Board Meeting papers for 30 March 2016

HAWKE'S BAY District Health Board Whakawāteatia	**DRAFT Hawke's Bay District Health Board Annual Plan 2016/17** 21
	HBDHB Board
Document Owner: Document Author(s):	Tim Evans, GM Planning Informatics and Finance Carina Burgess, Acting Head of Planning
Reviewed by:	Executive Management Team, HB Clinical Council, Consumer Council and MRB
Month:	March, 2016
Consideration:	For Information

RECOMMENDATION

That the Board

- The draft contents, timeline and process for the Hawke's Bay DHB Annual Plan 2016/17 and provide any feedback to Carina Burgess.

16

OVERVIEW

The first draft of the Hawke's Bay DHB Annual Plan is currently under development and is due to the Ministry of Health by 31st March.

It is important to note that the draft that is under development and the final guidance was only received from the Ministry of Health (MoH) on 26th Februray. We are also awaiting the final NZ health strategy's release as this will have an impact on the content of the plan.

The draft is being shared at this stage to gather any feedback as it develops.

Timeline

EMT	23rd February
MoH Planning Guidance & NZ Health Strategy finalised	26th February
MRB	9th March
Clinical Council	9th March
Consumer Council	10th March
Board	30th March
Ministry of Health	31st March

Process

The Minister has asked for a refreshed Statement of Intent (SOI) in this year's Annual Plan. The SOI was refreshed last year to incorporate Transform and Sustain. The refresh will focus on incorporating the NZ Health Strategy themes and how we measure the implementation and impact of Transform and Sustain.

Strategic Services, the PHO, Māori Health, Population Health and Health Services are working closely to develop this plan. Each section in Module 2B: Delivering on Priorities and Targets, has a

small working group who are responsible for agreeing actions, leads and timeframes which will lead to better ownership of reporting going forward. Due to conflicting priorities and the late release of guidance from the MoH, not all of these groups have been able to meet but they are all scheduled to occur within the next two weeks. Activities are still being reviewed by management so are subject to change before submission to the MoH.

Changes to the Annual Plan since 2015/16

All priorities in the plan have been reviewed in the working groups and are being sent out for agreement by wider stakeholders.

New or increased focus areas:

- Reducing childhood obesity has been introduced as a National Health Target
- Reducing Unintended Teenage Pregnancy is a National Priority
- The focus for Stroke has extended to cover timely transfer to inpatient rehabilitation
- Increased emphasis on plans to shift services into the community e.g. Health and Social Care networks, District nursing, engAGE, Pharmacy Facilitators etc.

Less focus:

- More Heart and Diabetes checks is no longer a health target but remains a priority
- Nationally there is less focus on child and maternal health activity such as antenatal education and LMC enrolment. However, these remain as activities relating to outcomes such as increasing breastfeeding rates and reducing SUDI in our Annual Plan.

Local Maori Health Priorities:

- Māori Workforce
- Obesity
- Alcohol and other drugs – NEW

ATTACHMENT

Hawke's Bay District Health Board Annual Plan 2016/17 **Draft v1.1**

Hawke's Bay District Health Board

Annual Plan 2016/17

Draft v1.1

OUR VISION

"HEALTHY HAWKE'S BAY"

"TE HAUORA O TE MATAU-A-MAUI"

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

OUR VALUES / BEHAVIOURS

TAUWHIRO

Delivering high quality care to patients and consumers

RARANGA TE TIRA

Working together in partnership across the community

HE KAUANUANU

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

AKINA

Continuously improving everything we do

Hawke's Bay District Health Board
Annual Plan 2016/17

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CONTENTS

STATEMENT FROM THE CHAIR AND CHIEF EXECUTIVE

X _____	**X** _____	**X**_____
Dr Kevin Snee	Kevin Atkinson	Hon. Dr Jonathan Coleman
Chief Executive - Hawke's Bay District Health Board	Board Chair – Hawke's Bay District Health Board	Minister of Health

LETTER OF SUPPORT FROM THE PRIMARY HEALTHCARE ORGANISATION

X _____

Liz Stockley

Chief Executive

Health Hawke's Bay - Te Oranga Hawke's Bay

1 INTRODUCTION & STRATEGIC INTENTIONS

1.1 Executive Summary

Hawke's Bay District Health Board (HBDHB) is a Crown Entity and is the Government's funder and provider of public health and disability services for the population in our defined district. Our vision is simple - we want everyone in Hawke's Bay district to be healthy. The funding and provision of services is guided by our statutory obligations and by priorities established at the national, regional and local levels. As an integrated health system, we rely on networks of suppliers across the spectrum of care and across New Zealand. Our organisation is the district's largest single employer making us a significant contributor to the local economy. The population of Hawke's Bay district has some unique characteristics compared to the rest of New Zealand in terms of health status and socio-demographics, and this provides us with some specific challenges.

Locally, we are guided by a health-sector strategic framework and our five year strategic programme - Transform and Sustain, which was launched in December 2013. Our three priority goals for Transform and Sustain are: responding to our population; delivering consistent high-quality care; and being more efficient at what we do. Through the programme we will contribute to the Government's priorities for the health system, which include fiscal discipline, working across government, shifting and integrating services, improving health information technology, achieving the National Health Targets, and tackling the key drivers of morbidity. The refreshed New Zealand Health Strategy will drive new initiatives and the five main themes will be embedded into everyday practice. We also work collaboratively for optimal arrangements by aligning our work to a Regional Services Plan developed on behalf of the six Central Region DHBs - Whanganui, Mid-Central, Wairarapa, Hutt Valley, Capital & Coast, and Hawke's Bay. Fiscal responsibility means that we plan for modest annual operating surpluses that enable us to invest in programmes that will deliver the necessary transformational change for ongoing quality improvement.

Our Statement of Intent outlines our strategic intentions for the next four years and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes. The health system outcomes are defined by the Ministry of Health as New Zealanders living longer, healthier and more independent lives, and a cost effective health system supporting a productive economy. Over time, we will measure progress towards our vision by considering patient and whānau experiences of care, resource sustainability and life expectancy gap as headline system outcomes plus a suite of eighteen key supporting dimensions that will be evidence of impact.

Targets for service performance standards for the 2016/17 year and are set out in the Statement of Performance Expectations grouped according to four reportable classes of outputs: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and Rehabilitation and Support Services. A set of financial statements for the 2015 to 2019 period is also included. Actual results will be audited against those forecasts by Audit New Zealand after the end of each financial year.

X_____

Board Member

X_____

Board Member

1.2 Context

Hawke's Bay District Health Board (HBDHB) is one of 20 District Health Boards (DHBs) that were established by the New Zealand Public Health and Disability Act 2000 (NZPHD Act). HBDHB is the Government's funder and provider of public health services for the 160,735[1] people resident in the Hawke's Bay district. A map of the district, which is defined by the NZPHD Act is shown in Figure 1. In 2015/16, HBDHB's allocation of public ealth funds will be $482 million, including 3.96%[2] of the total health funding that the Government allocates directly to all DHBs.

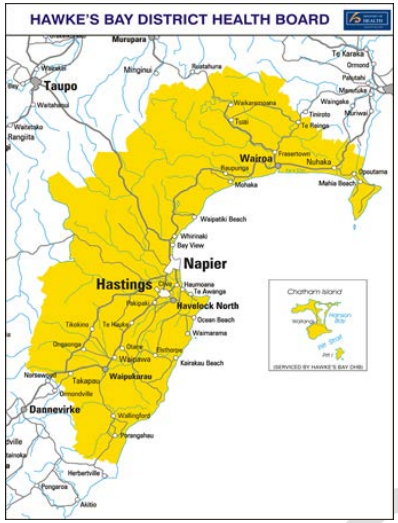

Figure 1: Hawke's Bay District Health Board District

Our objectives[3] are to improve, promote and protect the health, well-being and independence of our population and to ensure effective and efficient care of people in need of health services or disability support services. To achieve this, HBDHB works with consumers, stakeholder communities and other health and disability organisations to plan and coordinate activities, develop collaborative and cooperative arrangements, monitor and report on health status and health system performance, participate in training of the health workforce, foster health promotion and disease prevention, promote reduction of adverse social and environmental effects, and ensure provision of health and disability services.

[1] Estimated by Statistics New Zealand based on assumptions specified by Ministry of Health
[2] HBDHB share has increased from 3.89% in 2014/15.
[3] DHB performance objectives are specified in section 22 of the NZPHD Act.

Funding and Provision of Services

Each DHB has a statutory responsibility for the health outcomes of its district population as well as an objective under law to seek optimum arrangements for the most effective and efficient delivery of health services. This requires the health system to be integrated at local, regional and national levels.

As a funder, HBDHB buys health and disability services from various organisations right across New Zealand for the benefit of our population.

We fund and work very closely with Health Hawke's Bay – Te Oranga Hawke's Bay Primary Healthcare Organisation (the PHO) who coordinate and support primary health care services across the district. The PHO brings together General Practitioners (GPs), Nurses and other health professionals in the community to serve the needs of their enrolled populations. Other organisations we fund may be community-based private entities, such as residential care providers or individual pharmacists, or may be public entities, such as other DHBs. In 2015/16 we will fund over $222 million worth of services from other providers. 76.5% (2014/15 75%) of those services will be from primary care and private providers mostly based in Hawke's Bay communities and the other 23.4% will be from other DHBs for more specialised care than is provided locally. The local component is projected to grow by $8.4 million.

As a provider, we supply health and disability programmes and services for the benefit of our population and on referral for other DHBs' patients. This includes a full range of services from prevention through to end-of-life care that are provided through resources owned or employed directly by us. Where we cannot provide the necessary level of care locally, we refer patients to other DHBs and larger centres with more specialised capability.

Because population numbers are too small to justify a full range of service provision in every district, each DHB is also part of a regional grouping that is coordinated to optimise service delivery. HBDHB is part of the Central Region along with Whanganui, Mid-Central (Manawatu), Capital and Coast (Wellington & Kapiti), Hutt Valley and Wairarapa DHBs. There are approximately 884,000 people living in the Central Region - around 19% of the total New Zealand population.

Despite this larger grouping, a small number of specialised services cannot be efficiently provided even at the regional level and these are, therefore, arranged as national services

located at one or two provider hospitals for the whole of New Zealand. Examples are clinical genetics and paediatric cardiology. These services are planned and funded centrally by the National Health Board with all DHBs having access.

Organisational Overview

With over 2,800 employees, HBDHB is the district's largest employer. Our provider arm is known as Health Services and our frontline services are delivered to patients and consumers across the district in a number of settings. For example, we provide public health programmes in schools and community centres, inpatient and outpatient services in leased and owned health facilities, and mobile nursing services in people's homes. The main health facilities include Hawke's Bay Fallen Soldier's Memorial Hospital, Wairoa Hospital and Health Centre, Napier Health Centre and Central Hawke's Bay Health Centre. In addition, we have significant investment in clinical equipment, information technology and other (non-clinical) moveable assets. Corporate and clinical support services are located appropriately to provide effective back-up to our frontline services.

Our organisation is governed by a Board with eleven members, seven of whom are elected every three years (last election in 2013) and four of whom are appointed by the Minister of Health. The Board is advised by four committees that include clinical, community and consumer representation. The Board employs the Chief Executive Officer to lead an executive management team, who oversee the day-to-day operations of the organisation.

Icons made by Freepik from www.flaticon.com

Our population

In 2016/17, the Hawke's Bay district population will grow slightly to over 159,000 people. Most of our population live in Napier or Hastings - two cities located within 20 kilometres of each other that together account for more than 80% of the total numbers. About 10% of the population live in or close to Wairoa or Waipukurau, which are relatively concentrated rural settlements, and the remaining 10% live in rural and remote locations.

Compared to New Zealand averages, there are some important differences in the makeup of our population – we have a higher proportion of Māori (26% vs 16%), more people aged over 65 years (18% vs 15%) and more people living in areas with relatively high material deprivation (28% vs 20%). The 2013 New Zealand Index of Deprivation (NZDep13)[4] explains how relative deprivation, as one measure of socio-economic status, is an indication of disadvantage in terms of people's opportunity to access and use the health system.

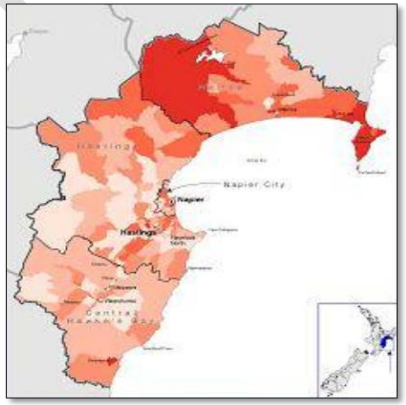

Figure 2: Hawke's Bay District relative deprivation – Darker colour higher deprivation, and lighter colour, lower deprivation

Figure 2, shows the pattern across Hawke's Bay DHB according to NZDep2006 – this is not expected to be markedly different to NZDep2013.

[4] NZDep2013 is a measure of the average level of deprivation of people living in an area at a particular point in time relative to the whole of New Zealand. The 2013 index was based on nine variables: - 2 related to income plus home ownership, family support, employment status, qualifications, living space, communications, transport. Result quoted is based on mesh-block data.

Health Status

In 2014 we produced the Health Equity in Hawke's Bay report, an analysis and report on health status in Hawke's Bay[5]. The main focus of the report was on equity because health inequities are differences in health status that are avoidable or preventable and therefore unfair.

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

Key findings:

- *More deaths at younger ages:* More Māori, more Pasifika and more people living in the most deprived parts of Hawke's Bay are dying at younger ages
- *Socioeconomic conditions:* Social inequity in Hawke's Bay is widening. The health impacts on children are more immediate and rates of admission to hospital for 0-14 year olds for conditions known to be strongly linked to social conditions are increasing, particularly for Pasifika and Māori children
- *Tobacco use:* The leading cause of avoidable deaths amongst Māori women is now lung cancer. High smoking rates amongst pregnant Māori women is a significant health issue.
- *Obesity:* One in three adults in Hawke's Bay is obese. Hawke's Bay men and women are less active in all age groups than their New Zealand average counterparts
- *Alcohol use:* One in every four adults in Hawke's Bay is likely to be harming their own health or causing harm to others through their alcohol use.
- *Access to primary care:* High self-reported unmet need and higher rates of avoidable hospital admissions, especially amongst 45-64 year olds, show that there continue to be access issues to primary care.

The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community. Since release, the findings of the report have been widely shared. The level of interest has been very positive and has led to the Hawke's Bay Intersectoral Forum[6] taking a role in putting together an action plan, with nominated sector leads, to address priority areas. This multi-agency approach aims to bring a full range of relevant providers together with public, philanthropic and private funders to implement novel opportunities to integrate efforts that will address inequity as a community.

The full Health Equity Report can be accessed from our website: www.hawkesbay.health.nz. Health status reviews rely on up-to-date population information and HBDHB conducts periodic updates with full reviews following the release of Census data. The next full review is likely to be conducted following the 2018 Census.

[5] Health Equity in Hawke's Bay, Hawke's Bay District Health Board. 2014. Available from www.Hawke'sbay.health.nz

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

1.3 Strategic Intentions

Integrating the funding and provision of health and disability services across national, regional and local levels necessitates alignment of strategic direction in the same manner.

National

The driving goals for Government and the State Sector are that New Zealanders have greater opportunities, enjoy greater security, and experience greater prosperity. The health system contributes to these goals by working towards New Zealanders living longer, healthier and more independent lives, and by supporting New Zealand's economic growth.

Government's priorities for the health system are communicated to all DHBs through the Minister of Health's annual "Letter of Expectations"[7]. For 2016/17 the Government's investment of an extra $3 billion in health over the past seven years is highlighted alongside a requirement that DHBs operate within allocated funding and drive efficiency in back-office processes and collaboration at national, regional and sub-regional levels. The Minister also expressed expectations regarding working across government, shifting and integrating services, improving health information technology, achieving the National Health Targets, and tackling the key drivers of morbidity.

The refreshed New Zealand Health strategy sets a clear strategic direction for the sector which DHBs will follow to ensure all New Zealanders live well, stay well and get well. The focus for the sector is based on five themes: People Powered, Closer to Home, Value and High Performance, One Team and Smart System.

There is an ongoing focus on the Better Public Services initiatives and the national health targets with a particular emphasis on reducing the incidence of obesity in New Zealand.

Regional:

A Regional Services Plan (RSP)[8] has been developed by the six central region DHBs to provide an overall framework for future planning around optimum arrangements and regionalisation. The RSP focuses on short to medium-term coordination of regional programmes, integration of vulnerable services and financial sustainability. AWAITING RSP DRAFT

Local

In 2013, we published Transform & Sustain[9], our strategic plan for 2014 – 2018. Transform & Sustain provides common understanding of our direction and began with sector-wide agreement on a common vision:

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

Underpinning that vision are values, principles, aims, goals and strategies that are summarised in our Strategic Framework in Appendix 1.

The logic that links the impact of our work locally to local, regional and national strategic intentions is shown in Figure 3 below.

[7] Minister of Health's Letter of Expectations, December 22nd 2015.

[8] Regional Services Plan 2016-2017, Central Region District Health Boards, 2015. Available from www.centraltas.co.nz

[9] Available from our website: www.hawkebay.health.nz

Figure 3: Connecting local activity to local, regional and national objectives

Our Challenges

Hawke's Bay DHB has made significant progress in the recent past. However, we continue to be challenged by ongoing issues, such as the growth in chronic illness, our ageing population and vulnerability in a large proportion of our community. Despite population growth[10] being modest, at about 2.7% in the next 10 years, we will see significant changes in age groups. In our population, the over 65s will grow by 16% and the over 85s will increase by 12%. The same age group of Māori and Pasifika people will grow even faster at 51% and 106% respectively.

Maori and Pasifika	2016	2025	Growth
0-14	15,770	16,450	4.3%
15-64	28,220	30,790	9.1%
65yrs +	3,010	4,550	51.2%
85 yrs +	160	330	106.3%

Total	2016	2025	Growth
0-14	34,150	33,170	-2.9%
15-64	97,960	96,070	-1.9%
65yrs +	29,190	33,960	16.3%
85 yrs +	3,480	3,930	12.9%

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

These projected population changes emphasise the need for HBDHB to maintain our focus on improving Māori and Pasifika health and to reorient our services to address and manage age-related health issues.

Risk and Opportunity

The health of our population can be described using the diagram in Figure 4, where everyone in the population fits within one of these categories.

Our focus will be to keep people healthyand well to require less hospital care.

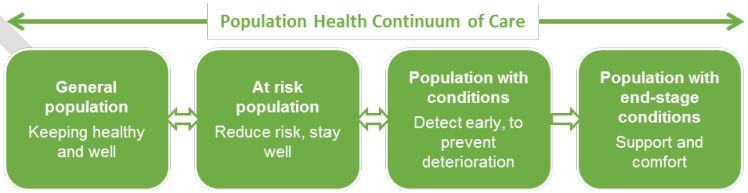

Figure 4: Population Health Continuum of Care

An increasing burden of long-term conditions is a worldwide issue as modern medicine reduces early death. This is particularly so in places with demographics like Hawke's Bay – an ageing population with areas of significant deprivation and vulnerability. New Zealand research shows that, generally, Māori develop ageing conditions about 10 years younger than non-Māori.

[10] Statistics New Zealand, Projections prepared for Ministry of Health, October 2014.

Therefore, due to age-related and other long-term conditions, we need to concentrate on three main themes:

1. Helping people to stay healthy and well and able to live independently in their own home for longer

2. Ensuring that people who have complex long-term illnesses are able to live to their full potential

3. Supporting frail elderly people and their families/whānau.so that they can put in place a better plan for how they want to be cared for as the end of their life approaches (advance care planning).

This needs to be done in an integrated and coordinated way, meaning that all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required. At the same time, by better understanding the changing needs and challenges of our ageing population and their inevitable frailty and dependency towards the end of a long life, we need to put in place better services designed to support the elderly and the changing needs of our population.

In Transform and Sustain, we have summarise these challenges into three priority goals:

- Responding to our population
- Delivering consistent high-quality health care
- Being more efficient at what we do

At the same time it is imperative that we remain financially robust so we are in a position to invest in programmes that will deliver transformational change.

Our Strategic Response

Considering the duties placed on us by the Treaty of Waitangi, the NZPHD Act and the national, regional and local context outlined above, HBDHB will prioritise our funding and provision of health and disability services based on our three priority goals.

Priority Goal 1: Responding to our Population

We have been too focused on the hospital when we could have been taking health services into the community. We have made progress in recent years but it has been slow, and there is still too much focus on meeting demand through secondary (hospital-based) care. We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting.

Barriers to accessing health care can occur for a number of reasons. For example, a person may be unable to get an appointment soon enough, may not have enough money to pay for an appointment at a medical centre or may not have the transport to get there. Often the services appear to be designed to suit the needs of professionals rather than patients. Our health workforce needs to have a good understanding of the people they serve; we need to have a stronger engagement with consumers. In particular, there are two main areas where we need to focus our attention.

Firstly, we must take action in regards to how we respond to the changing needs of our ageing population. We will focus on three responses:

Recognising that many older people are well, we will develop opportunities for them to contribute valuable consumer support and advice to the care system

We will provide care for our older people in their community with a clear intent to implement key care pathways and integrate service provision across primary and secondary settings

Aiming to begin earlier conversations about care towards the end of life, we will lead open and honest conversations with people and whānau about decisions that affect them. By doing so, we will get a better understanding of what matters to the person and their whānau during this time and will be able to focus on supportive care that is the most appropriate for them.

Secondly, the growing Māori and Pasifika population and the persistent inequities that we see in terms of their health outcomes, means that we have to find better ways of engaging with whānau. We will:

Create better working relationships that influence Māori and Pasifika health and well-being, acknowledging the formal and informal roles that community-based entities can bring to a

partnership. These include iwi, hapū, Treaty settlement entities, Māori providers, individual marae, Pasifika community churches and key Government agencies

Provide good cultural responsiveness training based on advice and support from experts in Māori and Pasifika cultural practices. We will ensure that the health system workforce is well prepared and responsive and that resource allocation and service monitoring are informed through effective engagement, especially with Māori

Work towards having a workforce that is more representative of our community. We have targeted a 10% year-on-year increase in the proportion of Māori staff employed and will focus on culturally appropriate recruitment across the system.

Priority Goal 2: Delivering Consistent High Quality Care

We generally deliver care to a high standard and we have seen some significant improvements in recent years. However, there are still too many examples where patient experience is inadequate and where mistakes that cause harm are made. Delivering high-quality care is about making sure we use all our resources in the best way, with the patients and their family/ whānau at the centre of that care. The best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible and without error or undue waiting. Every staff member should be aware of their own responsibilities in quality improvement and safety when delivering day-to-day care. Clinicians are not only responsible for the provision of high-quality patient care, their leadership is also important. Clinical participation in the leadership and governance of health services is essential for creating a culture of effective quality and safety.

Priority Goal 3: Being More Efficient at What We Do

The future will not look the same as the present and that future will require different ways of working to deliver more productive services. Reducing waste in health will make us more efficient and will ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time. The current systems do not effectively incentivise health providers to be responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.

We know that the whole public sector in New Zealand is facing a reduced growth in funding while, at the same time, the health system must deal with increasing expectations and changing needs. Transformation will rely on better understanding of value, smarter use of resources and frank communication among all stakeholders – this includes a clear responsibility on the population to take care of themselves (where they are able), and on providers to respond to reasonable expectations and true needs.

Achieving Regular Financial Surpluses

The DHB is responsible for most of the Government's spending on health in Hawke's Bay – surpluses are planned and must be delivered according to statutory obligations. This will allow us to invest in our infrastructure and services. Over the past four years, through hard work and good management, we have managed to generate an additional investment in our infrastructure with $34 million capital investment planned over the next three years.

Where to Next?

We are stepping up to deliver on our vision through Transform and Sustain. We must continue to recognise and research our population needs, work in partnership for quality health care and become more efficient at what we do. Transformation is happening and remains necessary to move forward in these areas.

The most effective way we can respond to these challenges is by transforming our services by improving quality. Transformation must lead to increased effectiveness – a more efficient system that maximises value for the population and reduces waste.

Financial sustainability is more likely to follow from an effective transformational change programme, where we work with our community so that our services meet their needs. Over time, through that transformation, achieving financial surplus will become business as usual.

How we will Assess Performance

The National Health Board monitors DHB performance on behalf of the Minister of Health. Financial and non-financial performance frameworks are in place as part of wider accountability arrangements providing assurance to the Minister about DHB performance in terms of the legislative requirements and Government priorities. In addition, HBHDB has implemented a performance monitoring process that is closely aligned to the national frameworks and that is used to generate a monthly report so that our Board can assess

and query progress against performance objectives set out in our Annual Plan and Statement of Performance Expectations.

Measuring Progress towards Our Vision

The implementation of Transform and sustain is monitored through a programme of work which is reported monthly. The programme focusses on the 11 key intentions that will support us to address our challenges. These are:

- **Transforming our engagement with Māori**
- **Transforming patient involvement**
- **Transforming health promotion and health literacy**
- **Transforming multi-agency working**
- **Transforming clinical quality through clinical governance**
- **Transforming patient experience through better clinical pathways**
- **Transforming through integration of rural services**
- **Transforming primary health care**
- **Transforming urgent care**
- **Transforming out-of-hours hospital inpatient care**
- **Transforming business models**

Figure 5 gives a good overview of the implementation of Transform and Sustain

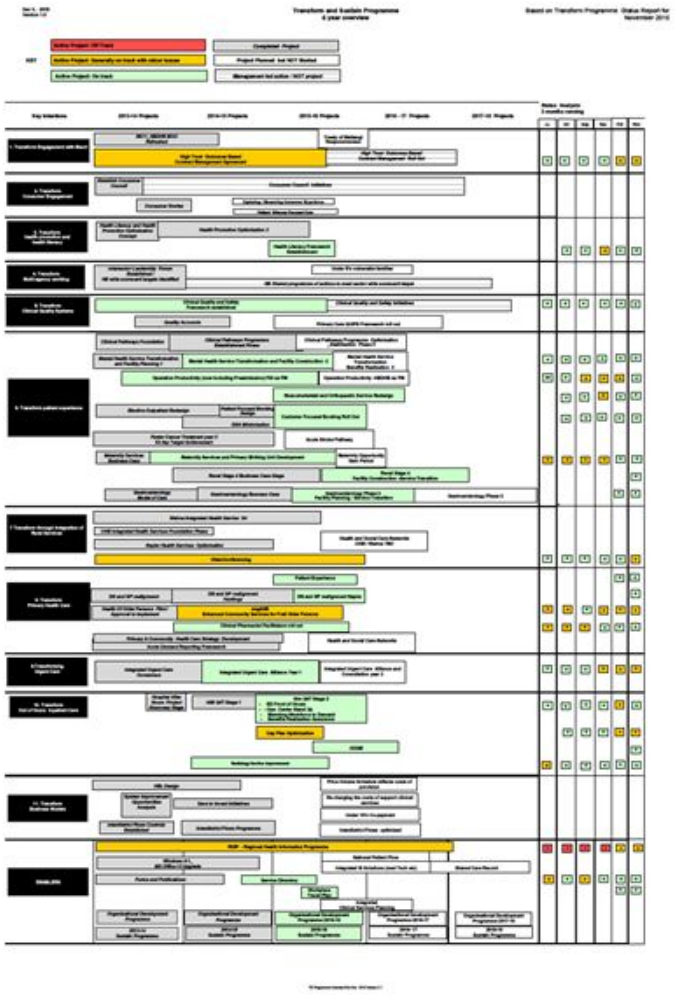

Figure 5: Transform and Sustain Programme Overview

DEVELOPING A BETTER PICTURE OF THIS

To measure the impact of Transform and Sustain we have developed the Hawke's Bay Health Sector performance and reporting framework (figure 6). Our "Vital Signs" represent the outcomes that we expect to see improving over the longer term. We measure the intended outcomes of our work as changes over time and we recognise that the health sector is not solely responsible for achieving them. However, they are all measurable and are aligned to Transform and Sustain objectives as well as NZ Triple Aim dimensions of quality improvement.

Beneath the "Vital Signs" we have a suite of indicators that make up "Supporting Dimensions" – these show the impact of health sector work contributing to the outcomes that we seek.

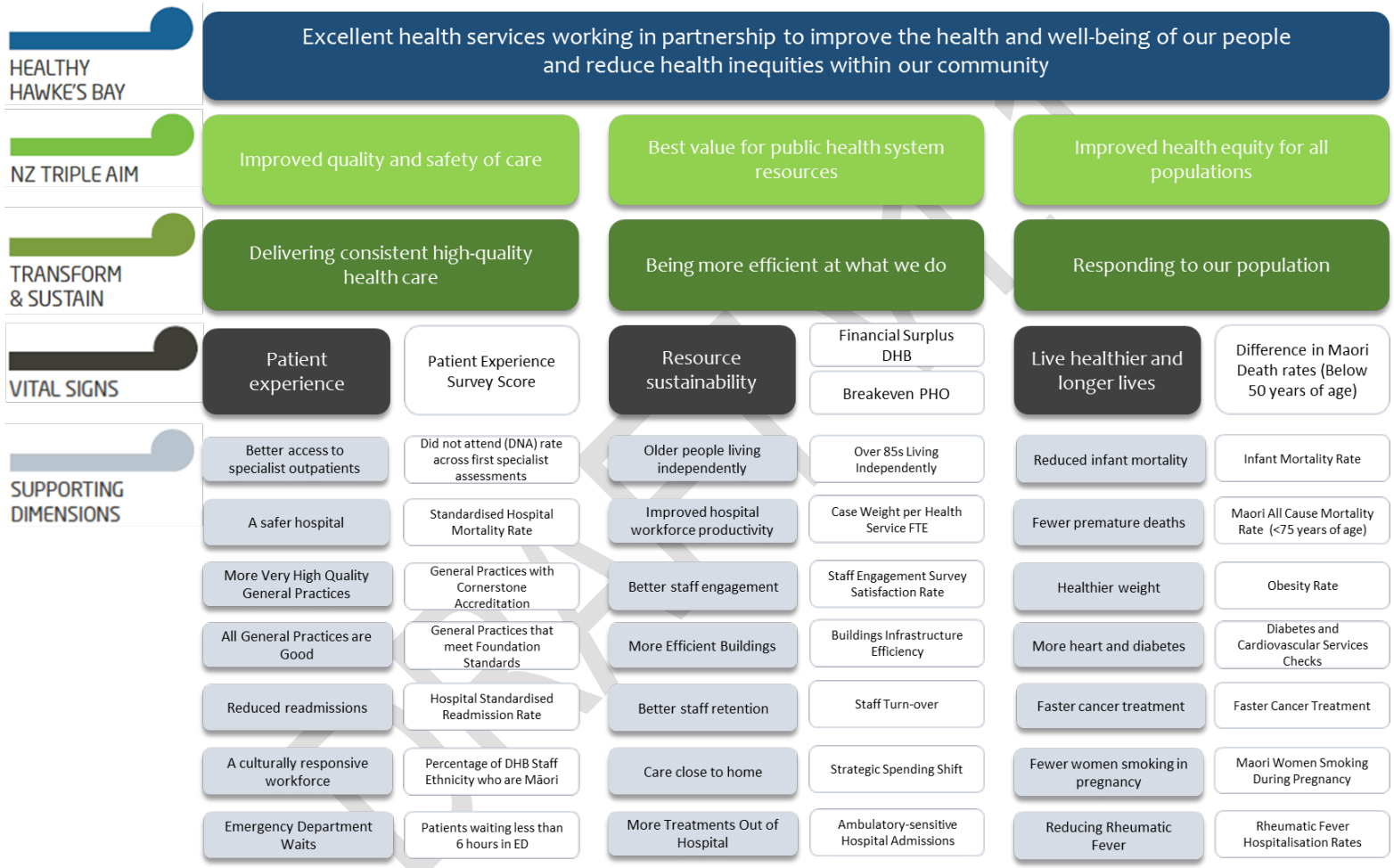

Figure 6: The Hawke's Bay Health Sector Performance Framework

2 MODULE 2

2.1 Implementation of the New Zealand Health Strategy

ONCE FINALISED VERSION OF NZ HEALTH STRATEGY RELEASED – This section will contain tangible, measurable and timebound actions to deliver the relevant roadmap actions from the NZ Health Strategy personalised to HBDHB.

Expected to put a table to cross reference to where there will be more detail of actions in the plan.

People Powered

This theme reflects the Government's priority of delivering 'better public services' and the opportunity to achieve this through more people-centred approaches to health services. A people-powered system will involve people not only as users of health services but also as partners in health care. It will support and equip all New Zealanders to be informed about and **involved** in their own health.

In order to acieve this, people need access to reliable, digestable information and provide feedback regarding health services. The system should be codesigned at every stage from planning to evaluation.

- Developing understanding of users of health services.
- Partnering with them to design services.
- Encouraging and empowering people to be more involved in their health.
- Supporting people's navigation of the health system.

Closer to Home

Most people, given the choice, would prefer to receive care and support in their home or community. Although there is a need for a hospital, the focus should be on shifting services out of specialist services and into the local communities.

Shifting services closer to home requires true collaboration both within the health sector and intersectoral. We need to work together more effectively to support children, families and whānau, particularly those at risk of poor health or social outcomes. The focus should be on prevention, early intervention, rehabilitation and wellness.

- Providing health services closer to home.
- More integrated health services, including better connection with wider public services.
- An investment early in life.
- A focus on the prevention and management of chronic and long-term conditions.

Value and High Performance

We need to make better use of our funding, better directing it to where the needs and value are greatest. Services need to be configured in a way that is more clinically and financially sustainable and equitable.

Smarter and more transparent use of information is fundamental in making improvements in the performance of the system.

- The transparent use of information.
- An outcome-based approach.
- Strong performance measurement and a culture of improvement.
- An integrated operating model providing clarity of roles.
- The use of investment approaches to address complex health and social issues.

One Team

In order to move in the direction set out in the Refreshed NZ health strategy we need to work as a more integrated and cohesive system. This needs to be led across clinical, managerial and governance domains. The workforce needs to be sustainable to meet the changing population needs and new models of care which may require some upskilling and broadening of scope of practice. The workforce could be supported by developing and draeing on skills in the wider NGO and volunteer communities.

Performance and planning system should support collaboration and the futuredirection

- Operating as a team in a high-trust system.
- The best and flexible use of our health and disability workforce.
- Leadership and management training.
- Strengthening the role for people, families and whānau and communities to support health.
- More collaboration with researchers.

Smart System

Having and sharing good quality information will drive better performance in the health system and support effective work with other government agencies. We need to actively scan, evaluate and develop knowledge and innovative technologies in a New Zealand context, and apply the best of these nationally.

- The increased use of analytics and systems to improve management reporting, planning and service delivery and clinical audit.
- The availability – at the point of care – of reliable and accurate information including on-line electronic health records.
- The health system as a learning system, that continuously monitors and evaluates what it is doing, and shares it.

2.2 Delivering on Priorities and Targets

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

Performance targets and activity milestones in respect of Government priorities have been set with reference to the National Health Targets[11] and the DHB Performance Measures[12] which are detailed in Module 7. Measurement against regional priorities is discussed in the Regional Services Plan[13] (RSP) and corresponding local activity is cross-referenced in this Module. HBDHB adds to assessment of performance by setting additional targets within our Statement of Performance Expectations (Module 3). The measures contained therein will be audited and used as the basis for our Annual Report for 2016/17 and as a key input to our Quality Accounts 2016.

The Minister of Health's annual "Letter of Expectations"[14] and the National Health Board planning guidelines provide a framework for highlighting Government's priorities in respect of the public health system. The sections below are categorised according to the planning guidelines with appropriate activity shown to illustrate key initiatives that are being implemented to achieve the given measures. An intervention logic approach has been used to illustrate how activity links to achievement of results. In addition, there are details of national and local priorities for Māori health as outlined in the guidance for DHB Māori Health Plans. Our Māori Health Plan 2016/17[15] is fully integrated into this Annual Plan but will be extracted as a stand-alone document only for submission to the MoH in order to comply with the requirements of our Operational Policy Framework.

Acknowledgement

The 2016/17 planning process for this Annual Plan included setting up groups of stakeholders around each priority area. Accountability for collating each section was shared between co-leads from HHB and HBDHB to ensure that there was PHO participation in the preparation of this plan. The public health unit and frontline clinicians played a vital role in developing the sections over the planning period in 2016.

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

[11] National Health Targets 2016/17
[12] NBHB Non-financial Performance Framework 2016/17
[13] Central Region's Regional Services Plan 2016/17
[14] Minister's Letter of Expectations, 22nd December 2015
[15] Our planning priorities for Māori health in 2016/17 are aligned to the national indicators for Māori health and to our three-year Māori Health Strategy, Mai – available from our website.

2.2.1 Child and Youth Health

A key focus of the Government is vulnerable families. Agencies need to be innovative, responsive and work together in order to provide services that best meet the needs of priority populations. DHBs are expected to continue to support cross-agency work that delivers outcomes for children and young people. A considerable body of evidence links adverse childhood circumstances to poor child health outcomes and future adult ill-health. These adverse health outcomes include low birth weight, infant mortality, poor dental health, poorer mental health and cognitive development and increased hospital admissions from a variety of causes. Maternity services are provided by a range of health professionals to women and families throughout pregnancy, childbirth and for the first six weeks of a baby's life. Child services continue thereafter with a number of primary, community, population-wide and hospital-based programmes aimed at ensuring that all children are regularly assessed against a raft of health and well-being indicators. Our focus in this part of the plan is on pre-pregnancy, maternal and pre-school services.

In this section

Reducing Unintended Teenage Pregnancy

[Guidance released from MoH end of February]

Short-term outcome	Activity	Monitoring & Reporting

Increasing Immunisations

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for people. The HBDHB Immunisation Steering Group provides a forum for a collaborative approach to improving the immunisation rates for Hawke's Bay children and adults. Representation on the Steering Group includes: Midwives, WC/TO, Secondary services, primary care, Māori providers, Health Hawke's Bay (HHB) PHO, HBDHB Immunisation Team, Public Health, National Immunisation Register (NIR), the Immunisation Advisory Centre (IMAC). New Zealand research has found that established relationships with a primary health care provider is critical in the timely delivery of immunisations and that there is a need for more effective facilitation of early engagement with primary health care providers.

