monitor and analyse Māori, Pacific and pregnant women referrals and service uptake, to ensure that there is no disparity of care, and to inform service planning for priority populations.	Report on number of people who accept cessation support (behavioural and/or pharmacological) in primary and secondary care, by ethnicity: How much was delivered; How well was it done; Is anyone any better off. Number of referrals; Number of quit attempts; Number of successful quits	Q2, 4
4	Support, and lead where appropriate, local health promotion activities including participation in the Wellington Regional Smokefree network and Smokefree Coalition.	Outcome achieved through health promotion activities reported in six monthly reports: How much was delivered; How well was it done; Is anyone any better off	Q2, 4

SUPPORTING SYSTEM INTEGRATION

2.2.13 HEALTH TARGET – CANCER SERVICES/ FASTER CANCER TREATMENT

Cancer is the country's leading cause of death (29.8%). Cancer is a major cause of hospitalisation and a significant driver of cancer cost. Prompt treatment is more likely to ensure better outcomes for patients and avoid unnecessary stress on patients and family at an already difficult time; it is also important that people have a clear expectation of how quickly they will receive treatment. We want to improve the quality of care and the patient's experience across the cancer pathway. Radiotherapy and chemotherapy are of proven effectiveness in reducing the impact of a range of cancers; delay to radiotherapy and chemotherapy is likely to lead to poorer outcomes of subsequent treatment. The Faster Cancer Treatment programme is designed to reduce waiting times for appointments, tests and treatment and standardise care pathways for cancer patients, wherever they live. The programme links with the whole range of initiatives designed to improve the prevention, diagnosis and treatment of cancer and support for patients and their families. Faster cancer treatment takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. This target supports our aims of maintaining high quality care and improving quality of life for people with cancer; effectively, equitably and sustainably meeting the future demand for cancer services, and ensuring fiscal responsibility of the health system. The target is that 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90% by June 2017. While the new target focuses on a smaller group of patients than the previous target, it has a whole of pathway approach covering all tests and investigations needed to confirm a diagnosis, as well as all forms of treatment including surgery.

Regional

	Action	Measure	Timeframe
The Central Cancer Network (CCN) will lead a work programme to improve: equity of access to cancer services; timeliness of services across the whole cancer pathway; and the quality of cancer services delivered. Key actions include:			
1	Update the Regional Cancer Centre Development Plan and implement priority areas for the following services: Radiation Oncology; Medical Oncology; Clinical Haematology	– Plan updated – Plan implemented	Q1 Q4
2	– CCN and DHBs ensure sustainability of nine FCT projects funded in round 1 – CCN to work with DHBs to agree and implement a regional prioritization approach to the second round of FCT funding – CCN and DHBs commence implementation of funded projects	– Regional approach agreed and implemented – Milestones in identified projects met	Q2 Q4
3	– CCN to provide regional quarterly analysis of FCT data to support DHBs to identify data quality issues and monitor progress against meeting the health target	– % of patients referred with a high suspicion of cancer who wait 62 days or less and need to be sent within 2 weeks, to receive their first treatment (or other management) to be achieved by July 2016. – % of patients (by DHB and ethnicity) with confirmed diagnosis of cancer who receive their first cancer treatments (or other management) within 31 days of decision to treat	Q1,2,3,4
4	Complete phased implementation of the regional Multidisciplinary Meeting (MDM) Implementation Plan within allocated funds for each DHB (approx. $450K pa for the region).	– Quarterly reporting against the plan – # of patients accessing MDMs (by DHB and ethnicity)	Q1,2,3,4
5	Undertake the following actions to support implementation of the tumour standards: – Undertake and analyse reviews of 2 more standards to inform regional service improvement initiatives – Implement the regional service improvement initiatives that were identified by the service reviews against the tumour standards in 2013-15 (Bowel, Lung, Gynae, and Breast).	 – Standard reviews completed – Implementation completed	 Q4 Q4
6	Implement the Supportive Care framework (Budget 2014)	– Framework implemented	Q4
7	Support the implementation of the National Cancer Health Information Strategy (to be released in Feb	– Strategy implemented	Q2

	2015).		
8	Coordinated approach to identifying actions to improve waiting times and quality of endoscopy / colonoscopy services in line with the Endoscopy Quality Improvement programme.	– # of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 2 weeks (14 days) – target 75% – # of people accepted for a diagnostic colonoscopy who receive their procedure within 6 weeks (42 days) – target 60% – # of people waiting for a surveillance colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date – target 60% – Sub-regional reporting	Q1,2,3,4
9	CCN, Central TAS, and the Regional Palliative Care Network develop a more strategic approach to palliative care and end-of-life service planning and delivery across the region, which is informing 2015/16 planning – CCN continues to engage with and support clinical leaders across cancer programme areas to lead and contribute to identified projects – CCN will support, facilitate and coordinate Māori Cancer Leadership in the Central region in partnership with National, Regional and Local partners	– Director work plans developed and completed	Q1 Q4
	Capital & Coast DHB		
	Action	**Measure**	**Timeframe**
1	Project manage and implement the following initiatives funded through the 2014/15 FCT RFP process: – Development and implementation of cancer health pathways as resource allows – Development of ambulatory model of care	– 40 pathways developed – Model developed and implementation plan prepared	 Q4 Q4
	– Pilot chemotherapy education and training for nurses – Implement the Cancer Nursing Knowledge and Skill Framework	– Pilot complete – Framework implemented	Q4
2	Service improvement initiatives identified as a result of tumour standards reviews in 2013/14: – Implement regional ProVation solution (endoscopy reporting system) – regional business case – Implement a regional EBUS service, regional approach to PET-CT contracting completed. – Implement a regional gynaecological cancer service in accordance with the business case.	– Initiatives implemented.	Q4
3	Provide regional partners with expert support for MDM for regional services.	– Support in place	Q4
4	Review patient management system	– Review completed	Q4
5	Radiation Oncology – Patient education initiative carried out – e-learning for MRTs implemented	– Initiatives implemented.	
6	Facilities and capacity planning carried out	– Plan completed	Q4
7	Implement a workforce initiative for medical physicists	– Initiative implemented	Q4
8	Support implementation of guidance on active surveillance for prostate cancer	– Guidance from Ministry utilised for implementation	Q4
9	Faster Cancer Treatment Target – Information system and data collection improvement (see Māori Health Plan) – Cancer health pathway implementation – Review of MDMs resourcing and functioning – Implementation of ambulatory model of care project findings – Implementation of tumour standard review findings from 2013/14 and 2014/15	– % of patients referred with a high suspicion of cancer, and a need to be seen within two weeks, who wait 62 days or less to receive their first treatment (or other management) – Target 85% – # of patients, ready-for-treatment, who wait less than four weeks for radiotherapy or chemotherapy	Q4
10	Improve timeliness and quality of the cancer patient pathway from the time patients are referred into the	– Improved timeliness	Q4

	DHB through treatment to follow-up/palliative care (see Regional actions above)		
11	Development and implementation of a single sub-regional service for endoscopy to improve waiting times and service quality Explore a single reporting mechanism for sub-regional endoscopy	– % of people accepted for an urgent diagnostic colonoscopy who receive procedure within 2 weeks (14 days) – target 75% – % of people accepted for a diagnostic colonoscopy who receive procedure within 6 weeks (42 days) – target 60% – % of people waiting for surveillance colonoscopy who wait no longer than 12 weeks (84 days) beyond planned date – target 60%	Q4
12	Improve equity of access by utilising the Equity of Health Care for Māori: A Framework	– % of people identified as Māori accessing cancer services	Q4
13	Support implementation of Budget 2014 initiatives	– Initiatives implemented	Q4

SUPPORTING SYSTEM INTEGRATION

2.2.14 HEALTH TARGET – ELECTIVES

Elective services, including cardiac, are an important part of the health care system for the treatment, diagnosis and management of health problems. Timely access to these services is also considered a measure of the effectiveness of the health system. Elective surgery is important to New Zealanders as these are essential services to reduce pain or discomfort, and improve independence and wellbeing, particularly for surgery such as cardiac, cataract, and major joint replacement. Electives are not delivered in isolation; a focus on one element of a service or one step in the pathway will lead to missed opportunities for change and ultimately prove unsustainable; therefore, system-wide thinking is an essential aspect in this area, leading to the growth of integrated care pathways and development models to better manage workflow between services that are acute and those that are elective.

Wairarapa DHB

	Action	Measure	Timeframe
1	Delivery against agreed volume schedule, including elective surgical discharges, to deliver Electives Health Target – Treat patients in accordance with assigned priority and waiting time; use national/nationally recognised tools – Participate in development and implementation of National Patient Flow – Electives funding allocated to support increased levels of elective surgery, specialist assessment, diagnostics, and alternative models of care	– Delivery against agreed volume schedule, including a minimum of 10,439 elective surgical discharges – Patient level data is being reported into the National Patient Flow collection, in line with specified requirements	Q1, 2, 3, 4
2	Support improvements in electives access, quality of care, patient flow management that maximise available capacity and resources. Consideration given to improving scheduling, patient pathways, use of alternative providers, management of follow-ups, referral management (and relationships with primary care), internal policies and processes, patient focussed booking, preadmission redesign, productivity and throughput of the Operating Theatres, enhanced recovery or rapid improvement, direct access to diagnostic or treatment	– Improvement in theatre utilisation – Reduction in patient cancellations – Increased theatre throughput	Q4
3	Standardised intervention rates and/or other mechanisms (such as demand analysis) used to assess areas of need for improved equity of access	– Refer to Performance Measures – System Integration, for Elective services standardised intervention rates (SI4)	Q4
4	Patient flow management continues to be improved to maintain reduced waiting times for electives, with patients waiting no longer than four months for first specialist assessment or treatment	– Elective Services Patient Flow Indicators expectations are met, and patients wait no longer than four months for first specialist assessment and treatment, and all patients are prioritised using the most recent national tool available – Refer to Performance Measures - Ownership Dimension, for Inpatient Length of Stay (OS3)	Q4

Regional - Capital & Coast DHB Lead *Improve access to elective services - Maintain reduced waiting times for elective first specialist assessment (FSA) and treatment - Improve equity of access to services, so patients receive similar access regardless of where they live*		
Action	**Measure**	**Timeframe**
Refer to Central Region Regional Services Plan 2015/16 for details on elective services, including otorhinolaryngology, orthopaedics, and ophthalmology services	– Regions Electives Health Target met – Patients wait no longer than 4 months for First Specialist Assessment (FSA) or elective treatment (ESPI 2 & ESPI 5) – Discharge target met – SIRs improved	Q4

SUPPORTING SYSTEM INTEGRATION

2.2.15 HEALTH TARGET – MORE HEART AND DIABETES CHECKS

Long-term conditions comprises the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori, Pacific and South Asian peoples. As the population ages, and lifestyles change, these conditions are likely to increase significantly. Cardiovascular disease (CVD) includes heart attacks and strokes – which are both substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. The indicator monitors the proportion of the eligible population who have had the blood tests for CVD risk assessment (including the blood tests to screen for diabetes) in the preceding five year period. By increasing the percentage of people being checked and improving on-going management of their care, the DHB will impact on speeding up the implementation of the Primary Health Care Strategy by ensuring primary care is better able to contribute to improved health outcomes. Consistent performance against this target, ensuring long-term conditions are identified early and managed, will help improve health and disability services people receive, and aid in the promotion and protection of good health and independence, and a reduction in inequity. Through the intermediate outcomes the target contributes to the high level outcome of New Zealanders living longer, healthier and more independent lives.

Sub-Regional

	Action	Measure	Timeframe
1	Utilise funding increase (2013) to enable on-going support for primary care to deliver on the health target and ensure its sustainability		
2	Ensure expertise, training, tools needed are available to complete the CVD risk assessment and management to meet clinical guidelines	– 90% of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years; increase in % of Māori assessed	Q1, 2, 3, 4
3	Ensure that IT systems that have patient prompts, decision support, and audit tools exist, are used and fully report performance		
4	Data collection protocol and capacity to capture patient risk levels based on their cardiovascular disease risk assessment result		
5	Quality improvement plans in place for managing people at risk		
6	Work in partnership with primary health care providers through the PHO Advisory Group (PHOAG) to strengthen current networks and focus on the primary care Health Targets 'More Heart and Diabetes Checks' and 'Better Help for Smokers to Quit 2.2.12	– IT tools are available, appropriate, and utilised	Q4

Capital & Coast DHB

	Action	Measure	Timeframe
1	Provision of patient dashboard to all practices		
2	Provision of weekly lists of patients requiring checks		
3	Unblended Peer group comparison reports	– 90% of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years; increase in % of Māori assessed	Q1, 2, 3, 4
4	Quarterly site visits and review of performance with each practice		
5	Financial incentives for performance		
6	Patient information campaign – including use of public media to encourage patients to request a check		
7	Point of care testing		
8	Provision of technical assistance for IT systems including development of reports on patients by level of risk and ethnicity which can be used to improve risk management planning		
9	Actions to support Māori access	– Improved access by Māori	Q4

National Entities – Health Promotion Agency

	Action	Measure	Timeframe
1	Support Health Promotion Agency in its work on CVD awareness and publicity campaigns that are continued	Support provided	Q4

SUPPORTING SYSTEM INTEGRATION

2.2.16 DIABETES CARE IMPROVEMENT PACKAGES

Diabetes is important as a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of a health service for people in most need. A diabetes test is included as part of the overall CVD risk assessment. This test is different from a diabetes annual review, which takes place when a patient, who has been previously diagnosed with diabetes, is seen by their health professional to review the management of their disease. Diabetes is a health issue that is growing in prevalence with increasing incidence in younger people - gestational diabetes is increasing, in parallel with the national rise in obesity. Adequate treatment targeting multiple risk factors can prevent or slow the progression of complications in people with diabetes. Despite improvements observed in several processes of diabetes care in the past decade, the control of risk factors remains challenging. Effective models of chronic care emphasise the need for a collaborative approach between patient and healthcare providers to achieve effective disease management. Our goal is to enable our people living with diabetes to be regarded as leading partners in their own care within systems that ensure they can manage their own condition effectively with appropriate support

Sub-Regional

	Action	Measure	Timeframe
1	Diabetes is the long-term condition of focus and ensuring Diabetes Care Improvement Packages (DCIP) are delivering the expected outcomes is the primary focus for DHBs. Successful models developed for DCIP can then be utilised for other services – We will continue to progress the Diabetes Care Improvement Plans (DCIPs) developed in 2013/14 and work towards consistency of plans and implementation across the sub-region – Assess the services against the 20 quality standards and develop a service improvement plan to address gaps – Pre-diabetes - recognise importance of identifying people with pre-diabetes and interventions	– Implementation of the 20 Quality standards – Reduction in proportion of patients with Hba1c above 64, 80 and 100 mmol/mol	Q1, 2, 3, 4 Q1

Capital & Coast DHB

	Action	Measure	Timeframe
1	A Diabetes Clinical Network has been established to advise the Long-Term Conditions Service Level Alliance with recommendations on service changes required. Implementation of 2012/13 DCIP will continue, overseen by an ICC Service Level Alliance Leadership Team: – Utilisation of the Atlas of Health Care Variation for Diabetes, the 20 quality standards and accompanying toolkit to review current services and identify improvements. – Review and maintenance of all practices' population plans – Further implementation of self-management programmes – Further workforce development - Ensure have baseline of current status of RNs with National Diabetes Nursing - Knowledge and Skill Framework (NDNKSF) levels. Online e-learning resource completed. - Ensure identified personnel have achieved or are working towards NDNKSF at appropriate level – speciality diabetes nurse (majority) or specialist diabetes nurse – Development of the secondary service into a Specialist service focused on complex, Type 1, paediatric, gestational and renal diabetes – Nurse practice partnership between hospital and primary care – Collaborative case service in priority practices Implement 'predictive risk modelling' to assist with the identification of those at risk of diabetes or LTC – Investigate a shared care approach between Pharmacies and GP practice for improved LTC management	– Group includes consumer representation. – Implementation of the 20 Quality standards. – Reduction in proportion of patients with Hba1c above 64, 80, and 100 mmol/mol.	Q1 Q4 Q4
2	PHOs will:	– # of practices with population plans	Q3

– Provide interventions for pre-diabetes, including Healthy Lifestyle education – Identify people with diabetes through programmes such as "More Heart and Diabetes Checks" – Manage people with diabetes through implementation of their practice population plans which include: - Subsidised GP visits - Individual education sessions from nurses, dieticians, podiatrists to enable patients to self-manage - Regular referral to retinal screening - Management of complications - Support for insulin commencement - Self-management programmes – Participate in the Nurse Practice Partnership by ensuring the practices all have access to diabetes nurse specialists and appoint at least one diabetes clinical champion – Participate in case collaboration	– # of referrals to self-management programmes – 90% of practices receive direct diabetes nurse specialist support Key performance indicators will be monitored: – Glycaemic control (measured by HbA1c) – Insulin starts – % of patients who have a retinal screen – # of nurses certificated at the generalist level on the National Diabetes Nursing Knowledge and Skill Framework	Q3 Q4 Q2, 4 Q2, 4 Q2, 4 Q2, 4

UPPORTING SYSTEM INTEGRATION

2.2.17 PRIMARY CARE AND INTEGRATION

For our population, an integrated health system will provide appropriate care closer to them, help keep them well at home, and provide responsive services in times of acuity; for the system, it will drive efficiencies and support sustainability within the limited health resource and escalating demands of services. The Alliance Leadership Teams (ALTs) across the sub-region are key drivers for integration and for delivering on the Triple Aim for the three sub-regional DHBs. While maintaining a whole of system view, the ALT programme has been developed through focusing on the complexity within the populations (Acute Demand & Long-term Conditions), targeted work specific to particular age groups (Frail Elderly, Youth, Children) and enablers that underpin the system (Health Pathways, Information Management, Primary Care Sustainability and Medication Management) across the DHBs. With the complexity of patients' needs and the need for integrated systems there are clear overlaps across the focus areas, which are managed through good communication across work streams; there is also overlap within DHBs work streams and across the DHBs that requires good management and active involvement. The ALTs, Primary Health Care leads, and Hospital leads are partners in planning service developments across the sub-region. Engagement is progressed and maintained through workshops and discussion forums including Service Level Alliances and Clinical Network meetings. Our local ALT contributes to and endorses the development process, direction, and deliverables of our DHB Annual Plans.

Sub-Regional

Includes Service Developments that are shared across Wairarapa DHB (Tihei), Hutt Valley (Hutt Inc.) and Capital & Coast (ICC) Integration Programme

	Action	Measure	Timeframe
1	**Overall Integration Programme Development** – Revision of the Alliance Leadership Team (ALT) Programme Frameworks. ALT-led integration programmes have been established in each DHB in the sub-region; collaborative efforts to align programmes; shared work streams and projects. – Implement the Integrated Performance Incentive Framework (IPIF) components and incorporate into the ALT Outcome framework – Development and implementation of ALT Communications Plan – Consumer Engagement Plan – Annual Review of Flexible Services Pool (FSP); key enablers to progress new models of integrated care and require annual review to align with priorities.	– Approval of Programme Framework by the three ALTs – Incorporate IPIF measures into the sub-regional ALT outcomes measures – Primary Care and Secondary Communications, Programme website, Grand Round sessions, Project Manager forum established – Consumer participation in work streams and Service Level Alliances as per ALT Consumer Engagement Plan – Approval of revised FSP by ICC ALT, Hutt INC, and Tihei Wairarapa	Q 2 Q 1, 2, 3, 4 Q 2 Q 1 Q 2
2	**Implementation of the IPIF** – The aim of the Integrated Performance and Incentive Framework (IPIF) is for DHBs, PHOs, general practice teams, and other primary care services, to work together to plan and provide health services. – IPIF is a core mechanism to lift performance, improve clinical integration, and improve quality in primary health care sector over the next three to five years. – In 2015/16 we will implement agreed work plans for: Capacity & Capability; Health Start; Healthy Ageing; Patient Experience	– As per national measure (including ethnicity targets/increase in Māori enrolled in PHOs – see Māori Health Plan for details) – Immunisation for Influenza at 65+ years for (see Māori Health Plan for details)	Q4 Q4
3	**Acute Demand - Primary Health Care Capability** – Primary Care Practices that deliver patient-centred services to enable population health improvements.	– Agreed standards to assess Primary Health Care Practice for their capability to provide patient-centred care, including: Practices being accessible and sustainable; Utilisation of pathways; General Practice deliverable packages of care; Risk stratification, population plans, and management of selected stratified populations; Uptake of Shared Electronic Health Record & Planning – Evaluation of Practices and PHOs against the agreed standards	Q1 Q2

	– Development of PHO lead development and support plan for their Primary Health Care practices against the agreed standards	Q3
	– Improvement in Practices and PHOs against the agreed standards	Q4
	– Implementation and on-going monitoring of Free <6's and Free<13's	Q4
Acute Demand - Primary Care Packages of Care (Shifting Services to community settings) – To support Primary Care Practices to deliver care closer to the patient, they will be supported and resourced through 'packages of care' associated with specific health pathways. – These packages may support additional acute care management, as well as elective services that would otherwise require a hospital intervention. – 'Packages' will include components of those measurable actions detailed here. The package approach will wrap around the patient/consumer, developing a seamless journey in addressing the health concern and related issues. The package will include, for example, capturing and communicating actions around the GP visit, procedure delivery, referrals, follow-up visits, and ensuring access (ambulance use, time, location).	– Develop and deliver Packages of Care Plan	Q4 (2,500 packages)
	– Increased community treatment and access, through funded primary care Packages of Care, for diagnosis and treatment: Cellulitis, DVT, joint injects, pipelle biopsy, mirenas and ring pessaries, home based support services, and flexible acute services	Q4
	– On-going support for diagnostics and treatment for cellulitis and suspected DVT(>100 each)	Q1
	– Gynaecology business case development	Q2
	– Implementation of pipelle biopsy, mirenas and ring pessaries in community packages	Q3
	– Carpel tunnel business case development	Q3
	– Implementation of joint injections packages	Q4
	– Acute management packages business case development	Q2
	– Implementation of acute management and home based support service	Q4
Acute Demand - Health Care Home (HCH) – This is a team based health care delivery model led by a primary care clinician that provides comprehensive and continuous health and social care with the goal of supporting individuals to obtaining maximised health outcomes. – They will deliver proactive care, timely unplanned care, as well as routine and preventative care. – Performance improvements measures will be identified as part of the quality framework being developed for HCH.	– Level of financial and non-financial support agreed	Q1
	– Agreed standards to assess Health Care Home accreditation Agreement of HCH model and business case Design HCH development plan	Q1
	– Identification of HCH Expressions of interest process HCH impact analysis Selection of practices for HCH transformation	Q2
	– Implementation of the HCH Initiate practice process review Implement change process Activate HCH HCH standards setting Evaluation brief developed Models of care developed for Community Nursing and Allied Health Roll out of HCH capacity development Reconfiguration of HCH practice workforce	Q3
	– Process evaluation for HCH implementation	Q4
Acute Demand - Primary Care Co-ordination of Acute Care – The coordinated delivery of primary and community based health services and resources to support general practice teams to manage patients in the community	– Review of existing co-ordination roles across the health system	Q1
	– Agreed model and business case for acute primary care co-ordination service	Q2
	– Implementation of the agreed primary care co-ordination service	Q3
Acute Demand - Primary Care Access to Community Support and Hospital Services (Shifting	– Identify Community and Health services that will support primary	Q1

	services through integration/promoting Care Closer to Home) – Access to community and hospital services will support the management of patients in the primary care. These services may support proactive care, planned care and acute unplanned care. – Review District Nursing under the Health Care Home workstream.	health care advanced services including: District Nursing services, Geriatric services, Allied health services, Urgent community care via ambulance, NASC – Model of care agreed – Review and develop plan for selected services to be responsive to primary care – Reorientation of selected services to be responsive to primary care	 Q3 Q3 Q4
4	**Information Management Service Level Alliance** (see DHB-level actions below) – Electronic Request for Advice Rapid access to specialist service advice for primary care will support the on-going care of people in the community. The Request for Advice project will deliver processes to enable this communication across the interface. – Shared Electronic Health Record (SEHR) The SEHR enables the sharing of patient information across the system by providing identified and approved hospital clinicians access to a summary of the patients' primary health care record. The SEHR project will focus on efforts to promote its on-going and increased use. – Patient Portal Patient Portal will enable patients and practices to interact via the secure portal. This service has been trialled in a number of practices, and implementation will be expanded across the sub-region. – Shared Care Request for Access Request for Access feature will enable Primary Care Practice to share selected parts of the patients' health record with identified health providers. This will allow information to be available for people who may have multiple providers involved in their care. The Service Level Alliance will consider options of how this feature may be best utilised to ensure accessibility, but maintaining patient confidentiality. – Shared Care Planning Shared Care Planning will build on the capability of sharing information, to developing a Shared Care Plan. A Pilot will be established in the sub-region to trial this new feature, and subsequent to the results, the process will be refined and expanded on. – Primary Care Access to the Hospital Health Record The expansion in the number of Primary Care based Clinicians accessing the Hospital health record will assist in providing a more complete view of a persons' health record while providing care, particularly post-discharge and for patients that have multiple contacts with Hospital Health Services. – E-referral Electronic referrals create efficiencies in attaining specialist advice and care. This service is in place, but require developments to enable referrals to the care coordination centre, inter-DHB referrals and inter-primary care practice referrals		Q2 Q3 Q4 Q3 Q2 Q4 Q2
5	**Long Term Conditions Service Level Alliances/Networks** – see Diabetes Care Improvement Plan 2.2.16 – see More Heart and Diabetes Checks 2.2.15 Respiratory Care Improvement Plan - respiratory conditions, COPD, and Pneumonia; raising awareness and risk identification – Access to primary care – Self-management and pulmonary rehabilitation – Risk stratification and flu vaccination in at risk individuals and smoking cessation. – Linking with Regional Public Health regarding wider health determinants, such as housing; there will also be a focus on smoking cessation. Self-Management and prevention (with Regional Public Health) – Prevention - see Healthy Families 2.2.6 – see Better Help for Smokers to Quit 2.2.12	– Three respiratory pathways will be completed and implemented; COPD, Cough, Pneumonia and OSA, with additional pathways will be prioritised by the ALT – Develop self-management model	Q4 Q2

	– see Palliative Care Section 2.2.4 – see Faster Cancer Treatment 2.2.13		
6	**HealthPathways** – Implement a mechanism for patient and carer access to non-clinical information health currently held within ' 3D.healthpathways.org.nz ' – Cancer pathways – Completion of 50 additional pathways – HealthPathways support increasing the number of services shifted to the community through Primary Care Options for Elective Care (see Acute Demand sections above) for example: – Joint Injections – Carpal Tunnel, Shoulder, Knee and Hip – Gynaecology procedures - Implement pipelle biopsy, mirena insertion and ring pessaries procedures in primary care – Non Melanoma Skin Cancer – Lesion removal in Primary Care – Improving and embedding pathways for primary care access to specialist nurse and/or doctor advice, for example: – Embedding frail but stable elderly pathways for dementia pathway – Local endorsement of regional orthopaedic pathways for HealthPathways website – Progress Sub-regional alignment of respiratory pathways – Direct referral for Carpal Tunnel Procedure and Colposcopy clinics – Post-implementation outcome measurement report	– # of pathways – Preferred option identified and implementation – Commence implementation – # of pathways gone live – % increase in clinicians utilising HealthPathways website page views and sessions BASELINE: 85 pathways currently localised – Implementation of dementia and frail elderly HealthPathways – Pathways uploaded – Pathways developed – Number of direct referral from PC – Outcome Report complete	Q4 Q2 Q3 Q4 Q4 Q2 Q2 Q4 Q4 Q4
7	**Frail Elderly Service Level Alliance (SLA)** see 2.2.18		
8	**Youth Health Service Level Alliance (SLA)** see 2.2.5 Youth Health Project – Youth Services		
9	**Vulnerable Children's Group** see 2.2.2 Children's Action Plan – Children's Teams		
10	**Medication Management Steering Group** – Medicines Strategy: development of a medicines strategy that will serve as a guide for future medication-related work programmes for 2015/16 and onwards; this will combine local health needs analysis information, national, and international evidence-based practices, and local stakeholder priorities – Medication Management Services Review: review medication management services across the sub-region to determine how these are able meet the requirements of Health Pathways that refer to this service – Community Pharmacy Services Agreement: Support the national process with DHBSS and DHB representatives to develop, consult on and implement a new patient-centred Community Pharmacy Services Agreement from 2016/17	– Development of a reference medicines strategy document with ability to commence work on high priority areas identified. – Implementation of recommendations for a sub-regional Medication Management Service – Consultation with pharmacies completed – Contracts signed by 100% of pharmacies	Q1 Q2 Q4 Q4
11	**Flat X-Rays and ultrasounds** Implement new Clinical governance across the sub-region to actively monitor and encourage consistency with clinical referral criteria	– Referrals are aligned with clinical criteria and aligned with regional population	Q3
12	**Implementation of National New born Enrolment Services (NES) within the sub-region** see 2.2.25 Maternal and Child Health	– NES implemented	Q2
	Capital & Coast DHB		
	Action	**Measure**	**Timeframe**
	The Capital & Coast DHB Integrated Care Collaborative (ICC) Programme was launched in 2012 and converted to an Alliance in 2013. The ICC has enabled strong linkages to be established with leads from across the sector to work towards improvements for the whole of the DHB. To date the ICC has delivered a Shared Electronic Health Record, the Diabetes Care Improvement Plan, Frailty Coding, Primary Options		

	for Acute Care, Oxycodone Prescribing Improvements, Free <6yo funding and developed a number of Child Health Pathways. These service developments have been delivered in accordance to the ICC Framework, which is based on consensus clinical lead developments and structured programme/project management processes. The ICC ALT has been key in driving improvements and will continue to build on these achievements, as well as through new transformational change opportunities. This section includes Capital & Coast DHB specific alliance developments, that are separate to the sub-regional developments included above.		
1	**Overall Programme Development** – Review of collective impact of ICC work streams – See Māori Health Plan for actions around reducing ASH rates	– Reduced growth in ED attendances – Reduced growth inpatient events (Total & >65y) – Maintain reduced LOS (Total <3days & over 65y <4.5) – Maintain reduced Bed days (Total <200*& over 65y <1000*) – Reduce ASH growth 0-74 & inequity for population groups – Reduce Readmissions rate Total <10% & over 75y <7& – Reduce growth ATR discharges >65y	Q1, 2, 3, 4
2	**Information Management Service Level Alliance** (Shifting Services through Integration)		
	– Electronic Request for Advice to specialist service advice for primary care will support the on-going care of people in the community	– Agreed process for Request for Advice process in sub-region – Consultant services enabled to provide timely advice to primary care – 5 Consultant services provide timely advice to primary care	Q2 Q3 Q4
	– Shared Electronic Health Record (SEHR) enables approved hospital clinicians access to a summary of the patients primary health care record	– 95% of patients within Primary Care Practices that have enabled the SCR – 25% of Hospital Clinician utilisation of the Primary Care Shared Care Record – Develop sub-regional implementation plan for SEHR us	Q4 Q4 Q4
	– Patient Portal will enable patients and practices to interact via the secure portal	– 20 Primary Care Practices that have enabled the Patient Portal – 50% of patient able to access the Patient Portal (in practices that have this service enabled)	Q4 Q4
	– Shared Care Request for Access will enable Primary Care Practice to share selected parts of the patients' health record with identified health providers	– Agreed process through for the application of the Request for Access feature in the sub-region – 1 sub-regional pilot – Trial Request for Access process sites – 3 in Capital & Coast DHB	Q2 Q4
	– Shared Care Planning to developing a Shared Care Plan	– Sub-regional DHBs and PHO agreement on Shared Care Plan process – Agreed solution to Shared Care Planning – Pilot Shared Care Plan in targeted practices initiated – Evaluation of the Shared Care Plan Pilot	Q1 Q3 Q4 Q1 2016/17
	– Primary Care Access to the Hospital Health Record	– Agreed solution to Primary Care Access in the sub-region – 100% of General Practice Primary Care Clinicians with access to the hospital health record	Q1 Q1
	– E-referral to create efficiencies in attaining specialist advice and care	– Multi provider e-referral sub-regional concept development complete – Multi-provider e-referral proof of concept trial – Multi-provider e-referral roll out plan developed	Q1 Q2 Q4

Regional		
Action	**Measure**	**Timeframe**
1 Hepatitis C Service – Work with Central Region, and engage with the sector including the Hepatitis Foundation, to develop a sustainable service, including a Health Pathway, for on-going identification, assessment, and treatment of new patients with hepatitis C	– Capital & Coast and Hutt Valley delivery (Hepatitis Foundation) – Develop new service sub-regionally – Deliver new service sub-regionally – Transition to regional service - Central Region	From Q1 Q3 Q4 From July 2016

SUPPORTING SYSTEM INTEGRATION

2.2.18 HEALTH OF OLDER PEOPLE

Older people (65+ years) sustain over one-third (37%) of the total health loss despite making up only 12% of the population; we are living longer, but not all of this time is spent in good health. Our population is also ageing and the prevalence of frailty (older adults who have an increased risk for poor health outcomes including falls, skin fragility, incident disability, hospitalisation, and mortality) will increase as the population ages. We are working sub-regionally and regionally on initiatives to protect vulnerable older people, provide good support and information for self-management, integrate and wrap services around the consumer to improve access and utilisation, up-skill our workforce, and improve communication and patient management systems.

