

# Central Region Regional Service Plan 2015/16



REGIONAL  
SERVICES PROGRAMME



Final Approved 21 Aug 2015

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## Office of Hon Dr Jonathan Coleman

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

21 AUG 2015

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 2015/16 Regional Service Plan

This letter is to advise you I approve the 2015/16 Central Regional Service Plan (RSP). I appreciate the significant work that is involved in preparing the RSP and thank you for your effort.

Good progress has been made with regional planning this year, particularly in relation to the alignment between the DHB Annual Plans and RSPs. However, we must continue to strengthen this alignment in the future if we are 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 2015/16 and to continue to work together to ensure service sustainability within the Region.

### Regional Service Plan Agreement

My approval of your RSP does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the National Health Board will be contacting you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the National Health Board 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

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# EXECUTIVE SUMMARY





## Executive Summary RSP 2015/16

This document outlines the Central Region's Regional Service Plan (RSP) 2015/16. This RSP has been developed collaboratively by the six District Health Boards in the Central Region and represents the strong clinical leadership in the regional networks. There is also a greater focus on the regional priorities as identified by the District Health Boards as well as National initiatives, as outlined in the guidance issued by the Ministry of Health. The DHBs are committed to ensuring equitable access to high quality services that are clinically and financially sustainable.

### 2015/16

The RSP has reached a level of maturity and direction reflected in the Region's commitment to determine priorities and deliver services that provide innovative solutions to address the health needs of our population.

### Priorities

The RSP 2015/16 regional priorities are a continuation from the 2014/15 RSP programme of work as endorsed by the six DHBs. These plans strengthen and support patient centric services, ensuring equity and access to services for Māori are addressed and aligned with DHB annual plans in the following areas:

- Elective Services
- Cardiac Services
- Mental Health and Addictions
- Stroke Services
- Health of Older People (HOP)
- Major Trauma
- Hepatitis C

The key enablers to change as outlined in this document consist of:

- Within Workforce, there is now a clear aim, direction and resources in place to support effective retention and quality of the service provided. In addition, the Central Region DHBs will work with primary and community organisations to advance regional workforce plans.
- Quality and Safety, the purpose of the Regional Quality Safety Alliance (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.
- Health of Māori by addressing this throughout the RSP as well as ensuring it is linked to each action plan. The RSP 2015/16 keeps a dedicated Māori action plan to keep focus on the Māori objectives.
- The Regional IT (Regional Health Infometrics Plan RHIP) activity is a core enabler. It facilitates outcomes that are achieved in action plans. Regional IT has committed to the action plans laid out in its schedule for 2015/16.
- Central Region-Health System Planning (CR-HSP) is a key element in regional planning that will inform and shape the RSP to maintain clinical sustainability and financial viability.
- A capital investment approach that provides traction on supply chain, procurement function and financial services, to help keep the focus on financial viability for the region.

- 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 Accident Compensation Corporation and the Ministry of Social Development.

### Progress in 2014/15

Numerous benefits have been realised through regional collaboration in 2014/15. These include, but are not limited to:

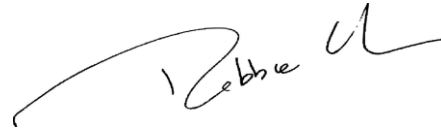
- Maori Health – the fourth Biennial Tū Kaha Central DHB Region Māori Health Development Conference held 29-31 October 2014. This was held to add ‘value to participants in terms of learning and as an opportunity to discuss and be informed of key regional issues’ to be used to help inform regional planning.
- Electives - development of a prioritisation tool for orthopaedic referrals – clinical pathways and assessment tools improve equity of access to appropriate clinical services, reduce waiting times and greater transparency of processes. Efficient utilisation of regional resources supports sustainable service delivery and financial benefits through increased productivity.
- Cancer - the region has consistently met the health target, all patients ready for treatment wait less than four weeks for radiotherapy or chemotherapy. Therefore people are diagnosed quicker with cancer and being offered different treatments as they are surviving longer.
- Cardiac - clinical pathways to address accelerated approaches to chest pain to support a reduction in waiting times for cardiac services, both elective and acute, improved prioritisation and selection of patients for appropriate intervention, the impact of this will be lower morbidity and mortality rates through quicker intervention and treatment.
- Mental Health - Maternal and perinatal service – providing a community service through acute packages of care (APOC) supporting mother and babies in their own environment rather than in acute hospital settings, that is, Care Closer to Home.
- Stroke - development of a regional strategy for transient ischaemic attacks (TIAs) through the rapid assessment and management of stroke to reduce the most common cause of long-term adult disability and death.
- HOP – roll out of Advanced Care Planning (ACP) - the value of ACP is that it gives a person the opportunity to develop and express their preferences for end-of-life care based on their personal views and values, a better understanding of their current and likely future health, and the treatment and care options available to them.
- Diagnostics - development of access criteria for community referrals that are patient-focused of high quality, timely, affordable and therefore sustainable. This ensures timely patient management, improves patient outcomes and achieves greater efficiency across the system.

### Our Future direction

As a Region our relationships have been strengthened through a shared vision of the future state. In 2016/17, we will be in a stronger position to focus on strategic priorities that will address the needs of our population in the Central Region. The emphasis will be on achieving better outcomes for patients, especially around ‘care arrangements’, as this will be the predominant area of focus and supports Care Closer to Home. This work will be supported by the CR-HSP which provides insight and information to strategically guide and systematically plan and prioritise a programme of work, to support clinically-led services that are fiscally accountable.



**Dr Virginia Hope**  
Chair, Capital & Coast DHB



**Debbie Chin, Chief Executive**  
Capital & Coast DHB



**Dr Virginia Hope**  
Chair, Hutt Valley DHB



**Warrick Frater**  
Interim Chief Executive, Hutt Valley DHB



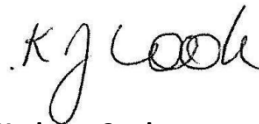
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Chair and Clinical Lead,  
Regional Services Programme



# CENTRAL REGION REGIONAL SERVICE PLAN 2015/16







## Introduction

In the 2015/16 Regional Service Plan (RSP) the Central Region is committed to a focus on equity, access and the clinical and financial sustainability of services.

This focus builds on the successes of regional collaboration and planning to date. The RSP has reached a level of maturity and direction reflected in the Region's commitment to determine priorities and deliver services that provide innovative solutions to address the health needs of our population.

The Region's geography and population of 884,038<sup>1</sup> are key considerations in how services are designed and delivered. The regional strategy considers this as it plans clinical services that are contemporary, are evidence-based and reflect best practice.

The region has 19% of New Zealand's population. Operating within our means in planning and a reliance on regional collaboration are central to the region's approach to the RSP. This underpins recognition by the Region that the 2015/16 RSP can no longer do things as they have been historically done.

The Central Region sets out its expectations in this plan and articulates its 10-15-year vision as follows:

**“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.”**

(Regional Combined Boards' Forum, May 2014)

The Central Region's strategy is based on the following core principles:

<b>Consolidation</b>	Continued focus on key priorities longer term while addressing new, emerging priorities.
<b>Commitment</b>	Regional priorities take precedence over sub-regional priorities/local priorities.
<b>Collaboration</b>	Regional solutions from which the greatest benefit is derived through collaborative efforts and investment

The region's DHBs (district health boards) are committed to better understand the existing barriers for collaboration while they continue to focus on supporting and progressing the regional priorities in. They acknowledge that leadership and resources are key to facilitating these priorities. Clinical leadership is a stated imperative for the Minister of Health.

The following regional priorities were adopted at the Combined DHB Boards' Forum in November 2014:

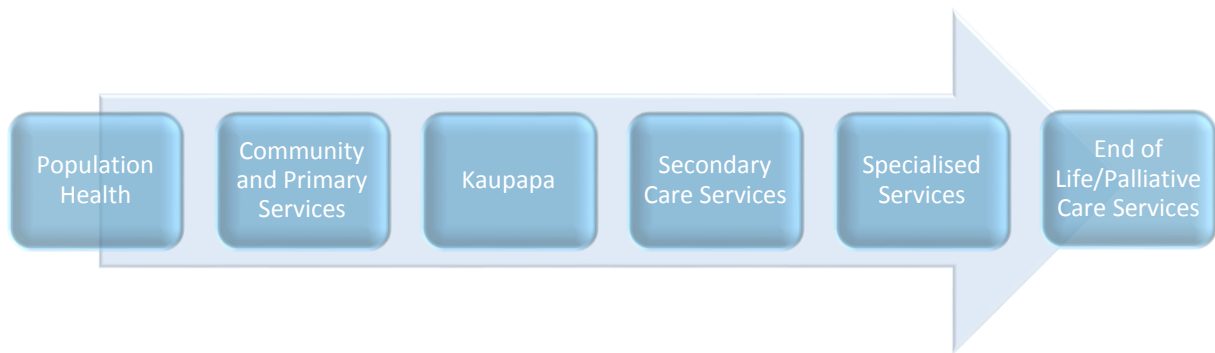
- Progressing Māori health outcomes.

<sup>1</sup> 2013 Population Census, Statistics New Zealand, published October 2014

- Regional information and communications technology (ICT).
- Cross-agency interfaces as an operational principle.
- Sustainability of clinical specialist services and the Health Systems Plan<sup>2</sup> (CR-HSP).
- Health Benefits Limited (HBL)<sup>3</sup> (or successor arrangements).

A whole-of-system, regional approach to planning is depicted in the diagram below. (Note that while it is depicted in a sequential manner there is acknowledgement that this is not a linear journey.)

**Figure 1 Continuum of services across the Central Region**

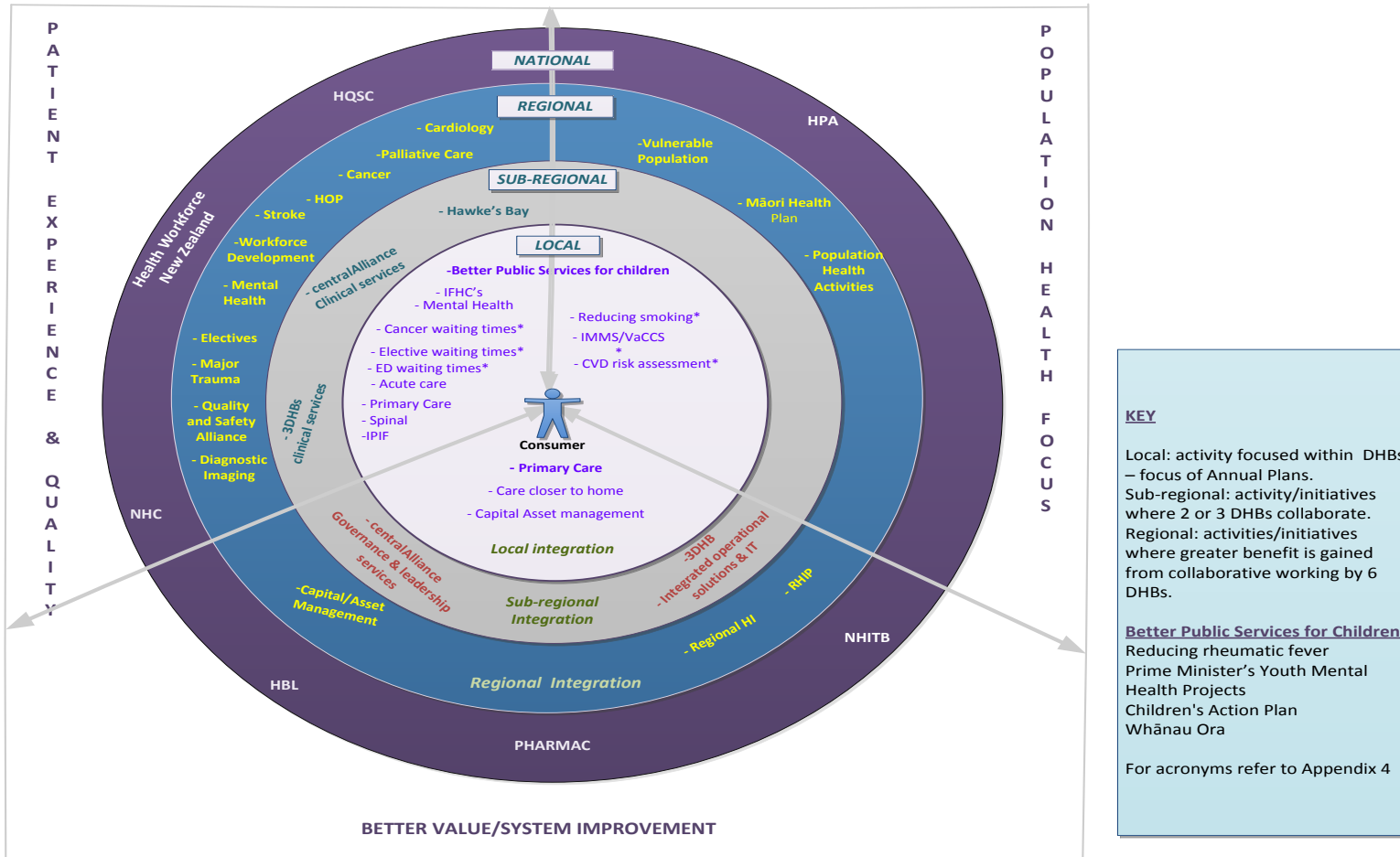


This system-wide view of health service planning and delivery is representative of the collective approaches required to ensure that the various activities and initiatives at the national, regional and DHB (local) levels are aligned. This 'line of sight' provides transparency on how local initiatives and national priorities inform the RSP. The Plan also enhances the view of the health of Māori integration into all health services. Note the links on page 45.

<sup>2</sup> The Health Systems Plan was previously known as the Regional Clinical Services Plan (RSCP)

<sup>3</sup> HBL is being disbanded. It is expected that HBL will be wound down once the appropriate transitional plans have been agreed

Figure 2 Initiative mapping: Line of sight of local, sub regional, regional and national plans



Note the links above, which depict how the line of sight is forged through connections between national, regional and local plans

Co-ordinated by:



## Consolidated achievements from regional commitment and collaboration

The regional planning process has brought a focus on the consolidation of successes to date. There is an expectation that the synergy between the regional, sub-regional and annual plans will reduce duplication and manage risks. Below is a high-level representation of the consolidated approach to achieving intended good patient outcomes for the region.

Figure 3 High-level view of consolidation process that leads to successful outcomes



The RSP draws on partnerships between a range of stakeholders to focus on regional priorities. The success from the consolidated efforts in each portfolio and its network groups can be illustrated below.

Table 1 Summary of consolidated outcomes achieved through collaborative network efforts

Portfolio	Network collaboration	Clinical impact	Patient outcome
Electives	General practitioner (GP) and orthopaedic networks	<ul style="list-style-type: none"> <li>Clinical support to GP</li> <li>Condition-based pathways</li> <li>Prioritisation tool for referrals to first specialist assessments (FSAs) and Community-Based Spine Clinic (CBSC)</li> <li>Development of clinical pathways</li> <li>Review of intervention rates</li> </ul>	<ul style="list-style-type: none"> <li>Earlier recognition and treatment</li> <li>Better management to improve outcomes</li> <li>Earlier access to specialists and reduction in waiting times</li> <li>Reduction in conditions progressing to chronic status or disability</li> <li>Improved care and outcomes to care</li> </ul>

Portfolio	Network collaboration	Clinical impact	Patient outcome
Health of Older People (HOP)	Regional and national networks and reference group input	Development of advanced care plans Multi-interventional approach to polypharmacy (MiAP)	People have the ability to self-determine care proactively More informed community with less risk of drug interactions and incorrect dosing
Cancer Services	Central Cancer Network (CCN) and National Cancer Network	62 days to treatment after suspicion of diagnosis	Earlier access to treatment Reduction in mortality
Cardiac Services	National Cardiac Networks	Completion of clinical care pathways	More responsive services that prevent debilitation and disability
Mental Health and Addictions	Central region Mental Health and Addiction Network (MHAN)	Innovative practice to facilitate a maternal and perinatal service within the local community	Service delivered to support clients close to community supports
Major Trauma	Regional Trauma Network National Trauma Network	Collaborates with other regional trauma services	Improved responses to major trauma and reductions in the risk of death and disability following trauma
Diagnostic Imaging	Regional Radiology Steering Group	Developed regional access criteria	Improved access to radiology in the community
Stroke Services	Clinical regional network Collaborates with other regional networks Collaboration with GP and community ambulance services	Access to organised stroke services Implementation of stroke rehabilitation services Developed a regional TIA (transient ischaemic attack) service	Reductions in mortality and disability following stroke
Quality and safety	Collaboration: Formation of CRQSA representing all DHBs	To be measured	To be measured

Note: Māori health and Quality & Safety consideration is a focus in every action plan, including workforce planning, and it also has its own action plan.

See Section Three – The Consolidated View on page 53 for a more comprehensive view of key successes under each portfolio: Electives, Cardiac Services, HOP, Stroke Services, Diagnostic Imaging, Cancer Services, Workforce, and Mental Health and Addictions.

## 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 2015/16 for Information Technology (IT) and Workforce are outlined in the combined priorities document<sup>4</sup>. Enablers can be incorporated into specific service priorities where applicable. The Central Region CR-HSP and the Capacity and Capability Plan are key drivers to planning, collaboration and the implementation of successful clinical plans.

## Next steps

- The region has committed to regional priorities which will be informed by our successes, which we will continue to consolidate in 2015/16 and link these to national targets and expectations. The region will continue to collaborate with all stakeholders to maximise our combined efforts with partners to achieve improved outcomes for the region's population.
- The region will strengthen the following core activities:
  - Health of Māori by addressing this throughout the RSP as well as ensuring it is linked to each action plan. The RSP 2015/16 keeps a dedicated Māori action plan to keep focus on the Māori objective.
  - The Regional IT (Regional Health Infometrics Plan [RHIP]) activity is a core enabler to facilitate outcomes is achieved in action plans. It also has a committed to an action plan that lays out its schedule for 2015/16.
  - Health system planning (CR-HSP) is a key element in regional planning that will inform and shape the RSP to maintain clinical sustainability and financial viability.
  - Cross-agency engagement is a consistent theme throughout the RSP. This is fundamental to the integration of the action plans as it draws the linkages to other agencies such as ACC and the Ministry of Social Development.
  - HBL (or a successor arrangement) is to continue to provide traction on supply chain, procurement function and financial services, to help keep the focus on financial viability for the region, from collective bargaining power.

<sup>4</sup> See Appendix 1 – Workforce Action Plan on page 121

# SECTION ONE

## STRATEGIC VISION AND OVERVIEW







## Strategic direction for the Central Region

“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.”

(Regional Combined Boards’ Forum, May 2014)

The Central Region’s Strategic Framework is as follows:

Figure 4 Central Region’s strategic framework November 2014



The Minister has advised that a refresh of the New Zealand Health Strategy is required “to provide DHBs and the wider sector with a clear strategic direction and road map for delivery of health services to New Zealanders into the future”. DHBs are encouraged to engage actively in the consultation. Alongside this activity the Minister expects a renewed focus on strategic direction to be evident in DHB annual plans for 2015/16. The Minister, in his Letter of Expectation<sup>5</sup>, has agreed the planning priorities for 2015/16. There is an increased focus on.

- clinical leadership

<sup>5</sup> The Minister’s Letter of Expectation to DHBs November 2014

- an expectation for DHBs to integrate services into the community in 2015/16 to focus on health targets.

Social Sector Trials are included as a cross-agency initiative for DHBs to continue to work with other organisations. This year the Ministry of Health (MoH) has added two priorities:

- Healthy Families NZ.
- Spinal cord impairment.

## Health of Māori

The Central Region is committed to ensuring that a focus on Māori health is woven through all health plans to address health inequalities in our regional work. The Ministry has developed 'Equity of Health Care for Māori: A framework'<sup>6</sup> to align mainstream health services with Māori acceptability criteria and facilitate seamless access to health services by Māori. As the region's DHBs collaborate on how to reduce health inequities, the Regional Māori Health Plans are a source of reference to inform health service planning and delivery; to improve Māori health and reduce outcome disparities by focusing on the key indicators. These health priorities are as follows:

Implementation of the Whānau Ora framework.

Implementation of the Māori Health Workforce Development Plan.

Hold and evaluate Tū Kaha biennial Central Region Māori conference.

Accelerate the performance against the annual Māori Health Plan indicators:

Ambulatory sensitive hospitalisation (ASH) rates.

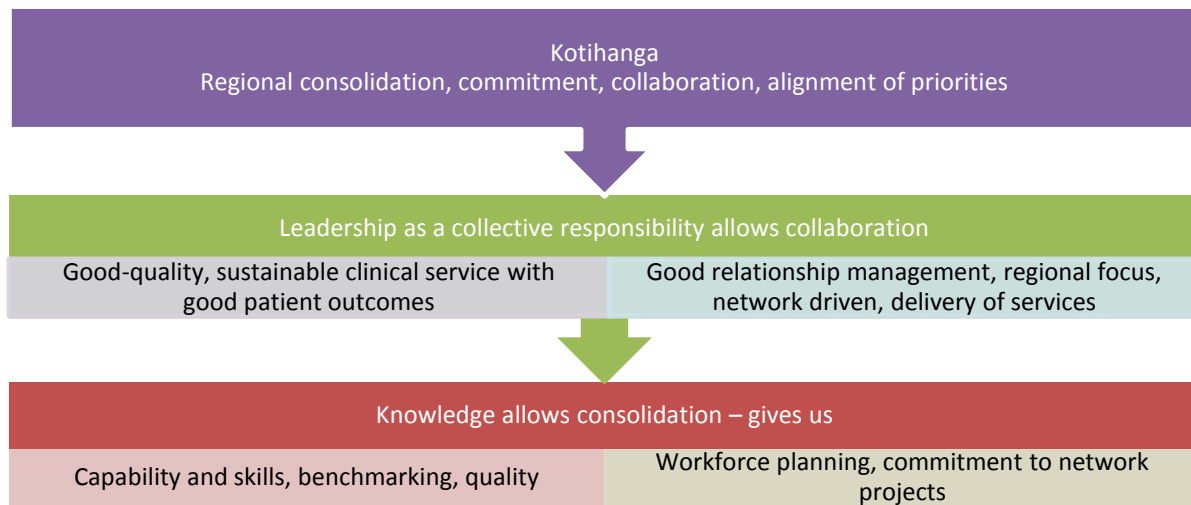
Cardiac.

Diabetes.

In 2015/16 the Central Region will adopt the following approach to support the achievement of the above priorities informed by the application of 'Equity of Health Care for Māori: A framework':

<sup>6</sup> 'Equity of Health Care for Māori: A framework', Ministry of Health, June 2014

**Figure 5 Principles of collaboration, leadership and knowledge**



### *The Central Region’s Outcomes Framework*

The region has taken an approach to consolidate the work in key areas of success. This has been beneficial and the region accepts that more work needs to be done before the full benefits of the collaborative approach to planning services can be realised. An operational ‘Outcomes Framework’ provides a logical framework for achieving our impacts, outcomes and objectives.

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

- New Zealanders live longer, healthier, more independent lives.
- Māori strategy is included seamlessly in all service plans.
- The health system is cost effective and supports a productive economy.
- Integrate clinical and quality focus into primary, community and in-hospital health care sector.

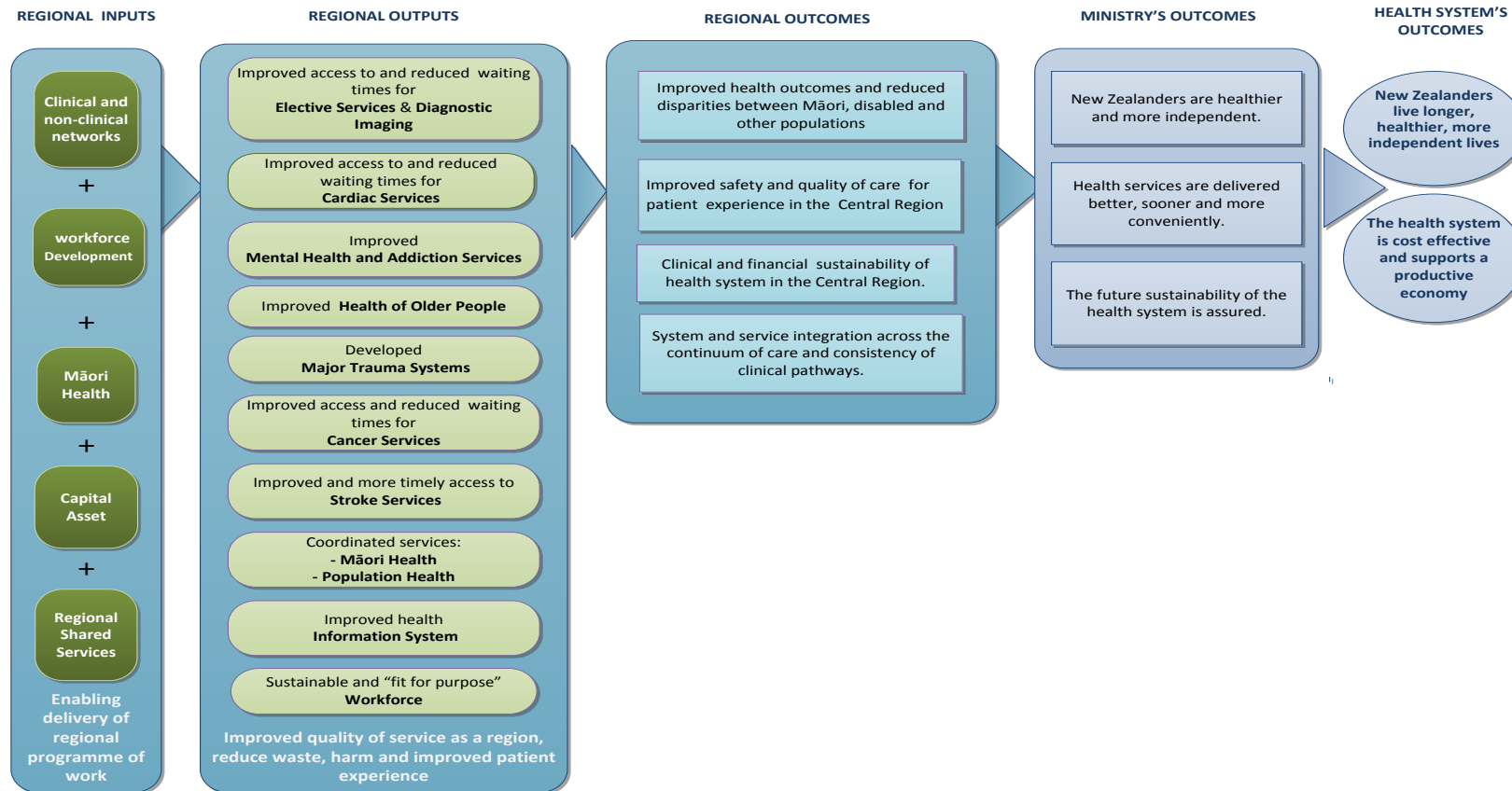
These health outcomes support the achievement of wider Government priorities and are not expected to change significantly in the medium term. The Central Region is weaving the Māori Health Strategy explicitly into this RSP.

Alongside the Outcomes Framework, the Triple Aim<sup>7</sup> principles will provide the Central Region with a mechanism to provide services that are sustainable, meet quality and safety expectations and are delivered within available resources. The achievement of these high-level outcomes, along with the operationally focused, clinically led outcomes across the network, will have real impacts on the lives of the Central Region’s population.

Deliverables that underpin the achievement of these impacts, outcomes and objectives are outlined in the Central Region’s implementation plans.

<sup>7</sup> The Triple Aim approach refers to the MOH quality care model

**CENTRAL REGIONAL OUTCOMES FRAMEWORK**



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

**Figure 6 Outcomes Framework diagram**

Co-ordinated by:



## The Central Region's profile

The Central Region comprises six DHBs configured into DHB alliances:

- MidCentral DHB (MDHB) and Whanganui DHB (WhaDHB) as the centralAlliance.
- Capital & Coast DHB (C&CDHB), Hutt Valley DHB (HVDHB) and Wairarapa DHB (WaiDHB) as the 3DHB alliance.
- Hawke's Bay DHB (HBDHB).

The region spans 39,482 square kilometres, with C&CDHB serving the region's largest population base, that is 7.4 times that of WaiDHB, which serves the region's smallest population. A more detailed population needs analysis is outlined in Appendix 2.

## The Central Region today

There are over 884,038 people in the Central Region – around 20% of the total New Zealand population. Today, about 80% of the people in the Central Region live in cities or major centres.

The Central Region has a strong focus on primary and community care and this is embodied in its adoption of the principles of Tamariki Ora and Whānau Ora.

There are seven public hospitals in the Central Region – Hawke's Bay, Whanganui, Palmerston North, Wairarapa, Hutt Valley, Kenepuru and Wellington. Each of these hospitals offers a range of medical services, such as child health, surgical, rehabilitation and care of the elderly.

Wellington Regional Hospital is the main provider of tertiary services such as cardiothoracic and neurological surgery. Hutt Valley and Palmerston North Hospitals also have specialised services. All DHBs to varying degrees purchase services within and out of the Central Region.

The challenges below require the Central Region DHBs to consolidate the work already underway to meet the health and social issues. We are living longer, but not all of this time is being spent in good health. This RSP highlights closer integration and alliances with key partners in primary care and other government sectors.

The challenges facing the Central Region relate to:

- **Equity:**

The Central Region is committed to building on the progress of the priorities in the 2014/15 RSP, increasingly threading the focus of designing services on a foundation of equitable access. This will ensure that all of the region's inhabitants have opportunities to access high-quality, safe health services. The 'Equity of Health Care for Māori: A framework' strategy is incorporated into a whole-of-system approach to service planning and delivery, from primary care through secondary care and into tertiary care where this is required.

- **Access:**

Criteria for access to services are being developed through networks and in partnership with community and primary health care services. These criteria will ensure a smoother integration of services to improve the patient journey.

The following is a summary of the major challenges driving change in how we deliver care to our population.

- **Demographic changes:**

Our population is ageing. It has been projected that between 2015 and 2025 there will be a 56.5% growth in the population aged 65 to 84 years and a 60.1% growth in the population aged 85-plus years.

- **Epidemiology:**

With longevity people tend to develop one or more long-term conditions that affect their health. In New Zealand, cancer and cardiovascular disease are the leading causes of early death and disability. Mental health disorders are the third-highest cause of health loss and have an impact on younger people.

- **Geography:**

As the population growth is concentrated in urban centres, it is a challenge to provide a full range of services and equitable access to rural populations.

- **Consumer and public expectations:**

Public expectations of health services are changing rapidly. Consumers and families/whānau expect to receive more personalised care, are focused more on quality of care and are often much better informed than they have previously been about their treatment options.

- **Tackling pervasive inequalities:**

The region has a cultural and socially diverse population, and has to address the variations in the life expectancy, mortality rates and health outcomes experienced.

- **Workforce:**

Changes in health needs and challenges in the recruitment of suitably skilled staff place pressure on the sustainability, safety and quality of current service models. Along with an ageing population the health workforce is also ageing, contributing to sustainable and appropriate workforce considerations. Attracting and retaining a younger workforce is difficult.

- **Medical technology:**

Advances in medical technology present opportunities to transform the ways that health services are delivered. These advances need to be viewed against the associated costs to ensure that investment is focused on those solutions that return maximum benefits.

- **The financial environment:**

DHBs in the Central Region operate within funding received from the Government. To maintain and ensure an operational surplus the region is required to collaborate to explore new efficiencies and productivity gains.

