

REGIONAL SERVICES PROGRAMME



Central Region Regional Service Plan 2016/17

Final - 7/7/2016

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Office of Hon Dr Jonathan Coleman

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

07 JUL 2016

Dr Kevin Snee
Lead Chief Executive Officer for Central Region District Health Boards
Hawke's Bay District Health Board
Private Bag 9014
Hastings 4156

Dear Dr Snee

Central Region 2016/17 Regional Service Plan

This letter is to advise you I approve the 2016/17 Central Regional Service Plan (RSP). I appreciate the significant work that is involved in preparing the RSP and thank you for your effort.

I am planning to strengthen the focus and role of RSPs in the future and you will be engaged in this process.

I acknowledge the good progress that has been made with regional planning this year, particularly in relation to the development of a strong regional vision, goals and outcomes. This is evident in the continued improvement in the alignment between the DHB Annual Plans and RSP, which should continue to be strengthened in the future in order to achieve the best use of resources.

As greater integration between regional DHBs supports more effective use of clinical and financial resources, I expect DHBs to make significant progress in implementing their RSPs during 2016/17 and to continue to work together to ensure service sustainability within the Region.

Regional Service Plan Agreement

Please note that my approval of your RSP does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. You will need to advise the Ministry of any proposals that may require Ministerial approval as you review services during the year.

My agreement of your RSP also does not constitute approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependent on both completion of a sound business case, and evidence of good asset management and health service planning by your DHBs.

I would like to thank all the people involved in developing the RSP for their valuable contribution and continued commitment to delivering quality health care to the population. I look forward to seeing your achievements throughout the year.

Finally, please ensure that a copy of this letter is attached to the copy of your signed RSP held by each DHB Board and to all copies of the Central RSP made available to the public.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc DHB Chairs and Chief Executive Officers in the Central Region

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

Executive Summary



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 (DHBs) 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 DHBs, as well as national initiatives, as outlined in the guidance issued by the Ministry of Health (the 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 the Ministry.

Priorities

The RSP 2016/17 national and regional priorities signal a continuation of the established programme of work and successes, across the region and aligning with DHB plans, thus ensuring health services are people-centred and focused on improving health outcomes. For 2016/17, the 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 District Health Board Chairs and Chief Executives



Dr Virginia Hope
Chair, Capital & Coast DHB



Debbie Chin
Chief Executive, Capital & Coast DHB



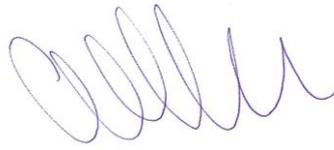
Dr Virginia Hope
Chair, Hutt Valley DHB



Dr Ashley Bloomfield
Chief Executive, Hutt Valley DHB



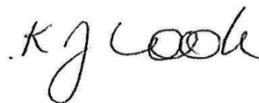
Dr Derek Milne
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Chief Executive, MidCentral DHB



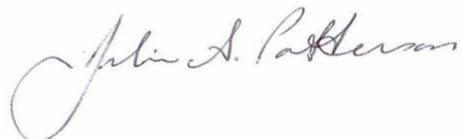
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Chair, Hawke's Bay DHB



Dr Kevin Snee
Chief Executive, Hawke's Bay DHB



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Chair, Whanganui DHB



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Chief Executive, Whanganui DHB



Oriana Paewai
Chair, Te Whiti ki te Uru
Central Region Māori Managers Forum

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, improving health equity for Māori, and on the adoption of work to implement the five key themes of the refreshed New Zealand Health Strategy through the 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 Central Region is committed to identifying and refining planning and service priorities to promote innovative localised solutions to improve health outcomes for our communities. An example is the Cardiac Services System of Care project which aims to co-create a cardiac services system across the Central Region for implementation in 2016/17.

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 whānau, 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 throughout 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 these bring to improving health outcomes. This is reflected in the application of the regional health Outcomes Framework (page 32) 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*

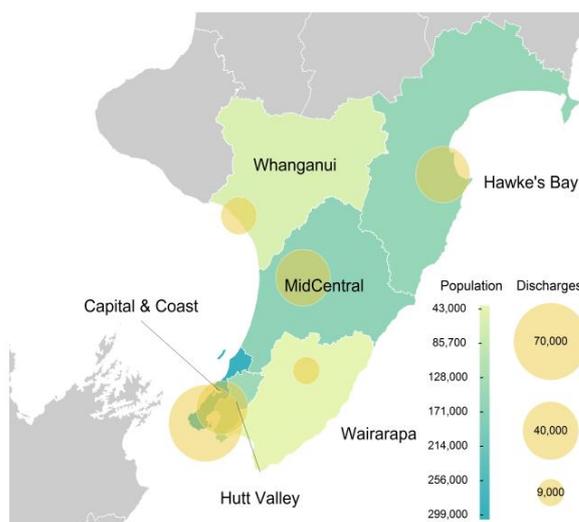
In each work area undertaken there is a clear, integrated '**line of sight**' between national, regional and local outcomes linking the key strategic priorities and expectations of the RSP to those of the DHBs and the Ministry.

In developing a regional approach to planning it has been critical to understand the diverse nature of the Central Region's population, deprivation, ethnicity and urban and rural geographic drivers, as

each of the six DHB areas is unique. The development of locally appropriate solutions to meet these needs is reflected in the tiered approach to regional information technology (IT) projects, workforce initiatives and sub-regional clinical networks. In working to improve health outcomes for our most deprived populations, and to improve equity of access to services, flexible and co-produced health planning is essential.

Our Region

Figure 1: Demographics



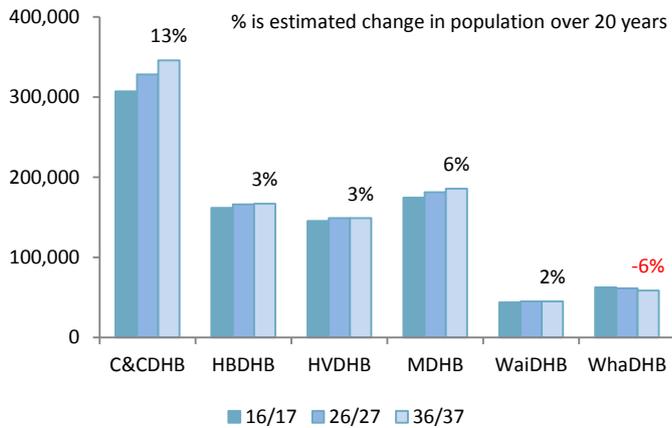
The Central Region is comprised of the six DHBs shown in the map. The largest population is in the Capital & Coast region and the smallest are in the Wairarapa and Whanganui.²

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 and 950,000 is the projected figure for 2036/37.

Figure 2: Population change



The estimated population growth will not be evenly distributed across DHBs, with the Capital & Coast DHB experiencing the greatest increase and Whanganui's DHB'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.

Figure 3: Population change by age group, Central Region

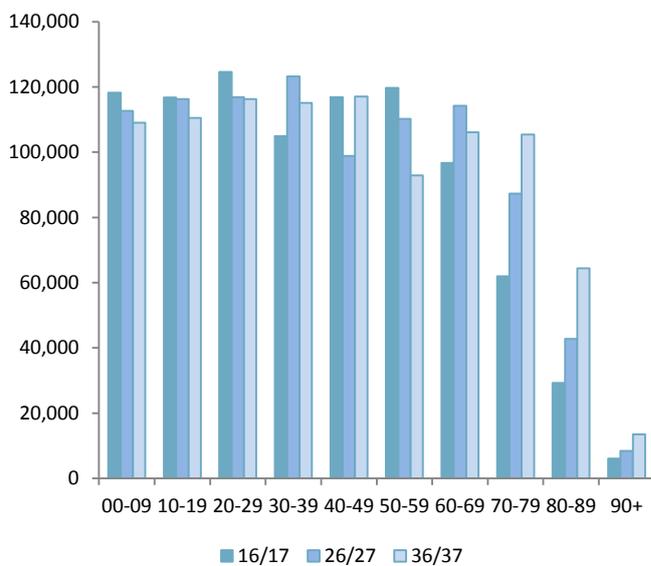


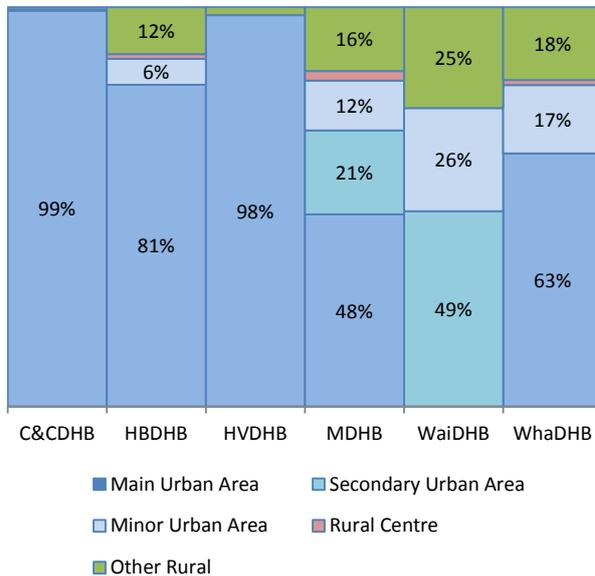
Table 1: Population change over 20 years, Central Region, more older people

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 group could impact on workforce capacity.

Geographical spread

Figure 4: Population by urban/rural categories by DHB
Source: Census 2013.



Ninety percent of the region's population live in urban areas. Table 2 shows that some DHBs have a greater proportion of rural dwellers, e.g. 25% of Wairarapa's population are rural dwellers.

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

Table 2: Population by urban/rural categories, Central Region

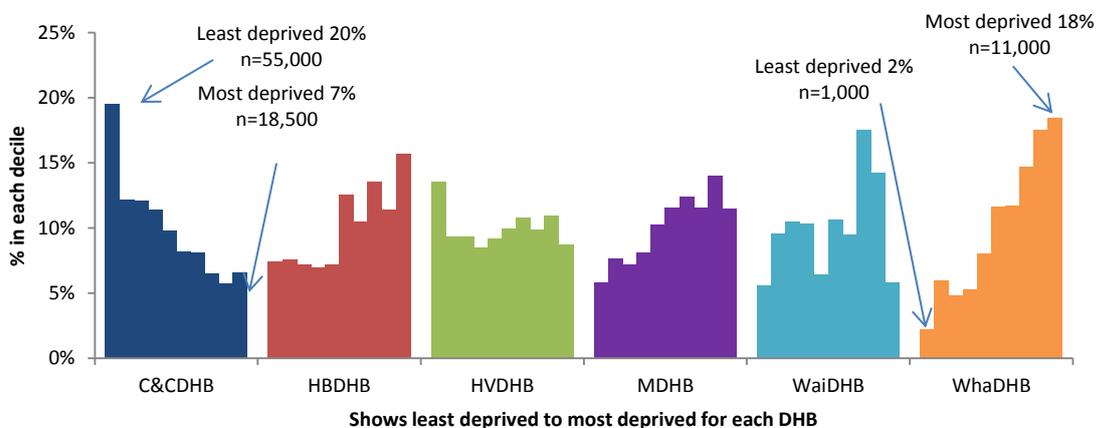
Urban/rural category	% of population
Main Urban Area	78%
Secondary Urban Area	6%
Minor Urban Area	6%
Rural Centre	1%
Other Rural	8%

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% vs 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 5: Deprivation profile by DHB, Central Region



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

Māori population

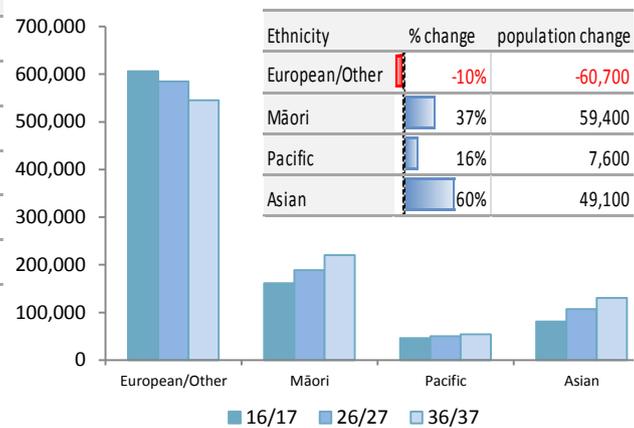
Hawke's Bay, Capital & Coast and MidCentral have the largest Māori populations in the region. Māori make up more of the Hawke's Bay and Whanganui population (one in four people identify as Māori).

Table 3: 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.

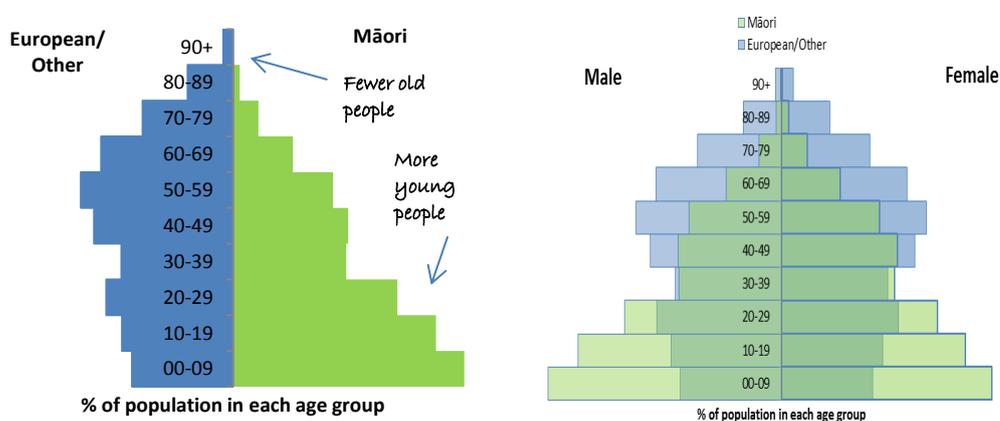
Figure 6: Population change over 20 years by ethnicity, Central Region



Source: Census 2013 projected.