Sub-Regional

	Action	Measure	Timeframe
1	**Needs Assessment and Service Coordination and Home & Community Support** – Implementing agreed recommendations from the review of Needs Assessment and Service Coordination (NASC) and Home & Community Support Services (HCSS) model & services – Implementing allocation of specific funding for in-between travel with home and community support providers – Participate in national roll out of Complaints Categorisation initiative – Implement reporting of NASC timeframes from referral to assessment then timely service allocation/decline *FOCUS is integral to most HOP processes and outcomes in this plan e.g. % of people, supported to live at home, Health Recovery programme, supported discharge triage, and InterRAI*	– Service Models and funding implemented as agreed – Allocation of funding for in-between travel implemented – Participation in working groups as appropriate – Complaints categorisation data available – See also Module 7 PP23 – Reporting to NASC time frames from referral to assessment then service allocation/decline	Q4 Q1, 2, 3, 4
2	**Comprehensive Clinical Assessment (InterRAI)** – Use InterRAI for analysis, benchmarking, and population planning, including analysis by population groupings including Māori & Pacific. – People needing an assessment are getting an assessment. Use access data for population groups to identify variations & take appropriate action	– Equitable access to InterRAI assessment (Contact & Home Care) based on proportion of population groups – See also Module 7 PP23	Q4
3	**Dementia care pathways** – Embedding Health Pathways in primary care – Dementia and Frail Elderly	– Progress on implementing health pathways for Dementia and frail Elderly (refer to each sub-regional DHB annual plans, and below, for further detail) – See also Module 7 PP23	Q4
4	**Supporting Carers -** Aligning systems to support carers across the three DHBs – Funding models – Information for carers	– Principles of alignment implemented (e.g. funding model for day activity support).All full time family carers able to access allocated support services (report by exception)	Q4
5	**HOP specialists in ARC & Primary Care** – Identification and active management of frail elderly across the health continuum, especially with regard to acute events. Reducing length of stay in hospital through a range of initiatives to enable timely and supported discharge – Service Level Alliance – Improved Integration and Partnership with Primary Care – Primary care visits to ARC delivered as part of the ARC service for residents	– Reduction in Length of Stay (LOS), bed days for people over 75 and reduced readmissions (refer to local DHB specifics) – See also Module 7 PP23 – Specialist medical input reported quarterly to the Ministry	Q4 Q1, 2, 3, 4
6	**Preventing Harm from Falls** – Develop an overview of falls related work across the sector (hospital, ARC, Home and Community Support Services, community)	– Summary of falls prevention management activity developed – # of people seen by FLS	Q2

	– Advance Fracture Liaison Service (FLS) and osteoporosis treatment for people at risk of further fragility fractures – Identify cost benefit of prescribing options for osteoporosis treatment, promote most cost effective with prescribers and divert potential savings to further establishment of the FLS (e.g. increased DEXA scan volumes, identification/coordination for fragility fractures)	– Establishment of Osteoporosis Health Pathway; count of patients will commence once the service is established and systems are in place – – Pharmaceutical baselines and targets to be established; savings and diversion options to be identified	Q2 Q4

Capital & Coast DHB

	Action	Measure	Timeframe
1	**Home & Community Support** – implement allocation of home and community support providers of specific funding for in-between travel – participation in any working groups to implement aspects of the negotiated in-between travel settlement – use the review recommendations to inform the process of procurement for Home and Community Support Services (HCSS) – use sub-regional and regional DHB benchmarking to monitor support of older people to live in the community	– Implemented within the nationally agreed timeline – New contracts implemented with HCSS – Older people receiving DHB funded supported to live at home as % of all older people receiving DHB funded support (annual snapshot as at June)	Q4 Q2

	2013/14 – % People 65+ supported to live in the community
Baseline	59%
Sub-regional ave.	63%
Target 2015/16	=/> 59%

2	**Rapid Response and Supported Discharge** Rapid response and discharge management services (wrap around services), specifically addressing those issues which have been identified by the DHB: – CaREFul model – including front door identification and stratification of frail older people & appropriate geriatric assessment – development of a quality improvement project *Discharge to Assess* to strengthen supported discharge process	Reduce average ALOS for people over 75 yrs

	2013/14 - Standardised ALOS, 75+ years, Acute
Baseline	4.99
National	4.68
Target 2015/16	4.68

– Maintain or reduce readmissions for people over 75yrs

	2013/14 - Standardised readmission rate 75+ years
Baseline	10.1%
National	10.6%
Target 2015/16	=/< 10.1%

– ED screening of people >75yrs (baseline to be established)
– Facilitated discharge through the CaREFul model - report on numbers achieved
– Discharge to assess measurement goal: Service model developed and target agreed; Business Plan approved and service implemented; target numbers to be developed

3	**Comprehensive Clinical Assessment (InterRAI)** – increase the number of older people who have received long-term support services (home or residential care) in the last three months who have had an InterRAI assessment and completed care plan [see information on InterRAI assessments below] – support ARC facilities - reporting on how many facilities are trained or engaged in training in the use of InterRAI – monitor use of InterRAI LTCF in ARC facilities via report of data from DHB Shared Services – measure use of InterRAI as a primary assessment to inform an integrated care plan (i.e. a care plan that goes beyond a single support service) – see sub-regional section above for NASC timeframes	– InterRAI HC target = 100% – All facilities to have RNs trained in InterRAI assessment and using it to inform care planning in ARC – InterRAI Long Term Care Facility assessment report on the % of residents who have a second assessment completed within 230 days of admission – InterRAI HC care plan shared with HCSS providers & Day Activity Support providers – All respite care providers able to access/read assessment and care plan	Q1, 2, 3, 4 October 2016 October 2016
4	**Dementia care pathways** – improve of dementia care pathways with a focus on earlier diagnosis and improving support and services available following a dementia diagnosis (e.g. education, information, on-going support) – GP training – WiAS – navigation & support – dementia educator for primary and community care	– CME training x 2 re pathway for cognitive impairment – Specialist services to direct primary care to pathway for reference – Increase number of referrals to Alzheimer's Wellington (serving Capital & Coast DHB & Hut Valley) – Baseline = primary care = 8 Target = 16 – WiAS programme implemented as resources allow – Dementia Pathway page views: **City** | **Oct – Dec 2014 baseline** | **2015-16 Target** Wellington | 2,491 | 7,500 Paraparaumu | 288 | 1,120	Q1, 2, 3, 4
5	**HOP specialists** – Increase or maintain optimal levels of use of DHB specialist Health of Older People Services (geriatricians, gerontology nurse specialists) to advise and train health professionals in primary care and aged residential care – Specialist support of ARC – Development of Nurse Practitioner role to provide community based nursing practice and advice – Analyse current geriatrician resource and investigate models of specialist geriatrician support for PHOs. – HOP specialists will continue to provide clinical and educational input for residential and primary care and maintain specialist inputs through; - Assessment, education and advice with regard to specific clients - Shared case review - Education forums – Improved Integration and Partnership with Primary Care. Develop PHO and specialist (ORA) integration of services for frail elderly supported in the community.	– Appoint a Nurse Practitioner or Nurse Practitioner in Training – Nurse Practitioners provide for education/ consultation/ liaison across Capital & Coast DHB aged residential care facilities – Target for Capital & Coast DHB Nurse Practitioners 2015/16 = 40 sessions. – Baseline for Kapiti Nurse Practitioner 2013/14 = 28 Session | | Specialist input for ARC | Baseline 2013-14 Q4 | 134 Target 2015/16 | =/>134 ave. per quarter – Specialist dementia care education provided for primary care practices with regard to using best practice through the dementia care pathway – Development of Frail Elderly health pathway – Reduced readmission rate for people >75yrs	Q1, 2, 3, 4

	Regional *The Regional Dementia Care Pathway Group will ensure people with dementia and their families and Whānau are valued partners in an integrated health and social support system that supports wellbeing and control over their circumstances*		
	Action	**Measure**	**Timeframe**
1	Identify and develop regional components of the dementia care pathways that are best achieved at a regional level and share learnings and resources across the region. For example: – Three components of dementia care pathways that are best achieved at a regional level are identified by 30 September 2015; – Two components of dementia care pathways are developed at a regional level by 31 March 2016	– Regional activity that supports DHB dementia care pathway development and implementation	Q 1, 2, 3, 4
2	Develop and commence delivery of dementia awareness and responsiveness education programmes for primary health care clinicians to improve awareness and responsiveness in primary health care (working in partnership with the dementia sector and primary health organisations). For example: – 100 primary care clinicians have attended dementia awareness and responsiveness programmes (number reported each quarter)	– Development and commencement of dementia awareness and responsiveness education programmes in Primary Health Care (as set out in the CFA variations).	Q 2, 4
3	Provide support and overview of the development and implementation of DHB dementia care pathways following the New Zealand Framework for Dementia Care		
4	Provide representation at a national level when requested by the Ministry of Health (the Ministry) (approximately twice a year) to provide an overview of DHB development and implementation of dementia care pathways and share learnings and ideas nationally.	– Regional representatives attended national meetings organised by the Ministry of Health	
5	**Regional Dementia Pathways Reference Group** - Provide support and overview of the development and implementation of DHB dementia care pathways following the New Zealand Framework for Dementia Care - Develop and commence delivery of dementia awareness and responsiveness education programmes for primary health care clinicians to improve awareness and responsiveness in primary health care. - Collaborate with Canterbury DHB (as Lead) to implement a regional response to new funding for Walking in Another's Shoes	– 100 primary care clinicians have attended dementia awareness and responsiveness programmes – Develop regional response to new funding	Q4 Q2
6	**Regional Advance Care Planning (ACP) Reference Group** - Regional ACP Reference Group is to act as a Central Region conduit for ACP and support regional ACP implementation through escalation of local innovations and collaboration. - Level 1 ACP training is prioritised as it builds capacity and capability to engage in ACP conversations - Promote ACP throughout the health system	– ACP is integrated into clinical pathways, such as dementia pathways – Identify ACP activity that could be collected to inform a regional dashboard or outcome measures – Level 1 training modules are promoted by local ACP governance groups evidenced by 60 new Level 1 certificates	Q4 Q3 Q4
7	**Health of Older people Network – Polypharmacy** - Evaluate quantitative and qualitative benefits of regional delivery of master classes in polypharmacy	– Identification of benefits and evaluation – Findings and future recommendations presented to REC	Q1 Q2
8	**Health of Older people Network – Regional Collaboration** - Establish regional dashboard for HOP utilising data available within InterRAI Clinical Repository to support the development of clinical pathways and cross sector engagement - Establish regular engagement opportunities with ACC to identify where the Central Region can collaborate to support wellness in older people	– Identify regional resource to support regional dashboard development and reporting – Run dashboard reports & refinements – ACC to join the HOP Network quarterly to update on cross sector priorities and operational opportunities for innovation – Central Region to provide Subject Matter Experts to ACC (as	Q1 Q1, 2, 3, 4 Q1 Q4

		requested) to support the cross agency work programme	
National Entities			
Action		**Measure**	**Timeframe**
1	Health Workforce New Zealand (HWNZ) – Regional Training Hubs with collaboration between HWNZ, DHBs, education providers and professional associations.	– Participate in workforce projects as they relate to health of older people	Q4
2	Health of Older People Steering group and Ministry of Health – Benchmarking for health of older people indicators and expenditure	– Contribute to developments and projects through representation on this group (e.g. Aged Residential Care workforce, national ARC contract review) – Participate in indicators/expenditure benchmarking as it relates to health of older people	Q4
3	NZ InterRAI Project Group – Benchmarking of InterRAI indicators to inform population planning	– Contribute to developments through representation on this group – Participate in InterRAI indicators benchmarking as it relates to health of older people	Q4

SUPPORTING SYSTEM INTEGRATION

2.2.19 MENTAL HEALTH AND ADDICTIONS – 'RISING TO THE CHALLENGE 2012-2017'

'There is no health without mental health'. Mental illness remains a leading cause of health loss for our populations, particularly for those aged 15-44 years. While there have been significant transformations in mental health and addiction services in the past two decades, the challenge remains of ensuring that health services work alongside families/whānau and communities so that young people have a healthy beginning and can flourish, and all people with mental health and addiction issues can access appropriate treatment and recover rapidly.

Our sub-regional DHBs are increasingly seeking to develop shared solutions to manage clinical, demographic and service pressures and the financial challenges that we face individually and collectively**.** In late 2014, the three DHBs integrated Mental Health, Addictions, & Intellectual Disability Service across the sub-region; the new Service was launched in February 2015. The shift is consistent with the directions for service development as set out by both the Ministry of Health's Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012-1017 and the Mental Health Commission's Blueprint II and the shift of mental health and addiction services closer to home. The move to a '3DHB Mental Health, Addictions, & Intellectual Disability Service' provides added opportunity for the services with Māori and Pacific people to enhance and progress linkages and connections across the broader sub-regional resources which would include the three Māori and Pacific Health Directorates and their respective Whānau Care teams. It will also include closer working connections with the community-based mental health and social service sector across the three DHB communities for people who access these services, and is committed to primary care being at the table in all possible initiatives.

Sub-Regional

	Action	Measure	Timeframe
	Better Use resources/value for money		
1	**Rising to the Challenge: Mental Health and Addiction Service Development Plan** – Undertake a stocktake of the Service Development Plan across the sub-region to identify and plan improve on any gaps against the key priority actions – Support the implementation of Commissioning Framework with agreed and required changes	– Stocktake completed; service provision and system gaps are identified – 2016/17 priority actions developed and agreed – Key changes are implemented	Q2 Q3 Q4
2	**Mental Health and Addiction Strategic Framework** – Improve integration of delivery for Mental Health & Addiction services with primary care and NGO services across sub-region to reduce inequalities and meet identified population needs – Develop a "Roadmap" which supports the implementation of the three DHB Mental Addiction and Intellectual Disability reconfiguration. Roadmap identifies actions and outcomes to provide services in ways that are efficient and effective(including cultural effectiveness), support service transformation, support NGO sustainability and strengthens a collaborative and integrated approach for a more unified delivery of Mental Health and Addiction services – Develop a strategic approach to ensuring NGO services form part of the mental health and addiction continuum which supports the sustainability of services and focuses on maintaining and improving the provision and quality of mental health and addiction services	– Stakeholder engagement process is completed and priority actions are identified – Sub-region Roadmap developed and key changes and effort/resource required to implement the Strategic Framework Priorities are identified – Roadmap Implementation Plan developed	Q1 Q2 Q3
	Improve integration between primary and specialist services		
3	**'Equally Well' – Improve the physical health of people with mental health and/or addiction** – Work collaboratively with primary care to improve the physical health of people with mental health and/or addiction issues – Use an alliance approach to increase awareness and collaboration to formally identify this group as a priority	– Baseline established for the % (number) of people with mental health and/or addiction issues accessing comprehensive annual physical health checks – Smoking cessation programmes are developed and implemented	Q4

	health group in relation to their physical as well as mental health and/or addiction issues – Facilitate integrated collaboration with PHO's and other partners to reduce the physical separation between mental health and/or addiction and primary care services	across the primary and specialist services for MH&A consumers	
	Cement and build on gains in resilience and recovery		
4	**Acute Adult model of Care** across sub-region – Implementation of change management plan (showing key phases and timing of changes) for an Acute Adult model of Care pathway across 3 DHB's (within a consistent Model of Care) in particular improving access for Māori and Pacific populations. – Improved workforce utilisation and community resources – Reduction in health inequalities through improved equity of access and outcomes across the services particularly for Māori and Pacific service users.	– Enhanced Acute Adult Model of Care completed and is consistent with collaborative approach to case management, reducing duplication and streamlining services across sub-region – Procurement process completed for enhanced Acute Adult Model of Care services – Implementation of new enhanced Acute Adult Model of Care services across sub-region	Q1 Q1 Q4
5	**Improving maternity and early parenting support** – Implement a Perinatal, Maternal, and Infant Mental Health strategy encompassing a stepped-care, cross agency pathway of care	– Implement planning workshop – Establish four workgroups (clinical pathway design, screening and assessment, target populations, training and education) – Develop an endorsement plan to obtain sign-off and agreement for participation for DHBs, PHOs, and NGOs. – Hold education and training sessions across the DHBs, NGOs, PHOs to introduce the strategy	Q3
6	**Implementation of the New Zealand Suicide Prevention Strategy 2006-2015 (and Action Plan), with Regional Public Health** – Deliver on the focus actions for 2015/17 sub-region DHBs Suicide Prevention Plans and Post Prevention Plan – Implement two-year (2015/17) Sub-Regional Suicide Prevention & Post prevention Plan by working with key stakeholders across our sub-region – Establish a Prevention and Postvention Governance Group – Increase knowledge of suicide prevention and Postvention amongst professionals and non-professionals, individually and collectively	– # community and professionals less distressed and has more skills to prevent and respond to suicide and suicide attempts – % of decrease in suicide intentional self-harm / suicide attempts – % of decrease in suicide deaths – Submit Suicide Prevention and Postvention Plan – 20th July	Q 1,2 3, 4 Q1
7	**Opioid Treatment Service** – Assess future need and demand for Opioid Treatment Service for the Capital & Coast and Hutt Valley DHB populations, and facilitate clients being transferred to GP authorised prescribing in primary care setting – Co-design new service model to ensure sustainability of the Wellington and Hutt Valley Opioid Substitution Treatments (OTS) Service to meet increased capacity and future unmet demand: - Increase resource capacity for Shared Care Secondary/Primary Opioid substitution medication support to clients in primary health care - Compete the Environmental Science Research (ESR) development for GP Prescribing in primary care - Upgrade implementation of prescribing software to incorporate the NZ Universal List of Medicines and enable linkages with external servers – Develop a policy for engaging greater GP participation to deliver on a 50/50 target delivering OTS in secondary and primary care – Develop a Consumer Feedback Process to reduce waiting list	– Upgraded (implement) Prescribing Software incorporates the NZ Universal List of Medicines and enable linkages with external servers implemented – Co-designed service model for Wellington and Hutt Valley Opioid Substitution Treatments (OTS) Service completed – Fully implemented consumer feedback process reduces waiting list – 3-4 GP consultation forums held to engage GPs with the OTS Service – Three training sessions (one at each sub-regional DHB) are held for GP's who are currently delivering OTS and/or who have indicated willingness for referred clients to receive OTS in primary health care setting – Policy for engaging greater GP participation in the delivery of opioid developed and signed-off by ALT (Service Level Alliance) – Consumer Feedback Process evaluation report completed	Q1 Q2 Q2 Q4 Q4 Q4 Q4

8	**Improving service users employment rates** – Increase access to employment specialists delivering evidence-informed individual placement and support services for service users who are most adversely impacted by mental health/addiction issues – Employment support services standardisation developed – Vocational services are considered for integrated with mental health services (rather than clinical services brokering services users to separate employment services)	– Standardised approach to supported employment across the sub-region, that is effective in achieving work placements (paid and non-paid) at a higher rate than non–standardised employment interventions – Vocational services options paper developed	Q2 Q3
	Delivering increased access for all age groups		
9	**Youth Evidence-Based Vocational Outcomes** – Develop and co-design a service model to improve youth access to Evidence-Based Vocational Outcomes across sub-region – Co-design service model for Youth Evidence-Based Vocational Outcomes for services sub-regionally	– Service co-design Youth Evidence-Based Vocational Outcomes Model of Care signed-off by all partners across sub-region – Youth Evidence-Based Vocational Service Implementation Plan designed	Q2 Q4
10	**Reducing harm from alcohol and improving treatments: CEP Youth Exemplar** – Establish a new system of care for 'co-existing enhanced' outpatient youth alcohol and other drug services (Youth AOD) across the sub-region; mental health, alcohol and other drugs services in partnership with sub-region clinical services and NGO alcohol and other drugs service providers at a local and sub-regional level – Implement recommendations in the Youth AOD Exemplar Plan for the delivery of improved performance for exemplar youth focused alcohol and other drug (AoD) and coexisting mental health services, and for sustainable service changes – Refer to: 2.2.5 Prime Minister's Youth Mental Health Project	– Recommendations/Actions implemented	Q4
11	**Services for youth** – Enhance delivery and integration of specialist mental health and addiction services with PHO's and other partners for Youth, through improved access to both planned and unplanned services across the sub-region – Develop and implement improved access to both planned and unplanned respite services across sub-region for youth – Co-design a service model to improve access and enhanced wellbeing within the family/ whānau, and supports families to care for the child or young person with mental health needs – Resources are better utilised by delivering planned and unplanned facility-based respite services	– Service co-design for enhanced Youth Respite Model of Care completed and is consistent with collaborative approach to case management, reducing duplication and streamlining services across sub-region – Procurement for enhanced Youth Respite Model of Care services – Implementation of new enhanced Youth Respite services across sub-region	Q4 Q4 Q4
12	**Children of parents with mental illness and/or addiction (COPMIA)** Improve support around COPMIA and increased social support for high needs families: – Promote support for service for users in their role as parents – Increase awareness of COPMIA and the importance of identifying whether service users have children – Ensure referral information includes information on whether service users have children – Ensure clinicians ask service users about their children and determine whether they have psycho-social needs – Develop information forum to educate staff and clinicians who work with adult services users – Identify and actively engage COPMIA Champions across the mental health and addiction service in the sub-region – Increase local partnerships with providers that have an on-going COPMIA programme – Sub-region will use the Ministry guidelines to inform further actions	– Two DHB staff education forums, including NGO, held – Champions across the primary and specialist sector identified – One champion from each group participates in raising awareness and educating adult mental health teams about COPMIA: – Intensive Recovery Sector; – Adult Community and Addictions; and – Forensic & Inpatient Rehabilitation – Local partnerships developed with those providers who have an on-going COPMIA programme	 Q4 Q4 Q4
13	**Review and improve follow-up care for young people (12-19), discharged from secondary mental health and addiction services** The Prime Minister's Youth Mental Health Project has 22 initiatives (see 2.2.5); our actions towards Number 6 (Improving Follow-up Care of Youth Discharged from DHB Secondary Specialist Services) include:		

	– Improving transition from mental health and addiction services - this is a key point in the recovery process, and how that is managed can have a long-term impact on a young person's mental health and well-being, whether transition occurs between child and youth services or adult mental health and addiction services, or to primary level services or self-management, the planning and execution of the transition is paramount – Implement the SLA (youth) mental health workgroup Work Plan for better integration between primary and secondary mental health services - the SLA (youth) mental health workgroup, with its mix of primary and secondary service providers, is well placed to outline the steps necessary to support youth in their successful transitions – Improve access to CAMHS and Youth AOD services through implementation of new client pathway to meet wait time targets and integrated case management	– Implement the SLA (youth) mental health workgroup work plan to support youth in their successful transitions. – Implement the new client pathway to meet the waiting time targets of that by 2016 will enable: 80% of youth to access services within 3 weeks and; 95% to access services within 8 weeks.	Q4 Q4
14	– **Older Person Wellness Planning Model of Care**. Enhance the delivery and integration of specialist mental health and addiction services within primary care and health of older people services across Wairarapa, Hutt Valley and Capital & Coast DHB's. In particular reduce the health inequalities through improved equity of access and outcomes across the services particularly for Māori and Pacific service users. – Co-design a new service model to ensure sustainability of the Wairarapa, Hutt Valley and Capital & Coast Housing and Recovery Service including: - Improve service design, delivery, workforce utilisation and community resources - Increase resource capacity to ensure service users are accessing a range of interventions in a range of community settings - Increase older persons ability to manage their own wellness and increase social relations and supports	– An increase in consumer and staff satisfaction – Reduction in health inequalities through improved equity of access and outcomes across the services particularly for Māori and Pacific service users – Service co-design Housing and Recovery Supported Accommodation Model of Care completed – Implementation of new enhanced Housing and Recovery Supported Accommodation Model of Care across Wairarapa, Hutt Valley and Capital & Coast DHB districts.	Q2 Q4 Q4 Q4
15	**Improving access for community-based offenders to Mental Health and Addiction Services** Evaluate Single Point of Entry AoD Service (SPOE) whose role is to provide screening/ assessing, treating (brief interventions) and/or coordinating referrals to other services and agencies for community offenders Specialist addiction services work closely across the spectrum of justice services, including police to ensure that people who are involved with justice services and have addiction issues receive timely, effective and streamlined access to addiction services	– # of community-based offenders accessing SPOE service; and referred on to Mental Health and/or Addiction Services – **%** of community-based offenders that receive brief assessments and interventions – % of community-based offenders that are referred on to other agencies – % of offenders that have been through SPOE service that have successfully completing treatment / program – Baseline: Ministry of Health target - 250 offenders access service per annum	Q 1, 2, 3, 4
16	**Implement recommendations from review to improve access to Health Services for people with hard of hearing and/or are deaf** – Stage 1 - review use and cost of New Zealand Sign Language (NZSL) interpreters across the sub-regional provider services – Stage 2 - design an agreed work programme which will identify ways to improve access to general and mental health and addictions services for people who are Deaf or hearing impaired across our sub-region	– # of number of people using interpreters and cost across the sub-region – % of deaf people whose recovery needs are met or exceeded	Q 1, 2, 3, 4
17	**Reduce use of Mental Health (Compulsory Assessment and Treatment) Act 1992: section 29 community treatment order for Māori Tangata Whaiora** See Māori Health Plan for details on initiatives	– # Number of Māori Tangata Whaiora / Service Users presenting under a CTO – % the use of CTO is reduced by 25% over the 1st & 2nd Q and 50% over 3rd & 4th	Q 1, 2, 3, 4

	Action	Measure	Timeframe
	Capital & Coast DHB		
1	**Inner City Solution** – Implement joined-up cross-sectoral approach between health, partner agencies, and across community sectors in order to improve outcomes for people with high and complex mental health and addiction needs, this Includes Regional Public Health working with two key secondary care service providers to establish discharge pathways for priority groups. – Co-design cross-sectoral service approach to improve access and enhanced delivery and utilisation of community resources in the Wellington district	– Community Solution cross-sectoral service approach completed and is agreed between the health, partner agencies and community sectors. – Community Solution Service Implementation Plan designed	Q1 Q1
2	**Improving service users employment rates** – Occupation Services for people with mental health and addiction issues (including young adults) – Increase resource capacity for Te Ara Pai General Adult Occupation Service	– Two additional employment consultants in General Adult Occupation Service	Q1
	Regional		
	Action	**Measure**	**Timeframe**
1	Capital & Coast DHB leads Adult Forensic Working Group activities Continue to develop and monitor/evaluate implementation of the comprehensive Central Region Adult Forensic Services Report	Finalise and get Mental Health & Addictions Network (MHAN) sign-off of Action/Implementation Plan	Q1, 2, 3, 4
2	Capital & Coast DHB leads Youth Forensic Working Group activities	Implementation/action plans across all community youth forensic settings developed	Q1, 2, 3, 4
3	Capital & Coast DHB leads Residential Addictions Working Group activities	Regional operation of new model and Plan implemented	Q1, 2, 3, 4
4	Hutt Valley DHB leads Regional Rehabilitation activities	Regional Rehabilitation activities delivered	Q1, 2, 3, 4
5	Access to a range of eating disorder services continues to be a priority area Hutt Valley DHB leads continuation of work undertaken over the last two years, following service reviews and reports with recommendations to MHAN	Implementation of actions identified and agreed by MHAN arising out of 2014 Report	Q1, 2, 3, 4
6	Capital & Coast DHB leads Youth Alcohol and Other Drugs activities Establish new dedicated Youth AoD Working Group and draw on expertise and advice of key DHB and NGO people and organisations nationally	Youth Alcohol & Other Drugs Working Group established and meeting regularly, with advice gained from national experts	Q1, 2, 3, 4
	National Entities		
	Action	**Measure**	**Timeframe**
1	**Youth Forensic Build** Establishment of a secure 10 bed inpatient facility, providing services that are appropriate for youth offenders affected by mental health and/or Alcohol and other drug disorders. Nga Taiohi, Capital & Coast DHB's 10 secure beds Youth Forensic facility will become the final phase stage of the Youth Mental Health Centre of Excellence. The services already established under the Centre of Excellence umbrella are: (1) Regional Rangatahi: Adolescent mental health inpatient unit, and (2) Hikitia Te Wairua: the national youth forensic Intellectual Disability Inpatient Unit. The Centre of Excellence concentrates local, regional and national expertise in youth mental health, especially the management and treatment of acute and forensic youth mental health.	Facility build completed which aligns service standards and the model of care with legislative requirements of treatment of inpatient youth offenders and, provide them with improved opportunities to recover and successfully reintegrate into the community. Opening of the Capital & Coast DHB secure youth forensic in-patient unit dedicated	Q3 Q3

SUPPORTING SYSTEM INTEGRATION

2.2.20 ACCESS TO DIAGNOSTICS

Sub-Regional

	Action	Measure	Timeframe
1	Radiology Service Improvement Initiative deliverables – Standardisation of data collection – Demand analysis/management (demand management strategy) – Standardisation of pathways, protocols and policies – Review of radiologist productivity – Review capacity and develop a single capital plan – Review patient flows – Offer patient choice and enable CT scanning closer to home or work. – Improve production planning	– CT 95% of accepted referrals for CT scans will be scanned and reported within 6 weeks – 85% of accepted referrals for MRI will be scanned and reported within 6 weeks – Coronary angiography – 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months	Q4 Q4 Q4
2	Develop supply-side radiology strategy for the sub-region	– Completed strategy	Q4
3	Review MRI Capacity in sub-region and complete business case for 3rd MRI as required Implement	– Review completed – MRI commissioned	Q1 Q3
4	Health pathways and clinical criteria are embedded in primary care so that community radiology access is increasingly determined by clinical need	– At least 75% of community radiology referrals are consistent with Health Pathways or Clinical Access Criteria.	Q3
5	Implement integrated laboratory service across the DHB sub-region for community and hospital patients and referrers – Communication & stakeholder engagement plan is developed – Laboratory service facilities are constructed on level 5 – Equipment is installed and ready for operation – Community collection service is ready for operation – Service provider is ready to commence service providing laboratory services – Health emergency plan for all laboratory services is developed – Information systems are ready for operational testing and certification – Construction of level 6 facility commenced	– Communication & stakeholder engagement plan developed by provider in conjunction with the 3 DHBs – Certificate of Public Use is sighted by the 3 DHBs Documentary evidence provided to 3 DHBs that analysers have been installed, tested and declared fit for use – Collection centre premises, phlebotomy staff & courier services in place – Phase one Transition Services have been completed to satisfaction of independent auditor – Health emergency plan is consistent with the 3 DHBs emergency management procedures – No unresolved issues or bugs that impact the delivery of laboratory services – Detailed design completed	Q1 Q2 Q2 Q2 Q2 Q3

Regional

	Action	Measure	Timeframe
1	Work with regional and national clinical groups to contribute to development of improvement programmes.	Agreed National Patient Flow system changes are implemented	Q3
		Representation, attendance and participation in national and regional clinical group activities.	Q4

SUPPORTING SYSTEM INTEGRATION

2.2.21 CARDIAC SERVICES

Heart disease affects many people in New Zealand. Patients with more severe heart disease may benefit from cardiac surgery; sometimes to reduce the risk of premature death, but usually to relieve symptoms of angina or prevent heart failure. As heart surgery carries substantial stress and risks for patients, it is not undertaken without serious consideration. However, because heart disease is a common cause of death and can occur suddenly with little or no warning, waiting for cardiac surgery is particularly stressful for patients and their families and those who care for them. One aim of our work is to address delays in diagnosis and treatment of Acute Coronary Syndrome; to ensure patients presenting signs of cardiac chest pains will have a significantly reduced risk of dying through rapid and improved access to assessment and treatment. To improve the quality of cardiac services we need good data on what is happening to cardiac patients in New Zealand; collecting national data on the cardiological assessment of elective and acute patients, prioritisation, and pre-operative, intra-operative and post-operative care is the essential ingredient for ensuring continuous quality improvement. There are five cardiac surgery centres across New Zealand – Auckland, Waikato, Wellington, Christchurch, and Dunedin.