Early enrolment with a General Practice (GP) and Well Child/Tamariki Ora (WC/TO) enables new-born babies to receive timely immunisation and other health checks. If infants are enrolled with a GP before they are six weeks of age then they can be effectively pre-called and vaccinated on time. The NIR is a tool that supports management of both individual and population health, and information from the NIR is used to assist with planning, targeting and monitoring of immunisation services. For those families/whānau not accessing primary care providers, it is important to offer opportunities for receiving childhood scheduled vaccinations in a safe environment. The Immunisation Team will continue to work collaboratively with Māori health providers, WC/TO providers, Before School Check (B4SC) coordinator, PHO, Family Start, and midwifery staff. We continue to provide staff from Māori health providers and Tamariki Ora with resources and training to promote the importance of immunisation with their families/whānau with a strong focus of "on time every time."

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	 **Increase Immunisation coverage in Children**	Continue to facilitate successful Hawke's Bay Immunisation steering group quarterly	**Health Target:** 95% of eligible children fully immunised by 8 months **PP21:** 95% of eligible children fully immunised by 2 years **PP21:** 95% of eligible children fully immunised by 5 years by June 2017 Equitable coverage across Māori, Pacific and Other
		Continue to implement strategies in the Immunisation Action Plan 'Improving Childhood Immunisation On Time Rates in Hawke's Bay'. These involve but are not limited to, identifying and referring due and overdue children who present in hospital services and monitoring and maintaining equity.	
		Datamart reports are used regularly to measure the coverage rate and identify increased numbers of declining or opt-offs or other gaps in service delivery.	
		HHB to support practices to review, audit and manage their Patient management systems for the systematic and timely review of children.	
		HHB and HBDHB to work collaboratively on promotion of Immunisation week in Q4 2017	
		TBC: Strengthen relationships with Māori Service Providers	
		Immunisation team to maintain working relationships with age appropriate services such as Tamariki Ora, Plunket, community oral health services and Before School Checks to ensure efficient use of resources for tracking children and appropriate service provision.	

Short-term outcome	Activity	Monitoring & Reporting
Support the cancer strategy goal of reducing the incidence of cancer thorough primary prevention by increasing HPV immunisation rates	Facilitate HPV stakeholders group, which is a sub group of and reports to The immunisation Steering Group.	**PP21:** 70% of eligible girls fully immunised with HPV vaccine Equitable coverage across Māori, Pacific and Other
	Activities TBC – Action plan in final draft and will be signed off by March 2016	

In 2014, Māori had the second highest rate of influenza confirmed hospitalisation, 49.2 per 100,000. The 65 years and over age group also have the highest rates of influenza admissions to ICU. A 75% influenza vaccination rate is required to provide the best protection for this age group and in particular for Māori. In 2014 (TBC 2015), 69% of those aged over 65 years were immunised against influenza (69% Maori and 71% Pacific). For the 2016 Influenza Immunisation Programme NIR reports are being developed by the Ministry of Health to more accurately measure influenza immunisation coverage by ethnicity. There continues to be difficulty to gather accurate coverage data for influenza as not all vaccination events are recorded or captured in the data.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Increase the % of Māori ≥ 65 years having annual influenza vaccination. Baseline = 68% (as at Dec 2014)**	Collaborate with Maori, remote providers and HHB to improve the uptake of influenza vaccination for Maori ≥ 65 years	75% of the eligible population over 65 are immunised against influenza annually Equitable coverage across Māori, Pacific and Other
		HHB general practice facilitation team will encourage practices to recall and campaign to get people in for vaccination between March and July 2017.	
		Practice PMS audit systems will be used to identify those eligible for influenza vaccination. The practice will then actively recall these people.	

Children's Action Plan

[Guidance released from MoH end of February]

Short-term outcome	Activity	Monitoring & Reporting

Reducing Rheumatic Fever

HBDHB previously had one of the highest rates of Acute Rheumatic Fever (ARF) in the country. Through combined efforts to reduce first episode Rheumatic Fever hospitalisation HBDHB 2014/15 achieved a rate of 0.6 per 100,000 population. HBDHB will continue to address Rheumatic Fever prevention through five main streams: School based Say Ahh programme in Flaxmere; Primary Care Say Ahh Programme; Child Healthy Housing programme; Communication /health literacy regarding sore throats; and Secondary Rheumatic Fever prevention programme. Our Rheumatic Fever Prevention Plan is updated regularly and the implementation is ongoing.

At the end of June 2017, the dedicated Ministry of Health led rheumatic fever prevention programme will end and current levels of government funding for rheumatic fever will cease. As HBDHB is a high incidence DHB, the MoH will continue to provide a proportion of the funding for a further five years. HBDHB is committed to providing the remaining funding resulting in a total investment of $458,364 annually.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Reduced incidence of first episode Rheumatic Fever** **Target Rate <1.5 per 100,000**	Continue Healthy Homes programme targeting 150 annual referrals to prevent Rheumatic Fever	Number of referrals Māori and Pasifika engagement
		Continue to promote and participate in cross agency work to develop a Hawke's Bay housing coalition	
		Regular meetings of the multiagency Rheumatic fever prevention steering group with HHB, HBDHB & TTOH to provide clear direction and monitoring for Rheumatic Fever Prevention & Management	Meetings held as per schedule & Clear direction and monitoring provided
		Continue delivery of the actions specified in the refreshed Rheumatic Fever Prevention Plan – Development of strategic framework and implementation plan to raise community awareness and health literacy on rheumatic fever	**PP28:** Progress against DHBs Rheumatic fever prevention plan
		Continue with Say Ahh programme in schools and in primary care	CFA reporting on Rapid Response sore throat service
		Set up a Rheumatic Fever Governance Group	Governance group established
Effective follow up of Identified Rheumatic Fever Cases		Continue to monitor time between admission and notification of all new cases of rheumatic fever to the Medical Officer of Health.	**PP28:** % of patients notified within 7 days of diagnosis
		Continue to monitor patients with a history of Rheumatic Fever are receiving monthly prophylactic antibiotics and carry out an annual audit in Q4 of Rheumatic fever secondary prophylaxis coverage for children aged 0-15 years, youth aged 15-24 years and adults aged 25+ years	**PP28:** % of patients receiving secondary prophylaxis within 5 days of due date
		Undertake case reviews of all Rheumatic fever cases and address identified system failures	**PP28:** 100% of notified RF cases have case review and actions addressed from lessons learned.

Prime Minister's Youth Mental Health Project

A significant number of young people in New Zealand will experience mental health problems during adolescence. Problems such as depression, anxiety and substance abuse can have life-long consequences. The current system for addressing youth health issues has some significant gaps and there are many barriers to access. Young people are often unable or reluctant to access primary care and mental health services as they are more geared towards adults or people with acute needs. Young people may require a unique mix of social, developmental and health services, and their family GP may not be the most suitable provider for this full range of care needed. The Government has launched the Prime Minister's Youth Mental Health project in order to achieve better mental health and well-being for young people including sub-groups of the population at comparatively higher risk of mental health issues, such as Māori and Pasifika.

HBDHB work closely with HHB to improve the health of youth in Hawke's Bay. A Youth Strategy is currently being developed and will be completed by July 2016. The strategy will define the youth population of Hawke's Bay and what a young person needs to be healthy. An outcome of this piece of work will be to form a group to take forward the changes required to meet the needs of youth in Hawke's Bay.

Implement targeted free primary healthcare for 13 to 17 year olds will help to improve access to services for youth. This initiative is included in the Access to Care section of the Annual Plan

Short-term outcome	Activity	Monitoring & Reporting
Improve student access to health services	Continue provision of School Based Health Services (SBHS) in decile 1-3 secondary schools, teen parent units and alternative education centres.	Number of youth accessing SBHS by ethnicity, gender and age **PP25**: quarterly quantitative reports on the implementation of SBHS.
	All decile 1-3 secondary schools, teen parent units and alternative education centres will have a Plan, Do Study Act (PDSA) cycle completed in the year, based on 'Youth Health Care in Secondary Schools: A Framework for Continuous Quality Improvement'.	**PP25:** quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools
	Deliver Mental Health 101 training to broaden knowledge and understanding of mental health for all service providers linked with secondary schools	No of MH 101 sessions provided Broad range of attendees at 101 sessions
	Deliver presentations in schools to increase student knowledge of accessing online e-therapy tools.	No of schools presentations
Improve the responsiveness of primary care to youth	Complete the Youth Strategy by July 2016 and form a group to implement the strategy	**PP25:** Report to outline actions taken to improve the health of the youth population
	TBC – Pending outcome of CAFS review	

Short-term outcome	Activity	Monitoring & Reporting
Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Other Drug (AOD) services	Formalise implementation of Transition Planning Checklist as standard practice in Q1; Amend discharge documentation to include standard prompt to primary referrer in Q2; Introduce "error flag" in patient administration system to prompt completion in Q3	**PP7:** 95% of clients discharged with have a transition (discharge) plan + Exception reporting
	Ongoing monthly audit and performance monitoring of compliance with transition plan policy	
Improve access to CAMHS and youth AOD services	Trial an initial phone contact by Choice Clinician and implement as standard practice if successful	**PP8:** 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year + Narrative report
	Liaise with KPI Forum stakeholders and other DHBs regarding "face-to-face" rule for first contact with children and families	
	DNA's and joint appointments – review policy and impact of current practice. Redesign if necessary	
Strengthen Youth Primary Mental Health through: • **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**	TBC – Primary Mental Health Review is being carried out. Recommendations from this review will inform activities	

Breastfeeding

Child health is a national priority. Research shows that children who are exclusively breastfed for around 6 months are less likely to suffer from childhood illnesses such as respiratory tract infections, gastroenteritis and otitis media. Breastfeeding benefits the health of mother and baby, as well as reducing the risk of SUDI and asthma. Breastfeeding is also linked to children maintaining healthy weight across their lifetime and reduced risk of obesity. Our Health Equity Report points out that Maori rates for breastfeeding in Hawke's Bay are persistently lower than that for non-Maori and we are committed to improving equity

A resource combining breastfeeding, Safe sleep and smoke free has been developed in collaboration with Mama Aroha targeting Maori but inclusive of all ethnicities. This resource is part of a Population health approach to influencing behavioural change around these key issues, and encourages consistent and appropriate messaging.

LMC leadership in the area of breastfeeding is essential to affecting positive change in the early postnatal period. All LMCs are required to undertake annual breastfeeding education and support the Ten Steps of BFHI, this is to maintain knowledge and prevent the giving of conflicting advice. Discussions are taking place with Choices Māori Midwives to examine data collection and improve strategies to increase breastfeeding rates of Māori women.

Below are the baseline rates for breastfeeding as of September 2015. Rates at 3 months and 6 months for this period are not directly comparable with results from earlier periods, because of the inclusion of data from Tamariki Ora providers and Plunket data. Prior to September 2015, Ministry level breastfeeding data did not include Tamariki Ora..

	Total	Māori	Pacific
Infants are exclusively or fully breastfed at 6 weeks	68%	58%	74%
Infants are exclusively or fully breastfed at 3 months of age	54%	46%	62%
Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)	56%	46%	57%

Baseline rates for breastfeeding as of September 2015. Source: Well Child/Tamariki Ora Quality Improvement Framework September 2015

	Total				Maori				Pacific			
	Sep-14	Mar-15	Change		Sep-14	Mar-15	Change		Sep-14	Mar-15	Change	
Infants are exclusively or fully breastfed at 6 weeks	72%	69%	↓	3%	61%	59%	↓	2%	75%	79%	↑	4%
Infants are exclusively or fully breastfed at 3 months of age	53%	52%	↓	1%	34%	39%	↑	5%	39%	56%	↑	17%
Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)	60%	57%	↓	3%	46%	48%	↑	2%	59%	51%	↓	8%

Change in rates since 2015/16 annual plan. Source: Well Child/Tamariki Ora Quality Improvement Framework March 2015, September 2014

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	Improve breastfeeding rates at 6 weeks	Encourage early postnatal referral to well child before 4 weeks, 6 days and antenatal referral to Well Child for the most vulnerable through stakeholder and governance groups	# referred antenatally to WC BF rate at discharge from maternity ward by ethnicity
		Facilitate intersectoral breastfeeding governance group attended by relevant DHB and community services/agencies (incl LMCs) quarterly to provide strategic direction. Breastfeeding governance group to monitor KPIs and drive performance in Maori and non-Maori	Quarterly Meetings
		Facilitate Hawke's Bay's Breastfeeding multi-agency clinical group to support breastfeeding workforce in Hawke's Bay. Ensure all staff working in antenatal and early postnatal have consistent messages, resources, training and coordination of breastfeeding activities across Hawkes Bay through operational group	Bi-monthly meetings Mama aroha talk card training
		A newly developed take home guide to Breastfeeding, smokefree and safe sleep to be distributed to every mother delivering in the DHB maternity unit.	% of mothers offered take home guide
		Review current targeted Breastfeeding services in Q1 and redesign effective breastfeeding intervention for Maori women	
		Promote breastfeeding benefits at DHB Antenatal Classes, MoH literature distributed by LMCs and Information given by clinic midwives and dieticians. Consistent messaging facilitated by breastfeeding multi-agency group	
Māori Health Priority	**Improve breastfeeding rates at 3 months and 6 months**	Local WCTO Quality Improvement group will continue to focus on improving Breastfeeding rates at 3 months as one of their top priorities	6 weekly meetings of WCTO QI group
		Women, Children and Youth and Maori Health Portfolios to coordinate breastfeeding strategy across Hawke's Bay ensuring a focus on equity	Fortnightly meetings
		Monitor Breastfeeding rates through Te Ara Whakawairora (TAW) reporting, championed by a member of the Executive Management Team (EMT)	Annual TAW report
		Include Early Childhood and HHB representatives on Breastfeeding governance and clinical groups	Representatives attending meetings

Sudden Unexplained Death of Infant (SUDI)

Reducing the rate of SUDI is a national priority. Sudden Unexpected Death in Infancy is the leading cause of preventable post-neonatal death in infancy. Māori infants are 5 times more likely to experience SUDI than non-Māori infants in New Zealand, with around 40 SUDI deaths among Māori per year. Hawkes Bay DHB is committed to reducing the rate of SUDI by decreasing the number of women smoking during pregnancy; encouraging more women to breastfeed; and increasing safe sleep knowledge and access to safe sleep spaced within whānau and the wider community. The Breastfeeding and Tobacco sections contain more detail regarding actions to promote breastfeeding and being smokefree.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Reduce the risk of SUDI in Hawke's Bay** ***Target rate <0.4 SUDI deaths per 1000 live births for Māori and non-Māori***	Coordinate quarterly multi-sectoral Safe Sleep Action Group including representatives from Smokefree, Iwi, community providers, Public Health, WCTO, breastfeeding advocates and Women, Children and Youth - to provide strategic guidance for SUDI activities, monitor outcomes and maintain policies. Extend invitation to include PHO & early childhood representatives on safe sleep action group to ensure consistent messaging.	Quarterly Meetings & new representatives included
		Support the provision of safe sleep education through online resources such as 'baby essentials online' and 'through the tubes'	
		Improve the provision of antenatal education which is responsive to the needs of Māori and includes advice on safe sleep practices and the benefits of breastfeeding and being Smokefree.	% and number of Māori, Pasifika, teen and those for whom English is a second language attending DHB funded antenatal education
		Socialise pathway for local health professional response when whānau are identified as requiring supported access to a safe sleep space for their infant's first year, or referral for tobacco cessation support.	
		Continue collaboration with Child and Youth mortality Review Committee to provide recommendations on SUDI activities.	
		DHB representative continue to attend meetings with LMCs	

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Caregivers are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1**	Meet quarterly with the WCTO providers in the region to monitor performance against SUDI indicators and strengthen collaborative approach to improve performance	
		Continue to facilitate WCTO Quality Improvement group with a focus on timely provision of core contact 1	
		Continue to implement automatic process for newborn enrolment with a PHO and registered with a GP, WCTO provider and Community oral health services	98% of newborns are enrolled with a PHO, GP, WCTO provider and COHS by three months.
		Continue Plan, Do, Study, Act (PDSA) Quality Improvement cycle to improve relationships with midwife/LMC to improve timeliness of referrals to WCTO	Number and % of referrals to WCTO completed by 6 weeks post-birth Number and % of infants receive Core Contact 1 by 6 weeks post-birth
		Implement recommendations from WCTO quality improvement group derived from a review of current practices in other DHBs to improve timeliness of referral to WCTO	

Oral Health

Increasing pre-school enrolments to community oral health services is a national priority. According to our Health Equity Report, dental conditions account for a large number of ambulatory sensitive hospitalisations (ASH) in the 0 – 4 year old population and rates for Māori are 4.3 times those of non-Māori. This reflects a higher prevalence of severe dental caries in this age group, of which some may have been preventable through better access to oral health services and use of preventable treatment. A project is underway to improve access to community dental services for Māori Tamariki (0-5 years). The project is focussing on patient and whānau centres booking system, reduction in (did not attend) DNA rates and improving community dental utilisation rates. Strategies to tackle childhood obesity will also have a positive impact on the oral health of children such as the promotion of healthy first foods are reducing sugar sweetened beverages. More details of this can be found in the Obesity section.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Improve the oral health of 5-year olds**	All babies are seen by an oral health clinician at a HBDHB Community Oral Health Clinic by 12 months of age	**PP11**: 67% of 5 year old examined who are carries free. Data for Māori, pacific and other Exception report and resolution plan for non-performance **SI5**: WHANAU ORA Key Indicator
		All Māori, Pacific and high risk children have fluoride applications at 6 month intervals	
		Implement initiatives from the Improving Access to Oral Health Services for Māori Tamariki (0-4 years) Project	
		Continue Quadruple New Born Enrolment (National Immunisation Register, GP, Well Child Tamariki Ora, Oral Health) for all babies born in HBDHB Maternity Services.	**PP13**: 95% of pre-school children are enrolled in the COHS Data for Māori, Pacific and other
		Ensure babies not born in HBDHB Maternity Services are enrolled through Well Child Tamariki Ora providers at Core Check 5 (9 months of age)	

2.2.2 Long Term Conditions

Prevention, Identification and Management

Long term conditions are ongoing, long term or recurring conditions. In Hawke's Bay, as around the world, the numbers of people living with LTCs is rising, causing premature mortality and morbidity, which is directly or indirectly linked with the underlying disease. Māori and Pacific people, people living in low socioeconomic circumstances, people with disabilities and people with mental health and addiction issues are disproportionately affected by some long term conditions, with a more significant impact from ill health and earlier mortality.

Better care and support for people with long term conditions is a priority for HBDHB in order to both achieve better health and well-being for our population and to manage the rising demand for services which is a threat to sustainability. Primary care takes the lead role in the management of most LTCs for most people most of the time. Our focus is on creating a more integrated system of care where primary care providers are supported by specialist services to provide high quality care to their patients. Collaborative clinical pathways and shifting resource into the community play a large role in achieving this. Supporting primary care to understand their population's long term conditions profile and to promote health literacy and self-management is alos a key focus of activity.

Long term conditions are a focus throughout the HBDHB Annual Plan 2016/17 but this section focusses on prevention, identification and management of obesity, diabetes, cardiovascular disease, tobacco smoking and mental health. In the development of this plan, HBDHB has worked closely with the public health unit (PHU) and Health Hawkes Bay (the PHO). Where relevant, other local partners have also been involved in the planning.

In this Section:

Obesity

The Health Equity in Hawke's Bay report identified an increase in obesity across the population with disparity in rates with Pasifika (68%) and Māori (51%) compared to total population (34%) - these are all above the national averages. Obesity is recognised as a major public health issue for New Zealand because obesity rates have increased substantially and significantly over the past 15 years and obesity increases a person's risk of dying young, by increasing the risk of cancer, heart disease, diabetes and other related medical conditions. Obesity is second only to tobacco on impact on the health of people in Hawkes Bay.

The leading factor in obesity is the obesegenic environment that includes easily accessible calorie-rich, nutrient-poor food and less physical activity. While the causes are identified, the systems we need to change to reduce obesity are complex. They include culture, economics, access, knowledge, family structure, working patterns, government policy and genetics all have a part to play in what we choose to eat and the amount of physical activity we do.

We know that maintaining a healthy weight during the early years of life has a lasting effect with people being more likely to maintain a healthy weight as an adult and have improved health outcomes. The evidence is increasingly showing that getting nutrition and weight right in the first five years is critical, so the HBDHB has been implemented a programme to support whanau to maintain healthy weight by partnering with Well Child providers to deliver Healthy First Foods, supporting early childhood providers to have healthy eating policies, and funding Active Families for children under 5 years. The next steps for HB DHB are to implement the childhood obesity strategy and develop a wider obesity response.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority		Support the Big change Starts Small campaign with local initiative	**TBC**
		Deliver the healthy first food programme via a train the trainer approach which targets Maori and Pasifika families	Six monthly update of progress
		Further utilisation of Patu and ironmaori Hikoi Koutou	**TBC**
Māori Health Priority	**Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions** **HEALTH TARGET**	Children identified as obese in B4 School check are referred to services including, clinical support, family based nutrition programme and lifestyle interventions	**HT:** 95 percent of obese children identified in the Before School Check (B4SC) programme will be referred on for nutrition, activity and lifestyle interventions. # and % of referrals declined by ethnicity **SI5**: WHANAU ORA Key Indicator
		Increase skills and resources to support referrers to increase whānau knowledge of healthy weight, eating and activity and awareness of referral options	

		Continue to fund Active Families Under 5 programme/s	Number of referrals to Active Families programme for Māori, Pacific and Other Total number declined to enrol in Active Families programme for Māori, Pacific and Other Total percentage of Māori, Pacific and Other that completed programme Total percentage of declined patients given nutritional advice 80% of participant report lifestyle changes

Living Well with Diabetes

In Hawke's Bay, as around the world, the numbers of people living with diabetes is rising. Our Health Equity Report shows that diabetes is one of the top seven causes of death and one of the five top causes of amenable mortality in Hawke's Bay, and that there are significant equity issues in people's care. Improved access to care and better management of diabetes is cited as one of the factors that will lead to a great reduction in amenable mortality disparities. Better care and support for people with diabetes is a priority for HBDHB in order to both achieve better health and well-being for our population and to manage the rising demand for services which is a threat to sustainability. Primary care takes the lead role in the management of most long-term conditions for most people, most of the time. Our focus for diabetes services is on creating a more integrated system of care where primary care providers are supported by specialist services to provide high quality care to their patients. In 2015/16 we have redesigned our podiatry services to improve access to community podiatrists for Māori, Pasifika and people living in areas of higher relative deprivation. We have also developed a Diabetes Clinical Pathway and continue to review existing diabetes services against the National Quality Standards for Diabetes Care. A key focus of activity is around empowering patients to manage their own conditions effectively through improved health literacy and self-management approaches such as the Stanford model.

Short-term outcome	Activity	Monitoring & Reporting
Improve the proportion of patients with good or acceptable glycaemic control	Prioritise support for Māori in proactive management of their diabetes by providing Services to Improve access (SIA) funding for Diabetic Annual Reviews (DAR).	**PP20**: % of patients with HbA1c above 64, 80 and 100 mmol/mol
	Fully implement and socialise the Diabetes Clinical Pathway across the sector by December 2016	
	Continue to support the implementation of the diabetes plan across the sector	
	Continue to promote the utilisation of the Stanford Programme in General Practices	Number of referrals from general practice
	All practices to complete a Diabetes Care Improvement Plan (DCIP) for 16/17 year incorporating how the 20 quality standards underpin service delivery and how the practice with provide education on diet, exercise and introduction to self-management strategies	28 DCIPs signed off % of diabetics with a DAR completed
	Subject to MoH support, using the CPI report, consolidated data from PMS will identify current cohort of diabetics in HB for more accurate identification and targeted interventions for service delivery	Establish monthly HbA1c reporting showing proportional changes with outcomes

Cardiovascular Disease

Cardiovascular Disease (CVD) is the leading cause of death in New Zealand. With prevalence rising at a rate that is exceeding population growth, it is a major health burden for New Zealand now and into the foreseeable future. As the population ages, and lifestyles change, CVD is likely to increase significantly without positive intervention. According to our Health Equity Report, ischaemic heart disease is the leading cause of avoidable mortality in Hawke's Bay across all ethnicities. However, the potential years of life lost rates for Māori and Pasifika are four and three times higher respectively than the non-Māori, Non-Pasifika population highlighting a significant equity issue. To reduce the risk of developing CVD, five yearly risk assessments should be carried out on the eligible population. While CVD risk assessment is no longer a health target or part of the reportable IPIF measures, it is considered as part of the whānau of IPIF achievements therefore there is commitment to ongoing improvement of performance in this area.

Short-term outcome	Activity	Monitoring & Reporting
Improve the proportion of the eligible population who have received a CVD risk assessment in the last 5 years	Support (WHO) to carry out PMS audits (how often?) with a particular focus on those who are coming due for Cardiovascular Risk Assessment (CVRA). Including those coming into the cohort, those that are due and those that will require rescreening	**PP20**: 90% of the eligible population will have had their CVD risk assessed in the last five years.
	Provide data to assist Practices to manage the total cohort of their screened population and allow internal benchmarking. Where appropriate, the General Practice facilitation team will work with practices to improve those outliers' performance	
	Specific outreach nursing services will target workplaces where there is a high volume of Māori men in the work place and offer incentives such as prize draws.	

Tobacco

Tobacco is a key contributor to health inequity in Hawkes Bay, as a result the Population Health Service has a focus on reducing smoking rates and are committed to the vision of a smokefree Aotearoa by 2025. The health sector has a role to improve, promote and protect the health and well-being of the Hawke's Bay population. This is delivered via a range of approaches including promoting Smokefree, screening for smoking, regulatory responses, providing cessation support and workforce development. However, the greatest impact occurs with a collaborative approach and to achieve this we work across a wide range of settings including increases in taxation; engaging in Smokefree education retailers, collaboration with Ngati Kahungunu Iwi Incorporated (NKII) and supporting local Councils to develop broader Smokefree Policies.

Hawke's Bay prevalence of tobacco use is higher than the national average and we believe that reducing tobacco consumption remains the best opportunity to improve Māori health and improve equity. In 2016/17 we will continue to focus on achieving the National Health Targets and improving smokefree environments particularly in pregnancy and for neonates, new-borns and infants who are so negatively affected by exposure to first and second-hand tobacco smoke.

Short-term outcome	Activity	Monitoring & Reporting
Reduce the prevalence of smoking 	Implement the co-created Regional Tobacco Strategy 2015 – 2020	Report update of implementation
	Continue to provide brief advice and support to quit smoking to hospital inpatients	**PP31**: 95% of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice & support to quit smoking
	Continue to offer GP Practices and their staff training, support and guidance on Smokefree systems, processes and policy development	**HT**: 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months Reports Provided to medical director – Primary Care Education provided to GPs in 2016/17
	Provide benchmarking data and audit support for high level leadership and governance structures to manage performance of the 'Better help for smokers to quit' Health Target in primary care. Encouraging the identity and development of Smokefree champions in practices where appropriate.	
	Review the forms used in the primary care Patient Management System to embed mandatory Smokefree fields.	

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Reduce the number of pregnant women who are not Smokefree**	Evaluate recent changes to documentation to ensure accurate data is being captured when being booked into the Maternity Unit.	**HT**: 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
		Scope opportunities to provide smokefree education to LMCs	
		Expand incentivised programme targeting young Māori women and their whānau by implementing recommendations from the recent evaluation of the programme and focussing on improving the proportion of referrals that quit long-term.	90% of young pregnant Māori women are referred to cessation support
		Continue to screen inpatients, offering support to quit for mothers and whānau and monitor Smokefree Rates at discharge from Maternity Unit	% of Women smokefree at discharge from maternity unit
		Continue to monitor the number of Māori Women that are Smokefree at 2 weeks postnatal	95% of pregnant Māori women are smoke free at two weeks postnatal **SI5**: WHANAU ORA Key Indicator
		Subject to the success of a funding bid being prioritised by Clinical Council – Expand on the pilot which involved GPs promoting early enrolment with LMCs and providing early intervention packs to pregnant women which include NRT and a referral to cessation support for smokers.	

Rising to the Challenge - TBC

By December 2015 the project to implement changes in mental health acute and community services will be nearing completion. This is a major project for HBDHB with investment of over $20 million in a new mental health facility and redesign of services for patients and their families. We will establish a number of new services by April 2015, while maintaining continuity of care for patients. These include:

- Establishing a specialist home based treatment team
- Transferring acute community based unplanned respite services to an NGO
- Extending community based resiliency programmes
- Developing NGO day programmes to support people to connect with their communities
- Continuing productive wards in mental health inpatient unit and Te Whare Aronui to release clinician time for direct patient care

Short-term outcome		Activity	Monitoring & Reporting
Better use of resources			
Improve integration between primary and			
Māori Health Priority	**Reduce the rate of Māori under Compulsory Treatment Orders (CTOs)**		**SI5**: WHANAU ORA Key Indicator

2.2.3 System Integration

Working Together for Better, Sooner, More Convenient Health Care

We recognise that our vision will not be achieved through the efforts of HBDHB alone because the root causes of poor health often lie outside the health sector and the health system's control. Ensuring that the social and physical environment we live in is one which promotes and protects health requires partnerships with whānau, Hapū and Iwi and working intersectorally across professional and organisational boundaries.

Formal, close working relationships exist with the PHO, General Practice, private hospitals, a variety of Non-Government Organisations (NGOs), local Government, Unions and individual HBDHB employees. Part of our transformational change relies on the strength of these relationships to test new ideas and initiatives, as well as for development of expanded scopes of practice and associated training, and provision of support for aged residential care nursing and carer development in partnership with the PHO. We are working with the PHO to deliver on the national health targets, develop more integrated urgent care services, implement a primary care strategy, realign our respective health promotion services to maximise value for money, and implement broader alliances with organisations in discrete locations who can work together to benefit from efficiency and scale to transform rural care delivery. Our alliance with the PHO continues to be developed locally to drive transformational change.

This section highlights some of the programmes that we are involved in with other entities across the systems, where we are collectively working for system-level quality improvement.

In this section:

Access to Care

A key National priority that has emerged, and is supported by the findings of our Health Equity Report, is improving the access of disadvantaged groups to primary and community care. We want to ensure that all our services are accessible and that everyone who needs care is enabled and empowered to seek that care as early as possible. Improving access to primary health care for youth (13-17 year olds) and Māori living in Hawke's Bay is a key local priority. The NZ Health Survey 2013-2014 found that unmet need for primary health care is greater common among Māori and Pacific adults and children, and in those living in the most deprived areas. There are low rates of unmet need for GP visits and after-hours services due to a number of barriers including cost, transport, geographical distance and the nature of some services in terms of providing a welcoming atmosphere.

It is important that Māori have access to General Practice services that are responsive to cultural difference, understand the broader determinants affecting inequitable health outcomes, and provide services to increase the opportunity for Māori to be more self-determining in managing their own health challenges.

For youth, HBDHB aims to improve access to health care by reducing the cost of General Practice services, though the provision of targeted subsidies. Furthermore, by improving access to health care for youth, HBDHB aims to improve health protective factors associated with health literacy and health choices developed in the teenage years and thereby reduce the onset and burden of chronic disease in later years.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Increase enrolments in the PHO**	Continue focus on new born enrolments	% of the population enrolled with a PHO
		Encourage people to reconnect with primary care providers when attending ED and provide GP enrolment packs for high needs, Māori and Pacific	
		Work with a number of GP practices to ensure systems adequately identify challenges for enrolment	
Improve access to primary care for Māori		Engage practices in a formal support quality programme 'He Taura Tieke' to increase the responsiveness to their Māori population	Annual GP utilisation rate by ethnicity 13 practices 2016/17 with He Taura Tieke' self-assessment and annual plan Evaluation of the training and customer service
		Implement Health Literacy programme into General Practice over the next 12 months	
		Continue to implement Health Literacy Campaign with actions to support more understanding in Māori communities of identified health issues	
		Continue to fund Whānau Wellness programme from SIA funding, providing 12 months of GP services free of charge to up to 300 whānau	
Improve access to primary care for Youth		Extend access to free GP services from 13 to under 18 year olds in practices that opt to be included	No of practices opting in

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially have been prevented by earlier access to treatment in primary care. While access to primary care is a large factor in reducing ASH rates, there are a number of other factors outside of the health sector which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). Because of this, there are a number of other sections within the annual plan that outline activities to reduce ASH rates such as Rheumatic Fever (Health Homes Programmes), Obesity, Oral Health, Tobacco, Cardiovascular Disease (CVD) and other Long Term Conditions. In Hawke's Bay there are large inequities evident in ASH rates for both 0-4 and 45-64 year olds. In the last year we have seen a reduction in ASH rates and a narrowing in the equity gap between Māori and Non-Māori however there is a long way to go and we are committed to concentrating efforts on vulnerable populations to improve equity. For children aged 0-4 years the top 5 ASH conditions are Asthma, Dental conditions, Upper respiratory infections and ENT, Lower Respiratory Infections and Cellulitis. For those aged 45-64 the top 3 ASH conditions are Cellulitis, Congestive Heart Failure (CHF) and Respiratory infections (COPD and Pneumonia).

Māori Health Priority	**Reduce Ambulatory Sensitive Hospitalisations for people aged 45-64**	Standardise clinical practice and through the development of a Cellulitis clinical pathway and the implementation and socialisation of the CHF Clinical Pathway	Pathways developed and implemented
		Subject to approval of a budget bid through the Clinical Council prioritisation process we will provide sustainable funding for nurse-led respiratory clinics which were piloted in 2015, a joint HHB and HBDHB initiative which was proven to be effective at encouraging self-management resulting in clinical, financial and organisational efficiency. A reduction in hospital admissions resulting from acute exacerbations of chronic respiratory disease was noted during this pilot period and may be attributable to the respiratory project.	Funding approved and sustainable service provided
		Provide reports to general practices which show their admission rates to hospital and emergency department attendances.	HBDHB develops reporting structure and link with key practice liaisons
		Clinical Nurse Specialist and Breathe HB to continue with Respiratory training in Primary care that has had a very good uptake to date.	Number of workshops provided across the health sector
Māori Health Priority	**Reduce Ambulatory Sensitive Hospitalisations for children aged 0-4**	Implement and socialise the Clinical Pathway for Wheeze in Preschool children	**SI5**: WHANAU ORA Key Indicator TBC
		Respiratory clinical nurse specialists to hold a pharmacy education session on Respiratory conditions including specific paediatric respiratory education.	TBC
		Provide reports to general practices and Clinical Nurse Specialist Paediatric Respiratory which show the paediatric patients that have been admitted to hospital for Asthma and wheeze so they can be followed up in the community and linked in with the most appropriate service to avoid readmission.	TBC
		Opportunistic flu vaccinations given to children seen in hospital with chronic respiratory conditions and those living with them	TBC

		Continue newborn enrolment programme to ensure all new borns are enrolled in NIR, a GP, Community Oral Health Service and Well Child/Tamariki Ora	TBC
		Continue Public Health nurse visits to Kohanga Reo to provide advice and education around all leading ASH conditions. Particularly for skin conditions with skin health talk cards and promotional posters which have been translated to Te Reo for Kohanga Reo and Kura Kaupapa	TBC
		Continue to provide consistent messages regarding health initiatives through Hawkes Bay Child Interagency Network Group with representatives from HBDHB child health team, early childhood centres, kindergartens and home-based childcare.	TBC

Data quality is a national Māori health priority, particularly in respect of the accuracy of ethnicity reporting in primary care patient management systems. Our commitment to accelerating Māori health and well-being means that we must have good data to gauge progress. The only way to be sure that ethnic disparities are reducing is by measuring indicators across ethnicities. Good ethnic data also enables us to target resources appropriately and to contribute to health research. We have made a commitment to the principle that all our measures should be provided by ethnicity and so we aim to disaggregate our monitoring and reporting increasingly over time.

Māori Health Priority	**Improve the collection and reporting of Māori ethnic data.**	Activities TBC	

Service Configuration (Including Shifting Services)

Alliancing in Hawke's Bay

HBDHB and HHB entered into an Alliance with effect from December 2013, formalising this with an Alliance Agreement in September 2014. The Alliance activities include: Promoting clinical leadership and supporting clinically led decision-making; Creating an environment in which Transform and Sustain culture, strategies and actions can be developed and implemented, as appropriate; Determining services to be funded from the Flexible Funding Pool; and Selecting, monitoring and managing district level issues relating to Integrated Performance and Incentive Framework

These activities are mainly supported through the pre-existing Hawke's Bay Clinical Council, which had been established in 2010. The Hawke's Bay Clinical Council provides clinicaly-led decision making and advice to the Hawke's Bay health system on resource allocation and key service changes. The Council also provides clinical leadership and oversight of clinical quality and patient safety locally. It seeks to break down boundaries across primary and secondary care to ensure that services are organised around the needs of people.

The Alliance Leadership Team (ALT) works closely with Clinical Council to deal with specific issues or barriers to achieving Alliance objectives. This may include appointment and/or coordination of service level advisory groups or working teams to support specific initiatives, ensuring connection to the Clinical Council for decision-making support and to Consumer Council for patient/whānau involvement. All service level advisory groups are linked to cross-sector clinical leadership and to consumer input in this way.

In response to the projected growth in the population of frail older people and a further growth in the numbers of people living with complex long term conditions, there is a need for primary care to be better positioned to address acknowledged challenges, to be more connected and collaborative, and to deliver services that are accessible and appropriate for the Hawke's Bay population. Other providers of health and social services in the community need to be more connected and services need to be joined up.

HBDHB and HHB are working with the health sector and consumers to develop the concept of Health and Social Care Networks. This concept is about the right clinician delivering an appropriate service in the most sensible location supported by a network of providers who understand and respond to the needs of the patient and their whānau, who in turn are empowered to manage their own health and social wellness. In the short term, this will see us delivering more services to work collaboratively with other organisations (across the health and social care spectrum) in specific geographical communities to deliver better care for individuals and whānau.