### *RSP linkages to primary care*

In the Central Region primary care provided by GPs is organised into groups of primary care practices called Primary Health Organisations (PHOs). In 2013/14 there were 10 PHOs in the Central Region, with the number per DHB being:

- four within C&CDHB<sup>8</sup>
- one within HVDHB<sup>8</sup>
- one within MDHB
- one within HBDHB
- two within WhaDHB<sup>9</sup>
- one within WaiDHB.

The Central Region RSP is not prescriptive in terms of how linkages are formed across the primary health system. However, the following specific linkages exist within current programmes:

**Figure 7 Primary care links into all regional services**



The improvement of Māori health to equitable rates is a combined responsibility. To accelerate improved Māori health outcomes, all services should be planned and co-ordinated within He Korowai Oranga<sup>10</sup> to integrate primary care with community and hospital services. The context for this has

<sup>8</sup> One shared PHO across both C&CDHB and HVDHB  
<sup>9</sup> One PHO that has practices across several DHBs nationally  
<sup>10</sup> Sir Mason Durie developed the He Korowai Oranga model to provide a consistent pathway.

been developed by Professor, Sir Mason Durie, to integrate with primary, community and hospital services. The context is as follows:

Pae Ora            Healthy Futures, which comprises three components.

Mauri Ora        Healthy Lives (energised/positive/invigorated).

Whānau Ora     Healthy Families (knowledge).

Wai Ora           Healthy environments (includes determinants of health, safety and nurturing).

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

The **Community Pharmacy Services Agreement** also has a strong linkage to the integration of pharmacy services. Sub-regional and individual DHB initiatives continue to evolve throughout the region, with a strong focus on integrating care services within communities.



# SECTION TWO

## THE CENTRAL REGION'S RESPONSE





## The Central Region overview

The Minister in his Statement of Intent 2014-2018 outlined the strategic direction for the Ministry. This is articulated as objectives to:

- maintain wellness for longer,
- improve the quality and safety of health services,
- make services more accessible,
- including Care Closer to Home,
- implement Rising to the Challenge,
- support the health of older people,
- make the best use of technology and ensure the security of patients' records,
- strengthen the health and disability workforce and
- support regional and national collaboration.

The Central Region priorities are a response to these objectives. These priorities address, direct and support improvement and the achievement of outcomes.

Progress on the RSP priorities is monitored by the region's DHB Boards at their Regional Combined Boards' Forum. The combined Boards are informed by quarterly reports of progress within the work streams.

The Central Region's response is contained in three core statements that have been developed during collaboration to date:

### 'We Can'

*work effectively together*

### 'We Understand'

*where value can be achieved*

### 'We Deliver'

*targeted support and enablers*

#### **We can** work *effectively* together

The key principles are **consolidation**, **collaboration** and a **commitment** to furthering regional successes. DHBs in the Central Region work effectively together through a concerted focus on:

- the Consolidation of current plans, which is the lynchpin to continuing the momentum gained in prior RSP initiatives whilst keeping traction, entrenching positive outcomes and addressing new, emergent priorities
- a Commitment to continued regional priorities to ensure that access, equity and sustainable clinical services remain the focus in the region. The region has agreed that regional priorities take precedence over sub-regional and local priorities
- Collaboration across the region at primary, community, secondary and tertiary levels, as well as inter-agency collaboration, which are pivotal in addressing regional priorities and deriving and implementing regional solutions.

**We understand** *where value can be achieved*

- The region has gained an understanding of where value can be achieved for our population's health outcomes whilst providing contemporary and sustainable clinical services. The region's population is wide spread and this is further impacted by geography. Access to clinical services need to be planned to ensure they are future proofed, contemporary and sustainable. New Zealanders are demanding a wider range of better-quality services. The principles of the Triple Aim framework are adopted in all service plans to ensure quality of health care delivery to the region's population. Cross-agency and inter-agency collaboration is a key factor in ensuring that services meet public and clinical expectations. Plans developed in this way are informed, balanced and more readily accepted by users.

**We deliver** *targeted support and enablers*

In order that we successfully deliver on the RSP, targeted enablers and support are described as follows.

Capability must be developed to understand and support the regional priorities through:

- **Workforce planning** – a Regional Director of Workforce Development (RDow) manages the workforce issues identified at a local level through the networks and aligns this with national priorities in accordance with Health Workforce New Zealand (HWNZ) guidelines. Strategies and collaboration to attract, retain and train appropriate staff for identified work areas are key priorities of this entity
- **Regional health information** – this assists the region to have systems and information to plan and deliver services. The region is committed to focusing its plans and services on validated information to inform its decisions, plans and services
- **Capacity and capital planning** – this is acknowledged as a foundation for better understanding the needs and cost drivers of the region. Regional negotiation determines where the resources and services are best used to achieve the biggest impacts. The region is planning considerations around capacity in the medium to longer term.

Improvements to patient outcomes are achieved through local and collaborative engagement in health planning and delivery. Clinical leadership and consumer input are imperative in all planning. Services delivered at the right time to the appropriate person in an environment close to home (BSMC - the better, sooner, more convenient approach as per the Ministry). Quality care and contemporary clinical best practice are offered and the adoption of the Triple Aim principles reinforces the regions commitment to providing good safe quality care.

Benchmarking provides the opportunity to produce quality plans and outcomes through modelling and capacity planning to ensure the plans are contemporary and robust.

The six DHB Boards at the November 2014 Forum concluded that they would endorse the following approach to ensure it maintained the momentum and remained focused on achieving the agreed plans and outcomes for the region. This approach takes account of the following when responding:

- The **scale** of the regional response will match the response required to achieve the articulated outcomes.
- The **value** that the region will achieve the RSP objectives for the region, with good clinical outcomes while being fiscally responsible from its focused plans.

- The **capability** that will be inherent in this coordinated effort to galvanise, redistribute and refocus the priorities and resources across the region for mutual benefit.

As the Board members at the forum in November 2014 articulated, “It is viewed as important to ensure that each DHB benefits from the investment of collaborative work to ensure we are achieving outcomes from collective effort”.

### Improving quality and safety

Improving the quality and safety of our health and disability services will lead to greater efficiencies and better value. New Zealanders are demanding a wider range of quality health services. The RSP applies the principles embedded in the Triple Aim (as below) to all its work streams. It has a dedicated programme that is committed to ensuring that the national entity focus is linked at regional and local levels. Inequalities exist in both access to and the quality of health services available across the region. A shared principle and intent for the future configuration of services is to ensure equitable access to high-quality, safe health services across the region.

Figure 8 Triple Aim quality diagram



### Sustainable service models

The region has committed to developing a CR-HSP that will focus on ensuring that primary care and secondary care services will integrate at both the local, regional and national levels within the constraints in which the sector operates. The CR-HSP will develop a framework for tertiary and secondary services, with active clinical engagement that is responsive to improving access and outcomes. Service models need to focus on ‘models of care (MoC), to inform sustainable current and future workforce investment, as well as capital and information.

Changes in service design reflect the changing health needs and population size of the Central Region. In particular, an ageing population, the increasing diversity of need and poorer health outcomes for Māori and Pacific peoples will require new models of care. The region is committed to implementing the Ministry’s ‘Equity of Health Care for Māori: A framework’ throughout service planning and service delivery.

A whole-of-system approach is being led by DHB clinicians and managers to integrate and transform the Central Region health system. Major Trauma<sup>11</sup> is a key piece of work implemented regionally that will support the sub-region and link into national plans to better respond to and manage trauma in New Zealand. This service focus keeps attention on regionally sustainable clinical service provision.

### *Living within our means*

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

All key strategies that affect patients in the region will need to consider the best funding models and mechanisms to support them. The regional, sub-regional and local DHB work programmes for 2015/16 are being more closely aligned with the strategic drivers and intentions set out in this RSP.

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.

### *ICT system - integration and service transformation*

The RHIP in accordance with the National Health IT Board (NHITB) is working towards an integrated regional clinical system that will be available to clinicians in the primary, secondary and tertiary settings. This will facilitate access to seamless clinical records to improve care to patients and enhance their health outcomes. It is anticipated that as information is readily available on demand when a patient is being seen, the opportunity for responsive care with minimal duplication and maximisation of timely care options. The table below outlines some benefits of greater interoperability within the Central Region.

<p><b>Access</b></p> <ul style="list-style-type: none"> <li>• Availability of services</li> <li>• Ability to access services</li> <li>• Consumer participation</li> </ul>	<ul style="list-style-type: none"> <li>• Improved waiting times for diagnostic imaging services</li> <li>• Improved availability of community-based health services</li> <li>• Reduced patient travel time and cost to access services</li> <li>• Increased interpretations by remote specialists</li> <li>• Increased patient participation in home care</li> <li>• Increased patient access to and use of their health records</li> </ul>
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<sup>11</sup> Major Trauma is a key Ministry priority



<p><b>Quality</b></p> <ul style="list-style-type: none"> <li>• Safety</li> <li>• Effectiveness</li> <li>• Appropriateness</li> </ul>	<ul style="list-style-type: none"> <li>• Fewer medical errors</li> <li>• Improved interpretation of diagnostic and laboratory results</li> <li>• Fewer adverse drug events</li> <li>• Fewer prescription errors</li> <li>• Improved prescribing practice</li> <li>• Increased speed and accuracy in detecting infectious disease outbreaks</li> </ul>
<p><b>Productivity</b></p> <ul style="list-style-type: none"> <li>• Efficiency</li> <li>• Care co-ordination</li> </ul>	<ul style="list-style-type: none"> <li>• Increased access to integrated patient information</li> <li>• Fewer duplicate tests and prescriptions</li> <li>• Fewer physician prescription call-backs</li> <li>• Reduced patient and provider travel costs</li> <li>• Improved information management resulting in reduced costs</li> </ul>

### *Building a workforce for the future*

As a region we are committed to strengthening innovation initiatives and adopting and exploring new ways of working while developing a sustainable workforce to meet future health needs. We will achieve this by ensuring that workforce development enables sustainable service delivery. The involvement of the clinical workforce is vital to delivering better frontline health services. This is in addition to their valuable service design and implementation input to clinical care and outcomes. The Ministry has co-opted the expertise of HWNZ<sup>12</sup> to support appropriate workforce planning to ensure sustainable service delivery into the future.

### *Central Region Health Systems Plan (CR-HSP)*

The CR-HSP (previously the RCSP) provides the foundation for planning medium- to long-term clinical services for the Central Region. Health service needs and plans are affected by developments in medical technology, contemporary clinical practice and pharmacology, which are evolving continuously. The CR-HSP in this context must support the longer-term capacity and development of the most appropriate services for the region to best meet the changing and current needs of the region’s population. The CR-HSP provides strategic direction for clinical planning to the region’s DHBs, that identify clinical priorities at their local levels and these feed into the regional priorities. Clinical services, the models of care and clinical pathways are all part of the complex matrix of such services. The CR-HSP provides a platform to guide DHB costing, funding and capacity. It underpins the medium- to longer-term funding plans to ensure the region is able to provide sustainable clinical services.

<sup>12</sup> See Workforce Planning on page 121



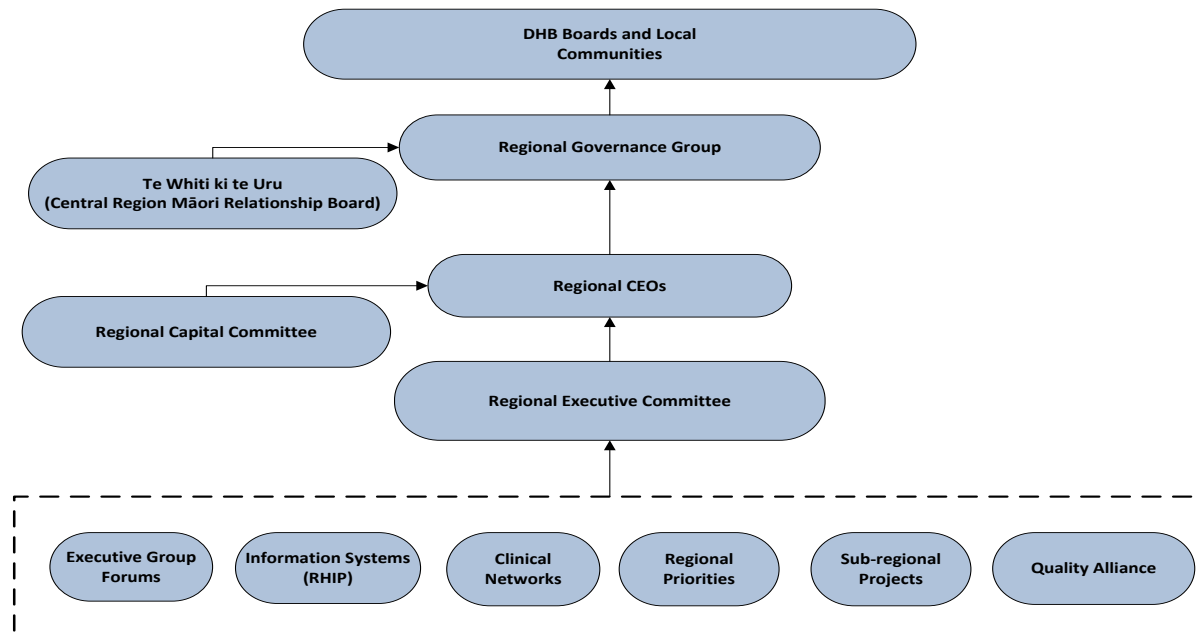
## Capital Planning

Capital Planning is a critical strategic activity and it is important that the signals for required investment are given early; so that there is sufficient time to effectively plan. It is equally important that sufficient time is built in for the critical conversation to ensue.

## Central Region leadership framework

In the Central Region we have made a commitment to ensure that each DHB within the region benefits from the investment in collaborative work to ensure the achievement of outcomes from the collective efforts. The Central Region DHBs' regional governance framework is as per Figure 9.

Figure 9 Central Region leadership framework



## Governance groups

### 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 2015/16 has been clinically led. The development and planning of this RSP have had strong clinical engagement at a regional governance level and have involved clinical networks. This high level of clinical leadership will continue throughout 2015/16. The Regional Combined Boards' Forum in November 2014 concluded that "to move forward Board and staff need to keep working together and this requires leadership at many levels". This



acknowledgement served to reinforce our commitment to providing strong leadership and support for regional and national priorities.

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

**Overview of the four Central Region governance groups that oversee clinical and business service activities.**

Details of the four key governance groups that oversee all clinical and business service activities are set out below.

- **The Regional Governance Group**

This group comprises the Chairs of the six Central Region DHBs and an independent Chair. The key accountabilities are to:

- approve the regional strategy for submission to individual DHBs
- appoint the directors of TAS
- monitor progress and performance against regional plans
- drive the regional collaboration agenda
- act as an escalation point for matters of strategic importance.

**Te Whiti Ki Te Uru (Central Region Māori Relationship Board)**

This regional forum comprises the six Chairs of the Māori Relationship Boards in the Central Region DHBs. The key objectives are to:

- provide advice to the Regional Governance Group on regional priorities for Māori health and provide effective iwi/Māori health leadership
- monitor the progress of agreed Māori health priorities in the RSP
- collaborate and identify synergies within the Central Region
- ensure a common approach to non-TAS issues
- ensure that 'Equity of Health Care for Māori: A framework' is incorporated in all service planning and delivery to maintain seamless mainstream services for Māori.

**The Central Region CEOs**

This group comprises the six CEOs of the Central Region DHBs. The key accountabilities are to:

- recommend the regional strategy to the Regional Governance Group and DHBs
- ensure the alignment of DHB annual plans with the RSP
- implement the agreed strategy
- approve service-level agreements for the work to be done with TAS
- maintain oversight of the delivery of the RSP, including DHB resourcing and roadblock removal.

### Regional Executive Committee (REC)

This group is the overarching executive and clinical leadership committee for the region, reporting to the regional CEOs. It comprises senior management and clinical representatives (including primary care). REC also includes consumer representation from across the region. Its objective is to ensure that the region takes a co-ordinated approach to planning and delivery. The key accountabilities are to

- work with the GMs Planning and Funding to propose strategic priorities, develop the RSP and recommend the RSP for approval to the regional CEOs
- monitor progress against the plan and ensure that appropriate actions are taken to ensure a successful delivery that optimises health outcomes, including the reduction of health disparities. The key accountabilities are to:
  - enhance clinical governance and reporting across all health care settings and services
  - oversee the work of the regional executive groups, working groups and clinical networks
  - review regional proposals and business cases, for example models of care, service changes, infrastructure developments and capital investment and re-investment, and make recommendations to the Regional Capital Committee and regional CEOs
  - implement an effective communication strategy to inform DHB communities, key stakeholder groups and the general public
  - develop and recommend to regional CEOs strategies to address emerging issues with regional impacts
  - negotiate service level agreements with TAS on behalf of the CEOs
  - act as the first point of escalation for issues that cannot be resolved through other fora
  - ensure strong engagement between management and clinicians.

These governance groups are supported by the following:

- **Central Region Quality and Safety Alliance**

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

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

- incorporate quality and safety goals into strategic plans and relevant agreements with health service providers
- promote the direction of quality and safety in line with policy and ensure that it is evidence-based. DHBs need to have aligned quality plans and risk management structures

- provide leadership with the promotion of a safety culture, where open communication is encouraged through the reporting, investigation and resolution of clinical quality and patient safety issues at a regional level. This includes the sharing of learning from adverse events
- provide input to regional planning that aims to improve quality and safety objectives, which includes vulnerable and isolated services
- define a core set of quality and safety measures based on national evidence
- establish an appropriate collection and reporting mechanism
- ensure the sustainability of tertiary services by working with REC to consider how best to deliver regional services safely.

### Regional Capital Committee

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

The Regional Capital Committee comprises the DHB CEOs, Chief Finance Officers and a clinical director to represent the various key stakeholders and the different professional perspectives that they bring to such decision-making. It allows DHBs to explore opportunities and assess priorities for regional capital investment.

The key accountabilities are to

- develop and maintain a 10-year regional capital plan
- engage with the Ministry and the Capital Investment Committee early in the capital planning process
- provide regional scrutiny for individual business cases costing over \$500,000
- ensure that regional benefits have been fully explored for
  - reducing fragmentation and unnecessary duplication
  - reducing variations in quality of care and access
  - preventing local DHB interests taking inappropriate priority over regional or national priorities
  - reducing service vulnerability risks.

### Regional ICT Governance

A Health Informatics Strategic Advisory Group is being established and will provide oversight and governance across regional ICT initiatives. The group will be chaired by the General Manager Health Informatics, TAS and include multi-disciplinary representatives across the health care spectrum.

The role of the group will be to provide leadership and advice on ICT issues to the region's CEOs. Its key tasks will be to:

- ensure resilient ICT service delivery
- ensure that the appropriate system and management controls are in place to protect identifiable patient information from inappropriate access or disclosure

- ensure that new ICT projects are aligned with the National Health IT Board strategy and Central Region's clinical priorities
- prioritise new projects and produce an annual work plan for approval by CEOs as part of the RSP
- report on progress as required
- report quarterly against the annual work plan as part of the RSP quarterly report
- ensure that appropriate actions are taken to address any barriers to regional working areas of underperformance against plan
- develop and implement a communications and clinical engagement strategy.

Regional Health Informatics outlines a strategy to transition towards a regional clinical record spanning primary, secondary and tertiary care. The systems are to be delivered in accordance with the ITHB Plan.

### Clinical networks and regional programmes of work

The Central Region DHBs manage the delivery of the priorities in this RSP through regional programmes of work and clinical networks. Each programme has a steering group, which has representation from the appropriate functional disciplines in order to provide advice to the business owner and programme manager.

A regional consumer network is being developed to provide proactive consumer input into regional planning and service development.

**Links of regional priorities within RSP Table 2 Illustrates priority linkage within the RSP**

Regional Priorities	Linkages of the priorities to RSP
<b>ICT</b>	Dedicated action plan Appendix 1 on pg. 57 and linked to all action plans as an enabler Executive summary priorities and next steps diagram pg. 22, Section One pg. 23, Regional ICT governance pg. 43, the Regional portfolio analysis pg. 152, Appendix 3
<b>Māori health</b> is woven throughout plan	<b>Executive summary</b> pg. 15, Kaupapa pg. 18 <b>Section One – Health of Māori</b> pg. 26/27, Outcomes Framework pg.28, Tamariki Ora and Whānau Ora pg. 31, linkage to primary care He Korowai Oranga pg. 32 <b>Section Two</b> – Implicit, specific mention of ‘Equity of Health Care for Māori: A framework’ pg. 37 <b>Section Three</b> – Implicit linking of the priorities as referenced in every action plan including specifically; Cancer Services pg. 69, Mental Health and Addictions pg. 93 and Workforce pg.121 and a dedicated action plan Appendix 1 pg. 57; governance group pg.40
<b>CR-HSP</b> – sustainable specialist clinical services	Executive summary priorities and next steps pg. 17 and pg. 22 RSP Section One sustainable service model pg. 39
<b>Cross-agency work</b>	Implicit in the document through network groups
<b>HBL</b>	Executive summary, Section One, Section Two, Regional Governance Group governance – oversees priorities, work of national entities and Section Three





# SECTION THREE THE CONSOLIDATED VIEW





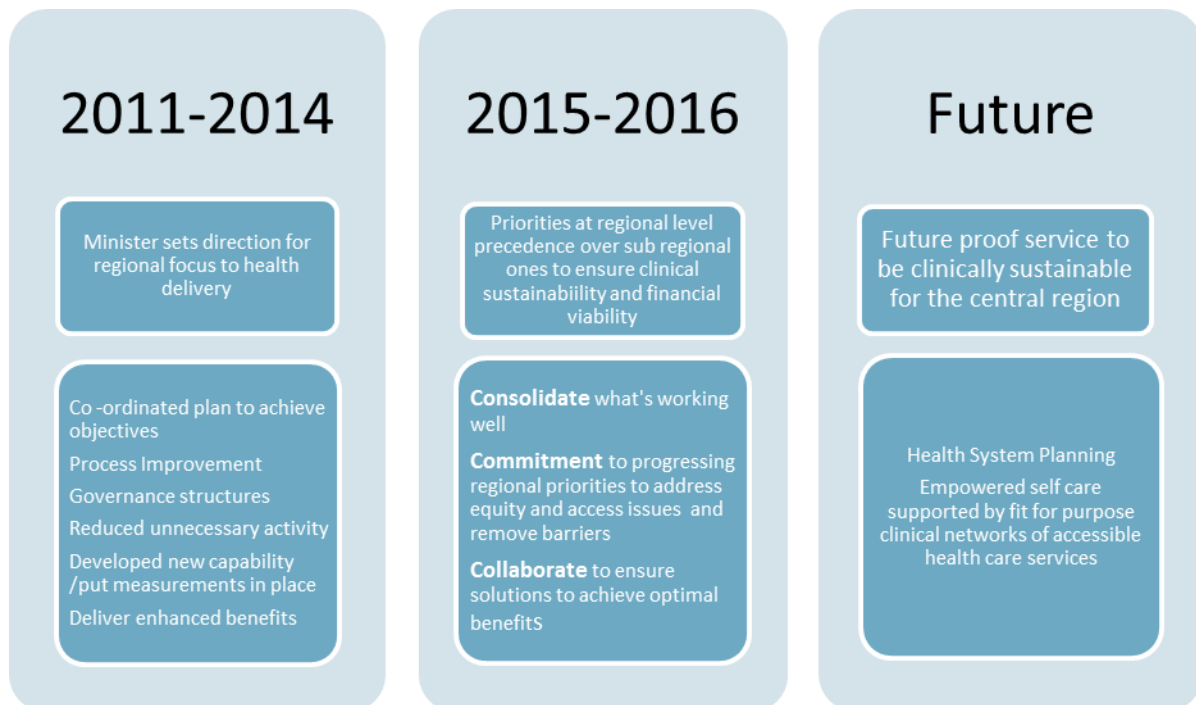


## The RSP 2015/16

The 2015/16 RSP plots the Central Region’s journey over a period of five years. In the 2015/16 RSP the focus is on consolidating the initiatives to strengthen services and building on them to work on increasingly positioning the region to achieve clinical sustainability and become financially viable.

The roadmap summarises the Central Region RSP from the initial phases to the current phase and into the future. The focus is on joining up the region’s clinicians, clinical systems and pathways to become a more regionally integrated health system. The roadmap has an outcome focus. Four key principles flow across the timeline, namely that in everything we do we aim to ensure equity of access, maintain clinical and financial sustainability, ensure consumer participation and ensure clinical engagement.

Figure 10 The Central Region roadmap

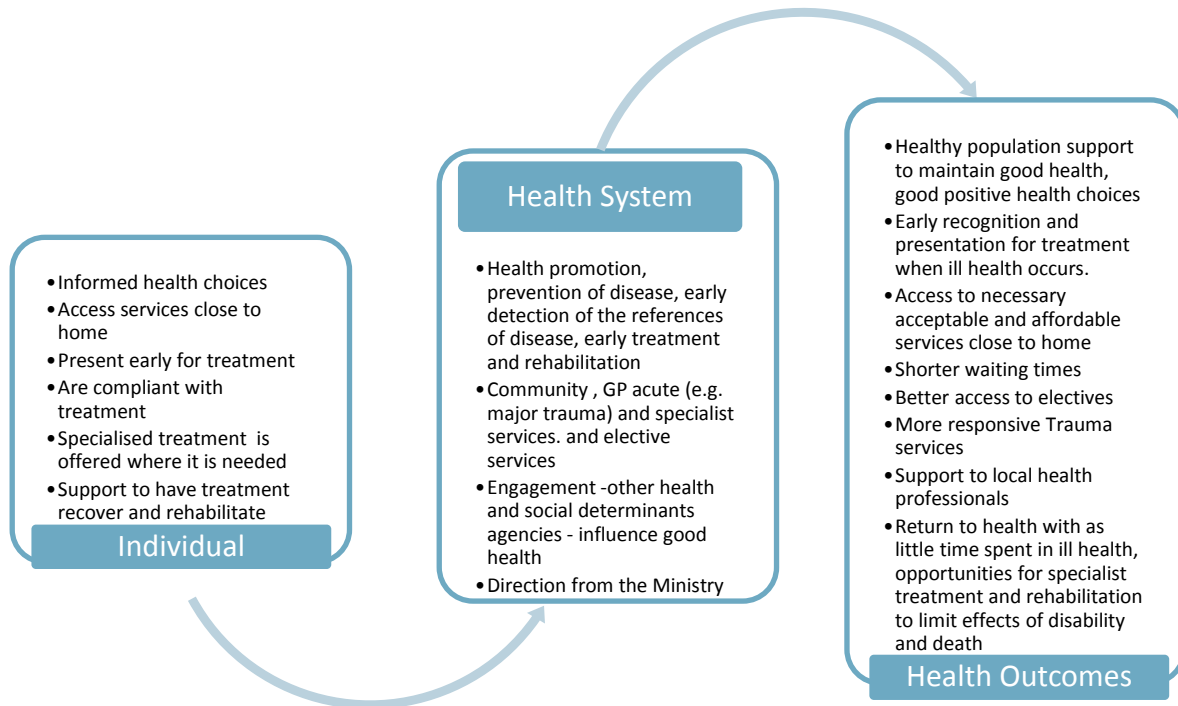


The RSP outlines how the six DHBs will work collaboratively in the alliances they have formed to achieve their priorities in 2015/16. The six DHB Boards consider, monitor and evaluate these priorities when they meet at their regional forum. Updates from quarterly reports are provided on the work streams.

### Process outline to achieve 2015/16 priorities

The Central Region acknowledges in its planning the complex interdependencies that exist in the interface between the individual and the health system to affect positive health outcomes, as illustrated in the diagram below. This focus is reflected in the regional priorities.

Figure 11 Interdependencies between individual, the health system and health outcomes



The priorities for 2015/16 are organised into four distinct portfolios that contain our action plans, which are informed by national expectations, the Minister of Health’s letter of expectation 2015/16 and the health needs assessment.

Table 3 Summary of portfolios and key objectives and deliverables

Implementation programmes – summary		
<ul style="list-style-type: none"> <li>Population health focus – includes plans focusing on population health and vulnerable populations within our communities</li> </ul>		
Portfolio	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		

Portfolio	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		
Portfolio	Key objective	Key Deliverable
Electives	Meet the Ministry's health targets	Reduce the waiting time to below four months
Major Trauma	Develop a regional response	Improve outcomes of major trauma
Diagnostic Imaging	Provide a regional service	Implement a picture, archiving and communication system (PACS) and radiology information system (RIS)
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

Note: Māori health care is an overarching consideration in all planning.

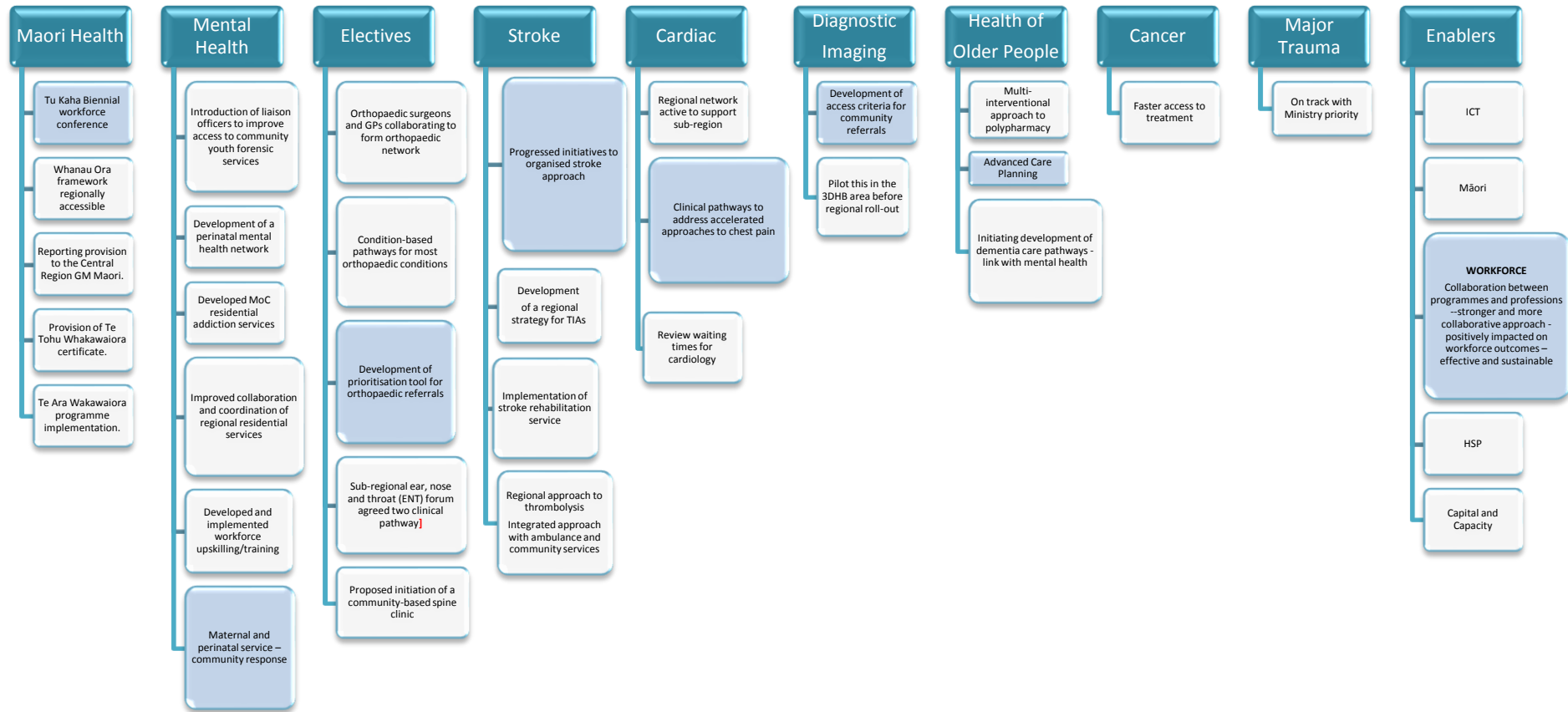
## *In Summary*

The RSP has proved to be the best option for the Central Region to position itself to offer safe, contemporary and quality clinical services. The region acknowledges that no DHB can operate in isolation or independently of each other if it is to offer equitable services to all of the Region's population. In order for the Region to remain clinically sustainable and financially viable all the DHBs must collaborate and make decisions that will offer the best opportunity to deliver these prioritised services.