Sub-Regional

	Action	Measure	Timeframe
2	Achieve standardised intervention rates for the local DHB populations	– Cardiac surgery: 6.5 per 10,000 of population – Percutaneous revascularisation: 12.5 per 10,000 of population – Coronary angiography: 34.7 per 10,000 of population	Q 1, 2, 3, 4
3	Manage waiting times for cardiac services, so that patients wait no longer than four months for first specialist assessment or treatment	– # waiting longer than 4 months for FSA or treatment	Q 1, 2, 3, 4
4	Continue the introduction of Accelerated Chest Pain Pathways (ACPPs) in Emergency Departments.	– ACPPs in place	Q1
5	– Contribute data to the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of ACS risk stratification and time to appropriate intervention – Develop processes, protocols and systems to enable local risk stratification and transfer of appropriate ACS patients – Work with the regional, and where appropriate, the national cardiac networks to improve outcomes for ACS patients – See Māori Health Plan for details on improving CVD angiogram service for Māori	– % of high-risk patients who receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0'). Target 70%; increase in % of Māori – % of patients presenting with ACS who undergo coronary angiography and have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days. Target 95%; increase in % of Māori	Q 1, 2, 3, 4
6	Work with regional/national cardiac networks to improve outcomes for patients with heart failure	– Regional and national outcomes	Q4

Capital & Coast DHB

	Action	Measure	Timeframe
1	Provision of a minimum of 162 total cardiac surgery discharges for the local DHB populations	– # of cardiac surgery discharges	Q 1, 2, 3, 4
1	– Sustain performance against cardiac surgery waiting list management expectations – Ensure consistency of clinical prioritisation for cardiac surgery patients, by using the national cardiac CPAC tool, and treating patients in accordance with assigned priority and urgency timeframe	– % of patients waiting longer than 4 months for cardiac surgery – % of patients undergoing cardiac surgery who have completion of Cardiac Surgery registry data collection within 30 days of discharge	Q1, 2, 3, 4
2	– Review the cardiac rehabilitation service (including heart failure) in collaboration with primary care – Implement review findings	– Review completed – Implementation completed	Q2 Q4
3	Acute Coronary Syndrome – Continue to resource support for ANZACS-QI data entry – Develop web-based referral system for ACS patients in the region with defined prioritisation criteria that enhances transparency and equity of access – Develop and implement chest pain pathway for primary care referral of suspected ACS – Contribute to the development of regional NSTEMI and STEMI pathways	– % of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS-QI ACS Cath/PCI registry data collection within 30 days – Web-based referral system in place – Chest pain pathway implemented – NSTEMI/STEMI pathways developed	Q1, 2, 3, 4 Q4 Q2 Q2

	– Funding of part-time position of ANZACS-QI nurse co-ordinators	– >95% completion of data for ACS patients going to cath lab	Q1
4	Work with CRCN to develop an appropriate service delivery model for tertiary services for the region	– Regional service model in place	Q4
5	– Sustain performance against cardiac surgery waiting list management expectations – Ensure consistency of clinical prioritisation for cardiac surgery patients, by using the national cardiac CPAC tool, and treating patients in accordance with assigned priority and urgency timeframe	– % of patients waiting longer than 4 months for cardiac surgery – % of patients undergoing cardiac surgery who have completion of Cardiac Surgery registry data collection within 30 days of discharge	Q1, 2, 3, 4
	Regional		
	Action	**Measure**	**Timeframe**
Central region DHBs will work under the umbrella of the Central Region Cardiac Network. The focus for 2015/16 will be on continuing to improve access to cardiac services, including: – patients with a similar level of need receive comparable access to services, regardless of where they live – more patients survive acute coronary events, and the likelihood of subsequent events are reduced – patients with suspected ACS receive seamless, co-ordinated care across the clinical pathway – patients with heart failure are optimally managed during admission and then after in the community , thus, reducing the need for further readmission – the introduction of Accelerated Chest Pain Pathways (ACPPs) in Emergency Departments, which began in 2014/2015			
1	Monitor, report and resolution of DHB performance of acute coronary syndrome key performance indicators for the Central Region	– Each region has established measures of ACS risk stratification and timeliness for patients to receive appropriate intervention. – 70% of patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') – Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days. – Over 95% of patients undergoing cardiac surgery will have completion of Cardiac Surgery registry data collection within 30 days of discharge	Q1, 2, 3, 4
2	Improve access to secondary and tertiary cardiac services	Standardised intervention rates: – Cardiac surgery: 6.5 per 10,000 of population – Percutaneous revascularisation: 12.5 per 10,000 of population – Coronary angiography: 34.7 per 10,000 of population – Proportion of patients scored using the national cardiac surgery Clinical Priority Assessment Criteria, and the proportion of patients treated within assigned urgency timeframes – The waiting list for cardiac surgery remains between 5% and 7.5% of planned annual cardiac throughput, and does not exceed 10% of annual throughput – Patients wait no longer than four months for cardiology first specialist assessment, or for cardiac surgery	Q1,2,3,4
3	Work with primary care to develop clear patient pathways that improve access to cardiac services	– Patient care pathways, minimum standards and prioritisation processes, including referral criteria are in place	Q2
4	Support the development of a regional cardiac service model that delivers sustainable and equitable access	– Deliver a regional cardiac service model that delivers sustainable access and addresses unmet need	Q2, 3
5	Enhancing regional tertiary services	– Identify and implement strategies that ensure critical mass, viability and safety of tertiary services.	Q4

SUPPORTING SYSTEM INTEGRATION

2.2.22 STROKE

Stroke falls under the category of long term conditions which are a significant cause of disability and premature death. Stroke can be prevented by timely risk assessment and detection of cardiovascular disease with early intervention to manage hypertension and arteriosclerosis. For those who do have strokes a comprehensive treatment and rehabilitation plan is required with management in accordance with the NZ Clinical Guidelines for Stroke Management 2010. Also, see PP20, Module 7, for definitions of a stroke unit and organised stroke services

Sub-Regional

	Action	Measure	Timeframe
1	Provide an organised stroke service for DHB population as recommended in NZ Clinical Guidelines for Stroke Management 2010 (the Stroke Guidelines) – actions towards ensuring: – Utilise stroke thrombolysis quality assurance procedures, including processes for staff training and audit – Provide care management plans/services for people who have had a stroke, thrombolysis, transient ischaemic attack; rehabilitation – Provide lead clinicians designated to stroke – Support and participate in national and regional clinical stroke networks to implement actions to improve stroke services. – Develop stroke pathways for primary care within the sub-regional HealthPathways.org.nz – Monitor telestroke developments in northern sub-region and where appropriate deliver on commitment to telestroke (and telemedicine as a whole); e.g. including equipment purchase and project to rollout implementation and processes around this	– % of potentially eligible stroke patients thrombolysed Target: 6% – % of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway Target: 80% – Proportion of patients with acute stroke who are transferred to in-patient rehabilitation service. – Proportion of patients with acute stroke who are transferred to in-patient rehabilitation service within 10 days of acute stroke admission. Target 60%. – People with stroke admitted to hospital and treated in a stroke unit under the care of an interdisciplinary stroke team – All eligible patients have access to thrombolysis – All stroke patients receive early active rehabilitation by a multidisciplinary stroke team – All people with stroke have equitable access to community stroke services, regardless of age or where they live – All members of the multidisciplinary stroke team participate in on-going education and training according to the Stroke Guidelines	Q 1, 2, 3, 4
2	Work with neighbouring DHBs to investigate the feasibility of establishing a sub-regional or regional stroke rehabilitation service: – Stock-take of current demand and rehabilitation expert resource – Design a sub-regional/regional rehabilitation service that meets everyone's needs	– Stock-take carried out and reviewed with recommendations – Rehab service designed and plan for implementation agreed	Q2 Q4

Capital & Coast DHB

	Action	Measure	Timeframe
1	Review patient pathway from admission to community to maximise the percentage of patients who are managed in the acute stroke unit, are transferred to rehabilitation and can access community rehabilitation at the optimal time. Key steps are: – Ensure that at least 80% of stroke patients are managed in the stroke unit by 30 June 2016; this will require establishing capacity in the stroke unit to manage post-thrombolysis patients – Ensure utilisation of inpatient rehabilitation unit is optimised – Patient pathway reviewed and report generated – Ensure appropriate community services are in place to allow stroke patient community management at the optimal time.	– % of potentially eligible stroke patients' thrombolysed. Target: 6%, Baseline 13% (Q1 14/14 –update when Q2 available) – % of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway Target: 80%, Baseline 58% (Q1 14/14 – to be updated when Q2 available) – Proportion of patients with acute stroke who are transferred to in-patient rehabilitation service – Handovers improved and education meetings provide; follow-up staff interviews to assess implementation efficacy	Q1, 2, 3, 4

	– Ensure that transitions of care are effective, efficient, and safe – Progress in improving acute stroke figures	– Proportion of patients with acute stroke who are transferred to in-patient rehabilitation service within 10 days of acute stroke admission. Target 60% – Acute stroke unit (Q2 2014/15 figures): admitted to ASU 58% baseline - target 80%; access to thrombolysis 13% - target 6%; rehab in-patient and community % - target % (tbc); working with primary care on cardiac education and training.	
2	Undertake quality and workforce improvement activities – Clinical audits and thrombolysis register – Staff education and training including support for clinical staff involved with stroke care to attend regional stroke study days	 – One stroke audit per year – Two staff members from acute and rehabilitations services to attend each regional study day	 Q4 Q4
3	Participate in regional and national stroke networks and implement agreed service improvement initiatives – Ensure staff have the capacity to contribute, receives appropriate support to attend meetings, and is engaged in planned service improvement discussions		 Q4
4	Planning for collection of data to establish baseline for on-going reporting of rehabilitation indicators	– Inpatient rehabilitation transfers are captured using admissions to rehab within 24 hours of discharge from acute service – Community assessments developed using current booking system	Q3 Q3
	Regional *- improve stroke prevention, stroke event survival, and reduce subsequent stroke events - improve access to organised acute and rehabilitation stroke services*		
	Action	**Measure**	**Timeframe**
	Develop and deliver a regional plan for stroke services Supporting the continued implementation of the New Zealand Clinical Guidelines for Stroke Management 2010 (the Stroke Guidelines).		Q4
	Organisation of stroke services All stroke patients admitted and treated in a stroke unit with an interdisciplinary stroke team (see PP20 for definitions of a stroke unit and organised stroke services).	– 80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	Q4
	Thrombolysis All eligible stroke patients have access to thrombolysis (see PP20 for definition of an eligible patient).	– 6% of potentially eligible stroke patients thrombolysed	Q4
	Rehabilitation All eligible stroke patients receive appropriate rehabilitation services (as defined by the National Stroke Network), supported by an interdisciplinary stroke team. All eligible stroke patients have equitable access to community stroke services, regardless of age, ethnicity or geographic domicile.	– Proportion of patients with acute stroke who are transferred to in-patient rehabilitation service – Proportion of patients with acute stroke who are transferred to in-patient rehabilitation service within 10 days of acute stroke admission. Target 60%	Q4
	Education, training and audit All members of the interdisciplinary stroke team participate in on-going education, training and audit programmes according to the Stroke Guidelines	– Support and participate in national and regional clinical stroke networks to implement actions to improve stroke services	Q4
	Workforce A regional workforce plan that supports the delivery and achievement of sustained, consistent and safe thrombolysis. Identified actions that the region will take to develop and implement an on-going education programme that supports a sustainable and quality clinical workforce.	– Support and participate in national and regional clinical stroke networks to implement actions to improve stroke services	Q4
	Information Technology Identified actions that the region will take to support improved information management, e.g., establishing a regional oversight role		Q4

SUPPORTING SYSTEM INTEGRATION

2.2.23 LONG-TERM CONDITIONS

Long-term conditions comprise the major health burden for New Zealand now and into the foreseeable future. This group of conditions is the leading cause of morbidity in New Zealand, and disproportionately affects Māori and Pacific peoples. As the population ages, and lifestyles change, these conditions are likely to increase significantly. Cardiovascular disease (CVD) includes heart attacks and strokes, which are both substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. Therefore, this health target includes indicators monitoring CVD and stroke management. Diabetes is important as a major and increasing cause of disability and premature death. It is also a good indicator of the responsiveness of a health service to the people in most need. The national health target, 'more heart and diabetes checks', measures DHB performance in systematic assessment to detect all people either at risk of or already affected by CVD and/ or diabetes in their eligible population. Indicators of performance for CVD and diabetes will include several key indicators of management, output and outcomes, covering diabetes, CVD and stroke. By increasing the percentage of people being checked and improving the on-going management of their care, the DHB will impact the priority of speeding up the implementation of the Primary Health Care Strategy by ensuring primary health care is better able to contribute to improved health outcomes.

Sub-Regional

	Action	Measure	Timeframe
1	Establish enablers – Work with the Ministry of Health to establish a baseline for the number of people enrolled in a LTC programme – Demonstrate clinical governance for LTC services that is supported via Alliancing; On-going workforce development in primary care, and clinical governance with a named clinical lead – IT systems to support risk stratification, case management, shared care and or clinical information sharing (focus on collaboration enablers); IT capability is to be maintained and improved including provision of audit tools and/or a dashboard reporting system. – Staff training and education around goal setting, motivational interviewing and shared decision-making concepts	– Baseline established – Clinical Governance in place – IT enablers in place – Evidence of staff training and education	Q4
2	Prevention – Programmes in place to ensure links are made between GP practices and community organisations to maximise physical activity, nutrition, quit smoking and reduction in alcohol use, including the promotion of Green Prescriptions – For further detail around supporting healthy environments, settings, and processes see 2.2.17 'Primary Care and Integration' , 2.2.12 'Better Help for Smokers to Quit' 2..2.3 Whānau Ora , 2.2.8 Equity and Māori Health, 2.2.9 Equity and Pacific Health, 2.2.6 Health Families NZ (with Regional Public Health), 2.2.15 More Heart and Diabetes Checks, 2.2.16 Diabetes Care Improvement Packages, and programmes to increase physical activity, improve nutrition, reduce smoking, and reduce harm from alcohol and link to the wider determinants of health, for priority populations, see the Regional Public Health Business Plan www.rph.org.nz, (overview Appendix 3)	– Green Prescription (GRx): # Referrals % Measure against baseline Baseline 3904 GRx Adult referrals minimum 110 GRx Active Families referrals minimum – Healthy Homes: # Homes insulated % Measure against baseline Baseline 250 Homes	Q 1, 2, 3, 4
3	Identification of risk – There will be systems in place for risk stratification of the population to identify people with LTCs. For further detail see sections on Diabetes 2.2.16, Heart and Diabetes checks 2.2.15, and Cardiac services 2.2.20. – PHOs will support implementation of proactive recall and management of at risk populations. For further detail see 2.2.15, More Heart and Diabetes Checks	– # PHOs using risk stratification tools	Q4
4	Management Long-Term Conditions Clinical Network will develop and maintain a work programme that incorporates: – Develop a sub-regional self-management framework – Undertake a stock take of self-management programmes across the sub-region, agree upon a definition and robust measurement of self-management – Development and implementation of new models of care to support people with LTCs	– Framework agreed and adopted – Stock take completed – New model of care developed, and implemented – # of people enrolled in a LTC programme – Reduced ASH rates for 45-64yrs (including	Q4 Q1 Q3 Q1, 2, 3, 4 Q4

	– Provision of multi-disciplinary teams including allied health and kaiawhina supporting service delivery in primary care – Provision of self-management support and education for people with LTCs. – For further detail on supporting outcomes for LTCs see 2.2.16 'Diabetes Care Improvement Packages', 2.2.15 'More heart and diabetes checks', and 2.2.17 'Primary Care and Integration' – PHOs will continue to support workforce development initiatives, including staff training and education in LTC management which includes: goal setting, motivational interviewing, and shared decision-making concepts	– Māori and Pacific Peoples) in respiratory illness, diabetes, congestive heart failure – Number of primary care staff who attend training in self-management	Q4
	Capital & Coast DHB		
	Action	**Measure**	**Timeframe**
1	The Long-term Conditions Service Level Alliance will continue to develop, implement and monitor service initiatives for LTC in accordance with its work programme. For further detail See sections Diabetes Care Improvement Packages 2.2.16, More Heart and Diabetes Checks 2.2.15, and Primary Care and Integration 2.2.17 for further detail.	– # of people enrolled in a LTC programme. – ASH rates	Q4 Q4

SUPPORTING SYSTEM INTEGRATION

2.2.24 SPINAL CORD IMPAIRMENT

The Spinal Cord Impairment (SCI) Action Plan 2014-19 was developed to deliver better services in a timely manner across the SCI continuum (acute care through to living in the community) for people of all ages with acquired or congenital SCI causing significant impairment. The Action Plan is designed to enable people with a SCI and their families/Whānau to achieve better outcomes and support them to remain well and live as independently as possible in their community. Major Trauma was a key priority for 2014/15 and is continuing to be implemented – it will create a platform to manage Spinal Cord Injuries.

Sub-Regional

	Action	Measure	Timeframe
1	Carry out sub-regional actions to support implementation of agreed nationally directed destination and referral processes for acute spinal cord injuries, and supra-regional spinal services (Counties Manukau DHB and Canterbury DHB) and Auckland DHB for children's spinal services.	Confirmation/exception report	Q 4
2	Follow Central Region process mapping for acute surgical spines. This process was implemented in December 2014, and will be reviewed by July 2015.	Review carried out Recommendations made on required amendments	Q1 Q4
3	Develop referral guidelines for secondary hospitals.	Referral guidelines in place	Q4
4	The Central Region process mapping for acute surgical spines agrees with the SCI pre-hospital destination and referral pathway.	Alignment of mapping and pathway	Q3
5	Engagement with Wellington Free Ambulance to implement the pathway.	Ambulance alignment with pathway	Q2

SUPPORTING SYSTEM INTEGRATION

2.2.25 MATERNAL AND CHILD HEALTH

Across the three DHBs, there is an increased focus on working with children and young people to support long-term outcomes of improved health and wellbeing for our population. In 2014/15 the Alliance Leadership Teams (ALT) identified child and maternal health as a key focus area; we have planned this with our wider sector including Primary Care providers, Lead Maternity Carers, Well Child/Tamariki Ora (WCTO) providers and Community Oral Health Services (COHS) to plan actions and deliver improvements. We have considered quality improvement activities at the sector level rather than the service level, and support integration between services to achieve improved outcomes and improved value for money. We are increasingly aiming for:

- Early intervention to prevent disease e.g. focus on immunisation and primary mental health services for youth
- Ensuring treatment is as close to home as possible e.g. increasing services available in the primary care setting
- Working with our intersectoral partners to ensure people receive services from the most appropriate provider and, where possible, minimise duplication of services by different entities. In the Wairarapa and Porirua we are working with the Social Sector Trials to improve health outcomes by taking an intersectoral approach. We are also focussing on early treatment of sore throats to prevent rheumatic fever across the sub-region.

Our objectives include: a system that provides Better Public Services is one that has: Fully immunised children; More responsive mental health services for youth; Early identification and support for vulnerable children; and, decreasing incidence of rheumatic fever.

Sub-Regional

	Action	Measure	Timeframe
1	Pregnant women, babies, children, and families have access to services that maintain good health and independence through: o Increasing the number of women who receive continuity of primary maternity care during their pregnancy and improved integration of system o Increasing the number of women who register with an LMC in their first trimester – see Primary Care and Integration 2.2.17, and Children's Action Plan 2.2.2, and Module 7, SI7 IPIF Healthy Start. - utilisation of "Find Your Midwife" website - primary care pathways / closer integration of services to support timely referral to LMC o Increasing access for Māori, Pacific, youth and other higher need pregnant women to pregnancy and parenting education, with Regional Public Health o Continuing to implement the newborn enrolment process across the sub-region, supporting early enrolment with a GP, WCTO provider, Community Oral Health Services (COHS) and National Immunisation Register (NIR) and screening for tuberculosis (BCG vaccine) and hearing checks at birth – refer also Module 7, IPIF S18 - working with PHO newborn enrolment champions to identify and address delays or capacity issues - see Māori Health Plan for further details on oral health initiatives o Increasing access to oral health services for under 18s o Managing the incidence of obesity with Regional Public Health (see Regional Public Health Business Plan 15/16) o Obesity initiative: Develop sub-regional Obesity Governance Group o Obesity initiative: Development of Maternal Green Prescription o Obesity initiative: Health 4 Life project delivery continues to be led via Regional Public Health and partner organisations B4School Checks o Improved information sharing between primary care and B4SC programme	– 95% of pregnant women receive continuity of primary maternity care through a community or DHB LMC – 80% of women who register with an LMC do so in their first trimester, with a focus on Māori and Pacific women living in areas of high deprivation – 30% of Māori, Pacific, and teen pregnant women completing DHB funded pregnancy and parenting education – 98% of newborns are enrolled with a GP, WCTO provider, COHS and NIR by three months of age – At least 90% of four yr old children receive a B4 School Check, including at least 90% of 4 yr olds living in high deprivation areas (Q5) – Decreasing arrears in access to oral health services for under 18s to under 15% (% of pre-school Māori children enrolled in the community oral health service) – NZ Health Survey measure of obesity in children 2-14 years; B4 School Checks for 4-year olds – Obesity Governance Group has been established, TOR completed and a work programme outlined – Maternal Green Prescription Programme is scoped and funding has been secured. Timeline and objectives are agreed.	Q4

	○ Working with local VHT teams to ensure all components of the check can be completed in "one stop" clinics for Q5 children, where possible ○ Continued input to Capital & Coast DHB B4SC Working Group by sub-regional providers to share learnings from programme delivery in different areas ○ Working with specific practices with high numbers of children who have not completed a B4SC to support appropriate service delivery models		
2	Services for pregnant women, babies, children and families deliver best possible outcomes and support equity of outcomes through: ○ Maternity - Increased identification of pregnant women that smoke upon registration with a DHB-employed midwife or LMC are offered brief advice and support to quit smoking, with Regional Public Health – see Better Help for Smokers to Quit 2.2.12 - Complete implementation of all recommendations from Gestational Diabetes Mellitus National Clinical Guideline (December 2014) ○ Infant - increased reporting and planning between sub-regional breastfeeding networks - actions to improve Māori breastfeeding rates (see Māori Health Plan for details) - progressing targets under WellChild/Tamariki Ora Quality Improvement Framework ○ Child - Increasing immunisation rates, see also Increasing Immunisation 2.2.10 - Decreasing ASH rates – see Modules 3 & 7 of DHB Annual Plan - Reducing rates of rheumatic fever with Regional Public Health – see 2.2.1; opportunities for improved integration with community paediatric resource ○ SUDI - support: safe-sleep environments, smoking cessation and breastfeeding, promotion of early enrolment with and quality of service provision by Lead Maternity Carers and Well Child Tamariki Ora providers (WCTO); See Māori Health Plan for SUDI actions	– 95% of mothers to be smoke free at two weeks postnatal (Well Child & Maternity Quality indicator) – Maintain Baby Friendly Hospital certification – 75% exclusive or fully breastfed at LMC discharge – 65% receiving breast milk at 6 months – 60% of all babies are exclusively/fully breastfed at three months of age (WCTO core check #3); – WellChild/Tamariki Ora Quality Improvement Framework Indicators: – 95% of infants (0-12 months) have received all WCTO core contacts (1-5) – 95% of children in the sub-region to be living in Smokefree homes at B4 School Check – 95% of children in the sub-region with an LTL score of 2-6 are referred to oral health services – Improved respiratory-related ASH among 0-4 year olds – Reduced inequity in child outcome indicators – Reduction in SUDI for Māori Tamariki	Q4
3	Services for pregnant women, babies, children and families are of high quality and are nationally consistent, by: ○ Maintain Maternity Quality & Safety Programme (MQSP) and demonstrate the DHB is identifying and addressing local and national quality improvement priorities ○ Involving LMCs and GPs in local MQSP Governance ○ Improved quality and safety of maternity services including improved access, outcomes and consumer satisfaction as measured by national and DHB data analysis and surveys, reduced variation in performance against the NZ Maternity Clinical Indicators ○ Production of an Annual Report on Maternity services, included as part of Women's Health Service Annual Clinical Report	– Maternity Quality Indicators: – Reduction number of standard primiparae who undergo caesarean section – Reduction number of babies born under 37 weeks gestation – See DHB-specific actions below	Q4
	Capital & Coast DHB		
	Action	**Measure**	**Timeframe**
	○ Obesity initiative: Implementing Project Energize within a number of schools across Capital & Coast DHB	– Obesity Pathway in place	Q2
	○ Obesity initiative: Draft pathway has been trailed with GPs in the Wellington area; finalise pathway	– AUT will run their evaluation process as is in line with the Project Energize programme in the Waikato; Evaluation includes waist circumference and fitness ability of the children as well as success of implementation and programme utilization	Q4
	○ Working with key agencies to ensure timely access of therapy to those with disabilities, as well as to enhance responsiveness to those families in distress due to the high care needs of challenging disabled young people		
	○ Improving inpatient facilities for children	– Reducing wait list time for Speech Language Therapy	Q2

	○ Work with agencies to reduce injury and fatality rates for children in the community, with particular focus on drowning and motor vehicle accidents ○ Continue improvements in access to tertiary subspecialties, e.g. paediatric surgery, endocrinology, respiratory, paediatric neurology and allergy **Continuity of Care** ○ Work with primary, secondary care and LMC networks through integration child health workstreams to develop more effective engagement and access to services and information particularly for Māori, Pacific and vulnerable women ○ Continued promotion of "Find a Midwife" website, and communications strategy which include social and visual media ○ Promote Māori and Pacific input to programme ○ Work with LMCs to promote pregnancy and parenting education, and provide up-to-date information on how to access **B4School Checks** ○ Continuation of the Capital & Coast DHB B4SC Working Group ○ Improved information sharing between GP teams and B4SC programme ○ Working with local VHT teams to ensure all components of the check can be completed in "one stop" clinics	– Māori and Pacific representation on MQSP Governance – 95% of pregnant women receive continuity of primary maternity care through a community or DHB LMC – 80% of women who register with an LMC do so in their first trimester, with a focus on Māori and Pacific women living in areas of high deprivation – 30% of Māori, Pacific, and teen pregnant women completing DHB funded pregnancy and parenting education	Q2 Q4 Q4 Q4

Regional			
	Action	**Measure**	**Timeframe**
	○ Capital & Coast DHB leads regional maternal and perinatal mental health activities. ○ Develop the continuum of perinatal and infant mental health services by implementing contracted acute services as part of this continuum. ○ Identify and deliver on the actions needed to achieve the following: – establishment of a regional clinical network with close links to clinical networks being established in the other North Island regions – co-ordinated and consistent approach to service delivery across the relevant region and the North Island – regional co-ordination and access to the perinatal and infant mental health acute services as part of the wider continuum – increased access to perinatal and infant mental health services – evaluation of the individual services within the continuum and the continuum as a whole co-ordinated, safe, and timely after-hours response.	– Increased awareness of and access to both acute inpatient and home-based perinatal and maternal mental health services, with progress towards increasing access reported each quarter – Quarterly reports on milestones available – Packages of Care procurement complete and operationalized – Training needs and options available to meet these identified through Clinical Network – Training packages reviewed/updated and programmes being delivered, to # trainees and # completions – e-Learning RFP completed, training programme put in production and being delivered	Regional Q1, 2, 3, 4

National Entities – Health Promotion Agency			
	Action	**Measure**	**Timeframe**
1	HPA Alcohol and Pregnancy work programme contributes towards a reduction in harms related to prenatal alcohol exposure by: reducing the number of women consuming alcohol while they are pregnant; increasing public awareness of the risk associated with alcohol consumption during pregnancy; and, supporting health professionals (particularly primary care providers) to respond in a routine, effective and consistent way to women who are drinking while pregnant or planning to become pregnant.	Support of work undertaken by the HPA to reduce alcohol consumption during pregnancy, including encouraging primary and secondary care health professionals to engage with and support alcohol and pregnancy initiatives, and working with HPA to identify and support innovative local practice that supports women to reduce alcohol consumption during pregnancy.	Q4
2	HPA also has a programme of work to support Alcohol Screening and Brief Intervention in primary settings. This aligns with DHB work in this area.	Support of alcohol screening and brief intervention where appropriate.	Q4

See section 2.2.17 for primary care details.

SUPPORTING SYSTEM INTEGRATION

2.2.26 MAJOR TRAUMA

A major trauma is an event requiring the treatment of two or more injuries generally relating to the head or spine, or refers to an Injury Severity Score greater than 15. Nationally there are approximately 2,000 major trauma events per year; on average each attracts a 15-day stay in an intensive care unit, and one-two years of rehabilitation. The establishment of a Major Trauma NCN is a quality initiative arising from the assumption that outcomes from major trauma can be improved. Major Trauma is a key piece of regional work that will support the sub-region and link into national plans to better respond to and manage trauma in New Zealand. A whole-of-system approach is being led by DHB clinicians and managers to integrate and transform the Central Region health system.

Regional

To implement a formal regional trauma system to ensure more patients survive major trauma and recover with a good quality of life.

	Action	Measure	Timeframe
1	**Workforce** Positions of Clinical Leader Trauma and Clinical Nurse Specialist (Capital & Coast DHB) established through a Ministry of Health initiative in 2015 - these roles will provide leadership and strategic direction, promote and co-ordinate priorities, and effectively engage key stakeholders involved in planning, developing, and providing trauma services both locally and regionally. Maintain DHB representative on the National Trauma Network Capital & Coast DHB host in Regional Trauma Symposium with national trauma specialists, surgeons, Wellington Free Ambulance, and Life Flight Air Ambulance – covering: getting from the road side to ICU; complex pelvic injuries assessment, intervention, surgery & recovery; and, regional systems - how to transfer patients	– Lead trauma clinical leads and co-ordinators established at sub-regionally – Improvement in health outcomes for trauma patients, better systems, and safety and quality improvements – Strong links established with the National and Central Regional Major Trauma Networks – Symposium delivered and attended by trauma clinicians	Q4 Q4
2	**Information Technology** Participate in establishing a regional oversight role to ensure any actions required to contribute to NZMTMD collection	– Data systems capable of recording fields in NZMTDS to enabled	Q4
3	Development and implementation of regionally-consistent local major trauma systems Contribute to regional three-year action plan as required	– Contribute to reporting on the NZMTMD on all mandatory fields – More patients survive major trauma and recover with a good quality of life	Q1 Q4

DELIVERING BETTER PUBLIC SERVICES

2.2.27 WORKFORCE

A sustainable workforce is a key enabler in ensuring that DHBs continue to provide the range and scope of services that are expected and needed of them by the Government and, more importantly, by the communities that they serve. Our workforce planning is a continual process that looks simultaneously at the short, medium, and long-term needs for staffing our services and support, and balances the different drivers in ensure we can deliver appropriate staff capacity and capability for current and growing demand.

Capital & Coast DHB

	Action	Measure	Timeframe
1	**Cultural Capability** Te Tohu Whakawaiora: Certificate in Health Care Capability *Raising Capability to Accelerate Māori Health Gain* – Ensure NZQA approved – 8 month pilot Feb 2015 – 2016 facilitated by Māori Health Directorate / Development Unit Wairarapa DHB and Capital & Coast DHB – Support implementation over H&D primary and secondary sectors post evaluation – Designed for non-Māori and Māori with minimal knowledge of Māori paradigms – Support engagement of DHB Boards, ELT and workforce to engage with training	National Certificate in Māori Management – Generic (workplace practices) Level 3	Q4
2	**Workforce reflects community** – Increase the capacity and capability of the Māori Health Workforce at Capital & Coast DHB so that the health workforce is reflective of the community we serve – Support DHB activity to recruit, develop and retain Māori health workforce	– Report on Tu Pounamu Steering Group key activities via MPB updates – Increased Māori workforce capacity	Q1,2,3,4
3	**Planning and Intelligence** – Support initiatives to improve accurate workforce ethnicity data collection – Link in with regional and national workforce strategy – See Central Region Regional Services Plan	– Accurate workforce ethnicity data – Work programmes aligned with regional and national workforce initiatives	Q1,2,3,4
4	**Recruitment: Tu Pounamu** – Reviewing and embedding initiatives that profile health careers to secondary school students – Priority to KOH (Ministry of Health Māori workforce programme) continue to supply Māori students into health careers profiling initiatives – Continue to support KOH as an effective component of Māori workforce development – Work with Directorates to ensure Māori workforce capacity is increased to better support the health needs and reflect the Māori population that we serve	– Health career profiling initiatives become business as usual – Increased number of Māori student attendance at health careers initiatives – Increased awareness in interview panels – Increased % Māori workforce capacity – Increased % Māori graduates offered AH employment	Q4
5	**Retention** – Work with priority directorates to ensure Māori new entry to practice are supported to support Māori workforce sustainability	– Identify number of Māori graduates who leave within 12 and 24 months of employment – Strategies to improve retention support processes for Māori workforce	Q4
6	**Best Value** Continue to support targeted organisational priorities – Working with our sub-regional neighbours – Living within our means	– Collaborative initiatives – Resource duplication and waste minimised – Operate within our allocated funding	Q1,2,3,4

4	**Health Literacy Skill development** – Support Child Health Service to implement health literacy Three Step Health Literacy communication 'A.B.C' (Ask – them what they know, Build – on what they have already, Check – back on their understanding) strategies for staff – Implement Health Literacy Project – four work streams – Support organisational service development to promote workforce health literacy capability – Rollout of 'A.B.C' strategies into other directorates (e.g. Medicine and Cancer)	– Staff receive Three Step Health Literacy communication information (resources, e-learning) – Increased awareness of requirements of a health literate organisation	Q4
5	**Did Not Attends (DNA)** – Work with DHB DNA Steering Group to improve data collection and systems and improve DNA capability including targeted pieces of work with services – Whānau Care Service continue to provide Outpatient Clinics Attendance support to support the reduction in Māori DNA in priority areas	– Reduced Māori did not attend (DNA) rates – Reduced Māori readmission and admission rates	Q4
6	**Long-Term Conditions Management (see Long-term conditions, 2.2. 23)** – Work with Charge Nurse Managers to ensure Māori patients and whānau who require specialty cultural, social and clinical support are referred to Whānau Care Services in a timely manner – Provide Cardiology Cultural Speciality Nursing Service – Support organisational patient pathway initiatives that support the "shorter safer patient journey" e.g. 6 hour Rule; Frail Elderly / kaumatua; Integration with primary care	– Improved patient satisfaction – Reduction in patient & whānau complaints – Improved management of frail elderly Māori between HHS and primary care	Q4
7	**Disability Tools (see Equity and Disability, 2.2.7)** – Work with Disability and Patient Administration Service to ensure Māori patients have Disability Alert in patient administration system – Support with Disability to educate staff to ensure Māori patients care is supported by Health Passport use, as appropriate	– Increase in Māori patients with disability alerts in the patient administration system – Number of Māori patients users identified in the patient management system – % positive feedback from Māori patients on Passport in surveys show Passports are being used effectively	Q4

Regional

	Action	Measure	Timeframe
1	Explore sharing of e-learning content across identified primary care services	Network identified and scoping carried out	Q4
2	Monitor and review effectiveness of recruitment action plan in hard-to-staff areas	Reduction in time to recruit	Q4
3	Build resilient and supported midwifery workforce	Quality-assured professional support framework implemented	Q4
4	Support HWNZ through Medical Workforce Taskforce to ensure sustainable and resilient workforce	Workforce development and training progressed	Q4
5	Te Rau Matatini Promote the Te Rau Matatini Whānau Ora 2014-17 model, and its adoption across Central Region Undertake workforce development, particularly in cultural competence for non-Māori/other ethnic specific services Support implementation of the Māori Health Workforce Development Plan Accelerate performance locally against annual Regional Māori Health Plan indicators.	– Consumers and their families/whānau receive services delivered in integrated ways appropriate to their cultural as well as health and social needs – Implement Te Tohu Whakawaiora. – Produce equity report to support regional reporting; includes immunisation, breastfeeding, ASH rate, oral health.	Regional quarterly

National Entity - HWNZ

	Action	Measure	Timeframe
1	Increasing the number of sonographers. The sonographer workforce needs to grow by 300 full time equivalent (FTE) employees over the period to 2023, more than double the current FTE numbers, to enable more timely delivery of healthcare services, and meet the faster cancer health target, increased demand from demographic change and growth of Sonography as a diagnostic tool.	Address key workforce requirements with respect to the sonography workforce	Q4
2	Expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses. A Government policy 2014 health workforce commitment is to expand the role and number of nurse practitioners, clinical nurse specialists and palliative care nurses.	DHB supports the regional approach to expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses	Q4
3	Expanding the role of specialist nurses to perform colonoscopies. A Government policy 2014 health workforce commitment is to expand the role of nurses and train specialist nurses to perform colonoscopies. The Ministry of Health is developing and implementing an advanced nursing role in endoscopy for senior nurses with relevant post-graduate education and experience.	DHB supports the regional approach to expanding the role of specialist nurses to perform colonoscopies	Q4
4	Increasing the number of medical physicists. There is a low retention rate of graduates from the Medical Physics programme and a low number of postgraduate positions available to graduates, despite reported staff shortages. The number of medical physicists needs to grow to enable more timely delivery of health care services and meet the faster cancer health target.	DHB supports the regional approach to addressing key workforce requirements with regard to the medical physicist workforce	Q4
5	Increasing the number of medical community based training places and providing access to primary care/community settings for prevocational trainees. As part of the revised New Zealand Curriculum Framework for Prevocational Medical Training, the Medical Council will require PGY1 and PGY2 interns to undertake one clinical attachment in a community-based setting by the end of 2020. HWNZ is working with the Medical Council, the Royal New Zealand College of General Practitioners and DHBs to ensure employment and funding arrangements support these requirements.	DHB supports the regional approach to providing access to community-based placements	Q4

SUPPORTING SYSTEM INTEGRATION

2.2.28 IT/IS

Information technology (IT) provides the platform to support improved information sharing and integrated health care. Well-designed IT solutions help us reduce costs and enable clinicians to work better together to enhance the patient and consumer journey improving their experience of giving them safer and faster care. However, greater utilisation of, and reliance on, technology requires effective management of IT assets. Sustained investment in IT will enable the health sector to manage increasing demand with limited resources. National implementation of new IT initiatives continues in 2015/16. The priority national initiatives that we support will be underpinned by national information platforms. Regionally and sub-regionally our health professionals and service providers are being supported to better co-ordinate and integrate care through information technology advances and better application and utilisation. Our approach relies on a strong primary care platform to support service transformation and provides us with opportunities to better manage demand and develop a more sustainable health system. DHBs are working with alliance leadership teams to strengthen this integration with primary care.