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

Figure 7: Māori have a younger age profile than European/Other, Central Region



Source: Census 2013 projected to 2016/17.

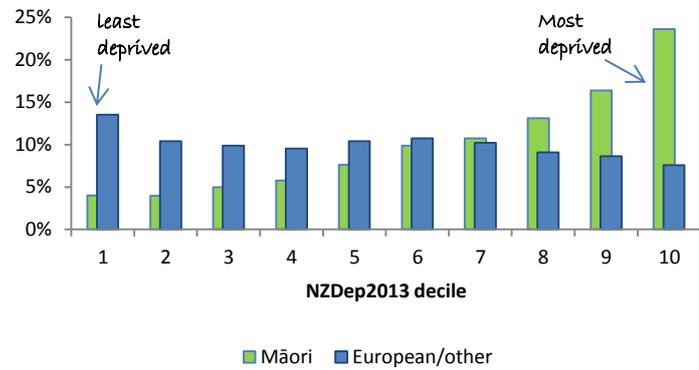
The Māori population has a greater proportion of children and young people and fewer older people than the European/Other population. The same is true for males and females (refer to the graph on the right).

Pacific populations also have a younger age profile, whereas the Asian population has a greater proportion in the working ages of 20-40 years old.

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 8: Māori are more likely to live in deprived areas, Central Region



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 9: 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).

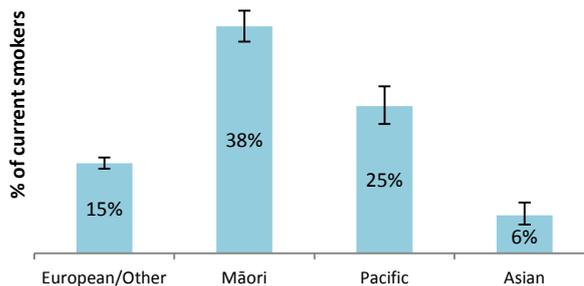
Household crowding as a percent of the local population has decreased in the Central Region since 2006.

Figure 10: Household crowding by DHB, 2013

DHB	Crowded in 2013		Change from 2006
	Number	Percent	
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).

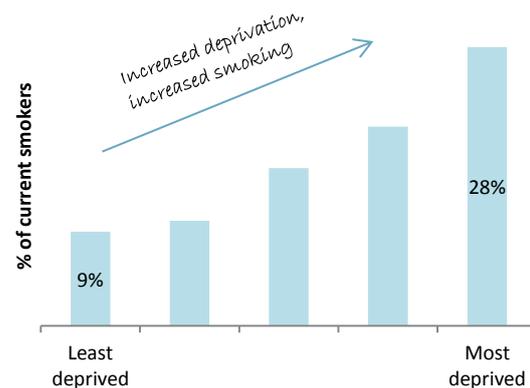
Figure 11: Māori are more likely to be smokers



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.

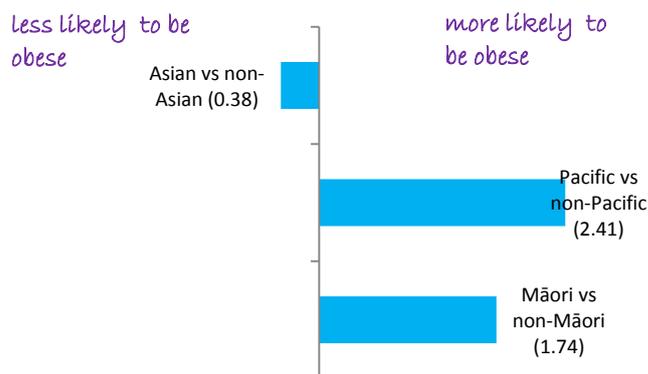
Figure 12: Smoking rates increase with deprivation



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

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

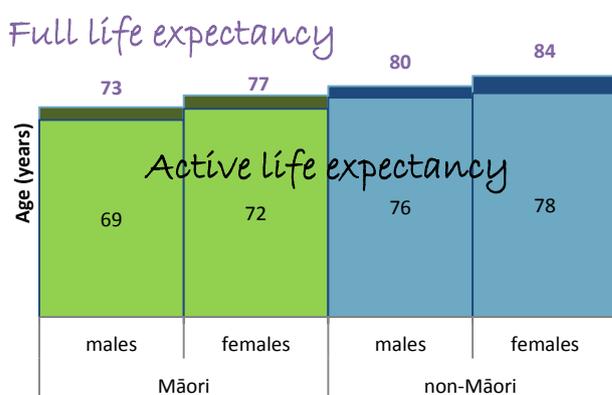
Figure 13: Adjusted rate ratios of obesity by ethnicity



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

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

Figure 14: 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 7 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 populations).⁴ The main causes of death are cancer, ischaemic heart disease, stroke and diabetes.

Over the next 20 years the Central Region population is expected to grow by 55,500, an increase of 6%. This growth will not be evenly distributed across the region, with most of the growth in the Capital & Coast population. Population growth will be highest in the older age groups as the population ages, which will impact on the type of services required. An estimated decrease in numbers in the 50-59 age group could impact on workforce capacity. Ninety percent of the region's population live in urban areas, although certain DHBs such as Wairarapa do have a higher proportion of rural dwellers, which has implications for access and travel times to services.

There will be greater ethnic diversity in the region with a large percentage increase in the Māori, Asian and to a lesser extent, Pacific populations. The age profile of the Māori population has a greater proportion of younger people and fewer older people than the European/other age profile. The DHBs in the region have differing deprivation profiles and with socio economic factors being an influence on health and life expectancy, it is an important factor to consider when planning health interventions and services. Māori are more likely to live in the most deprived areas in New Zealand, have higher rates of smoking and obesity, higher rates of chronic disease, higher mortality rates and

⁴ Age-standardised mortality rate (WHO World Standard Population). Mortality collection 2012. MoH December 2015.

lower life expectancy than non- Māori. Understanding the underlying risk factors in the demographics of a DHB can inform planning of interventions and services across the continuum of care.

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. These strategies include: the New Zealand Disability Strategy; Whānau Ora and 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 the 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 IT; 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; health and disability services are closely integrated with other social services; and health hazards are minimised.^{5,6}

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; and health information systems development.

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 Health Strategy has five interlinked themes built around a revised suite of population and person-centred principles for the sector.

⁵ For further detail refer to the Ministry's Statement of Intent 2014-2018 available at www.health.govt.nz.

⁶ The Ministry of Health Outcomes Framework is appended on page 112..

Figure 15: Five strategic themes of the Health Strategy



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

These shifts in focus provide 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 twenty six action areas that will contribute to a 5-year plan to deliver an improved New Zealand health system and improved health outcomes for New Zealanders. He Korowai Oranga, the Māori Health Strategy is a key priority both nationally and for the Central Region as to improve equity, Māori health outcomes need to improve to more closely reflect those of non-Māori populations. For similar reasons, 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing, a strategy for improving the health of Pacific peoples, is of key importance in achieving the goals of the New Zealand Health Strategy.

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 the following table).

Regional work that contributes to the implementation of the Health Strategy includes work already in progress.

Regional Outcomes	Improved health outcomes and reduced disparities between Maori, disabled and other populations				
	Systems and Service Integration across the continuum of Care and Consistency of Clinical Pathways	Improved Safety and quality of care of patient experience in the central region	Clinical and Financial Sustainability of the health system in the Central Region	Systems and Service Integration across the continuum of Care and Consistency of Clinical Pathways	Systems and Service Integration across the continuum of Care and Consistency of Clinical Pathways
Health Strategy Theme	People-powered Mā te iwi hei kawē	Closer to home Ka aro mai ki te kāinga	Value and high performance Te whāinga hua me te tika o ngā mahi	One team Kotahi te tīma	Smart system He atamai te whakaraupapa
Action Area	1. Inform people about public and personal health services so they can be 'health smart' and have greater control over their health and wellbeing.	6. Ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way.	13. Enable people to be partners in the search for value by developing measures of service user experience and improving public reporting of performance.	20. Improve governance and decision-making processes across the system in order to improve overall outcomes, by focusing on capability, innovation and best practice.	25. Increase New Zealand's national data quality and analytical capability to make the whole health system more transparent and provide useful information for designing and delivering effective services.
	2. Make the health system more responsive to people.	7. 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 and training.	14. Implement a framework focused on health outcomes to better reflect links between people, their needs and outcomes of services.	21. Clarify roles, responsibilities and accountabilities across the system as part of the process of putting the Strategy into action.	26. Establish a national electronic health record that is accessed through certified systems including patient portals, health provider portals and mobile applications.
	3. Engage the consumer voice by reporting progress against measures important to the public, building local responses and increasing participation of priority groups.	8. Increase the effort on prevention, early intervention, rehabilitation and wellbeing for people with long-term conditions. This includes addressing common risk factors.	15. Work with the system to develop a performance management approach with reporting that makes the whole system publicly transparent.	22. Create a 'one-team' approach to health in New Zealand through an annual forum for the whole system to share best practice and help build a culture of trust and partnership.	27. Develop capability for effectively identifying, developing, prioritising, regulating and introducing knowledge and technologies.
	4. Promote people-led service design, including for high-need priority populations.	9. Collaborate across government agencies, using social investment approaches, to improve the health outcomes and equity of health and social outcomes for children, young people, families and whānau, particularly those at risk.	16. Maintain the direction set by the Strategy through monitoring and evaluation, and advice from a Strategy Leadership Group.	23. Put in place a system leadership and talent management programme to enhance capacity, capability, diversity and succession planning throughout the sector.	
	5. In selected high-need communities, build on, align, clarify and simplify multiple programmes of social investment.	10. Involve health and other social services in developing shared care for older people with high and complex needs in residential care facilities or those needing support at home.	17. Align funding across the system to get the best value from health investment.	24. Put in place workforce development initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility.	
		11. Support clinicians and people in developing advance care plans and advance directives.	18. Continue to develop the application of the social investment approach to health investment with DHBs. Consider using this approach to improve overall outcomes for high-need priority populations, while developing and spreading better practices.		
		12. Review adult palliative care services to ensure all those who would benefit from palliative care at the end of their life are able to access high-quality care and have a seamless experience.	19. Continuously improve system quality and safety.		

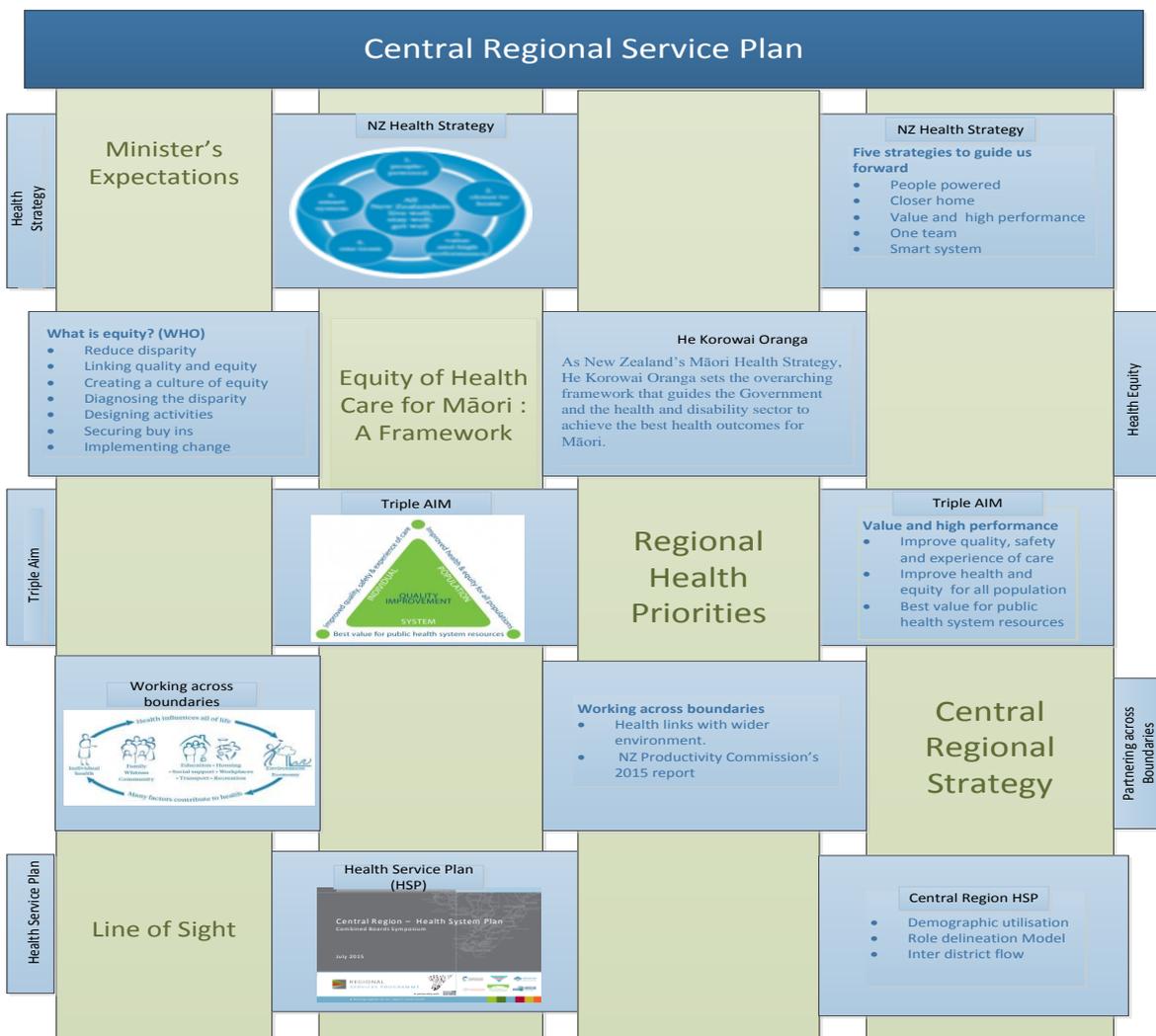
Regional Context

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.

