



Central Region Regional Service Plan 2014/15



REGIONAL
SERVICES PROGRAMME

> Working together for our region's future health



Final 22 August 2014

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Office of Hon Tony Ryall

Minister of Health

Minister for State Owned Enterprises

18 AUG 2014

Kevin Snee
Chief Executive Officer
Lead Chief Executive Officer for Central Region District Health Boards Hawkes
Bay District Health Board
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HASTINGS 4156

Dear Kevin

2014/15 Regional Services Plan

This letter is to advise you that I approve the 2014/15 Central Regional Services Plan (RSP) with one condition. I appreciate the significant work that has been undertaken and I thank you for your effort.

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 2014/15. Improving the alignment between DHB Annual Plans and RSPs is an important planning priority and I understand the alignment is better than in 2013/14, however we must continue to strengthen this alignment if we are to achieve the best use of resources.

Improving major trauma services is an important Government initiative as it is the leading cause of disability and death for people under 45 years of age. Regions were asked to focus on this area as a new priority for regional planning in 2014/15. I note there are variations in the approach across the four regions to implement regional major trauma systems and I expect you to continue to work collaboratively with the Clinical Leader for Major Trauma, and with the Ministry to implement and/or improve regional major trauma systems.

Regional Service Plan Agreement



My agreement to your RSP is on condition that a fully prioritised and costed regional Information Technology (IT) plan, with milestones covering the next three years, is provided to the Ministry by 30 September 2014. This plan will be used to establish a baseline against which progress will be monitored. I will be requesting quarterly reports on progress against the plan from the National Health IT Board. I have asked the Director of the National Health IT Board to specify these requirements in more detail in a separate letter to Julie Patterson, the regional CEO IT lead.

My agreement does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board (NHB). All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will contact you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require the Minister of Health's approval as you review services during the year.

In addition, my agreement of your RSP does not mean 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. Approval for equity or new lending is also managed through the annual capital allocation round.

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 RSP made available to the public.

Yours sincerely

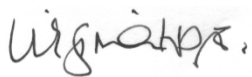
Hon Tony Ryall Minister of
Health

cc DHB Chairs and Chief Executive Officers in Central Region

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CENTRAL REGION REGIONAL SERVICE PLAN 2014/15



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Executive Summary

The Central Region is home to just under 879,000 New Zealanders whose health services are primarily delivered by six district health boards (DHBs).

1. Sustainable Services

In 2008 the Central Region DHBs developed a *Regional Clinical Services Plan*, and the first *Regional Service Plan (RSP)* in 2010/11. This document builds on the foundations set out in those plans. Within the 2014/15 RSP there is a clear recognition that we cannot continue to do things as we have in the past. There are genuine threats to the sustainability of some of the region's health services. There is a major financial imperative for change and, most importantly, we can and should be delivering even safer and higher-quality services to the population of our region.

The sustainability of health services across the region requires close attention. A number of the Central Region's health services require strengthening if they are to be sustainable. The Central Region is experiencing an increasing proportion of older persons and difficulties in maintaining and supporting a high-quality workforce. As such, a number of the region's services will prove difficult to operate effectively if we keep doing things the same way.

2. Financial Sustainability

The financial imperative can best be illustrated by the current deficit burden across the region. The region delivers health services to approximately 20% of New Zealand's population, but carried approximately 47% of the gross National Health Service's operational deficit in 2012/13.

A regional approach to health service delivery, if executed well, can and will address the key issues facing the Central Region. Regional planning and delivery of services for a population of fewer than one million, should allow the provision of nearly all modern-day health services. There are a small number of exceptions where a national approach is preferable. In most instances such an approach is already in place, albeit in need of strengthening in some particular instances.

A regional approach can provide necessary efficiencies in terms of high-cost facilities, technologies and the use of professional staff – both clinical and support. A regional approach should result in better support for health professionals across the region, with greater peer support and the provision of supervision, training opportunities and better working conditions. Such gains in support for health professionals will have real benefits in terms of the stability of the workforce, with improved retention and recruitment. It is self-evident that a highly trained, stable workforce is able to deliver improved standards of health services – safer health services – to the population it serves. A regional approach can and should mean greater equity of access to the services available to our population.