Sub-Regional

	Action		Measure	Timeframe
1	Windows and SQL Server Upgrade	–	Risk from servers running out of support operating and database systems are fully mitigated through transition to supported infrastructure or use of a Microsoft extended support agreement	Q2
2	Information Security & Governance Programme	–	All ICT policies are reviewed, and key recommendations from security audit reports are implemented	Q4
3	Integrated Laboratory Services ICT	–	The DHB Laboratory Information System is extended and fully operational to support the Integrated Laboratory Service	Q2
4	General Practice access to Hospital Information	–	General Practices have the ability to access their patient's record in Concerto in a secure manner	Q4
5	Patient Portals. Portals are an on-line IT tool that will enable individuals to have access to their own health information. It will also allow hospital based services, in particular, ED, to have access to a summary view of primary care information; eventually, it will enable patients to communicate with their primary health practitioners and add information to their health record. General Practice Patient Management System (PMS) vendors are developing portals, and Orion Health is developing a portal in conjunction with Canterbury DHB eSCRV project.	–	Develop an implementation plan with relevant PHOs to enable individuals to have access to their own health information and allow hospital based services, in particular, ED, to have access to a summary view of primary care information	Q4
6	Sub-regional Test Results Repository	–	A laboratory test results collection that is accessible by all clinicians across the sub-region is implemented and used	Q2
7	Electronic Test Ordering	–	GPs have capability of making electronic requests for laboratory test	Q2
8	NCAMP	–	Implementation of system changes required to support the National Collection Annual Maintenance Programme 2016	Q4
9	Actions supporting Primary Care and Integration initiatives	–	See 2.2.17	Q4

Capital & Coast DHB

	Action		Measure	Timeframe
1	Hospital Telephony (VoIP) System Replacement	–	Replacement of the current hospital telephony system which is out of support	Q4
2	PAS Platform Upgrade. The PAS supports and manages the administrative details of a patients encounter with a hospital or	–	Progress implementation of a supported system that is aligned with the regional plan	

	DHB service. It supports the management of the hospital resources used to provide patient care such as clinical staff, rooms, beds and equipment.			
3	Emergency Department System Replacement	–	Progress analysis and business case for a replacement to current ED application in line with regional and national standards	Q4
4	Theatre Department System Replacement	–	Progress analysis and business case for a replacement to current ED application in line with regional and national standards	Q4
	Regional			
	Action		**Measure**	**Timeframe**
1	Clinical Portal (Clinical Workstation & Data Repository) Implementation of a regional Clinical Workstation (Orion, Concerto) and Clinical data repository (mixed products). The CWS is a web based system, accessed via a single sign-on that connects multiple clinical applications and data sources to provide clinicians with secure access to patient data. A CDR is a database of patient identifiable clinical information such as medications, laboratory results, radiology reports, care plans, patient letters and discharge summaries.	–	In 2015/2016 will begin the transition to the Regional Clinical Portal by completing the impact assessments, analysis and planning to inform the transition business case	Q4
2	Radiology Information System	–	Full transition to the Regional Radiology System across sub-region	Q4
3	Regional Network	–	Full transition to the Regional Wide Area Network	Q2
	National Health IT Board			
	Action		**Measure**	**Timeframe**
1	eMedicines Reconciliation (eMR) - Implementation of electronic reconciliation of medicines on admission and discharge from hospital.	–	Analysis and planning to inform a business case for the implementation of eMR	Q3
2	ePrescription	–	Development of an implementation plan with the PHOs on the rollout of the NZ ePrescription Service	Q2
3	National Patient Flow Stage 3 National Patient Flow will create a new national collection that provides a view of wait times, health events and outcomes in a patient's journey through secondary and tertiary care	–	Collecting Phase 2 information from July 2015 and to collecting Phase 3 information	Q1 Q4
4	Finance Procurement Supply Chain	–	Implementation Planning for adoption of FPSC	Q4
5	National Infrastructure Programme	–	Analysis and implementation planning for transition to NIP and consumption of capability in advance of the full migration	Q3

DELIVERING BETTER PUBLIC SERVICES

2.2.29 QUALITY IMPROVEMENT

We have adopted a "whole of system" and sub-regional approach to quality improvement through improving patient flow across the health care continuum. Our organisational development framework supports new knowledge and leadership development, innovation, research and lean thinking/production management principles; this supports our strategic goal of 'effective, efficient and high quality services'. The Wairarapa, Hutt Valley, and Capital & Coast DHBs Quality, Patient Safety, and Risk Teams work collaboratively, sharing of resources, learnings from events, and best practice. We are improving our understanding of the 'patient experience' as it is vital to improving patient safety and the quality of service delivery - shown to be a sound indicator of the quality of health and disability services. Growing evidence indicates that better experience, developing partnerships with consumers, and patient and family-centred care are linked to improved health, clinical, financial, service, and patient satisfaction outcomes. By capturing and integrating the lessons from patient experiences in a quality improvement framework we will increase the chances of sustainable service improvement.

Sub-Regional and National Entity - Health Quality & Safety Commission

	Action	Measure	Timeframe
1	**Falls - Quality & Safety Marker (QSM)** • Clinically-led, multidisciplinary, Falls Prevention Group maintained to ensure focus remains on an integrated approach across each DHB – promotes hospital-wide programme for clinicians by clinicians, – Allied Health professionals support prevention work with primary care clinicians – nursing leadership works with Quality Improvement and Patient Safety Directorate, carrying out real-time audits – progress falls as a 'care sensitive indicator' across all clinical staff • Meet/sustain achievement at/or above identified QSM threshold for falls risk assessment and individualised care plans • Establish Falls Working Group, monthly care process auditing, and review results • Audit schedule focuses on auditing the compliance against the standard • Chair of Falls Management Group presents at nurses education sessions (reinforce the practise of assessing and documenting the falls risk assessments) • Sub-regional falls signalling initiative introduced as part of falls project (support effective falls assessment) • Wairarapa DHB to introduce an electronic incident management system in line with Hutt Valley DHB (ensure that the reporting is timely, effective, and more user-friendly) • Maintain Capital & Coast DHB Falls Prevention Committee	– 90 % of patients aged 75 and over (Māori & Pacific Islanders 55 and over) are given a falls risk assessment – 100 % of patients assessed as at risk of falling receive an individualised care plan addressing these risks. – Performance updates published by HQSC; included in DHB quality accounts – Improved compliance to risk assessment process and reduced hospital acquired pressure injuries – Committee supported by CNM and ADON to agree, implement, and monitor appropriate falls prevention actions	Q4 Q4 Q4 Q4 Q1
2	**Hand Hygiene - Quality & Safety Marker** • Meet and/or sustain achievement at/or above the identified QSM threshold for hand hygiene compliance • Gold Standard Auditor training to improve front-line ownership; focus of IPC Team to provide short, sharp education sessions on critical moments when hand hygiene should be performed • Quarterly review of audit results and actions taken to improve compliance • Training on extra gold hand hygiene auditors sub-regionally • Actively promoting the messaging for consumers "it's OK to ask your healthcare professional if they have cleaned their hands"	– 80 % compliance with good hand hygiene practice. – Increase in number of Gold Standard Ward based auditors and roll out across all inpatient wards	Q4 Q2
3	**Perioperative Harm - Quality & Safety Marker** • Introduce briefing and debriefing – monitor and use learnings from Pilot DHBs • Capital & Coast DHB lead national process on Checklist; Hutt Valley and Wairarapa DHBs participating in	– Sustain achievement at/above old QSM threshold of all three parts of the WHO surgical safety checklist being used in minimum of 90% of operations	Q3

	the new programme • Work with HQSC to implement new perioperative harm QSM for public reporting in 2016/17	– Strategy implemented that imbeds use of briefing/debriefing in each Theatre List – Checklist used as a communication tool – Evaluate audit results and implement strategies to improve compliance	Q3 Q3 Q4
4	**Surgical Site Infection (SSI) - Quality & Safety Marker** • Meet/sustain achievement at/or above the identified QSM threshold for the clinical standards specified by the Surgical Site Infection Improvement Programme, and that they are being adhered to in all hip/ knee and for Capital & Coast DHB cardiac operations • Commitment to examining results and taking action to improve quality and safety • Working Group established to focus on successful implementation of the SSI in cardio thoracic surgery • Embed as part of regular audit schedule with oversight by sub-regional IPCC • Support Surgical Site Infection programme - National Infection Surveillance Data Warehouse; Infections Management systems (ICNet NG system). • Adoption of Infections Prevention and Control Systems investment and implementation including local integrations	– 95% of hip and knee replacement patients receive cefazolin ≥2g as surgical prophylaxis – 100% of hip and knee replacement patients have recommended skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine – 100% of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision – 90% of operations have the teamwork and communication tool (briefing and debriefing) of the checklist used – Support for on-going hosting costs of the national surveillance data warehouse – Meet infection control expectations in accordance with Operational Policy Framework, Section 9.8 – Continue development of infection prevention and control systems at local DHB level – NB: Measuring will be developed throughout 2015/16, with reporting from Q1	Q4 Q1
5	**Patient Experience - Quality & Safety Marker** • Extending Primary Secondary Consumer Council (VOICE) sub-regionally • Establishing a sub-regional local Patient Experience Survey (extend from Capital & Coast DHB) • Support improved patient experience through increased patient involvement in decision making (at all levels) through the Consumer Council, and local and national patient feedback survey for capturing consumer feedback • Embed national inpatient patient experience survey and reporting system - patient experience indicators; to provide a nationally consistent model • Primary Care - patient experience survey and reporting system – in line with proposal to national in-patient experience survey to be used by PHOs; help measure and report how consumers and patients experience the health system from a primary care perspective (using National Enrolment System as a sampling base)	– Support HQSC implementation of two of the following – Medicine Reconciliation, Pressure Injury, Deteriorating Patient – Performance updates published by HQSC and included in DHB local quality accounts. – Reporting on patient experience as set out in performance measure DV3 'Improving patient experience' (see Module 7) – Actions implemented from monthly reports of consumer feedback from electronic survey – Consumer Council maintained – National in-patient survey to be incorporated in existing local patient experience surveys; survey patient experience of the care they received – 85% electronic responses for survey – See linkage to IPIF - section 2.2.17, Primary Care and Integration	Q1, 2, 3, 4
6	**Support projects that improve the quality of care, reduce patient harm, and contribute to the national patient safety campaign 'Open for Better Care'** • Sub-region is part of regional patient safety/Open for Better Care group (see Central Regional Services Plan) • Monthly teleconferences to share patient safety ideas • Refine use of the Global Trigger Tool to enable insight to service problems; consider expanding the scope of GTT to more services and greater levels of analysis; consider roll out of GTT from Capital & Coast DHB to Wairarapa and Hutt Valley DHBs • Progress optimisation of Audit processes (Capital & Coast DHB)	– Reporting on patient experience as set out in performance measure DV3 'Improving patient experience' (see Module 7) – As part of the regional patient safety/Open for Better Care group, updates produced and initiatives/resources shared across the region and sub-region	Q1, 2, 3, 4

7	**Improving patient safety and reducing healthcare harm** • Report all Serious and Adverse Events • Develop sub-regional clinical policies and protocols, • Progress the combining of Serious and Adverse Events systems across the DHBs	– Reporting of the serious and adverse events through the HQSC – Increased patient safety – Sub-regional perspective provided that shows mitigation of risk associated with staff working across three sites/different policies	Q2
8	**Support continued implementation of quality accounts** • Sub-regional DHBs have a development plan for the next set of quality accounts • Publish quality accounts, incorporating consultation with our local community and consumers • Utilise control charts to show success, and engage with primary health and Consumer Council VOICE around content	– 2014/15 Quality Accounts produced in accordance with guidance from HQSC – Consultation demonstrated – Measures defined – Control Charts in place	Q2 Q3 Q2 Q3
9	**Real Time Feedback** Following on from the expression of interest for the Real Time Feedback programme for Mental Health and Addiction services, support the implementation of the programme sub-regionally	– Real Time Feedback programme implemented across the sub-region – Information gleaned from survey incorporated into service improvement and design	Q4
10	**Continuous Improvement** Continue to imbed the Continuous Improvement Framework, training, coaching and delivery of further benefits across sub-region from reduction in waste/optimisation of process and tools	– Improvement in performance in the Balanced Set of Clinical and Quality Measures discussed at clinical and executive leadership groups (Capital & Coast DHB)	Q3
11	**Shared Workspaces** Progress development and implementation of shared workspaces across the sub-region where appropriate; for example risk management, reportable events, service management, and continuous improvement	– Shared workspaces implemented	Q4
12	**e-Medicine reconciliation** Implementation of the electronic medicine reconciliation platform to ensure medication safety - see section 2.2.27 (IT) Review of medicine reconciliation resource (staffing and system) to identify safety and efficiency issues	– Platform implemented	Q4
13	**Mortality and Morbidity Review** Undertake local, and support national, mortality and morbidity review Focus on Health Round Table data for more targeted activity	– Review undertaken	Q4
14	**Leadership** Capability and Leadership Programmes in place, and attended, to support improvement science and increased clinical leadership	– Meet expectations in Operational Policy Framework Section 9.3 & 9.4.6. – Provision of 'Xcelr8' and 'Collabor8' programmes (Hutt & Wairarapa DHBs)	Q4
	Regional		
	Objective	**Measure**	**Timeframe**
1	Region-wide clinical governance and quality improvement; shared values across primary and secondary	– Support Framework development	Q4
2	Support of HQSC initiatives	– Support readiness for supporting implementation	Q4
3	Reporting mechanisms - primary and secondary	– Participate in mechanisms alignment and integration	Q4
4	Nursing Sensitive Care Indicator Study as a basis for improvement programme	– Support implementation of regional improvement programme	Q4

'MODULE 3' STATEMENT OF PERFORMANCE EXPECTATIONS

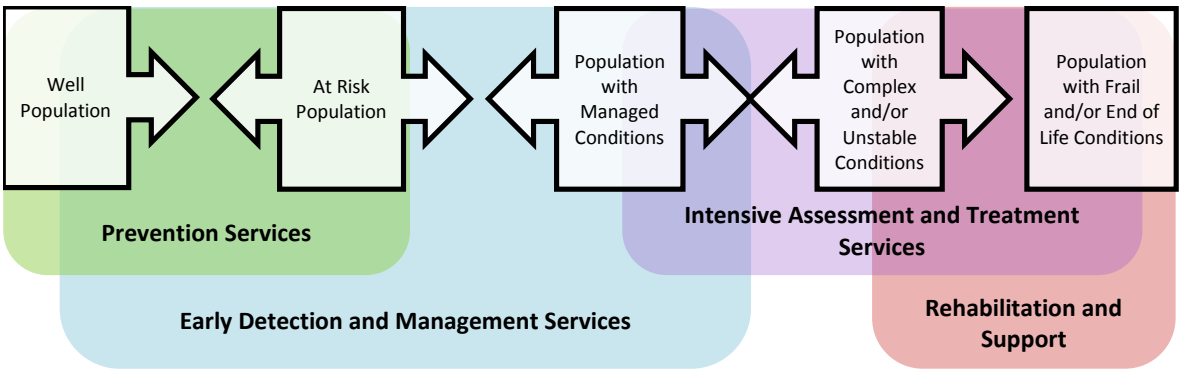
3.1 OUTPUT CLASSES CONTRIBUTING TO DESIRED OUTCOMES

One of the functions of this Annual Plan is to show how we will evaluate the effectiveness of the decisions we make on behalf of our population, we do this by providing a forecast of the services ('outputs') to be funded and provided in 2015/16. Our performance against these outputs is described our end-of-year Annual Report.[50] Module 4 details the revenue and expenses by each Output Class.

Our four Output Classes and their related services are:

1. Prevention Services
   - Health protection and monitoring services
   - Health promotion services
   - Immunisation services
   - Smoking cessation services
   - Screening services
2. Early Detection and Management Services
   - Primary care (GP) services
   - Oral health services
   - Pharmacy services
3. Intensive Treatment and Assessment Services
   - Medical and surgical services
   - Cancer services
   - Mental health and addictions services
4. Rehabilitation and Support Services
   - Disability services
   - Health of older people services

Scope of DHB Operations – Output Classes in the Continuum of Care



The outputs reflect a picture of health service activity across the whole of the Capital & Coast health system. We choose outputs that make the greatest contribution to the wellbeing of our population in the shorter term, and to the health outcomes that we are seeking to achieve over the longer term. These outputs also cover areas in which we are developing new services and therefore expect to see a change in activity levels or settings in the current year. To give a representative picture of our performance, the outputs have been grouped into four 'output classes' that are a logical fit with the stages spanning the continuum of care and are applicable to all DHBs.

[50] DHB performance is also measured by the Ministry of Health through quarterly reporting against the Performance Monitoring Framework. A copy of previous years' Annual Reports on Output Class delivery and achievement can be found on our DHB website

3.2 INTERPRETING OUR BASELINE AND TARGET PERFORMANCE

3.2.1 Types of measures

Identifying appropriate measures for each output class is difficult as it is important to do more than measure just the volumes of patients and consumers through our system. The number of services delivered or the number of people who receive a service is often less important than whether the right person or enough of the right people received the right service, and whether the service was delivered at the right time. Because of this complexity, in addition to volume, we have added a mix of output measures to help us to evaluate different aspects of our performance. The outputs are categorised by type of measure, which shows whether the output is targeting coverage, quality, quantity (volume), or timeliness. In addition, some of our performance measures look at the health of the people who live in our district (DHB of domicile view), while other performance measures relate to the performance of the services we provide, regardless of where people live (DHB of service view). When possible and relevant, we have also broken our performance down by ethnicity.

Type of Measure	Abbreviation
Coverage	C
Quality	Q
Volume	V
Timeliness	T
DHB of Domicile	DoD
DHB of Service	DoS

Ethnicity	Abbreviation
Māori	M
Pacific	P
Total (all ethnicities)	T

3.2.2 Standardisation

Different populations have different characteristics, and these different population characteristics can lead to different rates between populations. One such characteristic is the age structure of a population. It would be unreasonable to compare the hospital average length of stay in Wairarapa, which has a large proportion of elderly, directly to Capital & Coast, which has a smaller proportion of elderly. But, by standardising for age, we can see what the rates would have been if the two populations had the same proportion of people in each age group, and therefore draw comparisons. In the following outputs, if measures have been standardised (often by the Ministry of Health to allow comparison between DHBs), we have noted why and how.

3.2.3 Targets and Estimates

Some of our performance measures are demand-based, and are included to show a picture of the services that the DHB funds and provides. For these measures, there are no assumptions about whether an increase or decrease is desirable. For performance measures that are demand-based, we have provided an estimate of our 2015/16 performance (indicated with 'Est.'), based on historical and population trends.

3.3 OUTPUTS BY CLASS

3.3.1 Output class: Prevention Services

Description

'Preventative' health services promote and protect the health of the whole population, or identifiable sub-populations, and influence individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices.

Context

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and morbidity and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. It has been estimated that 70% of health funding is spent on long-term conditions. Two in every three New Zealand adults have been diagnosed with at least one long-term condition and long-term conditions are the leading driver of health inequalities. The majority of chronic conditions

are preventable or could be better managed. Tobacco smoking, inactivity, poor nutrition, and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions and are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. These prevention services also support people to address any risk factors that contribute to both acute events (e.g., alcohol-related injury) and the development of long-term conditions (e.g., obesity or diabetes). High health need and at-risk population groups (low socio-economic, Māori, and Pacific) who are more likely to be exposed to environments less conducive to making healthier choices are a focus. Preventative services are our best opportunity to target improvements in the health of these high need populations to reduce inequalities in health status and improve population health outcomes. These services also ensure that threats to the health of the community such as communicable disease, water quality, imported disease-carrying pests, are detected early and prevented, and ensure our ability to respond to emergency events such as pandemics or earthquakes.

Outputs

Health protection and monitoring services: enable people to increase control over their health and its determinants, and thereby improve their health through developing healthy public policy that addresses the prerequisites of health, such as income, housing, food security, employment, and quality working conditions. Health protection activity is enacted through a range of platforms, as described by the Ottawa Charter: public policy, reorienting the health system, environments, community action, and supporting individual personal skills. While health has a significant role here, some outcomes such as obesity require a whole of sector approach; our DHB and RPH work with other sectors (housing, justice, education) to enable this. Health promotion services: inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choice. Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The work spans primary and community care and allied health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service. Smoking cessation services: are provided by clinical staff to smokers to help smokers quit. Clinicians follow the ABC process[51]: **A**sk all patients whether they smoke and document their response; if the patient smokes, provide **B**rief advice to quit smoking; and if patient agrees, provide **C**essation support (e.g., a prescription for nicotine gum or a referral to a provider like Quitline). Screening services: encourage uptake of services predominately funded and provided through the National Screening Unit that help early identification of breast and cervical cancer, and carry out newborn hearing testing, and antenatal HIV screening.

How we will measure performance of our Prevention Services

Outputs	Outputs measured by	Measure type	DHB baseline	2015/16 Target/Estimate[52]	Baseline info	That will lead to these outcomes
Public health protection and regulatory services	The number of disease notifications investigated in the sub-region[53]	V	1,797	Est. 1,797	RPH[54], 2013/14	Environmental and disease hazards are minimised
	The number of environmental health investigations in the sub-region	V	684	Est. 684	RPH, 2013/14	
	The number of premises visited for alcohol controlled purchase operations in the sub-region	V	277	Est. 277	RPH, 2013/14	

[51] ABC for Smoking Cessation Quick Reference Card, PHARMAC

[52] Some of our performance measures are demand-based, and are included to show a picture of the services that the DHB funds and provides. For these measures, there are no assumptions about whether an increase or decrease is desirable. For performance measures that are demand-based, we have provided an estimate of our 2015/16 performance (indicated with 'Est.'), based on historical and population trends.

[53] RPH provides public health services to the sub-region, and data is currently not available at an individual DHB level.

[54] To provide an overview of public health services in the sub-region, this Annual Plan presents a subset of the activities that RPH intends to undertake in 2015/16. Please refer to the 2015/16 RPH Business Plan at www.rph.org.nz for a more comprehensive description of RPH's planned activities for the 2015/16 year.

Outputs	Outputs measured by	Measure type	DHB baseline	2015/16 Target/Estimate[52]	Baseline info	That will lead to these outcomes
Health promotion and preventive intervention services	Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	V	25	Est. 25	RPH, 2013/14	Children have a healthy start in life Lifestyle factors that affect health are well-managed Equitable health outcomes
	The percentage of infants fully or exclusively breastfed at 3 months	C	M: 46% P: 46% T: 61%	≥ 60%[55]	Plunket, 2013/14	
	Number of new referrals to Public Health Nurses in primary/intermediate schools	V, DoS	M: 463 P: 510 T: 1,197	Est. Total 1,197	RPH, 2014	
	The number of adult referrals to the Green Prescription programme in the sub-region	V, DoS	2,879	Est. 3,904	Sport Wellington, 2013/14	
Immunisation services	**IPIF Healthy Start:** The percentage of two year olds fully immunised	C	M: 92% P: 96% T: 94%	≥ 95%	2013/14	Environmental and disease hazards are minimised Children have a healthy start in life Equitable health outcomes
	Health Target: The percentage of eight month olds fully vaccinated	C	M: 92% P: 93% T: 93%	≥ 95%	2013/14	
	The percentage of Yr 7 children provided Boosterix vaccination in schools in the DHB	C, DoS	67%	2015: ≥ 70% 2016: ≥ 70%	RPH, 2013	
	The percentage of Yr 8 girls vaccinated against HPV (final dose) in schools in the DHB	C, DoS	64%	≥ 65%	RPH, 2013	
Smoking cessation services	**Health Target:** The percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	C	New measure	≥ 90%	n/a	Lifestyle factors that affect health are well-managed Equitable health outcomes
	Health Target: The percentage of hospitalised smokers receiving advice and help to quit	C	M: 89% P: 95% T: 92%	≥ 95%	2013/14	
	Health Target: The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit smoking	C	100%	≥ 90%	Q2, 2014/15	

[55] For performance measures that are broken down by ethnicity, the target/estimate is the same for all ethnicities.

Outputs	Outputs measured by	Measure type	DHB baseline	2015/16 Target/Estimate[52]	Baseline info	That will lead to these outcomes
Screening services	The percentage of eligible children receiving a B4 School Check	C	High dep[56]: 83% Total: 91%	≥ 90%	2013/14	Children have a healthy start in life Equitable health outcomes
	IPIF Healthy Adult: The percentage of eligible women (25-69) having cervical screening in the last 3 years	C	M: 60% P: 62% T: 79%	≥ 80%	National Screening Unit, 2013/14	
	The percentage of eligible women (50-69 yrs) having breast screening in the last 2 years	C	M: 63% P: 64% T: 69%	≥ 70%	National Screening Unit, 2013/14	

3.3.2 Output Class: Early Detection & Management Services

Description

Early detection and management services cover a broad scope and scale of services provided across the continuum of care activities to maintain, improve and restore people's health. These services include detection of people at risk and with early disease and more effective management and coordination of people with long-term conditions. These services are by nature more generalist, usually accessible from multiple providers, and at a number of different locations.

Context

New Zealand is experiencing an increasing prevalence rate of long-term conditions such as diabetes and cardiovascular disease, and some population groups suffer from these conditions more than others, for example, Māori and Pacific people, older people and those on lower incomes. The health system is also experiencing increasing demand for acute and urgent care services. For our DHB, diabetes, COPD, asthma, and chronic respiratory conditions are significant long-term conditions that are prevalent in our population. Early detection and management services based in the community deliver earlier identification of risk, provide opportunity to intervene in less invasive and more cost-effective ways, and reduce the burden of long-term conditions through supported self-management (avoidance of complications, acute illness and crises). These services deliver coordination of care, ultimately supporting people to maintain good health.

Outputs

Primary care services: are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals; aimed at improving, maintaining, or restoring health. High numbers of enrolment with general practice are indicative of engagement, accessibility, and responsiveness of primary care services. These services keep people well by: intervening early to detect, manage, and treat health conditions (e.g., health checks); providing education and advice so people can manage their own health; and, reaching those at risk of developing long-term or acute conditions. Oral health services: are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service. Pharmacy services: Include provision and dispensing of medicines and are demand-driven. As long-term conditions become more prevalent, we are likely to see an increased dispensing of pharmaceutical items. To improve service quality are introducing medication management for people on multiple medications to reduce potential negative interactive effects. We are implementing safe and effective pharmacy services across settings of care (hospital and community).

[56] 'High dep' refers to children living in high deprivation areas: See Atkinson, J., Salmond, S., & Crampton, P. (2014). *NZDep2013 Index of Deprivation*, Wellington: Department of Public Health, University of Otago.

How we will measure performance of our Early Detection & Management Services

Outputs	Outputs measured by	Measure Type	DHB baseline	2015/16 Target/Estimate	Baseline info	That will lead to these outcomes
Primary care services	The percentage of the DHB-domiciled population that is enrolled in a PHO	C, DoD	95%	≥ 95%	Jul 2014	Long-term conditions are well-managed Equitable health outcomes
	The rate ratio of nurse and GP visits by high need patients versus non high need patients	C, DoS	1.14	≥ 1.14	2013/14	
	The percentage of practices with a current Diabetes Practice Population Plan	Q, DoS	96%	100%	As at Mar 2015	
	Health Target: The percentage of the eligible population assessed for CVD risk in the last five years	C, DoS	M: 78% P: 81% T: 85%	≥ 90%	2013/14	
	The number of new and localised HealthPathways in the sub-region[57]	Q	83	≥ 150	Mar 2015	
	The average number of users (per month) of the HealthPathways website	V	824	≥ 1,000	Jan – Feb 2015	
Oral health services	The percentage of children under 5 years enrolled in DHB-funded dental services	C, DoD	M: 27% P: 34% T: 42%	2015: ≥ 85% 2016: ≥ 85%	PP13, 2013	Children have a healthy start in life Equitable health outcomes
	The percentage of adolescents accessing DHB-funded dental services	C, DoD	73%	2015: ≥ 85% 2016: ≥ 85%	PP12, 2013	
Pharmacy services	The number of initial prescription items dispensed	V, DoS	2,310,022	Est. 2,356,000	2013/14	Long-term conditions are well-managed
	The percentage of the DHB-domiciled population that were dispensed at least one prescription item	C, DoD	76%	Est. 76%	2013/14	
	The number of people registered with a Long Term Conditions programme in a pharmacy	V, DoS	6,685	Est. 6,600	2013/14	
	The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	V, DoS	109	Est. 200	2013/14	

[57] HealthPathways provides a manual for general practice teams to manage and refer their patients to secondary, tertiary, and community services. The pathways are designed for use during consultation with a patient and are jointly developed by consensus and collaboration between hospital clinicians and general practice teams. HealthPathways will increase co-ordination and collaboration between health services which will result in better quality of care for our population.

3.3.3 Output Class: Intensive Assessment & Treatment Services

Description

Intensive assessment and treatment services are complex hospital services. They are provided by specialists and other health care professionals in a hospital setting. Hospitals often provide these services because clinical expertise (across a range of areas) and specialist equipment need to be located in the same place. These services include inpatient, outpatient, emergency, and urgent care services. Our DHB provides an extensive range of intensive treatment and complex specialist services to our population. Our DHB also funds some tertiary and quaternary services that are provided by other DHBs, private hospitals, and private providers for our population. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. For planned (elective) services, access is determined by capability, capacity, resources, clinical triage, national service coverage agreements, and treatment thresholds.

Context

Equitable and timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention (i.e., removal of an obstructed gallbladder to prevent repeat attacks of abdominal pain/colic, and to reduce the risk of cancer and infection) or through corrective action (i.e., major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services also support improvements across the whole system, so that people can receive support in the community with confidence that complex intervention is available if needed. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Adverse events in hospital cause harm to patients, drive unnecessary costs, and shift resources away from other services. Improving our service delivery, systems, and processes will improve patient safety, reduce the number of hospital events causing harm, and improve outcomes for people using our services. There are expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments, and increased clinical leadership around improving service delivery and safety to improve the quality and efficiency of care being delivered. The changes being made to meet expectations are providing opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Outputs

Medical and surgical services: Unplanned hospital services (Acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need of care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned Services (Elective surgery) are services for people who do not need immediate hospital treatment and are 'booked' services. This also includes non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups, or preadmission assessments). National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service; addressing increasing needs and matching commitments to capacity. Cancer services: Cancer services include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre. Mental health and addictions services: Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates will be monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.

How we will measure performance of our Intensive Assessment & Treatment Services

Outputs	Outputs measured by	Measure type	DHB baseline	2015/16 Target/Estimate	Baseline info	That will lead to these outcomes
Medical and surgical services	**Health Target:** The percentage of patients admitted, discharged or transferred from ED within six hours	T, DoS	92%	≥ 95%	2013/14	People receive high quality hospital and specialist health services when
	Health Target: The number of surgical elective discharges	V, DoD	10,013[58]	≥ 10,439	2013/14	

[58] Note that the definition for this measure has been revised by Ministry of Health in 2015/16 to include arranged admissions and discharges from both medical and surgical wards. The 2013/14 baseline reported here has been updated to reflect these changes.