Figure 16: Key drivers for the 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 a socially integrated model of health and care. The traditional life course continuum of care shown in Figure 16 is reflective of a 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 17: Continuum of care across the Central Region

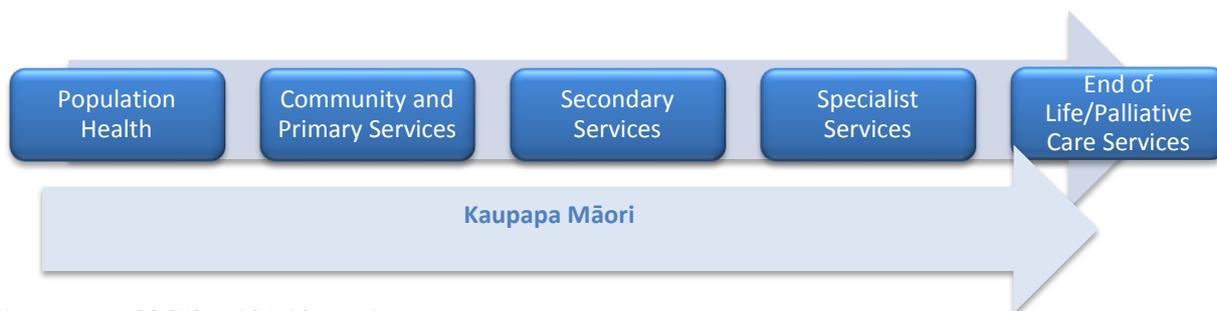
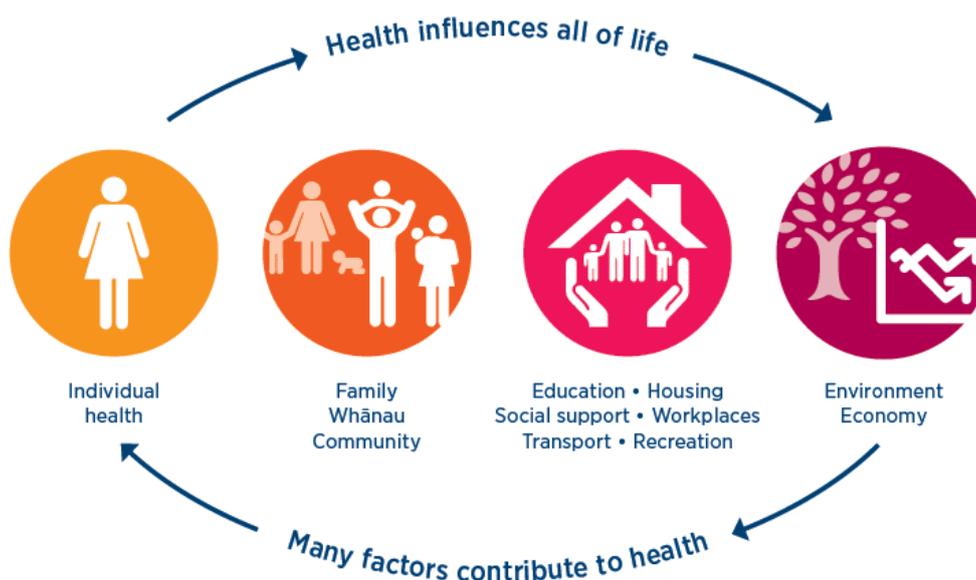


Figure 18: Health links with wider environment



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

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".⁷

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

The 2016/17 priorities are:

- Elective Services⁸
- 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

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, improved health equity and a collaborative person-centred approach to health care.

Improvements to patient outcomes are achieved through a local and collaborative engagement in health planning and delivery. Partnerships 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.

Examples:

- To co-create a cardiac services system of care across the Central Region. The project will help define the system of care across the continuum that the Central Region DHBs need to

⁷ TAS Board workshop

⁸ Aligned to Electives Funding Policy May 2016.

commission to provide sustainable specialist services. The final shape of these services will be co-designed in collaboration with service users and clinicians.

- Major Trauma⁹ 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.

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 the Accident Compensation Commission (ACC) and the Ministry of Social Development. The national Whānau Ora outcomes framework could be used to guide government sectors to work together and develop whānau identified initiatives in their own communities. Some DHBs across the Central Region are taking different approaches; using Whānau Ora intersector governance groups to advance whānau developed innovations and solutions.

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,¹⁰ sets the overarching framework that guides the government and the health and disability sector to achieve the best health outcomes for Māori. The Health 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 Health 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 the whānau and their communities.

We know our Māori communities have higher levels of deprivation, smoking and household crowding than other communities and that this varies across our region. Our response needs to be one that supports local solutions supported 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 activities. The Annual Maori Health Plans of DHBs have a set of standardised indicators that assist in measuring the performance of the sector and its impact on Maori Health. In addition, Tumu Whakarae has developed a non-performance programme, Te Ara Whakawaiaora, which ensures good monitoring of indicators that need improvement.

As the Regional Services plan prioritises Maori Health, we need to ensure that we make concerted effort to agree to the regional dashboard for monitoring of indicators, ensure we report by ethnicity so as not to hide inequity, and performance manage any agreed areas of non-performance. District Health Board General Managers Maori Health will partner with the networks for each priority area to ensure there is sound advice and support where there is none at present. Priorities of previous years will now become business as usual for ongoing implementation. Additionally, General

⁹ Major Trauma is a key Ministry priority.

¹⁰ <http://www.health.govt.nz/our-work/populations/Māori-health/he-korowai-oranga>.

Managers Maori Health will continue to implement the Pae Ora framework across DHBs and other sectors as appropriate for improving the health status of the region.

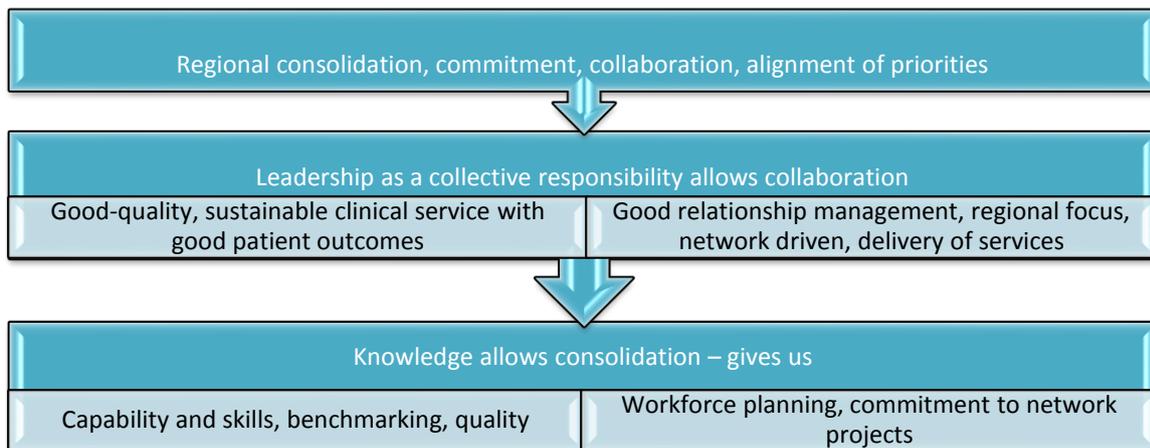
For 2016/17, our regional priorities are:

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

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 19: 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 a 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 the 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 Central Region has collectively agreed to focus on regional ‘care arrangements’ for health services. The region has committed to developing a planning focus to ensure that primary care and secondary care services are integrated at the local, regional and national levels to improve health outcomes and provide innovative solutions to improving equity in access to services. The

service models focusing on 'care arrangements' will inform sustainable current and future workforce investment, as well as capital and IT requirements.

Recent work¹¹ 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 lack of shared regional understanding of sub-regional networks, as well as the care arrangements for patients requiring specialist services across the Central Region and those being referred outside of it.

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 the optimal use of the skills and resources in the region, as well as meet the needs of the patients. All regional and DHB level planning for 'care arrangements' will be informed by palliative care and end of life care planning with the objective meeting the challenge of a 'good death' raised in the New Zealand Health Strategy.

Using the above approach, a project to co-create a cardiac services system of care across the Central Region is being developed for implementation in 2016/17. The project will help define the system of care across the continuum that the Central Region 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.

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-regional 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 so 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 Aim¹² to all its work streams with a dedicated programme committed to ensuring that the national priorities and direction are linked at the regional and local levels.

¹¹ NZ Role Delineation Model Central Region Assessment May 2015 – Health Partners Consulting Group.

¹² 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; and best value from public health system resources. This has been accepted by all relevant agencies – the Ministry (including the NHB), the

Increasing equity in both access to and the quality of health services available across the region is paramount in 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.

Figure 20: 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’, ‘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 these commitments and improving the health and wellbeing of their populations. There is no single simple measure that can demonstrate the impact of the work DHBs do, so a mix of indicators at a population and health service level are used to demonstrate the impact and effectiveness of improvement activities on the health status of the population and the effectiveness of the health system.

The region has taken an approach to consolidate the work in the identified priority areas. An operational ‘Outcomes Framework’ (Figure 21) 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*

National Health IT Board, the National Health Committee, Health Workforce New Zealand, DHBs and PHARMAC – as the overarching goal for improvement in health services.



- 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.

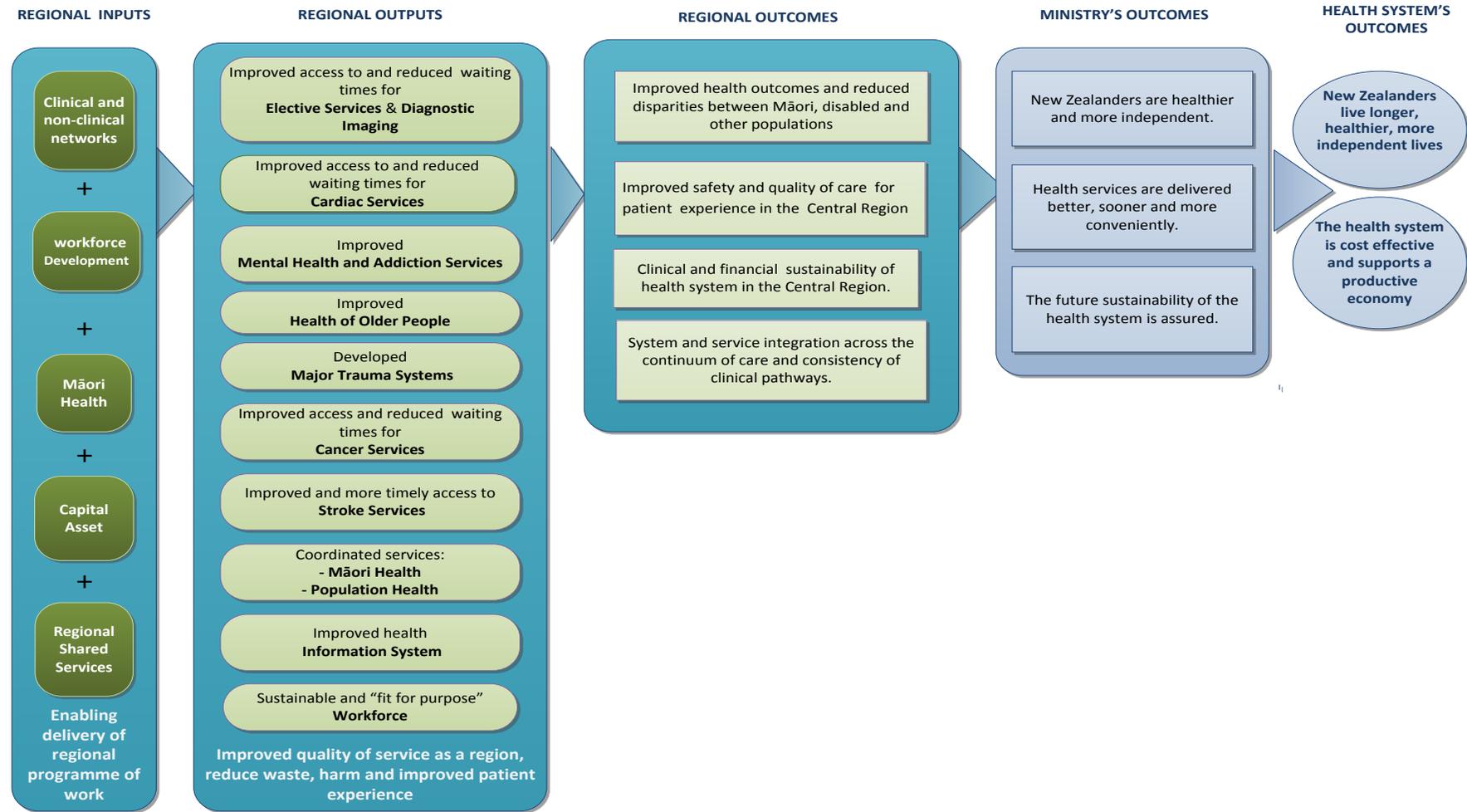
These health outcomes support the achievement of wider government priorities and are not expected to change significantly in the medium term.

Alongside the Outcomes Framework, the Central Region is weaving the Māori Health Strategy, He Korowai Oranga, across all planning activities. The Triple Aim principles give the Central Region 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 21 - CENTRAL REGIONAL OUTCOMES FRAMEWORK



Equity of care, access to safety and quality care, positive patient experience, clinically sustainable service → improved outcome.

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 a change of approach for each application/function aligned against a **Core, Common or Divergent model**.

For **Core** (what must be regional) these criteria have 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.

For **Common** (what must be shared) these criteria have 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.