At the combined DHB Boards Forum it was clear that while the RSP model has not as yet yielded all the benefits anticipated, it is on track to do so. This is evidenced by the commitment to regional work as its main focus. The ability to work together for collective good is the best way for the region to remain positioned to serve its people. The action plans are now more streamlined to prioritise those activities it can and needs to progress for sustainable and equitable services.



**Figure 12 the consolidated results of RSP collaboration by project**





# APPENDICES







## Appendix 1: Implementation of Action Plans

### *Central Region implementation plans 2015/16*

The following action plans focus on outlining the specific tangible and measurable actions to be undertaken in 2015/16 to deliver on identified service priorities and targets. Each plan outlines the context in which the work is developed, and the commitments included in the DHB annual plans contribute to the success of the regional plan. The region is establishing baseline data parameters for key work streams. This will enable the region to monitor changes in service performance and outcomes.

### *Index of Key Actions*

<b>Pages</b>	<b>Programme</b>	<b>Sponsors</b>
59	Health of Older People (HOP)	Julie Patterson
66	Māori Health	Julie Patterson
69	Cancer Services	Debbie Chin
80	Cardiac Services	Debbie Chin
87	Stroke Services	Kathryn Cook
93	Mental Health and Addictions	Julie Patterson
103	Electives	Kevin Snee
110	Hepatitis C	TBC
111	Major Trauma	Debbie Chin
115	Diagnostic Imaging	TBC
121	Workforce	TBC
129	Quality and Safety	Julie Patterson
132	Information Technology	Kathryn Cook
136	Capital Investment Approach	Julie Patterson



## Vulnerable Population

### 1. Health of Older People (HOP)

Sponsor Julie Patterson

Between 2014 and 2024 the Central Region population is expected to grow by 6% to approximately 935,315. The age group 65-84 years is expected to grow by 35% across the region and represents an increase of approximately 42,093 people. The 85-plus age group is projected to increase by 34% (5,718 people).

The 'Burden-of-disease' study<sup>13</sup> estimates how much healthy life is lost due to early death, illness and disability. Older people (65-plus years) sustain over one-third (37%) of the total health loss despite making up only 12% of the population. Different conditions contribute to health loss at different life stages. For those aged 65-74 years, cancers (29%) and vascular disorders (24%) remain leading causes of health loss, followed by musculoskeletal conditions (11%). For older adults (75-plus years) vascular disorders (35%) overtake cancers (18%) as the leading cause of health loss, with neurological conditions ranked third (10%).

The implication of this burden-of-disease study is that we are living longer, but not all of this time is spent in good health. The prevalence of frailty (older adults who have an increased risk of poor health outcomes including falls, skin fragility, incident disability, hospitalisation and mortality) will increase as the population ages. There is a need to increase the range and volume of interventions to manage frailty and disease-specific states aimed at keeping people well for longer.

However, 87% of older adults (65-plus years) are at home and not receiving any DHB-funded support services. Of those receiving DHB-funded support, 5% are in aged residential care and 9% are supported at home.

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.

Complex levels of integrated care are not indicated for all older people, but are required for certain sub-groups. The degree of integration is dependent on the needs of the target population. As older people's health needs change they will move between levels of care. The identification of the different needs of people is critical to ensuring they are cared for within appropriate levels of service delivery. In the next three years the Central Region will focus on the needs of those aged 75 years and older whose changing health status usually requires higher levels of service integration.

A health system that functions well for HOP is one that

<sup>13</sup> Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006-2016 (MoH, 2013)

- protects vulnerable older people
- provides choice and partners with older people and their families/whānau in their care decisions
- provides clear information and supports health literacy, self-management and person-centred care
- provides care that does not increase an older person's dependence
- is integrated around the older person to improve their overall quality of life
- supports the workforce to deliver the right service at the right time
- has consistent systems to support service planning, patient care and patient choice.

### *Strategic direction changes from the 2014/15 RSP*

At its 23 October 2014 meeting, the HOP Network decided to place the 'Specialist Health of Older People Workforce Capacity' project on hold. This will ensure that some of the stages of the 'Regional Clinical Services Plan' (or CR-HSP as it is now known) project are sufficiently developed to inform future work in this area. The HOP Network also noted the future national focus on the workforce in aged residential care and home and community support services. The HOP Network will monitor these other pieces of work and will re-evaluate its position as necessary.

### *To achieve the following outcomes*

#### **Regional objectives HOP**

- The focus for 2015/16 is to:
  - continue to provide support for and overview the development and implementation of DHB dementia care pathways following the New Zealand Framework for Dementia Care
  - develop regional components of the dementia care pathways and share learning and resources across the region
  - improve awareness and responsiveness in primary health care, working in partnership with the dementia sector and PHOs
  - provide representation at a national level when requested by MoH to provide an overview of the DHB development and implementation of dementia care pathways and share learning and ideas nationally
  - collaborate with Canterbury DHB (as lead) to implement a regional response to new funding for 'Walking in Another's Shoes'
  - contribute nationally, regionally and locally to support the implementation of 'Advance Care Planning – A Framework for the Central Region'
  - increase workforce capabilities in addressing the issue of polypharmacy to reduce the likelihood of older adults experiencing adverse events related to medicines
  - purposefully collaborate to ensure that regional and cross-sector opportunities for improvement are identified and supported

**Regional milestones and measures**

Quarterly reporting of progress on the key milestones in the RSP via the National Health Board accountability framework.

## Dementia

### Clinical Lead: TBC

The Central Region DHBs, under the governance of the Health of Older People (HOP) Network, will progress the development of local Dementia Pathways to meet the expectations outlined in the New Zealand Framework for Dementia Care 2013. This will be supported by the Regional Dementia Pathways Reference Group (RDPRG), which will act as the Central Region conduit for dementia pathway development and support regional implementation through collaboration and the escalation of local innovations.

RDPRG includes a wide range of expertise, providing an inclusive forum where members discuss strategic and operational issues associated with dementia pathways and identify opportunities for improvement, with the aim of supporting the Central Region's response to the framework.

A regional stocktake against the New Zealand Framework for Dementia Care 2013 will be complete by 30 June 2015. This will inform the components of dementia care pathways that are best achieved at a regional level.

Key actions	Milestone/Measurement	Clinical lead
Identify and develop regional components of the dementia care pathways that are best achieved at a regional level and share learning and resources across the region	Three components of dementia care pathways that are best achieved at a regional level are identified (September 2015)  Two components of dementia care pathways are developed at a regional level ( March 2016)	HOP Portfolio Managers RDPRG
Develop and commence delivery of dementia awareness and responsiveness education programmes for primary health care clinicians to improve awareness and responsiveness in primary health care	Develop a regionally consistent survey that measures primary care understanding of dementia diagnosis and management (October 2015)  Report on survey results regionally and to Ministry (June 2016)	HBDHB RDPRG
Collaborate with Canterbury DHB (as lead) to implement a regional response to new 'one-off' funding for 'Walking in Another's Shoes'	Develop regional response to new funding (December 2015)  Provide reporting data (as requested) to Canterbury DHB (June 2016)	HOP Portfolio Managers and HOP Network

## Advance Care Planning

Advance Care Planning (ACP) assists in the provision of quality health care and is becoming increasingly important due to the growing range of health treatment options available and the enhanced recognition of shared decision-making. The value of ACP is that it gives a person the opportunity to develop and express their preferences for end-of-life care based on their personal views and values, a better understanding of their current and likely future health, and the treatment and care options available to them.

In 2013/14 an ACP project team produced 'Advance Care Planning – A Framework for the Central Region'. The implementation of quality improvements identified in this framework will be supported by a Regional ACP Reference Group (RACPRG) with governance from the HOP Network.

RACPRG will support the strategic direction and regional implementation of the quality improvements identified in the ACP framework. It will foster the sharing of ideas and innovations and the dissemination of policies, guidelines, clinical pathways and resources to facilitate the growth of ACP across the region in a co-ordinated approach.

Key actions	Milestone/Measurement	Clinical lead
RACPRG will support regional ACP implementation in line with the Central Region's ACP framework	<p>ACP is integrated into clinical pathways, such as dementia pathways (June 2016)</p> <p>RACPRG will attend or teleconference with the National ACP Co-operative on ACP implementation in the Central Region (December 2015)</p> <p>RACPRG will act as a conduit to the National ACP Round Table representing the views of the Central Region (December 2015)</p> <p>Identify ACP activity that could be collected to inform a regional dashboard or outcome measures (March 2016)</p> <p>Report to the HOP Network and the Regional Executive Committee (REC) on progress against 'Advance Care Planning – A Framework for the Central Region' (June 2016)</p>	RACPRG
Level 1 ACP training is prioritised in DHB training plans as it builds capacity and capability to engage in ACP conversations	Level 1 training modules are promoted, as evidenced by 60 new Level 1 certificates (June 2016)	RACPRG Regional leads for the CMO group, DON group and DAH group

## Polypharmacy

Older people have a higher incidence than younger people of chronic health conditions. The use of multiple drugs is an accepted aspect of practice for common chronic conditions such as hypertension and diabetes. However, older adults on multiple medications are at high risk of drug-related problems because of complex drug regimes and physiological changes associated with ageing. Polypharmacy, particularly if it includes psychotropic medications, is an important risk factor for falls, increasing the risk by around 50%<sup>14</sup>. Polypharmacy causes significant preventable mortality and morbidity.

The regional delivery of master classes provides the opportunity to train a relatively large and targeted number of health professionals from multiple points in the system, at the same time raising awareness and capabilities in addressing the issue of polypharmacy.

### Polypharmacy – 2015/16

Key actions	Milestone/Measurement	Clinical lead
Evaluate quantitative and qualitative benefits of regional delivery of master classes in polypharmacy	Identification of benefits and evaluation (July – October 2015) Report prepared for REC (November 2015) Findings and future recommendations presented to REC (December 2015)	HOP Network

## Regional collaboration

Health care has not always been recognised as a team sport, as we have recently come to think of it. In the ‘good old days’, people were cared for by one all-knowing doctor who lived in the community, visited their homes and was available to attend to their needs at any time of the day or night. If nursing care were needed, it was often provided by family members or, in the case of a family of means, by a private duty nurse who ‘lived in’. Although this conveyed elements of teamwork, health care has changed enormously since then and the pace has quickened even more dramatically in the past 20 years<sup>15</sup>.

Teamwork or collaboration is critical to the success of health care services. Regional collaboration provides health professionals and managers with the opportunity to work in partnership with their peers, share opinions, and exchange clinical data to ensure that better patient outcomes are delivered equitably within a fiscally constrained environment.

<sup>14</sup> Boyle N, Naganathan V, Cumming RG. Medication and falls: risk and optimization. *Clin Geriatr Med* 2010;26:583-605

<sup>15</sup> Mitchell P, Wynia M, Golden R et al. Core Principles and Values of Effective Team-Based Health Care. Institute of Medicine. October 2012

*Regional collaboration – 2015/16*

Key actions	Milestone/Measurement	Clinical lead
Establish regional dashboard for HOP utilising InterRAI data to support the development of clinical pathways and cross-sector engagement	<p>Define population of interest utilising annual HOP Portfolio Managers' benchmarking to support decision-making and 'Equity of Health Care for Māori: A framework' (September 2015)</p> <p>Confirm acceptability to collect information on cognitive performance scores, social isolation, falls and nutrition (September 2015)</p> <p>Identify regional resource to support regional dashboard development and reporting (October 2015)</p> <p>Determine and report on the value of dashboard in supporting the development of regional opportunities or principles for supporting frail elderly and those in the last two years of life (June 2016)</p>	HOP Portfolio Managers HOP Network InterRAI System Clinicians
Identify local service innovations in HOP that support frail elderly and the last two years of life and consider suitability to be scaled up across the region	<p>Confirm regional definition of frailty (September 2015)</p> <p>Explore strategies to identify the last two years of a patient's life (March 2016)</p> <p>Stocktake of local service innovations that have the potential for regional deployment supporting the frail elderly and the last two years of life (August 2016)</p> <p>Present stocktake findings to the HOP Portfolio Managers, HOP Network and other relevant networks as indicated to better integrate services in this identified period of health care (December 2016)</p>	HOP Portfolio Managers HOP Network Regional Palliative Care Network



Key actions	Milestone/Measurement	Clinical lead
Establish regular engagement opportunities with ACC to identify where the Central Region can collaborate to support wellness in older people	<p>ACC to join the HOP Network quarterly to update on cross-sector priorities and operational opportunities for innovation (September 2015)</p> <p>Central Region to provide subject matter experts to ACC (as requested) to support the cross-agency work programme (June 2016)</p>	HOP Portfolio Managers and HOP Network

### Linkages to other work programmes

Dementia	Advance Care Planning
Regional Workforce Development Hub Dementia behaviour support advice role Mental Health and Addictions Network RACPRG	Regional Workforce Development Hub Regional ICT RDPRG National ACP Co-operative National ACP Round Table Regional collaboration project team

Polypharmacy	Regional collaboration
Regional Workforce Development Hub	Regional and national InterRAI teams Cross-sector priority work at MoH RACPRG 'Equity for Health Care for Māori: A framework'

### High-level actions 2016-2018

Continue to implement the regional components of dementia pathways.

Utilise the dashboard approach to support regional planning for frail elderly and those in the last two years of life.

## 2. Māori Health

### Sponsor Julie Patterson

As part of the Ministry's initiative to ensure that equity and access to services for Māori are facilitated by making all services responsive to the needs of Māori, the region is being innovative and exploring how to bring service provision closer to local communities.

Māori have poorer health outcomes, live shorter lives and have higher rates of chronic disease (such as cardiovascular disease and respiratory diseases) than the general population. There is a growing body of evidence showing that lower access rates to health services for Māori are contributing factors to the inequities in outcomes. Improving access to services will lead to a reduction in the health inequities between Māori and the general population. The Central Region's overarching strategic 'Regional Māori Health Plan, Tū Ora'<sup>16</sup> includes indicators to enable a measurement of the Central Region's progress in improving Māori health and reducing inequalities. In addition the Central Region led the development of a national-based tool for monitoring Māori health progress against the Māori Health Annual Plan indicators. This has enabled DHBs to better plan and monitor progress. The non-performance of particular indicators is managed through the newly developed Te Ara Whakawaiaora programme currently being rolled out across DHBs. This is a performance process established for executives and boards to better manage inequity and outcomes for Māori health.

The Central Region's vision is for an integrated primary health care system that is responsive to the needs of Māori. This will assist Māori to participate in easily accessible local primary health care services that improve their health. This integration is consistent with the Whānau Ora policy and is an approach that places whānau at the centre of service delivery. It requires the health sector to work in a more seamless way across sectors with expects of improved outcomes and results for New Zealand whānau. A National Whānau Ora Framework has been endorsed by the General Managers (GMs) Māori health group Tumu Whakarae and is essential for the Central Region's DHBs to maximise opportunities to align and progress initiatives across the region.

### Regional objectives

The Central Region DHBs will continue to work with iwi to improve Māori health by reducing health disparities among Māori. We will.

- ensure that Māori participate in and contribute to strategies for Māori health improvement
- foster the development of Māori capacity for participating in the health and disability sector
- continue to provide for the needs of Māori, providing relevant information to Māori for the purposes above
- reduce health inequalities, which will remain a core focus of our regional work, ensuring that our DHBs consolidate resources and understanding of how to reduce health inequalities, and implement monitoring to ensure that a focus is sustained on health inequalities at all organisational levels

<sup>16</sup> The Central Region's Māori Health Plan

The Māori health programme is sponsored by Julie Patterson (Chief Executive Officer [CEO], WhaDHB) and by the GMs Māori, Directors of Māori health and advisors for Central Region Māori Managers (CRMM). Oversight and governance are provided by Te Whiti Ki Te Uru<sup>17</sup>, a governance body made up of Chairs of Māori Relationship and Partnership Boards.

### Regional milestones and measures

Implement the Whānau Ora Framework – measured through quarterly reporting and feedback

Implement the Māori Health Workforce Development Plan – measured through quarterly reporting and feedback

Accelerate performance regionally against the annual Regional Māori Health Plan indicators –measured through quarterly reporting

*Executive lead: Steph Turner (Chair, CRMM)*

*Key actions – 2014/15*

Key actions	Milestone/Measurement	Clinical lead
Child health Work collaboratively to improve regional performance in annual Regional Māori Health Plan indicator areas relating to child health Work together to improve child health for Māori in the areas of immunisation, breastfeeding, ASH rates, sudden unexpected death of an infant and oral health	Health priorities of <ul style="list-style-type: none"> <li>• immunisation</li> <li>• breastfeeding</li> <li>• ambulatory sensitive hospitalisation rates (ASH)</li> <li>• oral health</li> <li>• identifying regional child health priorities</li> </ul>	DHBs
Implement the Central Region Māori Health Workforce Development Plan	Consolidation and evaluation of Whānau Ora Framework by 30 June 2016	DHBs
Annual Regional Māori Health Plan indicator performance Implement quarterly reporting against the annual Regional Māori Health Plan indicators Share best practice and innovation from high performers	Develop and successfully implement best practice for quarterly reporting of regional Māori indicators – report by 30 June 2016	With Central Region's Technical Advisory Services Limited (TAS)
Whānau Ora	Implement the Central Region Whānau Ora	DHBs

<sup>17</sup> The Central Region's Māori Relationship Board on page 41

Key actions	Milestone/Measurement	Clinical lead
<ul style="list-style-type: none"> <li>Implement regional Whānau Ora Framework</li> <li>Proactive support of Whānau Ora provider collectives</li> </ul>	Framework and Action Plan Ora Framework June 2016 Connection to child health	

### Linkages to other work programmes

Workforce	
Work in partnership with Regional Workforce Development Hub Strengthen the Nurse Entry to Practice (NETP) process for Māori recruitment Implement the Regional Māori Capability Framework	Development of region-wide Māori Cultural Training Programme to assist a better understanding and consideration of Māori health care amongst professionals

Information Technology	
Central repository website for base information Create intelligence about Whānau Ora advancement in the Central Region Create intelligence about Māori health workforce development advancement in the Central Region	Create intelligence about accelerating annual Regional Māori Health Plan indicator performance in Central Region A central repository information system is maintained, ensuring that all documents remain up to date

Child health	
Focus on child health priorities: <ul style="list-style-type: none"> <li>Immunisation</li> <li>Breastfeeding</li> <li>ASH</li> <li>Oral health</li> </ul>	Engage in best practice and shared learning in indicators

## Managing long-term conditions – regional and national priority

### 3. Cancer Services

#### Sponsor Debbie Chin

Care Closer to Home 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:

- cancer is the country's leading cause of death (29.8%)
- cancer is a major cause of hospitalisation and a significant driver of cancer cost
- while the overall 'risk' of developing cancer in New Zealand is decreasing, the number of people developing cancer is increasing mainly because of population growth and ageing. The number of cancer registrations is projected to increase annually by 2.6% from 2006-2016
- cancer continues to have inequalities with higher Māori incidence (20% greater), higher Māori mortality (80% higher) and Māori are more likely than non-Māori to have their cancer detected at a later stage of disease spread
- there are wide variations in survival rates between DHBs in New Zealand. Although both Māori and non-Māori showed an increase in survival over time (1994-2009), only the non-Māori change was statistically significant. For Māori the only tumour site to show a significant improvement in survival was cancer of the breast
- residents of more socioeconomically deprived areas are more likely to develop cancer, less likely to have their cancer detected early, and have poorer survival than residents of less deprived areas
- once people are diagnosed with cancer they are now less likely to die from it. This means that people are surviving longer, and being treated for longer periods of time, with different treatments.

#### Key achievements since July 2014

- The region has consistently met the Health Target: All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.
- Faster cancer treatment indicators have been reported quarterly since Quarter 3 2012/13. Regional results for Quarter 2 2014/15:
  - 69% of patients referred urgently with high suspicion of cancer who receives their first cancer treatment (or other management) within 62 days from date of referral.
  - 83% 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.

- Development of the first annual regional Cancer Centre Development Plan, aligned to relevant national plans. Implementation activities include:
  - Wellington Blood and Cancer Centre (WBCC) delivering the Ambulatory Care Programme of work across C&CDHB/HVDHB/WaiDHB
  - Regional Cancer Treatment Service (RCTS) implementing chemotherapy e-prescribing
- Review of services against the Lung, Gynaecological and Breast national tumour standards
- Colonoscopy service improvement including:
  - Implementation of the Global Rating Scale (GRS) quality processes
  - HBDHB/MDHB/HVDHB/WaiDHB implementation of ProVation (Endoscopy Reporting System)
  - Delivery of Ministry funded additional colonoscopy volumes and regional colonoscopy planning projects to support sustainable colonoscopy services
- Continued implementation of the new Cancer Nurse Co-ordinator roles
- Continued development of Multi-disciplinary Meetings (MDM) to increase patient access to an MDM opinion
- Delivery of nine projects across the region supported by Ministry Faster Cancer Treatment (FCT) funding to improve waiting times and to meet the new tumour standards
- Development of a strategic approach to supporting FCT in primary care

This programme of work will be led within the region by a lead CEO and facilitated and co-ordinated by Central Cancer Network (CCN). To note, CCN also covers Taranaki DHB for the purposes of cancer services due to the range/volume of tertiary services provided for their patients in the Central Region.

*To achieve the following outcomes*

### Regional objectives

Implementing the priorities of the National Cancer Programme remains the focus for regional planning. In particular to improve

- equity of access to cancer services
- timeliness of services across the whole cancer pathway
- the quality of cancer services delivered.

### Regional milestones and measures

#### Milestones

- Regional Cancer Centre Development Plan updated by July 2015 and implemented by June 2016
- Regional process for Round 2 of Ministry funded FCT request for proposal (RFP) completed by May

**Regional milestones and measures**

2015 and successful projects commenced by Oct 2015

- Service reviews against two more national tumours standards completed by June 2016
- Priority initiatives identified from service review against the bowel, lung, gynaecological and breast national tumour standard implemented by June 2016
- DHBs meeting the FCT cancer health target by July 2016
- Phase 1 implementation of the FCT in primary care strategy by June 2016
- Implementation of newly funded supportive care positions in DHBs by June 2016
- Ministry funded quality decision making recommendations implemented in DHBs by Jun 2016
- Service changes identified in the sub-regional colonoscopy service plans implemented by Jun 2016
- Integrated palliative care initiatives identified and implemented by June 2016

**Measures**

- All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy, reported monthly (PP30)
- FCT Indicators reported against monthly :
  - Cancer Health Target: 85 % of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) to be achieved by July 2016.
  - Percentage of patients (by DHB and ethnicity) with confirmed diagnosis of cancer who receive their first cancer treatments (or other management) within 31 days of decision to treat (PP30)
- Improved waiting times for colonoscopy (PP29):
  - Diagnostic colonoscopy: 75% people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days); and 60 % of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days)
  - Surveillance/Follow-up colonoscopy: 60 % of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date.
- MDM Development reported against quarterly (PP24) – improvements to the coverage and functionality of MDMs including expenditure against identified funding. Number of patient accessing MDMs (by DHB and ethnicity) will be reported quarterly.
- Progress updates in the Regional Service Plan quarterly reporting.

### 1. Shorter wait times for cancer treatment

National and regional radiation and medical oncology plans were developed late 2013/14. Identified priorities require implementation to ensure non-surgical cancer treatment services in the region develop in line with national direction and the region continues to meet the Policy Priority: All patients ready for treatment wait less than four weeks for radiotherapy or chemotherapy (PP30).



Key actions	Milestone/measurement	Clinical lead
Report against the shorter waits for cancer treatment target on a monthly basis	All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy, reported monthly (PP30)	DHBs
Update the Regional Cancer Centre Development Plan and implement priority areas for the following services: <ul style="list-style-type: none"> <li>• Radiation Oncology</li> <li>• Medical Oncology</li> <li>• Clinical Haematology</li> </ul>	Plan updated by July 2015 Plan implemented by June 2016	C&CDHB /MDHB
Monitor and address as appropriate Adjuvant treatment wait times	Monitoring process in place by July 2015	C&CDHB /MDHB

## 2. Implement the faster cancer treatment work programme

Focus areas for the FCT work programme for 2015/16 include continuing work on the collection and reporting of FCT indicators, implementing the new 62 day Health Target, improving access to MDMs, commencing implementation of the national tumour standards, continuing to develop and evaluate the impact of the Cancer Nurse Co-ordinator roles and developing primary care initiatives to support the identification of high suspicion of cancer.

The Ministry have initiated a second round of RFP funding for service improvements along the cancer patient pathway through to 2018. As a region there is approximately \$1.1 million over three years commencing in Oct 2015. A regional process will be undertaken to identify prioritised projects for funding relating to DHBs achieving the 62 day waiting time indicator and implementing the national tumour standards.

Key actions	Milestone/measurement	Clinical lead
<b>Ministry FCT RFP Projects</b> <ul style="list-style-type: none"> <li>• CCN and DHBs ensure sustainability of nine FCT projects funded in round 1</li> <li>• CCN to work with DHBs to agree and implement a regional prioritization approach to the second round of FCT funding</li> <li>• CCN and DHBs commence implementation of funded projects</li> </ul>	<ul style="list-style-type: none"> <li>• Regional approach agreed and implemented May 2015</li> <li>• <b>Successful projects commence Oct. 2015</b></li> <li>• Milestones in identified projects met</li> </ul>	DHBs /CCN



<p><b>FCT Indicators</b></p> <ul style="list-style-type: none"> <li>DHBs to continue to improve the quality of faster cancer treatment data-collection and reporting</li> <li>CCN to provide regional quarterly analysis of FCT data to support DHBs to identify data quality issues and monitor progress against meeting the health target</li> <li>DHBs to continue to identify and implement service improvements to support patients to receive their treatment in a timely manner</li> </ul>	<p>FCT Indicators reported against quarterly:</p> <ul style="list-style-type: none"> <li>Health Target: 85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) to be achieved by July 2016.</li> <li>% of patients (by DHB and ethnicity) with confirmed diagnosis of cancer who receive their first cancer treatments (or other management) within 31 days of decision to treat (PP30)</li> </ul>	<p>DHBs /CCN</p>
<p><b>MDM development</b></p> <p>Complete phased implementation of the regional Multi-disciplinary Meeting (MDM) Implementation Plan within allocated funds for each DHB (approx \$450K pa for the region). Priority activities:</p> <ul style="list-style-type: none"> <li>Continuing to maximise the functionality of MDMs, prioritise patients within current resources and seek to grow clinical resource where appropriate</li> <li>Progress development work related to an IT solution for patient tracking and MDM management in partnership with Southern Cancer Network (following successful Proof of Concept work in 2014)</li> </ul>	<ul style="list-style-type: none"> <li>PP24 reported quarterly – improvements to the coverage and functionality of MDMs including expenditure against identified funding.</li> <li>Number of patient accessing MDMs (by DHB and ethnicity) will be reported by CCN quarterly.</li> </ul>	

<p><b>FCT Indicators</b></p> <ul style="list-style-type: none"> <li>DHBs to continue to improve the quality of faster cancer treatment data-collection and reporting</li> <li>CCN to provide regional quarterly analysis of FCT data to support DHBs to identify data quality issues and monitor progress against meeting the health target</li> <li>DHBs to continue to identify and implement service improvements to support patients to receive their treatment in a timely manner</li> </ul>	<p>FCT Indicators reported against quarterly:</p> <ul style="list-style-type: none"> <li>Health Target: 85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) to be achieved by July 2016.</li> <li>% of patients (by DHB and ethnicity) with confirmed diagnosis of cancer who receive their first cancer treatments (or other management) within 31 days of decision to treat (PP30)</li> </ul>	<p>DHBs /CCN</p>
<p><b>Tumour standards</b></p> <p>Undertake the following actions to support implementation of the tumour standards:</p> <p>Undertake and analyse reviews of 2 more standards to inform regional service improvement initiatives.</p> <p>Implement the regional service improvement initiatives that were identified by the service reviews against the tumour standards in 2013-15 (Bowel, Lung, Gynae, Breast).</p> <p>Specific areas for new investment:</p> <ul style="list-style-type: none"> <li>Bowel – C&amp;CDHB &amp; WhaDHB implement the regional ProVation solution (endoscopy reporting system)</li> <li>Lung – C&amp;CDHB implement a regional EBUS service</li> <li>Lung – regional approach to PET-CT contracting and processes completed</li> <li>Gynaecological – Implement the regional gynaecology service model (business case currently under development and yet to be agreed)</li> </ul>	<p>Tumour standard reviews completed by June 2016</p> <p>Implementation priorities from previous reviews completed by June 2016</p>	<p>DHBs /CCN</p>
<p><b>Care coordination</b></p> <ul style="list-style-type: none"> <li>Ongoing development of the Cancer Nurse Coordinator positions</li> </ul>	<p>Reports provided</p>	<p>DHBs /CCN</p>

<p><b>FCT Indicators</b></p> <ul style="list-style-type: none"> <li>DHBs to continue to improve the quality of faster cancer treatment data-collection and reporting</li> <li>CCN to provide regional quarterly analysis of FCT data to support DHBs to identify data quality issues and monitor progress against meeting the health target</li> <li>DHBs to continue to identify and implement service improvements to support patients to receive their treatment in a timely manner</li> </ul>	<p>FCT Indicators reported against quarterly:</p> <ul style="list-style-type: none"> <li>Health Target: 85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) to be achieved by July 2016.</li> <li>% of patients (by DHB and ethnicity) with confirmed diagnosis of cancer who receive their first cancer treatments (or other management) within 31 days of decision to treat (PP30)</li> </ul>	<p>DHBs /CCN</p>
<p><b>FCT in primary care</b></p> <p>Implement FCT in Primary Care Strategic approach, including:</p> <ul style="list-style-type: none"> <li>Priorities identified in the national Prostate Cancer Awareness and Quality Improvement Plan implemented.</li> </ul>	<p>Implement guidance on the use of active surveillance treatment for prostate cancer care by Jun 2016</p>	<p>Primary care / CCN</p>
<p><b>Supportive care</b></p> <ul style="list-style-type: none"> <li>Implement the new Supportive Care framework</li> <li>Budget 2014 – New funding for Supportive care positions in DHBs – CCN to work with DHBs to coordinate the implementation of these new roles</li> </ul>	<p>Evidence of Framework in use</p> <p>New roles in place by June 2016</p>	<p>DHBs/CCN</p>
<p><b>National cancer health information strategy</b></p> <ul style="list-style-type: none"> <li>Support the implementation of the strategy (to be released in May 2015)</li> <li>Budget 2014 – Quality clinical decision making – CCN to work with DHBs to coordinate the implementation of these recommendations aligned with priority actions identified from the above strategy</li> </ul>	<p>Quality clinical decision making tools / recommendations implemented by June 2016</p>	<p>DHBs/CCN</p>

### 3. Improved waiting times for diagnostic services (colonoscopy)

The National Endoscopy Quality Improvement Programme (NEQIP) includes a set of actions to improve access to, and efficiency of, colonoscopy services including rolling out the New Zealand Global Rating Scale product, endoscopy workforce development and national governance structures.