Outputs	Outputs measured by	Measure type	DHB baseline	2015/16 Target/Estimate	Baseline info	That will lead to these outcomes
	The standardised[59] inpatient average length of stay (ALOS) in days, Acute	T, DoS	2.41[60]	≤ 2.41	12 months to Sept 2014	they need them
	The standardised[59] inpatient average length of stay (ALOS) in days, Elective	T, DoS	1.66[60]	≤ 1.59	12 months to Sept 2014	
	The rate of inpatient falls causing harm, per 1,000 bed days	Q, DoS	1.2	< 1.2	2013/14	
	The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Q, DoS	0.4	< 0.5	2013/14	
	The rate of identified medication errors causing harm, per 1,000 bed days	Q, DoS	0.2	< 0.2	2013/14	
	The weighted average score in the Patient Experience Survey[61]	Q, DoS	8.3	> 8.0	Oct 2014	
	The percentage of "DNA" (did not attend) appointments for outpatient *first* specialist assessments	Q, DoS	M: 11.6% P: 12.9% T: 5.6%	≤ 6.0%	2013/14	Equitable health outcomes
	The percentage of "DNA" (did not attend) appointments for outpatient *follow-up* specialist appointments	Q, DoS	M: 16.0% P: 16.6% T: 7.4%	≤ 6.0%	2013/14	
Cancer services	The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy	T, DoD	100%	100%	2013/14	People receive high quality hospital and specialist health services when they need them
	Health Target: The percentage of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred	T, DoD	82%	≥ 85%	Jul-Dec 2014	

[59] Standardised to diagnosis-related group (DRG) and co-morbidity/complication codes. See the Ministry of Health website (www.moh.govt.nz) for more information about how this is calculated.

[60] Note that the definition for this measure has been revised by Ministry of Health in 2015/16. There have been a number of methodological changes; key changes are that the measure now includes day cases and transfers between hospitals are now linked. The baseline reported here has been updated to reflect these changes.

[61] In this measure, patients rate aspects of their hospital visit, with 10 being the best possible score. A person's age and gender affects how they respond in the Patient Experience Survey. The weighted score accounts for differences in the age and gender structure between DHBs to allow comparison.

Outputs	Outputs measured by	Measure type	DHB baseline	2015/16 Target/Estimate	Baseline info	That will lead to these outcomes
Mental health and addictions services	The number of people accessing secondary mental health services	V	M: 2,072 T: 9,785	Est. Total 9,940	2013/14	People receive high quality mental health services when they need them Equitable health outcomes
	The percentage of people accessing secondary mental health services	C	M: 6.3% T: 3.3%	≥ 3.3%	2013/14	
	The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks	T, DoS	86%	≥ 95%	PP8, 2013/14	
	The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	T, DoS	86%	≥ 95%	PP8, 2013/14	
	The percentage of people admitted to an acute mental health inpatient service that were seen by mental health community team in the 7 days prior to the day of admission	Q, DoS	M: 62% T: 63%	≥ 63%	2013/14	
	The percentage of people discharged from an acute mental health inpatient service that were seen by mental health community team in the 7 days following the day of discharge	Q, DoS	M: 73% T: 70%	≥ 70%	2013/14	

3.3.4 Output Class: Rehabilitation & Support Services

Description

Rehabilitation and support services provide people with the support that they need to maintain their independence, either temporarily while recovering from illness or disability, or over the rest of their lives. Rehabilitation and support services are provided mostly for older people, mental health clients, and clients with complex health conditions. A 'needs assessment', coordinated by Needs Assessment and Service Coordination (NASC), determines which services a person may require. These services may be provided at home, as personal care, community nursing, or community services. Alternatively, people may require long- or short-term residential care, respite, or day services. Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are supported so that the person can live comfortably, have their needs met in a holistic and respectful way, and die without undue pain and suffering. Rehabilitation and support services may be delivered in coordination with other organisations and agencies, and may include public, private, and part-funding arrangements.

Context

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities. People whose needs are adequately met by these support services are less dependent on hospital and residential services and less likely to experience acute illness or deterioration of their conditions. As a result, effective support services will help to reduce demand for acute services and improve access to other services and interventions. Support services will have a major impact on the sustainability of hospital and specialist services and on the wider health system in general. It will also free up resources for investment into early intervention, health promotion, and prevention services that will help people stay healthier for longer. Our DHB has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in

this area and that our DHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

Outputs

Disability services: Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the DSS, which work with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports. Health of older people services: These are services provided to enable people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups.

How we will measure performance of our Rehabilitation & Support Services

Outputs	Outputs measured by	Measure type	DHB baseline	2015/16 Target/Estimate	Baseline info	That will lead to these outcomes
Disability services	The number of Disability Forums	V	CCDHB: 1 3DHB: 1	CCDHB: 1 3DHB: 1	2013/14	Responsive health services for people with disabilities
	The number of sub-regional Disability Newsletters	V	5	6	2013/14	
	The total number of hospital staff that have completed the Disability Responsiveness eLearning Module	Q	225[62]	550	As at April 2015	
	The total number of Disability Alert registrations[63]	Q	3,989	5,190	As at April 2015	
Health of older people services	The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical [InterRAI] assessment and a completed care plan	C, DoS	100%	100%	2013/14	Improve the health, well-being, and independence of our region's older people
	The total number of InterRAI assessments	V, DoS	5,912	Est. 6,043	2013/14	
	The number of people 65+ who are being supported to live at home	V, DoS	2,183	Est. 2,232	2013/14	
	The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home	C, DoS	59%	≥ 59%	2013/14	
	The number of subsidised aged residential care bed days[64]	V, DoS	553,496	Est. 560,627	2013/14	

[62] This measure is currently based on self-reported completion of the module. In 2015/16 we expect to have automated reporting in place.

[63] It is estimated that 23% of the DHB's population has a disability. Disability Alerts help clinicians to identify and respond to the needs of the patients with disabilities. By increasing the number of Disability Alerts, we can improve the quality of care for our patients with disabilities. In addition, Disability Alerts allow us to track outcomes (e.g., length of stay) for patients with disabilities so that we can identify areas in which we need to focus or improve.

[64] Subsidised bed days are any DHB-funded bed days including top-up clients and people paying less than the maximum client contribution.

Outputs	Outputs measured by	Measure type	DHB baseline	2015/16 Target/Estimate	Baseline info	That will lead to these outcomes
	The percentage of residential care providers meeting three or more year certification standards	Q, DoS	94%	≥ 95%	2013/14	

‘MODULE 4’
FINANCIAL PERFORMANCE

In line with the CCDHB Recovery Plan the budgeted result is planned to reduce from a $4 million deficit in 2014/15 to a $1.4 million surplus in 2015/16 and the same surplus in the out years.

Summary Financial table:

C&C DHB Annual Plan Financial Summary ($M)	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
Operating Revenue	863.0	919.3	938.9	975.7	996.3	1,002.9	1,007.0	1,012.0	1,017.1
Operating Expenses excluding NRH costs	857.1	901.3	949.7	981.6	1,000.3	1,001.5	1,005.6	1,010.6	1,015.6
Surplus / (Deficit) Excluding NRH costs	5.9	18.1	(10.8)	(5.9)	(4.0)	1.4	1.4	1.4	1.4
Operating costs New Regional Hospital	37.5	38.0	-	-	-	-	-	-	-
Total Surplus / (Deficit)	**(31.6)**	**(19.9)**	**(10.8)**	**(5.9)**	**(4.0)**	**1.4**	**1.4**	**1.4**	**1.4**

4.1 FINANCIAL ASSUMPTIONS

The assumptions are the best estimates of future factors which affect the predicted financial results. As such there is necessarily a degree of uncertainty about the accuracy of the predicted result, which is unable to be quantified.

Factors which may cause a material difference between these prospective financial statements and the actual financial results would be a change in the type and volume of services provided, significant movement in staff levels and remuneration, plus unexpected changes in the cost of goods and services required to provide the planned services.

4.1.1 Revenue

- PBFF Increase of $10.1M as per Funding Envelope.
- IDF levels based on Funding Envelope or agreed changes within the sub-region.

4.1.2 Expenditure

- Personnel expenditure increase in line with NTOS expectations
- NHPPD model for staff rostering across all Directorates
- Supplies and expenses based on current contract prices where applicable
- Depreciation to include base, plus work in progress, plus new purchases
- Capital Charge at 8% payable half yearly
- Debt renewals based on DMO quoted future rate projections
- Total Capital Expenditure of up to $25 million p.a. is planned from 2015/16

4.1.3 Financial Risks

There has been good progress over the last year on many of the initiatives that were included in the savings plan however the pressure continues and further change is required to ensure the DHB meets the fiscal targets. The savings strategies underpin the DHB getting to a surplus position.

The key risks and assumptions associated with this financial plan are;

- MECA increases higher than the funding increase;
- Not meeting elective targets;
- Acute demand exceeding plan;

- Inter-district inflows being below plan;
- Not realising the financial savings associated with change initiatives;
- Additional cost in CRISP, NZ Health Partnerships and NIP initiatives;
- Demand for aged residential care above plan;
- Community contract costs above plan.

4.2 CAPITAL PLAN

The operational capital funding requirements for the Provider Arm will be met from cash flow from depreciation expense and prioritised with the clinical leaders and managers both within the Directorates and across the Provider Arm. Only items of a legal & safety nature, or essential to support the District Annual and Strategic Plans, or yielding a fast payback have been included to be funded from the free/internal cash flow. The baseline CAPEX for 2015/16 of $23.9 million and $1.2 million for strategic CAPEX is required to be funded internally.

4.3 DEBT & EQUITY

4.3.1 Equity drawing

No additional deficit support is required for the 2015/16 financial year.

4.3.2 Core Debt

The net interest cost on the Core CHFA debt of $339 million is currently between 3.34 and 6.37 percent, and the plan assumes roll-over of maturing debt in 2015/16 of $34 million in Nov 2015 and April 2016 at between 2.93% and 3.31% over 10 years.

4.4 WORKING CAPITAL

The Board has a working capital facility with the Westpac bank, which is part of the national DHB collective banking arrangement negotiated by NZ Health Partnerships. This facility is limited to one month's provider's revenue, to manage fluctuating cash flow needs for the DHB.

4.5 GEARING AND FINANCIAL COVENANTS

No gearing or financial covenants are in place.

4.6 ASSET REVALUATION

Current policy is for land and buildings to be revalued every 3 – 5 years. A revaluation was last completed in the year ended 30 June 2013. CCDHB have not included an asset revaluation within the plan for the three years from 1 July 2015.

4.7 STRATEGY FOR DISPOSING OF ASSETS

The DHB regularly reviews its fixed asset register, and undertakes fixed asset audits in order to dispose of assets which are surplus to requirements. This ensures that the DHB reduces its level of capital to the minimum consistent with the supply of contracted outputs.

4.8 DISPOSAL OF LAND

All land that has legally been declared to be surplus to requirements will be disposed of following the statutory disposal process defined in the Public Works Act 1991, the Health Sectors Act 1993, the New Zealand Public Health and Disabilities Act 2000, the Reserves Act 1977 and the Maori Protection Mechanism Regulations set up to fulfil the Crown's obligations under the Treaty of Waitangi.
No land has been identified as surplus to requirements within this plan.

4.9 PROSPECTIVE FINANCIAL STATEMENTS

Capital & Coast DHB **Statement of Comprehensive Revenue & Expense** **Budget for the Four Years Ending 30 June 2019**	**Actual 2013/14 (000s)**	**Actual 2014/15 (000s)**	**Plan 2015/16 (000s)**	**Plan 2016/17 (000s)**	**Plan 2017/18 (000s)**	**Plan 2018/19 (000s)**
REVENUE						
Government and Crown Agency Sourced	952,591	970,198	983,472	982,112	987,012	991,936
Patient / Consumer Sourced	4,475	4,815	4,427	4,449	4,471	4,493
Funder Arm Sourced	5,269	5,670	6,234	6,266	6,297	6,328
Other Income	13,322	15,598	8,808	14,172	14,243	14,314
TOTAL REVENUE	**975,657**	**996,280**	**1,002,940**	**1,006,998**	**1,012,022**	**1,017,072**
OPERATING COSTS						
Personnel Costs						
Medical Staff	129,057	133,207	137,160	137,845	138,534	139,226
Nursing Staff	161,048	159,156	167,182	168,018	168,858	169,703
Allied Health Staff	55,206	56,120	54,819	55,092	55,368	55,645
Support Staff	8,986	8,359	8,547	8,589	8,632	8,676
Management / Administration Staff	54,799	56,518	58,924	58,352	58,642	58,869
Total Personnel Costs	**409,096**	**413,360**	**426,632**	**427,897**	**430,034**	**432,118**
Clinical Costs						
Outsourced Services	20,693	29,060	32,352	32,510	32,669	32,828
Clinical Supplies	119,545	122,443	106,376	106,908	107,442	107,980
Total Clinical Costs	**140,238**	**151,503**	**138,728**	**139,418**	**140,111**	**140,808**
Other Operating Costs						
Hotel Services, Laundry & Cleaning	15,579	15,238	15,103	14,972	14,972	14,972
Facilities	38,305	39,800	39,574	39,607	39,906	40,104
Transport	3,139	3,105	3,062	3,077	3,077	3,221
IT Systems & Telecommunications	13,692	14,252	13,556	13,623	13,623	13,623
Interest & Financing Charges	25,114	24,653	22,705	22,700	22,700	22,700
Professional Fees & Expenses	5,203	5,018	3,616	3,629	3,643	3,657
Other Operating Expenses	9,185	6,948	3,990	4,430	4,630	4,854
Democracy	837	446	511	513	515	518
Provider Payments	321,167	325,939	334,023	335,693	337,371	339,058
Recharges	(0)	1	1	1	1	1
Total Other Operating Costs	**432,221**	**435,399**	**436,140**	**438,244**	**440,438**	442,707
TOTAL COSTS	**981,556**	**1,000,262**	**1,001,500**	**1,005,559**	**1,010,583**	**1,015,632**
NET SURPLUS / (DEFICIT)	**(5,899)**	**(3,982)**	**1,440**	**1,439**	**1,439**	**1,439**

Provider Arm **Statement of Comprehensive Revenue & Expense** **Budget for the Four Years Ending 30 June 2019**	**Actual 2013/14 (000s)**	**Actual 2014/15 (000s)**	**Plan 2015/16 (000s)**	**Plan 2016/17 (000s)**	**Plan 2017/18 (000s)**	**Plan 2018/19 (000s)**
REVENUE						
Government and Crown Agency Sourced	55,816	59,105	54,819	48,828	49,072	49,317
Patient / Consumer Sourced	4,475	4,815	4,427	4,449	4,471	4,493
Funder Arm Sourced	556,163	556,133	579,144	582,039	584,950	587,874
Other Income	12,167	14,223	8,808	14,172	14,243	14,314
TOTAL REVENUE	**628,621**	**634,275**	**647,197**	**649,487**	**652,735**	**655,998**
OPERATING COSTS						
Personnel Costs						
Medical Staff	129,053	133,207	137,061	137,746	138,435	139,127
Nursing Staff	160,967	159,061	167,182	168,018	168,858	169,703
Allied Health Staff	55,206	56,098	54,800	55,073	55,349	55,626
Support Staff	8,986	8,359	8,547	8,589	8,632	8,676
Management / Administration Staff	49,599	50,774	52,911	52,730	52,992	53,191
Total Personnel Costs	**403,811**	**407,499**	**420,501**	**422,157**	**424,266**	**426,322**
Clinical Costs						
Outsourced Services	19,905	28,035	31,560	31,718	31,877	32,036
Clinical Supplies	119,545	122,443	106,376	106,908	107,442	107,980
Total Clinical Costs	**139,450**	**150,478**	**137,936**	**138,626**	**139,319**	**140,016**
Other Operating Costs						
Hotel Services, Laundry & Cleaning	15,574	15,233	15,096	14,965	14,965	14,965
Facilities	38,304	39,796	39,571	39,603	39,902	40,100
Transport	3,013	2,971	2,941	2,956	2,956	3,100
IT Systems & Telecommunications	13,326	13,944	13,528	13,596	13,596	13,596
Interest & Financing Charges	25,114	24,653	22,705	22,700	22,700	22,700
Professional Fees & Expenses	4,315	4,211	2,731	2,744	2,758	2,772
Other Operating Expenses	8,949	6,850	3,860	4,300	4,500	4,724
Democracy	371	417	471	473	475	478
Recharges	(2,160)	(2,188)	(2,187)	(2,187)	(2,187)	(2,187)
Total Other Operating Costs	**106,805**	**105,887**	**98,716**	**99,150**	**99,665**	**100,247**
TOTAL COSTS	**650,067**	**663,864**	**657,152**	**659,933**	**663,250**	**666,585**
NET SURPLUS / (DEFICIT) excluding NRH costs	**(21,445)**	**(29,588)**	**(9,955)**	**(10,446)**	**(10,516)**	**(10,586)**

Funder Arm
Statement of Comprehensive Revenue & Expense
Budget for the Four Years Ending 30 June 2019

	Actual 2013/14 (000s)	Actual 2014/15 (000s)	Plan 2015/16 (000s)	Plan 2016/17 (000s)	Plan 2017/18 (000s)	Plan 2018/19 (000s)
REVENUE						
Government and Crown Agency Sourced	894,521	908,774	926,468	931,101	935,756	940,435
Patient / Consumer Sourced						
Funder Arm Sourced						
Other Income	1,155	1,364	-	-	-	-
TOTAL REVENUE	**895,676**	**910,138**	**926,468**	**931,101**	**935,756**	**940,435**
OPERATING COSTS						
Clinical Costs						
Outsourced Services	8,130	8,130	8,130	8,130	8,130	8,130
Clinical Supplies						
Total Clinical Costs	**8,130**	**8,130**	**8,130**	**8,130**	**8,130**	**8,130**
Other Operating Costs						
Provider Payments						
Personal Health	668,314	672,115	696,761	700,245	703,746	707,264
Mental Health	99,444	100,875	100,795	101,299	101,806	102,315
Dissability Support Services	101,031	100,369	105,970	106,500	107,032	107,568
Public Health	1,494	1,621	1,873	1,882	1,892	1,901
Maori Health	1,778	1,422	1,533	1,541	1,548	1,556
Recharges						
Total Other Operating Costs	**872,061**	**876,402**	**906,932**	**911,466**	**916,024**	**920,604**
TOTAL COSTS	**880,191**	**884,532**	**915,062**	**919,596**	**924,154**	**928,734**
NET SURPLUS / (DEFICIT)	**15,485**	**25,606**	**11,407**	**11,504**	**11,603**	**11,701**

Governance, Financing & Administration
Statement of Comprehensive Revenue & Expense
Budget for the Four Years Ending 30 June 2019

	Actual 2013/14 (000s)	Actual 2014/15 (000s)	Plan 2015/16 (000s)	Plan 2016/17 (000s)	Plan 2017/18 (000s)	Plan 2018/19 (000s)
REVENUE						
Government and Crown Agency Sourced	2,254	2,318	2,184	2,184	2,184	2,184
Patient / Consumer Sourced						
Funder Arm Sourced	8,130	8,130	8,130	8,130	8,130	8,130
Other Income	-	11	-	-	-	-
TOTAL REVENUE	**10,384**	**10,460**	**10,314**	**10,314**	**10,314**	**10,314**
OPERATING COSTS						
Personnel Costs						
Medical Staff	4	-	99	99	99	99
Nursing Staff	81	95	-	-	-	-
Allied Health Staff	-	22	19	19	19	19
Support Staff	-	-	-	-	-	-
Management / Administration Staff	5,200	5,744	6,013	5,622	5,650	5,678
Total Personnel Costs	**5,285**	**5,861**	**6,132**	**5,740**	**5,768**	**5,796**
Clinical Costs						
Outsourced Services	788	1,025	792	792	792	792
Clinical Supplies	-	-	-	-	-	-
Total Clinical Costs	**788**	**1,025**	**792**	**792**	**792**	**792**
Other Operating Costs						
Hotel Services, Laundry & Cleaning	5	6	7	7	7	7
Facilities	1	3	4	4	4	4
Transport	126	134	121	121	121	121
IT Systems & Telecommunications	366	308	27	27	27	27
Interest & Financing Charges	-	-	-	-	-	-
Professional Fees & Expenses	888	807	885	885	885	885
Other Operating Expenses	237	97	130	130	130	130
Democracy	466	29	40	40	40	40
Recharges	2,160	2,189	2,189	2,189	2,189	2,189
Total Other Operating Costs	**4,249**	**3,573**	**3,402**	**3,402**	**3,402**	**3,402**
TOTAL COSTS	**10,322**	**10,459**	**10,325**	**9,934**	**9,962**	**9,990**
NET SURPLUS / (DEFICIT)	**62**	**1**	**(11)**	**380**	**352**	**324**

Eliminations
Statement of Comprehensive Revenue & Expense
Budget for the Four Years Ending 30 June 2019

		Actual 2013/14 (000s)	Actual 2014/15 (000s)	Plan 2015/16 (000s)	Plan 2016/17 (000s)	Plan 2017/18 (000s)	Plan 2018/19 (000s)
REVENUE							
Funder Arm Sourced		(559,024)	(558,593)	(581,039)	(583,904)	(586,783)	(589,676)
TOTAL REVENUE		**(559,024)**	**(558,593)**	**(581,039)**	**(583,904)**	**(586,783)**	**(589,676)**
OPERATING COSTS							
Clinical Costs							
	Outsourced Services	(8,130)	(8,130)	(8,130)	(8,130)	(8,130)	(8,130)
	Clinical Supplies						
Total Clinical Costs		**(8,130)**	**(8,130)**	**(8,130)**	**(8,130)**	**(8,130)**	**(8,130)**
Other Operating Costs							
	Provider Payments	(550,894)	(550,463)	(572,909)	(575,774)	(578,653)	(581,546)
	Recharges						
Total Other Operating Costs		**(550,894)**	**(550,463)**	**(572,909)**	**(575,774)**	**(578,653)**	**(581,546)**
TOTAL COSTS		**(559,024)**	**(558,593)**	**(581,039)**	**(583,904)**	**(586,783)**	**(589,676)**
NET SURPLUS / (DEFICIT)		**-**	**0**	**(0)**	**(0)**	**(0)**	**(0)**

Financial Position

Capital & Coast DHB
Statement of Financial Position
Budget for the Four Years Ending 30 June 2019

		Actual 2013/14 (000s)	Actual 2014/15 (000s)	Plan 2015/16 (000s)	Plan 2016/17 (000s)	Plan 2017/18 (000s)	Plan 2018/19 (000s)
Non Current Assets							
	Land	25,705	25,705	25,705	25,705	25,705	25,705
	Buildings	434,953	417,140	403,135	389,016	375,782	361,433
	Clinical Equipment	40,661	34,398	38,229	42,019	45,768	50,476
	Information Technology	14,977	11,962	10,715	10,449	9,165	7,861
	Work in Progress (Incl NRH)	10,014	7,906	7,906	7,906	7,906	7,906
	Other Fixed Assets	6,699	14,048	13,776	13,624	13,467	13,307
Total Non Current Assets		533,009	511,159	499,466	488,719	477,793	466,688
Current Assets							
	Cash	12,097	19,101	32,678	50,057	70,145	79,207
	Trust/Investments	7,116	7,619	7,619	7,619	7,619	7,619
	Prepayments	4,433	4,232	4,232	4,232	4,232	4,232
	Accounts Receivable	39,500	41,238	41,238	41,238	41,238	41,238
	Inventories	8,184	7,471	7,471	7,471	7,471	7,471
	Other Current Assets	-	-	-	-	-	-
Total Current Assets		71,331	79,662	93,239	110,618	130,706	139,767
Current Liabilities							
	Payables & Accruals	131,523	121,517	119,846	128,525	139,733	139,733
	GST & Tax Provisions	6,877	9,040	9,040	9,040	9,040	9,040
	Current Crown Debt - CHFA	71,240	34,326	34,326	34,326	34,326	34,326
	Capital Charge Payable	4,197	-	-	-	-	-
Total Current Liabilities		213,837	164,883	163,212	171,891	183,099	183,099
Net Current Assets		(142,507)	(85,221)	(69,973)	(61,273)	(52,393)	(43,332)
NET FUNDS EMPLOYED		**390,502**	**425,938**	**429,493**	**427,446**	**425,400**	**423,356**
Term Liabilities							
	Non Current Crown Debt - CHFA	269,107	305,954	305,954	305,954	305,954	305,954
	Restricted & Trust Funds Liability	7,290	7,776	7,776	7,776	7,776	7,776
	Non Current Provisions & Payables Personn	6,056	6,528	6,528	6,528	6,528	6,528
Total Term Liabilities		282,453	320,258	320,258	320,258	320,258	320,258
Net Assets		**108,049**	**105,679**	**109,234**	**107,187**	**105,142**	**103,098**
Equity							
	Crown Equity	421,366	422,880	425,094	421,609	418,124	414,639
	Revaluation Reserve	23,606	23,606	23,606	23,606	23,606	23,606
	Trust & special funds no restriction		99	-	-	-	-
	Retained Earnings	(336,924)	(340,906)	(339,466)	(338,027)	(336,588)	(335,148)
Total Equity		108,049	105,679	109,234	107,188	105,142	103,097
NET FUNDS EMPLOYED		**390,502**	**425,938**	**429,493**	**427,446**	**425,400**	**423,356**

Cash Flow

Capital & Coast DHB Statement of Cashflows Budget for the Four Years Ending 30 June 2019		Actual 2013/14 (000s)	Actual 2014/15 (000s)	Plan 2015/16 (000s)	Plan 2016/17 (000s)	Plan 2017/18 (000s)	Plan 2018/19 (000s)
Operating Activities							
	Government & Crown Agency Revenue Rece	965,707	990,144	983,281	993,848	996,211	1,001,167
	All Other Revenue Received	12,442	14,051	14,484	14,556	14,629	14,702
Total Receipts		**978,149**	**1,004,195**	**997,765**	**1,008,404**	**1,010,840**	**1,015,870**
	Payments for Personnel	(397,793)	(407,969)	(425,237)	(427,363)	(429,500)	(431,648)
	Payments for Supplies	(170,882)	(198,764)	(186,068)	(183,429)	(179,261)	(191,402)
	Capital Charge	(8,928)	(12,578)	(8,381)	(8,423)	(8,465)	(8,507)
	GST (net)	329	2,161	2,161	2,172	2,183	2,194
	Other Payments	(341,551)	(350,999)	(331,396)	(333,053)	(334,718)	(336,392)
Total Payments		**(918,825)**	**(968,149)**	**(948,921)**	**(950,096)**	**(949,761)**	**(965,755)**
Net Cashflow from Operating		**59,323**	**36,046**	**48,845**	**58,308**	**61,079**	**50,115**
Investing Activities							
	Sale of Fixed Assets	-	-	-	-	-	-
	Interest Receipts from 3rd Party	772	1,860	1,860	1,869	1,879	1,888
Total Receipts		**772**	**1,860**	**1,860**	**1,869**	**1,879**	**1,888**
	Land, Buildings & Plant	(12,341)	(6,594)	(8,876)	(8,876)	(9,876)	(8,876)
	Clinical Equipment	(3,658)	(2,974)	(12,000)	(12,000)	(12,000)	(13,000)
	Other Equipment	(1,546)	(484)	(500)	(624)	(624)	(624)
	Informations Technology	(8,150)	(5,529)	(3,624)	(3,500)	(2,500)	(2,500)
Total Capital Expenditure		**(25,696)**	**(15,581)**	**(25,000)**	**(25,000)**	**(25,000)**	**(25,000)**
Increase in Investments		-	-	-	-	-	-
Net Cashflow from Investing		**(24,924)**	**(13,721)**	**(23,140)**	**(23,131)**	**(23,121)**	**(23,112)**
Financing Activities							
	Equity Injections	-	5,600	5,600	-	-	-
	Deficit Support	6,000	-	-	-	-	-
	Interest Paid	(16,450)	(16,665)	(14,242)	(14,313)	(14,385)	(14,457)
	DMO	901	-	-	-	-	-
	Other Financing Activities	(3,563)	(3,753)	(3,485)	(3,485)	(3,485)	(3,485)
Total Financing Activities		**(13,112)**	**(14,818)**	**(12,127)**	**(17,798)**	**(17,870)**	**(17,942)**
Net Cashflow		21,287	7,506	13,578	17,379	20,088	9,061
Plus: Opening Cash		(2,074)	19,213	26,720	40,297	57,677	77,765
Closing Cash		**19,213**	**26,720**	**40,297**	**57,677**	**77,765**	**86,826**
Closing Cash comprises:							
Balance Sheet Cash		19,213	26,720	40,298	57,677	77,765	86,826
Balance Sheet Operating Overdraft		-	-	-	-	-	-
Total Cashflow Cash (Closing)		**19,213**	**26,720**	**40,297**	**57,677**	**77,765**	**86,826**

Reconciliation of Cash Flow

Capital & Coast DHB Reconciliation of Cashflow to Operating Balance Budget for the Four Years Ending 30 June 2019		Actual 2013/14 (000s)	Actual 2014/15 (000s)	Plan 2015/16 (000s)	Plan 2016/17 (000s)	Plan 2017/18 (000s)	Plan 2018/19 (000s)
Net Cashflow from Operating		**59,323**	**36,046**	**48,845**	**58,308**	**61,079**	**50,115**
Interest Income		**1,131**	**(2,514)**	**(1,842)**	**(1,851)**	**(1,860)**	**(1,869)**
Amortisation & impairment		**(1,669)**	**(2,578)**	**-**	**-**	**-**	**-**
Non cash PPE movements							
	Depreciation & Impairment on PPE	(32,841)	(35,197)	(35,569)	(35,747)	(35,926)	(36,106)
	Revaluation loss	-	-	-			
	Gain/Loss on sale of PPE	(47)	81	9	(9)	(9)	(9)
Total Non cash PPE movements		**(32,889)**	**(35,116)**	**(35,559)**	**(35,757)**	**(35,935)**	**(36,115)**
Interest Expense		(16,573)	(16,149)	(14,187)	(14,258)	(14,330)	(14,401)
Working Capital Movement							
	Inventory	(165)	713	-	-	-	-
	Receipts and Prepayments	(33,933)	27,180	10,933	(4,261)	(6,761)	4,472
	Payables and Accruals	18,877	(11,564)	(6,749)	(742)	(754)	(762)
Total Working Capital movement		**(15,222)**	**16,329**	**4,185**	**(5,003)**	**(7,515)**	**3,711**
Operating balance		**(5,899)**	**(3,983)**	**1,440**	**1,439**	**1,439**	**1,439**

Changes in Equity

Capital & Coast DHB Statement of Changes in Equity Budget for the Four Years Ending 30 June 2019	Actual 2013/14 (000s)	Actual 2014/15 (000s)	Plan 2015/16 (000s)	Plan 2016/17 (000s)	Plan 2017/18 (000s)	Plan 2018/19 (000s)
Total Equity at beginning of period	111,586	108,049	105,679	109,234	107,187	105,142
Total Comprehensive Revenue & Expense for the year - GFA	62	1	(11)	380	352	324
Total Comprehensive Revenue & Expense for the year - Provider	(21,445)	(29,588)	(9,955)	(10,446)	(10,516)	(10,586)
Total Comprehensive Revenue & Expense for the year - Funds	15,485	25,606	11,407	11,504	11,603	11,701
Equity injections	6,000	5,600	5,600	-	-	-
Capital Repaid	(3,485)	(3,485)	(3,485)	(3,485)	(3,485)	(3,485)
Other	(154)	(502)	-	-	-	-
Total Equity at end of the period	108,049	105,679	109,234	107,188	105,142	103,096

FTEs

Capital & Coast DHB FTEs by Class Plan for the Four Years Ending 30 June 2	Actual 2013/14	Forecast 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
Medical	805	827	819	820	820	820
Nursing	2,049	2,099	2,120	2,122	2,122	2,122
Allied Health	765	763	723	700	700	700
Non-Allied Health	188	176	180	170	170	170
Management/Clerical	835	841	864	864	864	864
Total FTEs	**4,642**	**4,706**	**4,707**	**4,676**	**4,676**	**4,676**

DHB Provider FTEs by Class Plan for the Four Years Ending 30 June 2	Actual 2013/14	Forecast 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
Medical	805	827	819	820	820	820
Nursing	2,048	2,097	2,119	2,120	2,120	2,120
Allied Health	765	762	723	700	700	700
Non-Allied Health	188	176	180	170	170	170
Management/Clerical	786	790	809	809	809	809
Total FTEs	**4,592**	**4,652**	**4,651**	**4,619**	**4,619**	**4,619**

DHB Governance & Administration FTEs by Class Plan for the Four Years Ending 30 June 2	Actual 2013/14	Forecast 2014/15	Plan 2015/16	Plan 2016/17	Plan 2017/18	Plan 2018/19
Medical						
Nursing	1	2	2	2	2	2
Allied Health		1				
Non-Allied Health						
Management/Clerical	49	51	55	55	55	55
Total FTEs	**50**	**54**	**57**	**57**	**57**	**57**

Capital & Coast DHB - OUTPUT CLASSES Statement of Objectives and service performance Budget for the Year Ending 30 June 2016 Statement of revenue and expenses by output class	Prevention (000s)	Early Detection and Management (000s)	Intensive Assessment and Treatment (000s)	Rehabilitation and Support (000s)	Total DHB (000s)
REVENUE					
Crown	10,165	203,052	663,235	107,021	**983,472**
Other			9,154	10,314	**19,468**
Total Revenue	**10,165**	**203,052**	**672,389**	**117,335**	**1,002,940**
EXPENDITURE					
Personnel			420,501	6,132	**426,632**
Depreciation			35,569		**35,569**
Capital charge			8,483		**8,483**
Provider Payments	9,157	172,925	59,442	92,499	**334,024**
Other	1,007	30,127	146,944	18,715	**196,794**
Total Expenditure	**10,165**	**203,052**	**670,939**	**117,346**	**1,001,501**
Net Surplus/(Deficit)	**-**	**-**	**1,450**	**(11)**	**1,440**

Capital & Coast DHB - OUTPUT CLASSES Statement of Objectives and service performance Budget for the Year Ending 30 June 2017 Statement of revenue and expenses by output class	Prevention (000s)	Early Detection and Management (000s)	Intensive Assessment and Treatment (000s)	Rehabilitation and Support (000s)	Total DHB (000s)
REVENUE					
Crown	10,215	204,065	666,543	107,555	**988,378**
Other	-	-	8,757	9,865	**18,620**
Total Revenue	**10,215**	**204,065**	**675,300**	**117,419**	**1,006,998**
EXPENDITURE					
Personnel			422,157	5,740	**427,897**
Depreciation			35,747		**35,747**
Capital charge			8,525		**8,525**
Provider Payments	9,203	173,789	59,739	92,961	**335,693**
Other	1,012	30,265	147,618	18,801	**197,697**
Total Expenditure	**10,215**	**204,054**	**673,788**	**117,503**	**1,005,559**
Net Surplus/(Deficit)	**0**	**11**	**1,512**	**(83)**	**1,440**

Capital & Coast DHB - OUTPUT CLASSES Statement of Objectives and service performance Budget for the Year Ending 30 June 2018 Statement of revenue and expenses by output class	Prevention (000s)	Early Detection and Management (000s)	Intensive Assessment and Treatment (000s)	Rehabilitation and Support (000s)	Total DHB (000s)
REVENUE					
Crown	10,266	205,083	669,869	108,091	**993,309**
Other	-	-	8,799	9,914	**18,713**
Total Revenue	**10,266**	**205,083**	**678,668**	**118,005**	**1,012,022**
EXPENDITURE					
Personnel		4,038	424,266	1,730	**430,034**
Depreciation			35,926		**35,926**
Capital charge			8,568		**8,568**
Provider Payments	9,249	170,629	60,038	97,455	**337,371**
Other	1,017	30,416	148,355	18,895	**198,683**
Total Expenditure	**10,266**	**205,083**	**677,154**	**118,081**	**1,010,583**
Net Surplus/(Deficit)	**0**	**0**	**1,514**	**(75)**	**1,439**

Capital & Coast DHB Statement of Objectives and service performance Budget for the Year Ending 30 June 2019 Statement of revenue and expenses by output class	Prevention (000s)	Early Detection and Management (000s)	Intensive Assessment and Treatment (000s)	Rehabilitation and Support (000s)	Total DHB (000s)
REVENUE					
Crown	10,317	206,106	673,211	108,631	**998,265**
Other	0	0	8,843	9,964	**18,807**
Total Revenue	**10,317**	**206,106**	**682,054**	**118,594**	**1,017,072**
EXPENDITURE					
Personnel		4,057	426,322	1,739	**432,118**
Depreciation			36,106		**36,106**
Capital charge			8,611		**8,611**
Provider Payments	9,295	175,531	60,109	94,123	**339,058**
Other	-	1,876	197,061	804	**199,740**
Total Expenditure	**9,295**	**181,464**	**728,207**	**96,666**	**1,015,632**
Net Surplus/(Deficit)	**1,022**	**24,642**	**(46,153)**	**21,928**	**1,439**

Capital & Coast DHB - Capex Plan

Total Capital Expenditure: $25,000,000.