Short-term outcome	Activity	Monitoring & Reporting

System Level Outcome Measures

[Guidance released from MoH end of February]

Short-term outcome	Activity	Monitoring & Reporting

Whānau Ora

HBDHB will continue to play a key role in supporting Whānau Ora by focusing on the five priority areas that contribute to Whānau Ora – Mental health, asthma, oral health, obesity and tobacco. We support the Whānau Ora policy and recognise the importance of working with other public sector agencies and local health providers in addressing the health needs of the whānau. Each of the five priority areas are recognised as Māori Health Priorities within the annual plan and specific activities for improving performance in these areas can be located in their respective sections.

The Whānau Ora performance indicators are:

- Mental Health: Reduced rate of Māori committed to compulsory treatment relative to non-Māori.
- Asthma (ASH – Access to care): reduced asthma and wheeze admission rates for Māori children (ASH 0-4 years).
- Oral health: Increase in the number of children who are caries free at age 5.
- Obesity: By December 2017, 95 percent of obese Māori children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.
- Tobacco: 95% of all pregnant Māori women smoke free at two weeks post-natal

Short-term outcome	Activity	Monitoring & Reporting
Contribute to achieving Whānau Ora across the whole of the health system focusing on progress in five key areas - mental health, asthma, oral health, obesity and tobacco – to achieve accelerated progress towards health equity for Māori;	Work with local Whānau Ora collective Takitimu Ora on development of a Youth Strategy	**SI5**: Report on progress in the 5 priority areas and impact on whānau, and how engaging with Whānau Ora commissioning agencies. KPIs reported in relevant sections
	Define what whānau centric services are to inform a model for working with whānau to influence future service delivery.	
	Focus on achieving health equity in the Whānau Ora key performance indicators through Māori Health Plan reporting. Specific actions to improve performance in each area can be found in the relevant sections of the Plan	

Cancer Services

Cancer services span the continuum from prevention and screening, through treatment and follow-up care. Faster Cancer Treatment (FCT) takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. Cancer treatment is provided by HBDHB through our own provider and in collaboration with a number of other providers. For example, all radiation treatments are provided for Hawke's Bay patients by MidCentral DHB, while some surgical treatments are outsourced to Capital & Coast, Hutt Valley and Auckland DHBs. There is local provision of outpatient-based chemotherapy plus coordination of all Hawke's Bay patients across and through all networked services. This requires a high level of inter-district collaboration to ensure that services are integrated and seamless for patients.

Achieving the Faster Cancer Treatment Health Target is a priority for HBDHB and has been highlighted by the Minister of Health as a key focus area for 2016/17

Short-term outcome	Activity	Monitoring & Reporting
Faster Cancer Treatment		

Breast and Cervical Screening are national Māori health priorities. Participation in the BreastScreen Aotearoa and National Cervical Screening Programme by Hawke's Bay Māori has been steadily improving, and while the screening sector has employed targeted approaches, a small inequity in screening coverage still persists. Service providers across the sector are singularly committed to improving Māori participation in both screening programmes with strong collaboration and cooperation evident. Hawke's Bay DHB, Health Hawke's Bay, BreastScreen Coast to Coast, Kahunungu Executive, Te Kupenga Hauora Ahuriri, Te Taiwhenua o Heretaunga, Kahungunu Health Services and Central Health continue to implement a joint plan for Hawke's Bay.

Māori Health Priority	**Achieve the National Cervical Screening Programme (NCSP) National target**	Continue regional coordination of services across the National Cervical Screening Programme - entailing collaborative partnerships, joint planning, coordination of services and activities, effective communication and strengthening supportive networks	70% of NCSP service providers participate in regional coordination activities.
		Continue to concentrate on Māori, Pasifika and Asian women by offering promotional $20 voucher to the women when their cervical smear test is completed.	Number of vouchers given to NCSP Māori, Pacific and Asian women.
		Support nurses to attend smear-taker training and pass their assessments, with specific focus on Māori and Pacific nurses and cultural competency.	Increased number of Māori and Pacific nurses completing smear taker training and passing their assessments.
		Continue recruitment and retention strategies targeting Māori and Pasifika populations using a mix of kanohi ki te kanohi, settings and community development approaches.	Number of Māori and Pasifika women able to be identified as completing screening as a direct result of these strategies.
		Manage a campaign during cervical screening month and provide support to community promotional events where there are a high number of Māori women present and where there is involvement of rural communities.	Number of Māori women able to be identified as completing screening as a direct result of campaign and promotional events.
		Continue to improve screening recall processes for Māori women to ensure they attend on-time three yearly screening.	80% of Māori women having had a cervical smear test in the past three years.
		Continue the quality improvement initiative 'Best Practice in Primary Care' (BPPC) project, focussing on NCSP systems and processes within general practice including improving access, service quality, data quality, patient management systems, compliance with NCSP Policies and Standards and HPV testing.	BPPC established in four new general practices by Q4.
		Continue focus on improving data quality through data matching between NCSP and general practices, and working with smear takers, laboratories and the NCSP register regarding recording ethnicity data.	98% of the Priority group women checked monthly have a correct ethnicity

	Improve the timeliness and experience of colposcopy for Māori Women	Continue to refine the referral process from primary care into colposcopy and work towards reducing DNAs for FSA and follow-up appointment, particularly for Māori women with high grade cytology results (CIN2 and CIN3).	90% of eligible Māori women with a high grade cytology result attend colposcopy FSA and follow-up appointments. Reduction in DNA rates for colposcopy FSA and follow-up appointments for Māori women with a high grade cytology result.
Māori Health Priority	**Achieve the BreastScreen Aotearoa (BSA) National target**	Continue regional coordination of services for BreastScreen Aotearoa screening pathways - entailing collaborative partnerships, joint planning, coordination of services and activities, effective communication and strengthening supportive networks.	70% of eligible women, aged 50 to 69 will have a BSA mammogram every two years.
		Continue focus on improving data quality through data matching between BreastScreen Coast to Coast and general practices.	Number of general practices data matched.
		Hold annual CME/CNE sessions on BSA and NCSP programmes, support cultural competency,	One CME/CNE session for BSA and one for NCSP per annum

Stroke

HBDHB will provide an organised acute stroke service for our population. The aim is that more people will receive access to organised stroke services, and stroke services will be timelier so that more patients survive stroke events and the likelihood of subsequent stroke events is reduced.

Short-term outcome	Activity	Monitoring & Reporting

Cardiac Services

Across the Central Region there is a commitment to improved and timelier access to cardiac services. HBDHB supports the regional programme outlined in the Regional Services Programme (RSP) and also works locally to improve access to cardiac diagnostics and specialist assessments, reducing waiting times for people requiring cardiac services, improve prioritisation and selection of cardiac surgical patients, increase cardiac surgical discharges and reduce variations in access.

Short-term outcome	Activity	Monitoring & Reporting
Contribute data to the Cardiac ANZACS-QI and Cath/PCI registry to enable reporting measures of Acute Coronary Syndrome (ACS) risk stratification and time to appropriate intervention.	Secure funding for a designated resource for coordination, data capture, data cleansing and performance monitoring	**PP20**: 95% of patietns presenting with ACS who undergo coronoray angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days
Patients with suspected ACS receive seamless, coordinated care across the clinical pathway.	Continue to implement agreed protocol for referring to Wellington when local access to angiography is not feasible within 72 hours	**PP20**: 70% of high-risk patients will receive an angiogram within 3 days of admission Target achieved in Māori, Pacific and Other
	Improve local access to coronary angiography by providing additional sessions on a Friday as required and investigate stand-alone cath lab capacity.	
	TBC - Review and audit the accelerated chest pain pathways (ACPPs) in the Emergency Department	
Access to Cardiac services is equitable	Deliver minimum target intervention rates for Cardiac surgery, Percutaneous revascularisation, and Coronary angiography.	Cardiac surgery: TBC per 10,000 Percutaneous revascularisation: TBC per 10,000 Coronary angiography: TBC per 10,000
	Manage waiting times for cardiac services so that patients wait no longer than four months for first specialist appointment (ESPI2) and or for treatment (ESPI5)	ESPI2 & ESPI5
Actions to Deliver on Regional Service Plan	Continue to work with the regional cardiac clinical network to implement actions to improve outcomes for people	RSP report
	TBC – Waiting on RSP development NB: HBDHB supports initiatives (e.g training for Echo at a regional level) with questions regarding funding	

Health of Older People

HBDHB is investing in improved services for frail older people. Services will be coordinated to support General Practices to provide care and support patients and families with LTCs to manage their care. In older people services, we will develop clusters of Practices supported by coordinated care teams, including pharmacy facilitators, district nurses, geriatricians, allied health and mental health. Over the next three years we will build MDTs that work with General Practice staff so staff can use their skills where they will make the biggest improvements in the health of people who are frail. Staff will have confidence to work across disciplines so we reduce the number of people involved in a patient's care.

Short-term outcome	Activity	Monitoring & Reporting
Actions to Deliver on Regional Service Plan		

Shorter Stays in Emergency Departments (ED)

Better, Sooner, More Convenient health services for New Zealanders in relation to ED means all New Zealanders can easily access the best services, in a timely way to improve overall health outcomes. A health system that functions well for people with acute care needs is one that delivers and coordinates acute care services in the hospital and community; improves the public's confidence in being able to access services when they need to; sees less time spent waiting and receiving treatment in the ED; moves patients efficiently between phases of care; and makes the best use of available resources. The ED target is not simply about ED efficiency – instead, it reflects patient flow and whole of system functioning.

Short-term outcome	Activity	Monitoring & Reporting
Achieve the national health target for shorter stays in the ED – 95% patients admitted, discharged or transferred from the ED within six hours Shorter Stays in Emergency Departments	•	•
	•	

Improved Access to Diagnostics

Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve patient outcomes in a range of areas

HBDHB is committed to improving access, quality of care and patient flow in diagnostic services. We have completed a Radiology Service Improvement Project aligned to the National Radiology Service Improvement Initiative. The initiatives put in place through this project have maximised efficiency within the service but demand continues to outweigh supply. This year we will continue to implement the service improvement initiatives and reporting from the project to ensure this becomes business as usual once the project is complete. We will also focus on standardising referral criteria to minimise unnecessary testing in the hospital and in the community.

From March 2015, colonoscopy access targets have consistently been exceeded. However, population projections and anticipated increased demand require the physical limitations and capacity constraints of the current facilities to be addressed. A project is underway for the development of new facilities and associated resources to support the sustainable improvement of endoscopy services. The preliminary design of new facilities is due to be completed by September and, pending approval, development will begin.

Short-term outcome	Activity	Monitoring & Reporting
Improve waiting times for CT and MRI	Continue to carry out relevant reporting and implement all service improvement initiatives beyond the end of the project	**PP29**: 95% of accepted referrals for CT scans and X% of accepted referrals for MRI scans will receive their scan within 6 weeks
	Forecast demand on radiologists and plan for leave cover in advance.	
	Use the learnings from the service improvement initiatives to apply to Ultrasound services	
Improve waiting times for colonoscopy	Update monthly reporting against all targets and exception reporting to inform Service manager of any issues requiring mitigation.	**PP29**: Urgent colonoscopy: TBC% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive), 100% within 30 days Non-urgent colonoscopy: TBC% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within TBC days Surveillance colonoscopy: TBC% of people waiting for a surveillance or follow-up
	Develop audit process to improve the quality of data in the reporting tool Provation to inform service improvements.	
	Complete design and Implementation of Map of Medicine Pathway for Colonoscopy and CT Colonoscopy. The pathway will promote the use of National Referral Criteria for direct access outpatient colonoscopy and standardise the triage process for surgical and medical colonoscopy referrals.	
	Work with the Ministry of Health to re-establish quality improvement systems (NEQIP) for endoscopy including improved regional collaboration	
	Continue to investigate regional collaboration for Endoscopic retrograde cholangiopancreatography (ERCP) such as leave arrangements and patient flow	

	Continue progress with project for Improving Endoscopy service by completing the preliminary design phase by September 2016	colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within TBC days
	Prepare the workforce for the stand alone endoscopy unit requiring change in practice and additional nurses and consultants.	
Improve access to cardiac diagnostics to facilitate appropriate treatment referrals	Ongoing monitoring of timely access to elective coronary angiography	**PP29**: 95 percent of people will receive elective coronary angiograms within 90 days.
	Ongoing implementation of agreed protocols for faster referral of high-risk patients to improve capacity for elective angiography.	
Actions to Deliver on Regional Service Plan	TBC –Finalised Regional Plan Continue to attend regional network for radiology for ongoing collaboration and sharing of learnings.	

Improved Access to Elective Surgery

HBDHB supports the national priority of more people receiving access to elective services in order to support New Zealanders to live longer, healthier and more independent lives. Through coordinated and integrated services, patients will have shorter waiting times for elective services meaning they receive faster access to health services, and can regain good health and independence sooner. Local projects/actions to support achievement of the elective surgery health target are focused around our 'Operation Productivity' – a clinically-led programme of work that is systematically identifying and implementing service improvements in our operating theatres and perioperative environment

Short-term outcome	Activity	Monitoring & Reporting
Increase access to elective surgery 	Increase the number of elective discharges to meet elective health target	TBC elective surgical discharges
	TBC – Action to continue Operation Productivity initiatives	
	Carry out review Surgical Service (Particular specialties?) to optimise capacity and efficiency and ensure the people with the greatest need are getting access to surgery.	TBC Service reviews completed
	Continue progress with Customer focused booking project to achieve a more responsive approach to booking that includes interaction with patients and specialty clinic teams to provide a choice of appointment times and locations, whilst assuring effectiveness, efficiency and safety of patient scheduling.	Reduction in DNA rate
Ensure equitable access to elective surgery	Deliver minimum target intervention rates for Major Joint Replacement and Cataract Procedures	Major Joint Replacement: TBC per 10,000 Cataract Procedures: TBC per 10,000
	Manage waiting times for elective services so that patients wait no longer than four months for first specialist appointment (ESPI2) and or for treatment (ESPI5)	ESPI2 & ESPI5
	Developed an end to end system that aligns with the Ministry of Health National Patient Flow specifications to ensure quality data capture, mapping, reporting and analysis to define the patient journey.	National Patient Flow Project Milestones
	Improve the consistency of prioritisation of orthopaedic patients by implementing the new Orthopaedic Clinical prioritisation tool once it is finalised Nationally.	
	TBC – Health Round table work to reduce elective inpatient length of stay	Target TBC
	Review clinical pathway for Hip and knee pain to improve self-management and non-surgical intervention in the community.	

2.2.4 Living within Our Means

In this section:

National Entity Priority Initiatives

NZ Health Partnerships Ltd

Workforce

Capital

Procurement

National Entity Priority Initiatives

Final List of National Entity priority initiatives are to be confirmed by Health Sector Forum – All actions TBC from 15/16

HBDHB is committed to working with the national entities in order to drive better economies of scale and to free up resources to move into frontline services. The table below outlines the major programmes of the national entities that we are committed to over the next year. Anticipated costs and benefits for all national programmes, where assessed and agreed, have been factored in to the HBDHB budgets for 2015/16.

Short-term outcome	Activity
National Health IT Board	In 2016/17 HBDHB will: - TBC – electronic Medicines Reconciliation e(MR) Progress - Implement Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR) in accordance with the Regional Health Informatics Plan (RHIP) timeline, which has been extended - Commence implementation of a supported Patient Administration System (PAS) in accordance with the RHIP timeline - Support the National Patient Flow work programme. HBDHB intends to be collecting Phase 3 information by July 2016 - Develop an implementation plan with Te Oranga Hawke's Bay – Health Hawke's Bay (the PHO), to enable individuals to have access to their own health information (patient portals) - TBC – National Maternity Information System Platform (MISP–NZ)" DHBs are to identify actions and milestones to show that MISP-NZ has been implemented, or is in the process of being implemented across all 20 DHBs
Health Quality and Safety Commission (HQSC)	Quality and safety is one of our strategic focus areas and we have a broad programme that is closely aligned to the work of the HQSC. We are committed to complying with the expectations of our Operational Policy Framework and to continuing to develop quality and safety management systems. HQSC programmes that we support include: - Surgical Site Infection Programme – national infection surveillance data warehouse and DHB infections management systems - Quarterly run of the national inpatient patient experience survey and reporting system - Ongoing links to support improvement science and increased clinical leadership - PHO implementation of the primary care patient experience survey and reporting system
Health Workforce New Zealand (HWNZ)	Strategic workforce development programmes for HBDHB are coordinated through the Central Region regional training hub. The 2015/16 programme of work is outlined in Action Plan 11 of the RSP and HBDHB is committed to supporting the regional approach to addressing workforce requirements. The RSP action plan "…acknowledges the alliance formed between the six Central Region DHBs and HWNZ as a critical nexus in addressing workforce priorities and enabling the region to

	cultivate the existing collaborative and cohesive network for developing valid workforce initiatives and innovations." Strict alignment with HWNZ priorities is maintained. • Increasing the number of sonographers • Expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses • Create new nurse specialist palliative care educator and support roles • Expanding the role of specialist nurses to perform colonoscopies • Increasing the number of medical physicists • Increasing the number of medical community based training places and providing access to primary care/community settings for prevocational trainees
National Health Committee	The DHB will work collaboratively with the NHC to solve sector issues by: - Engaging with and providing advice on prioritisation and assessments including through the National Prioritisation Reference Group - Referring technologies that are driving fast-growing expenditure to the NHC for prioritisation and assessment where appropriate - Introducing consistently or not introducing emerging technologies based on the NHC recommendations - Holding technologies, which may be useful but for which there is insufficient evidence or which the NHC is assessing for further diffusing, out of business as usual - Providing clinical and business expertise and research time to design and run field evaluations where possible.
Health Promotion Agency	We will support the HPA work programme in respect of promoting the national health targets, raising public awareness about rheumatic fever, reducing consumption of alcohol during pregnancy, and increasing alcohol screening in primary settings. More detail is shown in our 2015/16 Public Health Unit

TBC - Activities may change after NZ Health Partnerships National Planning Hui -

HBDHB will continue to work with NZ Health Partnerships Ltd and the other 20 DHBs in achieving the efficiencies available from the work completed on the four business cases.

NZ Health Partnerships Ltd	National Oracle Solution (formerly Finance, Procurement and Supply Chain) – Co-creation of a single financial management information system. HBDHB will commit resources to the implementation of Oracle system, and will fully factor in expected budget benefit impacts. Food Services Linen and Laundry Services National Infrastructure Platform The National Infrastructure Platform programme aims to achieve qualitative, clinical and financial benefits for DHBs through a national approach to IS infrastructure consumption. HBDHB is committed to working collaboratively with NZ Health Partnerships to progress the National Infrastructure Platform. DHBs will commit resources to the decision reached in relation to the implementation of the programme.

Workforce

HBDHB is faced with challenges relating to the ageing workforce, skill mix and the ability to retain skills and knowledge. These issues are heightened by increased patient expectations and, with a highly mobile workforce, by the availability of potentially better opportunities outside of New Zealand. From an organisational perspective, there is a need to develop more integrated sector-wide health service pathways making use of expanded scopes of practice in nursing, medical and allied health professional groups. We continue to develop new roles and changed roles as a result of developing and implementing new models of care. Our Transform and Sustain programme will continue to have an impact on the employees and health profession workforce across the district.

Similar challenges exist at the regional level and HBDHB is committed to the regional workforce plans as detailed in the RSP and to the workforce plans outlined within each of the regional priority service plans. We work closely with the Regional Training Director, all other Central Region DHBs, primary and community organisation to advance regional workforce plans.

In early 2016 we implemented all the requirements for a safe and competent workforce in terms of the Vulnerable Children's Act 2014 and its focus on new core workers. In 2016 we will implement all the requirements for existing core workers.

Short-term outcome	Activity	Monitoring & Reporting
Meet Government expectations for pay and employment conditions in the State Sector	All DHB single employer bargaining arrangements and individual employment arrangements that will be put in place in the 2015/16 years will: - Support the delivery of organisation and sector performance improvement, foster continuous improvement, advance our Transform and Sustain strategy and support effective employee engagement to deliver DHB outcomes - Enable the DHB to recruit and retain highly capable staff	
Meet the requirements of the Vulnerable Children's Act	Implement all requirements	All requirements implemented from July 2015
Actions to Deliver on Regional Service Plan	TBC – Finalised Regional Services Plan	

Māori Workforce & Cultural Competence

There is a general intention in Hawke's Bay to increase the Māori workforce across all government agencies. Under the organisational development component of Transform and Sustain, it is a district priority for Health Services to increase Māori staff representation in the health system. At June 2013, the proportion of Māori employed by HBDHB was 9.9% of total staff numbers. This has increased slowly and at the end of June 2015 was 12.3% against a target for the year of 12.97%. This target has increased by 10% to 14.3% by 30 June 2016 and as a stretch target is providing significant challenges to the DHB. It is a challenge we are up for and we are focused on increasing Maori staff representation in Nursing and Allied Health. In addition, we have raised the expectation of cultural competence across the workforce to ensure that services become more responsive to our Māori population in our quest for driving out inequity through our continued rollout of our Engaging Effectively with Maori training which 50% of our staff have completed as at 31 January 2016.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Improved recruitment and retention of Māori employees in areas with high proportion of Māori customers resulting in an increased proportion of Maori employed by HBDHB** TBC Target	Increase support for Māori nursing workforce through the Nursing Entry to Practice (NEtP) Programme	NEtP % Māori
		Maintain target focus and promote recruitment of Māori to all hiring managers	
		Extend focus of increasing Maori staff recruitment from Nursing to Allied Health	Number new Māori staff employed in Nursing and Allied Health roles.
		Use Māori and other relevant networks to promote vacancies to Māori - Investigate Māori placements into services of high utilisation	
		Connect Māori students with opportunities for health sector careers and career development through Turuki Māori Health Workforce and Incubator programmes	All schools with high Māori rolls engaged in Incubator programme
		15/16 Action - *Carry out a mid-term evaluation of Turuki Māori Health Workforce strategy April* 2016 – Do we have an action for 16/17 e.g implement outcomes of evaluation	
		Align Kia Ora Hauora students into DHB	
Māori Health Priority	**Improve Māori cultural competencies employees**	Continue to promote the "Engaging effectively with Māori" training package that was launched in 2014	% of staff completing Engaging effectively with Maori training and Treaty of Waitangi online training, by employment group & ethnicity
		Promote online cultural competence training through PHO and NGOs	
		Explore cross-agency experiential learning for non- Māori for up to 3 months at a time	

Clinical Governance and Leadership

HBDHB actively fosters Clinical Governance and Leadership in a number of ways. At the Governance level, our Board is advised by a Clinical Council that is made up of a number of primary care and secondary care clinicians with a balance of doctors, nurses and allied health representation. The Clinical Council meets monthly to consider proposals, reflect on performance and to clarify expectations from a clinical point-of-view. Our service level alliances are given effect through relationships and reference to our Clinical Council. Furthermore, Clinical Council has an important role in resource prioritisation and, for this 2015/16 Annual Plan, the Council initiated a specific process for input and influence over investment and disinvestment decisions within the overarching budgeting function. Other ways that we foster clinical leadership is through participation of clinicians in sector-wide leadership forums, regional and national clinical networks, and at the executive management table. In our provider arm, each directorate is led by a triumvirate that includes a Service Director, a Clinical Director and a Nurse Director. Going forward we will design Allied Health/Health professional leadership roles that will work as part of the Service Directorate teams. As a result, most clinical staff have a professional reporting line for supervision and professional support in addition to their usual managerial reporting line for personnel functions.

We launched in early 2014 our Transformation Leadership Programme for all Service Directorate teams and extended this to our department and speciality leaders. This has run through 2015 with programme refreshers for our Service Directorates held and Primary and Community leaders joining the programme in late 2016. This will continue in 2016/17.

Capital – To be reviewed

Regional capital investment approaches are outlined in the RSP, section 10. HBDHB is committed to working with the regional capital committee on the development of our local plans and assisting our regional colleagues in development of the regional capital plan and its implementation.

Formal asset management planning is undertaken at HBDHB. Our asset values will be updated by a Registered Valuer as at the 30 June 2015. Our Asset Management Plan has also been updated in 2014-15 incorporating a ten year plan for expenditure on our assets. Approvals at regional and national level are sought depending on the threshold of any proposed investment to help ensure that there is some national consistency in development of the health assets. We will continue to work nationally with the development of the various national initiatives and regionally on the development of a regional solution for our information technology applications.

Procurement – To be reviewed

The Ministry of Business, Innovation and Employment (MBIE) Government Rules of Sourcing (Rules) became mandatory for the public health sector on 1 February 2015. HBDHB intends to comply with the requirements set out in the Rules to the greatest extent that is practicable. Compliance with the Rules is subject to any statutory or similar obligation applying in respect to procurement e.g. pharmaceuticals from the pharmaceutical schedule (PHARMAC), being a requirement of s.23(7) of the NZ Public Health and Disability Act; in-scope procurement via Health Alliance (hA), being procurement covered by arrangements consented to by the Minister under s.24 of the NZPH&D Act

Major Strategic Asset Expenditure 2015-19				
	2015-16	2016-17	2017-18	2018-19
Mental Health Inpatient Unit	5,654	1,000	-	
Maternity development	2,035	227	-	
Napier Health Centre	81			
New stand-alone endoscopy	848	5,000	3,700	
Renal centralised development	665	1,400	-	
Oncology upgrade			200	800
Upgrade old MHIU	100	2,000	3,000	2,900
Ambulatory Care				2,000
Xray equipment	598	1,520		
Angio equipment		2,040		
MRI			2,460	
Laboratory	600	-		
Central Region IS Programme	1,391			
Health Benefits Limited				

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2.2.5 Improving Quality & Safety

Delivering consistent high quality care continues to be one of the key themes and enablers to achieving our Transform and Sustain strategy. Over the past twelve month the Quality Improvement and Patient Safety service has been evolving to support the Hawkes Bay health sectors quality improvement and patient safety framework - Working in Partnership for Quality Healthcare in Hawke's Bay. This framework identified clinical leadership and consumer partnership throughout the health sector as the most important aspect of improving quality health care and patient safety. We use our framework to align our local efforts in support of the national quality improvement work coordinated by the Health Quality and Safety Commission (HQSC). In 2015/16 we have established a new Quality Improvement and Patient Safety (QIPS) team and we appointed the Director of that service to Executive Management Team (EMT) in order to further raise the profile of quality and safety at HBDHB. With a focus on consumer engagement, the QIPS team provides support for integrated quality improvement and performance across the Hawke's Bay health sector and help clinical teams to recognise and define priority areas and to identify actions for implementation. Our focus for the coming year will be on continuing the sustain the improvements made in the past twelve months, continuing to meet the required Health and Disability Standards with our full year Certification Audit and to focus on growing the capability of our teams in regards to co-design and improvement methodologies, and enable a shift in the culture of the organisation see consumer engagement as the norm and move to becoming far more person and whānau centred.

Short-term outcome	Activity	Monitoring & Reporting
Improve HB Health Sector performance against all National Quality and Safety markers (QSM)	QIPS team to support operational teams by supplying regular performance data from routine monitoring and audits, interpreting data and assisting with the development of improvement opportunities	HQSC quarterly QSM reporting on all targets
	Front-line ownership of improvement targets driven by directorate leadership and oversight provided by Clinical Council representing sector wide clinical leadership.	
	Continue to share consumer stories monthly with all governance bodies and present quarterly quality dashboard.	
Reduce risk of harm from falls	TBC – link to falls project	90% of older patietns are given a falls risk assessment 98% of those at risk have an individual care plan completed
	Cross sector integrated approach through the Falls Minimisation Committee. Includes representation from primary, aged residential care and secondary care patients and NGPs Links to activity in hospital (intentional rounding, signalling tools in wards); urgent care (fracture liaison); community (aged residential care); and primary (pharmacy, green prescription).	
	Falls risk assessments and care plans completed for all admissions.	
	Clinical Nurse managers or Nurse Directors to investigate falls events and provide feedback and learnings to Chief Nursing Officer and Falls Minimisation Committee. Focus on reducing falls in older people that result in serious harm.	
	Implementation of engAGE orbit to support with falls minimisation (LINK to HoP section)	

Short-term outcome	Activity	Monitoring & Reporting
Reduce risk of healthcare associated infection	Maintain achievement at or above 80% compliance for hang hygiene	80% compliance with good hang hygiene practice
	Maintain the right number of trained hand hygiene auditors and promote good hand hygiene practices to staff, patients and visitors. Supported by the Chief Nursing Officer's sponsorship	
	Monitor quarterly results and implement related improvements, such as implementing local improvement methodology and front-line ownership through our gold auditors	
	Improve performance for clinical interventions specified by the surgical site infection improvement programme	95% of hip and knee replacement patients received surgical prophylaxis 100% of hip and knee replacement patients have appropriate skin prep
	Champions on the wards and in DSU to support the process and educate staff	
Reduce risk of perioperative harm	TBC by MoH Feb 16 – Commit to implementation of new Safe Surgery communications tool from 1st July	TBC
Improve medication safety	**TBC** - Continue to carry out medicines reconciliations and monitor and report these on a quarterly basis with an aim to spread medicines reconciliation through paper-based system	TBC - Commitment to implement eMR in 2016/17
	TBC - Perform user acceptance testing on Clinical Portal (due Quarter 2 2016) in preparation for eMeds implementation and support implementation of electronic medicine reconciliation platform when infrastructure available (dependent on regional programme)	
Improve Consumer engagement and experience	Continue with initiative to capture correct patient details at 'first point of contact' working closely with the Customer Focused Booking and National Patient Flow Projects	DV4 Quarterly Reporting TBC – QIPS team planning day
	Support implementation of the Patient Experience Survey in Primary Care. Opportunities for improvement will be identified, tracked and implemented (this was a lone bullet but seemed like an odd sentence on it's own so wondered if supposed to sit here)	
	Develop a consumer engagement strategy by the end of 2016	
	Implement a local consumer engagement survey aligned to sector wide values	

Short-term outcome	Activity	Monitoring & Reporting
	Continue to produce a Quality Dashboard to monitor Safety, Clinical Effectivness and Patient Experience.	
	Develop and Implement a health literacy framework	
	Consult with patients when developing Collaborative clinical pathways	
Improve Quality Improvement Capability and clinical leadership	Promote Key messages and theses of Patient Safety Week 2016	Quality accounts demonstrate building of capability for quality improvement and patient safety.
	Sustain the HB sector wide transformational leadership programme	
	Implementation of training and support to all teams in patient safety, QIP methodologies, health literacy and co-design with consumers	
Produce Annual Quality Accounts	HBDHB will continue to produce annual Quality accounts and circulate locally to show improvement in key quality and patient safety indicators	
Promote Regional Collaboration for Quality and Safety Initiatives	Implement HB secor wide consumer engagement strategy	
	Participate in central region's Quality and safety forum and quarterly Quality and Risk meetings to share learnings and build capability for improvement.	

Clinical Governance and Leadership

HBDHB actively fosters Clinical Governance and Leadership in a number of ways. At the Governance level, our Board is advised by a Clinical Council that is made up of a number of primary care and secondary care clinicians with a balance of doctors, nurses and allied health representation. The Clinical Council meets monthly to consider proposals, reflect on performance and to clarify expectations from a clinical point-of-view. Our service level alliances are given effect through relationships and reference to our Clinical Council. Furthermore, Clinical Council has an important role in resource prioritisation and, for this 2015/16 Annual Plan, the Council initiated a specific process for input and influence over investment and disinvestment decisions within the overarching budgeting function. Other ways that we foster clinical leadership is through participation of clinicians in sector-wide leadership forums, regional and national clinical networks, and at the executive management table. In our provider arm, each directorate is led by a triumvirate that includes a Service Director, a Clinical Director and a Nurse Director. As a result, most clinical staff have a professional reporting line for supervision and professional support in addition to their usual managerial reporting line for personnel functions.

2.2.6 Actions to Support Delivery of Regional Priorities

Our strategic intentions are aligned to those of our regional partners, as depicted in Figure 3 above. Delivery of regional programmes is carried out at regional and sub-regional level based on assessment of the most appropriate approach. Our commitment to regional collaboration is driven through membership of all major governance committees within the regional structure and by participation in clinical networks. DHB personnel are supported to participate in regional forums and regularly contribute to the development of plans and initiatives. The 2016/17 RSP implementation plans were presented to our Clinical Council for review and input before being presented to our Board for approval – this process ensures that our staff have good opportunity to contribute to developments and to prepare for the local impact of any change. We have outlined activity in support of regional priorities within the service actions above and the financial impact of those activities is provided for in operational budgets and within the core funding that HBDHB contributes to the operations of Central TAS as the Central Region's Technical Advisory Service (CR TAS). Regional priorities that are not mentioned above are included below.

Major Trauma

HBDHB is committed to the regional programme in respect of Major Trauma. There is a national objective of improving the survival and post-treatment impacts of major trauma by offering patients a more comprehensive and coordinated response.

Short-term outcome	Activity	Monitoring & Reporting
TBC – Regional Services Plan Finalised		

Hepatitis C

The MoH is working with regional groupings to deliver a single Hepatitis C clinical pathway to ensure consistency of services and care for patients. It is expected that Central Region pilot sites at Capital & Coast and Hutt Valley DHBs are transitioned to a full regional service within the 2015/16 year.

Short-term outcome	Activity	Monitoring & Reporting
TBC – Regional Services Plan Finalised		

Information Systems (IS)

HBDHB IS programmes are aligned to the work of the National Health IT Board (see National Entities above), the Central Region Information Services Plan – CRISP (See RSP, Section 10 Information Technology), and to Transform and Sustain.

We work closely with the PHO to ensure health data and information is accurate, secure and appropriately available. Data quality is a national Māori health priority, particularly in respect of the accuracy of ethnicity reporting in primary care patient management systems. Our commitment to accelerating Māori health and well-being means that we must have good data to gauge progress. The only way to be sure that ethnic disparities are reducing is by measuring indicators across ethnicities. Good ethnic data also enables us to target resources appropriately and to contribute to health research. We have made a commitment to the principle that all our measures should be provided by ethnicity and so we aim to disaggregate our monitoring and reporting increasingly over time. HBDHB is not considered a "Pasifika DHB" for the purposes of national Pasifika monitoring and reporting. However, in recognition of the disparities raised in our Health Equity Report and in other research, we are included in the national Pasifika data analysis.

Short-term outcome	Activity	Monitoring & Reporting
REGIONAL OUTCOME	What is HBDHB doing to support this? – link to National Entities above.	

3 STATEMENT OF PERFORMANCE EXPECTATIONS

SECTION TO BE AGREED – AWAITING FINAL MoH TARGETS

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

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

Service Performance

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

The system dimension: Best value for public health system resources

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

The population dimension: Improved health and equity for all populations

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

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

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

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

The HBDHB Statement of Performance Expectations for the 2015/16 year follows:

X _____ X _____

Board Member Board Member

3.1 OUTPUT CLASS 1: Prevention Services

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

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

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

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

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 5.

Prevention Services	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	11.4	6.1	10.0	6.5	6.9	7.3
Other sources	0.4	0.4	0.1	0.1	0.1	0.1
Income by source	**11.8**	**6.5**	**10.1**	**6.6**	**7.0**	**7.4**
Less:						
Personnel	1.3	1.4	1.4	1.5	1.5	1.5
Clinical supplies	0.1	0.1	0.1	-	-	-
Infrastructure and non clinical supplies	0.3	0.3	0.3	0.3	0.3	0.3
Payments to other providers	8.3	8.2	8.3	8.7	9.1	9.3
Expenditure by type	**10.0**	**10.0**	**10.1**	**10.5**	**10.9**	**11.1**
Net Result	**1.8**	**(3.5)**	**-**	**(3.9)**	**(3.9)**	**(3.7)**

Figure 5 - Funding and Expenditure for Output Class 1: Prevention Services

***Population and Individual Dimensions** Still to incorporate ethnicity into the table*

Short Term Outcome	Indicator	MoH Measure	Baseline	2015/16 Target	National Average
Less people smoke	% hospitalised smokers offered advice to quit	Health Target	98.2%	≥95%	
	% of PHO enrolled smokers offered advice to quit	Health Target	96.0%	≥90%	
	% of pregnant women offered advice and support to quit	Health Target	98.1%16	≥90%	
	% of pregnant Māori women that are smokefree at 2 weeks postnatal	MH			
Reduced Incidence of vaccine preventable illness	% of 8 month olds who complete their primary course of Immunisations	Health Target			
	% of 2 year olds fully immunised	PP21/ IPIF			
	% of 4 year olds fully immunised by age 5	PP21			
	% of girls that have received HPV dose three	PP21			
	% of high needs 65 years olds and over influenza immunisation rate	MH			
Reduced impact of Rheumatic Fever	Rheumatic fever hospitalisation rate per 100,000				
More women are screened for cancer	% of women aged 50-69 years receiving breast screening in the last 2 years				
	% of women aged 25-69 years receiving cervical screening in the last 3 years				
Reduce the rate of Sudden Unexplained Death of Infants (SUDI)	Rate of SUDI deaths per 1,000 live births				
Better rates of breastfeeding	Infants are exclusively or fully breastfed at 6 weeks of age				
	Infants are exclusively or fully breastfed at 3 months of age				
	Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)				
Delay conception in early teenage years	% of youth accessing CPO sexual health service who are Māori				

3.2 OUTPUT CLASS 2: Early Detection and Management Services

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

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

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

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

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 6.