Key actions	Milestone/measurement	Clinical lead
DHBs to take a coordinated approach to identifying actions to improve waiting times and quality of endoscopy/colonoscopy services in line with the Endoscopy Quality Improvement programme <ul style="list-style-type: none"> <li>DHBs commence implementing service changes as identified from sub-regional colonoscopy planning projects (completed Jun 2015):               <ul style="list-style-type: none"> <li>C&amp;CDHB (Lead)/HVDHB/WaiDHB</li> <li>MDHB (Lead) WhaDHB/HBDHB</li> </ul> </li> </ul>	Improved waiting times for colonoscopy (PP29): <ul style="list-style-type: none"> <li>Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within 2 weeks (14 days) – target 75%</li> <li>Percentage of people accepted for a diagnostic colonoscopy who receive their procedure within 6 weeks (42 days) – target 60%</li> <li>Percentage of people waiting for a surveillance colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date – target 60%</li> </ul>	DHBs

### 4. Palliative Care

Whilst palliative care services are identified within and primarily supported by the cancer programme, it is recognised that palliative care is wider than cancer. CCN, TAS and the Regional Palliative Care Network will continue work this year to develop a more strategic approach to palliative care and end of life service planning and delivery across the region, to inform planning.

Key actions	Milestone/measurement	Clinical lead
DHBs to work with specialist palliative care providers (Hospices and hospital palliative care teams) to implement the national specialist palliative care service specifications	Implementation plan priorities completed by Jun 2016	DHBs
Plan for the implementation of the model of care identified from the Palliative Care Council Last Days of Life initiative which is due for completion in Nov 2014	Plan implemented by Jun 2016	DHBs
Regionally address Senior Medical Officer (SMO) workforce vulnerabilities– refer to regional workforce priorities	Evidence of workforce initiatives	DHBs/TAS

Key actions	Milestone/measurement	Clinical lead
Develop clinical pathways to support cancer and non-cancer patients timely access to palliative care (Map of Medicine/Healthpathways)		DHBs/CCN
Three year HWNZ pilot of the Lower Nth Island Palliative Care Managed Clinical Network across C&CDHB, HVDHB and WaiDHB districts commenced	Identified initiatives for Year 2 of the pilot completed by Jun 2016	C&CDHB, HVDHB, WaiDHB

### 5. Clinical leadership

Clinical leadership is viewed as a key enabler in ensuring the success of the cancer programme. CCN directly contract regional medical, nursing and social work director roles to input into governance, work programme planning and project delivery.

Key actions	Milestone/measurement	Clinical lead
CCN continues to engage with and support clinical leaders across cancer programme areas to lead and contribute to identified projects. Clinical leadership include:  <i>Regional Cancer Nurse Directors</i>  <i>Regional Oncology Social Work Director</i>  <i>Regional Medical Directors</i>	Director work plans developed by Aug 2014 and completed by Jun 2015	CCN

### 6. Māori leadership

Cancer continues to have inequalities with higher Māori incidence (20% greater), higher Māori mortality (80% higher) and Māori are more likely than non-Māori to have their cancer detected at a later stage of disease spread. Addressing inequalities continues to be a key objective of all cancer projects to ensure we meet the goals of the Cancer Control Strategy. Regional and national leadership is viewed as a key enabler.

Key actions	Milestone/measurement	Clinical lead
CCN will support, facilitate and coordinate Māori Cancer Leadership in the Central Region in partnership with National, Regional and Local partners including:  <ul style="list-style-type: none"> <li>Working in partnership with Hei Ahuru Mowai: Māori Cancer Leadership Aotearoa; to develop</li> </ul>	Quarterly reporting of regional and national engagement	CCN

Key actions	Milestone/measurement	Clinical lead
and deliver the national work programme <ul style="list-style-type: none"> <li>Engagement with Tumu Whakarae – DHB GM Māori leadership</li> </ul>		
CCN will continue to lead a regional programme to analyse and address DHB system barriers in cancer care for Māori, aligned with national priorities and the Ministry 'Equity of Health Care for Māori: A framework'	Evidence of reducing inequalities	DHBs/CCN
DHBs achieve, exceed or at the minimum sustain national targets for breast and cervical screening rates for Māori	70% coverage rate target for Breast Screening 80% coverage rate for Cervical Screening	DHBs /BSCC /BSC /DHB Māori Managers

### *System integration and service collaboration*

CCN facilitates meetings and education opportunities for a range of regional service and professional groups. Cancer Consumer Representatives (CCR) are important partners in the delivery of the cancer programme and CCN facilitates the recruitment, training and deployment of CCRs across the region.

Key actions	Milestone/measurement	Clinical lead
CCN continues to facilitate communications and meetings with collaborative groups. Network groups include: <ul style="list-style-type: none"> <li>Central Region Palliative Care Network</li> <li>Regional Oncology Social Workers Forum</li> <li>Cancer Consumer Representatives Forum</li> <li>Cancer Nurses Forum</li> </ul>	Meetings held	CCN

*Linkages to other work programmes*

Linkages
<p>RHIP</p> <p>Local cancer network plans</p> <p>Māori Health Plans including TUMU Whakarae Regional Māori Health Monitoring Plan</p> <p>Diagnostic and elective surgery services</p> <p>Sub-regional plan i.e. 3DHB and centralAlliance</p> <p>Palliative care</p> <p>Primary care</p> <p>Other clinical networks in the region</p>

*High-level actions – 2015-2017*

Aligned with the Ministry NZ Cancer Plan: Better, Faster Cancer Care 2015-2018 the region will

- continue to meet radiation and chemotherapy wait times and improve service delivery regionally in line with national plans
- continue the focus on the Faster Cancer Treatment programme, including
  - meeting the new Health Target
  - improving MDM functionality
  - Improving care co-ordination and supportive care services for patients
- Further service reviews completed against national tumour standards and resultant service improvement plans implemented
- Sustain and regionally promote initiatives undertaken within the Ministry project funding for FCT
- Focus on enablers and barriers in Primary Care in relation to FCT
- Implement a more strategic approach to palliative care and end of life planning
- Continue to identify and address equity issues, especially those experience by Māori



## 4. Cardiac Services

### Sponsor Debbie Chin

Cardiovascular diseases are a leading cause of death in New Zealand and are responsible for 27% of all deaths annually. Within the set of cardiovascular diseases, ischaemic (coronary) heart disease is the second biggest killer (second only to cancer as a single cause of death) and is responsible for 18.8% of all deaths. The burden of heart disease is greatest amongst Māori. In 2010 Māori males had the highest age-standardised mortality rate for ischaemic heart disease (129.6 per 100,000 population compared with 83.3 for non-Māori), this was 56% higher for Māori than non-Māori males. The rate for Māori females (88.2) was nearly twice as high as the rate for non-Māori females (44.3)<sup>18</sup>.

Although age-adjusted death rates have declined steadily in the past few decades, the total number of cardiovascular events is projected to rise due to our ageing population and the increasing prevalence of cardiovascular risk factors such as diabetes and obesity. Many deaths are premature (accounting for 33% of lives lost between 45 and 64 years of age) and potentially preventable. A significant proportion of the New Zealand population has ongoing cardiovascular risk factors: 18% of the population are currently smokers, 38% eat fewer than three-plus servings of vegetables per day, 48% are physically inactive, 31% are obese and 16% have been diagnosed with high blood pressure<sup>19</sup>. It is conceivable that within a few decades the elderly will outlive their middle-aged children, who will die as a result of cardiovascular disease.

In general, poor health outcomes occur amongst Māori, Pacific and Asian people, those people living in socioeconomically deprived environments and people from communities located at a distance from their base hospitals. Hospitalisations are lower than expected/desired, suggesting service issues, although there is some evidence that health service under-use by people most in need is reducing.

The Central Region Cardiac Network (CRCN) is a programme of work led by CEO sponsor Debbie Chin (Interim CEO, C&CDHB) and Clinical Director Andrew Aitken (Interventional Cardiologist, C&CDHB).

It has a strong history of engaging clinical leaders in service improvement and works closely with the National Cardiac Network. CRCN comprises seven clinical leads from the represented DHBs, the seven being the six Central Region DHBs along with Nelson Marlborough DHB due to patient travel and service flow alignment. It also includes primary care, consumer, cardiac physiologist, Planning and Funding and Chief Operating Officer (COO) representatives.

The goal of CRCN is to enhance the collaboration and integration of cardiac services throughout the Central Region by

- reducing service inefficiencies
- improving equity of access and quality of services
- ensuring service sustainability, both clinical and financial
- providing the opportunity for innovation and shared learning
- influencing policy decisions at a national level for cardiac issues.

<sup>18</sup> Mortality and Demographic Data 2010, MoH

<sup>19</sup> New Zealand Health Survey 2012/13



The Central Region has performed below Ministerial expectations, particularly in the areas of angiography, cardiac surgery rates and ACS (acute coronary syndrome) reporting. CRCN's response to the issues facing the Central Region's population is to develop an integrated model of care system of early detection of risk factors within the primary sector, CRCN has also worked to ensure that there is appropriate and ready access to cardiac diagnostic and specialist assessments for primary care, with strong collaboration between secondary and tertiary service providers in the Central Region.

This will enable the management of service demand with an improved and integrated service delivery that achieves

- reductions in waiting times for cardiac services, both elective and acute
- improved prioritisation and selection of patients for appropriate intervention
- a flow-on effect to lower morbidity and mortality rates as a result of heart disease.

CRCN aims to enhance the equitable and appropriate access of patients to cardiology services across the region. To achieve this, CRCN recognises the importance of developing a service model that involves the integration of and collaboration between primary, secondary and tertiary service providers. In addition to this, the region has collaborated and agreed on the development of clear guidelines and protocols across primary, secondary and tertiary services. CRCN will work towards improving equitable access and addressing inequalities for Māori. These service improvement initiatives commenced in 2014/15 and will continue to be embedded and refined in the next financial year.

The Central Region Chief Executives Forum is concerned at the impact of a proposed service change for patients domiciled in the Nelson Marlborough DHB area for accessing cardiothoracic services at Capital & Coast DHB. The proposed service change will mean that Nelson Marlborough based patients are treated at Christchurch or Dunedin rather than at Wellington Hospital. Such a service change has a clinical variability and patient care impact and the CRCN will be the forum to advise the region accordingly.

*To achieve the following outcomes*

### Regional objectives

The focus for 2015/16 will be on continuing to improve access to cardiac services, including:

- patients with similar levels of need receive comparable access to services, regardless of where they live
- more patients survive acute coronary events, and the likelihood of subsequent events is reduced
- patients with suspected ACS receive seamless, co-ordinated care across the clinical pathway
- patients with heart failure are optimally managed during admission and afterwards in the community, thus reducing the need for further readmissions
- the introduction of 'Accelerated Chest Pain Pathways' (ACPP) in emergency departments, which began in 2014/15

### Regional milestones and measures

Co-ordinated by:



**Regional milestones and measures**
**Key actions**

- To continue to work with regional cardiac clinical networks and the New Zealand Cardiac Network to implement actions to improve outcomes for patients.
- To provide quarterly reporting at regional and DHB levels utilising the ANZACS-QI (All New Zealand Acute Coronary Syndrome Quality Improvement) and cardiac surgery registers

**Secondary services**

- All cardiac surgery patients are prioritised and treated in accordance with assigned priority and urgency timeframes
- Sustain performance against cardiac surgery waiting list management expectations

**ACPP**

- Continue the introduction of 'ACPP' in emergency departments, which began in 2014/15

**ACS**

- Implement regionally agreed protocols, processes and systems to ensure the prompt local risk stratification and management of suspected ACS patients
- Implement systems for the prompt transfer of high-risk patients to tertiary centres for appropriate interventions

**Heart failure**

- Implement locally, regionally and nationally agreed protocols, guidance, processes and systems to ensure the optimal management of patients with heart failure

The milestones for cardiac services in the Central Region are outlined under the achievement of national indicators below.

**Secondary services**

- Standardised intervention rates:
  - Cardiac surgery: 6.5 per 10,000 of population
  - Percutaneous revascularisation: 12.5 per 10,000 of population
  - Coronary angiography: 34.7 per 10,000 of population
  - Proportion of patients scored using the national cardiac surgery Clinical Priority Assessment Criteria, and the proportion of patients treated within assigned urgency timeframes
  - The waiting list for cardiac surgery remains between 5% and 7.5% of planned annual cardiac throughput, and does not exceed 10% of annual throughput
  - Patients wait no longer than four months for cardiology FSAs, and for cardiac surgery

**ACPP**

- Report quarterly on regional activity that supports ACCP development, implementation and quality improvement

**Regional milestones and measures**
**ACS**

- Each region will have established measures of ACS risk stratification and timeliness for patients to receive appropriate intervention
- 70% of patients will receive an angiogram within three days of admission ('day of admission' being 'Day 0')
- Over 95% of patients presenting with ACS who undergo coronary angiography will 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.

**Heart failure**

- Each region to report quarterly on activities to support improvements in the optimal management of people with heart failure

*Clinical lead: Dr Andrew Aitken*

Key actions	Milestone/measurement	Clinical lead
Monitor, report and resolution of DHB performance of ACS key performance indicators (KPIs) for the Central Region	<p>Full quarterly reporting to regional COOs</p> <p>Quarterly exception reporting to regional CEOs and Regional Governance Group</p> <p>Review of all Central Region DHBs' use of and contribution to ANZACS-QI reporting, which is a Ministry requirement. If DHBs are not meeting Ministry requirements, the CRCN will work with COOs and GMs Planning and Funding to ensure that steps are taken to resolve any performance issues and resource impediments to ensure targets are met</p> <p>Develop and disseminate quarterly bulletins to the cardiac sector that include ACS KPIs</p>	CRCN DHBs and COOs and GMs Planning and Funding
Improve access to secondary and tertiary cardiac services	<p>Monitor and review register of cardiac surgery patients to ensure that they are prioritised and treated in accordance with assigned priority and urgency timeframes by end of Q4</p> <p>Ensure that DHBs have processes in place to resolve issues if waiting times are not met</p> <p>Ensure the implementation of ACPP in all emergency departments in the Central Region by 31 December 2015</p> <p>In DHBs that have not achieved this, CRCN will work</p>	CRCN and DHBs

Key actions	Milestone/measurement	Clinical lead
	with COOs and GMs Planning and Funding to identify and resolve issues that have hindered progress	
Work with primary care to develop clear patient pathways that improve access to cardiac services	<p>Assist DHBs to work closely with primary health care in the development and implementation of patient care pathways. Aim to have these functioning by December 2015, with an initial focus on:</p> <ul style="list-style-type: none"> <li>• chest pain (acute and non-acute)</li> <li>• atrial fibrillation</li> <li>• heart failure</li> </ul> <p>Develop regional minimum standards</p> <ul style="list-style-type: none"> <li>• chest pain assessment</li> <li>• management of ACS atrial fibrillation</li> <li>• heart failure management</li> <li>• echocardiography referral guidelines</li> <li>• rehabilitation services</li> </ul> <p>Develop regional guidelines regarding prioritisation processes for FSA appointments, including referral criteria by December 2015</p> <p>Full quarterly reporting to regional COOs and GMs Planning and Funding</p>	CRCN and DHBs
Support the development of a regional cardiac service model that delivers sustainable and equitable access	<p>Develop a regional cardiac services plan for the next 5 years by Q2/Q3</p> <p>Confirm the model of provision of a visiting specialist cardiology service for WhaDHB by Q1</p> <p>Review and monitor the confirmed provision of cardiology services in Wairarapa ongoing</p> <p>Work with MDHB to inform the business case to set up a catheterisation (cath) lab starting June 2015</p>	CRCN
Enhancing regional tertiary services	<p>Identify the appropriate mix of tertiary services to be transitioned and delivered in secondary care (including financial and clinical impacts on services) by Q2/Q3</p> <p>Determine initiatives to ensure the critical mass, safety and viability of services across the region for cardiothoracic surgery services by end of Q1</p> <p>Develop a structural heart disease programme in the tertiary centre that accommodates future population</p>	CRCN, DHBs and COOs and GMs Planning and Funding

Key actions	Milestone/measurement	Clinical lead
	growth by end of Q4	
Improve access to cardiac investigations and build a sustainable workforce	Realign regional education programme with other regional/national initiatives concerning training and workforce.  Work with Regional Directors of Allied Health to progress and implement echocardiography and physiology KPIs	CRCN and DHBs

### Linkages to other work programmes

Sub-regional	
3DHB centralAlliance HBDHB Nelson Marlborough DHB	Incorporate sub-regional development and implementation into the regional cardiac plan

Information Technology	
Resourcing requirements to implement and integrate ANZACS-QI into the future Health Informatics environment will require full scoping and assessment	Work with TAS, RHIP, the GM of Health Informatics and individual DHB operational teams to ensure integration occurs within regional clinical workstation programmes  Quarterly monitoring of and reporting on progress until 30 June 2015

Workforce	
Improve access to cardiac investigations and build a sustainable workforce	Refer to regional workforce section pg. 134

## Māori Health

The Central Region's approach to improving Māori health and reducing inequalities is contained in its Regional Māori Health Plan, Tū Ora. Tū Ora includes indicators to enable performance measurement.

- Where cardiac data is available by ethnicity, this is included in indicator reports. In both the Māori indicator report and the cardiac KPI report, cardiovascular disease (CVD) risk assessments are provided by ethnicity (as is better help to quit smoking)
- The cardiac KPI report also includes ambulatory sensitive hospitalisations specifically for myocardial infarction plus angina and chest pain for Māori
- The standardised intervention rates for cardiac surgery, angioplasty and angiography take into account ethnicity in the calculation (as well as sex, age and deprivation), but are not available by ethnicity
- CRCN will integrate actions and work streams to ensure that Māori health outcomes are being achieved using the MoH Equity of Health Care for Māori Health A framework (where appropriate)

### High-level actions – 2016-2018

The main activities for this time period will be

- Service delivery
  - The continuing implementation of the agreed RSP and roadmap for a regional cardiac service in the Central Region.
  - Utilising the ANZACS-QI database extractions for management reporting and service development.
  - Monitoring and reporting on intervention rates.
  - Managing service demand through supporting pathway development and adherence.
  - An involvement in MDMs for case management and shared learnings.

## 5. Stroke Services

Sponsor Kathryn Cook

Care Closer to Home for New Zealanders in relation to stroke encompasses improved and timelier access to services.

Stroke is the second most common cause of death worldwide and the most common cause of long-term adult disabilities in developed countries. Stroke is a leading cause of health loss in New Zealand, accounting for 4% of deaths. Stroke costs New Zealand \$450 million a year in service delivery and rehabilitation. Reducing the burden of stroke is a key goal for health service planning. The key evidenced-based interventions that have been shown to reduce the burden of stroke on society include: a) organised acute and rehabilitation stroke services; b) the rapid assessment and management of transient ischaemic attacks (TIAs); and c) the provision of acute stroke thrombolysis to eligible stroke patients.

In the Central Region, five of the six DHBs have dedicated stroke units that provide specialised stroke services. Within DHBs beds are generally not ring-fenced. If however, where a dedicated stroke unit exists patients are admitted to the stroke unit or an appropriate inpatient setting whilst receiving intervention in line with the New Zealand Clinical Guidelines for Stroke Management 2010.

Rapid-access TIA pathways exist in all DHBs. Anecdotally, organisational interdependencies and diagnostic access continue to place limitations through the patient journey. The identification of these limiting factors and the development of strategies to address them provide opportunities within DHBs to improve the patient journey. Thrombolysis is offered in all six DHBs, but in many areas service provision is informal, often provided by non-stroke physicians or with stroke physician telephone back-up only (neither being evidenced-based practices) of limited quality. In addition, while access may be quite reasonable in Wellington and surrounds, regional centres struggle significantly with after-hours' service provision. Patients residing in rural areas often have no way to reach hospitals providing this service within the required timeframes. Measures to address this have been identified and tele-stroke is seen as a means to provide sub-regional and regional access, and support for thrombolysis. This was not achieved in the 2014/15 year and has been highlighted as a priority in the 2015/16 year, with implementation completed by December 2016 if approved by the local DHBs.

A review of quarterly thrombolysis data collected for the 2013/14 year demonstrated a steady improvement in the number of stroke patients thrombolysed for the region, from 6% in Q1 to 11% in Q4. In December 2015 a comparative analysis will be undertaken inclusive of the 2014/15 data. These findings will assist in informing further work plans for the following year's RSP.

Opportunities will be explored to strengthen linkages with non-government organisations (NGOs) such as the Central Region Stroke Foundation and ambulance service providers, thereby lessening the burden of care for families and the community.



The Central Region DHBs are currently collecting data that identifies Māori and Pacific peoples. At this point data is being monitored and reviewed and no target has been set. The Central Region has a slightly higher proportion of Māori than New Zealand overall (18% and 15% respectively); for example, one in four people in WhaDHB and HBDHB is Māori, while the largest proportions of Pacific people reside in the HVDHB and C&CDHB districts. There is an opportunity to enhance Māori and Pacific peoples' health through stronger engagement with Māori health providers (refer Māori Health Plan).

In October 2012 a Central Region Stroke Steering Group was established to provide leadership and guidance on improving stroke services throughout the Central Region. The key purpose of the work stream is to facilitate the implementation of the New Zealand Clinical Guidelines for Stroke Management 2010 to ensure that risks are reduced and improvements are made in the provision of acute and rehabilitation stroke services across the Central Region. This group consists of primary care, NGO and secondary care providers and is multi-disciplinary.

This is a continuation of the stroke services work programme in the 2014/15 RSP. The Stroke Steering Group will strive to make improvements and decisions regionally for implementation by individual DHBs.

*To achieve the following outcomes*

#### Regional objectives

- Care Closer to Home for New Zealanders in relation to stroke services means improved and timelier access to stroke services
- To improve stroke prevention and stroke event survival, and reduce subsequent stroke events
- To improve access to organised acute and rehabilitation stroke services
- More patients survive stroke events, and the likelihood of subsequent stroke events is reduced
- More people receive access to organised stroke services, which supports New Zealanders to live longer, healthier and more independent lives

#### Regional milestones and measures

##### Milestones

- Models of service and care
- Work with national and regional clinical stroke networks (including the Clinical Network Leadership Group, which is the national stroke network) to implement actions to improve outcomes for people who have stroke
- Strengthen relationships with primary care providers and NGOs, for example the Stroke Foundation, to support patients and their families
- To reduce the burden of care on communities
- Develop regionally agreed work plans for stroke improvements



**Regional objectives**

- Establish regionally agreed protocols, processes and systems to ensure that people with stroke receive care within an appropriately configured, organised stroke service, from the commencement of an acute event to the completion of community rehabilitation as appropriate, as recommended in the New Zealand Clinical Guidelines for Stroke Management 2010

**Measures**

To work towards national consistency, the following targets have been set:

- 6% of potentially eligible stroke patients thrombolysed
- Progress towards 80% of stroke patients admitted to stroke units. (Note that in small DHBs, stroke patients would be admitted to organised stroke services, with demonstrated stroke pathways)
- Proportion of patients with acute stroke who are transferred to inpatient rehabilitation services
- Proportion of patients with acute stroke who are transferred to inpatient rehabilitation services within 10 days of acute stroke admission. Target 60%

*Clinical lead: Jeremy Lanford*

Key actions	Milestone/Measurement	Clinical lead
Organised acute stroke services – All stroke patients admitted and treated in stroke units with interdisciplinary stroke teams		
Stroke data is collected and reported. This data includes: <ul style="list-style-type: none"> <li>total number of strokes</li> <li>Percentage of stroke patients admitted to organised stroke units (target 80%)</li> <li>percentage of ischaemic stroke patients thrombolysed (6%):               <ul style="list-style-type: none"> <li>Stroke patients who are 65-plus years of age</li> <li>percentage of Māori and Pacific (broken down into total number of strokes, thrombolysed and seen by stroke services)</li> </ul> </li> </ul>	Limiting factors to achieving targets are identified  Service improvement strategies developed to address these, e.g. patient flow practices that facilitate admission of stroke patients to acute stroke units (ASU)	All DHBs
Trend analysis of 2014/15 acute stroke data  Undertake a comparative analysis of	By 31 December 2015  The comparative analysis will inform service improvement initiatives to improve	Central Region Stroke Steering Group

Key actions	Milestone/Measurement	Clinical lead
2013/14 and 2014/15 data	outcomes, which in turn will inform planning for 2016/17 year	
Stroke rehabilitation services – All eligible stroke patients receive appropriate rehabilitation services (as defined by the National Stroke Network[NSN]), supported by interdisciplinary stroke teams All eligible stroke patients have equitable access to community stroke services, regardless of age, ethnicity or geographic domicile		
Continue to collect regional rehabilitation data. This data includes: <ul style="list-style-type: none"> <li>proportion of patients with acute stroke who are transferred to inpatient rehabilitation services</li> <li>proportion of people with acute stroke who are transferred to inpatient rehabilitation services within 10 days of acute stroke admission. Target 60%</li> </ul> Continue to monitor the average LOS in rehabilitation and identify areas for service improvement through the use of Australian Rehabilitation Outcome Centre (AROC) data	Limiting factors to achieving targets are identified Strategies developed to address these, e.g. patient flow practices/access to diagnostics, which facilitate admission of stroke patients to rehabilitation within 10 days The and consistent use of AROC standardised data is utilised to determine service improvement initiatives to improve patient outcomes Average LOS is monitored and measures are undertaken to address extended LOS	All DHBs
Regional rehabilitation definitions are agreed in line with national stroke rehabilitation requirements. These measures inform access to adequate stroke rehabilitation across the patient journey	Finalised 30 August 2015 Implementation of regional rehabilitation definitions by December 2015	Central Region Stroke Steering Group
Māori and Pacific people admitted with stroke have access to services that meet individual and whānau needs, reducing the burden of care, and are provided with participation from Māori health providers and primary care	The percentage of Māori and Pacific people presenting with stroke and transferred to rehabilitation within 10 days reflects improved access to stroke services	All DHBs
TIAs		
Implement regional TIA strategy to improve consistency of TIA services	TIA regional strategy implemented by 30 June 2016 including the implementation	Developed by Central Region Stroke Steering

Key actions	Milestone/Measurement	Clinical lead
Support implementation of the TIA tool for use by GPs	of a TIA tool.	Group Implemented by all DHBs
Thrombolysis – All eligible stroke patients have access to thrombolysis		
People experiencing acute ischaemic strokes have consistent access to quality-assured and regularly audited stroke thrombolysis services 24 hours, seven days per week at all Central Region DHBs (either directly or via support from a larger DHB)	6% of patients presenting with ischaemic strokes thrombolysed across the region by 30 June 2016	Central Region Stroke Steering Group Local DHB
Implement a Regional Thrombolysis Network including credentialing, audit processes, regional register, shared protocols, a regional back-up roster and regional case review <ul style="list-style-type: none"> <li>• MDHB, HBDHB and WhaDHB by tele-stroke (sub-region)</li> <li>• C&amp;CDHB, WaiDHB and HVDHB by telephone or tele-stroke (sub-region)</li> </ul>	Work stream is developed and credentialing, audit processes, regional register, shared protocols, a regional back-up roster and regional case review are established  Purchase of tele-stroke equipment for sub-region is agreed by local DHBs by 31 December 2015. Purchase of the equipment will be carried forward into 2016/17 as part of capital planning  An effective telephone back-up system in sub-regional areas is maintained  Sub-regional stroke thrombolysis networks implemented by 30 June 2016	Developed by Central Region Stroke Steering Group  Implemented by all DHBs
Promote integrated thrombolysis services with emergency and ambulance services  Clinical lead to undertake a formal update for emergency and ambulance services on thrombolysis	Integrated thrombolysis service with emergency and ambulance services promoted  Formal update provided by 30 June 2016. Local DHBs to outline what they offer	DHBs
Education, training and audit – All members of the inter-disciplinary stroke team participate in ongoing education, training and audit programmes according to the Stroke Guidelines		
Continuing stroke education	Two Central Region stroke education days to be completed by 30 June 2016 that include NGO, primary and care providers.	Central Region Stroke Steering Group
Ongoing thrombolysis education plan	Plan developed and implemented by 30 June	Central Region

Key actions	Milestone/Measurement	Clinical lead
developed	2016 Thrombolysis education day to be held for clinicians in August 2015	Stroke Steering Group
Quarterly thrombolysis audit and review	Audits are completed and reported on a quarterly basis	DHBs
<b>Workforce</b> A regional workforce plan that supports the delivery and achievement of sustained, consistent and safe thrombolysis  Identified actions that the region will take to develop and implement an ongoing education programme that supports a sustainable and quality clinical workforce		
Regional stroke service workforce strategy and education plan developed  Designate lead clinicians to stroke services for year two scoping document 2016/17	Investigate regional stroke workforce issues and resourcing and training needs and develop a regional workforce strategy by 31 March 2016	Central Region Stroke Steering Group

#### Linkages to other work programmes

Information Technology	
Identified actions that the region will take to support improved information management, e.g. establishing a regional oversight role	
Linkage	To be advised at a regional level

#### High-level actions – 2015-2017

The Central Region Stroke Steering Group will continue to set agreed targets and collect data quarterly in 2015/16. Work will continue on improving thrombolysis rates, TIA services, rehabilitation services, workforce issues and stroke prevention. The stroke work programme is scheduled to be completed by June 2016. The region will maintain service achievements and regional collaboration and reassess for further improvement needs in 2016. If no further improvement are required the Central Region Stroke Steering Group will be disestablished.

## 6. Mental Health and Addictions

### Sponsor Julie Patterson

Mental Health and Addiction Network (MHAN) works within the MoH vision of 'Care Closer to Home'. The Central Region provided MH&A services to 22,587 unique consumers aged 20-64 in 2012/13, giving an overall rate of approximately 5% of the adult population accessing MH&A services<sup>20</sup>.

This RSP is informed by the MoH document, 'Rising to the Challenge 2012-2017: The Mental Health and Addiction Service Development Plan' (SDP), which clearly articulates national service development priorities. The SDP aims to ensure that access and responsiveness are enhanced and integration is strengthened across the spectrum of health promotion, primary treatment, specialist treatment and support services, while improving value for money and delivering improved outcomes for people using services.

There have been significant transformations in MH&A services in the past two decades. However the challenge remains of ensuring that health services work alongside families/whānau and communities so that young people have a healthy beginning and can flourish, and all people with MH&A issues can access appropriate treatment and recover rapidly.

The Central Region aims for a sustainable, integrated and responsive continuum of care accessed locally and where possible delivered locally. If local service provision is not viable, services will be provided regionally.

The Central Region will forge stronger links and relationships with other public sector services, such as the Ministry of Justice, the Department of Corrections, New Zealand Police, the Ministry of Education, Housing New Zealand, the Ministry of Business, Innovation and Employment and the Ministry of Social Development. It will also work in partnership with NGO and community entities.

The integration of service delivery with primary care continues to be a goal of MHAN. More MH&A services will be delivered in local community settings, with increased involvement from tangata whaiora and families/whānau in care planning and delivery.

MHAN supports DHBs to share responsibility for developing treatment pathways that ensure seamless transitions for patients across boundaries, for example in relation to mild to moderate mental health issues and maternal health screening for early signs of depression.