- 2015/16 $23,876,000.
- 2016/17 $25,000,000.
- 2017/18 $25,000,000.
- 2018/19 $25,000,000.

Details for 2015/16 baseline $23,876,000:

- Buildings & Plant (8,876k)
- Clinical Equipment (12,000k)
- Other Equipment (500k)
- Information Technology (2,500k)

Total Approved Strategic Capital Expenditure:

- 2015/16 $1,124,000
- 2016/17 $0
- 2017/18 $0
- 2018/19 $0

Details for 2015/16 strategic $:1,124,000

CRISP Software Project Agreement

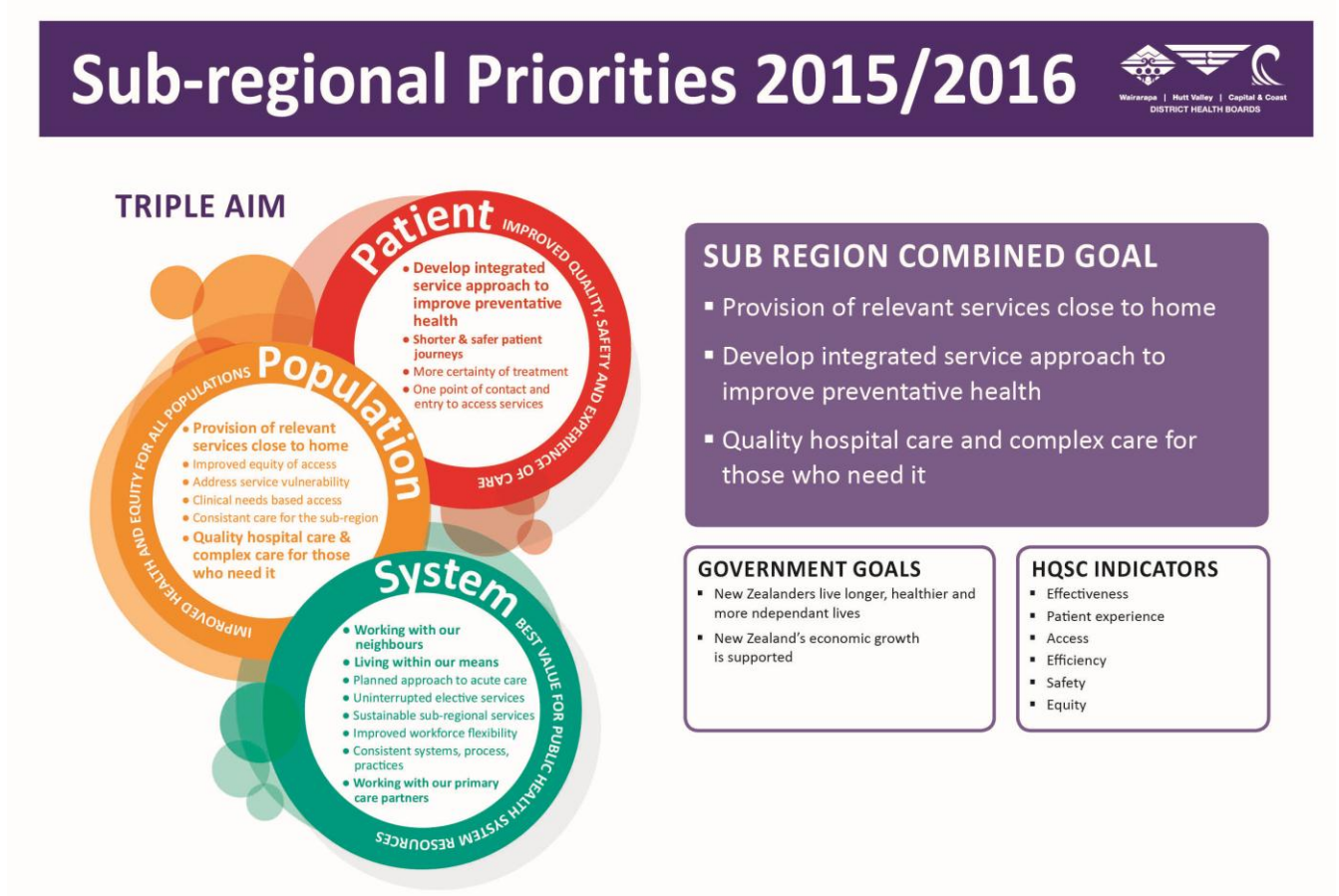
'MODULE 5' STEWARDSHIP

5.1 MANAGING OUR BUSINESS

Managing the business of a District Health Board requires a sound infrastructure that is fit for purpose, that will ensure it can deliver on intent and actions described in Modules 1 and 2 of this Annual Plan – ultimately to deliver better population health outcomes. The DHB is governed by a Board consisting of eleven members who are accountable to the Minister of Health and the public; it is a mix of members elected by the public and appointed by the Minister; the Boards' sole employee is the Chief Executive of the DHB. In early 2015 the Hutt Valley Board with Wairarapa Board decided to appoint Chief Executives dedicated to each DHB. Wairarapa, Hutt Valley, and Capital & Coast DHBs confirmed their intent to work collaboratively together on integrating practices and policies where appropriate.

5.1.1 Quality Assurance and Improvement

Wairarapa, Hutt Valley and Capital & Coast DHBs have a strong and positive culture of continuously improving the quality and safety of the services we provide. Our quality goals are underpinned by working together at all levels of our DHB to achieve patient centred care, openness and transparency, learning from error or harm and ensuring that the contributions of staff for quality improvement and innovation are truly valued. Our clinical and corporate governance framework ensures that systems are in place to guarantee the Board, clinicians, and managers share responsibility, and are held accountable, for patient care and minimising risks whilst continuously monitoring and improving the quality of clinical care. Our sub-regional approach is described in our quality framework:



We acknowledge the importance of forming partnerships with patients, their families, and the wider community as we listen and learn from their experience of our health care system. Their participation throughout each of our

goals is vital if we are to ensure the quality and safety of the services we provide. See section 5.2.1 for details of clinical leadership development to enable quality service provision.

5.1.2 Risk Management

Risk identification is generated through various methods within the three DHBs; these include:

1. Incident Management Reporting
2. Reportable Events
3. Complaints
4. Patient Satisfaction/Experience Surveys
5. Scheduled, or issues based, audit process
6. Internal &external audit
7. Mortality & Morbidity Reviews
8. Fraud Risk Assessment
9. Health & Disability Commissioner Reports
10. Staff meetings
11. Consumer Focus Groups

The process of managing risk involves the systematic application of the following steps:

1. Establishing the context - Identify the Risk: Risk categories; description; Unique identifier
2. Analyse the risk - Likelihood and Consequence tables; Risk Assessment Code (RAC)
3. Evaluate and prioritise the risk - Risk Tolerance and actions required
4. Treat (mitigate) the risk - Mitigation plan; Risk escalation
5. Monitor and review the risk - Risk Register
6. Communicate and consult

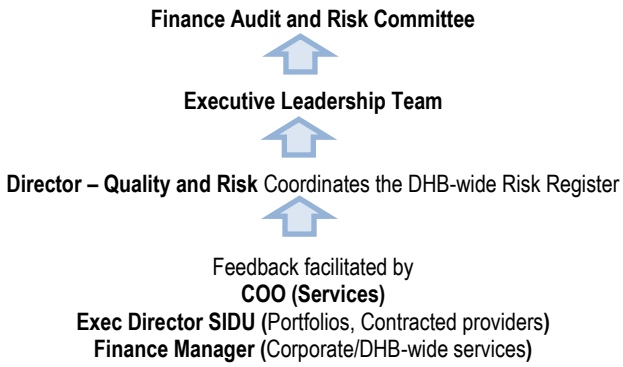
Decisions about risk need to be made within the context of the organisation's internal and external environment. Consultation and communication are essential components of risk discussion and risk identification. Context is about setting the parameters to be taken into account. Legal compliance provides the background context for controlling and moderating risk within the DHBs. Legislation directs how healthcare is provided and is the platform from which mitigation strategies commence. The aim at first is to identify and categorise health service delivery and system risks, regardless of whether they are beyond the control of the organisation. Risks to local populations can occur from local, sub-regional, regional and national delivery and systems.

The process next ensures that there is selection and categorisation of the key risks, so resources are directed at essential mitigation. Other sources for identifying risk include (but is not limited to) networking with peers, industry groups, Colleges and professional associations as well as the review of current DHB Risk Categories. Consistency is required in the way that risks are described and recorded on registers. This helps analysis, gives clarity and better supports how the risk can be effectively mitigated. A unique identifier is required for each assessed risk. This remains in place if the risk is increased or decreased.

Risk analysis combines estimates of likelihood and consequences to separate low acceptable risks from moderate, high and extreme levels of risk. After analysis of the risk, it is given a risk assessment code (RAC). This is a rating scale between 1– 4 and is formed by the risk assessment matrix ranking. The outcome of the analysis is a validated and prioritised list of ranked risks (RAC 1-4) for mitigation, which form the basis of the risk register and to determine at this stage if the risk is tolerable or not. Risk mitigation is the treatment given to risks to either reduce their likelihood or reduce the harm to a more acceptable level. Other options include: risk avoidance or risk transference, and may be considered when the ability to provide safe clinical care and/or cost benefit is evaluated.

Mitigation plans are integral to quality improvement initiatives. Risks that are identified as RAC 1 and RAC 2 – that is extreme and high risks – require formal mitigation plans; risks that are identified as RAC 3 - can be included as bullet point actions in the risk register; risk identified as RAC 4 – monitoring only. Any risk at service or Service/Portfolio Manager level, that cannot be mitigated or fails to progress over a 3 month period, will be escalated to the next management level through the regular reporting process. All risks on the Service/Portfolio Manager risk registers are to be reviewed quarterly or as circumstances change.

New risks will be evaluated and validated at performance meetings. Our Risk Reporting Framework is as follows:



5.1.3 National Entities Support

The sub-regional DHBs support the intent and initiatives of the seven National Entities. The work of three of these entities are described below, the remaining four have more specific actions associated with them for our DHBs and are described in Module 2 in the appropriate section: Workforce (Health Workforce NZ), IT (National IT Health Board), Quality Improvement (Health Quality & Safety Commission), Rheumatic Fever, Child and Maternal Health, and Immunisation (Health Promotion Agency).

5.1.3.1 Health Shared Services Initiatives

Procurement, Finance, Supply Chain Initiatives

In mid-2014 'healthAlliance' initiated 'National Procurement', a national integrated operating model for Procurement needs across the health sector. The model has three objectives for servicing the DHBs: deliver financial benefit from collective procurement of goods and services; managing risk through policy, probity, and best practice procurement; and, delivering a strong stakeholder experience supported by strong relationships and processes. As part of this approach we will:

- Continue to work towards more collaboration sub-regionally to improve resource use and support change, maximise combined leverage with suppliers, and standardise and align clinical and workflow practice;
- Provide clinical engagement and support around devices sub-regionally;
- Increase provision of support for other areas such as ICT technical services; and,
- Undertake a review of physical warehousing.

Linen & Laundry

Options are currently being assessed as part of completing the detailed business case for reducing the costs of Linen & Laundry services, while improving service delivery quality. Financial modelling in the Detailed Business Cases currently with DHBs for approval indicates that over the proposed 10 year contract term total sector benefits will be between $65m - $85m on a NPV basis. Individual DHB budgetary benefits will be advised when the Detailed Business Cases are approved, in line with existing agreements with DHBs.

- Laundry Business Case – analyse the potential to outsource or remain DHB owned.

National Infrastructure Platform

The vision is for a national infrastructure platform with agreed standards and policies and a single governing organisation, delivered out of significantly fewer than the 40-50 current physical data centres. It will also align the health sector's infrastructure services with the Government's overall Information Communications Technology goal of harnessing technology to deliver better, trusted public services. Financial modelling in the Detailed Business Cases currently with DHBs for approval indicates that over a 10 year timeframe total sector benefits will be $169m on a NPV basis. Individual DHB budgetary benefits will be advised when the Detailed Business Cases are approved, in line with existing agreements with DHBs.

Food

Options are currently being assessed as part of completing the business case for reducing the costs of Food services. It is a priority to improve the quality of hospital food service to ensure good nutrition for all patients. Financial modelling in the Detailed Business Cases currently with DHBs for approval indicates that over the

proposed 15 year contract term total sector benefits will be between $155m - $190m on a NPV basis. Individual DHB budgetary benefits will be advised when the Detailed Business Cases are approved, in line with existing agreements with DHBs.

- Food and cleaning services – RFP process will take place in late 2015.

5.1.3.2 National Health Committee

The DHB will work collaboratively with the NHC on the three following initiatives, by engaging with the National Prioritisation Reference Group and providing advice on prioritisation and assessments, and referring technologies that are driving fast-growing expenditure where appropriate. We will also discuss emerging technologies, holding technologies - which may be useful but for which there is insufficient evidence and the provision of clinical and business expertise to design, and run field evaluations where possible.

Pull model prioritisation (proactive programme) – This will prioritise future work programmes by undertaking review of two or three major programme budgets spends (Tier 1 comparative analysis). Business Plan intentions will compare musculo-skeletal and eye, and endocrinology and neoplasm; second tier of work will analyse specific disease states for suitability to undertake Health Technology Assessments and to lead the sector to develop improved models of care. Stakeholder engagement throughout process including with National Prioritisation Working Group established in early 2015. From this clinical outcomes will be improved and the cost curve for health bent by using a programme budget to identify large and fast growing health sector spends, where there are models of care which deliver outcomes which can be improved, and there is a reliance on technologies for which the evidence is untested. Notional budget will be identified through cost avoidance, efficiency and quality improvements and re-prioritisation.

Push model prioritisation (reactive programme) – There is a call for the health sector to refer significant technology issues to the NHC for assessment; undertaken with assistance from the National Prioritisation Working Group. Clinical outcomes will be improved and the cost curve for health bent by identifying new and significantly expanding technology cost drivers for the sector which are not captured by the NHC through the proactive referral process. Notional budget will be identified through cost avoidance, efficiency and quality improvements and re-prioritisation.

Innovation fund-evidence generation activity – This will trial promising technologies outside business as usual while evidence is gathered for final recommendations; or, hold technologies, which may be useful, but for which there is insufficient evidence, out of business as usual while the evidence is gathered in a standardised manner to support improved clinical outcomes in a fiscally sustainable manner. Notional budget will be identified through cost avoidance, efficiency and quality improvements and re-prioritisation.

5.1.3.3 PHARMAC

Hospital Medical Devices – PHARMAC Procurement Activity: National contracting is the first stage towards full management of hospital medical devices. This activity is also building PHARMAC's capability; it reflects the transition from national contracting towards steady state - which includes assessment of new devices, health technology assessment, active category management, category reviews and tendering. This will help achieve national consistency in medical devices, improve transparency of decision-making and improve the cost-effectiveness of public spending to generate savings for re-investment into health, i.e. reflects Cabinet requirement (August 2012) for PHARMAC to assume this role.

A minimum level of savings is achieved from nationally negotiated contracts based on the current mix of product use. The level of savings achieved could significantly increase if DHBs shift to the national contracts and increase the amount of these products in their overall product mix. PHARMAC expects to shift towards product standardisation in at least one category during 2015. This will lead to increased national consistency in product use. Product standardisation will lead to additional commercial gains beyond those achieved with national contracting. The DHB will continue to support PHARMAC's national contracting activity for hospital medical devices. This includes committing to implement new national medical device contracts, when appropriate and assisting with product evaluations where possible, and will support effective implementation of any product standardisation undertaken by PHARMAC during 2015/16.

5.1.4 Funding and Financial Assumptions

Capital & Coast DHBs Provider Arm provides a mix of secondary and tertiary services to local, regional and national populations. Most of the services are provided out of the main Wellington Regional Hospital campus in

Newtown, with a mix of out-patient, orthopaedic and older persons / rehabilitation services delivered out of the Kenepuru campus in Porirua. The resources required to deliver these services in 2015/16 include:

- $500m of land, buildings, clinical and other equipment mostly located on the hospital campus
- $1b of revenue, mainly provided by the Crown.

ALL A comprehensive plan is in place to address issues along the health continuum and establish sustainable clinical and financial outcomes. This plan is substantially based on productivity and efficiency as opposed to service reduction, and continues to be a revenue/cost reduction led recovery rather than a service reduction recovery. The principle continues to be that implementation occurs by Directorate and through Clinical leadership, reinforcing the development of a culture of accountability. This has required and continues to require:

- developing a comprehensive understanding of the cost and revenue drivers
- understanding the impact of actions and benefits of strategy along the health continuum
- transparency and accuracy in reporting
- addressing organisational change where required
- establishing and enabling accountable leadership at all levels with a focus on clinical leadership
- building organisational capability – leadership, staff, systems, processes, skills, business acumen.

Our key areas of priority include:

- Improvements to efficiencies from working collaboratively across the sub-region
- HealthPathways
- Supplies management
- Personnel costs
- Revenue
- Quality Improvements and changes to models of care which result in improvement in efficiencies and effectiveness.

5.1.5 Other DHB Ownership Interests

Our sub-regional DHBs jointly fund the Central Region Technical Advisory Service (TAS). TAS supports the six Central Region DHBs functions so they are able to meet the New Zealand Health Strategy and the New Zealand Public Health and Disability Act (2000) objectives around regional planning and delivery.

5.2 BUILDING CAPABILITY OVER THE NEXT 3-5 YEARS

5.2.1 Clinical Leadership

Clinical leadership is the operational system that allows health workers to do what is needed based on these goals. Clinical governance refers to the system where clinical goals are set and reported on, and through which health and disability services are accountable and responsible for continuously improving the quality of their services, creating an environment in which clinical excellence will flourish: clinical governance is the system – clinical leadership is a component of that system.

Across our sub-regional we recognise that increasing healthcare costs along with community expectations mean that transformational change is needed in the healthcare system to maintain and improve current health status across the population. We acknowledge that across the country in recent years there has been "increasing disengagement between clinicians and managers" with negative consequences[65].

Traditional management roles have involved coping with complexity, ensuring order and consistency, planning and budgeting, and problem solving. However, more important roles needed for leadership in the current environment are: coping with and delivering change; setting direction/developing a vision; and aligning, motivating, and inspiring people[66]. To achieve this locally, our clinical and executive leadership must collaborate at organisational and individual levels; seek greater efficiency in decision making; inspire the health team; and, socialise the use of evidence-based approaches and evaluation. This requires a team approach with clinicians and management

[65] Ministerial Task Group on Clinical Leadership "In Good Hands - Transforming Clinical Governance in New Zealand" February 2009
[66] Kotter J 1996 "Leading Change" Harvard Business School Press Boston 1996

participating in setting direction, overseeing operational work and taking responsibility for outcomes, including budgets.

We know that clinical leadership is a critical success factor in robust health service development including integration. To this end we are working to promote and enable improvement projects in which clinicians lead change. We endeavour to make sure that clinicians have access to all the relevant data, and are supported to create solutions; we enable robust dialogue to develop plans that meet competing requirements; embed joint responsibility for costs and outcomes (opportunities to re-invest gains); allow time invested in planning with all stakeholders from the outset; continue to greater mutual understanding of the factors that drive clinical quality and costs. By working together we will maximise each individual's contribution – the whole is greater than the sum of its parts.

The professional and ethical obligations of senior doctors and dentists also mean an obligation, where possible, to undertake some type of leadership role in delivering care to patients, attending departmental meetings, and participating in quality and safety activities such as teaching, research, clinical audits, and peer review.

To support clinical leadership we are working on a sub-regional leadership framework: towards an integrated delivery of services backed by sound infrastructure; financial and clinical viability of services, facilities and support; a culture that supports health improvement and addresses disability needs locally and across our region. In addition, learning and development courses in clinical leadership will be developed, and options for engaging with consumers, embedding practice into the sub-regional clinical governance structure, supporting better understanding of service improvement language and literature.

By working together we will maximise each individual's contribution – the whole is greater than the sum of its parts. Only because we have such embedded clinical leadership that we have delivered consistency on all the parameters of the Triple Aim. The Capital & Coast DHB Board Chair has credited in part the impact of clinical leadership as supporting "decimation of the debt".

The Capital & Coast DHB standard job description commits staff to improving the health of our local people, families and communities – and reducing inequalities within our population.

5.2.1.1 Structures Enabling Leadership

Capital & Coast District Health Board has a significant clinical leadership profile across the organisation including: Chief Medical Officer; Director of Nursing and Midwifery; nine Clinical Directors across the Directorates of Medicine, Cancer, and Community, Surgery, Women, and Children, Clinical Support Services, Mental Health and Addictions, Quality Improvement, Nursing and Primary Care; clinical leaders for Simulation Skills, Occupational Health, Research, Primary Care, and Physician Education; and, public health. We are also represented on the Sub-regional Clinical Leadership Group, which includes primary care. There are also around 43 Clinical Leaders across all departments.

Capital & Coast DHBs Integrated Care Collaborative Programme (ICC) Alliance Leadership Team (ALT) includes clinical leaders from across the sector who work in partnership with DHB and PHO management to drive improvements for the system through integration. The Clinical Leadership is extensive in the ALT, with both a Primary Care and Hospital Clinician partnered to be the co-leads for each workstream in the ICC programme of work. At the ALT they are able to champion their area of interest as well as provide leadership for overall system improvement. In addition to ALT level clinical leadership, clinicians provide leadership at the ground level though active participation in ICC developments. The principles of clinically-led co-design are incorporated into the ICC process which calls for all work to have a clinical lead, either in projects or in development of other process improvements. This enables the key leads to work across the system, but also expands the number of clinicians involved in integration work from across the sector. All of these processes build strength and integrity to the re-design of systems through the ICC – as this provides a platform for clinically-led transformational change.

5.2.1.2 Building on Clinical Leadership Success

The sub-regional Quality Awards held annually, demonstrate our excellence in Capital & Coast clinician leadership and innovations. Benefits from clinicians leadership in service improvement include: the work in pharmacy compounding of cytotoxic anti-cancer drugs which lead to financial savings of around $1 million and a faster service for patients; and, reviewing the use of anticoagulation with patients with atrial fibrillation resulted in establishment of a service that is unique to NZ and internationally, and will lead to significant health care savings and less deaths through stroke prevention.

The sub-regional Quality Awards held annually, demonstrate our excellence in Hutt Valley clinician leadership and innovations. Benefits from clinicians leadership in service improvement include: introducing lean management principles to the Child Development Service resulting in significantly reduced waiting times and better resource use, and improving the outcomes for patients having hip and knee replacement surgery by developing a Joint Care Clinic which provided education to the patients and families, from the spectrum of health professionals involved in the process.

The sub-regional Quality Awards held annually, demonstrate our excellence in Wairarapa clinician leadership and innovations. Benefits from clinicians leadership in service improvement include: a reduction in falls in the older residents at a local aged care facility from the training of staff with a tailored tool box of resources and strategies; and a new clinical tracking system which has helped staff identify and monitor where patients are at on their cancer diagnosis and treatment pathway, enabling faster care review and evaluation around treatment, and better patient outcomes.

Reducing the risk of falls at Capital & Coast DHB is happening because we are moving the focus away from incident reporting after they have happened towards effective interventions to prevent them happening and reduce harm from falls. We have established a clinically-led Falls Prevention Group that promotes the hospital-wide programme for clinicians by clinicians, and with our Allied Health professionals supporting prevention work with clinicians in primary care. To ensure our interventions are effective, nursing leadership works closely with our Quality Improvement and Patient Safety Directorate, carrying out real-time audits. Clinical leadership is critical to creating a culture that makes falls prevention everyone's business; by maintaining the Falls Prevention Group as multidisciplinary, we are able to progress falls as a 'care sensitive indicator' across all our clinical staff. Leadership in this area by clinicians also ensures that best practice and innovation is effectively captured and spread.

The Choosing Wisely programme at Capital & Coast DHB started in late 2014 with a Clinical Innovation and Demand Steering Group established by the Chief Medical Officer. Overseen by the Clinical Practice Committee, this programme encourages and advises on the optimal use of diagnostic testing and practice in a wide variety of clinical settings. This includes addressing investigations that are becoming obsolete, low yield tests and interventions, repeat testing frequency, and other demand management initiatives; clinicians are involved in shaping these clinical decisions. 'Choosing Wisely' is an internationally-recognised initiative to better healthcare delivery, particularly in relation to radiology and laboratory testing, in accordance with research and evidence. This aligns well with our on-going commitment to improving the clinical care we provide for our patients and to better involve clinicians in prudent clinical practice. The first initiative undertaken in 2014 concerned evidence and indications for pre-operative chest X-rays; in 2015/16 we are progressing rationalisation of IV fluids; removing routine pre-op chest x-rays; improving guidelines for abdominal films; introducing surveillance scanning in DHB of domicile; the examination of 'routine' testing requests (e.g. urine and sputum); introducing 'lab test of the week' campaign' promoting Shared Care Record review of Primary Care testing; and, on changing of urinary catheters.

The Capital & Coast DHB Child Obesity and Type 2 Diabetes Prevention Network (CODPN) was formed in 2012 out of concern for the high prevalence of obesity and increasing incidence of type 2 diabetes locally, and need to better of co-ordinate individuals and organisations undertaking relevant activities. The CCHDB CODPN has 80 local health professionals, including Capital & Coast DHB clinicians, researchers, NGOs, exercise and nutrition specialists, educators, marketing experts, and local government. The Network links obesity prevention activities in the district, provides a forum for communication, and builds connections between stakeholders. In 2013 the Network formed, the Healthy Future Families Trust - a non-profit organisation supporting work in the area of child obesity and type 2 diabetes prevention, funding health promotion activities that develop personal skills and strengthen community action (core principals of the Ottawa Charter for Health Promotion). It also undertakes and supports relevant research, and raises community awareness about child obesity and Type 2 diabetes. Specific projects include:

1. Reinstatement of the Capital & Coast DHB healthy food policy - we are working with a number of schools and the Wellington City Council to improve their food environments.
2. Development of produce gardens in low decile schools to enable children to learn to grow and cook healthy food; established in Porirua and Wainuiomata, we are extending this initiative to another six schools in the district.
3. Research into knowledge of Type 2 Diabetes in the population and effectiveness of knowledge-based interventions - a survey of over 400 members of the general public.
4. Funding of Whanau Fitness courses; a focus on Māori and Pacific families.
5. Participation in community festivals and health promotion events to raise awareness about Type 2 diabetes and prevention, run by diabetes nurse specialists who volunteer their time.

6. Implementation of the referral pathway for overweight and obese children.
7. Diabetes Prevention Education in Secondary Schools.

Capital & Coast DHB began the establishment of its Integrated Operations Centre (IOC), in late 2014. An IOC is fundamental to optimising the DHBs performance and a prerequisite to achieving further service integration with Wairarapa and Hutt Valley District Health Boards. The programme of work has included implementation of business processes, change management and technology changes required to achieve the objectives outlined below:

1. To optimise patient flow and consistently achieve Emergency Department and Elective Surgery targets.
2. To determine Nursing and Midwifery workforce requirements based on patient acuity.
3. To reduce weekend mortality rates and organisational risk exposure relating to visibility of workload and the management of tasks after hours.

The desired outcome is for Capital & Coast DHB to embrace change and achieve a whole of hospital commitment to safe staffing and better patient outcomes. It should be noted that the technology enablers for the programme align with Hutt Valley DHB and include the implementation of an IOC Dashboard, TrendCare (patient acuity and workload measurement), Orion Electronic Whiteboards and the selection of a preferred vendor to implement a Task Management solution. The expected benefits from achieving the above investment objectives are as follows:

1. Improved patient outcomes.
2. Reduction in the Relative Stay Index (RSI) – a measurement of length of stay.
3. Reduction in reportable events due to staffing levels.
4. Reduction in casual and overtime costs for Nursing and Midwifery beyond 2015/2016.
5. Reduction in weekend mortality rates.
6. Increase in Medical Emergency Team (MET) calls after hours (linked to better patient outcomes).
7. Improved staff satisfaction.

By June 2015 the IOC will be in place and the platform for realising the desired outcomes will be established. The realisation of the benefits in terms of achieving safe staffing and better patient outcomes is a journey that will take time. The IOC Programme has the commitment and involvement of clinical and operational leaders throughout the organisation and will be supported by a strong change management framework.

Sub-regionally, the oral health clinical care of our children is attended to by the 'Bee Healthy Regional Dental Service', a community-based dental service for all children aged between 0-18 years that examines around 43,000 children per year. Clinical leads working with management have developed strategies to improve health outcomes for all children and young people including approaches that involve early access to services which incorporate prevention strategies, education and appropriate timely treatment and reduce inequalities. The service receives clinical leadership from a Clinical Director, a specialist in dental public health, and from community dentists. To date we have embedded regional Clinical oversight to provide direction and consistency in developing service provision across the three District Health Boards (3DHBs), we are actively participating in regional child health networks, and finalise delivery on the Oral Health Business Case across the districts including introducing two towable mobile dental units servicing Wairarapa), 11 mobile dental units servicing Hutt Valley and Wellington, and eight community-based hubs. Over the next few years there will be a particular emphasis on Māori and Pacific population oral health. We will work with primary health care clinicians, education sector, Māori and Pacific communities, and Well Child providers to improve integration and seamless transitions between services.

With a focus on continuous clinical quality improvement we will work with service staff to embed the new model of care through standardised practices across three DHBs with consistent policies and procedures as appropriate, and enable clinicians and non-regulated staff to work at the top of their scope of practice. Clinical service delivery will be further enhanced through extending access to the patient management system sub-regionally and improving IT systems.

The Lower North Island Palliative Care Managed Clinical Network is contributing to the development of palliative care sub-regionally through an integrated service development project. The project is bringing clinical leadership to service delivery. A consortium of the sub-regional DHBs, Mary Potter Hospice, and Te Omanga Hospice, have joined the governance group including Hospice Wairarapa and Compass Health PHO. Last year a contract was signed between the Ministry of Health (Health Workforce New Zealand) and Capital & Coast DHB (for the Lower North Island Palliative Care Managed Clinical Network), to create a managed clinical network with a funding framework which supports an efficient and effective service model for palliative care, an innovative and sustainable workforce, and effective clinical leadership and governance.