For **Divergent** (What Will Not Be Shared) these 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 Māori participation and the support for vulnerable workforces, particularly in midwifery, while continuing to build on existing recruitment and retention strategies. In addition, the region will address the vulnerability of the palliative medicine workforce by implementing additional RMO trainees. In 2016, we will also be launching phase one of a long-term 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 DHB's professional groups and leaders have established a clear aim and direction that will result in resources in place to support and grow our workforce. This enables regional and local solutions to provide the range and scope of services that are needed by the communities they serve.

Living Within Our Means and 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 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.

Funding Mechanisms for Work to Deliver the Regional Health Plan

Funding for the Central Region RSP is supported in a variety of ways. The Regional priorities and work plans are developed and endorsed by the central regional clinical networks, regional work groups and DHB Boards. The Regional Governance Group provides oversight and the governance for the RSP process.

Any additional resource requirements are jointly considered by the Central Regional Planning & Funding and COOs. Material decisions are approved by CEOs. Resources are contributed to the delivery of the regional plan by DHBs via the input of individuals across the continuum of care. This contribution is usually in the form of time participating in workshops and regional network meetings and also includes development or review of work stream deliverables. This cost of this time is met by those organisations and individuals. The work to progress the National IS/IT priorities outside of the Regional Health Informatics Programme is the responsibility of DHBs to manage either individually or collectively.

Regional activity that needs capital funding follows the guidance of the capital investment requirements for DHBs.

Networks

Clinical networks and regional programmes of work

The region is committed 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, 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 the Central Cancer Network (CCN) Project Team. It should be noted that the CCN also covers the 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 continued clinical integration through support for the 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 Delineation¹³ 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 (for example, 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 Central Region and those being referred outside of it.

¹³ NZ Role Delineation Model Central Region Assessment, May 2015, Health Partners Consulting Group.

The opportunity exists to create a 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. In addition, the Central Region intends to take a coordinated and strategic approach to palliative care including end of life care planning in the region. At the regional level, Central Cancer Network (CCN) has resourced the Central Region Palliative Care Network (CRPCN) to share initiatives, contribute to national pieces of work and deliver a few regional projects as resources have allowed. There is an emerging regional conversation related to taking a more integrated approach to palliative care and end of life care service planning across all clinical networks in the region, particularly within Health of Older People and long term condition service development.





Regional Governance and Leadership

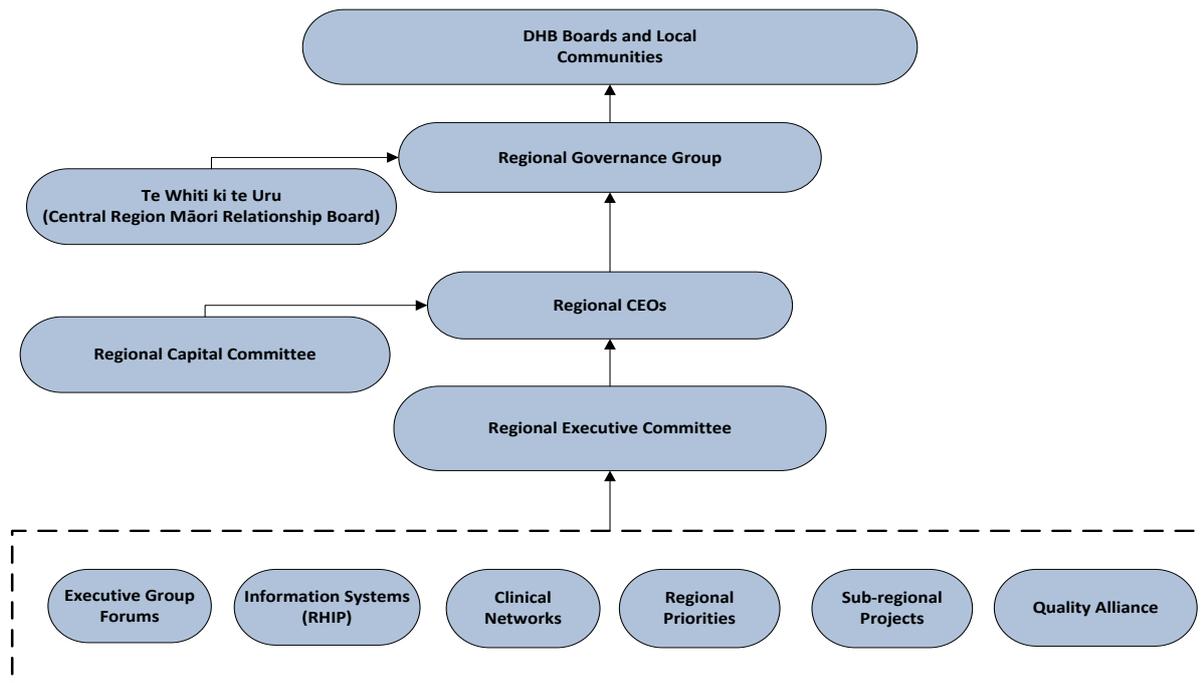


Regional Governance and Decision Making

“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 it benefits from the investment in collaborative work to ensure the achievement of outcomes from their collective efforts. The Central Region DHBs’ regional governance framework is shown below.

Figure 23: Central Region leadership frameworks¹⁴



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 has had strong clinical engagement at a regional governance level and has involved clinical networks.

The Combined Boards meet biannually to review the regional priorities against their performance and to determine new priorities that are emerging, and 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.

¹⁴ The structure is currently under review.

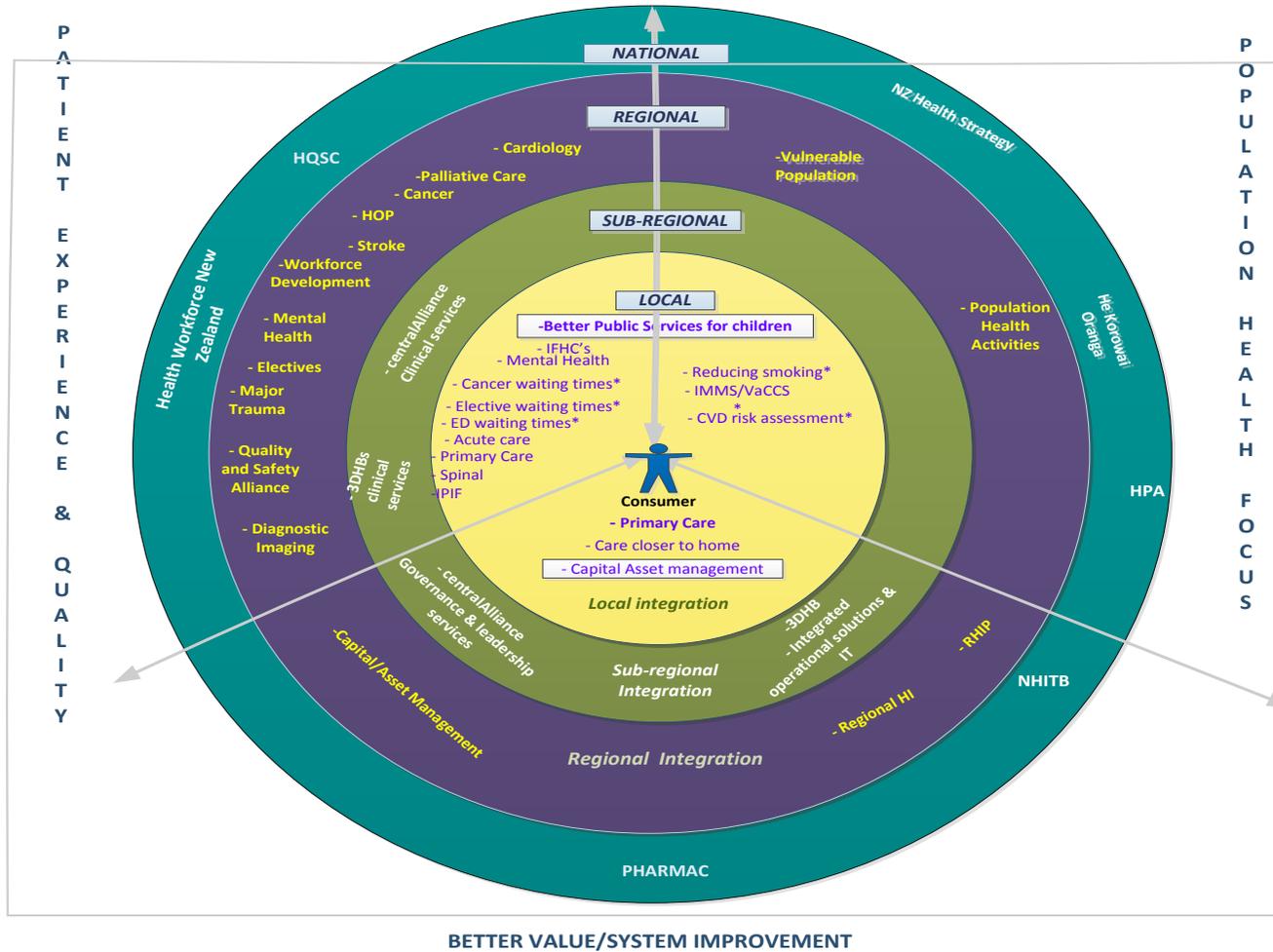


Line of Sight



Line of Sight

Figure 24: 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 6

Appendices

Planning Priorities

Appendix 1

Planning Priorities

Central Region implementation plans 2016/17

The DHB Action Plans focus on outlining the specific tangible and measurable actions to deliver on identified service priorities and targets. Each one outlines the context in which the work is developed, and the commitments included in the Annual Plans contribute to the success of the Regional Plan.

Index of Key Actions

	Programme	Pages	Sponsors
WORK PROGRAMMES	Cancer Services	61	Debbie Chin
	Cardiac Services	55	Debbie Chin
	Diagnostic Imaging	86	Ashley Bloomfield
	Electives	73	Kevin Snee
	Health of Older People (HOP)	44	Julie Patterson
	Hepatitis C	77	Debbie Chin
	Information Technology	102	Kathryn Cook
	Major Trauma	82	Debbie Chin
	Mental Health and Addictions	67	Julie Patterson
ENABLERS	Stroke Services	50	Ashley Bloomfield
	Quality and Safety	98	Julie Patterson
	Workforce	90	Julie Patterson

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 ensure 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 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:

- The growth in knowledge and understanding from consumers and health professionals of advance care planning
- The development of a regional approach to implementing advance care planning through sharing of resources, expertise and innovations
- Opportunities for regional developments to support people with dementia and their family/whānau, identified through a comprehensive stocktake
- The establishment of a regional agreement on the indicators to support the delivery of a regional dashboard for stakeholders across the community, primary and secondary care
- The piloting of a multi-interventional approach to polypharmacy in the Whanganui region. This resulted in medication modifications in 86% of those seen, supported consumers 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?

In response to the themes articulated in the NZ Health Strategy Review and Health of Older People's Strategy Review, the 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. Broadly, it will:

1. Establish and maintain national and regional relationships to better understand opportunities for integration which improve the health outcomes for older people (system integration).
2. Utilise understanding of national policy and cross sector work programmes to inform care arrangements for older people and support for their carers (care arrangements).
3. Utilise national datasets to inform care arrangements and make recommendations to relevant stakeholders to inform service planning and improvements (regional models for older people).
4. Support clinicians to be leaders where their expertise and qualities are relevant and promote their contribution for regional leadership in the health of older people.

The work programme outlined is supported by the Health of Older People Network and three project teams:

1. Regional Dementia Pathways Reference Group (RDPRG)
2. Regional Advance Care Plan Reference Group (RACPRG)
3. Regional Benchmarking Group

These project teams represent a broad range of stakeholders who have been nominated by their respective organisations to contribute subject matter expertise and include representation from primary care, secondary care, consumer, community care and NGO sectors.

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 Region's 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 and whānau in supporting the older person's wellbeing and function.
- Utilising relevant datasets and business intelligence to inform service planning and improvements 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 and innovations identified through the New Zealand Framework for Dementia Care stocktake in 2015 are implemented.
- Annual regional planning meeting in November between the HOP Portfolio Managers, HOP Network and relevant external stakeholders such as MOH, ACC, HQSC.
- Clinical leadership is evident within the region for health of older people.