Early Detection and Management	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	86.5	90.1	92.7	94.7	99.4	103.0
Other District Health Boards	2.8	2.9	2.8	2.8	2.9	2.9
Other sources	4.5	4.0	3.4	3.4	3.5	3.6
Income by source	**93.8**	**97.0**	**98.9**	**100.9**	**105.8**	**109.5**
Less:						
Personnel	5.1	5.3	5.6	5.7	5.8	5.9
Outsourced services	0.1	0.1	-	-	-	-
Clinical supplies	0.5	0.4	0.5	0.4	0.4	0.4
Infrastructure and non clinical supplies	1.4	1.4	1.4	1.5	1.5	1.5
Payments to other District Health Boards	2.4	2.6	2.5	2.5	2.5	2.6
Payments to other providers	81.9	86.5	88.3	92.4	96.2	98.9
Expenditure by type	**91.4**	**96.3**	**98.3**	**102.5**	**106.4**	**109.3**
Net Result	**2.4**	**0.7**	**0.6**	**(1.6)**	**(0.6)**	**0.2**

Figure 6 –Funding and Expenditure for Output Class 2: Early Detection and Management Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
More enrolment with primary care	• Proportion of the population enrolled in the PHO	97.3%[16]	≥97%	
More pregnant women under the care of a Lead Maternity Carer (LMC)	• % of women booked with an LMC by week 12 of their pregnancy	51.4%[17]	≥80%	
Hospital service users are reconnected with primary care	• Rate of high intensive users of hospital ED as a proportion of Total ED visits	5.5%[18]	≤5.4%	
More checks for people at risk of long-term conditions	Health Target: More heart and diabetes checks • % of the eligible population having had a CVD risk assessment in the last 5 years	87.7%[19]	≥90 %	87%
Better oral health	% of eligible pre-school enrolments in DHB-funded oral health services % of enrolled preschool and primary school children not examined according to planned recall % of adolescents using DHB-funded dental services % of children without decay at 5 years of age Mean 'decayed, missing or filled teeth' score at Year 8	73.9%[20] 4.0%[25] 84.5%[25] 56.5%[25] 1.0825	≥90% ≤5% ≥85% ≥66% ≤0.87	73% 57%
Improved management of long-term conditions	Proportion of people with diabetes who have good or acceptable glycaemic control	49.2%[21]	≥55%	
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days	92.6%[22]	≥95%	

[16] Mar 2015
[17] Jul-Sep 2014
[18] Dec 2014
[19] 5 Years to Dec 2014
[20] 2014 Calendar Year
[21] 12 months to Dec 2014
[22] Dec 2014

	% of accepted referrals for MRI scans who receive their scans within 6 weeks	61.3%[27]	≥85%	
Avoidable hospitalisation is reduced	Ambulatory sensitive hospitalisation rate 0-4 years Ambulatory sensitive hospitalisation rate 45-64 years	TBC TBC	TBA TBA	
More pre-schoolers receive Before School Checks	% of 4-year olds that receive a B4 School Check	81%[23]	≥90%	91%

[23] Apr 2015

3.3 OUTPUT CLASS 3: Intensive Assessment and Treatment Services

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

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

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

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

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 7.

Intensive Assessment and Treatment	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	295.1	303.3	313.8	319.5	322.6	325.5
Other District Health Boards	5.8	6.1	5.7	5.9	5.9	6.1
Other sources	10.1	10.0	9.5	9.6	9.7	9.8
Income by source	**311.0**	**319.4**	**329.0**	**335.0**	**338.2**	**341.4**
Less:						
Personnel	158.7	165.1	175.1	180.3	183.2	186.2
Outsourced services	15.7	13.1	10.6	11.0	11.2	11.3
Clinical supplies	43.3	39.9	42.1	35.5	33.3	34.1
Infrastructure and non clinical supplies	40.5	40.2	38.3	40.2	43.4	43.5
Payments to other District Health Boards	43.9	47.4	45.8	46.1	46.4	46.6
Payments to other providers	11.9	10.9	14.2	14.8	15.3	15.8
Expenditure by type	**314.0**	**316.6**	**326.1**	**327.9**	**332.8**	**337.5**
Net Result	**(3.0)**	**2.8**	**2.9**	**7.1**	**5.4**	**3.9**

Figure 7 –Funding and Expenditure for Output Class 3: Intensive Assessment and Treatment Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
Less waiting for ED treatment	Health Target: Shorter stays in EDs • % of patients admitted, discharged or transferred from an ED within 6 hours	91.5%[24]	≥95%	94%
Faster cancer treatment	Health Target): Faster Cancer Treatment • % of patients who 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	61.5%[29]	≥85%	66%
More elective surgery	Health Target: Improved access to elective surgery • Number of elective surgery discharges[25]	6,103[26]	≥7,109	
Better long-term conditions management	• Acute coronary syndrome ➢ % high-risk patients receiving an angiogram within 3 days ➢ % of angiography patients whose data is recorded on national databases • Stroke ➢ % of potentially eligible patients who are thrombolysed ➢ % of patients admitted to the demonstrated stroke pathway	50.7%[27] 12.3%[32] 6%[32] 82.1%[32]	≥70% ≥95% ≥6% ≥80%	
Equitable access to surgery	• Standardised intervention rates for surgery (per 10,000 population) ➢ Major joint replacement ➢ Cataract procedures ➢ Cardiac surgery	21.3[28] 52.1[33]	≥21.0 ≥27.0	

[24] Oct-Dec 2014
[25] Health Target Elective Discharges is a number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB district.
[26] 12 months to Jun 2014
[27] Oct-Dec 2014
[28] 12 months to Dec 2014

	➢ Percutaneous revascularisation ➢ Coronary angiography	5.733 10.933 36.233	≥6.5 ≥12.5 ≥34.7	
Shorter stays in hospital	• Average length of stay (days) ➢ Elective ➢ Acute	 1.7429 2.7934	 1.59 2.79	 1.67 2.64
Fewer readmissions	• Acute readmissions to hospital	7.6%	Reduce	7.8%
Quicker access to diagnostics	• % coronary angiography completed within 90 days • Diagnostic colonoscopy ➢ % urgent cases performed within 14 days ➢ % diagnostic cases performed within 42 days • Surveillance colonoscopy ➢ % waiting less than 84 days beyond planned date	89.8%[30] 92.6%[35] 39.7%[35] 50.7%[35]	≥95% ≥75% ≥65% ≥65%	
Fewer missed outpatient appointments	• Did not attend (DNA) rate across first specialist assessments	7.2%[31]	≤7.5%	
Better mental health services ➢ Improving access	Better access to mental health and addiction services • Proportion of the population seen by mental health and addiction services ➢ Child & youth (0-19) ➢ Adult (20-64) ➢ Older adult (65+)	 4.1%[32] 5.1%[37] 1.15%[37]	 ≥4% ≥5% ≥1.15	
Reducing waiting times	Shorter waits for non-urgent mental health and addiction services for 0-19 year olds % of people seen within 3 weeks of referral Mental Health Provider Arm			

[29] 12 months to Sep 2014
[30] Dec 2014
[31] Oct-Dec 2014
[32] 12 months to Sep 2014

16

	Addictions (Provider Arm and NGO) % of people seen within 8 weeks of referral Mental Health Provider Arm Addictions (Provider Arm and NGO)	56.737 88.3%37 82.037 96.1%37	≥80% ≥80% ≥95% ≥95%	
Improving access and coordination	Improving mental health services using discharge planning % children and youth with a transition (discharge) plan	24.0%33	≥95%	
Increasing consumer focus	More equitable use of Mental Health Act: Section 29 community treatment orders Rate of s29 orders per 100,000 population	81.5%38	≥80%	

[33] Oct-Dec 2014

3.4 OUTPUT CLASS 4: Rehabilitation and Support Services

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

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

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

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 8.

Rehabilitation and Support	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	66.1	68.0	69.1	74.0	77.2	79.7
Other District Health Boards	3.0	3.1	3.0	3.0	3.1	3.1
Other sources	0.4	0.4	0.3	0.3	0.3	0.3
Income by source	**69.5**	**71.5**	**72.4**	**77.3**	**80.6**	**83.1**
Less:						
Personnel	5.7	6.0	6.3	6.5	6.6	6.7
Outsourced services	0.1	0.1	0.1	0.1	0.1	0.1
Clinical supplies	0.7	0.7	0.7	0.6	0.6	0.6
Infrastructure and non clinical supplies	1.7	1.7	1.7	1.8	1.8	1.9
Payments to other District Health Boards	3.7	4.0	3.9	3.9	3.9	3.9
Payments to other providers	55.6	56.0	59.2	62.0	64.5	66.3
Expenditure by type	**67.5**	**68.5**	**71.9**	**74.9**	**77.5**	**79.5**
Net Result	**2.0**	**3.0**	**0.5**	**2.4**	**3.1**	**3.6**

Figure 8 –Funding and Expenditure for Output Class 4: Rehabilitation and Support Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
Better access to acute care for older people	Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 75-79 years 80-84 years 85+ years Acute readmission rate: 75 years +	 139.538 183.138 25438 10.939	 ≤139.5 ≤183.1 ≤231.0 <10%	 10.7%
Better community support for older people	% of people receiving home support who have a comprehensive clinical assessment and a completed care plan	100%[34]	≥95%	
Increased capacity and efficiency in needs assessment and service coordination services	Average time from assessment to coordination (65 years and over) Number of needs assessments completed (Disability services) Average time from referral to assessment (Disability services)	7.3 days[35] 61840 6.5 days[40]	<7.3 days >600 <10 days	
Prompt response to palliative care referrals	Time from referral receipt to initial Cranford Hospice contact within 48 hours	92.0%[36]	>80%	
More day services	Number of day services	20,754[37]	≥21,791	
More older patients receive falls risk assessment and care plan	% of older patients given a falls risk assessment % of older patients assessed as at risk of falling receive an individualised care plan	91.8%[38] 76.0%[43]	90% 98%	

[38] Oct-Dec 2014
[34] 12 months to Sep 2014
[35] Dec 2014
[36] Oct to Dec 2014
[37] 12 months to Sep 2014
[38] Oct-Dec 2014

4 FINANCIAL PERFORMANCE

Planning regulations require the DHB's Annual Plan to contain detailed financial budgets, and information on how the DHB's performance both as a funder and as a provider of services will be demonstrated. This module contains audited financial statements for the 2014/15 financial year, forecast financial statements for 2015/16, and projected financial statements for the 2016/20 period. Separate financial performance statements for the funding of services, providing of services, and governance and funding administration are also included for each of these periods. Performance against the 2016/17 financial year projections will be reported in the 2016/17 Annual Report.

4.1 Projected Financial Statements

Introduction

Hawke's Bay District Health Board was planning to deliver a surplus of $3 million in each of the plan years. This is consistent with the DHB's recent track record, and enables us to fund a proportionate capital programme, including in the plan period the completion of major mental health, maternity, endoscopy and renal facilities associated with service redesign.

The financial numbers are also consistent with the DHB's "Transform and Sustain" strategy. Resource deployment and assumed efficiencies are focussed on our three strategic challenges: responding to our population and patients; systematically ensuring quality in all of our services; and increasing our productivity.

Projected Financial Statements

Reporting entity

The financial statements of the District Health Board comprise the District Health Board, its 25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited. The District Health Board has no subsidiaries.

Cautionary Note

The prospective financial information presented in this section is based on one or more hypothetical but realistic assumptions that reflect possible courses of action for the reported periods concerned, as at the date the information was prepared. Actual results achieved for the period covered are likely to vary from the information presented, and the variations may be material.

The underlying assumptions were adopted on 28 May 2015.

Accounting Policies

The projected financial statements in this plan have been prepared in accordance with generally accepted accounting practice in New Zealand (NZ GAAP). They comply with Public Benefit Entity Standards (PBE Standards) issued by the New Zealand Accounting Standards Board (NZASB) of the External Reporting Board (XRB). The forecast financial statements have been prepared on a consistent basis.

The District Health Board prepared its financial statements for the year ended 30 June 2015 in accordance with NZ GAAP that applied at that time. They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other financial reporting standards, as appropriate for public benefit entities.

The terminology used in the financial statements is that of the PBE Standards.

The accounting policies applied in the projected financial statements are included as an appendix.

Projected Statement of Comprehensive Revenue and Expense

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Ministry of Health - devolved funding	446,490	454,030	481,942	490,978	502,232	511,629
Ministry of Health - non devolved contracts	12,646	13,541	3,700	3,758	3,818	3,878
Other District Health Boards	11,613	12,078	11,548	11,724	11,903	12,085
Other government and Crown agency sourced	6,375	6,661	6,578	6,682	6,787	6,894
Patient and consumer sourced	1,718	1,471	1,479	1,502	1,526	1,550
Other	7,355	6,667	5,166	5,226	5,308	5,393
Operating income	486,197	494,448	510,414	519,870	531,574	541,429
Employee benefit costs	170,779	177,815	188,426	194,000	197,094	200,259
Outsourced services	15,925	13,308	10,654	11,141	11,252	11,364
Clinical supplies	44,641	41,109	43,432	36,463	34,272	35,137
Infrastructure and non clinical supplies	43,872	43,585	41,717	43,917	47,056	47,287
Payments to non-health board providers	207,758	215,630	222,194	230,359	237,910	243,392
Operating expenditure	482,975	491,448	506,424	515,880	527,584	537,439
Surplus for the period	3,222	3,000	3,990	3,990	3,990	3,990
Revaluation of land and buildings	-	41,232	-	-	-	-
Other comprehensive income for the period	-	41,232	-	-	-	-
Total comprehensive income for the period	**3,222**	**44,232**	**3,990**	**3,990**	**3,990**	**3,990**

Table 1 – Projected Statement of Comprehensive Revenue and Expense

Projected Statement of Changes in Net Assets/Equity

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Equity as at 1 July	**46,277**	**49,142**	**93,017**	**96,650**	**100,283**	**103,916**
Total comprehensive income for the period:						
Funding of health and disability services	11,165	2,947	3,990	3,990	3,990	3,990
Governance and funding administration	120	139	-	0	0	0
Provision of health services	(8,062)	(86)	-	-	-	-
Revaluation of land and buildings	-	41,232	-	-	-	-
	3,222	44,232	3,990	3,990	3,990	3,990
Repayments to the Crown (equity repayments)	(357)	(357)	(357)	(357)	(357)	(357)
Equity as at 30 June	**49,142**	**93,017**	**96,650**	**100,283**	**103,916**	**107,549**

Table 2 - Projected Statement of Comprehensive Revenue and Expense and Projected Statement of Changes in Net Assets/Equity

Projected Statement of Financial Position

in thousands of New Zealand Dollars

As at 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Equity						
Paid in equity	37,586	37,229	36,871	36,515	36,158	35,801
Asset revaluation reserve	31,744	72,976	72,976	72,976	72,976	72,976
Asset replacement reserve	14,437	15,627	-	-	-	-
Accumulated deficit	(34,625)	(32,815)	(13,198)	(9,208)	(5,218)	(1,228)
	49,141	**93,017**	**96,650**	**100,283**	**103,916**	**107,549**
Represented by:						
Current assets						
Cash	8	7	7	7	7	7
Short term investments	17,000	7,474	10,469	4,667	7,655	16,041
Short term investments (special funds/clinical trials)	3,064	3,172	3,172	3,173	3,173	3,173
Receivables and prepayments	17,516	17,774	18,133	18,502	18,885	19,262
Loans (Hawke's Bay Helicopter Rescue Trust)	11	12	13	13	14	15
Inventories	3,713	3,768	3,845	3,922	4,003	4,083
Assets classified as held for sale	1,744	1,275	-	-	-	-
	43,056	33,482	35,639	30,284	33,737	42,581
Non current assets						
Property, plant and equipment	110,389	160,830	165,876	175,584	178,648	176,730
Intangible assets	3,757	3,870	4,721	5,739	5,881	5,714
Investment property	153	140	140	140	140	140
Investment in associates	4,030	5,414	6,805	6,805	5,636	4,467
Other long term investments	-	-	-	-	-	-
Loans (Hawke's Bay Helicopter Rescue Trust)	67	55	42	-	-	-
	118,395	170,308	177,583	188,268	190,305	187,051
Total assets	**161,451**	**203,790**	**213,223**	**218,552**	**224,042**	**229,632**
Less:						
Current liabilities						
Payables and accruals	35,027	33,274	33,982	34,669	35,388	36,096
Employee entitlements	32,219	32,639	32,660	33,599	34,658	35,820
Loans and borrowings	10,268	-	-	6,000	11,500	-
	77,514	65,914	66,642	74,268	81,546	71,916
Non current liabilities						
Employee entitlements	2,295	2,360	2,431	2,501	2,580	2,667
Loans and borrowings	32,500	42,500	47,500	41,500	36,000	47,500
	34,795	44,860	49,931	44,001	38,580	50,167
Total liabilities	**112,309**	**110,774**	**116,573**	**118,269**	**120,126**	**122,083**
Net assets	**49,141**	**93,017**	**96,650**	**100,283**	**103,916**	**107,549**

Table 3 - Projected Statements of Financial Position

Projected Statement of Cash Flows

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	483,371	496,499	509,033	523,377	535,173	545,178
Cash paid to suppliers and service providers	(285,591)	(304,738)	(290,079)	(310,224)	(313,462)	(319,389)
Cash paid to employees	(168,618)	(175,281)	(188,334)	(188,724)	(192,970)	(195,487)
Cash generated from operations	**29,162**	**16,480**	**30,620**	**24,429**	**28,741**	**30,302**
Interest received	1,246	1,364	1,008	582	270	339
Dividends received	60	60	60	60	60	60
Interest paid	(2,531)	(2,510)	(2,089)	(2,575)	(2,575)	(2,575)
Capital charge paid	(3,664)	(3,923)	(4,055)	(4,354)	(4,566)	(4,908)
	24,273	11,470	25,544	18,142	21,930	23,218
Cash flow from investing activities						
Proceeds from sale of property, plant and equipment	(1,839)	-	1,275	-	-	-
Acquisition of property, plant and equipment	(10,815)	(19,278)	(23,923)	(22,025)	(17,310)	(13,425)
Acquisition of intangible assets	(266)	(944)	(1,500)	(1,562)	(1,275)	(1,050)
Acquisition of investments	(92)	(1,391)	(1,379)	-	-	-
	(13,013)	(21,613)	(25,527)	(23,587)	(18,585)	(14,475)
Cash flow from financing activities						
Proceeds from borrowings	-	-	5,000	-	-	-
Repayment of borrowings	-	-	-	-	-	-
Repayment of finance lease liabilities	(375)	(268)	-	-	-	-
Equity repayment to the Crown	(357)	(357)	(2,022)	(357)	(357)	(357)
	(733)	(625)	2,978	(357)	(357)	(357)
Net increase/(decrease) in cash and cash equivalents	10,527	(10,768)	2,995	(5,802)	2,988	8,386
Cash and cash equivalents at beginning of year	9,330	19,857	9,090	12,085	6,283	9,271
Cash and cash equivalents at end of year	19,857	9,090	12,085	6,283	9,271	17,657
Represented by:						
Cash	8	7	7	7	7	7
Short term investments	19,849	9,082	12,078	6,276	9,264	17,650
	19,857	9,090	12,085	6,283	9,271	17,657

Table 4 - Projected Statement of Cash Flows

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Projected Funder Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Income						
Ministry of Health - devolved funding	446,490	454,030	481,942	490,978	502,232	511,629
Inter district patient inflows	8,647	8,015	7,483	7,595	7,709	7,825
Other income	145	137	93	95	96	98
	455,282	**462,182**	**489,518**	**498,668**	**510,037**	**519,552**
Expenditure						
Governance and funding administration	3,002	2,781	3,140	3,298	3,172	3,203
Own DHB provided services						
Personal health	197,837	206,380	215,584	216,270	219,538	222,853
Mental health	24,537	24,366	25,005	25,084	25,462	25,845
Disability support	10,003	9,161	14,677	14,725	14,946	15,172
Public health	562	502	4,327	4,339	4,407	4,475
Maori health	418	414	601	603	612	622
	233,357	240,824	260,194	261,021	264,965	268,967
Other DHB provided services (Inter district outflows)						
Personal health	44,342	48,370	46,784	47,071	47,360	47,649
Mental health	2,394	2,428	2,398	2,412	2,427	2,442
Disability support	3,307	3,210	3,000	3,019	3,037	3,056
Public health	-	-	-	-	-	-
Maori health	-	-	-	-	-	-
	50,043	54,009	52,182	52,502	52,824	53,147
Other provider services						
Personal health	88,074	89,857	97,312	102,935	107,795	111,144
Mental health	10,133	10,467	10,994	11,640	12,195	12,578
Disability support	54,236	56,109	56,409	57,793	59,418	60,705
Public health	1,457	1,515	1,515	1,621	1,705	1,762
Maori health	3,815	3,674	3,782	3,868	3,973	4,056
	157,715	161,622	170,012	177,857	185,086	190,245
Total Expenditure	**444,118**	**459,235**	**485,528**	**494,678**	**506,047**	**515,562**
Net Result	**11,165**	**2,947**	**3,990**	**3,990**	**3,990**	**3,990**

Table 5 - Projected Funder Arm Operating Results

Projected Governance and Funding Administration Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Income						
Funding	3,002	2,781	3,140	3,298	3,172	3,203
Other government and Crown agency sourced	-	-	-	-	-	-
Other income	5	8	30	8	8	8
	3,007	2,789	3,170	3,306	3,180	3,211
Expenditure						
Employee benefit costs	858	716	1,044	1,010	1,020	1,030
Outsourced services	392	410	507	437	442	446
Clinical supplies	2	(0)	1	-	-	-
Infrastructure and non clinical supplies	708	591	685	916	765	773
	1,961	1,717	2,237	2,363	2,227	2,249
Plus: allocated from Provider Arm	927	933	933	943	953	962
Net Result	**120**	**139**	**-**	**0**	**0**	**0**

Table 6 - Projected Governance and Funding Administration Operating Results

16

Projected Provider Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Income						
Funding	233,357	240,824	260,194	261,021	264,965	268,967
Ministry of Health - non devolved contracts	12,646	13,541	3,700	3,758	3,818	3,878
Other District Health Boards	2,965	4,063	4,065	4,129	4,194	4,260
Accident Insurance	5,903	6,143	6,164	6,261	6,359	6,459
Other government and Crown agency sourced	472	518	414	421	428	435
Patient and consumer sourced	1,718	1,471	1,479	1,502	1,526	1,550
Other income	7,205	6,522	5,043	5,123	5,204	5,287
	264,267	273,082	281,060	282,215	286,494	290,836
Expenditure						
Employee benefit costs	169,920	177,099	187,382	192,990	196,074	199,229
Outsourced services	15,533	12,898	10,148	10,704	10,810	10,918
Clinical Supplies	44,639	41,110	43,431	36,463	34,272	35,137
Infrastructure and non clinical supplies	43,164	42,994	41,032	43,001	46,291	46,514
	273,256	274,100	281,993	283,158	287,447	291,798
Less: allocated to Governance & Funding Admin.	927	933	933	943	953	962
Surplus for the period	**(8,062)**	**(86)**	-	-	-	-
Revaluation of land and buildings	-	41,232	-	-	-	-
Net Result	**(8,062)**	**41,146**	-	-	-	-

Table 7 – Projected Provider Arm Operating Results

4.2 Significant Assumptions

General

- Revenue and expenditure has been budgeted on current Government policy settings and known health service initiatives.
- No allowance has been made for any new regulatory or legislative changes which increase compliance costs.
- No allowance has been made for the costs of unusual emergency events e.g. pandemic or earthquake.
- Allowance has been made for the implementation costs of and net savings from regional and national entity initiatives as advised by the Ministry of Health.
- No allowance has been made for any additional capital or operating costs that may be required by the National Oracle Solution (NOS) shared financial platform solution managed by New Zealand Health Partnerships Limited (NZHPL).
- Allowance has been made for net additional costs arising from the Regional Health Information Project (RHIP, formerly CRISP) of $0.7 million in 2015/16 with full implementation complete by June 2016.
- Catch-up demographic funding for 2015/16 has reduced the pressure for material performance improvement actions in 2015/16. However $4.3 million of new investment in service provision and the full year impact of ongoing transformation expenditure has required an $8.5 million efficiency programme for the 2015/16 year.
- Unless otherwise stated, increases in revenue and expenditure due to changes in price levels have been allowed for at 1.95%, 2.125% and 2.15% for 2017/18, 2018/19 and 2019/20 respectively based on Treasury forecasts for CPI inflation (30 June Year composite rates based the 31 March rates in the Half Year Economic and Fiscal Update 2015 published 15 December 2015).

Revenue

- Crown funding under the national population based funding formula will be $459.9 million for 2016/17. Funding for the 2017/18, 2018/19 and 2019/20 years will include nominal increases of $8.5 million per annum.
- Crown funding for non-devolved services of $29.3 million is based on agreements already in place with the appropriate Ministry of Health directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- None of the $5 million of funding left with the Ministry of Health in 2011/12 due to sales proceeds from the Napier Hill site sale, will be drawn down in 2016/17.
- Inter district flows revenue is in accordance with Ministry of Health advice.
- Other income has been budgeted at the District Health Board's best estimates of likely income.

Personnel Costs and Outsourced Services

- Workforce costs for 2016/17 have been budgeted at actual known costs, including step increases where appropriate. Increases to Multi Employer Collective Agreements have been budgeted in accordance with settlements, or where no settlement has occurred, at the District Health Board's best estimate of the likely increase. Increases of 0.7% per annum have been allowed for 2016/17, 2017/18 and 2018/19, which is the District Health Board's best estimates of likely increases.
- Establishment numbers for management and administration staff have been capped by the Minister of Health at 417 FTEs, the same as 2015/16. The District Health Board is managing internally to a cap of 400 FTEs.

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted the District Health Board's best estimates of likely cost.
- No allowance has been made for cost increases/decreases relating to fluctuations in the value of the New Zealand Dollar.

Services Provided by Other DHB's

- Inter district flows expenditure is in accordance with MoH advice.

Other Provider Payments

- Other provider payments have been budgeted at the District Health Board's best estimate of likely costs

Capital Servicing

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives. The investments in NZHPL and RHIP give the DHB a right to use the systems they provide, so they are considered to have indefinite lives, and consequently no amortisation has been allowed for.
- The drawdown of $5 million of debt funding in June 2016 for the new Mental Health Inpatient Unit (Nga Rau Rakau), as agreed with the Minister of Health as part of the disposal of the Napier Hill site, has an assumed interest rate of 3.42% being 15 points above 10 year government stock rate on 21 January 2016. Interest rates of 4.3%, 4.65% and 4.8% have been applied from the maturity dates of expiring facilities in 2017/18, 2018/19, and 2019/20 respectively based on 15 points above Treasury forecasts for 10 year bonds (30 June Year composite rates based on the 31 March interest rates in the Half Year Economic and Fiscal Update 2015 published 15 December 2015. No maturities or new borrowings are expected in 2016/17.
- The capital charge rate remains at 8%.

Investment

- The purchase of class B shares in New Zealand Health Partnerships Limited (NZHPL), relating to the Finance, Procurement and Supply Chain shared service, was completed in 2014/15 and took the total investment to $2,504,071. No allowance has been made for any further investment. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- The investment in RHIP has been included at $650,000 for 2016/17, taking the total investment to $5,844,000. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- No collaborative regional or sub-regional initiatives have been included other than CRISP.
- No increase in funding for existing associate organisations, Allied Laundry Services Limited and Central Technical Advisory Services have been allowed for.
- Property, plant, equipment, intangible asset expenditure, and investments in other entities are in accordance with the table below :

Investment	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Buildings and Plant	4,710	8,619	4,800	5,500
Clinical Equipment	9,407	6,040	4,500	3,900
Other Equipment	2,800	3,510	3,545	4,588
Information Technology	3,125	2,550	2,100	3,000
Capital Investment	**20,042**	**20,719**	**14,945**	**16,988**
New technologies/Investments	1,000	1,000	1,000	1,000
Investment in CRISP	650	7	-	-
Total Investment	**21,692**	**21,726**	**15,945**	**17,988**

Capital Investment Funding

- Capital investment will be funded from a number of sources including working capital in accordance with the following table:

Investment Funding	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Total Investment	21,692	21,726	15,945	17,988
Funded by:				
Depreciation and amortisation	15,151	16,521	17,531	18,463
Operating surplus	3,000	3,000	3,000	3,000
Cash holdings	(657)	5,764	(151)	(5,481)
Capital Investment Funding	**22,049**	**22,083**	**16,302**	**18,345**

Property, Plant and Equipment

- Hawke's Bay District Health Board is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. The last revaluation was at 30 June 2015, and no adjustment has been made for the effect of any other revaluation over the time horizon of the plan.

Debt and Equity

- Debt will be at the levels in the table below. Loans and borrowings are included in the table at face value. This differs from the projected financial statements (see above) in which these instruments are carried at fair value as required by PBE standards.

Debt	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Borrowing	47.5	47.5	47.5	47.5
Finance leases	-	-	-	-
Total debt	**47.5**	**47.5**	**47.5**	**47.5**
Debt/(Debt+Equity) Ratio	*33.0%*	*32.1%*	*31.4%*	*30.6%*

- No debt funding from the Crown is planned for the four year planning period. There are no banking covenants relating to the debt.

Key Lenders	Facility	Limit $'m	Termination Date
Crown	Term Debt	$47.5 million	31 December 2021

- Equity movements will be in accordance with the table below.

Equity	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Opening equity	93.0	96.7	100.3	103.9
Surplus	4.0	4.0	4.0	3.9
Equity repayments (FRS3)	(0.3)	(0.4)	(0.4)	(0.3)
Closing equity	**96.7**	**100.3**	**103.9**	**107.5**

Additional Information and Explanations:

Disposal of Land

- Disposal of land is subject to current legislative requirement and protection mechanisms. Hawke's Bay District Health Board is required to notify land declared surplus to previous owners for offer back prior to offering it to the Office of Treaty Settlements, and before any sale on the open market.

5 STEWARDSHIP & ORGANISATIONAL CAPABILITY

In order to make progress against our strategic outcomes, we have put in place our 'Transform and Sustain' programme, which in time will transform the whole Hawke's Bay health system. Some work is already underway and we are building on those successes and we are using the New Zealand Triple Aim as a guide to ensure we keep change in balance.

Delivering on Transform and Sustain will mean people in Hawke's Bay will experience:

A health system that is responsive to need

Consistent high-quality health care

A more efficient health system

We are also implementing some cultural and structural changes to the system to support transformation and align it with the values that underpin our vision:

TAUWHIRO: delivering high-quality care to patients and consumers

RĀRANGA TE TIRA: working together in partnership across the system

HE KAUANANU: showing respect for each other, our staff, patients and consumers

ĀKINA: continuously improving everything we do.

QUALITY

Transform and Sustain is providing:

- An organisational development programme to support our workforce so they are empowered and valued to make the biggest contribution they can
- A means of reviewing progress in the three aims we have identified
- A model to measure, target and report our expenditure so we move our resources to where we bring about transformational change.

The Sustain programme consolidates the improvements we make in order to support the Transform programme that, together, will significantly improve the value of our services to the people of Hawke's Bay.

Creating Headroom for Change

Over the recent past, individuals across the health system have worked extremely hard to make the improvements that have been necessary. It is important we recognise those efforts and create the right environment and culture for ongoing change that links quality improvement and system integration. While we know we can't make change everywhere at once, we need to identify those services that could lead and support others.

The objectives of the programme cannot be achieved in one year, but readying the whole system for transformation is not something that we could put off. Rather, we have attempted to free-up some systems and processes so those who are ready can make a start. Time and energy continues to be invested in establishing, strengthening and maintaining relationships for better liaison across the system. The transformation agenda has taken time to initiate, but the momentum is gathering as people's expectations change and we respond to patients' needs in different ways.

In the first instance, we attempted to pinpoint opportunities that could easily be implemented in order to release some time and create the space for everyone to come together to design innovative solutions. That included identifying better administrative processes and more flexible budgeting, removing obstacles, facilitating better working partnerships and supporting the generation of new ideas while spending less time on non-essential tasks.

Fundamentally, teams at all levels are being encouraged to make more time to discuss, plan, implement and review improvement opportunities. Managers and team leaders are being supported to make this happen.

5.1 Organisational Development

Workforce

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

Organisational development programmes are focusing on the following:

- Embedding our new Service Directorate structure of Service Director, Medical/Surgical Director and Nurse Director
- Clinical leadership and engagement
- Talent Management Programme including succession planning
- Transformational management and leadership capability
- Increasing staff engagement, health and well-being
- High performing teams, including re-skilling and up-skilling of staff
- New roles and capabilities to support new models of care and new ways of working
- Building capability, through structured development of current staff and recruitment of high calibre individuals
- Increasing Māori staff representation and increasing effective engagement with Māori
- Maintaining high levels of Union engagement
- Continued development of smart systems and reporting
- Full implementation of the new Health and Safety in Employment Act including our new risk management approach to health and safety management.
- Enhanced blended and on-line learning and development programmes for clinicians and staff

Our Child Protection Policies comply with the requirements of the Vulnerable Children Act, 2014. A copy is available from our website: www.Hawke'sbay.health.nz

Communications

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

Health Information

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

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

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

5.2 Key Intentions

We have described what our core challenges are:

1. Responding to our population - we believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau
2. Delivering consistent high-quality health care - the best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible without error or undue waiting
3. Being more efficient at what we do - reducing waste in health will make us more efficient and ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time.

Transform and Sustain includes a number of key intentions that, when implemented, will support us to address our core challenges.

- **Transforming our engagement with Māori**
- **Transforming patient involvement**
- **Transforming health promotion and health literacy**
- **Transforming multi-agency working**
- **Transforming clinical quality through clinical governance**
- **Transforming patient experience through better clinical pathways**
- **Transforming through integration of rural services**
- **Transforming primary health care**
- **Transforming urgent care**
- **Transforming out-of-hours hospital inpatient care**
- **Transforming business models**

Processes for Achieving Regular Financial Surpluses

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

Hawke's Bay DHB continues with its strategic direction to provide a $3m year-on-year surplus. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community.

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

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

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

SHIFTING RESOURCES

To ensure that our change in focus is also matched by a shift of resources, we have agreed measures to monitor changes in deploying resources over time. Figure 3 illustrates a model for measuring and managing a shift of resources. The aim is to measure, monitor and realign expenditure in these categories and to shift resources purposely.

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

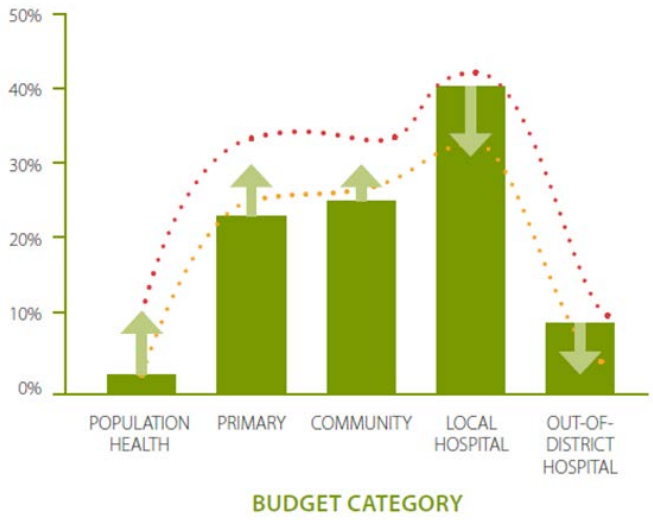

Figure 3: A model for changing resource deployment in a health system

Summary

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

Note A: Subsidiary Companies and Investments

Currently, there are no subsidiary companies in which HBDHB has a controlling interest[39] and HBDHB has no plans to acquire shares or interests in terms of section 100 of the Crown Entities Act 2004. HBDHB has an interest in one multi-parent subsidiary: Allied Laundry Services Limited. Other shareholders are MidCentral DHB, Taranaki DHB, Whanganui DHB, Capital and Coast DHB and Hutt Valley DHB. Allied Laundry Services Limited has an exemption from producing a Statement of Intent (SOI). MidCentral DHB will report on Allied Laundry Services Limited in its SOI, on behalf of Hawke's Bay, Taranaki and Whanganui DHB

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

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

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

6 SERVICE CONFIGURATION

6.1 Service Coverage and Service Change

The Minister explicitly agrees to the level of service coverage for which the MoH and DHBs are held accountable. Service coverage information demonstrates how Government policy is to be translated into the required national minimum range and standards of services to be publicly funded. In the current environment of increasing resource constraints and rising demand, it is likely that the level of services provided in some locations and the standard of some services will be adjusted and that access to some services may have to be modified. Service and care pathway reviews will specifically address the issue of coverage and access as will national, regional and local integrated planning. HBDHB does not expect any exceptions to service coverage. In terms of performance measure SI3 (refer Appendix 2), should any unintended gaps in service coverage be identified by the DHB or MoH then the DHB will report progress achieved during the quarter towards resolution of exceptions.

In accordance with the Operational Policy Framework procedure regarding service change, early discussions have been held with the DHB's Relationship Manager about our service improvement plans. The table below is a high-level indication of some anticipated change.

Change	Description	Expected Benefits

7 APPENDICES

7.1 APPENDIX 1A Our Strategic Framework

7.2 APPENDIX 2 Notes to the Financial Statements

REPORTING ENTITY

Hawke's Bay District Health Board is a District Health Board established by the New Zealand Public Health and Disability Act 2000. The District Health Board is a crown entity as defined by the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The District Health Board is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

The Hawke's Bay District Health Board's primary objectives are the funding and provision of health, disability and mental health services to the people of Hawke's Bay. Accordingly the District Health Board is a public benefit entity for financial reporting purposes.

The projected financial statements of the Hawke's Bay District Health Board comprise the District Health Board, its 25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited which is jointly controlled by the six district health boards in the central region.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently to all periods.

Statement of compliance

The financial statements of the district health board have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). The financial statements have been prepared in accordance with Tier 1 Public Benefit Entity (PBE) accounting standards, and comply with those standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars unless otherwise specified.

Income and cost allocation

Output classes

Income and expenditure for each output class funded or provided by the Hawke's Bay District Health Board and reported in the statement of service performance, has been derived using the allocation system outlined below.

Direct revenue and costs are allocated directly to output classes. Indirect costs are allocated to output classes using appropriate cost drivers such as volumes provided.

The purchase units that comprise an output class change over time as clinical practice and medical technology develop. Consequently while the figures prepared for each year reported in the annual report will be consistent with the figures for each year reported in its associated annual plan, they are not necessarily consistent with the annual reports and annual plans of other years.

Performance against budget

The budget figures are those approved by the District Health Board in its annual plan. The budget figures are prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the District Health Board for the preparation of the financial statements.

Patient Care Revenue

Ministry of Health population-based revenue

The Hawke's Bay District Health Board receives annual funding from the Ministry of Health based on Hawke's Bays share of the national population. Revenue is recognised in the year it is received.