The Network employs three 'clinical leads' to progress the work of the Network across the Wairarapa, Hutt Valley, and Capital & Coast DHBs through to December 2016, to find a sustainable solution to the critical shortage of specialist medical, nursing, and allied health workers, which is a national problem.

5.2.1.3 Clinical Leadership for 2015/16 and beyond

Capital & Coast District Health Board has developed a Strategic Plan for Clinical Leadership across the DHB, including sub-regional work. Our 'out of hours' work is about all Clinical Leaders creating a more responsive and less wasteful system, improving access for patients, and promoting continuous improvement in the delivery of our services. Our challenges around this are about while shift patterns all meet College and MECA requirements, the work patterns that we are operating to are biased to normal business working hours, this means that those needing urgent healthcare, wherever they are in the health system, are not always able to receive it in a timely way, which in turn can have safety and outcome implications. Making use of clinical leadership; we will over the year analyse what is needed in order to update the current model of care, to deliver safer and more responsive care, within the resources of the DHB.

5.2.2 Quality Systems

In recent years, the Mid Staffordshire hospital scandal in England has provided a deeply tragic illustration of what can happen, even in otherwise high-performing health systems, when governance and management fails. There were multiple drivers behind this failure, but one of the key issues highlighted in the public enquiry was an overly narrow focus on meeting national access targets and achieving financial balance. These goals were given priority at the expense of the quality and safety of care, which ended up causing immense suffering to many patients and their families. The enquiry highlighted the critical importance of focusing on quality and safety indicators alongside financial performance and government targets. Developing a comprehensive measurement framework for performance and quality in healthcare is a challenging task with a number of complex elements - some helpful principles: scientific methods [should] be used to design systems and performance metrics, and these should be evidence based, valid, reliable and credible to the extent possible. Measures need to be acted on by clinicians and healthcare professionals, thus their participation and support is critical. Performance measures should be understandable, clinically relevant, useable, timely and updated frequently to reflect changes in knowledge, evidence or technology, contributing to continuous improvement and leading to a sustained health system.
Our services strive to be patient-focused and evidence-based: 'patient–focused' care responds to patient priorities and expectations, shares management of care with the patient and optimises health outcomes; 'evidence-based practice' involves the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research.[67]
We have adopted a "whole of system" approach to improving patient flow across the health care system and extending to a sub-regional approach. Additionally, our organisational development framework supports new knowledge and leadership development, innovation, research and lean thinking/production management principles. This approach also supports the strategic goal of 'effective, efficient and high quality services'. The Wairarapa, Hutt Valley, and Capital & Coast DHBs Quality, Patient Safety, and Risk Teams are continuing to work more collaboratively. The sharing of resources, learning's from events and good news stories are now common place.

The three DHBs are working towards a clinical governance framework that combines activities and governance where it makes sense to do so. At this stage, this is working collaboratively on enhancing the clinical governance structures for the 1- and 2-DHB services, and the development of an integrated governance structure for the sub-regions services. As part of a joint clinical governance framework for Quality, Patient Safety and Risk, consideration is being given to develop a governance structure across the sub-region for ethics, credentialing, research, policies. Several of our quality initiatives are developed with consideration for the Health Quality & Safety Commission (HQSC) work national programmes including: medication safety; quality accounts; mortality reviews; management of reportable events; surgical checklist. We recognise the importance of strong infection prevention and control processes and are participants in the hand hygiene, surgical site infection surveillance and central line associated bacteraemia programmes.

A '3DHB' Balanced Scorecard has been developed where HQSC Quality Markers are reported on and exceptions are discussed. Learning's are shared across the three DHBs where variance on reporting occurs; this is one of the

[67] Sacket DL, Rosenberg WMC, Gray JAM, Richardson WS. 1996. Evidence based medicine: what it is and what it isn't. *British Medical Journal* 312 (13 January 71–72).

ways in which increased integration lead to quality improvement. Sharing of information received from the HQSC Patient Experience Programme is shared, thus providing a platform for shared learning form the sub-region.

Measurement of quality goals occurs to ensure that any changes are improvements, alongside using standardised improvement science methodology assist in ensuring quality assurance and improvement, these include but are not limited to Hospital Balanced Scorecards, Patient Experience surveys, increased participation of consumers and their experience being evident in quality projects, reduced harm associated with surgery, increased compliance with reporting, reduction in avoidable mortality rates, and a decrease in errors related to medication management.

Understanding the 'patient experience' is vital to improving patient safety and the quality of service delivery - it has been shown to be a sound indicator of the quality of health and disability services. Growing evidence indicates that better experience, developing partnerships with consumers, and patient and family-centred care are linked to improved health, clinical, financial, service, and patient satisfaction outcomes. By capturing and integrating the lessons from patient experiences in a quality improvement framework we will increase the chances of sustainable service improvement.

The Capital & Coast DHB In-Patient Experience Survey focuses on the dimensions of care that make the most difference to patients' care and treatment, and tells us how we are performing on each of those dimensions. To date 4,979 patients have taken part.

The Capital & Coast DHB established in 2015 a Consumer Council to provide a voice for consumers to improve the quality, safety, and experience of care; it promotes equity of access and treatment to ensure that services are consumer-focused and organised around the needs of individuals and whānau. The Council is known as 'VOICE for Consumers' – Visibility-Ownership-Involvement-Communication-Engagement.

5.2.3 Information Technology

5.2.3.1 Key issues

In reviewing what priorities areas for IT were required for 2015/16, we identified the following clinical technology and communications issues:

- Reducing Acute Demand – via primary-secondary integration
- Reducing Medication Errors through primary-secondary integration, eMedicines Reconciliation, ePrescription
- Reducing demand for diagnostics through Regional Test Results Repository, Electronic Laboratory Test Ordering, Regional PACS Archive, Regional Radiology Information System
- Meeting regulatory and compliance requirements through Information Security & Governance Programme, NCAMP, National Patient Flow, Microsoft Windows Server and SQL replacement
- Ensuring business continuity through replacement of out-of-support systems e.g. Telephony (VOIP), Pharmacy Information System, ED & Theatre replacement and PAS platform upgrade
- Improving patient experience and care e.g. Shared Care, Patient Portals, Maternity Information System, Support for Single Services, Telemedicine
- Increasing the value from ICT investments through Regional Network, National Infrastructure Programme, Finance Procurement Supply Chain, Regional planning, Regional Procurement

5.2.3.2 Key sub-regional IT initiatives for 2015/16

- Windows and SQL Server Upgrade
- Information Security & Governance Programme
- Integrated Laboratory Services ICT
- General Practice access to Hospital Information
- Patient Portals
- Regional Test Results Repository
- Electronic Test Ordering
- NCAMP

5.2.3.3 Local Initiatives

In 2015/16 Capital & Coast DHB areas of focus include:

- Hospital Telephony (VOIP) System Replacement
- PAS Platform Upgrade
- Emergency Department System Replacement
- Theatre Department System Replacement

- Consider implementation of Scanning of Documents into the Medical Applications Portal (MAP) - current availability of electronic clinical information in MAP along with the implementation of E-tree and the Shared Care Record has improved the access to patient information for Clinicians. There are opportunities to further improve access to clinical information and reduce duplication by continuing to move towards an integrated clinic record.
- Consider implementation of U Book - an application that has been developed by Hutt Valley Health and successfully used since 2012. The product improves management of and streamlines the process of creating multiple outpatient clinic appointment requests and bulk printing of letters of invitation. It enables patients to book their own appointment via the internet and receive confirmation of their booking; the application interfaces with the patient management system and monitors the responses from patients.
- Consider implementation of Appointment Information Management System (AIMS**) -** developed and successfully used by Hutt Valley Health. It provides patients with the opportunity to choose their own method of reminding about their clinic appointments and enables the booking staff to manage this by sending reminders to 'all' patients within a certain group.

5.2.3.4 Regional IT

In addition to our sub-regional and local projects, we are working regionally across the six DHBs together on implementing:

- Regional Clinical Portal (Clinical Workstation & Data Repository)
- Regional Radiology Information System
- Regional Network

5.2.3.5 National Health IT Board

All of our effort supports and delivers on the National Health IT Board proposed initiatives of:

- eMedicines Reconciliation
- ePrescription
- National Patient Flow Stage 3
- Finance Procurement Supply Chain
- National Infrastructure Programme

See Module 2, 2.2.27 for further detail of these projects.

5.2.4 Non-financial Monitoring

In the role as a funder of health services, the sub-regional Service Integration and Development Unit (SIDU) holds over 700 contracts and service agreements with the organisations and individuals who provide the health services required to meet the needs of our population. The delivery and quality of outputs against these agreements are monitored through regular performance reports and data analysis, and reporting of adverse incidents, routine quality audits, service reviews and issues-based audits. A key mechanism for monitoring our performance is the 'non-financial monitoring framework'. It is a tool to provide assurance that DHBs deliver in terms of the legislative requirements, and in terms of Government priorities. A summary of the monitoring framework, including our targets (where appropriate) has been included in Module 7 (Performance Measures) of this Annual Plan.

SIDU coordinates a Routine Audit Programme to monitor provider performance against the agreement(s) held by the DHB. Additional Special Audits can be requested if there are particular concerns or 'red flags' with a provider's performance. The Central Region Technical Advisory Service (Central TAS) completes these audits on the DHB behalf, and coordinates national and regional audits. Central TAS is also able to provide SIDU with a Provider Risk Assessment (PRA) rating. This rating whether it is high, medium or low, ensures the DHBs keep alert to 'at risk' providers. In addition to the Routine/Special Audit Programme, Audit & Compliance (A&C) – National Health Board, provide an audit service by requesting and getting permission from the DHB to conduct claims audits. SIDU collates the requests and responses for these audits for its three DHBs, and monitors progress of any issues identified through the A&C Monthly Report.

There are two main financial effects of A&C activities – Recoveries and Future Losses Averted – both of which support claimant behaviour changes. The areas that A&C cover include Pharmacy, Capitation (PHO's, Dental, Laboratories, Maternity), and Financial (Health of Older Persons, Mental Health, Personal Health). Two other bodies also provide comprehensive audit processes to SIDU - Medicines Control (Ministry) – who audits pharmacies against licence requirements, and HealthCERT (Ministry) – a provider monitoring website for Aged Residential Care (ARC) facilities.

For SIDU, the Government Rules of Sourcing (GROS) are an effective tool to support good practice procurement, including monitoring provider performance. Engagement and continued dialogue with providers are essential to the results that are achieved, and strengthen the DHBs accountability for how we spend taxpayer's money. Strong processes mean that providers are chosen who demonstrate they fully understand and have the capability to deliver on the service specification(s), and meet all other contractual conditions. The three DHB Provider Arm services are actively involved in regular programmed internal audits as well as the annual statutory audit to ensure the accuracy and integrity of the DHBs financial results.

5.2.5 Capital Development

5.2.5.1 Regional planning support

Good-quality capital investment planning is critical for long-term health sector sustainability. The National Health Board (NHB) continues to collect regional capital plans separately from Regional Service Plans (RSP). The RSPs focus on individual service priority areas, while the Regional Capital Plans to cover all service needs for the next 10 years. Objectives of the regional approach to capital investment:

1. DHB regional capital plans over the long-term to be informed by local and regional service planning and DHB facility assessments and asset management
1 Regions engage early with the Capital Investment Committee (CIC) on the long-term capital intention planning process
2 Regions prioritise capital intentions over 10 years
3 DHBs have quality asset management planning.

The Regional Capital Plans provide an overview of DHB capital intentions and enable regional discussions, identifying local and regional capital work plans for 2015/16.

5.2.5.2 Local Capital

Capital & Coast District Health Board Total Capital Expenditure: $20,000,000.

- 2015/16 $18,876,000.
- 2016/17 $20,000,000.
- 2017/18 $20,000,000.
- 2018/19 $20,000,000.

Details for 2015/16 baseline $18,876,000:

- Buildings & Plant (5,876k)
- Clinical Equipment (11,000k)
- Other Equipment (500k)
- Information Technology (1,500k)

Total Approved Strategic Capital Expenditure:

- 2015/16 $1,124,000
- 2016/17 $0
- 2017/18 $0
- 2018/19 $0

Details for 2015/16 strategic $:1,124,000

- CRISP Software Project Agreement

5.2.5.3 Energy Efficiency

In 2015 we developed a sub-regional Statement of Intent for Energy usage within the DHBs, specifically electricity and gas usage. By the end of 2016 work evolving from this will enable us to reduce our energy consumption by 10%. Our longer term objectives (to 2021) are to:

- reduce our energy costs without compromising service delivery (reduce energy consumption by 2018 by 20% over 2015 levels)
- align our energy management to the International Standard ISO 50001 - world's best practice
- integrate our energy management with the DHBs sustainability policies and programme
- give an appropriate priority to energy efficiency investments
- commit the appropriate organisational resources to energy management
- actively participate in a regional approach to energy management
- consider life cycle costs and environmental sustainability for all new projects, both energy and maintenance
- minimise the CO_2 emissions generated by our energy usage
- minimise the environmental impact of our energy usage

- provide a continuous commitment to improvement in energy performance for our facilities
- ensure positive assessment of energy efficient and environmentally sustainable designs for new buildings and refurbishments, including life cycle analysis of the projects
  We intend to establish the Wairarapa, Hutt Valley, and Capital & Coast DHBs as New Zealand bench mark sites for energy efficiency in DHBs and the Crown property portfolio.

5.3 WORKFORCE

5.3.1 Managing our Workforce within Fiscal Restraints

The sub-regional DHBs meet the Government's 'Expectations for Pay and Employment Conditions in the State Sector' both within the bargaining strategies and parameters agreed with DHB Shared Services, and within our own strategies. We will continue to collect appropriate workforce metrics and data on MECA interpretation, implementation for areas aligned with areas of focussed growth for the DHB and make such information available to DHB Shared Services on request to inform the process of collective bargaining. We endeavour to progressively practice pro-active national and international recruitment strategy implementation to support in areas of higher recruitment and retention needs, e.g. drives to recruit for radiology, sonographers and other hard-to-fill roles, participation in the Kiwi Health Jobs initiatives, as well as NETP and RMO ACE recruitment initiatives.

In order to deliver on shorter patient journeys as a goal the focus will remain on applying the workforce in areas of high impact to support a cost effective but high quality 24/7 hospital services. Innovative adjustments to pay structures for those not on collective agreements to promote internal relativity and equity will be investigated to facilitate and promote employee engagement and improved staff retention.

The HR Resources Plan 2014-2016 has been developed for the sub-region to ensure staff management policies and processes align with organisational goals. The Plan provides a platform from which to implement a range of initiatives to enhance staff management practices. At a strategic level, the HRS Plan contains a number of objectives around enhancing leadership capability across our three DHBs and developing a framework to improve employee engagement, with the aim of contributing to the enhancement of patient outcomes. At a more operational level, the Plan contains initiatives to support managers in effectively leading their staff and delivering services to patients. One such initiative is a programme of work to introduce consistent HR policies and procedures across the sub-region.

The DHBs also intend to continue to build and maintain high quality leadership in delivering quality services to patients and this is reflected in the work occurring to develop a leadership and management framework for the sub-region that is aligned to the HWNZ and national General Manager, HR work that is occurring. The framework will provide a structured approach to the development of leaders and managers to ensure they possess the capabilities required to manage the challenges facing the health sector both today and in the future. The framework will also provide leaders, both clinical and non-clinical, with a transparent career structure through which to progress. This work will be aligned to the work occurring within HWNZ which has included and leadership and management as one of six priority areas.

5.3.2 Strengthening our Workforce

Capital & Coast DHB employs approximately 4,500 full-time equivalent positions. Of this, 79% are clinical staff (allied health, nursing, medical professionals) and 21% support staff (administration, management). Of the total staffing budget for the DHB, the clinical workforce consumes approximately 79% and the support staff around 21%.

For clinical staff development the DHB works with our Regional Training Hub Director to develop and deliver a workforce plan as part of the 2015/16 Central Region Regional Service Plan.

5.3.2.1 Regional collaboration

The sub-regional DHBs will continue to work with our regional DHB partners and Health Workforce New Zealand to develop and deliver national and regional workforce plans. We will also work with HWNZ and the GMRS on workforce intelligence and planning. Capital & Coast DHB is introducing a whole of organisation learning and management system that will facilitate learning and enable it to record and report on learning and development within the organisation; this will greatly assist in the building of capability across the organisation.

5.3.2.2 Nursing Symposium

The inaugural sub-regional Nursing Symposium was held in 2014 and attended by over 200 nurses from the sub-region. Nurses came from primary & secondary care, tertiary education and community providers across the DHB areas; it will be held every two years. The purpose of the symposiums are to awareness about working together across the health care system in partnership and collaboration with each other in the best interests of the populations served by all. Topics are selected by a Steering Group representing nurses from a wide range of settings, and typically cover: Population Health Care and its Challenges; Addressing the challenges that long-term conditions management present; Information Technology and Integrated Care; and, Health Workforce Development. Improved understanding of each of them helps nurses to build relationships across the wider health care system.

5.3.2.3 Māori workforce and leadership

To support our aim of eliminating inequity, we are working on improving the capacity of our Māori health care workforce. District Health Board Chief Executives, in partnership with DHB Māori Leadership, support and facilitate executive and clinical leadership roles to be accountable for performance against relevant health achievement areas for Māori. This also requires that Māori Health Plan priorities have the same Mana (prominence) and status as Health Targets in terms of performance improvement and reducing inequalities.

Capital & Coast DHB is supporting the Te Ara Whakawaiora (Tumu Whakarae -National GM Māori Forum project). This involves enabling the implementation of a resource for the DHB Board and Executive Leadership Team to better understand Māori Health indicator areas, and following through on the nationally DHB CE-endorsed Tumu Whakarae recommendations of 2013, that a standardised Māori health performance report be used by DHBs on a monthly basis to monitor performance. Specifically we are working on:

1. 'Te Ara Whakawaiora' (Tumu Whakarae - national General Managers Māori Forum project) - supporting the development and implementation of a resource for the Board and Executive Leadership Team to better understand Māori Health indicators
2. Treaty of Waitangi – Māori Health Directorate and Human Resources joint work on supporting and developing online training 'Healthcare and the Treaty of Waitangi' - Mauriora Associates, and proving Robert Consedine training
3. Development of Key Performance Indicators of Māori health and a reporting framework for the Executive Leadership Team

5.3.2.4 Culturally Competent Workforce

Improving the health status of Māori and reducing health care inequality is a key priority for Capital & Coast DHB. Appropriate responses to the needs and diversity of Māori within the hospital will contribute to progression of this imperative. 'Tikanga Guidelines' resource aims to help staff with the hospital to provide culturally responsive health and disability services to Māori. These guidelines are underpinned by Māori values, protocols, concepts, views of health and Te Tiriti o Waitangi.

Tikanga Māori Education is available to all DHB staff members to learn about the disparities in health status that exist between Māori and non-Māori, and how the incorporation of tikanga into clinical practice and work processes enables cultural competence, promoting more equitable outcomes from health care interventions. Each attendee receives a pocket-sized booklet - 'Tikanga Māori , A Guide for Health Care Workers', a snapshot of culturally responsive goals and processes for staff to consider during delivery of health & disability services, supplementary to the Code of Health & Disability Services Consumers' Rights. Te Reo classes are also available to all staff.

5.3.2.5 Allied Health, Scientific, and Technical

Encompassing over 50 professional groups working in a variety of health and disability services, Allied Health, Scientific, and Technical (AHS&T) staff deliver vital services, treatments, and assessments and utilise a range of technologies to measure, test, and treat patients and their health conditions. Our AHS&T professions are working hard to align across the sub-region in their approach to planning and improvement. We believe AHS&T practitioners can be agents for change across the health sector due to their perspective on integration which results in a seamless health system journey for their patients; ability to enable person-centred care and care closer to home; and, empowering individuals to take charge of their health and self-management of long-term conditions[68], reducing unnecessary and inequitable burden on the system and population.

We have developed a vision and strategic plan for the AHS&T professions for the sub-region which is being implemented throughout 2015/16; however, a change in culture, practice, and some structures will be required to fully establish AHS&T systems to their full potential. We will be supporting the shared care record is a crucial enabler for transformational change for these professions, and will support planning together as virtual teams. Sonography remains one of the most vulnerable of our workforces, and we are supporting the national approach to this issue.

5.3.2.6 Community Oral Health Service

There is a Dental therapist workforce capacity issue both nationally and locally. Our regional oral health service is looking at working on a national level to develop strategies to address this issue locally. The service had approximately 20% less therapist capacity in the 2014/15 year which contributed to the arrears. The service attends the Employers Forum held at Otago University, where new graduates are recruited each year; however, one of the on-going issues we face is retaining recent graduates as with their dual scope of practice that includes hygiene as we are unable to compete with the remuneration offered for this dual scope by private practice. As part of our workforce strategy dental therapy Scholarships are being reintroduced as well as the service participating in clinical placement for 3rd year dental students. Some of the impacts we expect to see over the year include:

- The number of children who are enrolled but not seen will decrease;
- The number of children who do not turn up for their appointments will decrease;
- The number of children enrolled into the service will increase;
- The ambulatory sensitive hospitalisation rates for 0-4 year olds for dental conditions decrease;
- All children receive equitable level of care; and,
- The oral health database 'Titanium' is used sub-regionally

See also Module 7 for measures related to child oral health.

5.3.3 Safe and Competent Workforce under the Vulnerable Children Act

The Vulnerable Children Act 2014 (VCA) contains workforce requirements relating to: Child Protection Policies and Worker safety checks. We have established a VCA Working Group which is chaired by a Sub-Regional Quality team; this group ensures adherence to VCA requirements across the sub-region. We report on our compliance around the VCA in our DHB Annual Reports.

5.3.3.1 Child Protection Policies (sections 17, 19 and 20 of the Vulnerable Children Act)

Child Protection Policies reflect the Government's vision for a children's workforce that works together more effectively, with shared skills and language, and a common appreciation of the needs of the child. Under the VCA, we and the organisations we contract/fund to provide children's services must have child protection policies in place, this includes any directly or indirectly funded organisation that provides services to one or more children or adults in respect of one or more children: all DHB funded service providers now sign a variation of service agreement, regarding requirements under the VCA, to adopt and review child protection policies. Our DHB Child Protection Policies guide our staff to identify and report child abuse and neglect, as well as helping to build child protection cultures and to support staff to ensure children are kept safe. Our policy is on our three DHB internet

[68] 'Self-management' is one of the critical components in improving health care for people with long-term conditions; support includes developing a holistic view and awareness of the need to engage the 'identified person' within their wider social context, particularly whānau and family; our approach is patient-centred, culturally relevant, and spans the entire health system journey.

sites; we also have a sub-regional overarching Child Protection Policy. The policies have a three-yearly review date.

5.3.3.2 Children's Worker Safety Checking

On 1 July 2015 the first phase of new improved safety checking of people who work with children comes into force. New government regulations made under the Vulnerable Children Act 2014 will require State-funded organisations who work with children to have all their paid children's workforce safety checked. We have the appropriate policies and practices in place in across the sub-region to ensure compliance with the requirements for this safety checking. We have updated our Child Protection Policies to ensure systems are in place to identify and report on child neglect and abuse – effective 1 July 2015. As part of this, we ensure current practice either complies with the requirements for safety checks and updating other policies, guidelines, and practice to continue to assist in ensuring a safe environment for children and other vulnerable clients when they interact with the DHBs.

We comply with workforce restrictions preventing people with certain serious convictions from being appointed to roles that involve working alone with, or with primary responsibility for or authority over, children; a Vetting Policy relating to safety checks of all core and non-core workers by Human Resources has been developed. Core workers will be safety checked before commencing work from July 2015; non-core workers starting in a new role will be safety checked before commencing work from July 2016; core workers in current roles will be safety checked by mid-2018; non-core workers continuing in current roles will be safety checked by July 2019. From 1 July 2015, the Act will also prohibit people with certain child abuse, sexual offending or violence convictions from working in core worker roles (these are specified in Schedule Two of the Act). Anyone convicted of the listed offences won't be able to work in core children's worker roles unless they are granted an exemption.

5.4 ORGANISATIONAL HEALTH

It is as priority of the DHBs in our sub-region to be a good employer. The DHBs are committed to applying the seven Key Elements of "the Good Employer' as prescribed by the EEO Commissioner. The elements are:

1. Leadership, accountability, and culture
2. Recruitment, selection, and induction
3. Employee development, promotion, and exit
4. Flexibility and work design
5. Remuneration, recognition, and conditions
6. Harassment and bullying prevention
7. Safe and healthy environment

The Human Rights Commission reviews and analyses the reporting of good employer obligations by Crown entities in their annual reports. It also monitors their progress towards equal employment opportunities (EEO) and provides good employer guidance. The Commission's annual good employer review gives Crown entities an indicator report showing their reporting progress.

Capital & Coast District Health Board received a report with 100% compliance on reporting against the seven elements of a good employer for 2014. Our sub-regional DHBs are working together to develop and implement policies that are consistently applied across all sites, this includes having an equal employment opportunities focus within relevant polices. A rigorous recruiting and selection procedure is followed within each DHB and across DHBs as required, to ensure fairness and equal opportunity. Staff development needs are considered for all staff and personal performance and plans that also consider development are a requirement for all employees. Forums are in place at each DHB that consider workplace practices and health and safety matters. These include employees from across the organisations.

Each DHB has a zero tolerance policy with regard to bullying and harassment. The DHBs are currently consulting with staff and unions on a new bullying, harassment, and victimisation prevention policy and code of conduct that will operate across the sub-region. They are also consulting on how these should be implemented and it is envisaged that there will be widespread education around these policies. The Protected Disclosure Act 2000 and the individual DHBs related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation or the mechanisms covered by the Employment Relations Act 2000. Employees also have 'no questions asked' access to the employee assistance programme.

‘MODULE 6’
SERVICE CONFIGURATION

6.1 SERVICE COVERAGE

All DHBs are required to deliver a minimum of services, as defined by the Service Coverage Schedule (SCS). DHBs deliver services in two ways – either by providing a service, or by paying other agencies to deliver it. The volume of service delivery is determined by a number of factors, including; the Minister’s and Ministry’s expectations; national and best practice guidelines; health needs assessments at a local level; and, population profiles. We plan to deliver services in a way that is Better, Sooner, More Convenient for the benefit our community as a whole. We have not identified any significant service coverage issues for 2015/16.

We have on-going challenges in service provision in the Wairarapa. A major issue has been and will remain the attraction of fulltime vocationally registered medical staff. ‘Gaps’ are filled with locum personnel and this is expensive and lacks continuity. Working in partnership with our neighbours is planned to remedy this yet progress remains slow. Service provision will evolve with services being respectful of both the requirement of the different populations and the concept of true partnership.

6.2 SERVICE CHANGE

Changes to services are always carefully considered, not only for the benefits they can bring, but also the impact they might have on other stakeholders. All service changes with likely material impacts must be signalled to the Ministry of Health for an opinion about whether or not they can, or should, be actioned. If the impact is significant, consultation with key stakeholders, including our community, may be required before Ministerial approval is given.

The table below describes the changes to our services that have been proposed for implementation in 2015/16; however, it has yet to be determined that there is a proven need for all changes to take place - should the DHB consider in due course that a change is warranted, a formal service change process as outlined under the Operating Policy Framework (OPF) will be followed to ensure service coverage and the Minister’s and the Ministry’s requirements are met.

	Capital & Coast DHB Proposed Change	Description	Benefits
6.2.1	Needs Assessment & Service Coordination (NASC) programme; Home Based Support Services(HBSS)	Current contracts are due for retendering according to Government Procurement Guidelines and procurement best practise. Investigating approaches to procurement for NASC programme and HBSS with the intention of engaging providers in 2015/ 2016. The service and funding models will be developed during 2015 to inform the procurement process.	Greater alignment of NASC and HBSS with Primary Health; Increased responsiveness to acute demand pressure.
6.2.2	Mental Health & Addictions service: new sub-regional model service changes involve review of current mental health and addiction services across sub-regional space. Some new services are planned to begin from July 2015, others will require phased introduction over 2015/16.	Mental Health Acute Day Service support services: Community Day Programme (Mental Health Acute Day Service) provided in a non-hospital community setting. Adult Crisis Respite Service (including Community Based Enhanced Mental Health Recovery Service (CBEMHRS). Acute Adult model of Care across sub-region (Wairarapa, Hutt Valley, Capital & Coast). Implementation of change management plan (showing key phases and timing of changes) for an Acute Adult model of Care pathway across sub-region (within a consistent Model of Care). Older Person Wellness Planning Model of Care: Enhance the delivery and integration of specialist mental health and addiction services within primary care and health of	Improve the integrated delivery of Mental Health & Addiction Services and reduce inequalities which meet identified population need and national requirements.

	Capital & Coast DHB Proposed Change	Description	Benefits
		older people services across Hutt Valley and Capital & Coast DHBs. In particular reduce the health inequalities through improved equity of access and outcomes across the services particularly for Māori and Pacific service users.	
	A phased approach would be undertaken to purchasing through a mixed contestable and negotiation process and contestable Request for Proposal (RFP) process.	Services For Youth: Enhance the delivery and integration of specialist mental health and addiction services with PHO's and other partners for Youth through improved access to both planned and unplanned services across the sub-region (Wairarapa, Hutt Valley, Capital & Coast). Improve integration between primary and specialist services: Facilitate integrated collaboration with PHO's and other partners to reduce the physical separation between mental health and/or addiction and primary care services to improve the physical health of people with mental health and/or addiction. Alcohol and Other Drugs: Undertake a stocktake across the sub-region to identify and plan for improving on any gaps against the SDP key priority actions for Alcohol and other Drugs.	The shift is consistent with the directions for service development as set out by both the Ministry of Health's Rising to the Challenge: The Mental Health and Addictions Service Development Plan 2012-1017 (SDP) and the Mental Health Commission's Blueprint II.
6.2.3	Primary Care	Developing Health Care Homes, which will identify new Primary Care Models; integration of community health services including CNSs, District Nursing, Allied Health, and NASC, and oncology and palliative care and services relating to the rehabilitation of older people in the community. Implementing Primary Options for Acute Care (POAC) and Person-Centred Acute Community Care (PACC).	Deliver appropriate treatment in primary care settings (BSMC), through integration, health homes, and community based specialist advice; need to develop complex care management.
6.2.4	Integrated Laboratory Service	In April 2015 the Boards of the sub-regional DHBs made the decision to proceed with a fully outsourced integrated laboratory service model with Southern Community Laboratories (SCL). As part of this arrangement, SCL has set up a new company called Wellington SCL Limited (WSCL) for the delivery of integrated laboratory services for the greater Wellington region; a contract was signed in May 2015. The first stage of fitting out the new laboratory at Wellington Regional Hospital began in May, and will be completed by October 2015; the integrated laboratory service will commence 1 November 2015 under a 5 plus 5 year agreement with WSCL, delivered at the four hospital based laboratories; Wellington, Kenepuru, Hutt, and Masterton. Patient safety and quality of services will continue to be paramount with no reduction in service or quality of services under the proposed integrated laboratory model.	For patients and health professionals: – avoid unnecessary duplication of tests /patient discomfort – one consistent process for requesting tests and timeframes for getting results back – upgraded laboratories and equipment, which will improve quality including meeting key turnaround times – releasing money for reinvesting into front line services – improved access to community blood collection services for high need populations; community collection locations remain the same
6.2.5	Capital & Coast DHB	The scheme will provide a subsidy for primary care	Refocusing Capital &

	Capital & Coast DHB Proposed Change	Description	Benefits
	Primary Sexual Health - Subsidy scheme for general practice	providers who see a patient under 20 years old, when the primary reason for the visit is sexual health related. General practices, Youth One Stop Shops (YOSS), and the University Health services in the Capital & Coast DHB area can access the scheme.	Coast DHB Primary Sexual Health Subsidy scheme for general practice allows for more targeted application of resources and better value for money.

6.3 SERVICE ISSUES

No other service issues for Capital & Coast DHB identified.

‘MODULE 7’
PERFORMANCE MEASURES

The DHB monitoring framework provides a rounded view of performance using a range of markers. Four dimensions are identified reflecting DHB functions as owners, funders, and providers of health and disability services.