The following generic areas will be developed across all work streams in this 2015/16 RSP:

- 'Equity of Health Care for Māori: A framework'
- Care pathways
- Consumer involvement
- Peer support

The work programme is divided into the following projects

- Low prevalence/high needs

<sup>20</sup> Source: PRIMHD, New Zealand Census 2013

- Adult forensic
- Residential addictions
- Youth services
  - Youth forensic
  - Youth alcohol and other drugs (AoD)
  - Youth acute inpatient
- Eating disorders
- Maternal and perinatal
- Workforce

### Regional milestones and measures Central Region 2015/16

#### MoH regional objectives

##### To improve:

- access to the range of eating disorder services
- adult forensic service capacity and responsiveness through the national forensic network
- youth forensic service capacity and responsiveness
- perinatal and maternal mental health acute service options as part of a continuum
- MH&A service capacity for people with high and complex needs

##### Measures:

- Reduction in wait lists and times for people in prisons requiring assessments for forensic services (from x to y against targets set for each quarter)
- Increased access rates to youth forensic services in community, court liaison and Child, Youth and Family (CYF) youth justice residence settings
- Increased access to perinatal and maternal health services (numbers increased from x to y in each quarter)
- Baseline datasets are established to measure and report on progress within and across projects

#### Central Region Care Pathways development principles

MHAN will adopt a guiding document on care pathways that include a focus on ensuring equitable health outcomes for Māori

All care pathways and service models are jointly designed in collaboration with all relevant stakeholders, including, tangata whaiora and whānau, Māori, Pasifika and other cultures, other services; and any other concerned party

Care pathway mapping is included in all service planning, so that tangata whaiora journeys contain a more

**Central Region Care Pathways development principles**

seamless experience, are more easily navigated and that services respond better to their needs

**Measures:**

Active engagement and input by tangata whaiora and all other relevant stakeholders is visible in service planning, delivery and evaluation

Evidence of consideration and incorporation of Māori health equity issues and actions in planning and developing care pathways, services and workforce

*MHAN clinical lead: Dr Alison Masters (C&CDHB)*

***Mental Health and Addictions – overarching themes and goals***

The 2015/16 RSP for MH&A aims to reflect the intent, outcomes sought and directives and directions in the SDP.

Throughout this MH&A plan, we will

- use ‘tangata whaiora’ (people seeking wellbeing) for consumer/service user.
- incorporate the needs of, and culturally appropriate service responses for, other cultures and ethnicities in service design and delivery
- map and improve seamless and navigable care pathways for tangata whaiora to produce more effective interventions and better outcomes. This includes mapping and co-ordinating tangata whaiora journeys in partnership with the NGO/community sector
- seek and include genuine tangata whaiora, consumer leadership and cultural input into all stages of service development
- use a co-design approach and models<sup>21</sup> to inform transformational change in planning, designing, delivering and monitoring/evaluating services in the Central Region
- develop and strengthen links with national/regional/local MH&A consumer networks, groups and organisations, as well as with the Regional Consumer Workforce project
- promote and support the expansion of peer support workforce capacity/capability and evidence-based models, and replicate these for other service settings and modalities.

There will be a focus in 2015/16 on achieving more equitable health care for Māori, extending across all MH&A work programmes and priorities. We will develop principles and actions based on the recent ‘Equity Health Care for Māori: A framework’. The initial emphasis for 2015/16 will be on increasing leadership, knowledge and commitment in health organisations, as defined in the framework, and in particular the following actions:

- Actively seek partners within and beyond the health sector to improve service integration, planning and support for Māori
- Support the development of care pathways that increase equitable health outcomes for Māori

<sup>21</sup> E.g. Waitemata Co-Design Model ([www.healthcodesign.org.nz/introduction.html](http://www.healthcodesign.org.nz/introduction.html))



- Build and maintain a workforce responsive to the health care needs and aspirations of Māori

In addition, the Central Region will pursue the following goals and actions in relation to Māori (and Pasifika and other local populations needing/using services) across all work programmes:

Goal	Outcome	Regional actions
Increased use of Pae Ora and Whānau Ora approaches (and similar integrated models relating to other cultures), with strong linkages within and between sectors and agencies  Strengthened linkages across all work streams with Māori, Pasifika and other cultural initiatives and entities	Tangata whaiora and their families/whānau receive services delivered in integrated ways appropriate to their cultural as well as health and social needs	Promote the Te Rau Matatini Whānau Ora 2014-17 model, and its adoption across Central Region  Undertake workforce development, particularly in cultural competence for non-Māori/other ethnic-specific services

## 1. Services for people with high and complex needs

### 1.1 Adult forensic services

This RSP will build on work undertaken in earlier years to map and improve the tangata whaiora journey across the continuum of care, to increase forensic service capacity and responsiveness, and to assist the Central Region in making a robust regional contribution to the national network of forensic inpatient services. The plan will also contribute to the objectives outlined in the SDP to identify and meet the needs associated with mental health issues for people within prisons.

Key actions	Milestone/Measurement	Clinical lead
Continue to develop and monitor/evaluate and implement the comprehensive Central Region Adult Forensic Services Report and recommendations presented to MHAN in 2014  Connect with and contribute to work and joint planning of national network of forensic inpatient services  Having an established baseline, provide datasets demonstrating reduced waiting list times and times for MH&A assessments in prisons	Agreed action plan approved by MHAN August 2015 and initiated by September 2015  Ability to measure the involvement of inter-agency collaboration across forensic service settings, national and regional networks, and other services. They are in place by September 2015 and reported to MHAN quarterly thereafter  Wait lists/times reduction targets established and met by June 2016	Lead: C&CDHB  Adult Forensics Working Group to co-ordinate



### 1.2 Residential addictions services

A comprehensive review of services in 2014 led to recommendations to MHAN for a new model of care, that locates outcome-focused services more locally across the region, and which uses resources more efficiently and effectively. The following actions are based on engagement, communication and implementation processes leading to agreed changes in service location, configuration and modality. This will include the Ministry's intention to devolve the methamphetamine bed funding within the regional services.

Key actions	Milestone/Measurement	Clinical lead
Following roadshow consultations and any revisions, seek approval of final model by MHAN  Develop business case for new model	Proposed model approved by MHAN by August 2015  New model business case developed and approved by MHAN February 2016  Procurement process completed by June 2016	Lead: C&CDHB  All regional DHBs  Regional Portfolio Manager, Working Group Chair, TAS Project Managers

## 2. Youth services – regional development and integration

The aim for 2015/16 in this area is to increase awareness of and access to all Central Region youth service options in MH&A, across all acute inpatient and NGO/community settings.

We will also focus on encouraging and strengthening links between the various types of service responding to the health and allied needs of young people. Youth MH&A service matrix models used successfully in other regions (including peer support) will be researched and where appropriate adopted/adapted.

The outcome sought from these activities is that a comprehensive picture is available to communities and service providers of what youth-focused/friendly options exist, how they are accessed, what the pathways between them and how young people and their families/whānau can navigate them.

### 2.1 Youth forensic services

The RSP focus for 2015/16 will be on developing sustainable community youth forensic services and increasing access to them. Service development and action plans will be developed to support the delivery of non-stigmatising and developmentally and culturally appropriate forensic services for youth, particularly those in the community.

Key actions	Milestone/Measurement	Clinical lead
Continue implementation of Community Youth Forensic Service Plan (MoH expectation). Increase access to community youth forensic services (MoH expectation)	Quarterly implementation reports to MHAN to show progress towards meeting plan objectives. Actions to be in progress or completed by June 2016. Establish access rate baseline data measures by December 2015. Demonstrates increased access rates overall, as well as in each setting by June 2016- i.e. This includes court liaison, CYF youth justice residences, and community)	Lead C&CDHB Youth Forensic Working Group to co-ordinate

### 2.2 Youth AoD

In 2015/16 the Central Region will address gaps in services for young people experiencing problems with AoD (and generally other co-existing issues). This will be led by a dedicated working group, and will involve participation, advice and other contributions from key national experts at a consultative workshop as well as collaboration with agencies from other sectors.

Key actions	Milestone/Measurement	Clinical lead
Establish a Youth AoD Working Group, which will draw on advice from experts and organisations nationally, to develop a new model of care Investigate funding options – including joint funding across government agencies and/or packages of care Research workforce needs and develop strategies and training to meet them Consult on model with full range of stakeholders	Youth AoD Working Group established and meeting regularly by September 2015 Hold workshop of national experts to gain advice on best practice (including workforce needs) in youth AoD by December 2015 MHAN considers draft model of care and draft service configuration by June 2016	Lead: C&CDHB – Regional Portfolio Manager, Dr Karin Isherwood All regional DHBs Working group to co-ordinate

### 2.3 Youth acute inpatient model of care

In 2015/16 the Central Region will examine the range of services provided in inpatient settings for young people requiring acute levels of care, including forensic, AoD the Rangaitahi unit, paediatric inpatient unit/s and youth acute packages of care (APOC). The focus will be on developing a model of care that encompasses all these services across the region, increasing integration between services

and referring agencies, and improving the journeys of young people into, through and out of this matrix of services.

Key actions	Milestone/Measurement	Clinical lead
Establish designated Youth Acute Working Group, and/or seek guidance and input from the other Youth Working Groups, to develop a new model of care for acute inpatient youth services to meet present and future needs of the region	<p>Youth Acute Working Group established by September 2015</p> <p>Draft Model of Care (MoC) developed and presented to MHAN by June 2016</p>	<p>C&amp;CDHB – Regional Portfolio Manager</p> <p>All regional DHBs</p> <p>Working group to co-ordinate</p>

### 3. Eating disorder services

This is a continuation of the past two years' work in Central Region Eating Disorder Services (CREDS), including service reviews and reports with recommendations to MHAN. Paediatric inpatient units remain a strong link, providing support for medical stabilisation prior to entry to the regional service. For the 2015/16 period access to a range of eating disorder services remains a priority area for MoH.

Key actions	Milestone/Measurement	Clinical lead
Continued regional provision of eating disorder inpatient services to ensure sustainable inpatient and community services	Quarterly progress reports to MHAN to demonstrate increased access to services across the region by June 2016	Lead: HVDHB All regional DHBs
Increase access to acute and community eating disorder services across the region	Quarterly Regional Clinical Network reports demonstrate examples of integration, communication and collaboration	
Support and contribute to the work and effectiveness of the Regional Clinical Network, working with the Regional Co-ordinator		

### 4. Maternal and perinatal

Building on last year's successful development of the community-based service model, the 2015/16 RSP will focus on MoH's expectations, objectives and actions for perinatal/maternal mental health:

- Develop the continuum of perinatal and infant mental health services by implementing contracted acute services as part of this continuum.

Identify and deliver on the actions needed to achieve the following:

- Establishment of a regional clinical network with close links to clinical networks being established in the other North Island regions.

- Co-ordinated and consistent approach to service delivery across the region and the North Island.
- Regional co-ordination and access to perinatal and infant mental health acute services as part of the wider continuum.
- Increased access to perinatal and infant mental health services.
- Evaluation of the individual services within the continuum and the continuum as a whole.
- Co-ordinated, safe and timely after-hours response.

Key actions	Milestone/Measurement	Clinical lead
Continue implementation of the MHAN report and recommendations for improving maternal and perinatal service provision across the region Increase access to acute perinatal and infant mental health services Coordinated, safe and timely after-hours response across the continuum of care	Mapping of care pathways to be completed by December 2015 Access to both acute inpatient, home-based perinatal and maternal mental health services to be measured each quarter, and any increase in access to be reported by June 2016 Data collection for the after-hours service response co-ordination to be in place by June 2016 Summary report of after-hours service response co-ordination completed by June 2016	Lead: C&CDHB Working group, all regional DHBs and clinical network

## 5. Workforce

Continue to build on the partnership formed in 2013 between TAS and Te Pou to complete workforce actions in the Central Region. The goal is to align service planning with workforce planning and development through the promotion of the 2014 Workforce Stocktake findings. To achieve this TAS will develop communication across the wider spectrum of services, from DHB to PHO and NGO services. This work is facilitated in conjunction with workforce section on pg.132, 133 and 140 of the RSP.

### Key actions – 2015/16

Key actions	Milestone/Measurement	Lead
Work with MHAN project groups to identify and advise on workforce development needs and opportunities	Quarterly progress reporting to MHAN	Lead: TAS Workforce Planning lead
Maintain and develop linkages to other National and Regional	Quarterly monitoring and reporting to	TAS Workforce Planning

Key actions	Milestone/Measurement	Lead
Workforce Development Programmes to build workforce capacity and capability within the Central Region	Te Pou and MHAN	lead

### Linkages to other work programmes

Māori mental health
<p>In alignment with the Central Region's approach to improving service capability for Māori health, MHAN will:</p> <ul style="list-style-type: none"> <li>enable Māori to participate in and contribute to strategies for Māori health improvement</li> <li>foster the development of Māori capacity for participating in the health and disability sector</li> <li>provide relevant information to Māori for the purposes above</li> </ul> <p>There will be continuing development of a monitoring framework that includes National Health Index-level data analysis. This will assist to identify and agree service gaps for Māori and other ethnic groups. The Regional Portfolio Manager will assist in facilitating agreement via MHAN on opportunities to target actions within each service priority to improve Māori health outcomes</p> <p>Data analysis to National Health Index level across all six Central Region DHBs for each work stream will gauge levels of service utilisation and levels of access for respective services by DHB for Māori populations. This will include utilisation of the PRIMHD data to be collated on a regional basis, with regular reporting back to DHBs to assist in the monitoring of service utilisation, and to enable an effective capability to measure Māori health services' efficacy</p> <p>There will be links between this RSP and the DHBs' Māori Health Plans. In mental health, these relate to reducing the rates of Māori on community treatment orders compared with other ethnicities</p>

HOP and dementia programmes		
Goal	Outcomes	Regional actions
Maintain and develop linkages and communication between MHAN and the HOP Network	Trends, issues and emerging needs and solutions are shared across networks and services	Maintain regular communication with the TAS HOP Network and project  Identify and disseminate issues and solutions

Information Technology
<ul style="list-style-type: none"> <li>MHAN will continue to work with the RHIP to ensure an integrated approach on IT</li> </ul>

### Information Technology

- Ensure MHAN involvement in all regional working groups involved in the development of regional applications

### CAPEX

For the 2015-2017 years, key high-level actions will be informed by:

the Minister of Health's priorities

meeting the objectives set out in the SDP (MoH) and Blueprint II – Improving Mental Health and Wellbeing for all New Zealanders: How things need to be (June 2012, Mental Health Commission)

Central Region priorities delivered regionally, sub-regionally and locally

All key actions will be designed to:

improve national consistency in access, service quality and outcomes for people who use MH&A services and their families/whānau and communities

be client focused

support services to be delivered as locally as possible

### Linkages

- Māori Health
- HOP dementia pathways
- Workforce
- Health Informatics Programme
- Linkages to other programmes – Māori Health, HOP, RHIP, CAPEX

## 7. Electives

### Sponsor Kevin Snee

The six Central Region DHBs will work collaboratively to improve the delivery of elective services with the 2015-16 RSP continuing to focus on surgical specialties.

A regional approach to elective services benefits patients through having regionally developed clinical pathways and assessment tools improve equity of access to appropriate clinical services, reduced waiting times and greater transparency. Efficient utilisation of regional resources supports sustainable service delivery and financial benefits through increased productivity.

The Central Region's population (just under one million) allows most services to be provided within the region. The age group 65-84 years is expected to grow by 36% across the region between the 2013/14 year and the 2023/24 year. This represents an increase of approximately 41,037 people. The 85-plus age group is projected to increase by 29% (4,560 people) (MoH Projection Data, November 2014).

The expected growth in the older persons' population will continue to challenge hospital services. Providing sustainable elective services to meet demand is an important focus for the 2015/16 RSP.

Given demand growth and elective capacity constraints within the DHBs, improving service delivery requires a whole-of-sector approach. Improvement includes optimising the patient experience by ensuring transparency of processes, so that from the first contact with a health care professional a patient receives consistent messaging regarding their expected clinical pathway.

The challenge of achieving the four-month waiting times milestone for FSAs and surgical procedures by 31 December 2014/15 has been significant for most Central Region DHBs. Sustaining reduced waiting times will require a commitment to implementing both clinical and non-clinical systems and processes which support DHBs in maintaining this target. This will also support efforts to improve fairness through improving equity of access.

Successful elective services will

- support the workforce to deliver the right service at the right time
- be timely (patients are seen within MoH-required timeframes)
- be fair (improved equity of access)
- deliver consistent systems and processes to support service planning, patient care and patient choice
- be transparent (all health professions involved in the patient episode of care understand and are aware of the systems and processes and are able to provide consistent messages to patients)
- maximise hospital resources (DHB clinical and management teams have access to best-practice information, enabling the most efficient and effective use of resources).

### *Strategic direction for 2015/16 RSP*

The establishment of regional clinical teams with both GP and hospital specialist members have been successful in developing regional condition-based clinical pathways. The teams have also proven effective both in delivering planned outputs and as a mechanism for developing positive working



relationships between DHB clinical and management teams, including a deepened understanding of the different issues facing the sectors. The success of the approach supports ongoing improvement of elective services utilising this delivery model.

One of the outcomes from the clinical workshops was the acknowledgement that a consequence of clinical pathway development is a perception that demand pressure is being pushed from specialist services to primary care. Establishing a pilot for a non-surgical elective pathway will enable the assessment of a model to support primary care in managing those patients who will not be assessed by specialist services. The pilot will involve therapist assessment and treatment services for a musculoskeletal condition(s).

### Regional objectives

The focus for 2015/16 is to

- maintain the focus on improving equity of access by reducing variations in systems and processes and supporting clinical pathway development
- continue the development of condition-based regional clinical pathways for otorhinolaryngology (ORL), orthopaedic and ophthalmic services
- support and monitor the implementation of clinical pathways endorsed by regional clinical groups
- continue to strengthen communication processes to ensure awareness of the regional electives work plan across the sector and provide mechanisms to support feedback
- collaborate with other regional elective teams to share learning and outcomes, thus maximising the delivery of elective services nationally
- identify opportunities to increase workforce capabilities to provide quality services that are delivered at the right time, at the right location by the appropriate health care professional
- purposefully collaborate to ensure that regional and cross-sector opportunities for elective service improvements are identified and supported.

### Regional milestones and measures

Regional milestones and measures include

- sustaining the four-month waiting time milestone
- meeting discharge targets
- improving surgical intervention rates (SIRs). Note: Await agreement by COOs and GMs for all Central Region DHBs to accept the current national average at a minimum, especially orthopaedics

*Executive lead: Chris Lowry (COO, C&CDHB)*

The Central Region DHBs will continue to identify and support the implementation of best practice in the development of referral guidelines for general practice and hospital systems and processes. Opportunities to provide innovative, safe, quality solutions for elective service delivery will be



identified and progressed where these solutions are supported by Central Region DHBs and agreed to by the Central Region COOs and GMs Planning and Funding.

The analysis and evaluation of information will support Central Region DHBs in identifying what is working well and measuring the success of elective service initiatives.

### *Non-specialty specific actions*

Key actions	Milestone/Measurement	Clinical lead
Continued reporting of elective services performance indicators (ESPI)2 and 5	Escalation system to regional COOs in place – ongoing	Central Region COOs
Continued monthly reporting of elective discharges and case-weights	Monthly reports generated for the region and escalation system to regional COOs in place – ongoing	Central Region COOs
Final Elective Services Productivity and Workforce Programme (ESPWP) report completed and endorsed by clinical networks, COOs and GMs Planning and Funding	Final ESPWP report delivered to MoH by 30 October 2015, these will indicate the financial benefit and sustainability of services	Jocelyn Carr
Identify opportunities to develop further regional pathways	Opportunities are identified and endorsed by Central Region COOs and GMs Planning and Funding (1 November 2015)	Central Region COOs and GMs Planning and Funding
Additional regional pathways are developed	Additional pathways are endorsed by appropriate regional clinical groups by 30 June 2016	Regional clinical group(s)

### *Otorhinolaryngology (ORL)*

A sub-regional ORL group began meeting prior to 1999 and has continued to meet monthly. The group includes hospital specialists from HBDHB, MDHB, WhaDHB and Taranaki DHB (TDHB). Because of this historical connection, TDHB is joining the Central Region DHBs to develop regional elective ORL clinical pathways. For the purposes of regional pathway development, general practice is now represented in this group.

Using the 3DHB and Auckland DHB ORL pathways as a baseline, the sub-regional group has developed clinical pathways for chronic and acute rhinosinusitis and vertigo. Links have been developed between the two sub-regional ORL groups that will enable further collaboration across the Central Region.

*Clinical lead: Paul Mason (ORL Surgeon, HBDHB)*

Key actions	Milestone/Measurement	Clinical lead
Regional pathways for vertigo and acute and chronic rhino sinusitis are available for Central Region DHBs for localisation	Pathways published in Map of Medicine (30 September 2015)	Sub-regional ORL clinical group
Develop two additional ORL clinical pathways	Two additional ORL clinical pathways endorsed by sub-regional clinical group (28 August 2015)	Sub-regional ORL clinical group
Two additional ORL pathways are available to Central Region DHBs for local implementation	Pathways published in Map of Medicine (30 September 2015)	Sub-regional ORL clinical group
Identify systems and processes to support Central Region DHBs in improving the delivery of ORL elective services	Systems and processes documented and disseminated to Central Region DHBs through clinical and management groups	Regional ORL group
Identify opportunities for Central Region DHBs to collaborate to enhance the delivery of ORL elective services	Opportunities are identified and escalated to Central Region DHB COOs for further exploration (30 September 2015)	Regional ORL group
Support and monitor the implementation of ORL pathways in the Central Region	Pathways are implemented and utilisation monitored including improving the patient experience (31 December 2016)	Regional ORL group

## Orthopaedics

*Clinical lead: Mr Tim Love (Orthopaedic Surgeon, MDHB)*

The establishment of the Central Region Orthopaedic Network in May 2014/15 has been a successful collaboration of primary care and hospital specialists from each of the Central Regional DHBs. The network has developed and endorsed four clinical condition pathways and developed a tool for prioritisation of referrals for orthopaedic FSAs. An acute spinal pathway has been developed and endorsed and is being trialled by the six Central Region DHBs. Three of the six Central Region DHBs have implemented a surgical prioritisation tool developed by C&CDHB.

The focus for the 2015/16 year will be on the further development and implementation of clinical pathways and tools developed by the network and the further identification and implementation of best-practice systems and processes (clinical and non-clinical) to enhance the delivery of elective orthopaedic services.

Key actions	Milestone/Measurement	Clinical lead
Community-based Spine clinic ( CBSC) pilot completed	CBSC evaluation is presented to stakeholders (1 November 2015)	Central Region Orthopaedic Network
All regional orthopaedic clinical pathways are available to Central Region DHBs for localisation	Pathways published in Health Pathways and Map of Medicine (30 September 2015)	Central Region Orthopaedic Network
Successful enhanced recovery after surgery (ERAS) processes have been identified and made available to Central Region DHBs	Central Region DHBs have information to assist in determining the ERAS processes to be implemented in their DHBs, including <ul style="list-style-type: none"> <li>• pre-assessment</li> <li>• pharmaceutical management</li> <li>• physiotherapy</li> <li>• discharge planning</li> </ul>	Central Region Orthopaedic Network and elective services managers
Identify opportunities for Central Region DHBs to collaborate to enhance the delivery of orthopaedic elective services	Opportunities are identified and escalated to Central Region DHB COOs for further exploration (30 September 2015)	Central Region Orthopaedic Network
Support and monitor the implementation of Orthopaedic pathways in the Central Region	Pathways are implemented and utilisation monitored including improving the patient experience (31 December 2016)	Regional Orthopaedic Network

## Ophthalmology

*Clinical lead: TBA*

Key actions	Milestone/Measurement	Clinical lead
Regional pathways for macular degeneration and glaucoma are developed	Pathways are endorsed by regional ophthalmology clinical group by 31 July 2015	Regional ophthalmology clinical group
Regional pathways for macular degeneration and glaucoma are available for Central Region DHBs to implement	Pathways are published in Health Pathways and Map of Medicine (30 September 2015)	Regional ophthalmology clinical group
If identified, additional ophthalmic	Additional pathways are endorsed by regional ophthalmology clinical group	Regional ophthalmology

Key actions	Milestone/Measurement	Clinical lead
pathways will be developed	by 31 July 2015	clinical group
Additional regional ophthalmic pathways are available for Central Region DHBs to implement	Pathways are published in Health Pathways and Map of Medicine(30 September 2015)	Regional ophthalmology clinical group
Identify systems and processes to support Central Region DHBs in improving the delivery of ophthalmic services	Systems and processes are documented and disseminated to Central Region DHBs through clinical and management groups	Regional ophthalmology clinical group
Identify opportunities for Central Region DHBs to collaborate to enhance the delivery of ophthalmic elective services	Opportunities are identified and escalated to Central Region DHB COOs for further exploration (30 September 2015)	Regional ophthalmology clinical group
Support and monitor the implementation of Ophthalmology pathways in the Central Region	Pathways are implemented and utilisation monitored including improving the patient experience (31 December 2016)	Regional Ophthalmology Network

Linkages to Information Technology	
Regional capacity model developed for all acute and elective services	Capacity model for 2015-2025 completed and available for Central Region DHBs (July 2015)
Information solutions will be agreed to analyse: <ul style="list-style-type: none"> <li>regional theatre utilisation at a DHB level</li> <li>regional comparative KPI data at specialty and DHB levels</li> </ul>	Central Region COOs and GMs Planning and Funding endorse and develop an implementation plan (31 December 2015)

Linkages to Workforce	
Evaluate opportunities to utilise physiotherapists in the delivery of elective services	Regional clinical pathways for elective orthopaedic and ORL services utilise physiotherapists in the delivery of assessment and treatment services in specified clinical pathways

### Māori Health

The Central Region's approach to improving Māori health and reducing inequalities is contained in its Regional Māori Health Plan, Tū Ora. The Central Region's electives programme is committed to improving equity of access through the development of clinical pathways and consistent systems and processes

Where elective services data is available by ethnicity and a regional approach can offer the opportunity to improve access for Māori, this will be considered in regional pathway development and available for implementation at a local DHB level



## 8. Hepatitis C

### Sponsor TBC

Hepatitis C is a new initiative in the 2015/16 Regional Service Plan. A three year pilot in Capital & Coast, Hutt Valley and Wairarapa DHBs was contracted directly by the Ministry of Health and delivered by the Hepatitis Foundation between 2012 and June 2014. The objectives of the Pilot were to:

- Increase awareness of hepatitis C in the community
- Improve access to and uptake of hepatitis C testing, assessment, and treatment
- Improve health outcomes for people living with hepatitis C
- Improve data quality to enable the programme to address the disease burden.

The Ministry evaluated the pilot and the Minister of Health approved the reintegration of hepatitis C services into a DHB-led rather than NGO-led model of service delivery.

In 2015/16 financial year the Central Region will be working towards planning and delivering a hepatitis C service for the whole region to ensure continuity of care for those patients currently in the pilot sites and the ongoing identification, assessment and treatment of new patients with hepatitis C. The following is the plan of work.

### Key Actions 2015/16

Key Actions	Milestone/Measurement	Lead
Develop project plan for delivery of integrated hepatitis c services across the region	Quarter 2	C&CDHB, HVDHB & WaiDHB
Develop a sustainable service including a health pathway through engagement across the Central Region and the Hepatitis Foundation.	Quarter 3	C&CDHB, HVDHB & WaiDHB
Prepare implementation	Quarter 4	C&CDHB, HVDHB & WaiDHB
Implemented	2016/17	C&CDHB, HVDHB & WaiDHB

## 9. Major Trauma

### Sponsor Debbie Chin

A major trauma is defined as an event requiring the treatment of two or more injuries generally relating to the head or spine, or refers to an Injury Severity Score greater than 12.

Trauma is a major health burden in New Zealand. Approximately 2,500 New Zealanders die per year as a result of trauma and approximately 30,000 require hospital care for their injuries. Trauma is the leading cause of death and hospitalisation between the ages of five and 45. It is estimated that trauma patients in New Zealand have a 20% rate of preventable mortality as a result of the lack of an organised system of trauma care throughout the country. The rate of preventable morbidity is not known but is expected to be many times greater than the predicted preventable mortality rate. Of all trauma admissions to hospital, approximately 10% have severe or life-threatening injuries. These patients are time-critical, are highly vulnerable to any deviation from best practice in early decision-making and service provision, and require the comprehensive input of specialised trauma services. After the Ministry established a Major Trauma National Clinical Network (MTNCN) to improve outcomes from major trauma, a national clinical lead was appointed to ensure oversight through a planned and consistent approach to major trauma in New Zealand. Each region will focus on a regional approach to major trauma.

- The establishment of MTNCN is a quality initiative that is tasked with improving outcomes from major trauma.
- The development of a Central Region Major Trauma Network is part of the RSP Plan (2014-2017) and reflects the national priority.
- The three-year plan 2014-2017 identifies the following objectives:
  - To designate trauma clinical leads within the region.
  - To establish a process to collect and report on trauma data.
  - To establish a three-year Central Region Major Trauma Plan.

A regional approach to the management of major trauma will constitute the development of a trauma network that will support the collation and coordination of the six Central Region DHBs' plans and a referral pathway to the regional centre at C&CDHB, that supports timely referrals and treatment where required.

Developing a regional plan for major trauma presents several challenges due to the relative geographical isolation of some Central Region DHBs. While certain activities will align, it is expected that a regional approach will constitute the collation and co-ordination of the six Central Region DHBs' plans for the purposes of reporting against the actions and milestones that each identifies.

The Central Region Major Trauma Working Party will identify personnel in each Central Region DHB and work with them to progress the development of a three-year Central Region Major Trauma Plan. The Central Region will work through a process to achieve trauma verifications status with the Royal Australasian College of Surgeons. Major trauma has interdependency with diagnostic imaging services.

The collection of key data elements will be progressed. Processes will be developed both regionally and at a DHB level to enable the collection of patient-level major trauma data from 1 July 2015.



To achieve the following outcomes

Regional objectives
<p>Designated DHB clinical leads, co-ordinators and a regional clinical lead are identified</p> <p>A process is established to collect and report the data required to implement a national register</p> <p>A three-year Central Region Major Trauma Plan is developed to enable the collection and reporting of nationally consistent major trauma data and the development of local and regional major trauma systems</p>
Regional milestones and measures
<p><b>Milestones</b></p> <p>Identify the actions that the region will undertake to support DHBs' engagement with MTNCN</p> <p>Develop a three-year regional action plan that will deliver:</p> <ul style="list-style-type: none"> <li>the collection and reporting of a nationally consistent major trauma dataset</li> <li>the implementation of local and regional major trauma systems</li> </ul> <p><b>Measures</b></p> <p>For the 2015/16 year it is expected that processes for enabling the commencement, collation and measuring of reporting on the full New Zealand Major Trauma Dataset (NZMTD) will evolve</p>

Lead: Chris Lowry

Clinical lead: Mr Grant Kiddle (C&CDHB)

Key actions – 2015/16

Key actions	Milestone/Measurement	Lead
<p>The Central Region Major Trauma Working Party will be established</p> <p>MTNCN will review a base plan developed by C&amp;CDHB and build on this</p> <p>Present data analysis to regional GMs and COOs for support</p>	<p>31 December 2015</p> <p>March 2016</p> <p>March 2016</p>	<p>Chris Lowry</p>
<p>Terms of reference for the Central Region Major Trauma Working Party will be defined</p>	<p>30 September 2015</p>	<p>Chris Lowry</p>
<p>An approved major trauma work plan will be developed for year one and priorities established for years two and three, including:</p> <ul style="list-style-type: none"> <li>the collection and reporting of a nationally consistent major trauma dataset</li> <li>the implementation of local and regional major trauma</li> </ul>	<p>31 March 2016</p> <p>June 2015</p> <p>Participate in national initiatives to ensure the accuracy and quality of trauma data, and the governance of trauma data</p>	<p>Chris Lowry</p> <p>Signed off by clinical leads as identified by DHB</p>



Key actions	Milestone/Measurement	Lead
<p>systems</p> <p>Submit plan to regional GMs and COOs for endorsement</p>	<p>A key quality marker we will measure is major trauma in-Hospital death</p> <p>30 September 2015</p>	
<p>The three-year Regional Major Trauma Plan is completed and approved</p>	<p>30 June 2015</p>	<p>Chris Lowry</p>
<p>Each Central Region DHB will identify a designated clinical lead for major trauma</p>	<p>30 August 2015</p>	
<p>Each Central Region DHB will establish a co-ordinator function. This will enable the identification of those patients who meet the criteria indicating major trauma and the capture of relevant data</p>	<p>1 July 2015</p>	
<p>C&amp;CDHB pilot patient identification and data collection system</p>	<p>Commenced by 1 August 2015</p> <p>Completed by 31 July 2015</p>	
<p>Central Region DHBs pilot patient identification and data collection system</p>	<p>Commenced by 1 August 2015</p>	
<p>Central Region DHBs roll out patient identification and data collection system</p>	<p>October 2015</p>	
<p>The Central Region DHBs align local trauma definitions with those used in NZMTD</p>	<p>1 July 2015</p>	
<p>The regional plan for the collection and reporting of a nationally consistent dataset is implemented</p>	<p>31 December 2015. Datasets received by NZMTD from the Central Region's DHBs support the collection and reporting of a nationally consistent major trauma dataset</p>	

### High-level actions – 2015-2017

Actions identified in the Central Region Major Trauma Plan for the 2015/16 year relating to the implementation of local and regional major trauma systems are completed by 30 June 2016.