Ministry of Health contract revenue

For contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service (exchange contracts), revenue is recognised as services are provided.

For other contracts (non-exchange) the total revenue receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the

contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Revenue from other district health boards

Inter district patient inflow revenue occurs when a patient treated within the Hawke's Bay District Health Board region is domiciled outside of Hawke's Bay, and is recognised at time of discharge. The Ministry of Health credits Hawke's Bay District Health Board with a monthly amount based on estimated patient treatment for non-Hawke's Bay residents within Hawke's Bay. An annual wash-up occurs at year end to reflect the actual non-Hawke's Bay patients treated at Hawke's Bay District Health Board.

Other Crown entity contracted revenue

Other Crown entity contract revenue is recognised as revenue when services are provided and contract conditions have been met.

Other operating revenue

Revenue is measured at the fair value of consideration received or receivable.

Interest revenue

Interest revenue is recognised using the effective interest rate method.

Rental income

Rental income from investment property is recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Sale of goods

Revenue from goods sold is recognised when Hawke's Bay District Health Board has transferred to the buyer the significant risks and rewards of ownership of the goods and the District Health Board does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Provision of services

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date.

Vested assets

Where a physical asset is gifted to or acquired by the Hawke's Bay District Health Board for nil or nominal cost, the fair value of the asset received is recognised as income when control over the asset is obtained.

Donated services

The activities of the Hawke's Bay District Health Board are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the District Health Board.

Other operating expenses

Operating lease payments

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

Financing Costs

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Attributed interest on finance leases are charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

Capital Charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

Investments in bank term deposits are initially measured at the amount invested. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest rate method, less any provision for impairment.

Debtors and other receivables

Receivables and prepayments are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that the Hawke's Bay District Health Board will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Loans

Loans are initially recognised at fair value, then at amortised cost using the effective interest rate method.

Inventories

Inventories held for distribution

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost on a first in first out basis, adjusted where applicable for any loss of service potential. Where inventories are acquired through non-exchange transactions, cost is the fair value at the date of acquisition.

Inventories held for sale

Inventories held for sale or use in the provision of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The cost of purchased inventory is determined using the weighted average cost method.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale, are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increase in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, plant and equipment

Property, plant and equipment consists of the following asset classes: land; buildings; clinical equipment; information technology; motor vehicles; and other equipment.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years. The carrying value of land and buildings are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense. Surplus property is carried at the book value on the date the property was declared surplus less impairment losses until it is disposed of.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the District Health Board and the cost of the item can be measured reliably. Work in progress is recognised at cost, less impairment, and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying value of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in the revaluation reserve are transferred to accumulated surpluses/(deficits).

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to Hawke's Bay District Health Board and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates have been estimated as follows:

Class of Asset	Estimated Life	Depreciation Rate
Buildings	5 to 40 years	2.5% to 20%
Clinical equipment	2 to 32 years	3% to 50%
Information technology	3 to 10 years	10% to 33%
Motor vehicles	3 to 20 years	5% to 33%
Other equipment	3 to 30 years	3.3% to 33%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an assets is reviewed, and adjusted if applicable, at each financial year end.

Impairment of property, plant and equipment and intangible assets

Hawke's Bay District Health Board does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Property, plant and equipment held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and the availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include costs of materials and services, employee costs and and any directly attributable overheads. Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset.

Rights in shared software developments are considered to have indefinite useful life as the district health board has the ability and intention to review any service level agreement indefinitely. As the rights are considered to have indefinite life, the intangible asset is not amortised and is tested for impairment annually.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the assets is available for use and ceases at the date the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangibles assets have been estimated as follows:

Type of Asset	Estimated Life	Amortisation Rate
Acquired computer software	3 to 15 years	6.7% to 33%
Developed computer software	3 to 15 years	6.7% to 33%
NZ Health Partnerships Ltd Class B shares	Indefinite	Nil
Interest in CRISP	Work in progress	Nil

Impairment of intangible assets

Hawke's Bay District Health Board does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and the availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

Intangible assets subsequently measured at cost that have an indefinite useful life, or are not yet available for use, are not subject to amortisation and are tested annually for impairment.

Investment properties

Investment properties are properties which are held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. If there is evidence supporting a material difference in value, an external, independent valuation

company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued, will provide an assessment of the fair values of the properties. The fair values are based on market values, being the estimated amount for which a property could be exchanged on the date of valuation between a willing buyer and a willing seller in an arm's length transaction after proper marketing where the parties had each acted knowledgeably, prudently and without compulsion.

Any gain or loss arising from a change in fair value is recognised in the surplus or deficit. Rental income from investment property is accounted for as described in the accounting policy on rental income (see above).

When an item of property, plant and equipment is transferred to investment property following a change in its use, any differences arising at the date of transfer between the carrying amount of the item immediately prior to transfer and its fair value is recognised directly in equity if it is a gain. Upon disposal of the item the gain is transferred to accumulated surpluses/(deficits). Any loss arising in this manner is recognised immediately in the surplus or deficit.

If an investment property becomes owner-occupied, it is reclassified as property and its fair value at the date of reclassification becomes its cost for accounting purposes of subsequent recording. When Hawke's Bay District Health Board begins to redevelop an existing investment property for continued future use as investment property, the property remains an investment property, which is measured based on the fair value model, and is not reclassified as property, plant and equipment during the redevelopment.

Investments in associates

Investments in associate entities are accounted for using the equity method. An associate is an entity over which the district health board has significant influence, and that is neither a subsidiary nor an interest in a joint venture. The investment is initially recognised at cost and the carrying amount is increased or decreased to recognise the district health board's share of the surplus or deficit of the associate after the date of recognition. Distributions received from an associate reduce the carrying amount of the investment.

If the share of deficits of an associate equals or exceeds the district health board's interest in the associate, further deficits are not recognised. After the district health board's interest is reduced to zero, additional deficits are provided for, and a liability is recognised, only to the extent that the district health board has incurred legal or constructive obligations or made payments on behalf of the associate. If the associate subsequently reports surpluses, the district health board will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised.

Borrowings and finance leases

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method. Borrowings are classified as current liabilities unless Hawke's Bay District Health Board has an unconditional right to defer the settlement of the liability for at least 12 months after balance date.

Finance leases transfer to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased asset or the present value of the minimum lease payments. The finance component is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the district health board will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the leased term and its useful life.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave and continuing medical education leave earned, but not yet taken at balance date, retiring and long service leave entitlements expected to be settled within 12 months, and sick leave.

The liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward on balance date, to the extent that it will be used by staff to cover those future absences.

The liability and an expense are recognised for bonuses where it is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on: likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlements information; and the present value of the estimated future cash flows.

Superannuation schemes

Defined contribution schemes

Obligations for contributions to Kiwisaver and the Government Superannuation Fund are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

The Hawke's Bay District Health Board makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and included in financing costs.

Taxes

Goods and services tax

All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables that are presented on a GST inclusive basis. Where GST is not recoverable as an input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

GST relating to revenue from the Crown is recognised when the income is accrued in accordance with section 9(7) of the Goods and Services Tax Act 1985.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Hawke's Bay District Health Board is a public authority and consequently is exempt from the payment of income tax under section CB3 of the Income Tax Act 2007.

7.3 APPENDIX 3 Dimensions of DHB Performance

Summary Table: 2016/17 Performance Expectations

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

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

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

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – establishment of baseline (no target/performance expectation is set)

Performance measure	2016/17 Performance expectation/target				
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19				
	Age 20-64				
	Age 65+				
PP7: Improving mental health services using transition (discharge) planning	Long term clients	Provide a 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				
	Age 0-19	<= 3 weeks	80%	<=8 weeks	95%
	Addictions (Provider Arm and NGO)				
	Age 0-19	<= 3 weeks	80%	<=8 weeks	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1				
	Ratio year 2				
PP11: Children caries-free at five years of age	Ratio year 1				
	Ratio year 2				
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1				
	% year 2				
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1				
	0-4 years - % year 2				
	Children not examined 0-12 years % year 1				
	Children not examined 0-12 years % year 2				
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke) Focus area 1: Long term conditions	Report on delivery of the actions and milestones identified in the Annual Plan.				
Focus area 2: Diabetes services	Reporting on implementation of actions in the Diabetes plan "Living Well with Diabetes"				
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c indicator).				
Focus area 3: Cardiovascular (CVD) health	Indicator 1: 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.				
	Indicator 2: 90 percent of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years.				
	Report on delivery of the actions and milestones identified in the Annual Plan				

Performance measure	2016/17 Performance expectation/target
Focus area 4: Acute heart service	70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') by ethnicity.
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.
	Over 95 percent of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge.
	Report on deliverables for acute heart services identified in annual plan and actions and progress in quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI
Focus area 5: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway
	80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission
	Report on delivery of the actions and milestones identified in the Annual Plan.
PP21: Immunisation coverage	Percentage of two year olds fully immunised
	Percentage of five year olds fully immunised
	Percentage of eligible girls fully immunised - HPV vaccine
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 Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment. The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment.
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. Provide quarterly quantitative reports on the implementation of SBHS, as per the template provided. 2. Provide 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. Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) 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 Maori, Pacific and low decile youth populations. 2. Provide quantitative reports using the template provided under PP26 *Initiative 5*: Improve the responsiveness of primary care to youth. 1. Provide 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. Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's 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.

Performance measure	2016/17 Performance expectation/target	
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for each focus area: • Primary Mental Health • District Suicide Prevention and Postvention • Improving Crisis response services • Improve outcomes for children • improving employment and physical health needs of people with low prevalence conditions	
PP27: Supporting vulnerable children	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	
	Hospitalisation rate (per 100,000 DHB total population) for acute rheumatic fever	
	Reports on progress in following -up known risk factors and system failure points in cases of recurrent rheumatic fever.	
PP29: Improving waiting times for diagnostic services	1. Coronary angiography – 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	
	2. 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)	
	3. Diagnostic colonoscopy a. 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days b. 70% of people accepted for a non urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days	
	Surveillance colonoscopy c. 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days	
PP30: Faster cancer treatment	Part A: Faster cancer treatment 31 day indicator	85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat
	Part B: Shorter waits for cancer treatment radiotherapy and chemotherapy	All patients ready-for-treatment receive treatment within four weeks from decision-to-treat.
PP31: Better help for smokers to quit in public hospitals	95 percent of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age group 0 – 4 years	
	Age group 45-64 years	
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region	
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 (as identified by the DHB or by the Ministry)	
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 DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate.
	percutaneous revascularization	a target rate of at least 12.5 per 10,000 of population
	coronary angiography services	a target rate of at least 34.7.5 per 10,000 of population

Performance measure	2016/17 Performance expectation/target	
SI5: Delivery of Whānau Ora	Performance expectations are met across all the measures associated with the five priority areas: • Mental health • Asthma • Oral health • Obesity • Tobacco and narrative reports cover all areas indicated	
SI6: IPIF Healthy Adult - Cervical Screening	80% of eligible women have received cervical screening services within the last 3 years	
OS3: Inpatient Length of Stay	Elective LOS	The suggested target is 1.55 days, which represents the 75th centile of national performance.
	Acute LOS	The suggested target is 2.35 days, which represents the 75th centile of national performance.
OS8: Reducing Acute Readmissions to Hospital	tba - indicator definition under review	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections Focus area 1: Improving the quality of identity data	New NHI registration in error A. Greater than 2% and less than or equal to 4% B. Greater than 1% and less than or equal to 3% C. Greater than 1.5% and less than or equal to 6%	
	Recording of non-specific ethnicity Greater than 0.5% and less than or equal to 2%	
	Update of specific ethnicity value in existing NHI record with a non-specific value Greater than 0.5% and less than or equal to 2%	
	Validated addresses unknown Greater than 76% and less than or equal to 85%	
	Invalid NHI data updates (no confirmed target)	
Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS Greater than or equal to 97% and less than 99.5%	
	National collections file load success Greater than or equal to 98% and less than 99.5%	
	Standard vs edited descriptors Greater than or equal to 75% and less than 90%	
	NNPAC timeliness Greater than or equal to 95% and less than 98%	
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	
Developmental measure DV4: Improving patient experience	No performance target set	

HAWKE'S BAY District Health Board Whakawāteatia	**DRAFT Central Region Regional Service Plan 2016/17** 22
	HBDHB Board
Document Owner: Document Author(s):	Tim Evans, GM Planning Informatics and Finance Carina Burgess, Acting Head of Planning
Reviewed by:	Executive Management Team, HB Clinical Council, Consumer Council and MRB
Month:	March, 2016
Consideration:	For Information

RECOMMENDATION

That the Board

Note the contents and provide any feedback you may have to Carina.Burgess@hbdhb.govt.nz

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ATTACHMENT

Central Region, Regional Service Plan 2016/17 **Draft v5**

Central Region

Regional Service Plan 2016/17

DRAFT 1 V5

REGIONAL SERVICES PROGRAMME

> Working together for our region's future health

REGIONAL SERVICES PROGRAMME

CENTRAL REGION DISTRICT HEALTH BOARDS

www.centraltas.co.nz

> Working together for our region's future health

Draft 1 version 5 15/3/2016

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Executive Summary Regional Service Plan 2016/17

"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 reason in the right place at the right time."[1]

This document outlines the Central Region's Regional Service Plan (RSP) 2016/17. This RSP has been developed collaboratively by the six District Health Boards in the Central Region and represents the strong clinical leadership in the regional networks. There is also a greater focus on the regional priorities as identified by the District Health Boards as well as National initiatives, as outlined in the guidance issued by the Ministry of Health (Ministry).

The Central Region DHBs are committed to ensuring equitable access to high quality services that are clinically and financially sustainable. The development of the refreshed New Zealand Health Strategy and its five interconnected key themes is an emergent addition to the already established activities being undertaken throughout the region to deliver on national and regional priorities.

In developing this plan each work area undertaken by the region has ensured there is a clear integrated ***'line of sight'*** between national, regional and local actions linking the key strategic priorities and expectations of the RSP to those of the DHBs and Ministry.

Priorities

The RSP 2016/17 national and regional priorities signal a continuation of the established programme of work and successes, across the region aligning with DHB plans, ensuring health services are people centred and are focused on improving health outcomes: For 2016/17 priorities are:

- Elective Services
- Cardiac Services
- Mental Health and Addictions
- Stroke Services
- Health of Older People
- Major Trauma
- Hepatitis C
- Cancer Services
- Diagnostics Imaging

Enablers

- Information Technology
- Workforce
- Quality and Safety

[1] Central Region Combined District Health Boards' Forum 16 May 2014

Central Region Board Chairs and Chief Executives

Dr Virginia Hope
Chair, Capital and Coast DHB

Debbie Chin
Chief Executive, Capital and Coast DHB

Dr Virginia Hope
Chair, Capital and Coast DHB

Ashley Bloomfield
Chief Executive, Hutt Valley DHB

Derek Milne
Chair, Wairarapa DHB

Adri Isbister
Chief Executive, Wairarapa DHB

Phil Sunderland
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Kathryn Cook
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Chief Executive, Whanganui DHB

Dr Kenneth Clark
Chair and Clinical Lead
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> Working together for our region's future health

Central Region's Regional Service Plan 2016/17

Introduction

This document outlines the Central Region's Regional Service Plan (RSP) 2016/17. The RSP has been developed collaboratively by the six District Health Boards (DHBs) in the Central Region and reflects a strong focus on co-production and co-design principles across the regional work programme. In developing the 2016/17 plan the six DHBs in the region acknowledge that while the regional work programme has reached a level of maturity and direction, the refreshed New Zealand Health Strategy and the evolving nature of the health sector pose new challenges.

For 2016/17 the region will focus on improving health outcomes and reducing disparities for Maori and on the adoption of work to implement the five key themes of the refreshed New Zealand Health Strategy through integration and reduction of siloed working. We will ensure that our key portfolio areas are aligned to our regional shared purpose and regional planning outcomes.

The Region is committed to identifying and refining planning and service priorities to promote innovative localised solutions to improve health outcomes for our communities – as an example a project to co-create a cardiac services system of care across the central region is being developed for implementation 2016/17. The project will help define the system of care across the continuum that the Central Region District Health Boards (DHBs) need to commission to provide sustainable specialist services – the final shape of these services will be co-designed in collaboration with service users and clinicians.

The 2016/17 Plan

The 2016/17 RSP builds on current initiatives aimed at strengthening services and contributing to improved outcomes for patients and their whanau, service sustainability, across-sector integration and financial viability. As a region our focus is on working in partnership with communities, our clinicians and health service providers to become a more regionally integrated health system designed to improve health outcomes.

Four key principles underpin this approach and are reflected through-out all planning activities: we aim to ensure **equity of access**; **maintain clinical and financial sustainability**; **ensure consumer participation;** and **ensure clinical engagement.**

The Central Region acknowledges in its planning the interdependencies that exist in the health system and the complexities this brings to improving health outcomes. This is reflected in the application of the regional health outcomes framework (page 34) as a guide in prioritising and aligning our work programme. The five regional planning outcomes are;

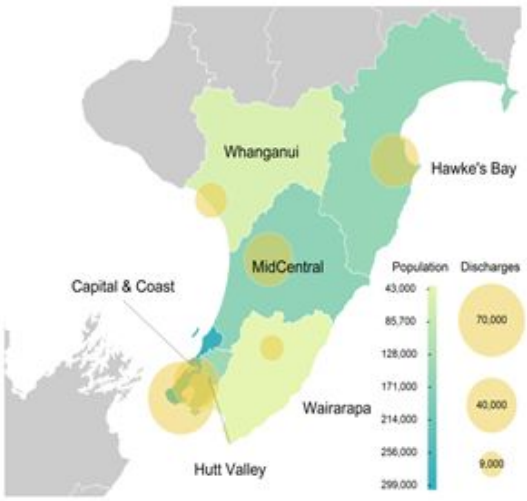
1. *Improved, quality, safety and experience of care*
2. *Improved health and equity for all populations*
3. *Best value for public health system resources*
4. *Improved system integration and consistency*
5. *Improved clinical and financial sustainability.*

In each work area undertaken is a clear integrated ***'line of sight'*** between national, regional and local outcomes linking the key strategic priorities and expectations of the RSP to those of the DHBs and Ministry.

In developing a regional approach to planning it has been critical to understand the diverse nature of the Central Regions population, deprivation, ethnicity and urban and rual geographic drivers – each of the six DHB areas is unique. The development of localy appropriate solutions to meet those needs is reflected in the tiered approach to regional Information Technology projects, workforce initiatives and sub-regional clinical networks. In working to improve health outcomes for our most deprived populations and to reduce inequities in access to services, flexible and co-produced health planning is essential.

Our Region

Demographics



The Central Region is comprised of the six DHBs shown in the map. The largest population is in Capital & Coast and the smallest are in the Wairarapa and Whanganui.

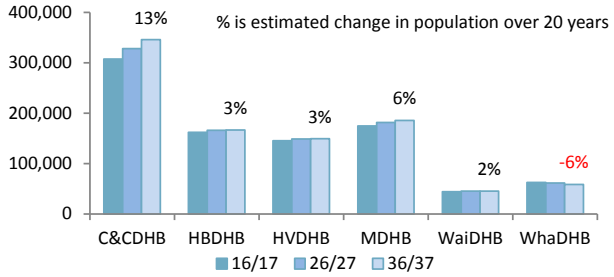
Central Region population
895,000
(19% of NZ total)

In 20 years
Central Region population
950,500
(growth of 6%)

[2] 895,000 is the 2016/17 figure projected from the 2013 census. 950,000 is the projected figure for 2036/37.

Population change

Figure 1: Population estimates and change by DHB



In 20 years the Central Region will have **86,000** more people aged 70+ (growth of 89%)

The estimated population growth will not be evenly distributed across DHBs, with C&CDHB experiencing the greatest increase and WhaDHB's population expected to decrease.

Population growth will be highest in the older age groups as the population ages while younger age groups decrease in number.

Table 1: Population change over 20 years, Central Region, more older people

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

Figure 2: Population change by age group, Central Region

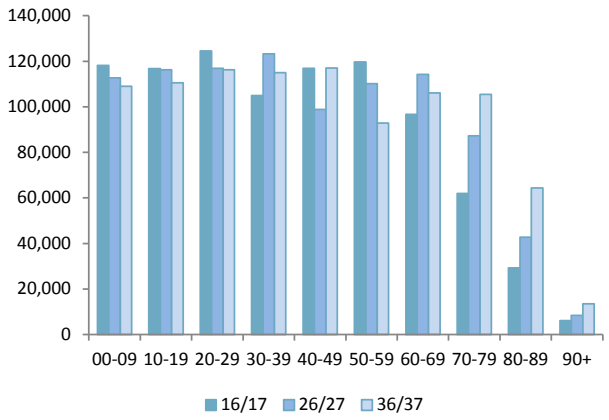


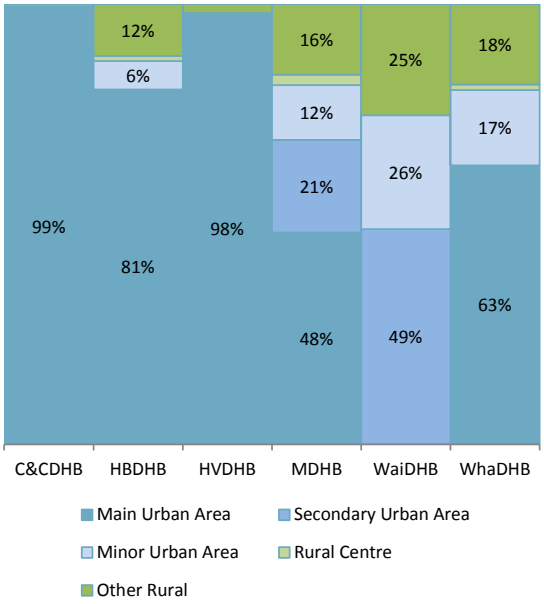
Table 2: Population change over 20 years, Central Region, more older people

Age groups	% change	population change
00-09	-8%	-9,100
10-19	-5%	-6,200
20-29	-7%	-8,300
30-39	10%	10,100
40-49	-	200
50-59	-22%	-26,900
60-69	10%	9,500
70-79	70%	43,500
80-89	120%	35,200
90+	122%	7,400

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

Geographical spread

Figure 3: Population by urban/ rural categories by DHB



Source: Census 2013.

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

Table 3: Population by urban/ rural categories, Central Region

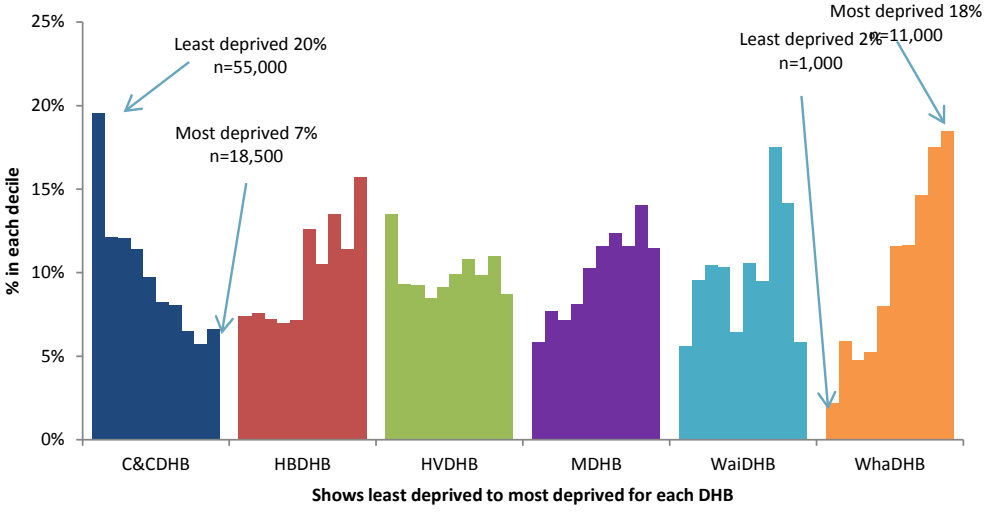
Urban/rural category	% of population
Main Urban Area	78%
Secondary Urban Area	6%
Minor Urban Area	6%
Rural Centre	1%
Other Rural	8%

Source: Census 2013.

Deprivation

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

Figure 4: Deprivation profile by DHB, Central Region



Source: Socioeconomic deprivation indexes NZDep2013, derived from Census 2013.

Māori population

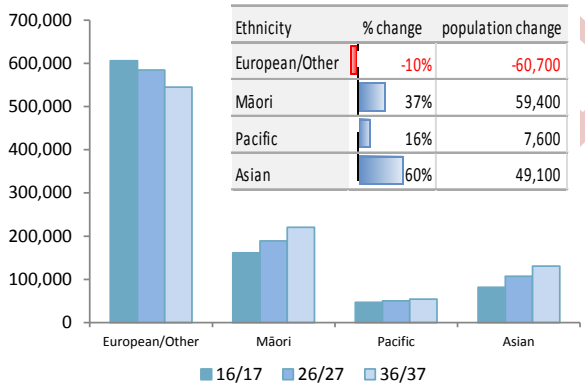
Hawkes Bay, Capital & Coast and MidCentral have the largest Māori populations in the region. Māori make up more of the Hawkes Bay and Whanganui population (one in four identifies as Māori).

Table 4: Māori population by DHB 2016/17

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

Source: Census 2013 projected to 2016/17.

Figure 5: Population change over 20 years by ethnicity, C Region

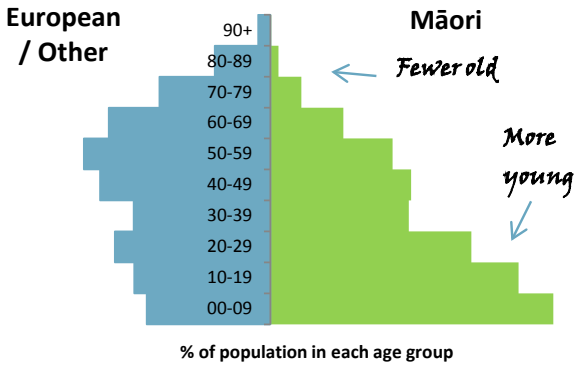


Source: Census 2013 projected.

17

The region will have greater ethnic diversity as the Māori, Asian (and to a lesser extent Pacific) populations increase. CCDHB is the only DHB expected to see an increase in their European/Other population. DHBs in the region will see the biggest population increase for Māori, except CCDHB and HVDHB which will see their biggest population growth in the Asian population.

Figure 6: Māori have a younger age profile than European/Other, Central Region



Source: Census 2013 projected to 2016/17.

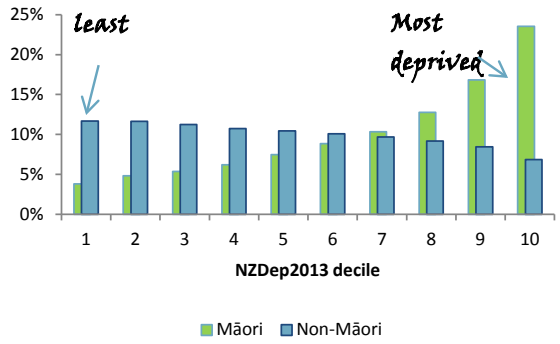
The Māori population has a greater proportion of children and young people and fewer older people than the European/ Other population.

Pacific populations also have a younger age profile. The Asian population has a greater proportion of 20-40 year olds.

Māori are more likely to live in the most deprived areas in New Zealand.

Socioeconomic deprivation affects health outcomes such as higher rates of chronic disease, higher mortality rates and lower life expectancy for Māori than non- Māori.

Figure 7: Māori are more likely to live in deprived areas, NZ



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

Crowding affects Pacific Peoples, then Māori more than other groups. Children are more likely to live in crowded households than other ages.

Figure 8: Household crowding by ethnicity, 2013, NZ

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

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

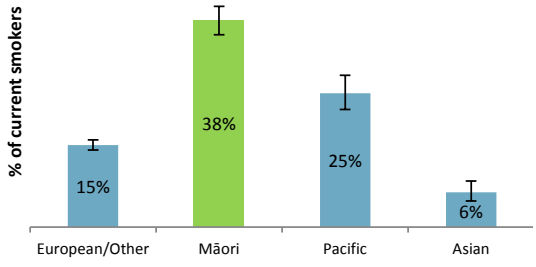
Household crowding as a percent of the local population has decreased in the Central Region since 2006.

Figure 9: Household crowding by DHB, 2013

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

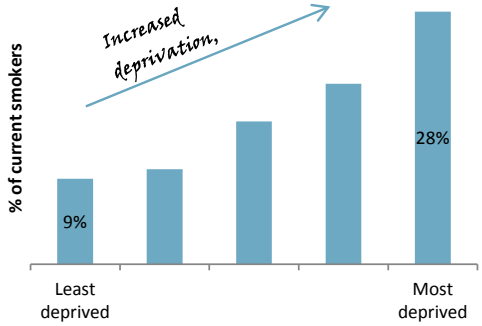
Source: MoH 2014. Analysis of Household Crowding (census 2013).

Figure 10: Māori are more likely to be smokers



Source: New Zealand Health Survey 2014/15. National figures.

Figure 11: Smoking rates increase with deprivation

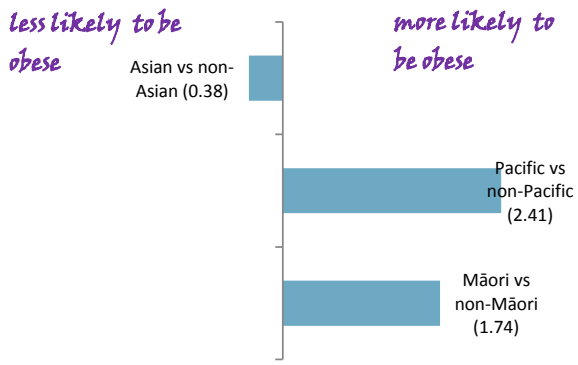


Source: New Zealand Health Survey 2014/15. National figures.

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

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

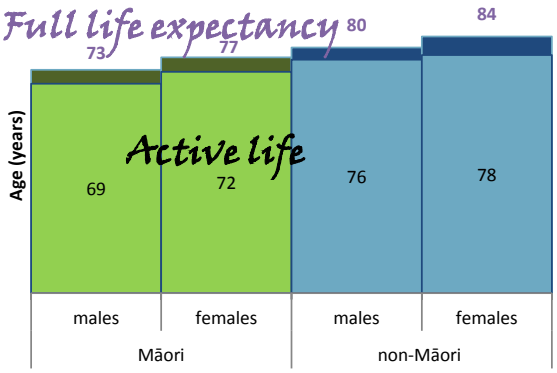
Figure 12: Adjusted rate ratios of obesity by ethnicity



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

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

Figure 13: Life expectancy at birth, Māori and Non-Māori, 2013



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

Life expectancy is estimated to be seven years longer for Non-Māori than Māori, comparing by gender. The gap is biggest between Māori males and Non-Māori females (11 years). Māori also have fewer active years in their lifetime.

Rates of mortality are higher for Māori than non-Māori (649 compared to 363 per 100,000 population).[3] The main causes of death being cancer, ischaemic heart disease, stroke and diabetes.

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

National Context

At the highest level, DHBs are guided by the New Zealand Public Health and Disability Act 2000 with the New Zealand Health Strategy providing an overarching direction supported by a range of population and other health strategies including; the New Zealand Disability Strategy; He Korowai Oranga - Māori Health Strategy, 'Ala Mo'ui – Pathways to Pacific Health and Wellbeing; Health of Older People Strategy; Primary Care Strategy and Rising to the Challenge: Mental Health and Addiction Service Development Plan.

The high-level health system outcomes are that all New Zealanders live longer, healthier and more independent lives and the health system is cost-effective and supports a productive economy. The Ministry has three high-level outcomes that support the achievement of the above 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.

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

Additional Government commitments focus on ensuring that: the public is supported to make informed decisions about their own health and independence; emphasis is given to integrated and personalised support services being provided for people who need them; and that health and disability services are closely integrated with other social services; and health hazards are minimised[4] [5].

Alongside these longer-term goals and commitments, the Minister of Health's annual 'Letter of Expectations' signals annual priorities for the health sector. The 2016/17 focus is on: integrating the five themes of the refreshed New Zealand Health Strategy; working across government; shifting and integrating services between primary and secondary care; tackling obesity; delivery of national health targets; fiscal discipline and performance management; health information systems development.

[4] For further detail refer to the Ministry of Health's Statement of Intent 2014-2018 available on their website – www.health.govt.nz.

[5] The Ministry of Health Outcomes frame work is appended on page 105

Implementation of the New Zealand Health Strategy

The refreshed New Zealand Health Strategy is underpinned by the goal of '**All *New Zealanders live well, stay well, and get well'***. The Strategy has five interlinked themes built around a revised suite of population and person centered principles for the sector.

Five strategic themes of the Strategy

The 2016/17 Central Region RSP reflects the five key themes of the revised Strategy and aligns these to aspects of the current regional work programme. We recognise that the implementation of the strategy will evolve over time; the Central Region DHBs planning will be adaptive including the key principals and associated actions.

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

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

This shift in focus provides a challenge to the way the Central Region collaborates and plans, reflecting a strategic move away from traditional and established ways of working in health and care. The five themes are accompanied by 20 Action Areas that will contribute to a five year plan to deliver an improved New Zealand health system and improved health outcomes for New Zealanders. The five Central Region priority outcomes: **Improved, quality, safety and experience of care; Improved health and equity for all populations; Best value for public health system resources; Improved system integration and consistency; Improved clinical and financial sustainability** are aligned to the five themes and associated actions of the Health Strategy. (See table in the next page)

Regional work that contributes to the implementation of the strategy includes work to progress

Regional Outcomes	Improved health and equity for all populations				
	Improved, quality, safety and experience of care	**Improved, quality, safety and experience of care**	**Best value for public health system resources * Improved clinical and financial sustainability ***	**Best value for public health system resources * Improved system integration and consistency ***	**Improved system integration and consistency**
Health Strategy Theme	**People-powered**	**Closer to home**	**Value and high performance**	**One team**	**Smart system**
Action Area	1. Improve coordination and expand delivery of information to support self-management in health through digital solutions.	3. Ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way.	7. Implement service user experience measures.	13. Improve governance and decision-making processes across the system, through a focus on capability, innovation and best practice, in order to improve overall outcomes.	18. Increase New Zealand's national data quality and analytical capability to improve transparency across the health system.
	2. Promote people-led service design including for high-need priority populations.	4. Enable all people working in the health system to add the greatest value by providing the right care at the earliest time, fully utilising their skills	8. Implement a health outcome-focused framework to better reflect links between people, their needs, and outcomes of services.	14. Clarify roles and responsibilities and accountabilities across the system as part of the implementation of the Strategy.	19. Establish a national electronic health record that is accessed via certified systems including patient portals, health provider portals, and
		5. Increase the effort on prevention, early intervention, rehabilitation and wellbeing for long-term conditions and for obesity.	9. Work with the system to develop a performance management approach with reporting that enhances public transparency.	15. Establish a simplified and integrated health advisory structure.	20. Develop capability for effective identification, development, prioritisation, regulation, and uptake of knowledge and technologies.
		6. Collaborate across government agencies, using social investment approaches, to improve the health outcomes and the equity of health and social outcomes for children, families and whānau, particularly those at risk.	10. Align funding across the system to get the best value from health investment, starting with better access to those most in need, improved delivery of major capital expenditure, and more effective commissioning by contracting for outcomes.	16. Implement a system leadership and talent management programme and workforce development initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility.	
			11. Develop and use a health investment approach with DHBs and consider using this to target high-need priority populations to improve overall outcomes while developing and spreading better practices.	17. Create a 'one team' approach for health through an annual whole of system forum, sharing best practice and contributing to a culture of trust and partnership.	
			12. Continuously improve system quality and safety.		

Regional Context

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

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

The Central Region has developed a model, using a whāriki design demonstrating the weaving of many strands to create strong and durable health services, bringing together the key national, regional and local strategic drivers for the RSP.

Figure1 Key Drivers for RSP

The interconnected and 'whole of system' approach to service planning required to deliver on the suite of national and regional priorities is complex and reflects the nature of socially integrated model of health and care. The traditional life course continuum of care shown in Figure 4 is reflective of single sector approach to planning – the refreshed New Zealand Health Strategy asks that the wider environmental and community links of health and care become a feature of our planning and approach.

Figure 14 Continuum of Care across the Central Region

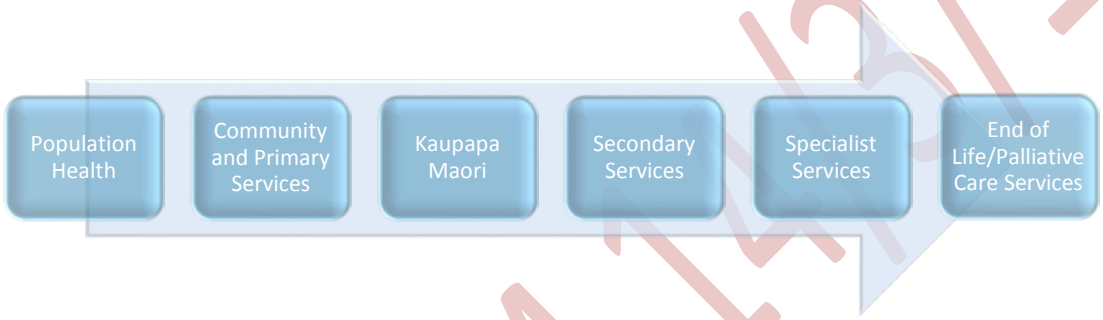


Figure 3 health links with wider environment

This system-wide, co-ordinated view of health and social service planning and delivery is representative of the collective approaches required to ensure that the various activities and initiatives at the national, regional and DHB (local) levels are aligned. The Plan also enhances the view of the health of Māori integration into all health services and provides 'line of sight' and transparency on how local initiatives and national priorities inform the RSP.

Regional Priorities

"It is as important to ensure that each DHB benefits from the investment of collaborative work to ensure we are achieving outcomes from collective effort[6]".

The Central Region DHBs priorities reflect those of the Ministry and those contained in the Minister of Health's Letter of Expectation. These priorities address, direct and support improvement activities and set expected high level outcomes.