3. Improving Quality

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

The Central Region's RSP vision, as articulated by the DHBs, is as follows:

There will be a regionally integrated system of health service planning and delivery that will lead to on-going improvements in the sustainability, quality and accessibility of health services.¹

This vision can be further articulated as a carefully governed evolution of the Central Region's health services, from the current configuration of delivery by autonomous DHBs to a new environment in which health services are delivered to the region's

¹ Regional Vision and Strategy Workshops – May, July and November 2013

population by a matrix of regional, sub-regional and local arrangements.

This future configuration will be designed and developed on a foundation of equitable access across the region to high-quality, safe health services. Key contributors to achieving this vision will be

- ensuring that services provided by our DHBs are safe and of high quality for our population,
- ensuring we are fiscally responsible, with the region's matrix of health services matched to available resources,
- a consistent and compatible infrastructure across the region's health services, with consolidation of infrastructure where appropriate,
- a sustainable, well supported workforce with enabled clinical leadership,
- a commitment to integrated models of health services and governance. Health services will integrate primary, secondary and tertiary services across future community- and hospital-based services and
- a commitment to consumer and community involvement in the planning and implementation of regional health services.

This updated Central Region RSP 2014/15 describes a vision for the future of health services in the Central Region and provides a framework for the six Central Region DHBs to continue to plan and work co-operatively. This approach builds on the achievements of earlier years while focusing on tangible activities. Clinical networks, sub-regional initiatives and work towards the effective integration of hospital- and non-hospital-based services under the 'Better, Sooner, More Convenient' programme are outlined. The governance mechanisms being put in place for regional planning, funding and service delivery are described.

However, it is important to preserve the flexibility for DHBs to plan services, noting that one-size-fits-all solutions are not always the most appropriate

ways to reconfigure services. For this reason the RSP specifies activities that occur on a sub-regional basis.

To date the clinical and managerial leaders of the six Central Region DHBs, in partnership with other service providers and consumers, have collaborated to implement the 2013/14 RSP.

2013/14 – Progress to Date

The clinical and managerial leaders of the six Central Region DHBs have worked collaboratively to implement the 2013/14 RSP. To date the Central Region has achieved the following:

- An integrated approach to managing heart disease between Whanganui DHB and the local primary care sector has resulted in an overall improvement in cardiac intervention rates for the local population, and more risk assessments for the targeted population.
- Advance Care Planning (ACP) has progressed. There is a growing understanding of ACP within primary and secondary care and collaboration between DHBs and primary care is seen as a critical success factor. An ACP Framework for the Central Region has been developed that aligns with the national direction and provides a regional response to ACP for its population.
- The Central Region continues to improve access to organised stroke services. All DHBs in the region now have stroke units or stroke pathways in place to improve outcomes for people who have experienced strokes.
- The Central Region has consistently met the national target of 6% of patients presenting with ischaemic stroke being thrombolysed; the region is currently tracking at 8%.
- The Central Region is working towards improving mental health and addiction services. The stocktakes, gap analyses and recommendations for improvements to services have been completed for adult and youth forensics, regional rehabilitation, regional addiction and the regional eating disorder service.



SECTION ONE

Strategic Vision and Overview

Government Expectations 2014/15

In setting expectations for 2014/15, the Government has been clear that the public health system must continue to deliver better, sooner, more convenient health services and lift health outcomes for the population within carefully considered funding increases. The Government has made a commitment to delivering better public services for New Zealanders, particularly vulnerable children, a continued focus on access targets and an emphasis on preventive targets. District Health Boards (DHBs) are expected to work closely with other social sector organisations, including non-government organisations (NGOs), to meet this commitment.