Actions identified in the Central Region Major Trauma Plan for the 2016/17 year relating to the implementation of local and regional major trauma systems are actioned – 30 June 2017. Local and regional major trauma systems are established.

Actions	Milestone/Date
Support the development and implementation of destination protocols in the region in collaboration with pre-hospital ambulance providers	30 June 2016 Implementation of destination protocols in line with national roll-out
Participate in national initiatives to ensure the accuracy and quality of trauma data, and the governance of trauma data	30 June 2016 Data collection implemented in all DHBs and uploaded to national registry.  A key quality marker we will measure is major trauma in-hospital death
Support quality improvement initiatives including the development of regional trauma guidelines	30 June 2016 Regional trauma guidelines progressed
Develop regionalised recruitment, training and retention initiatives to ensure that there is a regional approach to the appropriate level of workforce required to deliver the future service	30 June 2016 Trauma training for clinical staff continued and other trauma training opportunities explored
Utilise the lessons learned from the centralAlliance service review to inform the region of the proposed future service model for the region	30 June 2016 Delivery of lessons learned from centralAlliance service review

### Linkages to other work programmes

Sub-regional	
3DHBs centralAlliance	30 June 2015 Delivery of lessons learned from centralAlliance service review

## 10. Diagnostic Imaging

### Sponsor TBC

Care Closer to Home in relation to diagnostic imaging means that all New Zealanders are provided with patient-focused and regionalised diagnostic imaging services that are high quality, timely, affordable and therefore sustainable.

DHBs face challenges due to increased patient demand and the need to improve the access, quality, sustainability and affordability of services. Diagnostic imaging in the Central Region continues to be identified as a vulnerable service as a result of these tensions. This is unsustainable from both capacity and financial perspectives. To resolve this we must find new and better ways of organising, funding and delivering services. New ways of working, new tools, flexible locations, demand management strategies and workforce mobility are required. While not named as a Ministerial priority, the MoH National Radiology Service Improvement Initiative has made funding available to DHBs to enable quality improvement initiatives to be rolled out.

By providing diagnostic information at critical points in the patient journey, imaging services rationalise the need for intervention and target where it will have the greatest benefit. Diagnostic imaging supports DHBs in meeting current and new national targets, and allows the adoption of new models of care such as clinical pathways and virtual clinics. These opportunities are designed to improve care for the patients and achieve greater efficiency across the system. As part of this service improvement, access to diagnostic imaging services by ethnicity will also be captured and analysed.

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

Workforce recruitment and retention and profession shortage issues continue to affect all diagnostic imaging professions, in particular radiologists and sonographers. Ultrasound workforce numbers are a significant issue for the region and nationally. There is a need to look at the diagnostic imaging service as a whole, including the primary sector. This is compounded by a lack of cohesion in sub-regional and regional contracting relationships with private imaging providers.

As part of this wider diagnostic imaging programme, a cost-effective and accessible primary care radiology service needs to be developed through improvements in community referrals and clinical pathways. The outcome of this may require clinical leadership, regional consistency and behaviour change.

Greater integration across the 3DHBs, including the 3DHB Radiology Service programme, will continue. This work will involve the pooling of budgets for capital and operational expenditure to fund these fundamental service initiatives. A failure to address these issues will continue to keep the diagnostic imaging service under tension, with a result that KPIs and wait time indicators may not be met.

The Central Region programme of work for diagnostic imaging is led within the region by lead CEO and sponsor, chaired by Chris Lowry (COO, C&CDHB) and facilitated and co-ordinated by the Regional Radiology Steering Group, which is clinically led by Dr James Entwisle.

To achieve the following outcomes

### Regional objectives

The regional objective will be to continue to focus on the regional work programme managed by the Regional Radiology Steering Group, in consultation with appropriate sub-regional groups, and includes:

- regionalisation: overall regionalisation of diagnostic imaging services in the Central Region, stage one being the 3DHB Radiology Service
- IT infrastructure: supporting the development and installation of a regional RIS solution through the RHIP
- workforce: investing and improving the workforce to become regionally sustainable in the future
- clinical indicators: standardising clinical indicators and implementing appropriate access criteria across the Central Region to improve equitable and timely access to diagnostic imaging
- developing a cost-effective and accessible primary care radiology service through improvements in community referrals and clinical pathways
- participating in activities relating to the development and implementation of the National Patient Flow (NPF) system, including adapting data collection and submission to allow reporting to the NPF as required
- working with regional and national clinical groups to contribute to the development of improvement programmes

### Radiology

DHB actions are meant to support improvements in radiology services. These include deliverables under each National Radiology Service Improvement Initiative that are aimed at supporting improved access, quality of care and patient flow management, or that maximise available capacity and resources

### Regional milestone and measures

The substantive milestone for diagnostic imaging across the Central Region:

To create a patient-focused, high-quality, timely and affordable regionalised radiology service by 2016. This will be measured by:

- agreed NPF system changes that are implemented
- representation and attendance at, and participation in, national and regional clinical group activities

CT - 95% of accepted referrals for CT scans will receive their scans within six weeks (42 days)

MRI - 85% of accepted referrals for MRI scans will receive their scans within six weeks (42 days)

*Clinical lead: Dr James Entwisle*

*Key actions – 2015/16*

The vision for the Central Region radiology services is to provide the Central Region with a patient-focused and regionalised diagnostic imaging service that is high quality, timely, affordable and therefore sustainable.

All work undertaken by the Regional Radiology Steering Group will contribute to the achievement of this vision. The key actions for the 2015/16 year are detailed as follows:

Key actions	Milestone/Measurement	Clinical lead
<p><b>KPIs</b></p> <p>Work with all DHBs to ensure that they have systems in place to manage and improve their individual CT and MRI waiting time indicator performance, while ensuring patient safety and improving access for all patient groups, including elective procedures and colorectal cancer</p>	<p>Quarterly reporting</p> <p>KPIs and reporting on KPIs to the Central Region's COOs and GMs Planning and Funding</p> <p>Identify barriers to efficient performance and service improvement</p> <p>Make recommendations to assist in the removal of barriers to efficient performance and/or improvement in service initiatives</p>	<p>Central Regional Radiology Group and DHBs</p>
<p><b>Service vision</b></p> <p>Work with all DHBs and their sub-regional constructs to ensure that service delivery is consistent with the aims of the regional radiology vision for the Central Region, namely a patient-focused and regionalised diagnostic imaging service that is high quality, timely, affordable and sustainable</p> <p>Work with COOs and GMs Planning and Funding to support radiology diagnostic procedures and interventions to occur closer to home for some patients where practicable/suitable (domicile scanning)</p> <p>Support Planning and Funding to implement the National Radiology Access Criteria (NRAC) or Central Region Radiology Access Criteria (CRRAC)</p> <p>Regional Positron emission tomography (PET) service</p>	<p>Continue to work with the 3DHBs' to support its delivery of service reconfiguration across 3DHBs. This will include attendance at regular 3DHB meetings and taking lessons learned back to the regional table</p> <p>C&amp;CDHB to pilot 'Choosing Wisely'<sup>22</sup></p> <p>To quantify current referrals to the DHB of domicile for radiology imaging by Q2</p> <p>COOs and GMs to consider implications of domicile scanning and financial impact on DHBs</p> <p>Monitor the implementation of NRAC/CRRAC across the Central Region and report on traction and/or barriers</p> <p>Analyse costs and patient data/volumes/trends by Quarter 2</p> <p>Develop an options paper that includes private fixed, public fixed or mobile PET service model by Quarter 4</p>	<p>Central Region Radiology Group and DHBs</p>
<p><b>Workforce development</b></p> <p>Establish regional network for radiology registrar training in line with the Royal</p>	<p>Q2: Co-ordinate and set up a Radiology Registrar Regional Training Network in line with college requirements</p>	<p>Central Region Radiology Workforce</p>

<sup>22</sup> 'Choosing Wisely' is about helping doctors and patients to engage in conversations to reduce the overuse of tests and procedures, and supports patients in their efforts to make smart and effective care choices

Key actions	Milestone/Measurement	Clinical lead
Australian and new Zealand College of Radiologists		Working Group
<b>Governance and programme structure</b> Operationalise and maintain the necessary governance, business-as-usual and change-control systems to deliver the regional RIS and PACS work programme, including the systems delivered by Regional Health Informatics Programme	Q1: Define scope Define what we understand is required to govern regional systems once implemented Support Regional Health Informatics Programme roll-out of regional RIS Q1 and Q2 Work with DHBs to develop a radiology informatics framework that includes: <ul style="list-style-type: none"> <li>regular reporting</li> <li>business intelligence</li> <li>dashboard</li> <li>business as usual and service improvement</li> </ul> Q1: Implement structure Work with individual DHB operational teams to implement and maintain the necessary structure for managing the RSP work programme, including the systems delivered by Regional Health Informatics Programme (Regional PACS/RIS)	Central Region Radiology Group, COOs, GMs Planning and Funding, REC and Operations and Governance (PACS/RIS) Working Group
<b>Service improvement plans</b>	Continue to monitor radiology DHB service improvement plans, which are part of the MoH-funded Service Improvement programme and provide opportunities to share learning across the region	

### Linkages to other work programmes

Sub-regional	
3DHB CRRAC programme	31 December 2015 Delivery of 3DHB service integration and improvement 30 June 2016 Delivery of lessons learned from 3DHB programme



<b>Information Technology</b>	
<p>Operationalise and maintain the necessary governance, business-as-usual and change-control systems to manage the IT systems delivered by Regional Health Informatics Programme (RIS/PACS)</p> <p>Develop radiology informatics and business intelligence for the regional RIS that ensure appropriate resources are provided within DHBs to measure KPIs and service improvement and enable proactive production planning</p>	<p>30 June 2016</p> <p>Work with TAS, Regional Health Informatics Programme and individual DHB operational teams to maintain the necessary structure for managing regionalised radiology IT systems</p> <p>Engage Health Informatics to develop and implement a radiology informatics and business intelligence strategy</p> <p>3DHB to be the pilot site for trialling initial initiatives</p>

<b>Workforce</b>	
<p>Develop a vulnerable workforce programme for diagnostic imaging, starting with sonography</p>	<p>Refer to Regional Workforce section pg. 134</p>

<b>Māori Health</b>	
<p>Develop and implement a framework to review Māori health outcomes</p>	<p>The Steering Group will integrate actions and work streams to ensure that Māori health outcomes are being achieved using the MoH Equity of Health Care for Māori: A framework (where appropriate)</p> <p>Capture MRI and CT Central Region data by ethnicity to determine equity issues</p>

### High-level actions – 2016-2018

<b>Actions</b>	<b>Milestone/ate</b>
<p>All DHBs have systems in place to manage their CT and MRI waiting time indicators to ensure patient safety and improve the patient experience for all patient categories, including elective procedures and colorectal cancer</p>	<p>30 June 2016</p> <p>Waiting time indicators for CT and MRI are achieved</p>
<p>Develop a plan for delivering the future regional diagnostic imaging service</p>	<p>30 June 2016</p> <p>Future service development plan</p>
<p>Develop regionalised recruitment, training and retention initiatives to ensure that there is a regional approach to the appropriate level of workforce required to deliver the future service</p>	<p>30 June 2016</p> <p>Regionalised recruitment, training and retention</p>

Actions	Milestone/ate
Pilot a nuclear medicine reporting programme using regional RIS	30 June 2017 Deliver a regional reporting model

### High-level actions – 2016/17

The main focus for diagnostic imaging in this time period is as follows:

- All DHBs have systems in place to manage their CT and MRI waiting time indicators to ensure patient safety and improve the patient experience for all patient categories, including elective procedures and colorectal cancer.
- The waiting time indicators for CT and MRI are achieved.
- Diagnostic imaging contributes to the local and regional development and implementation of access criteria and treatment pathways.
- Continue to develop the use of service-wide MDMs.
- Utilise the lessons learned from the 3DHB service configuration and adapt/adopt into the regional view where appropriate as part of achieving the long-term vision of the regional diagnostic imaging service.
- Develop, agree on and commence implementation of a plan for delivering the regional diagnostic imaging service vision.
- Develop regionalised recruitment, training and retention initiatives to ensure that there is a regional approach to the appropriate level of workforce required to deliver the service vision.



## Regional enablers – Regional and National Priorities

### 11. Workforce

#### Sponsor TBC

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

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

The Central Region has identified 21 workforce priorities for 2015/16 and onwards. 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.

Under the leadership of the Regional Director of Workforce Development working in conjunction with the Central Region DHBs professional groups (GMs Human Resources [GMsHR], Directors of Nursing [DON], Midwifery Leaders Group [MLG], Directors of Allied Health, Technical and Scientific [DAH], Chief Medical Officers [CMO], Directors of Pacific Health [DoPH], Central Region Maori Managers [CRMM]) and Regional Programme Planning and Improvement Managers and Networks, there is now a clear aim, clear direction and the resources in place to support all those staff across the Central Region who are committed to improvement and want to see their workforce trained effectively so that retention remains high as does the quality of the service provided. In addition, the Central Region DHBs will work with primary and community organisations to advance regional workforce plans.

This plan acknowledges the alliance formed between the six DHBs and HWNZ as a critical nexus in addressing workforce priorities and enabling the region to cultivate the existing collaborative and cohesive network for developing valid workforce initiatives and innovations.

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.

*To achieve the following outcomes*

#### Regional objective

- Support the HWNZ mission to ensure a health workforce in New Zealand that is both sustainable and fit for purpose

**Regional Workforce Key Actions**

- E-Learning - Explore sharing content across identified primary services within health sector
- Midwifery - Develop professional support framework
- Midwifery - Develop programme focusing on career planning, leadership and ageing workforce
- Allied Health Technical and Scientific - Establish AHTS new graduate framework
- Medicine - Improve sustainability and resiliency of workforce
- Pacific - Increase sustainability and resilience of Pacific health workforce
- Māori and Pacific - Increase workforce regionally in health (supported by regional GMsHR)
- Pacific - Develop a culturally aware workforce
- Māori - Develop a culturally aware workforce (supported by regional GMsHR)
- Sonography - Implement regional workforce plan
- Echocardiography - Develop a sustainable workforce
- Nursing - Specialist nurses are available to perform colonoscopies
- Nursing - Support the development of the advanced practice nursing workforce
- Medicine - Increase and improve resilience of palliative SMO workforce
- Kaiāwhina and Allied Health Assistant Workforce – Support national project and regional AHA programme
- ACP - Increase ACP training in identified high-need priority areas
- Mental Health and Addiction - Implement 2015 workforce plan
- Nursing - Increase nurse leaders with emphasis on Māori and Pacific
- Allied Health Technical and Scientific - AHTS career pathways available
- Medicine - Ensure effective leadership
- Leadership – Support regional alignment with national domains

**Milestone/ Measurement**

Quarterly reporting of progress on the key milestones in the RSP via the National Health Board accountability framework

*Lead: Roy Pryer*

Key actions	Deliverables	Milestone/Measurement	Lead
<b>E-learning shared content is accessible to the health workforce across the central region</b>			
<b>E-Learning</b> Explore sharing	E-Learning content is accessible across	Q2: Network with PHO L&D contacts Q3-4: TNA with identified regional	<b>Regional development</b> WF Hub, DHB and PHO

Key actions	Deliverables	Milestone/Measurement	Lead
content across identified primary services within health sector	primary and secondary sector	PHOs including IT system accessibility Q4 onwards: Develop and agree regional plan for implementation of feasible shared content (implementation 2016- 17)	L&D leads <b>Regional implementation</b> DHB and PHO L&D leads
<b>Actively support and contribute to midwifery workforce</b>			
<b>Midwifery</b> Develop professional support framework	Regional midwifery professional support framework	Q1: Develop and implement midwifery professional support model pilot Q3 onwards: Complete model pilot evaluation Q4 onwards: Establish a regional professional support framework from evaluation results	<b>Regional development</b> MLG <b>Regional implementation</b> MLG
<b>Midwifery</b> Develop programme focusing on career planning, leadership and ageing workforce	Strategic plan to address current ageing workforce and future role development  Regional education framework for leadership identification and development	Q1-3: Undertake stocktake of midwifery workforce Q3 onwards: Develop and implement a strategic plan to address current ageing workforce and workforce need (to include regional leadership education framework)	<b>Regional development</b> MLG, GMsHR and RDoWD <b>Regional implementation</b> MLG
<b>Actively support and contribute support to Allied Health, Technical and Scientific workforce</b>			
<b>Allied Health Technical and Scientific</b> Establish AHTS new graduate framework	Regional framework for new graduate programme for Occupational Therapists and Social Workers working in mental health	Q1-2: Scope professional postgraduate study with associated Te Pou funding Q3-4: Develop and implement regional framework	<b>Regional development</b> DAHs, RDoWD <b>Regional implementation</b> DAHs
<b>Actively support and contribute to Medical workforce</b>			
<b>Medicine</b> Improve sustainability and resiliency of workforce	All HWNZ funded trainees have access to career plans  Development of regional agreed orientation programme for RMOs  Support the DHBs to	Q1-4: Continue to provide RMO career pathway planning and support aligned with MCNZ guidelines Q3 onwards: Scope and develop regional plan for potential registrar positions in hard-to-staff/vulnerable specialties Q3 onwards: Scope and develop a	<b>Regional development</b> CMOs, COOs/GMsPF, GMsHR, Prevocational Educational Supervisors and RMO Coordinators  <b>Regional implementation</b>

Key actions	Deliverables	Milestone/Measurement	Lead
	integrate increased number of PGY1 (NZ permanent residents and citizens)	regional orientation programme for RMOs utilising nationally developed online programmes	CMOs, GMsHR, COOs/GMsPF, Prevocational Educational Supervisors and RMO Coordinators
<b>Actively support and contribute to increasing participation of Māori and Pacific in workforce</b>			
<b>Pacific</b> Increase sustainability and resilience of Pacific health workforce	Increased PDRP and QLP workforce uptake in Pacific nursing and midwifery workforce Regional succession plan for Pacific leaders	Q3-4: Increase PDRP and QLP hospital based nursing and midwifery Pacific workforce uptake Q4 onwards: Scope Pacific Leadership Programme with identified future Pacific workforce leaders across disciplines	<b>Regional development</b> DoPH, DON, MLG and RDoWD <b>Regional implementation</b> DoPH, DON and MLG
<b>Māori and Pacific</b> Increase workforce regionally in health (supported by regional GMsHR)	Increase in regional recruitment of Māori and Pacific in nursing, midwifery, medicine and allied health	Q1-2: Benchmark current Māori and Pacific workforce Q2: Identify and agree regional and local recruitment targets Q3 onwards: Development of regional recruitment plan if appropriate	<b>Regional development</b> CRMM, DoPH, GMsHR and regional professional leads <b>Regional implementation</b> CRMM, DoPH, GMsHR and regional professional leads
<b>Promote and support culturally responsive workforce</b>			
<b>Pacific</b> Develop a culturally aware workforce	Develop regional strategic action plan to increase Pacific responsiveness training (implementation and evaluation in 2016 onwards)	Q1-3: Undertake TNA of cultural responsiveness training Q4 onwards: Develop cultural responsiveness plan from TNA (with implementation 2016-17)	<b>Regional development</b> DoPH and RDoWD <b>Regional implementation</b> DoPH
<b>Māori</b> Develop a culturally aware workforce (supported by regional GMsHR)	One regional Māori Capability programme	Q2: Evaluate Māori Capability Programme pilot (September 2015) Q3 onwards: Develop and implement strategic rollout plan for one regional programme	<b>Regional development</b> CRMM and GMsHR <b>Regional implementation</b> CRMM and GMsHR
<b>Regional approaches to actively support vulnerable workforces</b>			
<b>Sonography</b> Implement regional workforce plan	Increase in sonography training numbers and recruitment with	Q1- 3: Develop regional strategy aligned to national work including trainee solution with quarterly	<b>Regional development</b> HWNZ, DAHs, GMsHR, RDoWD, Regional

Key actions	Deliverables	Milestone/Measurement	Lead
	alignment to national work and regional strategy	workforce benchmarking Q3-4: Implement regional strategy	Sonography Workforce Group <b>Regional implementation</b> HWNZ, DAHs, GMsHR, Regional Sonography Workforce Group
<b>Echocardiography</b> Develop a sustainable workforce	Develop and implement workforce development plan for echocardiography workforce resulting in reduced vacancies within workforce  Regional career pathway framework	Q1: Complete a stocktake of workforce numbers to determine current and future workforce planning requirements Q2-3: Develop regional plan based on findings in Q1 Q3- 4 onwards: Implement regional plan and monitoring framework	<b>Regional development</b> Regional Professional Leads and Networks, COOs, DAHs, GMsHR and RDoWD <b>Regional implementation</b> HWNZ, DAHs, GMsHR, Regional Sonography Working Group, DHBs
<b>Nursing</b> Specialist nurses are available to perform colonoscopies	Strategic regional plan aligned to national plan as appropriate	Q1-4: Scope and identify nursing workforce initiatives in conjunction with MoH and HWNZ Q4 onwards: Complete a regional plan if appropriate to align regional initiatives with national bowel screening action plan	<b>National development</b> MoH <b>Regional development</b> DONs, GMsHR and RDoWD <b>Regional implementation</b> DONs, GMsHR
<b>Nursing</b> Support the development of the advanced practice nursing workforce	Increase number of CNS and NP roles in region (for action 2016 onwards)	Q1-2: Benchmark of current CNS and nurse practitioner roles within regional health sector Q2 onwards: Regional job standardisation of CNS roles with identification of LTC CNS roles Q4 onwards: Develop and Implement regional plan with monitoring framework for increasing CNS and NP numbers in region	<b>Regional development</b> DONs and Directors of Mental Health <b>Regional implementation</b> DONs and Directors of Mental Health
<b>Medicine</b> Increase and improve resilience of palliative SMO workforce	Increase in registrar training volumes (for action 2016 onwards)  Decrease in unfilled palliative care SMO	Q1: Review palliative care SMO workforce status Q2-3: Develop regional plan to increase HWNZ regional training volumes for Palliative SMO Q3-4: Implement regional plan with monitoring framework	<b>Regional development</b> Regional Cancer Network, GMsHR and CMOs <b>Regional implementation</b> Regional Cancer

Key actions	Deliverables	Milestone/Measurement	Lead
	positions within the region		Network, GMsHR and CMOs
<b>Kaiāwhina and Allied Health Assistant Workforce</b> Support national project and regional AHA programme	Development and implementation (2016 onwards) of regional action plans aligned to national initiatives for Kaiāwhina workforce, as appropriate.  AHA programme in 5/6 DHBs	Q1-4: Participate in national initiatives in formulating the national and regional unregulated workforce training structure (Kaiāwhina project) Q2-4: Further develop and embed the AHA programme in five out of six DHBs Q3-4: Develop and implement Kaiāwhina regional action plan	<b>National development</b> HWNZ and Careerforce <b>Regional development</b> GMsHR, DAHs, RDoWD <b>Regional implementation</b> TBA
<b>ACP</b> Increase ACP training in identified high-need priority areas	Increase in ACP level 1 and level 2 trained in high need areas for RMO workforce, Nursing workforce and Allied Health, Scientific and Technical Services workforce	Q1 onwards: Agreed 30% of regional nursing workforce/ 50% regional allied health, scientific and technical services workforce/ 15% RMO/ SMO workforce to undertake level 1 training by June 2016 Q1 onwards: Identify and support 20 nursing staff/ five allied health, scientific and technical service within the region to undertake L2 training in identified high-need areas/services within 2015-2018 period	<b>National development</b> National ACP Cooperative <b>Regional development</b> DONs, DAHs, CMOs <b>Regional implementation</b> DONs, DAHs, CMOs
<b>Mental Health and Addiction</b> Implement 2015 workforce plan	Implementation of workforce plan aligned with national work	Q1-4: Report quarterly to MHAN and Te Pou with identified workforce requirements for new service delivery models Q3 onwards: Implement workforce development needs for region aligned with the National Workforce Centres for Mental Health	<b>National development</b> Te Pou <b>Regional development</b> MHAN and professional groups <b>Regional implementation</b> Regional DHBs and NGOs
<b>Regional collaboration to further strengthen clinical leadership</b>			
<b>Nursing</b> Increase nurse leaders with emphasis on Māori and Pacific	Regional forum for nursing leaders	Q2 onwards: Develop a regional leaders forum Q3 onwards: Develop and implement leadership programme of work for forum members	<b>Regional development</b> DONs, CRMM and DoPH <b>Regional implementation</b> DONs, CRMM and



Key actions	Deliverables	Milestone/Measurement	Lead
			DoPH
<b>Allied Health Technical and Scientific</b> AHTS career pathways available	Implement AHP career pathway and develop technical profession pathway  Develop L&D framework for AHP Implement regional technical profession career pathway from 2016 onwards	Q1 onwards: Develop and implement allied health career pathway with regional scope fit (implementation 2016/17) Q2 onwards: Develop and implement L&D framework for AHP Q3 onwards: Develop technical profession career pathway framework (implementation from 2016-17)	<b>Regional development</b> DAHs, RDoWD  <b>Regional implementation</b> DAHs
<b>Medicine</b> Ensure effective leadership	10% of identified medical workforce to undertake appropriate training on clinical leadership within 2016-18 period	Q1-4: Scope and identify leadership training Q3 onwards: Agreed X% of identified medical workforce to undertake appropriate training on clinical leadership	<b>Regional development</b> GMsHR, CMOs <b>Regional implementation</b> CMOs
<b>Leadership</b> Support regional alignment with national domains	Regional embedding of leadership framework domains	Q2-4: Provide regional training plan to align to national framework Q4: Monitor regional uptake of existing leadership programmes and develop regional plan for future leadership and development programmes	<b>Regional development</b> GMsHR <b>Regional implementation</b> DHBs and PHOs

### Linkages to other work programmes

Mental Health and Addictions
HOP
Diagnostic Imaging
Cancer Services
Cardiac Services
Māori Health

### *High-level actions – 2016-2018*

Continue to focus on health sector integration between primary, secondary and tertiary services with a greater strategic oversight of the region's workforce (in alignment with national work) and ensure effective planning for getting in place the right role, right skills, right place and right time to support new models of care and service delivery. This builds on the actions in RSP 2015/16 to strengthen our workforce for the future.

The professional workforce groups across the region will build a strongly collaborative (team health) approach to resilience and sustainability into identified vulnerable workforces, and ensuring the effective capability of the current workforce with support and development will enable leadership and succession planning.

Meeting the complex care needs of an ageing population and workforce, with particular regard to Māori and Pacific populations, will continue to be a regional priority.

The focus will also continue on collaboration to share learning and development, which will include primary service partnerships to allow greater sharing of e-learning resources and the implementation of technological and system innovation.



## 12. Quality and Safety

### Sponsor Julie Patterson

Clinical leadership alongside patient and family partnership is internationally recognised as a key driver of improved care patient safety and effective clinical governance.

There is widespread recognition that effective clinical governance systems within health care form the foundation of safer systems for patients and staff. The aim for the Central Region is to work together as a region to continually improve the quality of care and to reduce patient harm and reduction of patient harm.

To help achieve this aim the Central Region Quality and Safety Alliance (CRQSA) has been established to lead this work. The mandate for the CRQSA is to work to achieve consistent standards of quality and safety of care and positive patient experiences regardless of where they enter the Central Region health system. The principal purpose of the CRQSA will be to provide a voice for clinical leadership across the continuum to positively influence health outcomes, including the reduction of health disparities for the people of our region. This alliance will strengthen previous regional quality and safety programmes of work by ensuring that partnerships are developed with the Health Quality and Safety Commission, ACC, consumers and their families and other interested parties to share expertise and monitor progress.

Leadership will be utilised to:

- Provide effective regional quality and safety strategic planning advice and recommendations to the REC,
- Promote the effective and appropriate sharing of quality and safety information and regional learning 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.
- Promote the use of the Equity of Health Care for Māori Framework
- Ensure that quality and safety programmes, systems and processes contribute to Pae Ora (MOH He Korowai Oranga 2014) and support and provide oversight to the Central Region Patient Safety Campaign group and other central region groups which lead the programmes of high patient harm such as falls pressure injuries. Infection prevention and medication safety.