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 carers 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)	85% response rate to stocktake/survey	Regional Dementia Pathways Reference Group (RDPRG)
	Collaborate with the non-government sector and community providers to complete current state (Q2)	Findings of regional stocktake reported to Health of Older People Portfolio Managers	
	Develop findings of the stocktake including identification of innovations and report to relevant stakeholders (Q3)	Project documents developed to support a regional approach (such as project brief and business case) as indicated	
	Develop a regional proposal that establishes an agreed set of principles and approaches 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	Launch the Henry Brodaty e-learning modules across the region in primary and secondary care (Q2)	Quarterly monitoring of the number of hits to the Goodfellow website hosting the Henry Brodaty modules from the Central Region	RDPRG
	Embed e-learning (Henry Brodaty) modules developed through the National Dementia Education Collaboration into General Practice (Q4)	Report local and regional access to Goodfellow website quarterly to DHBs and PHOs	
	Provide regional representation to the National Dementia Education Collaboration – Primary Care Dementia Education, to strengthen the national response to primary care education (Q4)	12 education sessions delivered to	



HOP Key Actions	Milestones	Measures	Leads
primary health care.	Report on the number of education sessions provided regionally to improve dementia awareness and responsiveness in primary care (Q4)	support the management of cognitive impairment within the region	
Provide DHBs with on-going support and overview so that DHBs identify and strengthen components of dementia care pathways within the parameters of the New Zealand Framework for Dementia care.	Utilise the expertise of the Chief Advisor for Health of Older People at Ministry of Health to develop principles for clinical leadership for HOP (Q2)	One regional forum delivered to strengthen regional clinical engagement and clinical leadership	RDPRG
	Develop a regional proposal which supports enhanced clinical leadership for older people (Q3)	Regional dementia care innovations are promoted through presentations and engagement at the RDPRG meetings	
	DHBs will provide access to "Living Well with Dementia Resource" to the person with dementia and their family and whānau (Q3)	500 of 'Living Well with Dementia' resources are distributed in the region	
	Review content and update local DHB health of older people webpages to better support information for people with dementia and their family/whānau (Q3)	Regional clinical lead for HOP is identified	
Proactively monitor and share InterRAI population and service data across the continuum to influence service improvements.	Publish regional benchmarking infographic which is aligned to the NZ HOP Strategy ensuring equity is reflected within infographic (Q1)	Quarterly publication of infographic	Regional Benchmarking Project Group
	Establish survey tool to determine reach into relevant sectors such as primary care, community care, NGO sector of the infographic (Q2)	25% response rate to survey is achieved	
	Launch survey and analyse results (Q3)	Central Region's InterRAI data is presented at regional forum to strengthen regional clinical	
	Evaluate the quality indicators in the infographic in response to survey and data trends and amend accordingly (Q4)		

Co-ordinated by:

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HOP Key Actions	Milestones	Measures	Leads
	Revise communications plan for infographic (as necessary) based on survey results (Q4)	engagement and clinical leadership	
	The HOP Network review regional InterRAI data and share findings with Portfolio Managers, reference groups and other relevant stakeholders (Q4)	Provide RDPRG and the regional advance care planning reference group with quarterly InterRAI data to inform service planning and improvements	
	Share the results from the 3DHBs activity on the development of interRAI outcome measures through the home and community support sector (HCSS) provider agreements (Q4)	Report on HCSS outcomes shared regionally	3 DHB (CCDHB, HVDHB, WaiDHB)

Linkages to other programmes	
Sub-regional	Central Cancer Network, Palliative Care Managed Clinical Network
Sub-regional	Central Cancer Network Palliative Care Managed Clinical Network
IT	Regional ACP Reference Group HOP Network InterRAI Data Analysis and Reporting Service
Workforce	Mental Health and Addictions Network Regional Workforce Development Hub
Capital investment	Not applicable
Māori health	Regional Benchmarking Project HOP Network
National	Health of Older People Steering Group

Co-ordinated by:

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<i>Roadmap</i>				
<i>Progress and achievements</i>	<i>June 2015</i>	<i>June 2016</i>	<i>June 2017</i>	<i>June 2018</i>
1. Dementia	✓	✓	✓	BAU
2. Regional benchmarking	✓	✓	✓	BAU



Stroke Services

Sponsor Ashley Bloomfield

The 2015/16 Stroke RSP 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/whānau.

In 2015/16, the Central Region has consistently exceeded the 6% thrombolysis rate. Where a DHB has not achieved, the 6% rate strategies have been implemented which have resulted in an improved DHB rate.

Strengthening consumer representation on the Central Region Stroke Network is an objective for the 2016/17 year.

Data collection has proved challenging for the Central Region, with timeliness being an issue. The 2016/17 RSP will identify options to improve the overall data management and collection, which will support decision making, service delivery and drive service improvement.

Strengthening linkages with primary care, NGOs 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 whānau and community to support improving health outcomes.

Objectives

- Improved primary and secondary stroke prevention and reduction in 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:

- ✓ 6% or more potentially eligible stroke patients are thrombolysed 24/7
80% of patients transferred to an Acute Stroke Unit or Organised Stroke Pathway.
- ✓ 80% 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			
<p>Tele-stroke: All people with a stroke have access to 24/7 thrombolysis supported through the use of tele-stroke</p>	<ul style="list-style-type: none"> Central Region DHBs complete participation in the Ministry tele-stroke pilot, HBDHB, MDHB, CCDHB... Allocation of required resources to support 24/7 access to thrombolysis using tele-stroke is determined which includes collaboration with: <ul style="list-style-type: none"> ➤ Radiology services ➤ Emergency departments ➤ Emergency services (ambulance) ➤ Support use of transport options if required to access thrombolysis Annual audit to be undertaken by all DHBs. DHBs 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. 	<ul style="list-style-type: none"> Tele-stroke implemented (Q2). Monitoring of thrombolysis rates and thrombolysis register continues (Q1–Q4). The Central regions eligible patients having had a stroke are thrombolysed achieving 6% of all or more. DHB's will contribute to the stroke thrombolysis quality assurance procedures which includes staff training and Audit. Sustainability of the 24/7 pilot will be determined by availability of required expertise and resources eg. radiology services and this will be monitored throughout the duration of the pilot. 	<p>All DHBs</p>

Stroke Key Actions	Milestones	Measures	Leads
<p>Communication Plan:</p> <p>A Central Region Stroke Network Communication Plan is developed and includes strategies to support the TIA tool in primary care.</p> <p>A more integrated Central Region stroke service which is better connected with wider public services</p>	<ul style="list-style-type: none"> Engagement with primary care (PHO), NGOs and iwi health providers is undertaken prior to the development of the Communication Plan. Strengthen linkages with Stroke Central Region Including improving communication and feedback loop. 	<ul style="list-style-type: none"> Enhanced integration with primary care, NGOs and iwi. Health providers' are achieved. The engagement process is completed by Q3. The Communication Plan is developed by Q3. 	Central Region Stroke Steering Group
<p>All stroke patients receive appropriate rehabilitation services and have equitable access to community stroke services, regardless of age, ethnicity or geographic domicile</p>			
<p>Rehabilitation:</p> <ul style="list-style-type: none"> All people <65 years with a stroke have access to rehabilitation Develop understanding of users of health services Partnering with patients, family/whānau to design services Encourage and empower patients and their family/whānau to be more involved in their health Support patient and family/whānau navigation of the health system Identify feasibility of a regional centre for <65 years rehabilitation by 30 June 2017 Ensure 80% of stroke patients who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission 	<ul style="list-style-type: none"> A needs analysis is undertaken to determine the requirements for rehabilitation for stroke patients <65 years, which takes into consideration requirements for: <ul style="list-style-type: none"> vocational rehabilitation family/whānau participation and support. DHBs will identify process requirement which will support data collection. All eligible patients suffering from stroke will have equitable access to community stroke services. <p>Monitor the % of all stroke admissions that:</p> <ul style="list-style-type: none"> are referred to community rehabilitation 	<p>The needs for access to rehabilitation for patients <65 years across the Central Region is determined by Q4.</p>	Central Region Stroke Steering Group

Stroke Key Actions	Milestones	Measures	Leads
<ul style="list-style-type: none"> Determine processes to collect the proportion of patients admitted with acute stroke who are referred to community rehabilitation and the proportion of those undergoing face-to-face community assessment within 5 days of discharge from hospital 	and <ul style="list-style-type: none"> the proportion of these who receive face to face community rehabilitation session within 7 days of in patient discharge. <p>No date has been set for formal collection as yet but all DHB's will be expected to be making progress towards.</p>		
Thrombectomy: <ul style="list-style-type: none"> Requirement to support a thrombectomy service based at CCDHB is determined Establish transport requirements and funding implications 	<ul style="list-style-type: none"> Central Region 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
Data management and reporting: <ul style="list-style-type: none"> Central Region DHBs support improved data management processes which enhance decision making, and drive service improvement and service delivery IT supports improved data collection Data continues to be collected for the following: <ul style="list-style-type: none"> 8% thrombolysis rate 80% of patients transferred to an Acute Stroke Unit or Organised Stroke Pathway ethnicity data is collected for Māori and Pacific (for the categories above) 	<ul style="list-style-type: none"> Options to improve and facilitate data collection, including IT requirements, are completed by Q4. All DHBs will achieve expected Target percentage at each quarter 	Data capture each quarter from each DHB and reporting. Failure to achieve target will require actions to resolve.	Central Region Stroke Steering Group
Training and education: All members of interdisciplinary stroke team participate in ongoing education and training	Annual Stroke Education Study Day is held, hosted by a DHB by Q4.		Central Region Stroke Steering Group

Stroke Key Actions	Milestones	Measures	Leads
according to the Stroke Guidelines			
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 DHBs

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 (BAU) by 30 June 2017
Capital investment	Provision of sustained tele-stroke services post the Ministry's pilot
Māori health	Engagement with Māori communities through improved communication and integration with primary care, NGOs 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
Transient ischemic attacks (TIAs)	✓			BAU
Rehabilitation	✓			
Thrombectomy	✓			BAU
Thrombolysis	✓			
Data management and IT	✓			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 Cardiac 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 Expected Clinical Standards. A regional picture, through the creation of an Expected Clinical Standards audit framework, will enable the Cardiac Network to identify any gaps in service delivery and will inform the development of an integrated model of care across the region.

The Cardiac Network's key achievements to date are:

- Successful implementation of Accelerated Chest Pain Pathways (ACPPs) within each DHB
- Completion of a visiting cardiac service for the Whanganui population
- The completion of the Expected Clinical Standards, which will soon be accepted by the National Cardiac Network as the New Zealand Expected Clinical Standards
- The completion of a regional proposal to 'build a sustainable echocardiography workforce' and an agreement in principle to a regional approach being taken by Chief Operating Officers (COOs) and General Managers Planning and Funding (GMs Planning and Funding)
- Significant improvement in performance against all the New Zealand Acute Coronary Syndrome's Quality Improvement (ANZAC QI) registry management indicators

What is the current year plan?

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

- The implementation of the New Zealand Expected Clinical Standards including an Acute Coronary Syndrome Action Plan.
- The development a Cardiac Services System of Care across the Central Region.

The successful implementation of these priorities will enable the Cardiac 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 Māori, Pacific and European patients
- Equitable access to cardiac services
- Clinical and financial sustainability of the 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:

Secondary Services

- Deliver a minimum target intervention rate for cardiac surgery, set in conjunction with the National Cardiac Surgery Clinical Network, to improve equity of access.
- Ensure appropriate access to cardiac diagnostics to facilitate appropriate treatment referrals, including angiography, echocardiograms, exercise tolerance tests, etc.
- Manage waiting times for cardiac services, so that patients wait no longer than four months for first specialist assessment or treatment.
- Undertake initiatives locally to ensure population access to cardiac services is not significantly below the agreed rates. This includes cardiac surgery, percutaneous revascularisation and coronary angiography.
- Sustain performance against cardiac surgery waiting list management expectations
- Ensure consistency of clinical prioritisation for cardiac surgery patients, by using the national cardiac CPAC tool, and treating patients in accordance with assigned priority and urgency timeframe (*for the five cardiac surgery providers only*).

Accelerated Chest Pain Pathways

- Review and audit Accelerated Chest Pain Pathways¹⁵ (ACPPs) in Emergency Departments.

Acute Coronary Syndrome

- Contribute data to the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of ACS risk stratification and time to appropriate intervention.
- Develop processes, protocols and systems to enable local risk stratification and transfer of appropriate ACS patients.
- Work with the regional, and where appropriate, the national cardiac networks to improve outcomes for ACS patients.

Heart Failure

- Work with the regional, and where appropriate, the national cardiac networks to improve outcomes for patients with heart failure.

¹⁵ Accelerated Chest Pain Pathways (ACPPs) are patient assessment pathways that speed up the diagnostic process for patients with chest pain, without compromising patient safety. ACPPs have significant potential as diagnostic tools to improve patient outcomes and save time and resources in Emergency Departments.

Measures

Secondary Services

- Agreement to and provision of a minimum of 6.5 per 10,000 total cardiac surgery discharges for local population in 2015/16 (*will be provided in electives funding advice*).
- Develop and agree a regional ACS Contingency plan that has systems in place that ensures ACS patients meet the door to cath target within 72 hours across the region.
- Modelling, which will examine the change rate and function of settings across the region in response to intervention rates, demographic changes, impacts of technology and existing models in place that could be considered.
- To inform stages two and three of the project, three Cardiac Network workshops have been scheduled to:
 - Identify the future cardiac service options
 - Obtain commitment from the Central Region Cardiac Network on the recommended cardiac system of care.
 - Endorse the final recommendations to Regional Chief Executives (CEs).

CR COOs and GM P&F will then present the final future model for cardiac services CR COOs and GM P&F will then present the final future model for cardiac services including an implementation plan to the Central Region CEs for approval.