The 2016/17 priorities are:

- Elective Services
- Cardiac Services
- Mental Health and Addictions
- Stroke Services
- Health of Older People
- Major Trauma
- Hepatitis C
- Cancer Services
- Diagnostic Imaging

Enablers

- Information Technology
- Workforce
- Quality and Safety
- Quality and Safety

These priorities are a continuation of those from the 2015/16 year, with the exception of Hepatitis C allowing the current work programme to continue and build on the structures already in place. In developing our regional work programme each priority area is part of an integrated focus on delivering improved health outcomes, reduced disparities and a collaborative person centred approach to health care.

Improvements to patient outcomes are achieved through local and collaborative engagement in health planning and delivery. Partnership between patients/consumers and clinical leaders are critical in all planning to ensure that the principles of co-production and co-design can contribute to sustainable service design. As an example, Major Trauma[7] is a key piece of work being implemented regionally that will support the sub-region and link into national plans to better respond to and manage trauma in New Zealand.

[6] TAS Board workshop

[7] Major Trauma is a key Ministry priority

In 2016/17 cross-agency engagement is a consistent theme throughout the RSP. This is fundamental to the integration of the action plans as it draws the linkages to other agencies such as ACC and the Ministry of Social Development.

Health Equity- Health of Māori

The improvement of Māori health outcomes is a combined responsibility across the health and social sectors. New Zealand's Māori Health Strategy, He Korowai Oranga[8] sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. The strategy was updated with input from across the sector during 2013/14 to ensure its relevance for the future. Pae Ora (Healthy Futures) is the Government's vision and aim for the refreshed strategy. It builds on the initial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments).

The intention for this refreshed model is to widen the response of sectors from whānau to whānau and their communities.

We know our Māori communities have higher levels of deprivation, smoking and household crowding than other communities and we know that this varies across our region – our response needs to be one that supports local solutions backed by regional capacity and planning.

The Central Region is committed to ensuring that a focus on Māori health is woven through all health plans to address health inequalities in our regional work. However, work in this area needs to be prioritised and lead regionally in partnership with DHB Maori Health managers and local iwi. While there is a desire to include the Ministry developed 'Equity of Health Care for Māori: A framework'[9] in to all planning work across the region this has not occurred consistently to date.

As the region's DHBs collaborate on how to reduce health inequities we need to move beyond a reliance on Regional Māori Health Plans as a source of reference to inform health service planning and delivery; to improve Māori health and reduce outcome disparities by focusing on the key indicators – a more joined up approach is called for.

For 2016/17 our regional priorities are as follows:

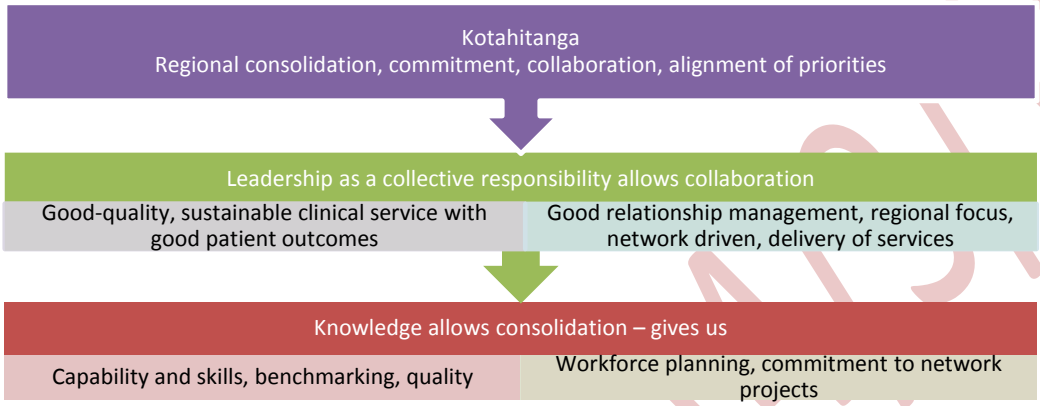
- Develop a functional Maori Health workplan
- Implementation of the Whānau Ora framework
- Implementation of the Māori Health Workforce Development Plan
- Hold and evaluate Tū Kaha biennial Central Region Māori conference
- Accelerate the performance against the annual Māori Health Plan indicators:
    - Reduce ambulatory sensitive hospitalisation (ASH) rates.
    - Reduce rates of heart disease.
    - Reduce rates of diabetes.

8 http://www.health.govt.nz/our-work/populations/Māori-health/he-korowai-oranga

9 'Equity of Health Care for Māori: A framework', Ministry of Health, June 2014

In 2016/17 the Central Region will adopt the following approach to support the implementation of the Māori Health Strategy - He Korowai Oranga to progress our priorities for Māori health.

Figure 9 Principles of collaboration, leadership and knowledge



Central Region 'Care Arrangements'

In seeking to improve equity of service access and improve health outcomes the Central Region is moving to the development of holistic 'care arrangements' to deliver services in way that is co-produced with our communities to meet their needs.

Consistent with the shifting of services to provide care 'Closer to Home' and the development of a 'One Team' approach Central Region Chief Executives have considered over the past few years how the region would operate if a whole of system approach was taken to planning and delivery of services. The pressures on services are increasing with demographic changes, improved diagnostics, up to date treatments and pharmacology, new technologies, financial parameters and patient expectations.

With this in mind the Region has collectively agreed to focus on regional 'care arrangements' for health services. The region has committed to developing planning focus to ensure that primary care and secondary care services are integrated at local, regional and national levels to improve health outcomes and provide innovative solutions to reducing disparities in access to services. Service models focusing on 'care arrangements' will inform sustainable current and future workforce investment, as well as capital and information technology requirements.

Recent work[10] undertaken by the region found that there is a lack of regional transparency, and agreement, regarding the development of clinical care arrangements for patients. This includes a

[10] NZ Role Delineation Model Central Region Assessment May 2015 - Health Partners Consulting Group

lack of shared regional understanding of sub-regional networks as well as the care arrangements for patients requiring specialty services across the Region, and those being referred out of the Region.

The opportunity exists to create regional, as well as sub-regional, agreement on the clinical care arrangements for patients who are moving between hospitals to receive optimal care. This could ensure optimal use of the skills and resources in the region as well as meet the needs of the patients.

Using the above approach, a project to co-create a cardiac services system of care across the central region is being developed for implementation 2016/17. The project will help define the system of care across the continuum that the Central Region District Health Boards (DHBs) need to commission to provide sustainable specialist services – the final shape of these services will co-designed in collaboration in service users and clinicians.

Local DHB Priorities

To sustainably cope with the increasing demand for services, DHBs must design pathways that influence the flow of people—delivering care in the most appropriate setting and reducing demand by supporting people to stay well and maximise their independence.

DHBs will work with their stakeholders to effectively coordinate care for the population and to influence demand. Over the past four years this approach has seen the development of several sub-regionals DHB networks delivering specialist clinical services such as maternity and oral surgery within the region. Ultimately, this approach and the flexibility it delivers will assist the DHBs to achieve their desired outcomes that people will receive the care and support they need, when they need it, in the most appropriate place and manner.

Improving quality and safety

Improving the quality and safety of our health and disability services will lead to greater efficiencies and better value. The RSP applies the principles embedded in the Ministry - Health Sector Triple Aim [11] to all its work streams with a dedicated programme committed to ensuring that the national priorities and direction are linked at regional and local levels.

Reducing inequalities that exist in both access to and the quality of health services available across the region is key to improving overall quality and safety . A shared principle and intent for all future planning and configuration of services is to ensure equitable access to high-quality, safe health services across the region.

[11] The Institute for Healthcare Improvement (IHI) developed the model of the 'triple aim' as a strategy to improve the United States health care system. It had three concurrent goals: better care for individuals, better health for populations and lower per-capita costs.
The Health Quality and Safety Commission, in partnership with the National Health Board (NHB), has agreed on a 'New Zealand Triple Aim', which is the simultaneous implementation of: improved quality, safety and experience of care; improved health and equity for all populations; best value from public health system resources.
This has been accepted by all relevant agencies – the Ministry of Health (including the NHB), the National Health IT Board, the National Health Committee, Health Workforce New Zealand, DHBs and PHARMAC – as the overarching goal for improvement in health services.

Figure 15 Triple Aim

Improving Health Outcomes for Our Population

In 2016/17 and beyond DHBs are required to deliver outcomes against the five key themes of the refreshed New Zealand Health Strategy. DHBs are also expected to deliver against the national health sector outcomes: 'All New Zealanders lead longer, healthier and more independent lives' and 'The health system is cost effective and supports a productive economy' and to meet Government commitments to deliver 'better public services'.

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

The region has taken an approach to consolidate the work in the identified priority areas. An operational 'Outcomes Framework' provides a logical framework for achieving our goals against five regional outcomes:

1. *Improved, quality, safety and experience of care*
2. *Improved health and equity for all populations*
3. *Best value for public health system resources*
4. *Improved system integration and consistency*
5. *Improved clinical and financial sustainability.*

The Outcomes Framework feeds into the Ministry's overarching outcome goals for the health system:

- 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.

These health outcomes support the achievement of wider Government priorities and are not expected to change significantly in the medium term.

Alongside the Outcomes Framework the Central Region is weaving the Māori Health Strategy across all planning activities. The Triple Aim principles will provide the Central Region with a mechanism to provide services that are sustainable, meet quality and safety expectations and are delivered within available resources. The achievement of these high-level outcomes, along with the operationally focused, clinically led outcomes across the network, will have real impacts on the lives of the Central Region's population.

Deliverables that underpin the achievement of these impacts, outcomes and objectives are outlined in the Central Region's implementation plans (Appendix 1).

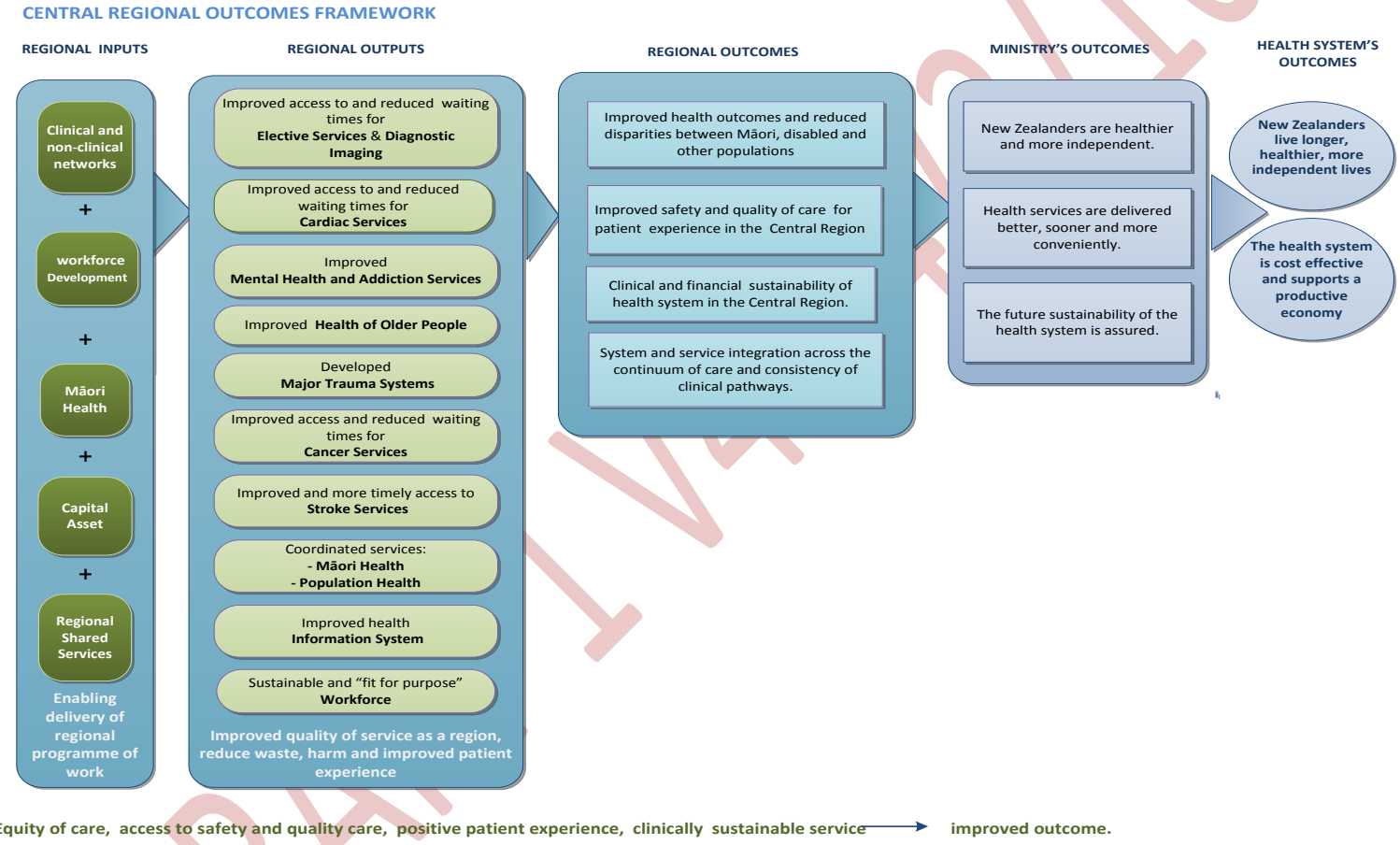


Figure 6 Outcomes Framework diagram

Enablers

The Central Region recognises that the following enablers provide the necessary support and evidence to achieve its priorities. The National Health IT Plan and Health Workforce Regional Work Plan outline the strategic focus. These plans include key priorities and programmes that are expected to be implemented regionally by DHBs. The regional priorities for 2016/17 for Information Technology (IT) and Workforce are outlined in the combined priorities document.

ICT system - integration and service transformation

The National Health IT Plan proposed that each region operate a common platform to support the delivery of integrated health services. The ability to deliver and configure services in a regional context is dependent on the underlying information infrastructure that supports making patient information available to the right health care providers in the right place and at the right time. The regional IT planning component of this RSP supports the regional service operating model and the national programmes of work as per the National Health IT Plan. The regional program of work (CRISP) has been recalibrated with change of approach for each application/function aligned against a **Core, Common, Divergent model**.

Core (What Must Be Regional) the following criteria has been applied:

- Single vendor, chosen by the region
- Agreed regional version of the software
- On the same regional hardware instance
- Supported by a single regional operating model
- Funded by the region
- Governed by the region with local input

Clinical Portal and Radiology Information System (RIS) are deemed Core.

Common (What Must Be Shared) the following criteria has been applied;

- Single regional vendor, chosen for the region
- DHBs will converge on an agreed regional version of the software
- Local shared hardware instance
- Supported by a single local operating model
- Funded locally by the sharing partners
- Governed locally by sharing partners but with input by the region

Patient Administration System (WebPAS) and ePharmacy are deemed Common.

Divergent (What Will Not Be Shared) the following criteria has been applied;

- Single local vendor chosen for the local conditions
- May scale to an agreed regional version of the software
- Will be on a local hardware instance

- Supported by a single local operating model
- Funded locally
- Governed locally

Building a workforce for the future

As a region we are committed to strengthening current initiatives and new ways of working while developing a sustainable workforce to meet future health needs.

A dynamic and sustainable workforce is vital in ensuring that DHBs can have the mix of skills and abilities to deliver 'care closer to home' and the flexibility to explore innovative ways of working as 'one team'. Our regional workforce programme will build on the 2015/16 work programme and is focused on increasing Maori participation and the support for vulnerable workforces, particularly in midwifery while continuing to build on existing recruitment and retention strategies. In 2016 we will be launching phase one of a long term of cultural responsiveness plan to enable our workforce to better meet the needs of our Pasifika population through the adoption of contemporary practice models to reduce inequity in health outcomes.

Collaboratively the Central Region DHBs professional groups and leaders have established a clear aim and direction that will result in resources in place to support and grow our workforce, therefore l enabling regional and local solutions to provide the range and scope of services that are needed by the communities that they serve.

Living Within Our Means & Capital Planning

We are increasing our focus on proven preventive measures and earlier intervention through incremental change to improve existing services. However, it is unlikely to be sufficient to meet the simultaneous challenges arising from fiscal constraints and the changing needs of the region's population. New incentives, financial and non-financial, may be needed to deliver better performance.

Capital Planning is a critical strategic activity and it is important that the signals for required investment are given early; so that there is sufficient time to effectively plan. It is equally important that sufficient time is built in for the critical conversation to ensue medium to major capital decisions are being tested regionally to ensure that the expected benefits of collaboration are maximised.

The Capital Planning Committee will provide solid input to inform planning and decision-making prior to capital requests being considered by the National Capital Investment Committee.

Capital Investment Committee is under review due to recent changes to CAPEX reporting requirements.

Networks

Clinical networks and regional programmes of work

The region is commitment to robust and balanced clinical leadership within the work planned for 2016/17 across each work area and the regional governance structures. Each of the 12 regional

programmes has a steering group, which is clinically led and has representation from the appropriate functional disciplines in order to provide advice to the business owner and programme manager.

Regional Cancer Network

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

Supporting Clinical Networks and Clinical Leadership

The Central Region is committed to the continued clinical integration through the support for existing clinical networks and the establishment of new networks that will contribute to our regional priorities and outcome goals.

There are a number of already established regional and sub-regional clinical service delivery networks, for example the Central Region Role Delineation[12] project (May 2015), identified functional improvements from the MidCentral, Hawke's Bay and Whanganui oral maxillo-facial network, the Whanganui and MidCentral maternity clinical network, and the clinical support service network supporting Wairarapa within the '3DHB' network (ie, Capital & Coast, Hutt Valley, and Wairarapa DHBs).

However, this same project also highlighted a key challenge for the region in that there is a lack of shared regional understanding of sub-regional networks as well as the care arrangements for patients requiring specialty services across the Region, and those being referred out of the Region.

Opportunity exists to create regional, as well as sub-regional, agreement on the clinical care arrangements for patients who are moving between hospitals to receive optimal care. The focus for 2016/17 will be on cardiac services.

[12] NZ Role Delineation Model Central Region Assessment May 2015, Health Partners Consulting Group

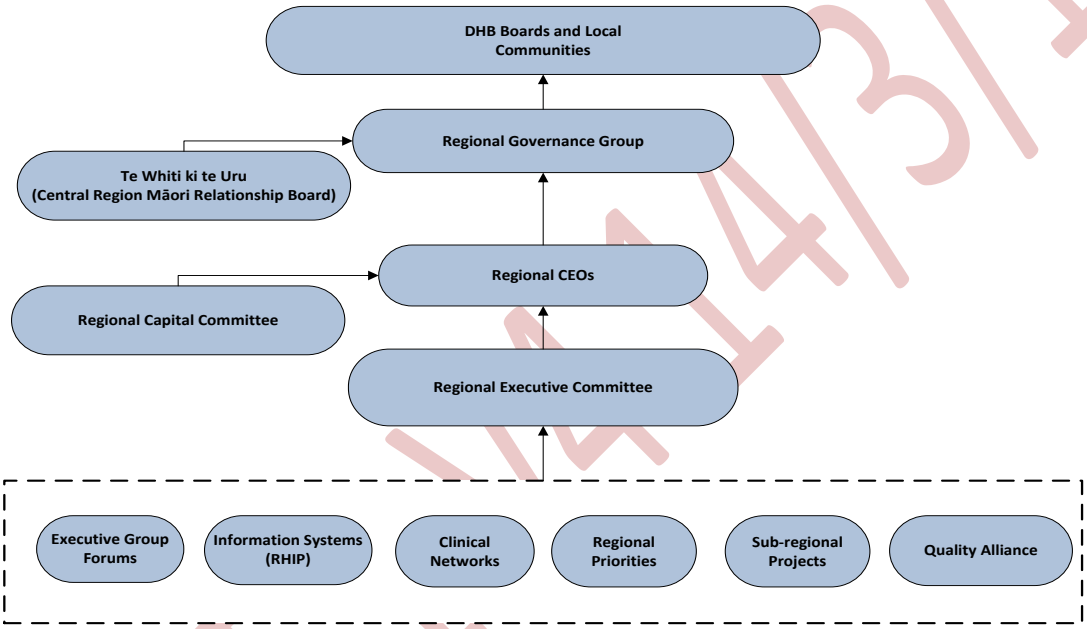
Regional Governance and Leadership

Regional Governance and Decision Making

"to move forward Board and staff need to keep working together and this requires leadership at many levels".

In the Central Region we have made a commitment to ensure that each DHB within the region benefits from the investment in collaborative work to ensure the achievement of outcomes from the collective efforts. The Central Region DHBs' regional governance framework is shown below.

Figure 7 Central Region leadership frameworks[13]



Promoting strong corporate and clinical governance

Effective leadership ensures that the region is moving in a consistent direction and is working collaboratively. The development of the RSP 2016/17 has been clinically led. The development and planning of this RSP have had strong clinical engagement at a regional governance level and have involved clinical networks.

The Combined Boards meet biannually to review the regional priorities against their performance and to determine new priorities that are emerging. They collaborate on the best way to manage these existing and new priorities. This is an opportunity to reflect on quarterly reports from programmes of work, and supply confidence and resources to assist in removing barriers to progress.

An Overview of the four Central Region governance groups that oversee clinical and business service activities is provided in Appendix 2.

[13] Structure under review currently.

REGIONAL SERVICES PROGRAMME

CENTRAL REGION DISTRICT HEALTH BOARDS

www.centraltas.co.nz

> Working together for our region's future health

Line of Sight

REGIONAL SERVICES PROGRAMME | CENTRAL REGION DISTRICT HEALTH BOARDS

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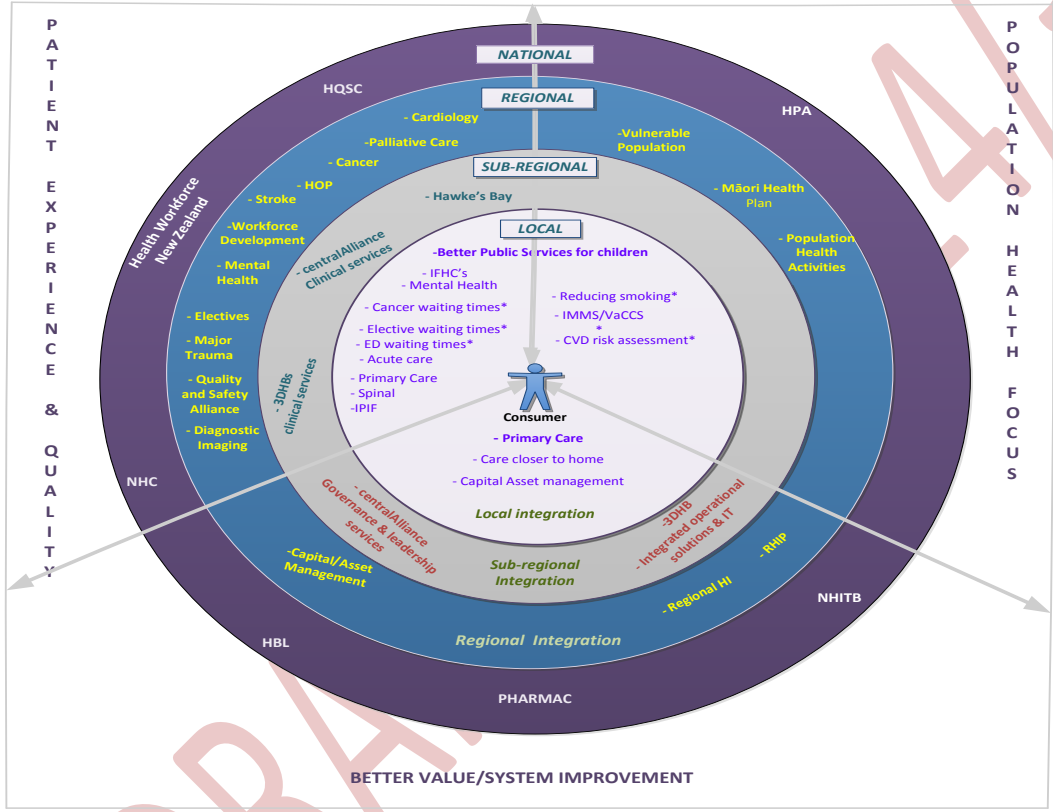
Line of Sight

Fig 10 Initiative mapping: Line of sight of local, sub regional, regional and national plans



KEY

Local: activity focused within DHBs – focus of Annual Plans.
Sub-regional: activity/initiatives where 2 or 3 DHBs collaborate.
Regional: activities/initiatives where greater benefit is gained from collaborative working by 6 DHBs.

Better Public Services for Children
Reducing rheumatic fever
Prime Minister's Youth Mental Health Projects
Children's Action Plan
Whānau Ora

For acronyms refer to Appendix 4

Appendices

Planning Priorities

Appendix 1

Planning priorities

Central Region implementation plans 2016/17

The action plans focus on outlining the specific tangible and measurable actions to deliver on identified service priorities and targets. Each plan outlines the context in which the work is developed, and the commitments included in the DHB annual plans contribute to the success of the regional plan.

Index of Key Actions

Health of Older People (HOP)

Sponsor: Julie Patterson

Complex levels of integrated care are not indicated for all older people, but are required for certain sub-groups. The degree of integration is dependent on the needs of the target population. As older people's health needs change they will move between levels of care. The identification of the different needs of people is critical to ensuring they are cared for within appropriate levels of service delivery.

The Central Region's vision for older adults is that there will be a regionally co-ordinated system of health service planning and delivery that will lead to ongoing improvements in the sustainability, quality and accessibility of health services for older people. This involves putting in place the tools, processes and education to bring people and organisations within the health system together, in order to place patients at the centre of the system and improve health and wellbeing.

In the next two years the Central Region will focus on the needs of those aged 75 years and older whose changing health status usually requires higher levels of service integration.

What are the achievements to date on the RSP journey?

The achievements by the Health of Older People Network and project teams are:

- Growth the knowledge and understanding with consumers and health professionals of advance care planning.
- Development of a regional approach to implementing advance care planning through sharing of resources, expertise and innovations.
- Identification through a comprehensive stocktake, opportunities for regional developments to support people with dementia and their family/whānau.
- Established regional agreement on the indicators to support the delivery of a regional dashboard for stakeholders across the community, primary and secondary care.
- The pilot multi-interventional approach to polypharmacy in the piloted in Whanganui region. This resulted in medication modifications in 86% of those seen, support for consumer to better self-manage their medicines and provided primary care with a specialist medicine advisory service to support clinical decision making for those with complex medicine regimes.

What is the current year plan – to achieve what this year that contributes to what in the longer terms?

In response to the themes articulated in the New Zealand Health Strategy Review and Health of Older Peoples Strategy Review, the Central Regions Health of Older People (HOP) Network will be a proactive regional forum responding to policy and research and collaborating with stakeholders and customers to improve the health outcomes for older people and their family/whānau/carers.

Objectives
In 2016/17 the HOP Network and associated project teams will focus on: • Establishing and maintaining national relationships with cross sector agencies and regional networks to better understand opportunities for system integration and connected services at a local or regional level for older people and their family/whānau • Promoting a shared understanding of integration utilising the Central Regions Integration Framework (2012) and associated resources. • Investigating and utilising approaches/tools which support transitions of care across the system for older people. • Investigating the barriers and needs of the carer in supporting the older person's wellbeing and function. • Utilising relevant datasets and business intelligence to inform the development of models of care which align to national strategy and support older people to live well, stay well and get well.

Measures
• Quarterly reporting of progress on the key milestones in the RSP. • The HOP Network will develop project documentation to describe what needs doing (Project Brief), how to do it (Project Plan) and why (Business Case) as indicated, to allow regional decision makers to decide on a course of action. • Regional opportunities for improvement, identified in the 2015/16 stocktake against the New Zealand Framework for Dementia Care, are implemented.

Key Actions for 2016/17

HOP Key Actions	Milestones	Measures	Leads
Complete a current state analysis of educational and support programmes to support people living with dementia and their informal careers that are in operation in the region.	Develop stocktake tool and engagement strategy to assess current state of education and support programmes ensuring equity is reflected within the data sought. (Q2)	Quarterly report on progress against RSP milestones	
	Collaborate with the non-government sector and community providers to complete current state (Q2).		
	Develop findings of the stocktake and report to relevant stakeholders (Q3).		
	Develop a regional proposal for a standardised approach to education and support programmes for people living with dementia and their informal care givers (Q4).		
Delivery of dementia awareness and responsiveness education programmes for primary health care clinicians to improve awareness and responsiveness in primary health care.	Provide regional representation to the National Dementia Education Collaboration – Primary Care Dementia Education, to strengthen the national response to primary care education (Q4).	Quarterly report on progress against RSP milestones	Regional Dementia Pathways Reference Group
	Embed e-learning (Henry Brodaty) modules developed through the National Dementia Education Collaboration into General Practice (Q4).		
	Report on the number of education sessions provided regionally to improve dementia awareness and responsiveness in primary care (Q4).		
Provide DHBs with on-going support and overview so that DHBs identify and strengthen	Strengthen the Central Region's clinical leadership on dementia (Q2).	Quarterly report on progress against RSP milestones	Regional Dementia Pathways Reference Group
	DHBs will provide access to "Living Well with Dementia Resource" to the person with dementia and their family and whānau (Q3).		

HOP Key Actions	Milestones	Measures	Leads
components of dementia care pathways within the parameters of the New Zealand Framework for Dementia Care.	Review content and update local DHB health of older people webpages to better support information for people with dementia and their family and whānau (Q3).		
	Update DHB locator pages on the Alzheimer's NZ website (Q4).		
	Regional forum delivered to strengthen regional clinical engagement and clinical leadership for healthcare professionals working with older people (Q4).		
Proactively monitor and share InterRAI population and service data across the continuum to influence service improvements.	Publish regional benchmarking dashboard ensuring equity is reflected within dashboard (Q1).	Quarterly report on progress against RSP milestones	Regional Benchmarking Project Group
	Establish survey tool to determine reach into relevant sectors such as primary care, community care and NGO sector (Q2).		
	Launch survey and analyse results (Q3).		
	Evaluate dashboard metrics in response to survey and data trends and amend dashboard accordingly (Q4).		
	Monitor progress on the Palliative Care InterRAI pilot (Q4).		
	Revise communications plan for dashboard (as necessary) based on survey results (Q4).		
	Utilise data to inform business case(s) (Q4).		

Linkages to other programmes	
Sub-Regional	Central Cancer Network, Palliative Care Managed Clinical Network
Sub-Regional	Central Cancer Network Palliative Care Managed Clinical Network

Linkages to other programmes	
IT	Regional Advance Care Planning Reference Group HOP Network InterRAI Data Analysis and Reporting Service
Workforce	Mental Health and Addictions Network Regional Workforce Development Hub
Capital investment	Not applicable
Maori Health	Regional Benchmarking Project HOP Network
National	Health of Older People Steering Group

Roadmap				
Progress and achievements	*June 2015*	*June 2016*	*June 2017*	*June 2018*
1. Dementia	✓	✓	✓	BAU
2. Regional Benchmarking	✓	✓	✓	BAU

Stroke Services

Sponsor Ashley Bloomfield

The 2015/16 Stroke Regional Service Plan focused on the continuation of the implementation of the NZ Stroke Foundation guidelines 2010. This approach has resulted in defining data collection including identifying Māori and Pacific patients who have experienced a stroke. Ethnicity data will continue to be collected in the 2016/17 RSP and will assist the national working group with service delivery decision making to reduce disparities and improve access to stroke services for Māori and Pacific patients and their families/whanau.
In 2015/16 the Central region has consistently exceed the six percent thrombolysis rate. Where a DHB has not achieved the six percent rate strategies have been implemented which have resulted in an improved DHB rate.

Consumer representation on the Central Region Stroke Network has not been achieved in the current year and will be an objective for the 2016/17 year.
Data collection has proved challenging for the Central Region with timeliness being an issue.
2016/17 RSP will identify options to improve overall data management and collection which will support decision making, service delivery and drive service improvement.
Strengthening linkages with primary care, NGO's and Iwi providers will be an objective for the 2016/17 year, which will support patients who experience stroke being able to access broader health services closer to home. To achieve this it will be necessary to strengthen the role for patients, families and whanau and community to support improving health outcomes.

Objectives

- Improved primary and secondary stroke prevention and reduce stroke related disability and mobility.
- Improved access to quality assured organised acute, rehabilitation and community stroke service for stroke patients.

All stroke patients regardless of age, gender, ethnicity or geographic domicile have equitable access to a high-quality stroke services

Measures

The Central region will know that the identified objectives are being achieved when;

- ✓ 8 percent or more potentially eligible stroke patient's thrombolysed 24/7.
- ✓ 80 percent of stroke patients who are transferred to inpatient rehabilitation services are transferred with 7 days of acute admission.

Key Actions for 2016/17

Stroke Key Actions	Milestones	Measures	Leads
People receive treatment closer to home via smart systems to improve stroke prevention and reduce stroke related disability and mortality.			
Tele-stroke; All people with stroke have access to 24/7 thrombolysis supported through the use of tele-stroke	• Central Region DHB's complete participation in the Ministry Tele-stroke pilot, HBDHB, MDHB, CCDHB	• Tele-stroke implemented - Q2	All DHB's
	• Allocation of required resources to support 24/7 access to thrombolysis using tele-stroke is determined which includes collaboration with; ➢ Radiology services ➢ Emergency departments ➢ Emergency services (Ambulance) ➢ Support use of transport options if required to access thrombolysis	• Monitoring of thrombolysis rates and thrombolysis register continue - Q1 - Q4 • The Central Region 's eligible stroke patients are thrombolysed achieving 6% or less	
	• Annual audit to be undertaken by all DHB's • DHB's to contribute to stroke thrombolysis quality assurance procedures including processes for staff training and audit. • Required resources to sustain 24/7 tele-stroke including any impact on DHB radiology services is determined	• A sustained workforce training for thrombolysis	
Communication Plan; A Central Region Stroke Network Communication plan is developed and includes strategies to support the TIA tool in primary care A more integrated CR stroke services which is better connected with wider public services	• Engagement with Primary care, (PHO), NGO's and Iwi Health Providers are undertaken prior to the development of the Communication plan • Strengthen linkages with Stroke Central Region Inc improving communication and feedback loop.	• Enhanced integration with Primary Care, NGO's and Iwi Health Providers are achieved • The engagement process is completed by Q3 • The communication plan is developed, Q3	Central Region Stroke Steering Group

Stroke Key Actions	Milestones	Measures	Leads
All stroke patients receive appropriate rehabilitation services and have equitable access to community stroke services, regardless of age, ethnicity or geographic domicile.			
Rehabilitation; • All <65 people with stroke have access to rehabilitation • Develop understanding of users of health services • Partnering with patients, family/whanau to design services • Encourage and empowering patients and their family/whanau to be more involved in their health • Supporting patient and family/whanau navigation of the health system • Identify feasibility of a regional centre for <65years rehabilitation 30 June 2017 • Ensure 80% of stroke patients are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission. • Determine processes to collect the proportion of patient admitted with acute stroke who are referred to community rehabilitation and the proportion of these undergoing face-to-face community assessment within 5 days of discharge from hospital	• A needs analysis is undertaken to determine the requirements for rehabilitation for stroke patients < 65 years of age, which takes into consideration requirements for; ➢ Vocational rehabilitation ➢ Family/Whanau participation and support • DHB's will identify process requirement which will support data collection	Need for access to rehabilitation for patients <65 years across the CR is determined by Q4	Central Region Stroke Steering Group
Thrombectomy; Requirements to support a thrombectomy service based at CCDHB is determined Establish transport requirements and funding implications	• CR requirements to support a thrombectomy service based at CCDHB will be determined by Q2 • Support use of transport options if required to access thrombectomy	Start collecting regional thrombectomy data by Q2	CCDHB – Clinical Lead

Stroke Key Actions	Milestones	Measures	Leads
Data management and reporting; CR DHB's support improved data management processes which enhances decision making, drives service improvement and service delivery Information technology supports improved data collection Data continues to be collected for the following; • 8%Thromboysis rate • 80% of patients transferred to an Acute Stroke Unit or Organised stroke pathway • Ethnicity data is collected for Maori and Pacific, (for the categories above)	Options to improve and facilitate data collection, including information technology requirement are completed by Q4		Central Region Stroke Steering Group
Training and Education; All members of interdisciplinary stroke team participate in ongoing education and training according to the Stroke Guidelines	Annual Stroke Education Study Day is held, hosted by a DHB by Q4		Central Region Stroke Steering Group
Workforce; Lead Clinicians such as physician, nurse and allied health are supported to participate in the Central region Stroke Steering Group,	All members maintain a good record of attendance	85% attendance rate is achieved for steering group members	All DHB's

Linkages to other programmes	
Other programmes	Linkages with; HOP network and cardiac network
IT	DHB IT systems to support data collection and analysis
Workforce	Education, training and audit to be business as usual by 30 June 2017
Capital investment	Provision of sustained tele-stroke services post the MoH pilot
Maori Health	Engagement with Maori communities through improved communication and integration with Primary care, NGO's and Iwi providers

Progress and achievements	June 2015	June 2016	June 2017	June 2018
Organised acute stroke services or Organised stroke pathway	✓	✓		BAU
Tele-stroke		✓		BAU
Communication Plan			BAU	BAU
TIA's	✓			BAU
Rehabilitation	✓			
Thrombectomy	✓			BAU
Thrombolysis	✓			
Data Management and Information technology	✓			BAU
Education Training and Audit	✓		BAU	BAU
Workforce	✓			BAU

Cardiac Services

Sponsor: Debbie Chin

The Cardiac Network recognises that there continues to be an inequity of access to services and quality of care issues for patients across the region. While the Network regularly monitors the region's performance against national health targets, there is a view that current service gaps exist across the region when compared to the New Zealand Cardiac Minimum Standards. A regional picture, through the creation of a Cardiac Minimum Standards audit framework will enable the Network to identify any gaps in service delivery and will inform the development of an integrated model of care across the region.