### Key Actions

- To develop a region wide clinical governance and quality improvement framework with identified and shared core values across primary and secondary sector
- To ensure central region partners with the Health Quality and Safety Commission Patient Safety Campaign to spread patient safety initiatives and perform well against the quality and safety markers and outcomes.
- To improve primary and secondary quality and safety reporting mechanisms and develop a patient safety and quality network that learns from each other

Key Actions
<ul style="list-style-type: none"> <li>To implement a regional improvement programme based on the results of the National Survey Care Indicators - Central Regional Report</li> </ul>

Sponsor: Julie Patterson

Lead: Sandy Blake

Key Actions – 2015/16

Key Actions – Quality and Safety	Milestone/Measurement	Lead
<ul style="list-style-type: none"> <li>To develop a region wide clinical governance and quality improvement framework across primary and secondary sector</li> </ul>	<ul style="list-style-type: none"> <li>Q1-2: Scope and share existing local DHB/ PHO clinical governance/ quality improvement frameworks</li> <li>Q3-4: Identify and agree core values (including an equity focus) which need to be aligned for clinical governance and quality improvement framework</li> <li>Q4 onwards: Endorse agreed core values for alignment at DHB level</li> </ul>	<p><b>Regional Development:</b> Regional DHB/PHO Quality and Safety Managers, CRQSA members</p> <p><b>Regional Implementation:</b> Regional DHB/PHO Q&amp;S Managers, CRQSA members</p>
<ul style="list-style-type: none"> <li>To ensure central region readiness for national Health Quality and Safety Commission initiatives</li> </ul>	<ul style="list-style-type: none"> <li>Q1-4: Develop “red flag” mechanism for reporting regional concerns from HQSC data on quality and safety issues raised</li> <li>Q1-4: Network and develop partnerships with HQSC programmes and the Patient Safety Campaign to influence and measure regional take up of HQSC initiatives including the patient safety markers and outcome measures of the programmes with the aim of reducing patient harm. Ensuring the incorporation of the Equity of Health Care for Māori framework and ensure that the programmes, systems and processes contribute to Pae Ora. Involving patients/whanau in patient safety and quality.</li> <li>Q2-3: Work with HQSC to influence and ensure data applicability and quality</li> </ul>	<p><b>Regional Development:</b> Regional DHB/PHO Q&amp;S Managers, CRQSA members, HQSC</p> <p><b>Regional Implementation:</b> Regional DHB/PHO Q&amp;S Managers, CRQSA members, HQSC</p>
<ul style="list-style-type: none"> <li>To improve primary and secondary quality and safety reporting</li> </ul>	<ul style="list-style-type: none"> <li>Q1: Identify PHO (primary) Quality and Safety (Q&amp;S) Managers</li> <li>Q2-3: Facilitate integration of primary</li> </ul>	<p><b>Regional Development:</b> Regional DHB/PHO Q&amp;S managers, CRQSA</p>

<p>mechanisms and develop a patient safety and quality network that learns from each other</p>	<p>and secondary quality and safety networks</p> <ul style="list-style-type: none"> <li>• Q2-3: Identify inconsistencies with DHB incident management policies and processes</li> <li>• Q3 onwards: Develop a regional clinical audit policy across primary and secondary health sector utilising current existing work programmes</li> <li>• Q4: Address identified inconsistencies with DHB incident management policies and processes across region and ensure they align to national reportable events policy</li> <li>• Q4 onwards: Endorsement of regional clinical audit policy across primary and secondary health sector through DHB leads</li> </ul>	<p>members, HQSC</p> <p><b>Regional Implementation:</b> Regional DHB/PHO Q&amp;S Managers, CRQSA members, HQSC</p>
<ul style="list-style-type: none"> <li>• To implement a regional improvement programme based on the results of the National Survey Care Indicators - Central Regional Report</li> </ul>	<ul style="list-style-type: none"> <li>• Q2: Identify the priority areas that require regional/ local level intervention/ action plan</li> <li>• Q3-4: Develop and implement appropriate action plan for priority areas</li> <li>• Q4 onwards: Evaluate and complete regional planning in readiness for next survey</li> </ul>	<p><b>National Development:</b> HQSC</p> <p><b>Regional Development:</b> DONs and Q&amp;S Managers</p> <p><b>Regional Implementation:</b> DONs and Q&amp;S Managers</p>

**Linkages to Other Work Programmes**


**High-Level Key Actions – 2015-2017**

Identified key actions will continue to focus on primary and secondary collaboration and integration while building expertise and capability in quality and safety leadership. There will be an increased focus on partnership and learning from both supporting organisations such as HQSC and ACC and patient and family partnership, in particular ensuring that the voice of the consumer is heard. The overarching aim is to provide safe and quality care to the people of the central region with our allocated resources.

## 13. Information Technology

Sponsor Kathryn Cook

The National Health IT Plan proposes 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 update 2013/14. The critical IT priorities for 2015/16 and beyond are included in the table below. The planning for ICT projects beyond 2015/16 will be part of a comprehensive regional ICT portfolio planning process, which will be established to address the imbalance in investment profiles across the region, an investment logic that suggests a balance between regional migrations and running existing business-as-usual environments.

### Regional milestones and measures

#### Reporting

The ICT portfolio will be reported monthly to regional CEOs and Regional Governance Group (RGG) and subsequently to the National Health IT Board (NHITB). A quarterly report will track progress against deliverables in the RSP

#### Key actions – 2015-2018

Key actions	Deliverable 2015/16	Deliverable 2016-2018	Responsibilities (for delivery and reporting)
<b>eMedicines programme</b>			
ePrescribing and Administration (ePA) MedChart	Regional approach agreed to implementing ePA into inpatient wards across the Central Region DHBs (incorporating NZULM - New Zealand Universal List of Medicines and New Zealand Formulary when sources are available)	To be decided	To be decided
eMedicine Reconciliation (eMR)	Medicine reconciliations business change at each of the Central Region DHBs will commence once the business change required is agreed with stakeholders	Uncompleted changes from 2015/16	TAS
ePharmacy Management (ePM)	Implement ePharmacy into Central Region DHBs using a single regional	ePharmacy implemented in all	TAS

Key actions	Deliverable 2015/16	Deliverable 2016-2018	Responsibilities (for delivery and reporting)
	instance (incorporating NZULM and New Zealand Formulary when sources are available) to enable the management of medications from a shared Central Region perspective.	Central Region DHBs	
<b>National solutions</b>			
Maternity Clinical Information System (MCIS)	Support the nationally led programme of implementing CleverMed. This includes a patient portal view and secondary care maternity management at HBDHB, HVDHB and C&CDHB	Completed	Each DHB responsible for its own project
National Patient Flow (NPF)	Phase 2 National Data Collection (referrals to FSAs) live (1 July 2015)  Regional patient administration system (PAS) approach to be scoped for NPF	Still to be defined-nationally led project	DHB delivery  For regional PAS only TAS
Finance, procurement and supply chain	To support the Finance, Procurement and Supply Chain programme, which aims to improve the way DHBs purchase goods and services	Deliverables still to be defined by this nationally led project	DHB delivery
National Data Centre Project (NIPS).	To migrate Central Region DHB hardware to the agreed NIP data centres to meet the requirements of the National Data Centre Project as the DHB deliverables are agreed	Deliverables still to be defined by this nationally led project	DHB delivery
Common operating environment upgrades	Replacement of Windows 2003 server at all DHBs	NA	DHB delivery
<b>eReferrals</b>			
eReferrals (as part of RHIP which has replaced CRISP)	Regional implementation of e-Referrals (electronic referrals), as part of Orion Health's Referral Management System (RMS) in RHI	Regional implementation of Stage 2 – complete	TAS Co-ordination

Key actions	Deliverable 2015/16	Deliverable 2016-2018	Responsibilities (for delivery and reporting)
	Clinical Portal. Transfer of care (GP to secondary) regional approach to be determined	Inter- and intra-DHB eReferrals within the RMS module in Regional Clinical Portal	
<b>Regional Clinical Portal</b>			
Regional Clinical Portal (as part of RHIP)	To implement Regional Clinical Portal, core and enhanced for all DHBs	Complete. Future development roadmap yet to be agreed	TAS
<b>Regional PAS</b>			
Regional PAS CTAS implementation for: WhaDHB MDHB HBDHB	Replace end-of-life PASs Implementation: WhaDHB MDHB HBDHB	Implementation completed: WhaDHB MDHB HBDHB	TAS
PAS implementation: 3DHB C&CDHB HVDHB WaiDHB	Replace end-of-life PASs at: C&CDHB HVDHB WaiDHB	To be defined	3DHB
<b>Regional RIS</b>			
Regional RIS	Implement regional RIS for HBDHB, C&CDHB, HVDHB and WaiDHB	Complete	TAS Reported in RSP

<b>Regional initiatives</b>			
Shared record	To agree the strategy for a Central Region solution that provides access to the universal patient records across all of health.	Agreement on a Central Region solution and progress with regional implementation	TAS
CCN-Provation	Electronic bronchoscope and endoscopic reporting tool implemented at MDHB as a result of	To be defined based on DHB business cases	DHB delivery

Regional initiatives			
	regional business case		
Tele-health	To scope and define a tele-health regional direction for the Central Region	To be defined	TAS
Regional Network	A regional network (WAN), including internet, connected health and intra- and inter-DHB data, to be implemented	Roll out according to the transitional plan to be completed	TAS
Regional Service Management	To establish an interim service to manage the ongoing delivery of regional applications  Agree on the design and transition plan for establishing a regional service delivery management system	Roll out according to the transition plan	TAS

Note: Details of the current ICT portfolio plan, including local projects, are available in a spreadsheet. An analysis of the current-year investment cannot be completed because the information supplied is not a full set of DHDs (see Appendix 4).



## 14. Capital Investment Approach

Sponsor Julie Patterson

### *Overarching statement*

Good-quality capital investment planning is critical for long-term health sector sustainability.

### *Background*

The National Health Board (NHB) continues to collect regional capital plans separately from RSPs. The RSPs focus on individual service priority areas, while the regional capital plans need to cover all service needs for the next 10 years. This work is informed by the CR-HSP.

### *Objectives*

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

### *Actions required*

The Regional Capital Plans deliver the following:

- An overview of DHB capital intentions.
- Enables regional discussion.
- Identifies local and regional capital work plans for 2015/16.



## Links to DHBs' Annual Plans

Action plans	C&CDHB Module	HVDHB Module	WaiDHB Module	MDHB Module	HBDHB Module	WhaDHB Module
<b>HOP</b>	2.2.18	2.2.18	2.2.18	Chapter 2.4.34	2	2
<b>Māori Health</b>	2.2.8	2.2.8	2.2.8	Chapter 2.4.39*	2	2
<b>Cancer Services</b>	2.2.13	2.2.13	2.2.13	Chapter 2.3.30/31	2	2
<b>Cardiac Services</b>	2.2.21	2.2.21	2.2.21	Chapter 2.6.48	2	2
<b>Stroke Services</b>	2.2.22	2.2.22	2.2.22	2.3.25	2	2
<b>Mental Health and Addictions</b>	2.2.19	2.2.19	2.2.19	Chapters 2.3.28 & 2.4.35	2	2
<b>Electives</b>	2.2.14	2.2.14	2.2.14	Chapter 2.6.51	2	2
<b>Hepatitis C</b>	2.2.17*	2.2.17*	2.2.17*			
<b>Major Trauma</b>	2.2.26	2.2.26	2.2.26	Chapter 2.6.51	2	2
<b>Diagnostic Imaging</b>	2.2.20	2.2.20	2.2.20	Chapters 2.3.23 & 2.6.51	2	2
<b>Information Technology</b>	2.2.28	2.2.28	2.2.28	Chapter 2.6.49	2	2
<b>Workforce</b>	2.2.27	2.2.27	2.2.27	Chapter 2.5.43/45/46	2	2

\* (Primary Care and Integration)

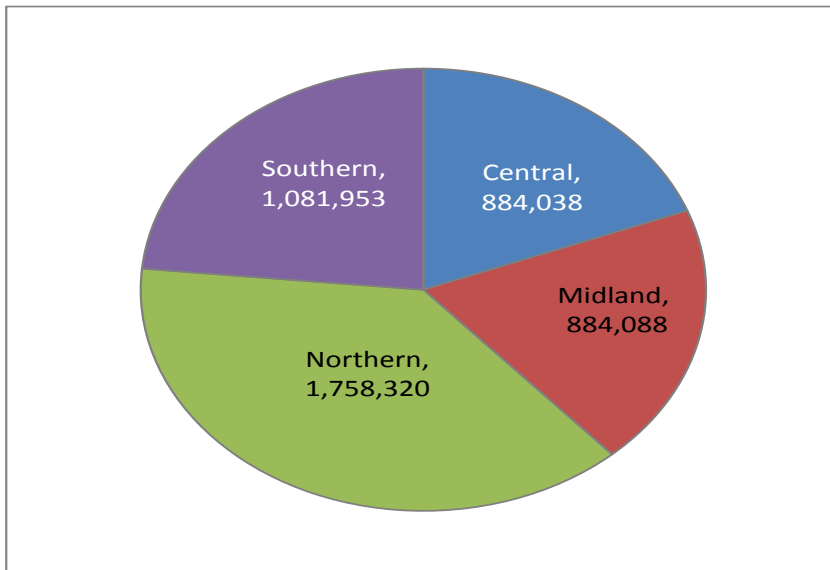


## Appendix 2: The Central Region Demographics

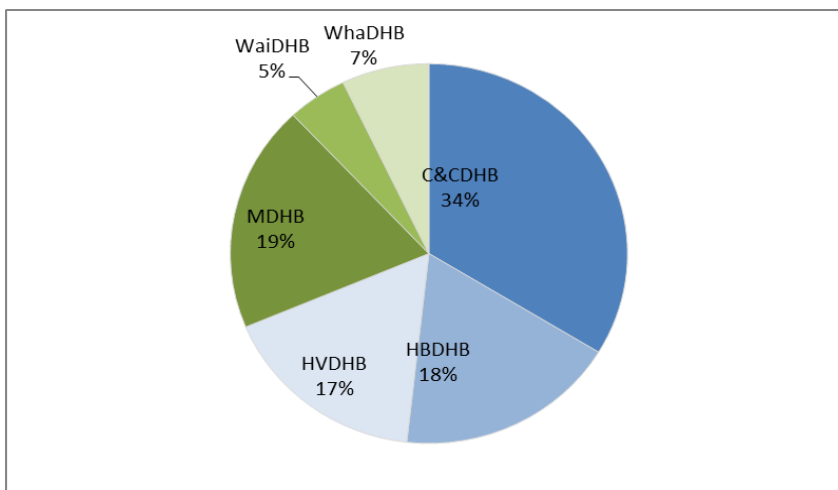
### Overview

The Central Region consists of six DHBs (Capital & Coast, Hawke’s Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui) with a combined population of 884,038 projected for 2015/16. 19% of New Zealand’s population lives within the Central Region<sup>23</sup>.

**Figure 13 National population breakdown by region 2015/16**



**Figure 14 Central Region population breakdown by DHB 2015/16**



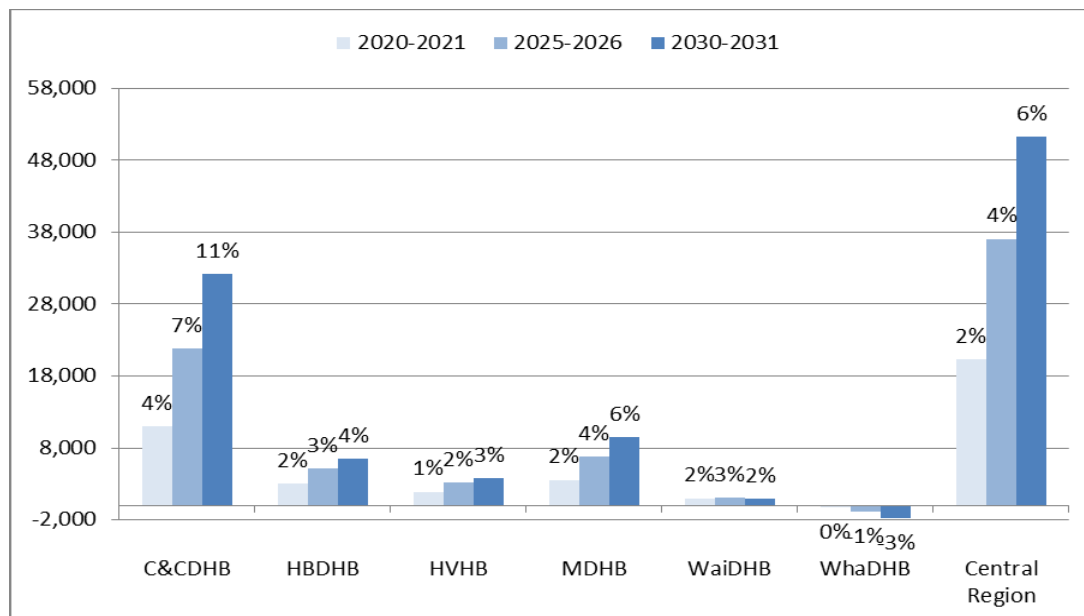
<sup>23</sup> Demographic data is based on population projections released in November 2014 based on the 2013 Census (projections produced by Statistics New Zealand according to assumptions specified by MoH). Unless otherwise specified, data is for the estimated 2015/16 resident population

Projections for the next 15 years are that the population of the Central Region will increase and become more elderly and more ethnically diverse, with significant increases in the Māori, Pacific and Asian populations.

It is projected that in the next 15 years<sup>24</sup> the region’s population will increase by nearly 60,000 (6.8%) to 935,315. The Central Region’s population is expected to grow by an average of 0.45% per annum for the next 15 years<sup>25</sup>. This is the lowest growth rate of the four regions and slightly less than half the national growth rate of 0.96% per annum.

More than half of the projected growth will be within the current C&CDHB catchment area, which is expected to increase by approximately 34,000 individuals (a 12% increase). All other DHB populations are expected to increase in size between 2% and 6%, except WhaDHB, which projects a population decrease of 3%.

**Figure 15 Central Region population growth from 2015 to 2016 by DHB**



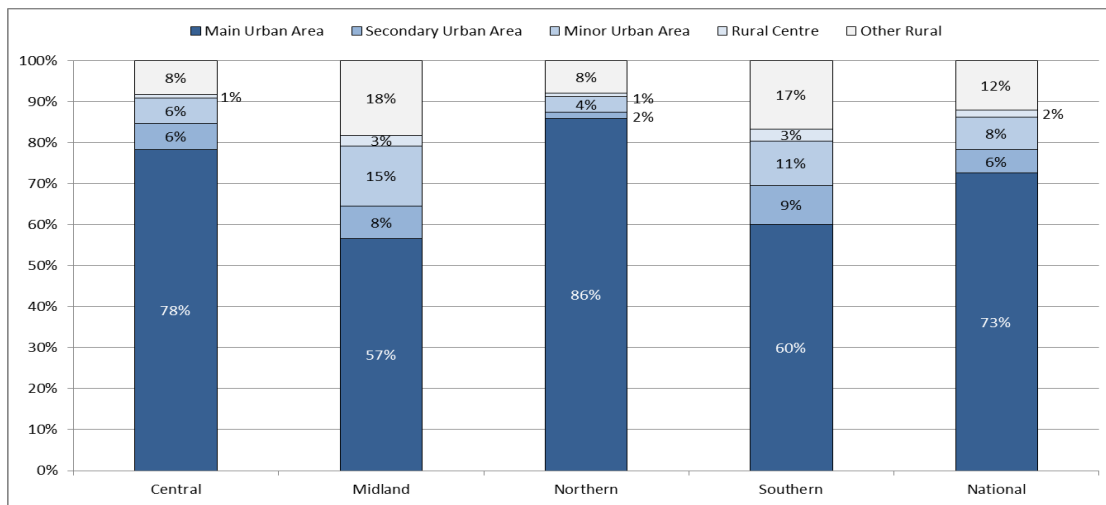
### Urban/Rural Distribution

Compared with all regions, the Central Region has the second highest proportion of urban people, with 78% living in main urban areas (the Northern Region has the highest with 86%). The Central Region is tied with the Northern Region for the lowest proportion of people living in rural areas. This makes the Central Region slightly more urban and less rural than New Zealand as a whole.

<sup>24</sup> MoH Projection Data November 2014, based on 2013 Census

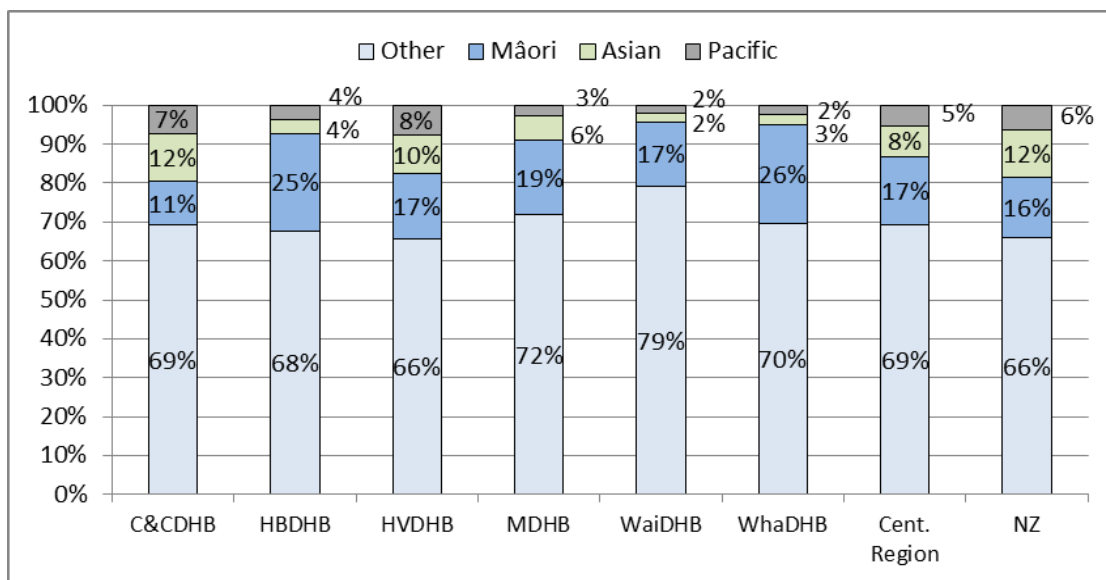
<sup>25</sup> MoH Projection Data November 2014, based on 2013 Census

Figure 16 Regional breakdown by urban/rural populations, 2013 Census



Within the Central Region each DHB has a unique distribution of urban and rural populations. C&CDHB and HVDHB are both made up almost entirely of urban dwellers (close to 100%). WaiDHB has the highest proportion of rural dwellers, with 25% living in areas designated 'Other Rural' and 26% living in 'Rural Centres'. HBDHB, WhaDHB and MDHB all have majority urban populations with significant numbers of rural dwellers<sup>26</sup>. A large proportion of the rural population is distributed sparsely over rugged terrain.

Figure 17 Central Region DHBs breakdown by urban/rural populations, 2013 Census



<sup>26</sup> Statistics New Zealand: New Zealand Deprivation Data 2013 Census

## Age Distribution

The specific age distributions of the DHBs within the Central Region vary.

WaiDHB and WhaDHB have the highest percentages of people 65 and over (20% and 19% respectively). These are notably higher than those of C&CDHB and HVDHB, whose populations over 65 only account for 13% and 14% respectively<sup>27</sup>.

**Table 4 Age distribution of each DHB 2015/16**

	Age Group:	0-14yrs	15-39yrs	40-64yrs	65-84yrs	85yrs +
C&CDHB	Population	54,495	112,925	95,355	33,725	4,670
	% of DHB	18%	37%	32%	11%	2%
HBDHB	Population	34,155	44,665	53,255	25,260	3,400
	% of DHB	21%	28%	33%	16%	2%
HVDHB	Population	29,315	46,415	48,265	18,150	2,405
	% of DHB	20%	32%	33%	13%	2%
MDHB	Population	33,880	54,140	53,655	26,005	3,570
	% of DHB	20%	32%	32%	15%	2%
WaiDHB	Population	8,403	11,483	15,115	7,833	1,048
	% of DHB	19%	26%	34%	18%	2%
WhaDHB	Population	12,700	17,403	20,505	10,348	1,498
	% of DHB	20%	32%	33%	17%	2%
Central Region	<b>Population</b>	<b>172,948</b>	<b>287,030</b>	<b>286,150</b>	<b>121,320</b>	<b>16,590</b>
	<b>% of region</b>	<b>20%</b>	<b>32%</b>	<b>32%</b>	<b>14%</b>	<b>2%</b>

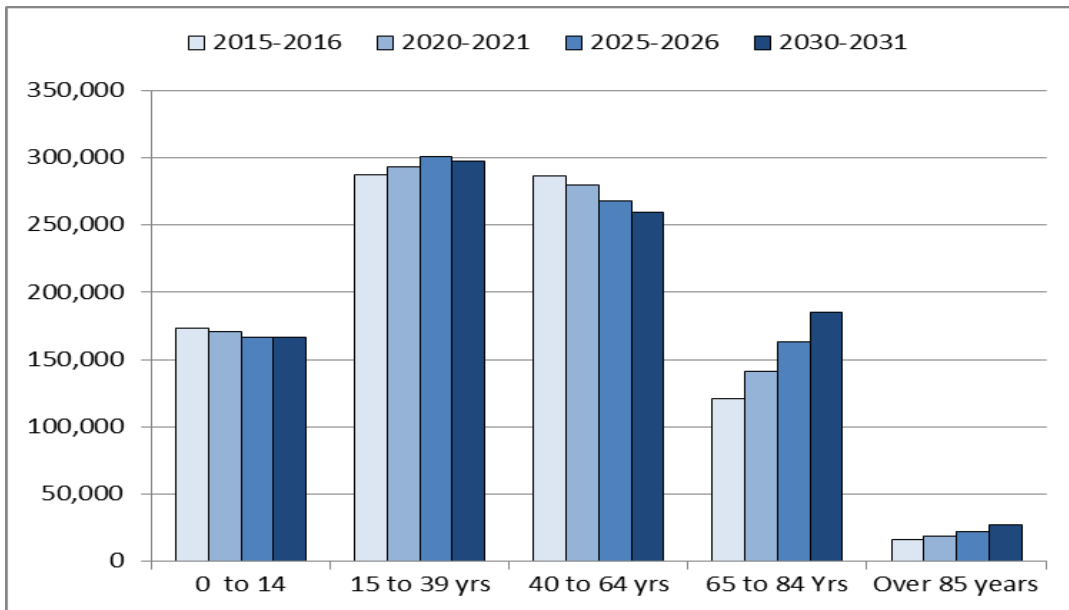
It is projected that in the next 15 years all DHBs in the region will see a substantial increase in the older age groups. The population aged 65 to 84 years of age is expected to increase by approximately 64,000 to account for 25% of the population (rather than the current 14%). Over-85-year-olds will also increase, although not by as much as previously predicted. Current projections expect the population aged 85 years and older to increase from 15,693 (2% of the population) to an estimated 25,118 (3% of the population). The over-85 population breakdown is projected to comprise 2% Māori, 25% Asian and 1% Pacific, with the majority made up of 'other' ethnic groups. It is projected that by 2030/31 the over-85-year-old population will become more ethnically diverse, with 8% Asian (up from 3%), 5% Māori (up from 3%) and 2% Pacific (up from 1%).

The population aged 40 to 64 is projected to decrease (from the current 33% of the population to 28%) as people age into the 65- to 84-year age band. The percentage of people 14 years and under will also decrease (from 20% in 2015/16 to 18% in 2030/31).

These trends are very similar to those seen at a national level.

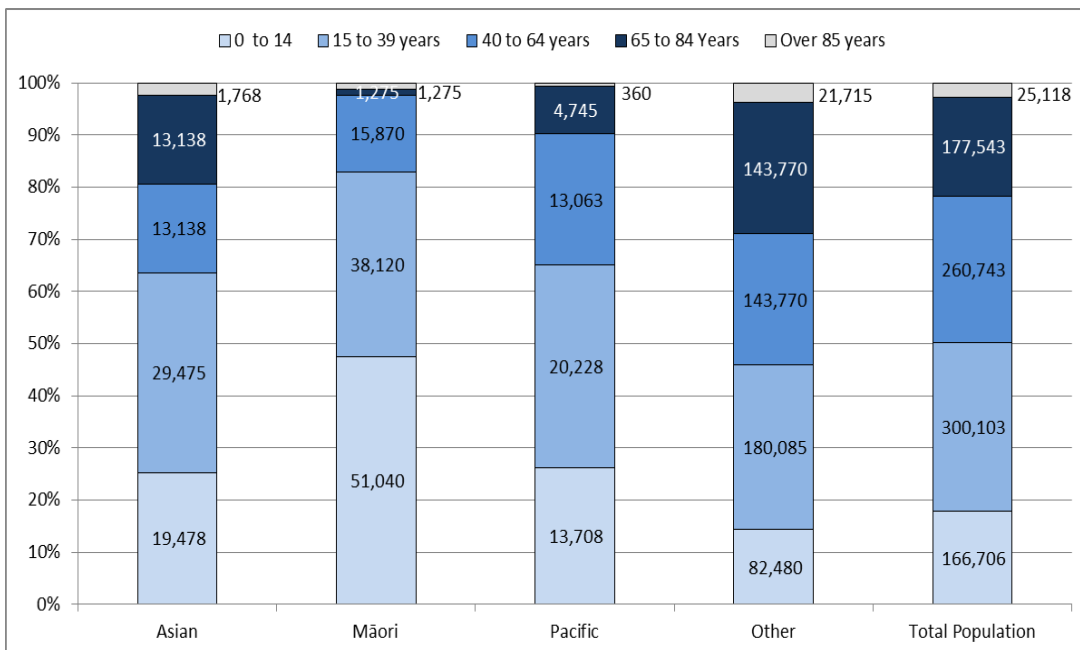
<sup>27</sup> MoH Projection Data November 2014, based on 2013 Census; see reference page 1

Figure 18 Projected population by age band



Asian, Māori and Pacific peoples have younger populations than other ethnicities. Currently 70% of Māori in the Central Region are under the age of 40 compared with 68% of the Pacific and 65% of the Asian populations. This is in contrast to other ethnicities, of whom only 45% are under 40. Projections to 2029 are that Māori and Pacific populations will continue this trend, while Asian populations are expected to drop to approximately 55%.

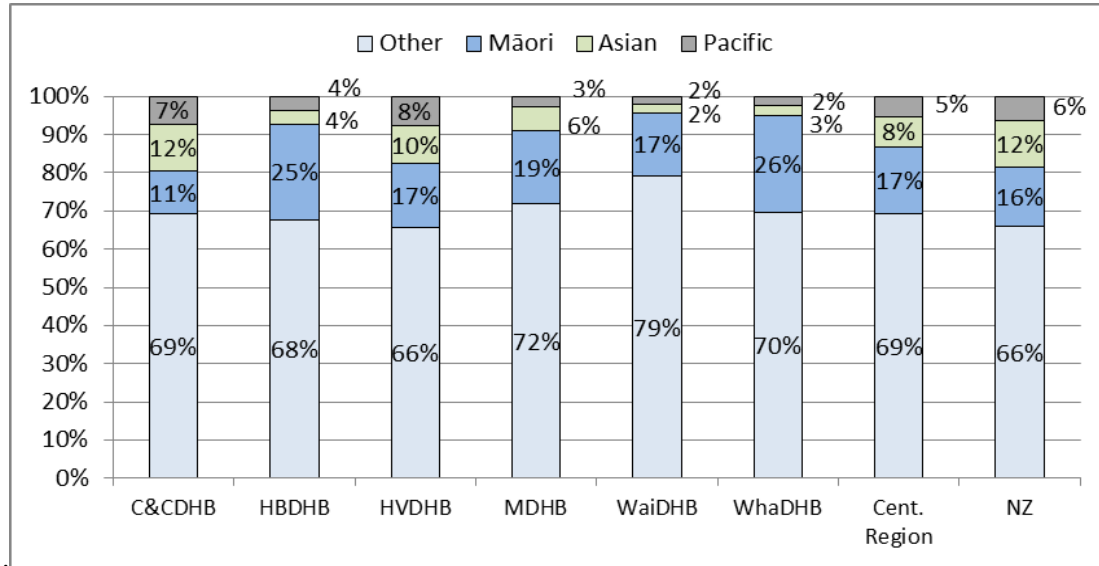
Figure 19 Age breakdown of ethnic groups 2015 /16



### Ethnicity distribution

The Central Region’s ethnic distribution compares similarly to that of the whole of New Zealand, although with slightly fewer Asian peoples (8% of the population compared to a national figure of 12%)<sup>28</sup>.

Figure 20 Central Region ethnicity make-up by DHB 2015/16



As with age distribution the ethnic make-up of each DHB is distinct. HBDHB and WhaDHB have the largest proportion of Māori (25% and 26% respectively). C&CDHB and HVDHB have the largest proportions of both Pacific (7% and 8% respectively) and Asian peoples (12% and 10%).

The Central Region’s Asian population is projected to increase by 44% to approximately 100,000 by 2029. This growth is much higher than in previous projections and Asian populations are now expected to become larger than Māori and Pacific populations. In the same period the region’s Māori population is expected to increase by 13% to approximately 20,000 and Pacific peoples to increase by 15% to approximately 7,000.