Acute Coronary Syndrome

- 70% of patients will receive an angiogram within 3 days of admission ('day of admission' being 'Day 0'). This will also be reported by ethnicity.
- Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days.
- Over 95% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge.
-

Key Actions for 2016/17

Cardiac Key Actions	Milestones	Measures	Leads
<p>Improved and timelier access to quality cardiac services:</p> <p>Identify the activity data that will inform the development of a regional action plan to address barriers and timely access to Acute Coronary Syndrome (ACS) services</p>	<p>The Cardiac Network will work with each DHB in the region to complete an initial gap analysis to assess the DHBs' performance against the New Zealand Expected Clinical Standards and then develop DHB Action Plans to implement these standards and the echocardiography guidelines (Q2–Q4).</p> <ul style="list-style-type: none"> • Minimum Standards gap analysis report completed • All regional clinical leads actively lead the development and implementation of Minimum Standards action plans within their DHB • Each DHB clinical lead engages primary care to implement Minimum Standards <p>Review ACS protocols</p> <ul style="list-style-type: none"> • Develop greater transparency of patient waiting times • Implement a regional risk stratification referral score • Determine options to optimise angiography and angioplasty for MidCentral and Hawke's Bay DHBs • Develop and agree a regional ACS Contingency plan that has systems in place that ensures ACS patients meet the door to cath target within 72 hours across the region. 	<p>Quarterly report on progress against RSP milestones to the Cardiac Network, Regional Executive Committee, COOs and GMs Planning and Funding.</p> <p>Minimum Standards audit framework.</p>	<p>Dr Nick Fisher</p>
<p>Equitable access to services, regardless of where the patient lives</p>	<p>Develop a Cardiac Services System of Care across the Central Region by Q2:</p> <p>The diagnostics stage one, will include collecting and analysing information to better understand cardiac services in the Central Region region including:</p> <ul style="list-style-type: none"> • the current status of services, data, demand for services and population health prevention activities that will drive future demand • Existing available information about Central Region cardiac services to identify information gaps modelling the historical patterns of use and the placement of patients accessing services, including ethnicity, 	<p>Quarterly report on progress against RSP milestones to the Cardiac Network, Regional Executive Committee, COOs and GMs Planning and Funding and Regional CEs</p> <p>Performance against cardiac key</p>	<p>Dr Andrew Aitken</p>

Cardiac Key Actions	Milestones	Measures	Leads
	<p>deprivation and locality, to better understand the patient journey</p> <ul style="list-style-type: none"> Data from the National Health Committee and PHARMAC <p>Using information collected in stage one, stage two will describe the current model of care, across home, primary, secondary and tertiary settings, in relation to:</p> <ul style="list-style-type: none"> Workforce: highlighting the current workforce and identifying pressure points and workforce patterns Technology: including current approaches and investment. <p>Future Options Development (stage three)</p> <p>Building on the information collected in stages one and two, options for future models of care will be developed, based on:</p> <ul style="list-style-type: none"> a horizon scan to explore different models in different jurisdictions, both nationally and internationally modelling, which will examine the change rate and function of settings across the region in response to intervention rates, demographic changes, impacts of technology and existing models in place that could be considered To inform stages two and three of the project, three Cardiac Network workshops have been scheduled to: <ul style="list-style-type: none"> Identify the future cardiac service options Obtain commitment from Network for the recommended model of care Endorse the final recommendations to Regional Chief Executives (CEs). 	<p>performance indicators (KPIs).</p>	



Cardiac Key Actions	Milestones	Measures	Leads
	<p>Clinical and Financial Sustainability (stage four)</p> <p>In stage four the future options will be assessed according to impact on affordability, clinical safety, and equity for all population groups.</p> <p>Implementation Options (stage five)</p> <p>The final stage will be conducted by the Central Region's Chief Operating Officers (COOs) and General Managers Planning and Funding (GM P&F) who will assess each option and discuss with their local teams to determine the model of care for the future. Criteria for assessment will need to include:</p> <ul style="list-style-type: none"> • whether this will improve outcomes for patients • workforce demands • any capital investment that may be required <p>CR COOs and GM P&F will then present the final future model for cardiac services including an implementation plan to the Central Region CEs for approval.</p>		

Linkages to other programmes

Workforce	Continue to progress the echocardiography workforce proposal
Capital investment	Facilities and equipment to accommodate additional cardiac service delivery
Māori 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
New Zealand 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 to date

- The region has consistently met PP30: all patients, ready for treatment, wait less than 4 weeks for radiotherapy or chemotherapy
- Improved performance against the FCT indicators (regional results for quarter two 2015/16):
 - 75% of patients referred urgently with high suspicion of cancer and a need to be seen within 2 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 receive 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 the Ministry's 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 FCT 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 services and equitable outcomes with respect to cancer treatment and cancer outcomes

This programme of work will be led within the region by a lead CE and facilitated and coordinated by the CCN. It should be noted that the CCN also covers the 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 days – CCN DHBs achieve that at least 90% of patients referred with a high suspicion of cancer and a need to be seen within 2 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 (performance expectation 85%)
- Shorter waits for cancer treatment (policy priority 30) all patients ready for treatment wait less than 4 weeks for radiotherapy or chemotherapy
 - Improving waiting times
 - cancer multidisciplinary meetings
- – monitor improvements to the coverage and functionality of multidisciplinary meetings
- Provide a confirmation 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):
 - 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive); 100% within 30 days
 - 70% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days); 100% within 90 days
- Surveillance colonoscopy (policy priority 29) – 70% 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 <ul style="list-style-type: none"> 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) 	<p>Systems developed as appropriate.</p> <p>Monthly breach reporting and investigation.</p> <p>Milestones specific to each project.</p> <p>Project Plan developed by August 2016. Implementation completed by June 2017.</p>	<p>DHBs achieve that at least 90% of patients referred with a high suspicion of cancer and a need to be seen within 2 weeks have their first treatment (or other management) within 62 days by June 2017.</p> <p>DHBs demonstrate improvements in the number of records submitted, with 15-25% of cancer registration cohort reported within the 62 day health target.</p> <p>DHBs achieve the performance expectation of 85% of patients with a confirmed diagnosis of cancer receive their first treatment (or other management) within 31 days of decision to treat (Policy Priority 30)</p>	<p>DHB and CCN FCT clinical champions</p> <p>As identified in each project</p> <p>Regional Radiology Group</p>
National Tumour Standards CCN, in partnership with DHBs, coordinates reviews of services against two National Tumour Standards and identifies key activities to address issues identified as a result of completed reviews	<p>Prioritised National Tumour Standards for review identified by July 2016.</p> <p>Reviews completed by June 2017.</p>	<p>Completion of reviews and development of implementation plans to address gaps by June 2017.</p>	<p>CCN/DHBs</p>

Cancer Key Actions	Milestones	Measures	Leads
Multidisciplinary Meetings (MDMs) <ul style="list-style-type: none"> DHBs implement MDM clinical resourcing business cases Scope feasibility of implementing NZCHIS MDM Project (in progress) recommendations for 2016/17 and 2017/18 	<ul style="list-style-type: none"> Priorities implemented by June 2017. Scoping completed December 2016. 	See FCT target.	DHBs/CCN
Equity <ul style="list-style-type: none"> Partner with MDHB to develop tools to support health service planners and providers to implement the <i>Equity of Health Care for Māori: A framework</i> 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 	<ul style="list-style-type: none"> Equity Framework tools developed by July 2017. CCN to promote the tool to cancer service providers in the region by July 2017. Implementation priorities for 2016/17 identified by July 2016 and completed by June 2017. Evaluation commences July 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. 	<p>Equity Framework tool developed. Tool promoted to cancer service providers regionally.</p> <p>Measures currently under development – equity-focused measures to be developed.</p> <p>Measures currently under development – equity-focused measures to be developed.</p>	<p>MDHB/CCN</p> <p>CCN</p> <p>DHBs/CCN</p>
FCT in primary care <ul style="list-style-type: none"> Continue to build on initiatives to drive a strategic approach to FCT in primary care as advised by DHB Alliance Leadership Teams (ALTs) CCN Priority Clinical Pathway project continues, including implementing 	<p>Implementation Plan for 2016/17 developed by August 2016.</p> <p>Planned clinical pathways developed and implemented by June 2017.</p>	<p>Priorities in the Plan implemented.</p> <p>Number of active cancer clinical pathways.</p>	<p>Alliance Leadership Teams/CCN</p> <p>CCN/HealthPathways/Collaborative</p>

Cancer Key Actions	Milestones	Measures	Leads
the prostate cancer management and referral guidance			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 August 2016. Initiatives delivered by July 2017.	Shorter waits for cancer treatment (policy priority 30) – all patients ready for treatment wait less than 4 weeks for radiotherapy or chemotherapy.	RCTS/WBCC
Colonoscopy/endoscopy Continue implementation of sub-regional colonoscopy service plans	Priorities in sub-regional plans implemented by June 2017: <ul style="list-style-type: none"> • C&CDHB/HVDHB/WaiDHB • MDHB/WhaDHB/HBDHB. 	Diagnostic colonoscopy (policy priority 29): <ul style="list-style-type: none"> • 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive), 100% within 30 days • 70% of people accepted for non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days), 100% within 90 days. Surveillance colonoscopy (policy priority 29): <ul style="list-style-type: none"> • 70% 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 	Sub-regional Colonoscopy Plan Leadership Groups

Cancer Key Actions	Milestones	Measures	Leads
		120 days.	

Linkages to other programmes

Sub-regional

- 3DHB alignment across CCDHB/HVDHB/WaiDHB
- Central Region 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 NZ Cancer Health Information Strategy (NZCHIS) (2015)
- Scope feasibility for Central Region 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

Capital investment

- Implementation of ProVation is completed across all DHBs

Māori health

- Ethnicity data quality (NZCHIS)
- Cervical screening (Tumu Whakarae programme)
- Breast 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.

Co-ordinated by:



Mental Health and Addictions

Sponsor: Julie Patterson

In the year 2014/15, Central Region DHB and NGO providers of specialist Mental Health and Addictions (MHA) services saw a total of 32,771 unique people of all ages across the Central Region (MidCentral, Hutt Valley, Hawke's Bay, Whanganui and Capital & Coast DHBs). This equates to 3.7% of the total Central Region population. In 2014/15, MHA services were accessed by:

- 9,002 people (3.8%) aged 0-19
- 22,099 people (4.3%) aged 20-64
- 1,670 (1.2%) aged over 65.¹⁶

"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)¹⁷

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 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:

¹⁶ Data received from SIDU 2016.

¹⁷ Cited in *Te Rau Hinengaro: New Zealand Mental Health Survey*, Wellington: MoH, 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 July 2012, <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 BAU (via quarterly monitoring)
- Development of workforce development plans for all Central Region MHA services

What is the current year plan?

The 2016/17 RSP is moving away from separate service work streams and will focus on developments that enhance collaboration across service areas to reduce the siloed nature of service provision.

Much of the work for 2016/17 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 5-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 presented in 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 for 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 outcome-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 the range of services provided, links between primary and secondary care, and service user pathways into, through and out of services
- Hui held within the Central Region for primary and secondary care integration, with particular reference to improving the 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 on services for eating disorders, maternal and perinatal mental health, and forensic mental health
- Implementation of 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 provides 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 work streams (Q1–Q4).	Report summarising development areas for regional work streams and identifying health equity improvements for populations, including recommendations presented to MHARL based on evaluation processes. Workforce Development Plan to be developed for youth MHA services based on needs analysis from evaluation.	MHARL, DHBs, NGOs
	Community Youth Forensic Plan implemented (Q1).	Plan achievement summarised marking completion of all objectives.	MHARL, DHBs
	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 is 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). <i>This will incorporate the implications of the</i>	Business case for model implementation is complete, including procurement processes. Workforce development and Service Change Plans created. Adult residential AOD model of care implementation has begun across the Central	MHARL, DHBs, NGOs

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.	<i>replacement legislation for the Alcoholism and Drug Addiction Act (1966).</i>	Region (Q4).	
	Maternal and perinatal services will fully implement the additional Ministry funding requirements, including workforce development (Q1–Q4).	Implementation achievements summarised. Baseline and quarterly data demonstrate increased access and community contacts, and decreased wait times and 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). <i>Regional forums will involve primary care, including NGO, secondary, kaupapa Māori and Pasifika services.</i>	Findings disseminated to be incorporated in future planning and development.	MHARL, DHBs, NGOs, primary care
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

<i>Linkages to other programmes</i>				
<i>Sub-regional</i>	Youth AOD Exemplar Project, 3DHB MHA Strategic Plan			
<i>IT</i>	Regional Health Informatics Programme (RHIP), Health Pathways, Map of Medicine			
<i>Workforce</i>	Regional Workforce Development Hub, Te Pou, Te Rau Matatini, Matua Raki			
<i>Capital investment</i>	No capital investment foreseen for the 2016-17 period, but across the year opportunities for future year investments may arise			
<i>Māori health</i>	Central Region Māori Managers			
<i>Roadmap</i>				
<i>Progress and achievements</i>	2014/15	2015/16	2016/17	2017/18
Regional rehabilitation and extended care	✓	BAU		
Youth	✓	✓	✓	✓
Adult	✓	✓	✓	✓
Physical wellbeing	✓	✓	✓	✓
Workforce	✓	✓	✓	✓



Elective 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 Māori and non-Māori.

The Central Region 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, Ophthalmic and otorhinolaryngology services and the collection of information and data to develop a regional view of day of surgery cancellations and theatre utilisation, as well as 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 that have achieved the following outcomes:

1. The development of 18 orthopaedic pathways
2. The development of three otorhinolaryngology pathways
3. A prioritisation tool for orthopaedic referrals for First Specialist Assessment FSA
4. Regular reporting of day of surgery cancellation and theatre utilisation

What is the current year plan?

1. Individual DHBs are working on theatre utilisation and efficiency. The regional focus will be on sharing information and learning about theatre utilisation and productivity programmes 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 targets and additional elective orthopaedic and general surgery discharges
- The population of the Central Region will receive improved equity of access to elective services
- Central Region DHBs will maintain the 4 month waiting time milestone for first specialist assessment and 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 monthly progress on key milestones to Regional Electives Steering Group



Key Actions for 2016/17

Electives Key Actions	Milestones	Measures	Leads
Individual DHBs continue with work in relation to theatre utilisation and productivity programmes, which are being initiated to improve access for patients, maximise theatre utilisation and efficiency across the region, and ensure DHBs are able to meet their elective targets	<ul style="list-style-type: none"> Results shared across Central Region DHBs to inform planning and collaborative improvement. Opportunities for shared improvements across the region. 	DHB COOs and GMs Planning and Funding have clarity about theatre utilisation rates to inform planning and collaboration across the Central Region (Q3). Patient access to elective services is improved as evidenced by DHBs meeting targets for elective services (Q4).	Central Region DHBs and General Managers Planning and Funding
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	<ul style="list-style-type: none"> 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 Māori, Pacific, primary care, Consumer, allied health. Key stakeholders, the Governance Group and regional networks to identify clinical pathway development that would support improved patient access and quality of care and service delivery. Completion and implementation of an FSA triage tool for Ophthalmology Completion and implementation of a model of care for Avastin Collation of population, workforce and 	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 RSP milestones to the network, Regional Executive Committee, COOs and GMs Planning and Funding Reports on patient satisfaction completed and shared across the Central Region DHBs (Q4).	Central Region Governance Group Central Region clinical networks

Electives Key Actions	Milestones	Measures	Leads
	productivity data and information to inform planning <ul style="list-style-type: none"> The Central Region Elective Services Health Targets are met Regional networks to identify options to 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 		

Linkages to other programmes

Sub-regional	Cardiac, workforce, diagnostics work programmes
IT	Regional information – capacity planning
Workforce	Elective workforce

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 virus (HCV) treatment services and approved the following recommendations:

- Resources in the next 3 to 5 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 RSP 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 the Capital & 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 the 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:

- Engagement with 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.
- Analysis has been undertaken of service delivery across pilot and non-pilot sites
- Planning communications with key stakeholders regarding the new service being developed and transition of existing clients
- Planning the transition of current patients in the pilot sites to primary care
- Identifying clinical and diagnostic capacity and capability requirements to deliver pathway
- The development of a business case for resources required across the Central Region from 1st July 2016
- Planning a procurement process to establish the proposed new service

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

- Scoping information requirements and channels to identify new patients
- Working with Map of Medicine and Health Pathway staff to revise clinical pathways

What is the current year plan?