The Network's key achievements to date are:

- Successful implementation of Accelerated Chest Pain Pathways within each DHB
- Completion of a visiting cardiac service for Whanganui population
- The completion of the Cardiac Minimum Standards which has now been accepted by the National Cardiac Network as the New Zealand Cardiac Minimum Standards
- The completion of a regional proposal to 'Build a sustainable echocardiography workforce' and agreement in principle to a regional approach by Chief Operating Officers and General Managers Planning and Funding
- Significant improvement in performance against the all New Zealand Acute Coronary Syndrome's Quality Improvement (ANZAC QI) registry management indicator.

What is the current year plan – to achieve what this year that contributes to what in the longer terms?

The Network has identified two key priorities to progress this year:

- the implementation of the NZ Cardiac Minimum Standards and
- the development of an integrated regional cardiac service model.

The successful implementation of these priorities will enable the Network to better monitor the achievement of the Central Region's Health System Outcomes which are:

- Improved health outcomes and patient experience.
- Reduced disparities in health status between Maori, Pacific and European.
- Equitable access to cardiac services.
- Clinical and financial sustainability of health system.
- System and service integration across the continuum of care.

Objectives

The focus for the region in 2016/17 will be to continue to improve access to cardiac services including:

- improved and timelier access to cardiac services
- patients with a similar level of need receive comparable access to services, regardless of where they live
- more patients survive acute coronary events, and likelihood of subsequent events are reduced
- patients with suspected Acute Coronary Syndrome (ACS) receive seamless, co-ordinated care across the clinical pathway
- patients with heart failure are optimally managed at admission, reducing the need for further readmission
- reviewing and auditing Accelerated Chest Pain Pathways (ACPPs) in Emergency Departments.

Measures

Quarterly reporting of progress on the key milestones in the RSP via the New Zealand Cardiac Minimum Standards audit framework will measure the achievement of the New Zealand Cardiac Minimum Standards and the development of a Regional Cardiac Service Model.

Key Actions for 2016/17

Cardiac Key Actions	Milestones	Measures	Leads
Improved and timelier access to quality cardiac services	The Network will work with each DHB in the region to complete an initial gap analysis to assess DHBs performance against the New Zealand Cardiac Minimum Standards and then develop DHB action plans to implement Minimum Standards, and the echocardiography guidelines (Q2 – Q4).	Quarterly report on progress against RSP milestones to the Network, Regional Executive Committee, COOs and GMs Planning and Funding Minimum Standards audit framework	Dr Nick Fisher
Equitable access to services regardless of where the patient lives	Develop a regional cardiac service model strategy that identifies clear actions that take into account the: • inequities identified from the cardiac minimum standards gap analysis and ANZACS – QI data, • anticipated future population demographics in the region This work will ensure the equitable delivery of cardiac services for the region over the next 5 years (Q2 – Q4) and should allow the development of a template for planning for what services need to be provided and in which locations, as well as who is best equipped to provide that service.	Quarterly report on progress against RSP milestones to the Network, Regional Executive Committee, COOs and GMs Planning and Funding Performance against cardiac key performance indicators	Dr Andrew Aitken

Linkages to other programmes	
Workforce	Continue to progress the Echocardiography workforce proposal
Capital investment	Facilities and equipment to accommodate additional cardiac service delivery
Maori Health	Continue to capture ethnicity data across both priorities to access the reduction in disparities

Progress and achievements	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020
NZ Cardiac Minimum Standards	✓	✓	✓	BAU	BAU	BAU
Regional Cardiac Service Model	✓	✓	✓	✓	BAU	BAU

Cancer Services

Sponsor: Debbie Chin

Better sooner more convenient health services for New Zealanders in relation to cancer means all New Zealanders can easily access the best services, in a timely way to improve overall cancer outcomes.

Key drivers for cancer services are:

Currently the key driver for cancer services relates to the Ministry working with the health sector to ensure patients have timely access to appointments, tests which detect cancer and cancer treatment. This work is being done by the Faster Cancer Treatment (FCT) programme which aims to improve the quality and timeliness of services for patients along the cancer pathway.

Key achievements since July 2015

- The region has consistently met PP30: all patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.
- Improved performance against the Faster Cancer Treatment (FCT) indicators (regional results for Quarter 2 2015/16):
  - 75% of patients referred urgently with high suspicion of cancer and a need to be seen within two weeks who receive their first cancer treatment (or other management) within 62 days from date of referral (Health Target)
  - 88% of patients referred urgently with a high suspicion of cancer who receives their first cancer treatment (or other management) within 31 days of decision to treat.
- Completion of reviews of services against the Gynaecological and Breast national tumour standards and commencement of Upper GI and Head & Neck reviews
- Commencement of the following project supported by Ministry FCT funding to improve waiting times and to meet the new tumour standards:
  - CCN - Priority Cancer Pathways Implementation Project (via Healthpathways and Map of Medicine)
  - CCDHB/HVDHB/WaiDHB - Emergency Presentation of Colorectal Cancer - Identifying Factors Affecting Late Presentation - How Can We Improve Patient Awareness and Health Seeking Behaviours to Improve Overall Outcomes
  - CCDHB/HVDHB/WaiDHB - Development and Implementation of a Pacific Faster Cancer Treatment Plan
  - MDHB - Secondary Services Pathways Development
  - TDHB - Defining the Uro-oncology Patient Pathway
  - WhaDHB – Individual cancer follow up plans
- Commencement of a strategic approach supporting FCT in Primary Care
- Planning and implementation of the newly funded psychological and social support initiative
- Completion of the CCN Supportive Care Framework and commencement of implementation

- Joint cancer centre development activities including the regional implementation of the eviQ Antineoplastic Drug Administration Course (ADAC) for nursing.

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

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

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

Measures

- Faster Cancer Treatment
  - Health Target 62 day – CCN DHBs achieve at least 90% of patients referred with a high suspicion of cancer and a need to be seen within two weeks have their first treatment (or other management) within 62 days by June 2017
  - DHBs demonstrate improvements in the number of records submitted with 15-25% of cancer registrations cohort reported within the 62 day health target
  - 31 day indicator (policy priority 30) – proportion of patients with a confirmed diagnosis of cancer who receive their first treatment (or other management) within 31 days of decision-to-treat.
- Shorter waits for cancer treatment (policy priority 30) – all patients ready-for-treatment wait less than four weeks for radiotherapy or chemotherapy
- Improving waiting times – cancer multidisciplinary meetings – monitor improvements to the coverage and functionality of multidisciplinary meetings
- Provide a conformation and exception report each quarter against identified actions the DHB and PHO(s) will undertake to implement the prostate cancer management and referral guidance
- Diagnostic colonoscopy (policy priority 29)
  - TBC% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive); 100% within 30 days
  - TBC% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days); 100% within TBC days
- Surveillance colonoscopy (policy priority 29) – 65% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days.

Key Actions for 2016/17

Cancer Key Actions	Milestones	Measures	Leads
FCT Target • DHB/CCN to continue to develop systems to enable active patient tracking and management aligned with RHIP and NZCHIS • DHBs continue to monitor and actively investigate breaches against the target • DHBs/CCN continue implementation of the six projects across the region supported by Ministry FCT funding • Work with the Regional Radiology Group to identify and implement initiatives to improve timeliness of access to diagnostics)	Systems developed as appropriate Monthly breach reporting and investigation Milestones specific to each project Project plan developed by Aug 2016 Implementation completed by Jun 2017	CCN DHBs achieve at least 90% of patient referred with a high suspicion of cancer and a need to be seen within two weeks have their first treatment (or other management) within 62 days by June 2017 DHBs demonstrate improvements in the number of records submitted, with 15-25% of cancer registrations cohort reported within the 62 day health target	DHB and CCN FCT clinical champions As identified in each project Regional Radiology Group
National Tumour Standards CCN, in partnership with DHBs, co-ordinates reviews of services against two national tumour standards and identify key activities to address issues identified as a result of completed national tumour standard reviews	Prioritised tumour standards for review identified by July 2016 Reviews completed by June 2017	Completion of reviews and development of implementation plans to address gaps, by June 2017	CCN / DHBs
Multidisciplinary Meetings (MDMs)			

Cancer Key Actions	Milestones	Measures	Leads
• DHBs implement MDM clinical resourcing business cases • Scope feasibility of implementing NZCHIS MDM Project (in progress) recommendations for 2016/17 and 2017/18	Priorities implemented by Jun 2017 Scoping completed Dec 2016	(see FCT Target)	DHBs/CCN
Equity • Partner with MDHB to develop tools to support health service planners and providers to implement the *Equity of Health Care for Māori: A framework* resource. • Continue implementing and evaluating the CCN Supportive Care Framework • Continue service development work related to the Psychological and Social Support roles initiative and participate in national evaluation	• Equity Framework tools developed by Jul 2017 • CCN to promote the tool to cancer service providers in the region by Jul 2017 • Implementation priorities for 2016/17 identified by Jul 2016 and completed by Jun 2017 • Evaluation commences Jul 2016 • DHBs will have completed mapping the current state and have developed and implemented required service changes to embed this new service • DHBs provide data to inform the national evaluation process as required	Equity Framework tool developed Tool promoted to cancer service providers regionally Measures currently under development - equity focussed measures to be developed Measures currently under development - equity focussed measures to be developed	MDHB / CCN CCN DHBs/CCN
FCT in Primary Care • Continue to build on initiatives to drive a strategic approach to FCT in primary care as advised by DHB Alliance Leadership	Implementation plan for 2016/17 developed by Aug 2016	Priorities in the plan implemented	Alliance Leadership Teams / CCN

Cancer Key Actions	Milestones	Measures	Leads
Teams (ALTs) • CCN Priority Clinical Pathway project continues, including implementing the prostate cancer management and referral guidance	Planned clinical pathways developed and implemented by Jun 2017	Number of active cancer clinical pathways	CCN / HealthPathways / Collaborative Clinical Pathway
Access to radiotherapy and chemotherapy The two cancer centres will collaborate as appropriate on regional service development opportunities related to the implementation of the updated National Radiation Oncology Plan and Medical oncology Model of Care	Initiatives identified by Aug 2016 Initiatives delivered by Jul 2017	Shorter waits for cancer treatment (policy priority 30) – all patients ready-for-treatment wait less than four weeks for radiotherapy or chemotherapy	RCTS/WBCC
Colonoscopy/Endoscopy Continue implementation of sub-regional colonoscopy service plans	Priorities in sub-regional plans implemented by Jun 2017: • CCDHB / HVDHB / WaDHB • MDHB / WhaDHB / HBDHB	Diagnostic colonoscopy (policy priority 29): • TBC% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days • TBC% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within TBC days Surveillance colonoscopy (policy priority 29) – • 65% of people waiting for a surveillance or follow-up colonoscopy will wait no longer	Sub-regional Colonoscopy Plan leadership groups

Cancer Key Actions	Milestones	Measures	Leads
		than 12 weeks (84 days) beyond the planned date, 100% within 120 days.	

Linkages to other programmes	
Sub-Regional	• 3DHB alignment across CCDHB/HVDHB/WaiDHB • Central Alliance across MDHB / WhaDHB
IT	• Engagement with RHIP development to implement enablers for active patient tracking for cancer patients • Implementing processes to ensure all new information initiatives align with the New Zealand Cancer Health Information Strategy (2015) • Scope feasibility for Central to implement NZCHIS MDM Project (in progress) recommendations for 2017/18 (tbc - dependent on available resources) • National Linear Accelerator and Workforce Plan (due for publication June 2016) will have new metric/data requirements • National Patient Flow project
Workforce	
Capital investment	Implementation of ProVation is completed across all DHBs
Maori Health	• Ethnicity data quality (NZ Cancer health Information Strategy) • Cervical cancer screening (Tumu Whakarae programme) • Breast cancer screening (Tumu Whakarae programme) • Community based cancer health literacy Kia Ora E Te Iwi programme • DHBs continue to support and implement the cancer nurse coordinator initiative

Roadmap is determined by the National Cancer Plan 2015-1018

Mental Health and Addictions

Sponsor: Julie Patterson

In the year 2014/2015, Central Region DHB and NGO providers of specialist mental health and addiction (MHA) services saw a total of 32,771 unique people of all ages across the Central Region (MidCentral, Hutt Valley, Hawkes Bay, Whanganui and Capital and Coast District Health Boards). This equates to 3.7% of the total Central Region Population. In2014/15, MHA services were accessed by:

- 9002 people (3.8%) aged 0-19
- 22,099 people (4.3%) aged 20-64,
- 1670 (1.2%) aged over 65[14].

"Mental Disorder is common in New Zealand: 46.6% of the population are predicted to meet criteria for a disorder at some time in their lives with 39.5% having already done so and 20.7% having had a disorder in the last 12 months." (Ministry of Health, 2008) [15]

These statistics indicate the importance of providing services that are person and whānau focused, closer to home, integrated, and connected.

A key priority for the Central Region is to ensure that connections and links exist between DHBs and other health and social services in the community.

The MHA Regional Leadership group (MHARL, previously MHAN) has responsibility for the development of the strategic direction of MHA services, and aims to ensure that these are accessible, easily navigated and integrated across the Central Region and beyond.

This Regional Service Plan (RSP) is aligned with key documents such as:

- Blueprint II for Mental Health Services in New Zealand (2012), Rising to the Challenge
- The Mental Health and Addiction Service Development Plan 2012–2017 (SDP)
- The draft refreshed New Zealand Health Strategy (2015)

Other documents that will guide the sector are:

- MHA Outcomes Framework
- MHA Commissioning Framework
- MoH Equity Framework
- He Korowai Oranga
- Ala Mo'ui and the Productivity Commission Report
- More Effective Social Services.

What are the achievements to date on the RSP journey?

Achievements made in 2015/16 include:

[14] Data Received from SIDU 2016.

[15] Cited in *Te Rau Hinengaro: New Zealand Mental Health Survey,* Wellington: Ministry of Health, 2008 and similar figures quoted in Warwick Brunton. 'Mental health services - Mental health and mental illness', Te Ara - the Encyclopaedia of New Zealand, updated 13-Jul-12 URL: http://www.TeAra.govt.nz/en/mental-health-services/page-1

- Consultation and agreement on new model of care for Residential Alcohol and Other Drug (AOD) services
- Enhancements to delivery and data measures of Eating Disorder services
- Development of Maternal/Perinatal Clinical Network, including development of videoconferencing, SharePoint and e-learning
- Continued improvements in youth and adult Forensic services through implementation of service development plans
- Movement of Regional Rehabilitation and Extended Care project development to business as usual (via quarterly monitoring)
- Development of workforce development plans for all Central Region MHA services.

What is the current year plan – to achieve what this year that contributes to what in the longer terms?

The 2016/2017 RSP is moving away from separate service workstreams and will focus on developments that enhance collaboration across service areas to reduce the siloed nature of service provision.

Much of the work for 2016/2017 year will be considering the way services are delivered (including service action plans), enhancing data use, and supporting higher levels of integration between primary and secondary care. The aim is to inform the development of a five year strategic approach to Central Region MHA services.

The goals for the Central Region of what will emerge for people, who use services, and service providers, are present within the Objectives section.

Objectives

The Central Region will consider the way services are delivered (including service action plans), enhance data use, and support higher levels of integration between primary and secondary care.

The regional objectives are that tāngata whaiora will experience:

- smoother movement between categories of care, especially primary and secondary
- improvements in their wellbeing, including physical health.
- greater awareness of and easier access to services they need
- a comprehensive range of acute MHA services if they are new mothers or soon-to-be mothers
- a diverse and integrated range of services for those moving through the justice system

For 2016/17, there is a strong focus on services that:

- are outcomes focused
- are equitable for all people
- are recovery focused
- incorporate peer support and consumer leadership
- support young people, including Supporting Parents Healthy Children (formerly COPMIA)
- address the needs of women with MHA issues in their maternal/perinatal stage
- provide integrated care pathways for people with MHA issues
- improve people's physical wellbeing alongside their MHA issues.

Measures

- Scoping of models of care and service delivery models takes place for a variety of MHA services to explore range of service provided, links between primary and secondary, and service user pathways into, through and out of services.
- Hui held within the Central Region in regards to primary and secondary care integration, with particular reference to improving physical health and wellbeing of people with low prevalence disorders.
- Access rates, waiting times and regional provision data demonstrate access to services, with particular focus in services regarding eating disorders, maternal and perinatal mental health and forensic mental health.
- Implementation of regional service plans and regional workforce development plans in some service areas will continue to demonstrate achievement towards a sector that is easier to access, supports people when they need it, and provide a wide range of services.

Key Actions for 2016/17

MHA Key Actions	Milestones	Measures	Leads
Youth Services Improve youth services across the Central Region to ensure the provision of quality service options that improve people's wellbeing by being seamless, integrated, navigable and easily accessible.	Evaluation of requirements, including requirements for models of care and/or service delivery models, for all regional workstreams. (Q1-Q4).	Report summarising development areas for regional workstreams and identifying health equity improvements for populations, including recommendations, presented to MHARL based on evaluation process. Workforce Development Plan to be developed for youth MHA services based on needs analysis from evaluation.	MHARL, DHBs, NGOs, TAS
	Community Youth Forensic Plan implemented. (Q1).	Plan achievement summarised marking completion of all objectives.	MHARL, DHBs, TAS
	Analyse access data for youth forensic services (across court liaison, CYF youth justice residences and community) and eating disorder services, to demonstrate regional access. (Q1-Q4).	Quarterly reports demonstrate changes in access rates, and reflect different ethnicities, to enable service development in this area to occur. Eating Disorder regional service provision summarised, including access data that reflects different ethnicities, to show regional access and diversity of service.	MHARL, DHBs, SIDU
Adult Services AOD services will deliver a stepped care model that people can access services that match their needs. Maternal and Perinatal services will	Adult residential AOD model of care implementation process meeting milestones, including service change, peer support, whānau ora and workforce development. (Q1-Q4). *This will incorporate the implications of the*	Business Case for model implementation complete, including procurement processes. Workforce development and service change plans created. Adult residential AOD model of care implementation begun across the Central Region	MHARL, DHBs, NGOs, TAS

MHA Key Actions	Milestones	Measures	Leads
continue providing enhanced integrated acute care responses, access to a broader range of services, and be supported by the Clinical Network. Adult forensic services will look into processes to enhance the delivery of timely and responsive services.	*replacement legislation for the Alcoholism and Drug Addiction Act (1966).*	(Q4)	
	Maternal and Perinatal services will fully implement the additional MoH funding requirements, including workforce development. (Q1-Q4).	Implementation achievements summarised. Baseline and quarterly data demonstrate increased access, increased community contacts, decreased wait times, and decreases admissions to inpatient facilities.	MHARL, DHBs, CCDHB SMMHS
	Reduction in waiting lists and times for people in prisons requiring assessment by forensic services. (Q1-Q4).	Quarterly reports will demonstrate reductions, and reflect different ethnicities.	MHARL, DHBs, SIDU,
Physical Wellbeing and High, Complex Needs Linkages Increase the physical wellbeing of people who have high and complex needs using MHA services through enhanced integration between primary and secondary care.	Two forums held to improve integration between primary and secondary care (Q2 /Q4). *Regional forums will involve primary care (including NGO), secondary, kaupapa Māori and Pasifika services.*	Findings disseminated to be incorporated in future planning and development.	MHARL, DHBs, NGOs, Primary Care, TAS
Workforce Implement the 2015-2020 workforce plans.	Report quarterly to MHARL and Te Pou with identified workforce requirements for new service delivery models (Q1-Q4) Implement workforce development needs for the region aligned with the National Workforce Centres for Mental Health (Q3 onwards)	Implementation of the 2015-2020 workforce plans.	MHARL, Regional DHBs and NGOs, TAS

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Linkages to other programmes	
Sub-Regional	Youth AOD Exemplar Project, 3DHB MHA Strategic Plan
IT	Regional Health Informatics Programme (RHIP), Health Pathways, Map of Medicine
Workforce	Regional Workforce Development Hub, Te Pou, Te Rau Matatini, Matua Raki
Capital investment	No capital investment foreseen for the 2016-17 period. Across the year opportunities for future year investments may arise.
Māori Health	Central Region Māori Managers
Roadmap	

Progress and achievements	*2014/15*	*2015/16*	*2016/17*	*2017/18*
Regional Rehabilitation and Extended Care	✓	BAU		
Youth	✓	✓	✓	✓
Adult	✓	✓	✓	✓
Physical Wellbeing	✓	✓	✓	✓
Workforce	✓	✓	✓	✓

Electives Services

Sponsor Dr Kevin Snee

The strategic direction for elective services for all New Zealanders is improved and more timely access to elective services. This means that:

- More people will receive access to services which support New Zealanders to live longer, healthier and more independent lives
- People have shorter waiting times for elective services and can regain good health and independence as soon as possible
- People with a similar level of need receive comparable access to quality services regardless of where they live.

To achieve this, the health system needs to function in a way that:

- Increases elective surgery discharges
- Increases first specialist assessments
- Reduces waiting times for people needing elective services
- Improves the prioritisation of patients
- Supports innovation and service development
- Supports regional and national collaboration
- Ensures equitable access to elective services between Maori and non-Maori.

The CR is focusing on a regional approach to improve elective services by developing regional collaboration and information sharing; and working with key stakeholders to identify opportunities that will maximise regional resources and capacity. Through this approach, the aim is to deliver improved equity of access and quality of care for patients through the development of better systems and processes.

Regional Programmes are focusing on improved orthopaedic, ophthmalic and otorhinolaryngology services and the collection of information and data to develop a regional view of day of surgery cancellations and theatre Utilisation; and capacity and capability requirements in relation to the workforce delivering elective services.

What are the achievements to date on the RSP journey?

The electives work programme has been progressed by regional networks who have achieved the following outcomes:

1. The development of 18 orthopaedic pathways
2. The development of 3 otorhinolaryngology pathways
3. A prioritization tool for orthopaedic referrals for FSA
4. Regular reporting of DOS cancellation and Theatre Utilisation.

What is the current year plan – to achieve what this year that contributes to what in the longer term?

1. To improve theatre utilisation which will improve access for patients, maximise efficiencies across the region, and support DHBs to meet their targets for elective services
2. To continue to collaborate regionally to implement elective services initiatives in progress, such as regional clinical pathways for clinical conditions; and to identify areas where regional collaboration could contribute to improved patient outcomes

Objectives
• The Central Region DHBs will deliver elective volumes including Elective Health Target and additional elective orthopaedic and general surgery discharges • The population of the Central Region will receive improved equity of access to elective services • Central Region DHBs will maintain the 4 month waiting times milestone for first specialist assessment and treatment • Improved systems and processes will support the enhanced utilisation of regional capacity and resources

Measures
Complete quarterly project status and progress reports to National Health Board. Report progress on key milestones to Regional Electives Steering group monthly.

Key Actions for 2016/17

Electives Key Actions	Milestones	Measures	Leads
CR Theatre Utilisation Improvement Programme initiated to improve access for patients, maximise theatre utilisation and efficiency across the region, and ensure that DHBs are able to meet their elective targets	• Theatre utilisation work programme developed and approved by relevant regional networks, and Governance Group • Report completed on theatre utilisation in the CR based on available data • Results shared across the CR region to inform planning • Opportunities for regionalisation discussed and solutions developed.	Quarterly report on progress against PSP milestones to the Network, Regional Executive Committee, COOs and GMs Planning and Funding DHB COOs and GMs Planning and Funding have clarity about theatre utilisation rates to inform planning and collaboration across the CR Q3 Patient access to elective services is improved as evidenced by DHBs meeting targets for elective services Q4	CR Electives Governance Group CR Regional Clinical Networks
To continue to collaborate regionally to implement elective services initiatives in progress, such as regional clinical pathways for clinical conditions; and to identify areas where regional collaboration could contribute to improved patient outcomes	• Framework in place for elective services to ensure consistency across elective services, which includes a process to ensure governance • Regional networks in place for specialty groups which are representative and include Maori, Pacific, Primary Care, Consumer, Allied Health • Key stakeholders, Governance Group and regional networks to identify clinical pathway development that would support improved patient access and quality of care and service delivery. • The Central Region Elective Services Health Targets are met • Regional networks to identify options to	Framework agreed and in place to guide all elective services initiatives Q1 Governance Group in place to provide leadership and consistency across all elective services initiatives Q1 Governance Group meeting schedule set, minimum quarterly meetings Q1 Targets are reported on quarterly by DHBs and met Quarterly report on progress against	CR Governance Group CR Clinical Networks

Electives Key Actions	Milestones	Measures	Leads
	develop services with known issues • Barriers to regionalisation discussed and solutions developed • Patient satisfaction surveys developed and initiated to inform ongoing planning and service development	PSP milestones to the Network, Regional Executive Committee, COOs and GMs Planning and Funding Reports on patient satisfaction completed and shared across the CR DHBs Q4	

Linkages to other programmes	
Sub-Regional	Cardiac, Workforce, Diagnostics Work Programmes
IT	Regional information – capacity planning
Workforce	Elective work force
Capital investment	
Maori Health	

Roadmap				
Progress and achievements	*June 2015*	*June 2016*	*June 2017*	*June 2018*
Theatre Utilisation	✓	✓	✓	BAU
Clinical Pathways	✓	✓	✓	BAU

Hepatitis C

Sponsor: Debbie Chin

Background

In January 2015, the Minister of Health considered advice on the future configuration of hepatitis C treatment services and approved the following recommendations:

- Resources in the next three to five years will be primarily directed towards targeted detection, management and treatment of hepatitis C in populations who are most at-risk.
- Primary and secondary care services will be extended to provide improved assessment and follow-up services for all people with hepatitis C.

Following the Minister's approval, the Ministry provided advice to the DHBs via the Regional Service Plan Guidelines. This detailed the commitments requested from the regions regarding development and implementation of hepatitis C services during the 2015/16 financial year.

The hepatitis C pilot was delivered by the Hepatitis Foundation New Zealand (the Foundation) in Capital and Coast, Hutt Valley and Wairarapa DHBs between 2012 and 2015.

CCDHB was contracted in 2015 to support the planning, development and implementation of integrated hepatitis C assessment and treatment services across primary and secondary care for the Central Region. This was to ensure there is no disruption of hepatitis C assessment and support services and the timely transition of patients and data to the DHBs. The aims were to ensure continuity of care for patients in the pilot sites (including transferring them and their records from Hepatitis Foundation), and to increase the identification, assessment and treatment of new patients with hepatitis C. Implementation of services is required to start from 1 July 2016 (provided sustainable funding has been agreed).

What are the achievements to date on the RSP journey?

Since this project started in the 2015/16 RSP year,

- A project scope and plan have been developed.
- Engagement with most services across the region has taken place including with specialist and primary services, needle exchange services, and CADS.
- A working group has been established to guide the localisation of the pathway –established mechanisms for this to occur are in place and drafted Terms of Reference agreed.

Remaining work planned or under way in 2015/16 includes:

- Undertaking analysis of service delivery across pilot and non-pilot sites
- Planning the transition of current patients in the pilot sites to primary care (delayed by unavailability of data from Hepatitis Foundation and achievable only when pilot patient data is received)
- Scoping information requirements and channels to identify new patients
- Working with Map of Medicine and Health Pathway staff to revise clinical pathways
- Identifying clinical and diagnostic capacity and capability requirements to deliver pathway
- Developing business case for resources required across the Central Region from 1st July 2016.

What is the current year plan – to achieve what this year that contributes to what in the longer terms?

For 2016-17 RSP year, the project plans (subject to sustainable funding) to:

- Transition patients from the sub-regional pilot to primary care practitioners (subject to receipt of sufficiently detailed Pilot patient data from Hepatitis Foundation)
- Ensure all components of the clinical pathway are in place, including Fibroscan availability
- Promulgate and implement Hep C clinical pathways in sub-regional and Central Region DHBs
- Raise community and GP awareness and education about Hepatitis C virus (HCV) and risk factors for infection
- Monitor volume of HEP C diagnoses, Fibroscanning and treatment

MoH Regional Objectives

- To implement a single clinical pathway for hepatitis C care across all regions in order to provide consistent services which maximise the wellbeing if all New Zealanders living with hepatitis C.
- To implement integrated hepatitis C assessment and treatment services across community, primary and secondary care services in the region.

MoH Reporting Measures

- Quarterly narrative report on progress of the key actions.
- Report six monthly broken down by quarters on the following measures:

Measures	**Data and source**
Number of people diagnosed with hepatitis C per annum (by age)	Total number of people with a positive HCV PCR test in the DHB region (data from 5 reference labs provided to regional DHBs).
Number of HCV patients who have had a Fibroscan in the last year (by age and ethnicity), for (a) new patients (b) follow up	Total number of hepatitis C Fibroscans performed annually (data from the delivery of Fibroscans in primary and secondary care).
Number of people receiving PHARMAC funded antiviral treatment per annum (by age and ethnicity).	Total number of people prescribed antiviral treatment who have hepatitis C (data from PHARMAC provided to regional DHBs).

Key Actions

Actions to support implementation of integrated hepatitis C assessment and treatment services include:

- raising community and GP awareness and education of the hepatitis C virus (HCV) and the risk factors for infection
- providing targeted testing of individuals at risk for HCV exposure
- raising patient and GP awareness of long term consequences of HCV and the benefits of treatment, including lifestyle management and antiviral therapy
- providing community based access to HCV testing and care that will include Fibroscan services to all regions as a means for assessment of disease severity and as a triage tool for referral to secondary care and prioritisation for antiviral therapy
- establishing systems to report on the delivery of Fibroscans in primary and secondary care settings
- providing community based ongoing education and support (including referral to needle exchange services, community alcohol and drug services, GP primary care services or social service agencies)
- providing long term monitoring (life-long in people with cirrhosis and until cured in people without cirrhosis)
- providing good information sharing with relevant health professionals
- working collaboratively with primary and secondary care to improve access to treatment.

Note: a document (Guidance to support the development of regional services to deliver identification and treatment for people at risk of or with Hepatitis C) is being developed by the Hepatitis C Implementation Advisory Group that will include more information on the clinical pathway, minimum requirements, minimum standards and data collection will be available on the Nationwide Service Framework Library website once it is finalised.

Key Actions for 2016/17

Hep C Key Actions	Milestones	Measures	Leads
Transition of pilot patients in sub-regional DHBs to primary care practitioners completed		By 1 July 2016 - Quarterly report on progress	CCDHB, HVDHB & WaiDHB
All components of clinical pathway in place in sub-region including Fibroscan availability to primary care		Q1 - Quarterly report on progress	CCDHB and Central Region DHBs
All components of pathway in place across Central region		Q2 - Quarterly report on progress	MDHB, WDHB, HBDHBs
Promote and implement Hep C clinical pathway in sub-region		Q1 - Quarterly report on progress	Health Pathways, CCDHB, HVDHB, WaiDHB
Promote and implement Hep C clinical pathway in all Central region DHBs		Q1-2 - Quarterly report on progress	All Central Region DHBs
Raising community and GP awareness of / education on the hepatitis C virus and risk factors for infection		Q1 – 4 - Quarterly report on progress	RPH, Health Pathways
Monitor and report on volume of Hep C cases presenting to primary care		Q1 – 4 – Six-monthly report (by quarter) on specific data measures required by MoH	Central Region DHBs / TAS
Monitor and report on number of Fibroscans undertaken		Q1 – 4 - Six-monthly report (by quarter) on specific data measures required by MoH	Central Region DHBs / TAS
Monitor and report on number of people receiving antiviral treatment		Q1 – 4 - Six-monthly report (by quarter) on specific data measures required by MoH	Central Region DHBs / TAS

Roadmap				
Progress and achievements	*Jun 2015*	*Jun 2016*	*Jun 2017*	*Jun 2018*
Planning and implementation of transitioning pilot patients to primary care		✓	✓	
Implement clinical pathways across Central Region and raise awareness/education - Hep C and risk factors		✓	✓	

Major Trauma

Sponsor Debbie Chin

Trauma is a major health burden in New Zealand, with approximately 2,500 New Zealanders dying per year as a result of trauma and approximately 30,000 require hospital care for their injuries. [16] The Ministry of Health established a Major Trauma National Clinical Network (MTNCN) to improve patient outcomes from major trauma.

What are the achievements to date on the RSP journey?

The achievements made by the Major Trauma National Clinical Network group to date include:

- Establishment of a regional network consisting of a clinical lead and nurse lead for trauma from each of the DHBs in the central region
- A regional trauma symposium is now held each year
- We have been working with Midland Regional Trauma System (MRTS) to assist with establishing their trauma registry as the national registry and ensuring that privacy and security requirements are met
- A central region trauma data collection form has been developed. Regional registry training has been completed. Data is now being collected and submitted to the national registry.

What is the current year plan – to achieve what this year that contributes to what in the longer terms?

The Regional Major Trauma network priorities to achieve this year are:

- To continue to collect and refine the trauma data
- Commence monitoring and analysis of the data to assist with identifying areas for improvement for the network to focus on
- Complete the development of local and regional trauma systems supported by appropriate trauma policies and guidelines
- Finalise the central region component of the National Destination policy

The fit with the Health strategy roadmap and Central regions health System outcomes are in the following areas:

- Improved management of trauma within each DHB and across the region will result in better outcomes and patient experience
- Better coordination of the management of trauma will ensure that resources are applied appropriately, quality and safety standards achieved, and a streamlined system that supports timely access to the right level of care.

The immediate and long term impact on the patient, families and health providers is significant as a result of major trauma. The Central Region DHBs will work together and with key partners, to reduce the impact of major trauma by ensuring that patients will receive appropriate and timely care following a major trauma incidence.

[16] Central Region Regional Services Plan 2015/16

Objectives
To implement a regional major trauma system that will result in a reduction of preventable levels of mortality, complications and lifelong disability of clients who have sustained a major trauma (as defined by the Major Trauma National Clinical Network17). Input the New Zealand Major Trauma National Minimum Dataset (NZMTNMDS) for major trauma patients to the National Major Trauma Registry Develop and implement regionally consistent clinical guidelines for the management of major trauma patients Develop and implement regional destination policies for major trauma patients (in collaboration with DHBs, ambulance providers and the National Major Trauma Clinical Network)

Measures
Quarterly reporting of the NZMTNMDS on all mandatory fields for major trauma patients to National Major Trauma Registry. Report in the second and fourth quarters of 2016/17 on actions above.

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[17] Major trauma patients are defined as ISS>12 using AIS 2005 Update 2008.

Key Actions for 2016/17

MT Key Actions	Milestones	Measures	Leads
Report the New Zealand Major Trauma National Minimum Dataset (NZMTNMDS) for major trauma patients to the National Major Trauma Registry.	Major trauma data will be collected consistently across the region from July 2016. Data will be reported through the National Major Trauma registry via the regional arrangements with Midland Regional Trauma System and available from July 2016. Analysis of the data will support the identification of key areas for improvement and will commence on the availability of the reports.	Quarterly reporting through to National Major Trauma Registry will be achieved within agreed timeframes with Midland Regional Trauma System. Quarterly report and analysis will be reviewed and signed off by the Central Region Trauma Network. Central Region Trauma Network will use quarterly data to revise work programme and inform on-going improvement activities.	
Develop and implement regionally consistent clinical guidelines for the management of major trauma patients.	Clinical Guidelines will be developed consistently across the region and adapted to meet each DHBs specific requirement by December 2016. Regional guidelines will be confirmed to support the timely and appropriate transfer of patients to the regional centre by December 2016.	Appropriate transfer of patient's guideline will be approved by Central Region CEOs by December 2016. Implementation of appropriate transfer of patients guideline will be completed by end of Quarter 4.	
Develop and implement Regional Destination Policies for major trauma patients (in collaboration with DHBs, patients, ambulance providers and National Major Trauma Clinical Network).	Development of regional destination policy for major trauma. This will be developed in consultation across the central region DHBs and key partners, including patients. Regional destination policy for major trauma signed off by regional clinical leads and regional CEO's. Implementation of regional destination policy will be achieved consistently across the regional DHBs. Local trauma champions will work with local teams to ensure smooth implementation.	Regional destination policy for major trauma patients will be finalised and published regionally by August 2016. All Central Region DHBs have implemented the Regional Destination policy for major trauma by end of quarter four 2016/17.	

Roadmap						
Progress and achievements	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020
Data Collection and reporting	N/A		Ongoing	Ongoing	Ongoing	Ongoing
Development of Clinical Guidelines	N/A	Development phase				
Develop and implement Regional Destination Policies	N/A	Development phase	Completed			

Diagnostics

Sponsor: Ashley Bloomfield

Diagnostic imaging supports clinical decisions which enhances the patient journey and therefore enabling DHBs to meet current and new national targets, and allows the adoption of new models of care such as clinical pathways and virtual clinics. These opportunities are designed to improve care for the patients and achieve greater efficiency across the system. This has resulted in a significant growth in demand on services. The Region's focus will be to work with key stakeholders across the health system to identify ways to best manage growing demand.

The Central Region's DHBs currently operate their diagnostic imaging services in relative isolation (although there is co-operation). The phased introduction of a regional Radiology Information System across the Central Region DHBs will enable greater consistency, quality of care and clinical access to patient images and records no matter where the patients are seen.

Workforce recruitment, retention and profession shortage issues continue to affect all diagnostic imaging professions, in particular radiologists, sonographers and Nuclear Medicine MRTs. Ultrasound workforce numbers are a significant issue for the region and nationally. There continues to be a need to look at the diagnostic imaging service as a whole, including the primary sector. The challenge for the region is the lack of cohesion and future alignment of local DHB plans to ensure successful recruitment.

The achievements made by the Regional Radiology Steering Group are:

- The success of the international Sonography recruitment campaign which included the regions attendance at the recent Society of Diagnostic Medical Sonography (SDMS) conference in Dallas, Texas which has attracted 294 people to the KiwiHealth jobs website, 165 of these from Canada. There have been ten genuine enquiries and a further six sonographers have been contacted by the region. The region has developed and endorsed consistent recruitment policies and procedures.
- The implementation of the Community Referred Radiology Access Criteria sub-regionally, led by three DHB and the National Radiology Access Criteria by the northern DHBs.
- The establishment of the Operations and Governance RIS/PACs Group to support and guide the implementation of RIS across the region including policies that will support business as usual.

What is the current year plan – to achieve what this year that contributes to what in the longer terms?