<sup>28</sup> MoH Projection Data November 2014, based on 2013 Census; see reference page 155



Figure 21 Projected change in ethnicity breakdown over time

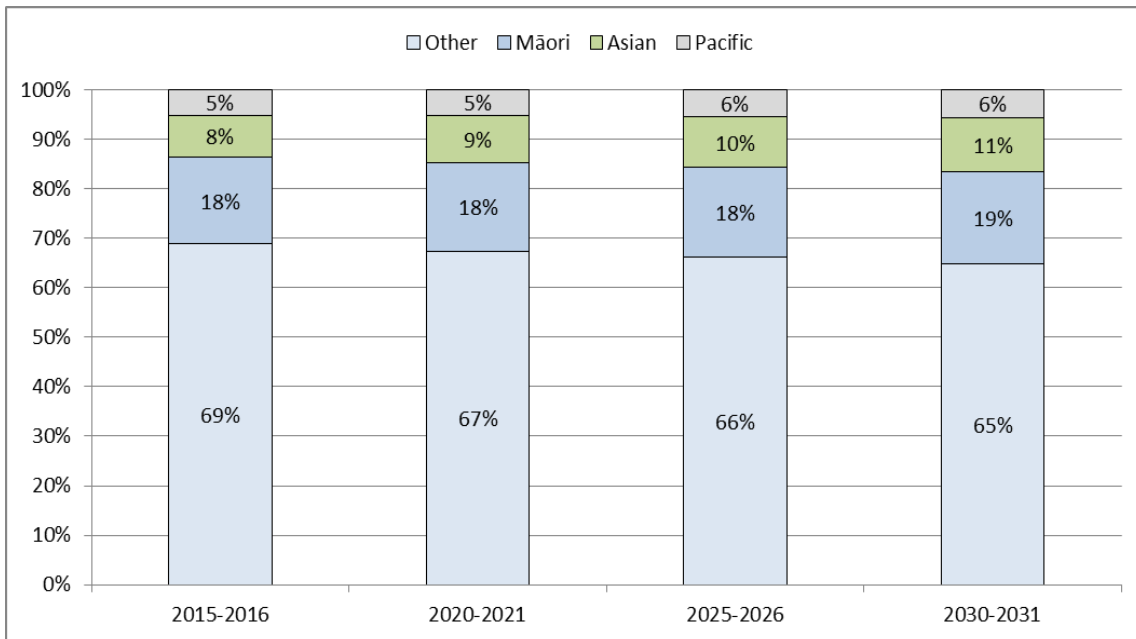
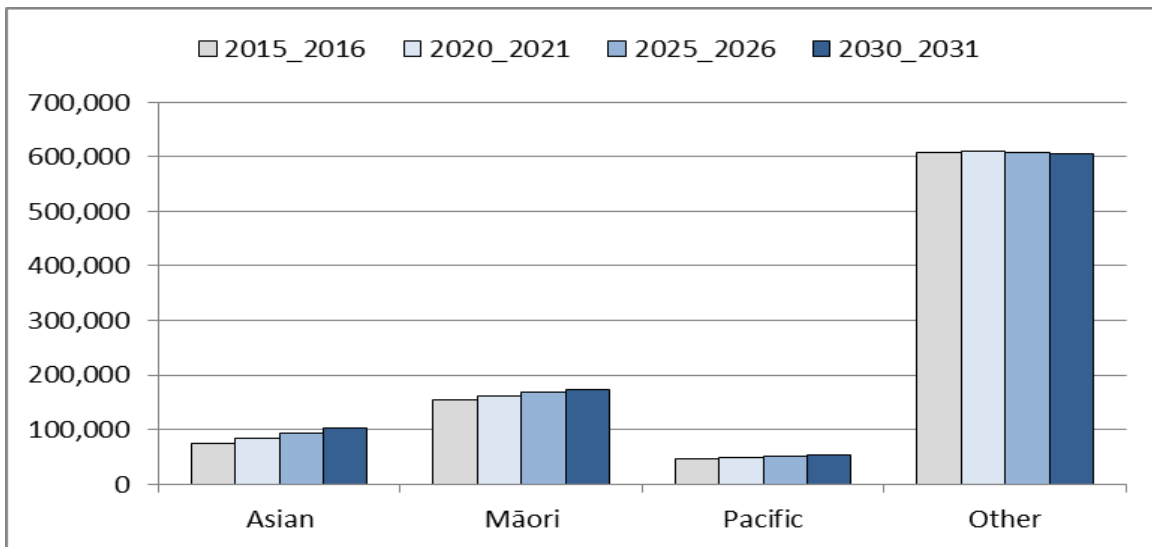


Figure 22 Population growth by ethnicity



### Deprivation distribution

Socioeconomic deprivation is measured using the New Zealand Deprivation (NZDep) Index. This is divided into five quintiles, with Quintile 5 living with the highest level of deprivation and Quintile 1 the lowest.

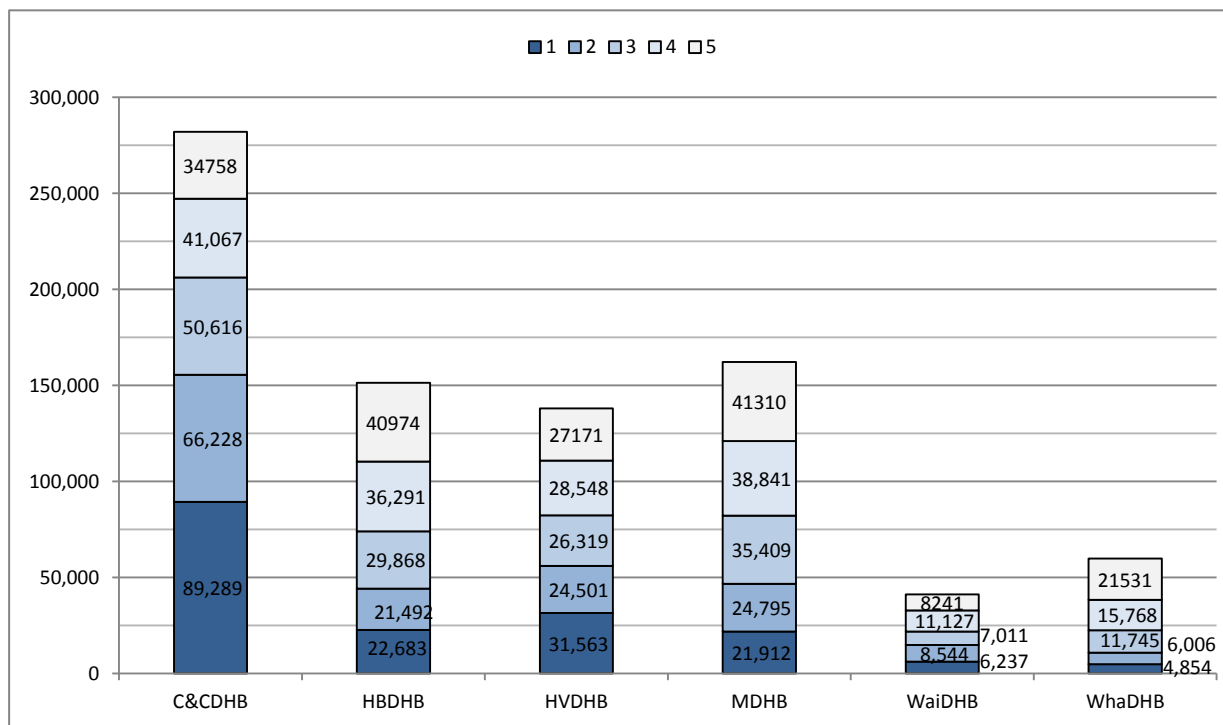
While C&CDHB has the lowest proportion of people in Quintile 5 (12%), the larger population means this represents 35,000 people, the third highest Quintile 5 population in the region<sup>29</sup>. MDHB and HBDHB have the highest Quintile 5 populations with approximately 40,000 (25%) and 41,000 (27%) respectively.

WhaDHB has the highest proportion of the population in Quintile 5 with 36% (approximately 22,000 people).

**Table 5 Quintile 5 populations by DHB**

	C&CDHB	HBDHB	HVDHB	MDHB	WaiDHB	WhaDHB	National	Central Region
Quintile 5 population	34,758	40,974	27,171	41,310	8,241	21,531	833,169	173,985

**Figure 23 DHB breakdown by deprivation quintiles (population)**



### Disparities and inequalities

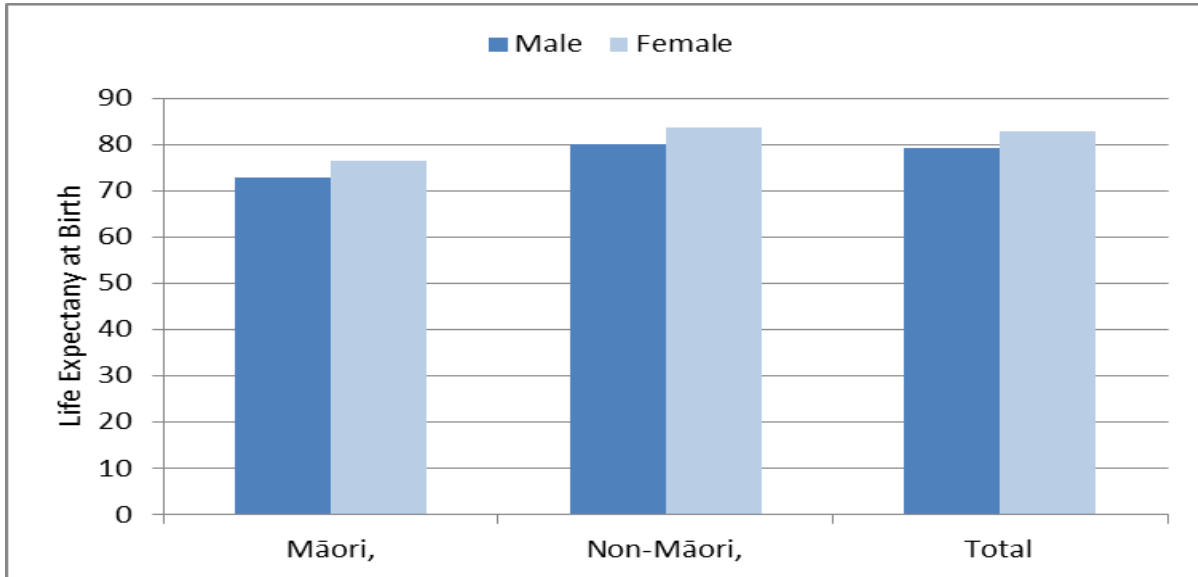
Inequalities in health status exist across the Central Region relating to ethnicity, age bands and socioeconomic deprivation.

Analysis undertaken for the 2010 Social Report identified an association between life expectancy and the levels of deprivation in the areas where people live. Males in the least deprived areas could

<sup>29</sup> MoH Projection Data November 2014, based on 2013 Census

expect to live 8.8 years longer than males in the most deprived areas. Likewise the latest life expectancy data<sup>30</sup> shows that while life expectancy continues to improve, gaps remain significant, with a seven year gap in life expectancy between Māori and non-Māori New Zealanders.

**Figure 24 Life expectancy in Māori and non-Māori at birth 2012**



Analysis undertaken for the Burden of-Disease study found that, “Māori had, on average, shorter lives than non-Māori, an inequality that was even greater if only healthy years are considered. Despite their shorter lives, both Māori males and females lived on average longer in poor health than did their non-Māori counterparts”<sup>31</sup>.

These outcomes relate to data indicating that nationally Māori and Pacific peoples have higher incidences of cardiovascular disease, smoking-related diseases, diabetes and cancer.

**Table 6 Selected national chronic disease incidences (per 10,000 population per year) by ethnicity**

Disease	Pacific	Māori	Other	Total
Ischaemic heart disease	419	364	331	340
Stroke	318	238	170	179
Diabetes	370	218	79	97
Chronic obstructive pulmonary disease	290	285	102	120

<sup>30</sup> New Zealand Period Life Tables: 2011-2012 (Statistics New Zealand)

<sup>31</sup> Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006-2016 (MoH 2013)

Disease	Pacific	Māori	Other	Total
Asthma	135	101	41	51
All cancer	561	617	623	624
Lung cancer	50	84	31	35
Breast cancer	43	56	38	40

The Central Region needs to improve population health outcomes and reduce inequalities affecting these population groups, as well as older adults and those with high needs and disabilities.

### *Burden of Disease*

The Burden of disease study found that, when adjusted for population size and age, health loss in 2006 was at least three times higher in Māori than in non-Māori for 13 specific conditions.

The following summary presents selected findings from the report Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006-2016 (MoH, 2013).

The study is a systematic analysis of health loss by cause for New Zealanders of all ages, both sexes and both major ethnic groups. Burden-of-disease studies estimate how much healthy life is lost due to early death, illness or disability. Health loss is estimated using a measure called the DALY (disability-adjusted life year).

### *Health loss from all*

- In 2006 New Zealanders sustained health loss totalling almost one million years of healthy life (955,000 DALYs). Just over half (51%) of this total health loss resulted from fatal outcomes, with non-fatal outcomes accounting for 49%.
- Older people (65-plus years) sustained over one-third (37%) of the total health loss despite making up only 12% of the population.
- Adjusting for age, males experienced 55% more fatal health loss than females but a lighter burden of non-fatal health loss (16% less).
- Adjusting for age and population size, health loss in Māori was almost 1.8 times higher than that in non-Māori, with more than half of Māori health loss occurring before middle age. If Māori had experienced similar rates of health loss to non-Māori at all ages, health loss among Māori would have been 42% less and that of the whole population 7% less.
- Total DALYs lost are projected to increase from 955,000 in 2006 to 1.085 million in 2016, a rise of 13.4%. This assumes a continuation of recent demographic trends (population growth and ageing) and epidemiological trends (disease and injury incidence and mortality). Projected increases in population size and ageing explain 80% of this trend, with epidemiological changes explaining the remaining 20%.

### *Health loss by condition group*

- In 2006 cancers (17.5%) and vascular and blood disorders (17.5%) were the leading causes of health loss at the condition group level, followed by mental disorders (11%), musculoskeletal disorders (9%) and injury (8%).
- Different conditions contribute to health loss at different life stages, with the following leading condition groups:
  - Childhood (0-14 years): infant conditions and birth defects (49% of health loss in this age group).
  - Youth (15-24 years): mental disorders (31%) and injury (27%), with reproductive disorders also important for females.
  - Young adults (25-44 years): mental disorders (25%) and injury (15%), with reproductive disorders also important for females.
  - Middle age (45-64 years): the well known chronic diseases of cancers (24%) and vascular disorders (16%) start to come to prominence.
  - Older adults (65-74 years): cancers (29%) and vascular disorders (24%) remain leading causes of health loss, followed by musculoskeletal conditions (11%).
  - Older adults (75-plus years): vascular disorders (35%) overtake cancers (18%) as the leading cause of health loss, with neurological conditions ranked third (10%).
- Māori sustain greater health loss in most condition groups. On an absolute scale, 26% of the excess burden experienced by Māori is caused by vascular disorders, 15% by cancers, 12% by mental illness, 11% by injury, and 9% by diabetes and other endocrine disorders.
- The leading causes of health loss at the condition group level are projected to remain the same from 2006 to 2016, assuming a continuation of recent demographic and epidemiological trends.

### *Implications of the key findings*

- We are living longer, but not all of this time is spent in good health. The small expansion in poor health between 2006 and 2016 adds impetus to prioritising policies that reduce morbidity as well as mortality.
- New Zealand is undergoing a ‘disability transition’, with 50% of health loss now accounted for by non-fatal, disabling conditions – and this proportion is projected to increase.
- Coronary heart disease and stroke are still important causes of health loss in New Zealand (9% and 4% respectively). Much of this burden is avoidable through a combination of prevention and treatment.
- Ongoing and new challenges include mental health disorders, neurological conditions (including dementia), musculoskeletal conditions (including osteoarthritis and back disorders), chronic pain syndromes, sleep disorders and reproductive disorders.
- There is considerable scope for prevention, with tobacco, diet, physical activity, alcohol, obesity and diabetes all important, potentially modifiable risks to health.

The regional priorities take these findings into account and seek to address them in the action plans.



## Appendix 3: Central Region ICT portfolio investment analysis

### Central Region ICT initiatives financial summary

Total Capex (\$'000s) 2015/16

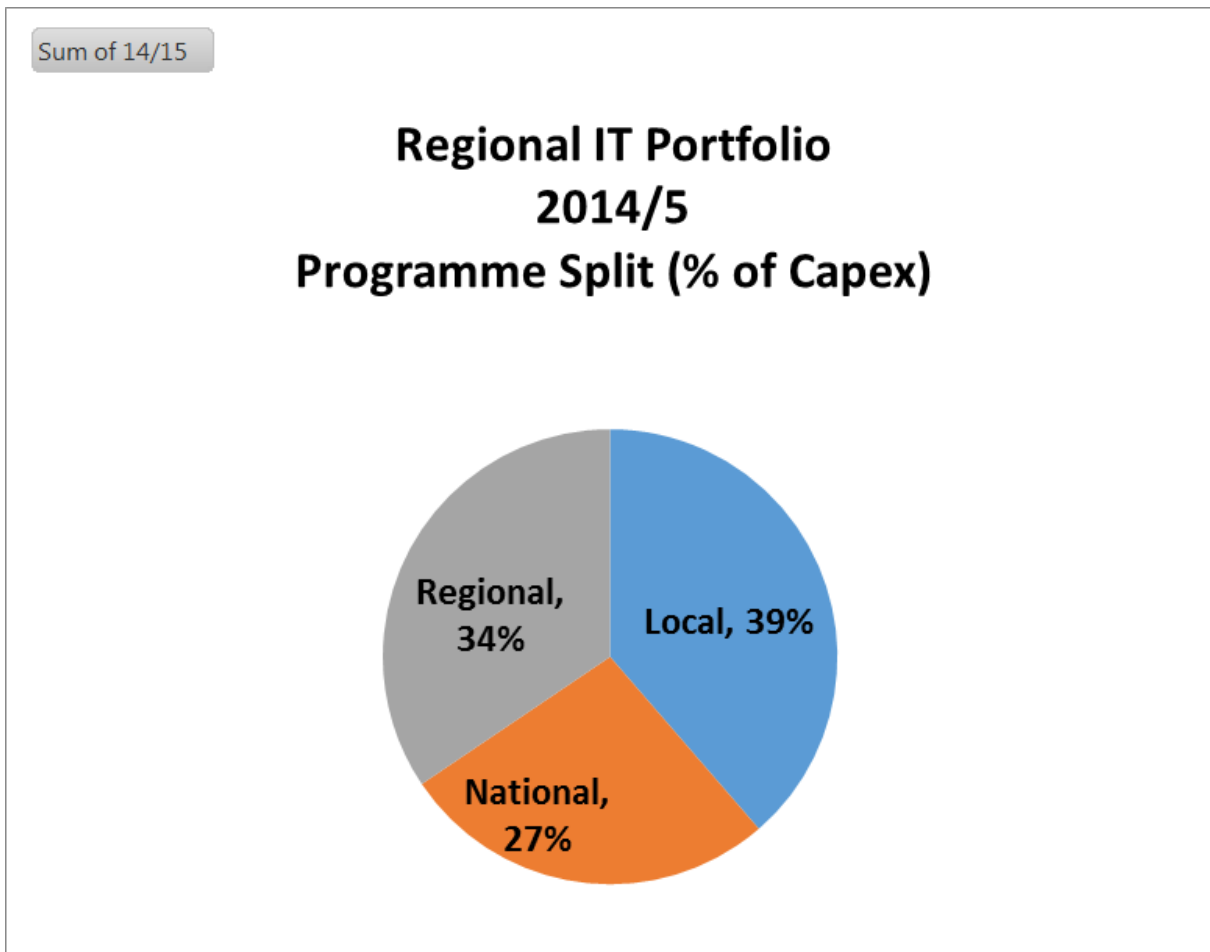
**Table 7 Capex schedule for 2016/15, by DHB and \$'000s (no rollover capex included)**

	C&C DHB	HVDHB	WaiDHB	MDHB	HBDHB	WhaDHB	Total
National		1,480	880		365	890	3,615
Regional		2,967	1,150	2,447	1,491	2,274	10,329
Local		920	288	1,680	2,535	830	6,353
Total		5,367	2,318	4,127	4,391	3,994	20,297

The above table shows the allocation of Capex to whether the project is nationally or regionally or locally led.

The Central Region ICT portfolio categorises the regional ICT projects according to a number of programme classes, National, Regional and Local. These programme classes have been derived from the ITHB Plan, updated October 2013 as nationally lead, regional lead for TAS projects have some regional coordination and local, i.e. sub-regional or local initiatives.

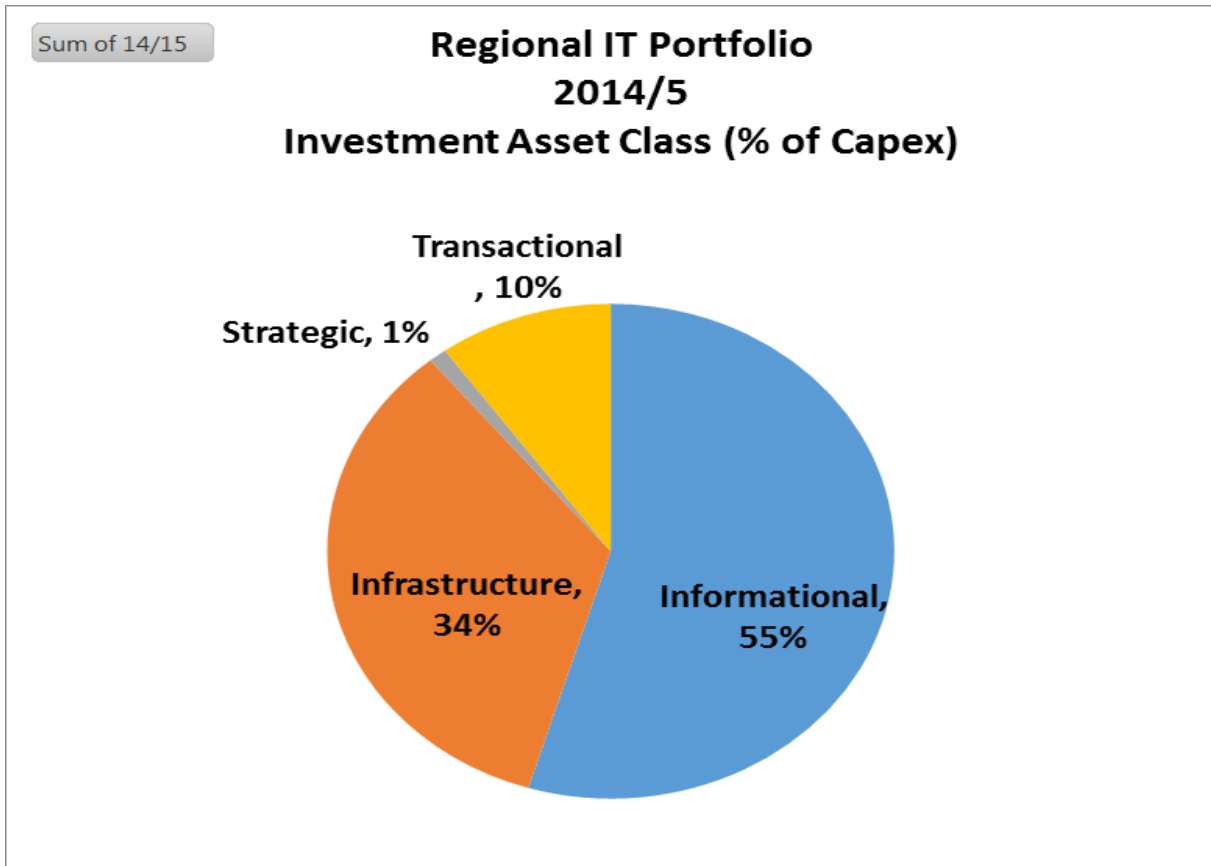
Figure 25 Regional portfolio balance



The regional IT portfolio programme split in the above figure shows a large investment in the 2014/15 year in the regional platform programme, which is associated with the investment in RHIP. Investment in future years has not been defined in detail, but clearly shows the need to have a more systematic, longer-term investment focus. This is also highlighted in an analysis of the investments in the various asset classes below.



Figure 26 Regional IT investment asset portfolio 2014/15



*Investment analysis*

Investment portfolio approach in the above figure for the regional ICT projects has used the Centre for Information Systems Research at MIT’s model as described in the ITHB Plan (updated October 2013). The investments in the various asset classes show a majority of investments in informational assets, less in infrastructure and transactional assets and little in strategic priorities. Currently the eMedicines, integrated care and regional RSP programmes are classified as strategic assets whose investments have yet to be quantified through any business case process.

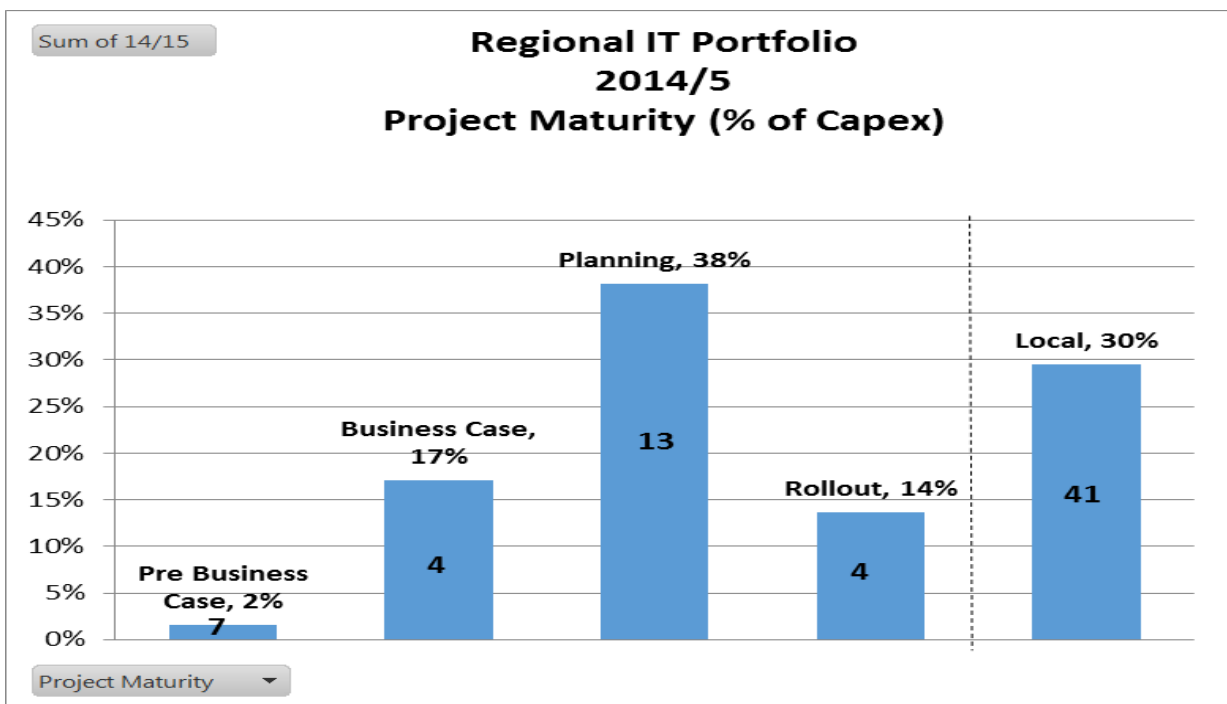
**Table 8 Definition of investment asset classes**

Investment asset class	Definition
Strategic	<ul style="list-style-type: none"> <li>Innovation</li> <li>Major change</li> <li>Facilitation</li> <li>High value add</li> </ul>

Investment asset class	Definition
	Interact with customers
Informational	Increased control Better information Better control Improved quality Faster cycle time
Transactional	Cut costs Increase throughput
Infrastructure	Business integration Business flexibility Reduced marginal costs of business units' IT Reduced IT costs Standardisation

Note: Sourced from Centre for Information Systems Research – MIT Sloan

Figure 27 Regional IT project maturity portfolio 2014/15



## Project maturity

Each programme/project was assigned a project maturity classification, i.e.:

- pre-business case
- business case
- planning
- roll-out.

The figure above only includes projects that have capital assigned to them in the regional capital plan and includes all national, regional and local projects. It shows the percentage of capex and the number of projects at each maturity level. Pre-business case maturity is the lowest level of maturity and includes all those projects that have been prioritised but have yet to be fully scoped to a business case level.

Maturity levels were not available for sub-regional and DHB projects for this analysis, but will be collated for the next regional ICT profile plan and are classed as 'local' in the figure above.

This shows that the flow of investment through the project lifecycle in terms of number of projects was consistent.

The concerns from this figure are that there is limited visibility of the potential costs of projects in the pre-business case stage, and there are a large number of projects listed at the concept stage with no costs associated with them and therefore not counted in the above analysis. Some of these can also be accounted for because the carryover Capex information has yet to be included in the regional capital plan.

## Appendix 4: Glossary

<b>Acronym</b>	<b>Definition</b>
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
AHP	Allied Health Practitioner
AHTS	Allied Health Technical and Scientific
ANZACS-QI	All New Zealand Acute Coronary Syndrome Quality Improvement
AoD	Alcohol and Other Drugs
AROC	Australian Rehabilitation Outcome Centre
ASH	Ambulatory sensitive hospitalisation
BAU	Business As Usual
BSCC	Breast Screen Coast to Coast
C&CDHB	Capital & Coast District Health Board
CBSC	Community-Based Spine Clinic
CCN	Central Cancer Network
CCR	Cancer Consumer Representatives
CEO	Chief Executive Officer
CNS	Clinical Nurse Specialist
COO	Chief Operating Officer
CRCN	Central Region Cardiac Network
CREDS	Central Region Eating Disorder Services
CRISP	Central Region Information Systems Plan (replaced by RHIP)
CRMM	Central Region Māori Managers
CRQSA	Central Region Quality and Safety Alliance
CRRAC	Central Region Radiology Access Criteria
CT	Computed Tomography
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
ePM	ePharmacy Management
ESPI	Elective Services Performance Indicator
ESPWP	Elective Services Productivity and Workforce Programme
FCT	Faster Cancer Treatment
FSA	First Specialist Assessment
FTE	Full-Time Equivalent
GMsHR	General Managers Human Resources
GP	General Practitioner
HBDHB	Hawke's Bay District Health Board
HBL	Health Benefits Limited
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
L&D	Learning and Development
MCNZ	Medical Council of New Zealand
LTC	Long Term Condition
MDHB	MidCentral District Health Board
MDM	Multi-disciplinary Meeting
MH&A	Mental Health and Addiction
MHAN	Mental Health and Addiction Network
MiAP	Multi Interventional Approach to Polypharmacy
MoC	Models of Care
MoH	Ministry of Health
MRI	Magnetic Resonance Imaging
MTNCN	Major Trauma National Clinical Network
NCAMP	National Collections Annual Maintenance Project
NEQIP	National Endoscopy Quality Improvement Programme
NESP	Nurse Entry to Specialist Practice
NETP	Nurse Entry to Practice



NGO	Non-Government Organisation
NP	Nurse Practitioner
NHC	National Health Committee
NHITB	National Health IT Board
NPF	National Patient Flow
NRAC	National Radiology Access Criteria
NZMTD	New Zealand Major Trauma Dataset
ORL	Otorhinolaryngology
PACS	Picture, Archiving and Communication System
PAS	Patient Administration System
PET	Positron Emission Tomography
PDRP	Professional Development Recognition Programme
PGY	Postgraduate Year
PHO	Primary Health Organisation
QLP	Quality and Leadership Programme
RACPRG	Regional ACP Reference Group
RDoW	Regional Director of Workforce
RDPRG	Regional Dementia Pathways Reference Group
REC	Regional Executive Committee
RFP	Request for Proposal
RHIP	Regional Health Infometrics Plan
RIS	Radiology Information System
RQSA	Regional Quality and Safety Alliance
RCSP	Regional Clinical Services Plan
RCTS	Regional Cancer Treatment Service
RMO	Resident Medical Officer
RMS	Referral Management System
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