For 2016-17 RSP year, the project plans (subject to sustainable funding) are 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 HCV clinical pathways in sub-regional and Central Region DHBs
- Raise GP awareness and education about new HCV pathway and risk factors for infection
- Monitor volume of HCV diagnoses, Fibroscanning and treatment

Regional Objectives

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

Reporting Measures

- Quarterly narrative report on progress of the key actions
- Report 6-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 five 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 HCV assessment and treatment services include:

- raising community and GP awareness and education of the HCV and the risk factors for infection
- providing targeted testing of individuals at risk of 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 Fibroskan 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 Fibroskans 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 it)
- providing good information sharing with relevant health professionals
- working collaboratively with primary and secondary care to improve access to treatment.

The Central Region will be guided by the Ministry's April 2016 document:

Guidance to support the development of regional services to deliver identification and treatment for people at risk of or with hepatitis C

This is available on the Nationwide Service Framework Library website:

<http://nsfl.health.govt.nz/dhb-planning-package/guidance-support-development-regional-hepatitis-c-services>



Key Actions for 2016/17

Hepatitis C - Key Actions	Milestones	Measures	Leads
Implement integrated hepatitis C virus (HCV) assessment and treatment services across community, primary and secondary care services in the Central Region. Specifically to: <ul style="list-style-type: none"> • 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 HCV clinical pathways in sub-regional and Central Region DHBs • Raise GP awareness and education about new HCV pathway and risk factors for infection • Monitor volume of HCV diagnoses, Fibroscanning and treatment. 	Pilot patients in sub-regional DHBs transitioned to primary care practitioners (by Q1)	All pilot patients transferred, progress reported quarterly	3DHB
	All components of clinical pathway in place in pilot sub-region, including Fibroscan availability to primary care (Q2)	Quarterly narrative report on progress	3DHB
	All components of pathway in place across remainder of Central Region (Q3)	Quarterly report on progress	MDHB, WhaDHB, HBDHB
	HCV clinical pathway promoted and implemented in sub-region (Q1)	Quarterly report on progress	3DHB, Health Pathways
	HCV clinical pathway promoted and implemented across all Central Region DHBs (Q1–Q2)	Quarterly report on progress	All Central Region DHBs
	Raising community / GP awareness of / education on HCV and risk factors for infection (Q1–Q4)	Quarterly report on progress	MoH, Health Pathways, Map of Medicine
	Monitor and report on volume of HCV cases presenting to primary care (Q2 and Q4)	6-monthly report (by quarter) on specific data measures required by the Ministry	Central Region DHBs
	Monitor and report on number of Fibroscans undertaken (Q2 and Q4)	6-monthly report (by quarter) on specific data measures required by the Ministry	Central Region DHBs
Monitor and report on number of people receiving PHARMAC-funded antiviral treatment (Q2 and Q4)	6-monthly report (by quarter) on specific data measures required by the Ministry	Central Region DHBs	

Hepatitis C - Key Actions	Milestones	Measures	Leads
<p>Note: These milestones and measures may need to be reviewed to reflect the impact of recently announced funding for HCV DAAs and the improvements to treatment options this will bring.</p>			

<i>Roadmap</i>				
<i>Progress and achievements</i>	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 – hepatitis 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 requiring hospital care for their injuries.¹⁸ The Ministry 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 MTNCN 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 the 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, and data is now being collected and submitted to the national registry.

What is the current year plan?

The MTNCN 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 Region's 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 are achieved, and there is 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 with key partners, to reduce the impact of major trauma by ensuring that patients will receive appropriate and timely care following a major trauma incident.

¹⁸ 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 life-long disability of clients who have sustained a major trauma (as defined by the MTNCN¹⁹).

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 MTNCN).

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.

¹⁹ 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 NZMTNMDS for major trauma patients to the National Major Trauma Registry	<p>Major trauma data will be collected consistently across the region from July 2016.</p> <p>Data will be reported through the National Major Trauma registry via the regional arrangements with the Midland Regional Trauma System and available from July 2016.</p> <p>Analysis of the data will support the identification of key areas for improvement and will commence on the availability of the reports.</p>	<p>Quarterly reporting through to the National Major Trauma Registry will be achieved within agreed timeframes with the Midland Regional Trauma System.</p> <p>Quarterly report and analysis will be reviewed and signed off by the Central Region Trauma Network.</p> <p>The Central Region Trauma Network will use quarterly data to revise work programme and inform ongoing improvement activities.</p>	
Develop and implement regionally consistent clinical guidelines for the management of major trauma patients	<p>Clinical guidelines will be developed consistently across the region and adapted to meet each DHB's specific requirements by December 2016.</p> <p>Regional guidelines will be confirmed to support the timely and appropriate transfer of patients to the regional centre by December 2016.</p>	<p>Appropriate transfer of patient guidelines will be approved by Central Region CEOs by December 2016.</p> <p>Implementation of appropriate transfer of patient guidelines will be completed by end of quarter four 2016/17.</p>	
Develop and implement regional destination policies for major trauma patients (in collaboration with DHBs, patients, ambulance providers and MTNCN)	<p>Development of regional destination policy for major trauma. This will be developed in consultation across the Central Region DHBs and key partners, including patients.</p> <p>Regional destination policy for major trauma signed off by regional clinical leads and regional CEOs.</p> <p>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.</p>	<p>Regional destination policy for major trauma patients will be finalised and published regionally by August 2016.</p> <p>All Central Region DHBs have implemented the regional destination policy for major trauma by end of quarter four 2016/17.</p>	



<i>Roadmap</i>						
<i>Progress and achievements</i>	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020
Data collection and reporting	N/A		Ongoing	Ongoing	Ongoing	Ongoing
Develop clinical guidelines	N/A	Development phase				
Develop and implement regional destination policies	N/A	Development phase	Completed			

Co-ordinated by:



Diagnosics Imaging

Sponsor: Ashley Bloomfield

Diagnostic imaging supports clinical decisions which enhance the patient journey and therefore enable DHBs to meet current and new national targets, and allow 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 Central 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 cooperation. The phased introduction of a regional RIS 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.

What are the achievements to-date?

- The success of the international donography recruitment campaign, which included the Central Region's attendance at the recent Society of Diagnostic Medical Sonography (SDMS) conference in Dallas, Texas. This attracted 294 people to the KiwiHealth jobs website (165 of these from Canada). There have been 10 genuine enquiries and a further six sonographers have been contacted by the Central Region, which 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 BAU.

What is the current year plan?

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

- To continue to support the implementation of the RIS
- To continue to work in a cohesive manner to address workforce shortages
- For 3DHB to 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 in 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.



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 RIS.	A report detailing the regional governance structure is reviewed and signed off by RRSB (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.	<p>Quarterly report on progress against RSP milestones to the Cardiac Network, Regional Executive Committee, COOs and GMs Planning and Funding.</p> <p>Evaluate and monitor outcomes achieved from implementing workforce initiatives by Q3–Q4.</p>	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.	<p>Quarterly report on progress against RSP milestones to the Cardiac Network, Regional Executive Committee, COOs and GMs Planning and Funding.</p> <p>Evaluate and report outcomes from the pilot initiative by Q3.</p>	Dr James Entwistle

Linkages to other programmes

Sub-regional	3DHB to work with the Central Region Cardiac Network to develop: <ul style="list-style-type: none"> • service model for performing and reporting cardiac CT • criteria and pathways
IT	Implementation of RIS
Workforce	Sonography Recruitment and Retention Campaign

Roadmap

Progress and achievements	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020
Workforce	✓	✓	✓	BAU	BAU	BAU
Radiology Information System (RIS)	✓	✓	✓	✓	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 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, to provide those services that are critical to their communities. It is also important to be clear about what the current workforce looks like and the current gaps.

The Central Region is committed to aligning to the New Zealand Health Strategy by advancing 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, and ensuring workforce training is effective, thereby resulting in retention of staff across the whole health sector.

This planning acknowledges the alliance formed between the six DHBs, Health Workforce NZ (HWNZ) and the National Strategic Workforce Team located in the DHBSS to jointly address workforce priorities and enable 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 the 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 the retention and quality of the workforce
- Medicine – improve the sustainability and resiliency of the workforce
- Nursing – support the development of the nursing workforce
- Allied health, scientific and technical (AHST) – support the development of the AHST workforce
- Cultural responsiveness – support the cultural development of the workforce with the recruitment reflecting population demographics
- Kaiāwhina – support the national project through the regional support framework
- Mental health and addictions – implement 2015 Workforce Plan
- Advance care planning (ACP) – 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.	Established regional professional support framework for Central Region.	Midwifery Leaders Group
	Q2 onwards: develop and establish a regional professional support framework (with evaluation of framework in 2017-18).		
Medicine Improve sustainability and resiliency of workforce	Q1 onwards: continue to develop a regional orientation programme for Resident Medical Officers (RMOs) utilising nationally developed online programmes.	Development of regional agreed orientation programme for RMOs.	CMOs, GMsHR, COOs/GMsPF, Prevocational Educational Supervisors , RMO Coordinators, Regional Cancer Network and RMO Unit Managers
	Q1: identify potential funding streams for additional palliative medicine registrar training positions with DHB COO, Chief Medical Officer (CMO), RMO Unit Manager and associated hospices for CCDHB and MCDHB.	Complete DHB integration for increased number of PGY1 and support increase of CBAs in conjunction with DHBs and regulatory authorities.	
	Q1–Q2: scope current and identify future potential community-based attachments (CBAs).	CBA framework.	
	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.	Increase in palliative medicine registrar training positions in region.	
	Q3–Q4: develop a regional framework to ensure that current CBA initiatives are available for utilisation within region.	Decrease unfilled palliative care Senior Medical Officer (SMO) positions.	
	Q4 onwards: implement regional RMO orientation programme.		
	Q4: stocktake current palliative medicine training positions in region.		

Workforce Key Actions	Milestones	Measures	Leads
Nursing Support the development of the nursing workforce	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 the government).	Endoscopic trained nursing workforce.	DONs and Directors of Mental Health
	Q1 onwards: continue to develop and implement the Regional Plan with monitoring framework for utilising (top of scope) Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP) positions in the 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.	Strategic Regional Bowel Screening Plan aligned to the National Plan as appropriate.	
	Q4 onwards: benchmark current NP and CNS positions within region.	Full utilisation of CNS and NP positions in region.	
Allied health, scientific and technical Supporting the development of the AHST workforce	Q1–Q4: continued development and implementation of regional recruitment and retention of sonography initiatives.	AHST career pathways available to enable career progression and talent management.	DAHs, GMsHR, Regional Echocardiography Working Group, Cardiac Network, Regional Sonography Workforce Group, Regional Radiology Group
	Alignment of regional workforce policies and procedures for sonography.	Develop a sustainable echocardiography workforce for service provision and echocardiography guidelines (Minimum Standards).	
	Q1 onwards: commence the process for allied health career pathways to be introduced at MCDHB and WDHB.	Regionally sustainable sonography workforce and decrease in unfilled sonography vacancies.	
	Q1 onwards: continue to implement regional echocardiography Workforce Plan and monitoring framework.		
	Q3: implement the allied career pathways at MCDHB and WDHB.		
	Q3: design a learning and development framework for allied health career framework.		
Q3–Q4: evaluate and monitor outcomes achieved from implementing sonography workforce initiatives.			

Workforce Key Actions	Milestones	Measures	Leads
Cultural responsiveness Support cultural development of workforce with reflection of recruitment aligned to population demographics	Q1–Q4: quarterly benchmarking of Pacific and Māori workforce.	Increase in regional recruitment of Māori and Pacific peoples 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 a 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 first 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–Q2: regional sharing and understanding of 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–Q3: regional agreement on principles for secondment opportunities and develop secondment letter agreement template.	process. Regional shared commitment to talent management through development of talent networks.	
	Q3 onwards: development of secondment framework (with scheduled implementation in 2017).		
Mental health and addictions Implement 2015 Workforce Plans	Q1–Q4: report quarterly to the Mental Health and Addictions Network (MHAN) and Te Pou with identified workforce requirements for new service delivery models.	Implementation of the Workforce Plan aligned with national work.	MHAN, regional DHBs (including regional professional leads) and NGOs
	Q3 onwards: implement workforce development needs for regional alignment with the National Workforce Centres for Mental Health.		
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, AHST and RMO/SMO workforces in high-need service areas through publication of module and utilising DHB intranets (with monitoring through existing ACP).	Increase in ACP level 1 trained in high-need areas for RMO workforce, nursing workforce and AHST workforce.	DONs, DAHs, CMOs, regional ACP group
	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.		