The Regional Radiology Steering Group's priorities for 2016/17 are:

- To continue to support the implementation of the Radiology Information System
- To continue to work in a cohesive manner to address workforce shortages.
- For 3DHB support and engage with cardiology to develop a pilot framework that enhances coronary computed tomography.

Objectives
The regional objective will be to continue to focus on the regional work programme managed by the Regional Radiology Steering Group that includes: • IT infrastructure: supporting the development and installation of a regional RIS solution through the Regional Health Informatics plan • workforce: investing and improving the workforce to become regionally sustainable in the future • clinical indicators: standardising clinical indicators and implementing appropriate access criteria across the Central Region to improve equitable and timely access to diagnostic imaging • working with regional and national clinical groups to contribute to the development of improvement programmes

Measures
Quarterly reporting of progress on the key milestones in the RSP.

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Key Actions for 2016/17

Diagnostics Key Actions	Milestones	Measures	Leads
IT infrastructure: supporting the development and installation of a regional RIS solution through the RHIP	'In conjunction with the RHIP Steering Group, develop a regional structure to govern and support the implementation of Radiology Information System.	A report detailing the regional Governance structure is reviewed and signed off by RRSG. Completed Q2	TBC
Workforce: Develop and strengthen the workforce to be a structure that is regionally sustainable and supportive.	Develop and implement regional recruitment and retention initiatives to address vulnerable workforces, commencing with Sonographers through reviewing and improving ongoing training and educational opportunities for all disciplines and ensuring sufficient staffing resource to maintain service provision	Quarterly report on progress against RSP milestones to the Network, Regional Executive Committee, COOs and GMs Planning and Funding Evaluate and monitor outcomes achieved from implementing workforce initiatives by Q3 – 4.	Diane Orange
Service Improvement: the Central Region will work to improve equitable and timely access to diagnostic imaging services.	3DHB to develop alongside cardiology a pilot framework that will assess the costs/benefits of coronary CT in the CT area to maximise non-invasive cardiac imaging and reduce coronary imaging.	Quarterly report on progress against RSP milestones to the Network, Regional Executive Committee, COOs and GMs Planning and Funding Evaluate and report outcomes from the pilot initiative by Q3.	Dr James Entwistle

Linkages to other programmes	
Sub-Regional	3DHB to work with the Central Region Cardiac Network to develop: • Service model for performing and reporting cardiac CT • Criteria and pathways
IT	Implementation of RIS
Workforce	Sonography Recruitment and Retention Campaign
Capital investment	
Maori Health	

Roadmap						
Progress and achievements	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020
Workforce	✓	✓	✓	BAU	BAU	BAU
Radiology Information System	✓	✓	✓	✓	BAU	BAU
Demand Management	✓	✓	✓	✓	BAU	BAU

Workforce

Sponsor Julie Patterson

A sustainable workforce is a key enabler in ensuring that DHBs continue to provide the range and scope of services that are demanded of them by the Government and, more importantly, by the communities that they serve.

Workforce planning is a continual process that has to look simultaneously at short-, medium- and long-term demands and needs, and balance these many different drivers in such a way as to ensure that DHBs can deliver now, and in the future, staff who are trained and experienced in the areas required in order to provide those services that are critical to their communities. Being clear what the current workforce looks like and the current gaps.

The Central Region is committed to aligning to the New Zealand Health Strategy by progressing the workforce priorities that were progressed in 2015-16 with a further one workforce priority identified for 2016/17. It is envisaged that, when combined, they will help to consolidate the good work already done while at the same time help to create a more coherent and resilient strategy for future development.

The Central Region is committed to improvement, ensuring workforce training is effective thereby resulting in retention of staff across the whole health sector.

This plan acknowledges the alliance formed between the six DHBs, HWNZ and the National Strategic Workforce Team located in DHBSS to jointly address workforce priorities and enabling the region to cultivate the existing collaborative and cohesive network for developing valid workforce initiatives and innovations. This includes the development and implementation of the national leadership framework and initiatives undertaken by National GMsHR.

Please note all measures will relate to quarterly increments to support the achievement of the work streams. In addition, all work streams will be categorised under the HWNZ governance categories to enable monitoring for workforce development.

Objectives
Support the HWNZ and National DHB Strategic Workforce Group mission to ensure a health workforce in New Zealand that is both sustainable and fit for purpose.

Key Actions
• Midwifery - Provide midwifery professional support to ensure retention and quality of workforce. • Medicine - Improve sustainability and resiliency of workforce. • Nursing - Support the development of the nursing workforce. • Allied Health, Scientific and Technical – Support the development of the AHST workforce • Cultural Responsiveness - Support cultural development of workforce with reflection of recruitment aligned to population demographics • Kaiāwhina - Support national project through regional support framework. • Mental Health and Addiction - Implement 2015 workforce plan. • Advance Care Planning - Improve regional ACP awareness and training in identified high-need priority areas. • Talent Management and Succession Planning - Appropriately enable regional workforce talent management and succession planning.

Key Actions for 2016/17

Workforce Key Actions	Milestones	Measures	Leads
Midwifery Provide midwifery professional support to ensure retention and quality of workforce	Q1: Continue model pilot evaluation. Q2 onwards: Develop and establish a regional professional support framework (with evaluation of framework in 2017-18).	Established regional professional support framework for central region.	Midwifery Leaders Group
Medicine Improve sustainability and resiliency of workforce	Q1 onwards: Continue to develop a regional orientation programme for RMOs utilising nationally developed online programmes. Q1: Identify potential funding streams for additional palliative medicine registrar training positions with DHB COO, CMO, RMO Unit Manager and associated hospices for CCDHB and MCDHB. Q1-2: Scope current and identify future potential community based attachments (CBA). Q2: Establish a minimum of one additional palliative medicine training position for region for start end of 2016 year with plans in place for further training position for end of 2017 year. Q3-4: Develop a regional framework to ensure that current CBA initiatives are available for utilisation within region. Q4 onwards: Implement regional RMO orientation programme. Q4: Stocktake current palliative medicine training positions in region.	Development of regional agreed orientation programme for RMOs Complete DHB integration for increased number of PGY1 and support increase of community based attachments in conjunction with DHBs and Regulatory Authorities Community Based Attachment Framework Increase in Palliative Medicine registrar training positions in region Decrease unfilled palliative care SMO positions	CMOs, GMsHR, COOs/GMsPF, Prevocational Educational Supervisors , RMO Coordinators, Regional Cancer Network and RMO Unit Managers
Nursing Support the development of the	Q1 onwards: Continue to develop a regional plan to align regional workforce initiatives with national bowel screening action plan (awaiting approval and delivery of national plan by Government).	Endoscopic trained nursing workforce Strategic regional bowel	DONs and Directors of Mental Health

Workforce Key Actions	Milestones	Measures	Leads
nursing workforce	Q1 onwards: Continue to develop and implement regional plan with monitoring framework for utilising (top of scope) Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP) positions in region. Focus on supporting employment models to maximise outputs (standardisation of position profiles and KPIs) for requirement for CNS group to be positioned for nurse prescribing. Q4 onwards: Benchmark current NP and CNS positions within region.	screening plan aligned to national plan as appropriate. Full utilisation of CNS and NP positions in region.	
Allied Health Scientific and Technical Supporting the development of the AHST workforce	Q1-4: Continued development and implementation of regional recruitment and retention sonography initiatives. Alignment of regional workforce policies and procedures for sonography. Q1 onwards: Commence the process for AH career pathways to be introduced at MCDHB and WDHB. Q1 onwards: Continue to implement regional echocardiography workforce plan and monitoring framework. Q3: Implement the AH career pathways at MCDHB and WDHB. Q3: Design a learning and development framework for AH career framework. Q3-4: Evaluate and monitor outcomes achieved from implementing sonography workforce initiatives.	AHST career pathways available to enable career progression and talent management Develop a sustainable echocardiography workforce for service provision and echocardiography guidelines (minimum standards). Regionally sustainable sonography workforce and decrease in unfilled sonography vacancies.	DAHs, GMsHR, Regional Echocardiography Working Group, Cardiac Network, Regional Sonography Workforce Group, Regional Radiology Group

Workforce Key Actions	Milestones	Measures	Leads
Cultural Responsiveness Support cultural development of workforce with reflection of recruitment aligned to population demographics	Q1-4: Quarterly benchmarking of Pacific and Māori workforce.	Increase in regional recruitment of Māori and Pacific in nursing, midwifery, medicine and allied health. Regional strategic action plan to increase pacific responsiveness training to meet the cultural needs of Pacific Peoples accessing DHB health care services. Development of a culturally aware workforce to meet needs of Māori population.	CRMM, DoPH, GMsHR and regional professional leads
	Q1 onwards: Continue to develop and implement strategic rollout plan for one regional Māori Capability Programme		
	Q2 onwards: Phase one of implementation of Pacific cultural responsiveness plan (with further phased implementation and evaluation (from 2017 onwards).		
	Q2-3: Review agreed local and regional recruitment targets.		
	Q3 onwards: Commence 1st phase of rollout of Māori Capability Programme to region as per plan for identified DHBs with identified percentages of staff in targeted high need areas.		
Kaiāwhina Support national project through regional support framework	Q1 onwards: Scope current sector and Kaiāwhina workforce to align to Kaiāwhina 5 year action plan.	Development of regional framework and resources to support workforce into career building and career pathways	GMsHR, DONs, MLG, DAHs
	Q3: Development of regional framework for supporting workforce to include training initiatives and staff with formal qualifications for agreed profession groups.		
Talent Management and Succession Planning	Q1-2: Regional share and understand HBDHB Talent Management Programme.	Regional secondment framework with monitoring and evaluation	GMsHR

Workforce Key Actions	Milestones	Measures	Leads
Appropriately enable regional workforce talent management and succession planning	Q2 -3: Regional agreement on principles for secondment opportunities and develop secondment letter agreement template Q3 onwards: Development of secondment framework (with scheduled implementation in 2017).	process Regional shared commitment to talent management through development of talent networks	
Mental Health and Addiction Implement 2015 workforce plans	Q1-4: Report quarterly to MHAN and Te Pou with identified workforce requirements for new service delivery models Q3 onwards: Implement workforce development needs for region aligned with the National Workforce Centres for Mental Health.	Implementation of workforce plan aligned with national work.	Mental Health and Addiction Network, Regional DHBs (including regional professional leads) and NGOs
Advance Care Planning (ACP) Improve regional ACP awareness and training in identified high-need priority areas	Q1 onwards: Continue increasing level one uptake of ACP training in Nursing, Allied Health, scientific and Technical and RMO/SMO Workforces in high need service areas through publication of module and utilising DHB intranets (with monitoring through existing ACP Q3 onwards: Regional ACP Group working in conjunction with DHB Learning and Development teams to enable phased regional transfer of ACP planning and support back into DHBs.	Increase in ACP level 1 trained in high need areas for RMO workforce, Nursing workforce and Allied Health, Scientific and Technical Services workforce.	DONs, DAHs, CMOs, Regional ACP group

REGIONAL SERVICES PROGRAMME

CENTRAL REGION DISTRICT HEALTH BOARDS

www.centraltas.co.nz > Working together for our region's future health

Linkages to other programmes	
Cardiac	Echocardiography workforce
Diagnostic imaging	Sonography workforce
Cancer	Palliative medicine workforce

Roadmap				
Progress and achievements	*June 2015*	*June 2016*	*June 2017*	*June 2018*
E-Learning - Explore sharing content across identified primary services within health sector	✓	BAU	BAU	BAU
Midwifery - Provide midwifery professional support to ensure retention and quality of workforce	-	✓	BAU	BAU
Medicine -Improve sustainability and resiliency of RMO workforce	✓	✓	✓	✓
Medicine - Increase and improve resilience of Palliative SMO workforce	-	✓	✓	BAU
Nursing - Specialist nurses are available to perform endoscopies to support national bowel screening initiative	-	✓	✓	✓
Nursing - Support the development of the advanced practice nursing workforce (Clinical Nurse Specialists and Nurse Practitioners)	-	✓	✓	BAU
Allied Health Scientific and Technical - AHST career pathways available to enable career progression and talent management	-	✓	BAU	BAU
Māori and Pacific - Increase workforce regionally in health to reflect demographic population (supported by regional GMsHR)	✓	✓	✓	BAU

Progress and achievements	*June 2015*	*June 2016*	*June 2017*	*June 2018*
Pacific - Develop a culturally responsive workforce to meet the cultural needs of Pacific Peoples accessing DHB health care services	-	✓	✓	BAU
Māori - Develop a culturally aware workforce (supported by regional GMsHR)	✓	✓	✓	BAU
Echocardiography - Develop a sustainable workforce for service provision and echocardiography guidelines (minimum standards)	-	✓	✓	BAU
Sonography - Develop and strengthen the sonography workforce to be a structure that is regionally sustainable and supportive	-	✓	✓	BAU
Kaiāwhina - Support national project through regional support framework	-	✓	✓	✓
Leadership - Support regional alignment with national domains	-	✓	✓	BAU
Talent Management and Succession Planning -Appropriately enable regional workforce talent management and succession planning	-	-	✓	BAU
Mental Health and Addiction - Implement 2015 workforce plans	✓	✓	✓	BAU
Advance Care Planning (ACP) - Improve regional ACP awareness and training in identified high-need priority areas	-	✓	✓	✓

Quality and Safety

Sponsor: Julie Patterson

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

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

The Central Region Quality and Safety Alliance (CRQSA) was established June 2014, with the over arching aim of achieving consistent high quality and safety of care and positive patient experiences for people and their families/ whānau.

The CRQSA provides a voice for clinical leaders across the region to positively influence planning, reduce health disparities and improve health outcomes for communities.

Partnership between the CRQSA, HQSC, ACC and Ministry of Health quality programmes has been established and will be strengthened through active participation, information sharing and collaborative initiatives that improve the health and wellbeing of communities.

Objectives

- Provide effective regional quality and safety planning, advice and recommendations to the Regional Executive Committee
- Promote the effective and appropriate sharing of quality and safety information and learnings that supports a regional perspective on patient safety issues
- Influence and support clinicians and managers to implement systems and processes that will improve the quality and safety of the care delivered

Measures

- Established relationships with Chairs of PHO and DHB Clinical Governance Boards
- Improve patient outcomes and reflect improvement strategies in CRQSA work programme
- Improve outcomes and experiences for people and their families/ whānau and reflect improvement strategies in the CRQSA work programme

Key Actions for 2016/17

Q and S Key Actions	Milestones	Measures	Leads
Strengthen alliance with primary care participation in the central region	Q1: Scope opportunities for further engagement points with PHO and DHB Clinical Governance Boards Q2-3: Develop and agree future engagement strategy Q3- 4: Implementation of engagement strategy	Established relationships with Chairs of PHO and DHB Clinical Governance Boards	CRQSA
Improve patient outcomes through collaboration on areas of high patient harm with support from HQSC programmes	Q1-4: Utilise HQSC regional data on identifying areas of improved patient outcomes/ areas of risk Q3-4: Develop a regional shared learning framework	To regionally mark against the national average in the quality and safety markers and outcome measures set by HQSC through sharing regional learnings Establish a regional shared learning framework for improving patient outcomes	CRQSA
Support the regional approach of person and Whānau centred care consumer partnerships with implementation of Relationship Centred Practice training	Q1: Coordinate information on consumer structures and approaches utilising regional linkages on creating agreed consumer approach across the region Q2-3: Develop a training package to support the implementation of a person and Whānau centred approach Q4: Regional phased implementation of the Relationship Centred Practice training	Information collected and shared on consumer groups and approaches in central region Linkages and relationships formed among consumer groups Training package developed on the person and Whānau centred care approach To provide central region training	CRQSA

Q and S Key Actions	Milestones	Measures	Leads
		on person and Whānau centred care (Relationship Centred Practice training)	
Continue to strengthen partnerships with the quality and safety programme of the HQSC, ACC and the Ministry of Health to promote shared learnings	Q1: Scope opportunities for shared learning events Q1-4: Collaborate with national partners to contribute to HQSC open book	Shared learning events for the region resulting in reduction in patient harm in area of focus Regional contribution to HQSC 'Open Book' Regional Adverse Event Management Policy	CRQSA

Roadmap

Progress and achievements	*June 2015*	*June 2016*	*June 2017*	*June 2018*
To develop a region wide clinical governance and quality improvement framework across primary and secondary sector	-	✓	BAU	BAU
To ensure central region readiness for national Health Quality and Safety Commission initiatives	-	✓	BAU	BAU
To improve primary and secondary quality and safety reporting mechanisms and develop a patient safety and quality network that learns from each other	-	✓	BAU	BAU
To implement a regional improvement programme based on the results of the regional Nursing Sensitive Care Indicator Survey	-	✓	BAU	BAU

Progress and achievements	*June 2015*	*June 2016*	*June 2017*	*June 2018*
Strengthen alliance with primary care participation in the central region	-	✓	✓	BAU
Improve patient outcomes and reflect improvement strategies in CRQSA work programme	-	-	✓	✓
Support the regional approach of person and Whānau centred care consumer partnerships with implementation of Relationship Centred Practice training	-	-	✓	✓
Continue to strengthen partnerships with the quality and safety programme of the HQSC, ACC and the Ministry of Health to promote shared learnings	-	✓	✓	BAU

Information Communication Technology (ICT)

Sponsor: Kathryn Cook

The National Health IT Plan proposed that each region operate a common platform to support the delivery of integrated health services. The ability to deliver and configure services in a regional context is dependent on the underlying information infrastructure that supports making patient information available to the right health care providers in the right place and at the right time. The regional IT planning component of this RSP supports the regional service operating model and the national programmes of work as per the National Health IT Plan. The critical IT priorities on going are included in the table below. The regional program of work (CRISP) has been recalibrated with change of approach for each application/function aligned against a Core, Common, Divergent model.

To be Core (What Must Be Regional) the following criteria has been applied;

- Single vendor, chosen by the region
- Agreed regional version of the software
- On the same regional hardware instance
- Supported by a single regional operating model
- Funded by the region
- Governed by the region with local input

Clinical Portal and Radiology Information System (RIS) are deemed Core.

To be Common (What Must Be Shared) the following criteria has been applied;

- Single regional vendor, chosen for the region
- DHBs will converge on an agreed regional version of the software
- Local shared hardware instance
- Supported by a single local operating model
- Funded locally by the sharing partners
- Governed locally by sharing partners but with input by the region

Patient Administration System (WebPAS) and ePharmacy are deemed Common.

To be Divergent (What Will Not Be Shared) the following criteria has been applied;

- Single local vendor chosen for the local conditions
- May scale to an agreed regional version of the software
- Will be on a local hardware instance
- Supported by a single local operating model
- Funded locally
- Governed locally

Objectives
The regional aims are: • Adopt the regional mantra of introducing the core components of the regional solution • Comply with national reporting requirements • Promote the adoption of the Shared Electronic Health Record for the region's population
Measures
Quarterly reporting.

Key Actions for 2016/17

ICT Key Actions	Milestones	Measures	Leads
Regional Program			
CRISP Workstreams – support the recalibration of the program of work	• Implement interim Service Delivery model to support Whanganui and Mid Central go lives • Implement Service Delivery model long term prior to any other DHBs implementing • Support the BAU use of PACs Archive • Support the Revera infrastructure platform as BAU • Introduce Orion CP and Carestream RIS as Core, starting with Whanganui • Introduce WebPAS as common including go live for Whanganui, Mid Central and Wairarapa • Support the implementation of ePharmacy Management as common	• By April 2016 • By October 2016 • On going • On going • April 2016 • 2017 • 2016	Each DHB responsible
Regional Service Management	• Interim model established prior to first site go live • Long term model and transition plan established prior to second site go live	• By April 2016 • By August 2016	All DHBs All DHBs
National Solutions			
National Patient Flow	• Phase 1 National Data Collection validation complete and action plans in place • Phase 2 National Data Collection commenced and reporting in full by • Phase 3 National Data Collection live	• 1 March 2016 • 1 July 2016 • 1 July 2017	Each DHB responsible
National Data Centre Project (NIPS).	• To migrate Central Region DHB hardware to the agreed NIP data centres to meet the requirements of the National Data Centre Project as the DHB deliverables are agreed • Adoption of IaaS as per National Program of work	• Dates to be reconfirmed	DHB delivery
Shared Electronic Health Record (SeHR)	• Participate in workshops being held to agree the model for implementation • Ensure that regional solutions are aligned to the national ability to access and to share information	• Base SeHR in place by 201 • Full SeHR in place by 2020	All DHBs

ICT Key Actions	Milestones	Measures	Leads
	• Transition to the national SeHR		
ePrescribing and Administration (ePA) MedChart	• Regional approach aligns with national approach. ePA will be implemented into inpatient wards across the Central Region DHBs after CP has been implemented	• All DHBs implemented	All DHBs
eMedicine Reconciliation (eMR)	• Medicine reconciliations business change at each of the Central Region DHBs will commence once the business change required is agreed with stakeholders		All DHBs
Tele-health	• To scope and define a Tele-health regional direction that can be then aligned with the national direction	• To be defined	

Linkages to other programmes	
Sub-Regional	Central Cancer Network, Palliative Care Managed Clinical Network
IT	Regional Advance Care Planning Reference Group, HOP Network
Workforce	Mental Health and Addictions Network, Regional Workforce Development Hub
Capital investment	Not applicable
Maori Health	Regional Benchmarking Project, HOP Network

Roadmap				
Progress and achievements	*June 2015*	*June 2016*	*June 2017*	*June 2018*
	✓	BAU		
	✓			

APPENDIX 2

Governance Groups

Group	Membership	Role
The Regional Governance Group	This group comprises the Chairs of the six Central Region DHBs and an independent Chair. The key accountabilities are to:	• approve the regional strategy for submission to individual DHBs • appoint the directors of TAS • monitor progress and performance against regional plans • drive the regional collaboration agenda • act as an escalation point for matters of strategic importance.
Te Whiti Ki Te Uru (Central Region Māori Relationship Board)	This regional forum comprises the six Chairs of the Māori Relationship Boards in the Central Region DHBs. The key objectives are to:	• provide advice to the Regional Governance Group on regional priorities for Māori health and provide effective iwi/Māori health leadership • monitor the progress of agreed Māori health priorities in the RSP • collaborate and identify synergies within the Central Region • ensure a common approach to non-TAS issues • ensure that 'Equity of Health Care for Māori: A framework' is incorporated in all service planning and delivery to maintain seamless mainstream services for Māori.
The Central Region CEOs	This group comprises the six CEOs of the Central Region DHBs. The key accountabilities are to:	• recommend the regional strategy to the Regional Governance Group and DHBs • ensure the alignment of DHB annual plans with the RSP • implement the agreed strategy • approve service-level agreements for the work to be done with TAS • maintain oversight of the delivery of the RSP, including DHB resourcing and roadblock removal.

Group	Membership	Role
Regional Executive Committee (REC) (Currently under review)	This group is the overarching executive and clinical leadership committee for the region, reporting to the regional CEOs. It comprises senior management and clinical representatives (including primary care). REC also includes consumer representation from across the region. Its objective is to ensure that the region takes a co-ordinated approach to planning and delivery. The key accountabilities are to	• work with the GMs Planning and Funding to propose strategic priorities, develop the RSP and recommend the RSP for approval to the regional CEOs • monitor progress against the plan and ensure that appropriate actions are taken to ensure a successful delivery that optimises health outcomes, including the reduction of health disparities. The key accountabilities are to: • enhance clinical governance and reporting across all health care settings and services • oversee the work of the regional executive groups, working groups and clinical networks • review regional proposals and business cases, for example models of care, service changes, infrastructure developments and capital investment and re-investment, and make recommendations to the Regional Capital Committee and regional CEOs • implement an effective communication strategy to inform DHB communities, key stakeholder groups and the general public • develop and recommend to regional CEOs strategies to address emerging issues with regional impacts • negotiate service level agreements with TAS on behalf of the CEOs • act as the first point of escalation for issues that cannot be resolved through other fora • ensure strong engagement between management and clinicians.

These governance groups are supported by the following:

Central Region Quality and Safety Alliance

Clinical leadership for quality and safety is essential. In addition to REC a Regional Quality and Safety Alliance (RQSA) has been established. Members include the Chief Medical Officer, Director of Nursing, the Director of Allied Health, Director of Midwifery, and consumer, Māori, Pacific, primary care and quality managers' representatives.

The purpose of the RQSA is to provide strong clinical leadership across the continuum of care levels so that health service consumers experience a consistent quality of care. The RQSA operates within an agreed quality and safety work programme. The responsibilities of the group will be to

- incorporate quality and safety goals into strategic plans and relevant agreements with health service providers
- promote the direction of quality and safety in line with policy and ensure that it is evidence-based. DHBs need to have aligned quality plans and risk management structures
- provide leadership with the promotion of a safety culture, where open communication is encouraged through the reporting, investigation and resolution of clinical quality and patient safety issues at a regional level. This includes the sharing of learning from adverse events
- provide input to regional planning that aims to improve quality and safety objectives, which includes vulnerable and isolated services
- define a core set of quality and safety measures based on national evidence
- establish an appropriate collection and reporting mechanism
- ensure the sustainability of tertiary services by working with REC to consider how best to deliver regional services safely.

Regional Capital Committee

The Central Region DHBs are committed to achieving good governance on capital spending.

The Regional Capital Committee comprises the DHB CEOs, Chief Finance Officers and a clinical director to represent the various key stakeholders and the different professional perspectives that they bring to such decision-making. It allows DHBs to explore opportunities and assess priorities for regional capital investment.

The key accountabilities are to

- develop and maintain a 10-year regional capital plan
- engage with the Ministry and the Capital Investment Committee early in the capital planning process
- provide regional scrutiny for individual business cases costing over $500,000
- ensure that regional benefits have been fully explored

- reducing fragmentation and unnecessary duplication
- reducing variations in quality of care and access
- preventing local DHB interests taking inappropriate priority over regional or national priorities
- reducing service vulnerability risks.

Regional ICT Governance

A Health Informatics Strategic Advisory Group is being established and will provide oversight and governance across regional ICT initiatives. The group will be chaired by the General Manager Health Informatics, TAS and include multi-disciplinary representatives across the health care spectrum.

The role of the group will be to provide leadership and advice on ICT issues to the region's CEOs. Its key tasks will be to:

- ensure resilient ICT service delivery
- ensure that the appropriate system and management controls are in place to protect identifiable patient information from inappropriate access or disclosure
- ensure that new ICT projects are aligned with the National Health IT Board strategy and Central Region's clinical priorities
- prioritise new projects and produce an annual work plan for approval by CEOs as part of the RSP
- report on progress as required
- report quarterly against the annual work plan as part of the RSP quarterly report
- ensure that appropriate actions are taken to address any barriers to regional working areas of underperformance against plan
- develop and implement a communications and clinical engagement strategy.

Regional Health Informatics outlines a strategy to transition towards a regional clinical record spanning primary, secondary and tertiary care. The systems are to be delivered in accordance with the ITHB Plan.

Appendix 3

Minister Letter of Expectations

Office of Hon Dr Jonathan Coleman

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

22 DEC 2015

Dear

Letter of Expectations for DHBs and Subsidiary Entities 2016/17

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 $400 million, the largest share of new funding, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy

It is important that the health sector has a clear and unified direction. The refreshed New Zealand Health Strategy will provide DHBs and the wider sector with this direction, and sets a clear view of the future we want for our health system to ensure that all New Zealanders live well, stay well and get well.

While the Strategy is not yet finalised, DHBs need to be focussed on the critical areas to drive change that come out of the refreshed strategy. The draft covers five themes – people-powered, closer to home, value and high performance, one team, and smart system. The Strategy is supported by a Roadmap of Actions, which sets the direction for the next five years. I am aware that DHBs are already progressing work under some of the themes. I expect that this work will continue and, where possible, be accelerated over the coming year. If you are thinking about new initiatives, these should have a clear link to one or more of the five themes and the outcomes should be able to be clearly linked to the intent of the draft Strategy.

I thank you for your involvement to date in this work and finalised planning expectations will be provided to DHBs in the new year.

Living Within our Means

While the global economic environment continues to be challenging, DHB funding has been increased by around $3 billion over the last seven years. While the health system could always use more resources, DHBs need to budget and operate within allocated funding and must have detailed plans to improve year-on-year financial performance. Your DHB's financial performance is currently tracking to plan for 2015/16. I trust that you will continue to consider where your DHB can make efficiency gains. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. 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.

Working Across Government

Right now, a key focus of Government is vulnerable families. DHBs are already working closely with other social sector organisations to achieve sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as Whānau Ora, Social Sector Trials, Prime Minister's Youth Mental Health Project and Healthy Housing. I expect DHBs to continue supporting cross-agency work that delivers outcomes for children and young people. I also expect that DHBs will keep me and the Ministry of Health informed of work they are undertaking with other sector agencies.

In line with this, the cross-government work programme on the Better Public Service Result One: Reducing long-term welfare dependence, is being expanded to include a focus on reducing unintended teenage pregnancies. I expect DHBs to commit to help deliver on this sub-focus in their 2016/17 annual plans.

National Health Targets

All of the national health targets are very important for driving overall hospital performance, and have resulted in major improvements in the health outcomes of New Zealanders. Health target performance continues to improve, but DHBs must remain focussed on achieving and improving performance against the targets, particularly the Faster Cancer Treatment target.

I remain concerned about the overall pace of progress nationally on the Faster Cancer Treatment health target. Locally, has shown good improvement since the target was introduced and this progress needs to continue to ensure that the DHB meets both the current year's goal of 85 percent and the increased goal of 90 percent by June 2017. Faster cancer treatment is a significant priority for the Government with almost $63 million invested over the last seven years to deliver better, faster cancer care. Please ensure delivery of this health target is a priority for your DHB.

Tackling Obesity

A key focus area for 2016/17 will be actions to reduce the incidence of obesity. The Childhood Obesity package of initiatives aims to prevent and manage obesity in children and young people up to 18 years of age, and includes a number of cross-agency activities. The core of the plan is the new childhood obesity health target, which is: by December 2017, 95 percent of obese children identified in the B4 School Check programme will be referred to a health professional for clinical assessment and other interventions.

I expect all DHBs to continue to show leadership in this area and to deliver on the new health target, and to identify other appropriate activities they can undertake to help reduce the incidence of obesity.

Shifting and Integrating Services

Integrating primary care with other parts of the health service is vital for better management of long-term conditions, mental health, an aging population and patients in general. The pathways to achieve better co-ordinated health and social services need to be developed and supported by clinical leaders in both community and hospital settings. I expect DHBs to continue to move services closer to home in 2016/17, and DHBs need to have clear evidence of how they plan to do this.

Health IT Programme 2015-2020

Health information systems have a crucial role to play to make the health system more sustainable, and to improve productivity, efficiency, and health outcomes. The Health IT

Programme 2015–2020 begins with a design phase over the next nine months and I expect DHB, PHO and primary care representatives to be part of the co-design process. Meanwhile, DHBs will need to complete current regional and national IT investments, such as the foundation programmes currently under way.

Please note that all DHBs must refresh their statements of intent (SOIs) for tabling in 2016/17 to reflect the key priority areas outlined above, and a health equity focus, and build these SOIs into their annual plans.

Keep in mind that the Budget 2016 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available. Please share this letter with your clinical leaders and local primary care networks.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2016/17.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

Appendix 4

The Ministry's current outcomes framework

The Ministry's current outcomes framework (see Figure 1) has two outcomes for the health system:

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

These health system outcomes support the achievement of wider Government priorities and are not expected to change significantly over the medium term.

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

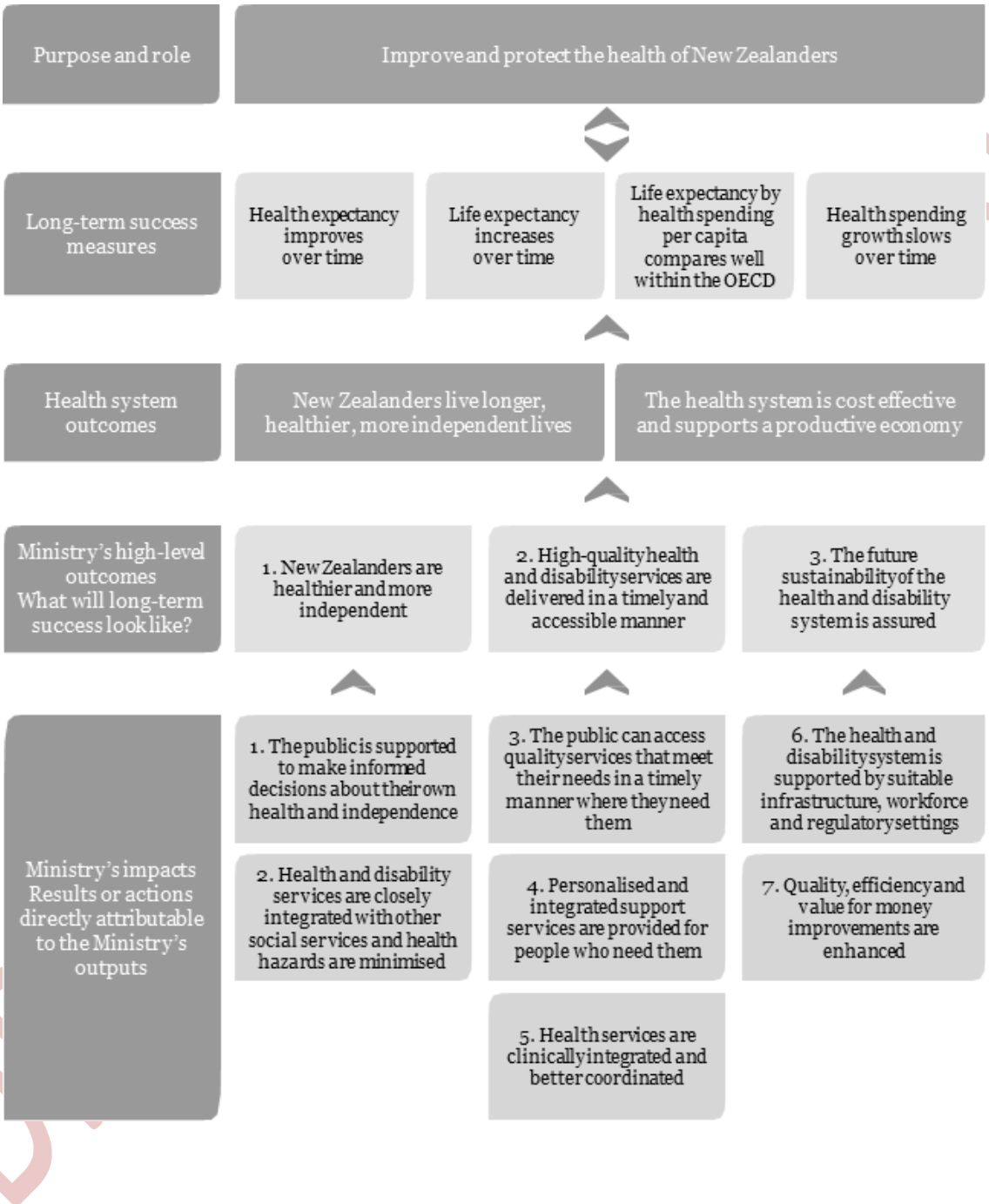
- New Zealanders are healthier and more independent
- high-quality health and disability services are delivered in a timely and accessible manner
- the future sustainability of the health and disability system is assured.

Many factors influence outcomes. In helping to achieve these outcomes, the Ministry will have a real impact on the lives of New Zealanders. The health and disability system is dynamic and integrated, and many of our activities contribute across a number of our long-term outcomes and impacts. The Ministry's work is directly aimed at achieving seven impacts, which contribute to our higher-level outcomes.

1. The public is supported to make informed decisions about their own health and independence.
2. Health and disability services are closely integrated with other social services, and health hazards are minimised.
3. The public can access quality services that meet their needs in a timely manner, where they need them.
4. Personalised and integrated support services are provided for people who need them.
5. Health services are clinically integrated and better coordinated.
6. The health and disability system is supported by suitable infrastructure, workforce and regulatory settings.
7. Quality, efficiency, and value for money improvements are enhanced.

The Ministry's current outcomes framework

Figure 1: The Ministry's current outcomes framework



Appendix 5

Portfolio Work Areas

Table 5 Summary of portfolios and key objectives and deliverables

Implementation programmes – summary		
Population health focus – includes plans focusing on population health and vulnerable populations within our communities		
Work Area	**Key objective**	**Key deliverable**
Health of older people (HOP)	Improve services for people with dementia	Develop care pathways
Tamariki Ora Well Child	Early access to services	Positive outcomes for child health
Managing long-term conditions – includes plans responding to the growing demand placed on the sector by chronic illnesses and other long-term conditions		
Work Area	**Key objective**	**Key deliverable**
Cancer Services	Faster access to treatment from time of suspicion of diagnosis	Treatment offered in 62 days to improve outcome and experience
Cardiac Services	Improvement in access to cardiac service equitably throughout the region	Timelier access to care, with clinical care pathways from community to in-hospital care
Stroke Services	Reduce risks and improve acute rehabilitation services	Stroke event survival/stroke prevention and reoccurrence of stroke/stroke rehabilitation
Mental Health and Addictions	Improve access, responsiveness, capacity and service options	Improved outcomes with improved access to a range of responsive services with adequate capacity
Specialist/Acute services including diagnostics – includes plans relating mainly to specialist hospital services		
Work Area	**Key objective**	**Key Deliverable**
Electives	Meet the Ministry's health targets	Reduce the waiting time to below four months
Major Trauma	Develop a regional response	Improve outcomes of major trauma
Diagnostic Imaging	Provide a regional service	Implement a picture, archiving and communication system (PACS) and radiology information system (RIS)

Implementation programmes – summary		
Regional enablers – includes plans that enable the environment for service transformation to exist		
Portfolio	**Key objective**	**Key deliverable**
RHIP (IT)	Integrate IT services	Standardised, integrated regional clinical portal
Workforce	A sustainable health workforce that is fit for purpose	Adequate recruitment and retention of identified health groups
Quality and Safety	Good-quality, safe health services	The Triple Aim informs quality and safety of health service
Regional Capital Investment Approach	Planned capacity of health services	Services are budgeted and affordable