DIMENSIONS OF DHB PERFORMANCE	DESCRIPTION	CODE
‘Policy priorities’	Achieving Government’s priority goals/objectives and targets	**PP**
‘System Integration’	Meeting service coverage requirements and supporting sector inter-connectedness	**SI**
‘Outputs’	Purchasing the right mix and level of services within acceptable financial performance	**OP**
‘Ownership’	Providing quality services efficiently	**OS**
‘Developmental’	Establishment of baseline (no target/performance expectation set)	**DV**

PERFORMANCE MEASURE	2015/16 PERFORMANCE EXPECTATION/TARGET Capital & Coast	
POLICY PRIORITIES (PP)		
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	3.74%
	Age 20-64	3.36%
	Age 65+	1.3%
PP7: Improving mental health services using transition (discharge) planning and employment	Long-term clients	Provide report as specified
	Child and Youth with a Transition (discharge) plan	At least 95% of clients discharged will have a transition (discharge) plan.
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm	
	<= 3 weeks	80%
	<= 8 weeks	95%
	Addictions (Provider Arm and NGO)	
	<= 3 weeks	80%
	<= 8 weeks	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1	0.67
	Ratio year 2	0.67
PP11: Children caries-free at five years of age	% year 1	67%
	% year 2	69%
PP12: Utilisation of DHB funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1	85%
	% year 2	85%
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1	85%
	0-4 years - % year 2	85%
	Children not examined 0-12 years % year 1	≤15%
	Children not examined 0-12 years % year 2	≤10%
PP20: improved management for long-term conditions (LTCs) CVD, diabetes, and stroke Focus area 1:Long-term Conditions	Report on delivery of the actions and milestones identified in the Annual Plan (teleconference Q1, Q3; narrative report on progress and LTC ASH rates Q2, 4)	
Focus area 2: Diabetes Management (HbA1c)	Narrative quarterly report on DHB progress towards meeting its deliverables for Diabetes Care Improvement Packages (DCIP) identified in the 2015/16 Annual Plan. Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (teleconference report Q1, 3; narrative report on progress for diabetes, including on the proportion of people with diabetes above 64mmol/mol and update on progress towards reporting HbA1c above 80 and 100mmol/mol.)	
Focus area 3: Acute coronary syndrome services	70 % of high-risk patients will receive an angiogram within 3 days of admission. (‘Day of Admission’ being ‘Day 0’)	
	Over 95 % of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	

	Over 95 % of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge.	
	Report on delivery of the actions and milestones identified in the Annual Plan, including actions and progress in quality improvement initiatives to support the improvement of ACS indicators as reported in the ANZACS-QI.	
Focus area 4: Stroke Services	6 % of potentially eligible stroke patients thrombolysed	
	80 % of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	
	Report on delivery of the actions and milestones identified in the Annual Plan	
PP21: Immunisation coverage	IPIF Healthy Start: % of two-year olds fully immunised	95%
	% of five-year olds fully immunised	95%
	% of eligible girls received HPV vaccine dose three	65% for dose 3
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan.	
	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan.	
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan. Provide relevant financial information.	
PP25: Prime Minister's youth mental health project	Initiative 1: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities. 1) Quarterly quantitative reports on the implementation of SBHS, as per the template provided. 2) Quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.	
	Initiative 3: Youth Primary Mental Health 1) quarterly narrative progress reports with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: • early identification of mental health and/or addiction issues • better access to timely and appropriate treatment and follow up • equitable access for Māori, Pacific and low decile youth populations.	
	Initiative 5: Improve the responsiveness of primary care to youth. 1) Quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliancing arrangements. 2) quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHBs youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme.	
PP26: The Mental Health & Addiction Service Development Plan Focus Area 1:	Report on the status of quarterly milestones - for a minimum of eight actions to be completed in 2015/16 and for any actions which are in progress/on-going in 2015/16	
Focus Area 2:	Report on the status of quarterly milestones - increased access for adults to Primary Mental Health which are in progress /on-going in 2015/19	
PP27: Delivery of the Children's Action Plan	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP28: Reducing Rheumatic fever	Provide a 'progress report' against DHBs' Rheumatic Fever prevention plan; including quarterly reporting of the Case Review (actions taken and lessons learned) of each new case of Rheumatic Fever.	
	Target - new cases per 100,000	1.3
	Hospitalisation rates (per 100,000 DHB total population) for acute Rheumatic Fever	55% reduction from baseline level for 2009/10-2011/12
PP29: Improving waiting times for diagnostic services	Coronary angiography 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	
	CT and MRI 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)	
	Diagnostic colonoscopy A. 75% of people accepted for an urgent diagnostic colonoscopy will receive their	

	procedure within two weeks (14 calendar days inclusive); 100% within 30 days. B. 65% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 120 days	
	<u>Surveillance colonoscopy</u> 65% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date; 100% within 120 days	
PP30: Faster cancer treatment	A: 31-day indicator Faster Cancer Treatment	<10% of the records submitted by DHB are declined
SYSTEM INTEGRATION (SI)		
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	%
	Age 45-64	%
	Age 0-74	%
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region (the report includes local DHB actions that support delivery of regional objectives)	
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long-term exceptions, and any other gaps in service coverage	
SI4: Standardised Intervention Rates (SIRs)	major joint replacement	an intervention rate of 21.0 per 10,000 of population
	cataract procedures	an intervention rate of 27.0 per 10,000
	cardiac surgery	a target intervention rate of 6.5 per 10,000 of population
	percutaneous revascularisation	a target rate of at least 12.5 per 10,000 of population
	coronary angiography services	a target rate of at least 34.7 per 10,000 of population
SI5: Delivery of Whānau Ora	Provision of a qualitative report identifying progress within the year that shows that the DHB has delivered on its planned Whānau Ora activity and what the impact of the activity has been; and demonstrate engagement	
SI6: IPIF Healthy Adult - Cervical Screening	80% of eligible women receive cervical screening services within the last 3 years	
OWNERSHIP (OS)		
OS3: Inpatient Length of Stay	Elective LOS	1.59 days (represents 75th centile of national performance)
	Acute LOS	2.41 days
OS8: Reducing Acute Readmissions to Hospital	Total population	Improvement on baseline performance
	75 plus	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	New NHI Registration in Error (causing duplication) > 2% and ≤ 4%	
	Recording of non-specific ethnicity > 0.5% ≤ 2%	
	Update of specific ethnicity value in existing NHI record with a non-specific value > 0.5% and ≤ 2%	
Focus area 1:Improving the quality of identity data	Invalid NHI data updates causing identity confusion confirmed incorrect updates/total number of queried updates % tbc	
Focus area 2:Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to NNPAC and NMDS ≥ 97% to < 99.5 %	
	National collections file load success ≥ 98% to < 99.5 %	
	Standard versus edited diagnosis code descriptors in the NMDS ≥ 75% to < 90%	
	Timeliness of National Non-admitted Patient (NNPAC) data ≥ 95% to < 98%	
Focus area 3:Improving the quality of the programme for Integration of mental health data (PRIMHD)	PRIMHD data quality Routine audits undertaken with appropriate actions where required	
OUTPUTS (OP)		
OP1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: A: 5% variance (+/-) of planned volumes for services measured by FTE B: 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, C: actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	
DEVELOPMENTAL (DV)		
DV3: Improving consumer experience	No performance target set	

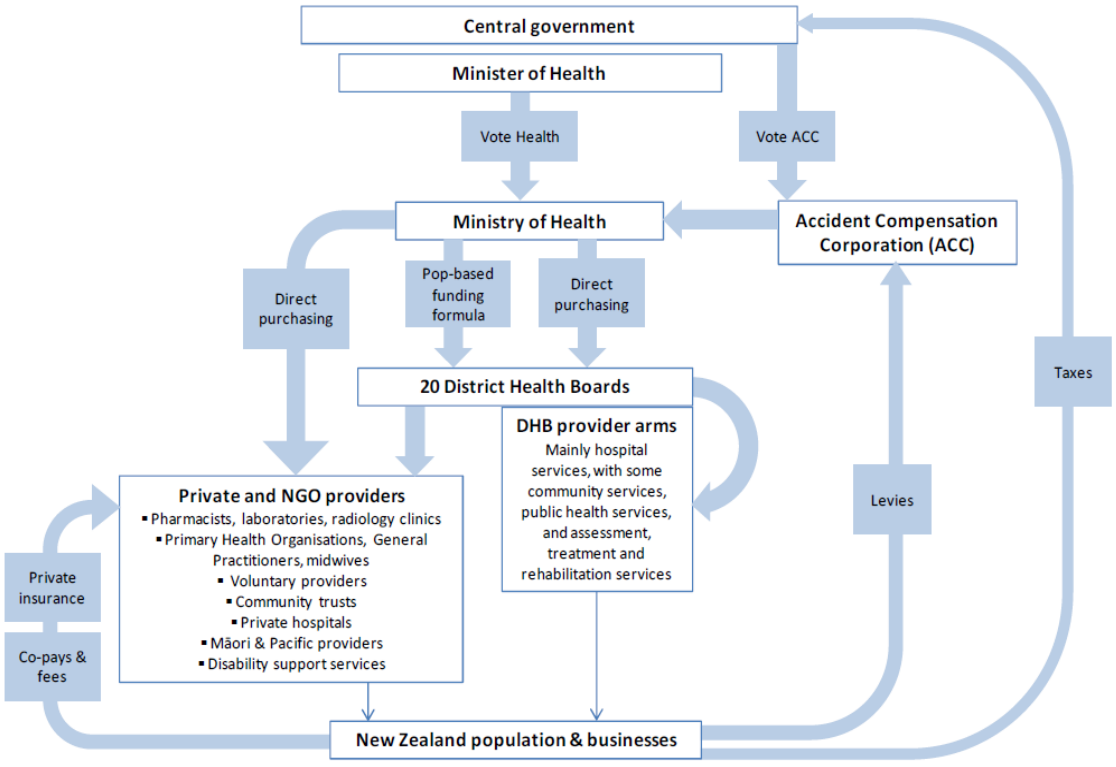
APPENDIX 1 – OBJECTIVES/ACCOUNTABILITY OF DISTRICT HEALTH BOARDS

Health services in New Zealand are provided through a network of government, nongovernment and private organisations. Total (public and private) health spending is around the OECD average both as a proportion of national income and in terms of purchasing power parity. Public funding accounts for around 83% of total health expenditure; this is relatively high by OECD standards, although not wildly so. The public health system is fairly comprehensive.

Hospital services are free, with prioritisation used to manage demand for elective services. Co-payments apply to some community services, including pharmaceuticals, general practice and some diagnostics. Certain services are not subsidised. These include optometry, orthodontics and most adult dental care.

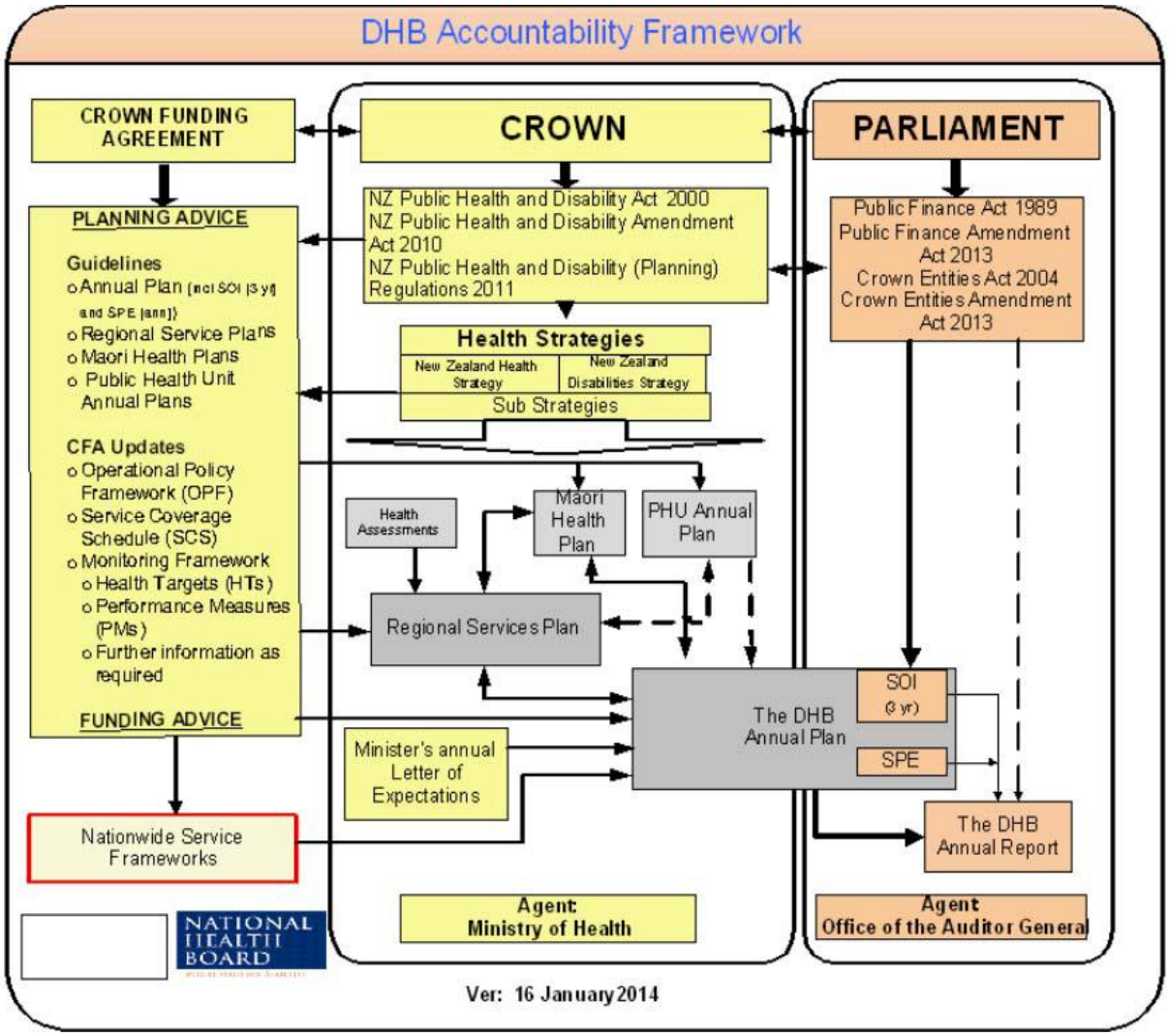
Under the New Zealand Public Health and Disability Act (2000), all District Health Boards must plan and deliver services under the following objectives:

1. To reduce health disparities by improving health outcomes for Māori and other population groups;
2. To reduce, with a view to eliminating, health outcome disparities between various population groups, by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;
3. To improve, promote, and protect the health of people and communities;
4. To improve integration of health services, especially primary and secondary health services;
5. To promote effective care or support for those in need of personal health or disability support services;
6. To promote the inclusion and participation in society and independence of people with disabilities;
7. To exhibit a sense of social responsibility by having regard to the interests of people to whom we provide, or for whom we arrange the provision of services;
8. To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services;
9. To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations;
10. To exhibit a sense of environmental responsibility by having regard to the environmental implications of our operations; and
11. To be a good employer.



Source: Ministry of Health

As a Crown Entity, Boards have overall responsibility for organisational performance and are accountable to the Minister, and through the Minister, to Parliament.



DHBs are subject to a range of formal accountability arrangements. Planning and reporting requirements are imposed under the Crown Entities Act, the New Zealand Health and Disability Act, and the Public Finance Act. The Ministry of Health sets out relatively detailed expectations of service coverage and priorities on an annual basis, with sometimes prescriptive requirements about outputs (or inputs).

APPENDIX 2 – TIRITI o WAITANGI / MĀORI HEALTH PLAN SUMMARY

Te Tiriti o Waitangi

The Treaty serves as a conceptual and consistent framework for Māori health gain across the health sector and the articles of Te Tiriti provide four domains under which Māori health priorities for the DHB can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities:

Kawanatanga (governance) Equated to health systems performance - measures that provide gauge of DHBs provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities; provides for active partnerships with manawhenua at a governance level.	***Te Ritenga*** (right to beliefs and values) Guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga.
	Oritetanga (equity) Achieving health equity, with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes, and health service utilisation.
	Tino Rangatiratanga (self-determination) Opportunities for Māori leadership, engagement, and participation in relation to DHB activities.

Our Māori Health Plan - Overview

It is well documented that the greatest disparities, in terms of life expectancy, are between ethnic groups and between populations with different socio-economic status, as measured by deprivation index. Given the inequitable rates of morbidity and mortality between the health of Māori and non-Māori, reducing disparities continues to be a key aim across the health sector with the intention of improving health outcomes for Māori and other vulnerable population groups. As such reducing the disparities that exist for Māori in the Capital & Coast district, through the achievement of better Māori health outcomes, needs to be the highest priority in order to achieve the vision of Whānau Ora, being vibrant healthy families.

National areas of focus for Māori health indicators are: data quality (accuracy of ethnicity reporting in PHO registers), PHO enrolment – access to care, ASH rates for 0 to 74 years, breast feeding rates, cardiovascular disease assessments, cancer screening, smoking cessation, influenza immunisation rates, SUDI, Rheumatic Fever, child oral health, and mental health.

Locally our DHB is also focussing on:

- respiratory health issues affecting 0 to 14 year olds
- diabetes
- Whānau Ora
- Māori Health Development
- Māori Mental Health
- Did Not Attends, and
- youth mental health

The full plan is available on our website.

APPENDIX 3 – REGIONAL PUBLIC HEALTH PLAN SUMMARY

Regional Public Health (RPH) is the Public Health Service that covers the sub-regions DHBs. It works in collaboration with Māori, Pacific peoples, communities, and providers across the health sector (primary health care in particular). Collaboration at local, sub-regional, central region and national levels is emphasised.

To focus action on more equitable health and wellbeing outcomes, RPH links with a wide range of government, non-government and community organisations, addressing barriers and enablers such as access to health care services, housing, income, employment and education.

The RPH annual business plan takes into account the Government's expectations as well as national, central region, sub-regional and local priorities. RPH contributes indirectly to many of the Government's and DHBs health targets and priorities. For example, activities to increase access to healthy food choices can over time, contribute to preventing diabetes and other long-term conditions. Of the specified Government and DHB health priorities, RPH services directly contribute to: Government health targets of Better help for Smokers to Quit and Increased Immunisation; and, Government health priorities: Reducing rheumatic fever, Children's action plan, Social sector trials (Porirua), Healthy Families NZ Lower Hutt, Equity and Māori health, Equity and Pacific peoples health, Primary care and integration, Long term conditions, Maternal and child health, and Mental health - Implementation of the New Zealand Suicide Prevention Strategy 2006-2015.

The complete RPH annual business is available at http://www.rph.org.nz

The Regional Public Health Planning Framework for 2015/16:

Vision: Equitable, sustainable and healthy futures for all

Bold Goal: Halving the rate of avoidable hospital admissions for Māori, Pacific and children by 2021

Inputs	Key principles	Core public health functions	Public health service outcomes
Health status of the population	Focusing on the health of communities rather than individuals	Health assessment and surveillance	A healthier and more productive population
Government	Influencing health determinants	Public health capacity development	Reducing health disparities, including a focus on Pacific peoples and vulnerable groups
Ministry of Health	Prioritising improvements in Māori health	Health promotion	Improving Maori health
National Health Board	Reducing health disparities, including a focus on Pacific peoples and vulnerable groups	Health protection	Increased safeguards for the public's health
District Health Boards	Basing practice on best available evidence	Preventive interventions	A reduced burden of acute and chronic disease
Service Integration and Development Unit	Building effective partnerships across the health sector and other sectors		
	Remaining responsive to new and emerging health threats		

APPENDIX 4 – GLOSSARY OF ACRONYMS

Term	Meaning
ABC	Ask about and document every person's smoking status, give Brief advice to stop to every person who smokes, and strongly encourage every person who smokes to use Cessation support (a combination of behavioural support and stop-smoking medicine) and offer to help them access it.
ACS	Acute coronary syndrome (ACS) refers to any group of symptoms attributed to obstruction of the coronary arteries.
Activity	In the context of Strategic Planning, Activities refers to the tasks, duties, projects, systems or processes that the planning entity uses to convert its Inputs (see Inputs) into Outputs (see Outputs).
ALOS	Average Length of Stay - a way of monitoring how long it takes for a particular health service to be delivered, from admission to discharge.
ALT	Alliance Leadership Team – the central decision making hub of an Alliance Contract, which provides a single flexible funding pool for doctors, nurses, pharmacists and other health professionals to pursue collaborative healthcare initiatives programmed by the Ministry of Health.
AMP	Asset Management Plan
AOD	Alcohol and Other Drugs
ARRC	Aged Related Residential Care
A/R	Wairarapa DHB Audit and Risk Committee
AT&R	Assessment, Treatment, & Rehabilitation
ASH	Ambulatory sensitive hospital admissions (ASH) are those admissions (mostly acute) that are considered by expert opinion to be potentially avoidable through interventions in out-of-hospital settings. They are an outcome indicator used to evaluate access to primary health care (e.g., GP visits).
B4SC	Before School Checks - one of the services offered under the Well Child/Tamariki Ora programme. This check occurs at age 4 to ensure any health issues that may affect learning are identified prior to the child beginning school.
BSMC	Better, Sooner, More Convenient – the Government's initiative to promote increased primary/specialist integration and collaboration. The original BSMC discussion document, produced by Minister Ryall, can be found at: http://www.national.org.nz/files/__0_0_health_lowres.pdf
CAMHS	Child & Adolescent Mental Health Services.
CAP	The Children's Action Plan (CAP) provides a high level programme framework for the Government's White Paper for Vulnerable Children (2012). It outlines a range of cross-government interventions targeting vulnerable children who are at risk of harm now or in the future
Capital & Coast DHB	Capital & Coast District Health Board. The district health board covering Wellington, Porirua and Kapiti (excluding Te Horo, Otaki and Otaki Forks Census areas) Territorial Authorities
CEO	The Chief Executive Officer (CEO) holds the highest possible delegation from a District Health Board (under the Public Health and Disability Act) for management matters relating to that DHB
CFO	Chief Financial Officer. The COO holds a delegation from the CEO, usually for matters relating to routine management of financial information services.
COO	Chief Operating Officer. The COO holds a delegation from the CEO, usually for matters relating to routine management of hospital health services (HHS).
CPHAC	Community and Public Health Advisory Committee - one of the three advisory committees that DHBs are required to establish under the NZ Public Health and Disability Act.
CPSA	District Health Boards are responsible for funding community pharmacy services to 900 community pharmacies in New Zealand through the Community Pharmacy Services Agreement (CPSA). The Pharmacy Services Advisory Group (PSAG) was set up to provide advice on operational aspects relating to the Agreement and a review group advises on any necessary changes.
CRISP	The Central Region Information Systems Plan (CRISP) is a major Information and Communication Technology (ICT) work programme within the Central Region RSP. This programme will deliver a range of clinical information systems, and includes the development of a Central Region ICT Strategy.
CTAS	Central Technical Advisory Services; responsible for facilitating production of the Central Region Regional Service Plan
CVD	Cardio Vascular Disease - a class of diseases that involve the heart or blood vessels (arteries, capillaries, and veins)
DCIP	The Diabetes Care Improvement Package (DCIP) is a community and primary care based programme, building on core diabetes services that were already being provided, to improve outcomes for people with diabetes. The package may differ between DHBs, depending on the needs in the area. DHBs may choose to deliver this through innovative nurse-led services such as practice clinics, patient group education or community outreach, which may include the up skilling of staff.
DHB	District Health Boards (DHBs) were established by the Public Health and Disability Act to pursue the Act's objectives. The Act also outlines the breadth of functions that DHBs have for the pursuit of their objectives.

DSAC	Disability Services Advisory Committee - one of the three advisory committees that DHBs are required to establish under the NZ Public Health and Disability Act
ECE	Early childhood education (also early childhood learning and early education) refers to the formal teaching of young children by people outside the family or in settings outside the home. "Early childhood" is usually defined as before the age of normal schooling.
ED	Emergency Department
EQI	The Endoscopy Quality Improvement Programme (EQI) is a workforce development programme which aims to ensure all New Zealanders receive the same high standard endoscopy care, no matter where they live in the country.
ERAS	Enhanced Recovery after Surgery (ERAS) programmes are also known as fast-track, rapid or accelerated surgery. The approach is evidence-based and involves a selected number of individual interventions that, when implemented as a group, demonstrate a greater impact on outcomes than would be the case if they were implemented individually. The underlying goal of ERAS is to enable patients to recover from surgery and leave hospital sooner, by minimising the stress responses on the body during surgery.
ESPIs	Elective Services Patient Flow Indicators - six ESPIs the Ministry of Health use to monitor the performance of DHB elective services within hospital & specialist services: 1.DHB services that appropriately acknowledge and process all patient referrals within 10 working days 2.Patients waiting longer than four months for their first specialist assessment (FSA) 3.Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT) 5.Patients given a commitment to treatment but not treated within four months 6.Patients in active review who have not received a clinical assessment within the last six months 8.The proportion of patients treated who were prioritised using nationally recognised processes or tools
ESPWP	The Elective Services Productivity and Workforce Programme (ESPWP) has been established with Cabinet approval to support and promote significant transformations in elective services productivity, and seeks proposals from DHBs to enhance elective services surgical discharges and productivity, patient outcomes, and cost effectiveness. The ESPWP supports the Government's policy of increasing average elective discharges nationally by 4000 per year, and there is a particular focus on DHBs who would need to increase their average discharges by more than 25% to meet their local demand over the next years.
FCT	The Faster Cancer Treatment (FCT) programme is part of the National Cancer Programme led by the Ministry of Health. It aims to improve the quality and timeliness of services for patients along the cancer pathway, and links with other programmes of work that will improve cancer diagnostic and treatment services.
FMIS	Finance Management Information System
GP	General Practitioner
HAC	Hospital Advisory Committees – responsible for monitoring the financial and operational performance of hospitals and related services
HBL	Health Benefits Limited. HBL is a shared services organisation set up to help DHBs deliver quality healthcare at a lower cost by working smarter and reducing duplication and administrative costs. HBL is owned by the New Zealand Government and is mandated to find ways of delivering greater quality to health delivery through more efficient processes.
HEEADSSS	The HEEADSSS assessment is a screening tool for conducting a comprehensive psychosocial history and health risk assessment with a young person. HEEADSSS also provides an ideal format for a preventive health check. It provides information about the young person's functioning in key areas of their life: H – Home E – Education & Employment E – Eating & Exercise A – Activities & Peer Relationships D – Drug Use/Cigarettes/Alcohol S – Sexuality S – Suicide and Depression S – Safety
HHS	Hospital Health Services - Health services managed and/or delivered by Hospital employees, as opposed to NGOs or community based organisations.
Hutt Valley DHB	Hutt Valley District Health Board, covering Lower and Upper Hutt Territorial Authorities.
ICC	Integrated Care Collaborative – a Capital & Coast DHB programme aimed at promoting increased integration and cooperation between primary and specialist services.
IDF	Inter-District Flow - a way of monitoring the funding exchanged between DHBs for services that are provided to each other's populations
IFHN	Integrated Family Health Network - a primary/specialist integration programme underpinning the Wairarapa DHB Tihei Wairarapa Primary Care
Inputs	Resources put into a system, or expended in its operation to achieve an output or result - in a strategic planning context this typically refers to resources within the control of the planning entity, such as funding, staff, time, rental and equipment, but can also include the contribution of other organizations in kind or in cash.
KPI	Key Performance Indicators (KPIs) refer to any essential data collection(s) required for performance monitoring. This data can be used to promote stakeholder accountability, to stimulate a desired level of performance, and to facilitate the effective exercise of routine management control. KPIs can be used to monitor the performance of specific activities, programmes, portfolios, polices or strategies.
LMC	Lead Maternity Carer - Most LMCs are midwives, though GPs and obstetricians may also carry out the role and/or work collaboratively with midwives as needed.

LTC	Long-term Conditions - The National Health Committee defines a long-term condition as any on-going, long-term or recurring condition that can have a significant impact on people's lives. Long-term conditions include diabetes, cardiovascular disease (including stroke and heart failure), cancer, asthma, chronic obstructive pulmonary disease, arthritis and musculoskeletal disease, dementia and mental health problems and disorders.
MDM	Multi-Disciplinary Meetings (MDMs) are deliberate, regular meetings either face-to-face or via videoconference at which health professionals with expertise in a range of different specialities discuss the options for patients' treatment and care prospectively. Prospective treatment and care planning involves making recommendations in real time, with an initial focus on the patient's primary treatment. MDMs facilitate a holistic approach to the treatment and care of the patient.
MHP	Māori Health Plans (MHPs) are fundamental planning, reporting and monitoring documents, which underpin the DHBs efforts to improve Māori health and reduce the disparities between Māori and non-Māori. An MHP provides a summary of a DHBs Māori population and their health needs. The plan then documents and details the interventions and actions the DHB plans to undertake to address health issues in order to achieve indicator targets set nationally, regionally and at district level.
NGO	Non-Government Organisation - any legally constituted organisation which operates independently from the government. The term is fairly generic and typically includes a wide variety of community based organisations, including charitable trusts, incorporated societies and commercial service providers.
NIR	The National Immunisation Register (NIR) is a computerised information system that has been developed to hold immunisation details of New Zealand children. The purpose of the NIR is to assist New Zealand to improve its immunisation rates. Improved immunisation coverage will offer individual protection against vaccine-preventable diseases and protection for the community against recurring epidemics.
Outputs	Outputs are the result of Activity (see Activity) - outputs specify the quality, volume and timeliness of the work, goods, or services planned or produced by the planning entity.
Outcomes	Outcomes refer to the contribution of an Activity towards some kind of change for a target population. At the highest level, the New Zealand Health Sector uses a 'Triple Aim' outcomes framework, which seeks a balance between the effects on Population Health, the Experience of Care and the Efficiency of the Healthcare System.
PBFF	Population Based Funding Formula - a method used by the Ministry of Health to determine how New Zealand's health budget ought to be distributed across DHBs.
PCI	Percutaneous Coronary Intervention (PCI), known as coronary angioplasty is a non-surgical procedure used to treat the stenotic (narrowed) coronary arteries of the heart found in coronary heart disease.
PHO	Primary health organisations (PHOs) are funded by district health boards to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO.
PPP	The PHO Performance Programme (PPP) has been developed by District Health Boards (DHBs), the Ministry of Health and the primary health care sector to support improvements in the health of people enrolled in a Primary Health Organisation (PHO). The Programme aims to: - Encourage and reward improved performance by PHOs in line with evidence-based guidelines - Measure and reward progress in reducing health inequalities by including a focus on high need populations
PSSG	Primary Secondary Strategy Group - The first meeting of the Hutt Valley Primary Secondary Strategy Group took place on 17 February 2011. This integrated hospital and community multidisciplinary group will meet monthly. Members are a mix of four hospital and five primary care clinicians, with some senior DHB clinical leaders and managers to help implement clinical decisions. The group's purpose is to improve primary and secondary integration to assist in keeping people of the Hutt Valley well and in the community.
REC	The Regional Executive Committee (REC) is the peak executive and clinical leadership committee in the Central Region Leadership Framework, reporting through to the regional CEOs. It comprises senior management and clinical representatives and consumer representation from across the region and its objective is to ensure that the region takes a co-ordinated approach to planning and delivery.
RGG	Regional Governance Group - All six DHBs within the Central Region have given support to new Regional Governance Arrangements, including the establishment of a Regional Governance Group. This will include the development of a set of principles to guide decisions of the Central Region's regional governance group, including in those principles the principle that the outcome of decisions of that group must not increase inequalities. The new Regional Governance Group is to hold its inaugural meeting in March. One of the Group's first tasks will be to review its terms of reference and re-submit these to the six shareholder boards for approval. Another task is to determine the board composition for TAS.
RSP	Regional Services Plan - since the New Zealand Public Health and Disability Amendment Act was passed in 2010, each DHB region in the country jointly prepares an RSP, which describes in detail how DHBs in the region will plan and work together on a regional basis. The plans are designed to support vulnerable services, give everyone better access to health services, link to the National Health Targets and improve health across the whole region
SBHS	The School Based Health Services (SBHS) programme receives funding from the government for 38,000 young people in all decile 1 and 2 secondary schools, alternative education and teen parent units. However, over the next four years, extra nurses will be embedded in all decile 3 secondary schools, expanding the nurse-led School Based Health Service (SBHS) to a further 18,000 potentially at-risk young people as part of the Prime Minister's Youth Mental Health Project.
SDP	Rising to the Challenge: The Mental Health and Addiction Service Development Plan (SDP) 2012–2017 sets out the Government's vision to guide the mental health and addiction sector, as well as clear direction to planners, funders and providers of mental health and addiction services on Government priority areas for service development over the next five years. The Plan focuses on four key areas: - making better use of resources

	- improving integration between primary and secondary services - cementing and building on gains for people with high needs - delivering increased access for all age groups (with a focus on infants, children and youth, older people and adults with common mental health and addiction disorders such as anxiety and depression
SIDU	The Service Integration and Development Unit - the establishment of SIDU in 2012 amalgamated the Planning and Funding functions of the Wairarapa, Hutt Valley, and Capital & Coast District Health Boards under a single sub-regional directorate.
SRCLG	The Sub-Regional Clinical Leadership Group (SRCLG) is led by clinicians from the Wairarapa, Hutt Valley and Capital & Coast District Health Boards, and has developed a significant work programme to develop services across the sub region. This work programme is identified as the '3D' or 3 DHB Health Services Development programme.
TAs	Territorial Authorities – Territorial Authorities are the second tier of local government in New Zealand, below regional councils. There are 67 territorial authorities: 13 city councils, 53 district councils, and the Chatham Islands Council.
TAVI	Transcatheter Aortic Valve Implantation - Catheter insertion of a new aortic valve to treat aortic stenosis. Aortic stenosis occurs when the aortic valve, which separates the main pumping chamber of the heart from the circulation, becomes partially narrowed. This reduces the flow of blood out of the heart. Transcatheter aortic valve implantation may be an alternative to surgical valve replacement in patients for whom conventional aortic valve replacement is not suitable, or who at very high risk.
WCTO	Well Child/Tamariki Ora (WCTO) is a free service that is offered to all New Zealand children from birth to five years. - Eight checks between 4-6 weeks of age to 4-4.5 years - B4 School Check at 4-4.5 years, including free eyesight and hearing test - a free Well Child/Tamariki Ora Health Book, with information for parents on protecting and improving their child's health and development.
Wairarapa DHB	Wairarapa District Health Board, covering Carterton, Masterton, and South Wairarapa Territorial Authorities
YOSS	Youth One Stop Shops (YOSS) provide a range of accessible, youth-friendly health and social services at little or no cost to young people, including primary health care, sexual and reproductive health, family planning and mental health services. The majority of clients are aged between 15 and 24 years.

Annual Plan 2015-16 & Statement of Intent 2015-19

Pursuant to Section 38 of the New Zealand Public Health and Disability Act 2000; Section 139 of the Crown Entities Act 2004; Section 49 of the Crown Entities Amendment Act 2013; New CE Act s149C.