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 (CNSs and NPs)	-	✓	✓	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

<i>Progress and achievements</i>	<i>June 2015</i>	<i>June 2016</i>	<i>June 2017</i>	<i>June 2018</i>
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 addictions – 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 overarching 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

- Establish relationships with Chairs of PHO and DHB Clinical Governance Boards
- Improve patient outcomes and reflect improvement strategies in the 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	<p>Q1: scope opportunities for further engagement points and establish relationships with PHO and DHB Clinical Governance Boards.</p> <p>Q2–Q3: develop and agree Future Engagement Strategy.</p> <p>Q3–Q4: implementation of Future Engagement Strategy.</p>	<p>Q1: Identifying chairs of local clinical governance boards/equivalent and sending key points from CRSQA meetings to be added to local agendas.</p> <p>Q2-Q3: Embed process for raising issues from local clinical governance boards to CRQSA.</p> <p>Q3-Q4: Maintain/increase membership of PHOs on CRQSA.</p>	CRQSA
Improve patient outcomes through collaboration on areas of high patient harm with support from HQSC programmes	<p>Q1–Q4: utilise HQSC regional data on identifying areas of improved patient outcomes/areas of risk.</p> <p>Q3–Q4: develop a regional shared learning framework.</p>	<p>To regionally mark against the national average in the quality and safety markers and outcome measures set by HQSC through sharing regional learnings.</p> <p>Establish a regional shared learning framework for improving patient outcomes.</p>	CRQSA
Support the regional approach of person and whānau-centred care consumer partnerships with implementation of Relationship Centred Practice training	<p>Q1: coordinate information on consumer structures and approaches utilising regional linkages on creating agreed consumer approach across the region.</p> <p>Q2–Q3: develop a training package to support the implementation of a person and whānau-centred approach.</p> <p>Q4: regional phased implementation of the Relationship Centred Practice training.</p>	<p>Information collected and shared on consumer groups and approaches in Central Region and available on SharePoint.</p> <p>Discussion item on every agenda regarding consumer input across the central region.</p> <p>Training package developed on the person and whānau-centred care approach.</p> <p>Report from HQSC regarding central region</p>	CRQSA

Q and S Key Actions	Milestones	Measures	Leads
		<p>themes from adult inpatient experience survey.</p> <p>To provide Central Region training on person and whānau-centred care (Relationship Centred Practice training).</p>	
<p>Continue to strengthen partnerships with the quality and safety programme of the HQSC, ACC and the Ministry to promote shared learnings</p>	<p>Q1: scope opportunities for shared learning events.</p> <p>Q1–Q4: collaborate with national partners to contribute to HQSC open book.</p>	<p>HQSC reports on every agenda for discussion/action.</p> <p>Regional contribution to HQSC 'Open Book'.</p> <p>Six-monthly report received from HealthCert MoH on regional learning from certification for distribution amongst quality managers.</p> <p>Regional collaboration on adverse event management policy development.</p> <p>Evidence of establishment of central region quality and safety groups such as infection control, falls events, incontinence management, pressure injury prevention, medication safety, central region quality managers, central region directors of nursing – with six-monthly updates from all groups to CRQSA.</p>	<p>CRQSA</p>



Roadmap

<i>Progress and achievements</i>	<i>June 2015</i>	<i>June 2016</i>	<i>June 2017</i>	<i>June 2018</i>
To develop a region-wide clinical governance and quality improvement framework across the primary and secondary sectors	-	✓	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 learn 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
Strengthen alliance with primary care participation in the Central Region	-	✓	✓	BAU
Improve patient outcomes and reflect improvement strategies in the CRQSA work programme	-	-	✓	✓
Support the regional approach of person and whānau-centred care consumer partnerships with the implementation of Relationship Centred Practice training	-	-	✓	✓
Continue to strengthen partnerships with the quality and safety programme of the HQSC, ACC and the Ministry 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 ongoing are included in the table below. The regional programme of work (RHIP) has been recalibrated with a change of approach for each application/function aligned against a Core, Common, Divergent model.

To be Core (What Must Be Regional) these criteria have 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) these criteria have 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) these criteria have 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 programme			
RHIP work streams – support the recalibration of the programme of work	<ul style="list-style-type: none"> Central Region Clinical Portal Application Phase 1 – in production and first DHB goes live WebPAS functional build complete and ready for deployment as Common. ePharmacy functional build complete and deployment as Common. Central Region Radiology Information System - functional build complete and deployment as core into first DHB. 	<ul style="list-style-type: none"> Q4 2016 Q4 2016 Q4 2016 Q4 2016 	RHIP Programme, CCDHB and WDHB, MDHB WDHB and RHIP Programme Regional Executive Lead
Regional Service Management	<ul style="list-style-type: none"> Regional Service Management <ul style="list-style-type: none"> Interim model in place to support Whanganui as the first DHB to on-board onto the Regional Clinical Portal Application. Full Regional Service Management model agreed and being deployed to support multiple applications and DHBs. 	<ul style="list-style-type: none"> Q2 2016 Q4 2016 	All DHBs – jointly managed by a Regional Governance Group
National solutions			
National Patient Flow	<ul style="list-style-type: none"> Phase 1: The National Data Collection validation completed and Action Plans in place. Phase 2: National Data Collection commenced and reporting in full. Phase 3: National Data Collection is live. 	<ul style="list-style-type: none"> Q1 2016 Q1 2016 Q4 2017 	All DHBs
National Data Centre Project (NIPS)	<ul style="list-style-type: none"> Adopt National programme of work following the outcome of the NIP review. 	Dates to be confirmed	All DHBs
Shared Electronic Health Record (SeHR)	<ul style="list-style-type: none"> Work with the Ministry to agree the model for implementation to ensure regional solutions are aligned to the national ability to access and to share information. Transition to the national SeHR. 	Base SeHR in place by 2018	All DHBs

ICT Key Actions	Milestones	Measures	Leads
ePrescribing and Administration (ePA) MedChart	<ul style="list-style-type: none"> Currently DHBs have development capability for ePA. Regional capability will be included into the definition and scope of CP Phase 2 (specified in the next financial year). 	All DHBs implemented – dependency is CP Phase 2 to support ePA.	All DHBs
eMedicine Reconciliation (eMR)	<ul style="list-style-type: none"> Medicine reconciliations business change at each of the Central Region DHBs will commence once the business change required is agreed with stakeholders. 	<ul style="list-style-type: none"> 2018 	All DHBs
SNOWMED	The Region currently has no defined and actionable plan for SNOMED, but following initial discussions, a regional discussion over the next quarter has been organised. This will enable an update on approach to be provided in the next RSP.		

Linkages to other programmes

Sub-regional	Central Cancer Network, Palliative Care Managed Clinical Network
IT	Regional ACP Reference Group, HOP Network
Workforce	Mental Health and Addictions Network, Regional Workforce Development Hub
Capital investment	Not applicable
Māori 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
Regional Governance Group	This group comprises the Chairs of the six Central Region DHBs and an independent Chair. The key accountabilities are to:	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • 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.
Central Region CEOs	This group comprises the six CEOs of the Central Region DHBs. The key accountabilities are to:	<ul style="list-style-type: none"> • 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. The REC also includes consumer representation from across the region. Its objective is to ensure that the region takes a coordinated approach to planning and delivery. The key accountabilities are to:	<ul style="list-style-type: none"> • 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 planning and ensure that appropriate actions are taken for a successful delivery that optimises health outcomes, including the reduction of health disparities. <p>The key accountabilities are to:</p> <ul style="list-style-type: none"> • 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 the 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 (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

- reduce fragmentation and unnecessary duplication
- reduce variations in quality of care and access
- prevent local DHB interests taking inappropriate priority over regional or national priorities
- reduce 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 the 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 under-performance against the Work 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's 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:

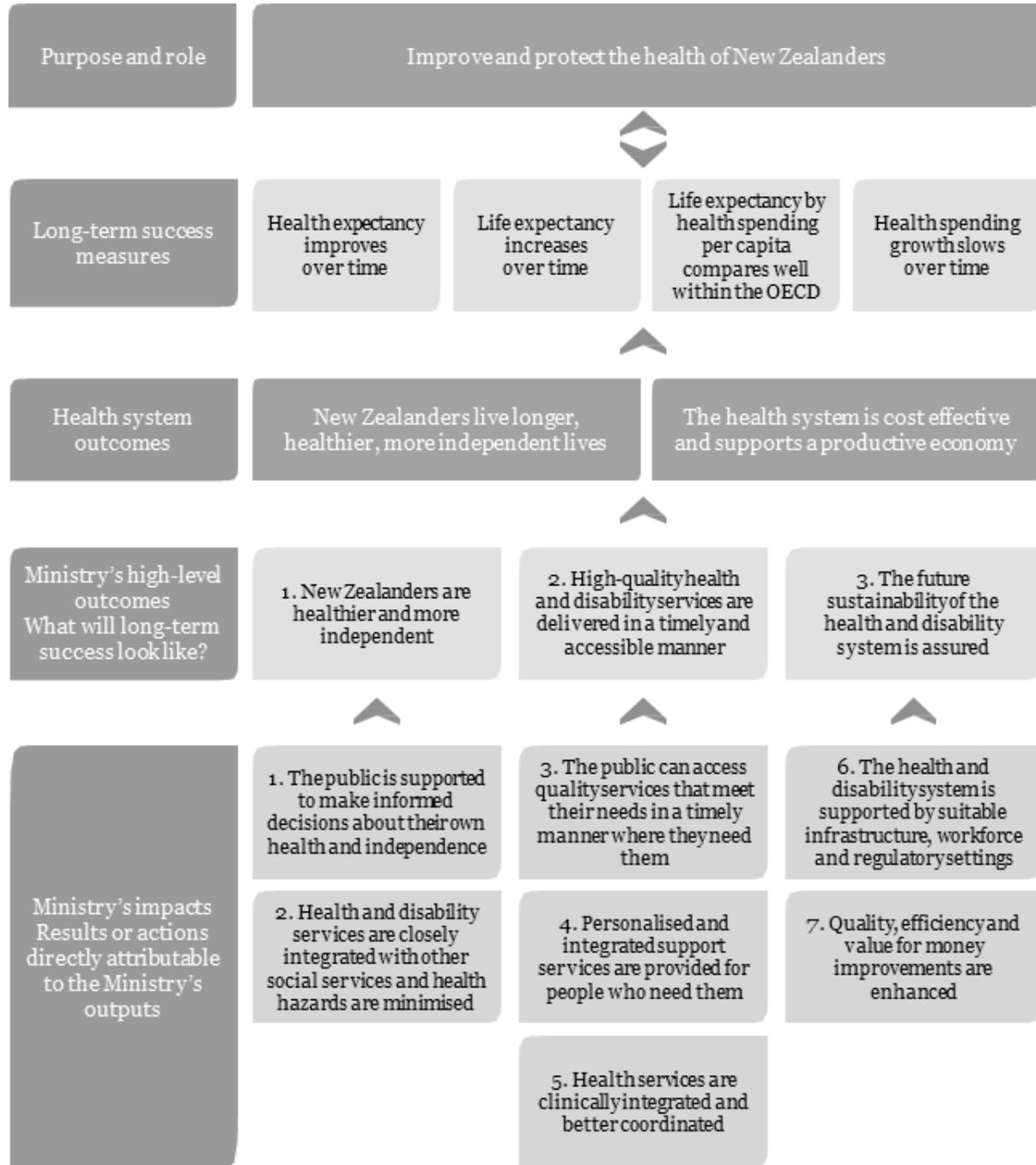
- New Zealanders are healthier and more independent
- high-quality health and disability services are delivered in a timely and accessible manner
- the future sustainability of the health and disability system is assured.

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 a suitable infrastructure, workforce and regulatory settings.
7. Quality, efficiency and value for money improvements are enhanced.

The Ministry's current Outcomes Framework

Figure 24: The Ministry's current Outcomes Framework





Appendix 5

Portfolio Work Areas

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 4 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



Implementation programmes – summary		
		Information System (RIS)
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



Appendix 6: Glossary

Acronym	Definition
3DHB	Strategic Alliance Comprising the Capital & Coast, Hutt Valley and Wairarapa DHBs
ACP	Advance Care Planning
ACPP	Accelerated Chest Pain Pathways
ACS	Acute Coronary Syndrome
AHA	Allied Health Assistant
AoD	Alcohol and Other Drugs
AROC	Australian Rehabilitation Outcome Centre
BAU	Business As Usual
CCDHB	Capital & Coast District Health Board
CCN	Central Cancer Network
CEO	Chief Executive Officer
CNS	Clinical Nurse Specialist
COO	Chief Operating Officer
CRCN	Central Region Cardiac Network
CRISP	Central Region Information Systems Plan (replaced by RHIP)
CRMM	Central Region Māori Managers
CRQSA	Central Region Quality and Safety Alliance
CYF	Child, Youth and Family
DHB	District Health Board
DON	Director of Nursing
ENT	Ear, Nose and Throat
eMR	eMedicine Reconciliation
ePA	ePrescribing and Administration
ESPWP	Elective Services Productivity and Workforce Programme
FCT	Faster Cancer Treatment
FSA	First Specialist Assessment
GMSHR	General Managers Human Resources
GP	General Practitioner
HBDHB	Hawke's Bay District Health Board
HOP	Health of Older People
HQSC	Health Quality and Safety Commission
CR-HSP	Central Region Health Systems Plan (replaces Regional Clinical Services Plan)
HVDHB	Hutt Valley District Health Board
HWNZ	Health Workforce New Zealand
ICT	Information and Communications Technology
IT	Information Technology
KPI	Key Performance Indicator
MDHB	MidCentral District Health Board
MDM	Multi-disciplinary Meeting
MHAN	Mental Health and Addiction Network
MoH	Ministry of Health
MTNCN	Major Trauma National Clinical Network
NGO	Non-Government Organisation



NP	National Radiology Access Criteria
NZMTD	New Zealand Major Trauma Dataset
ORL	Otorhinolaryngology
PACS	Picture, Archiving and Communication System
PAS	Patient Administration System
PET	Professional Development Recognition Programme
PGY	Postgraduate Year
PHO	Primary Health Organisation
QLP	Quality and Leadership Programme
RMO	Regional Medical officer
RSP	Regional Services Plan
SDP	Rising to the Challenge 2012-2017: The Mental Health and Addiction Service Development Plan
SMO	Senior Medical Officer
TAS	Central Region's Technical Advisory Services Limited
TIA	Transient Ischaemic Attack
TNA	Training needs analysis
WAN	Regional network
WaiDHB	Wairarapa District Health Board
WhaDHB	Whanganui District Health Board
WBCC	Wellington Blood and Cancer Centre

END