The Minister of Health also expects DHBs to focus strongly on care closer to home through service integration, particularly with primary care. This includes the development of integrated family/whānau health centres, direct-referral access to diagnostics, and clinical pathways involving community and hospital clinicians. The health of older people (HOP) is a key focus for the Minister of Health, in particular avoiding admissions and care after discharge.

Continued regional and national collaboration is expected to deliver gains in quality, efficiency and cost control and contribute to managing DHB financial performance. The Minister of Health continues to advocate for strengthened clinical leadership and engagement and expects to see improvements in productivity, patient safety and the quality of services.

An operational outcomes framework has been created to demonstrate how the Central Region proposes to deliver on these Minister of Health directions through achieving our impacts, outcomes and objectives.

Central Region Outcomes

Framework

The outcomes framework (Figure 1) feeds into the Ministry of Health's (MoH's) two overarching outcomes for the health system:

- New Zealanders live longer, healthier, more independent lives.
- The health system is cost effective and supports a productive economy.

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

MoH has three high-level outcomes that support the achievement of the above health system outcomes:

- New Zealanders are healthier and more independent.
- Health services are delivered better, sooner and more conveniently.
- The future sustainability of the health system is assured.

Working within the outcomes framework, the Central Region envisages enabling sustainability, quality and safety within available resources based on the Triple Aim principles. In achieving these high-level outcomes, the region will have real impacts on the lives of its population.

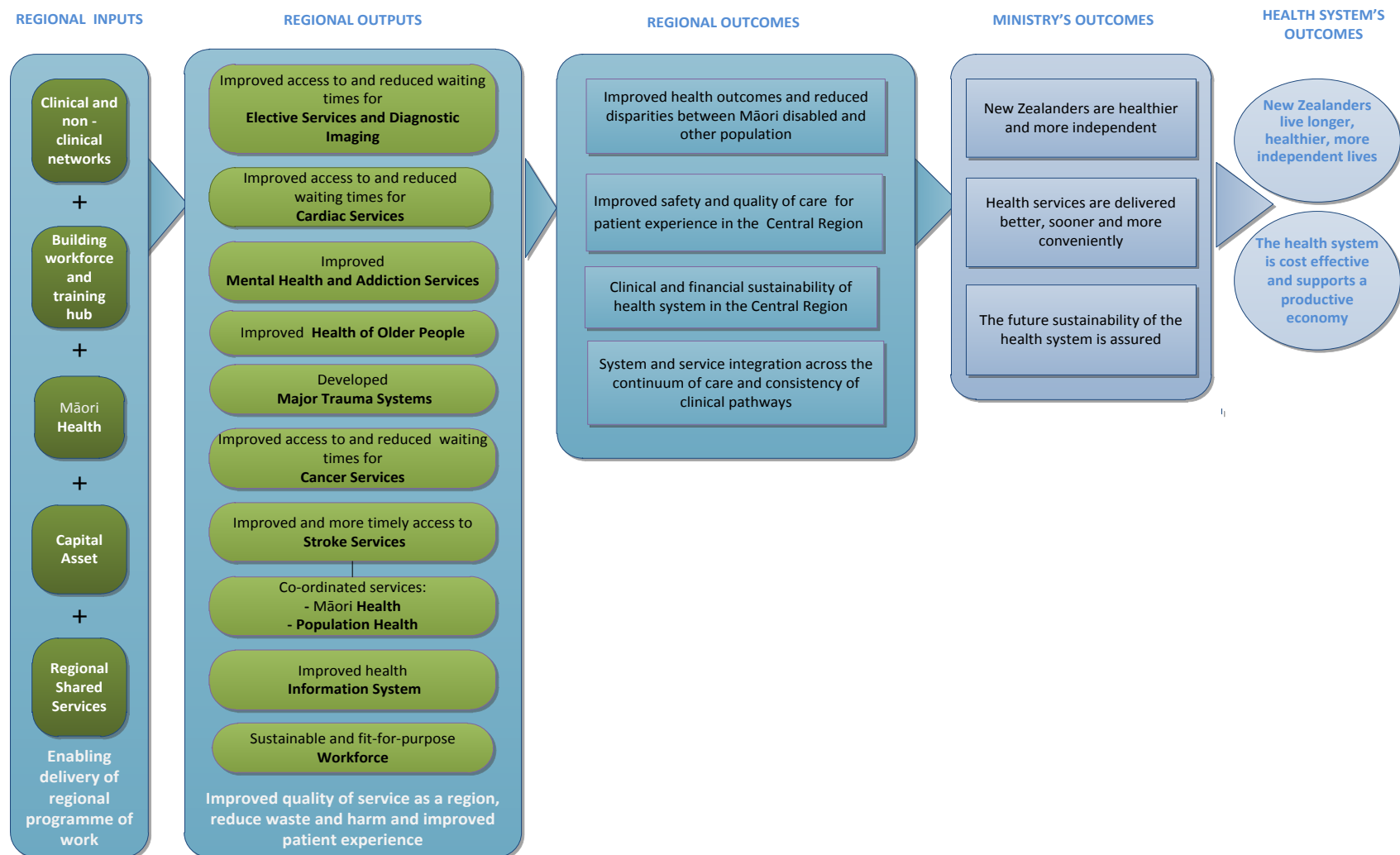
The following four impacts will be our focus and are reflected in our outcomes framework:

- Improved health outcomes for all of the 879,000 people living in the Central Region and reduced disparities between Māori, disabled and other populations.
- An improved safety and quality of care experience for patients in the Central Region.
- The clinical and financial sustainability of the Central Region's health system. This will ensure best value for public health system resources, and a capacity to meet demand while living within our means and
- System and service integration across the continuum of care and consistency of clinical pathways.

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

The region's outputs are a combination of work undertaken by Central Region's Technical Advisory Services Limited (TAS) and DHB clinical and non-clinical networks and working groups.

Figure 1 CENTRAL REGION OUTCOMES FRAMEWORK



Central Region working within outcomes framework enabling sustainability, quality and safety while making use of available resources (Triple Aim).

Profile of the Central Region 2014-2024

The Central Region is made up of six DHBs that service a population of just under 879,000; this represents approximately 20% of New Zealand's total population. The DHBs involved are Wairarapa, Whanganui, Hawke's Bay, MidCentral, Hutt Valley and Capital & Coast. The region covers an area of 39,482 square kilometres. Capital & Coast DHB services the region's largest population base; this is 7.4 times that of Wairarapa DHB, the Region's smallest.

Between 2014 and 2024 the Central Region population is expected to grow by 4.1% to approximately 915,000. There will be more elderly and fewer young people and these trends are expected in each of the region's DHBs. The ethnic composition of the region will become more diverse and there will be more people identifying as Māori, Pacific or Asian in all six DHB districts.

The Challenges Facing the Central Region

Our main challenges as a region are informed by the health needs analysis of the Central Region, regional priorities and Government expectations. 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 2014 and 2024 there will be a 33.1% growth in the population aged 65 to 84 years and a 29.2% growth in the population aged 85-plus years.

Epidemiology: More people are living longer with one or more long-term conditions affecting 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 affect younger people.

Geography: Population growth is concentrated in urban centres, which will place greater pressure on rural DHBs to provide a full range of health services to their populations.

Consumer and public expectations: Public expectations of health services are changing rapidly. Consumers and family/whānau expect to receive more personalised care, are focused more on quality of care and are often much better informed about their treatment options.

Tackling pervasive inequalities: There are variations in the life expectancy and mortality rates among the populations serviced by our DHBs.

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.

Medical technology: Advances in medical technology present opportunities to transform the ways that health services are delivered.

The financial environment: DHBs in the Central Region are operating with funding received from the Government. The pressure to operate within budget will grow as health care needs continue to grow. This requires us to demonstrate significant efficiencies and productivity gains.

The above challenges require the Central Region DHBs to progress 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. Changes in the way that health services are provided will need to be made if people and their families/whānau are to continue to receive high-quality health care. This *Regional Service Plan* (RSP) highlights closer integration and alliances with key partners in primary care and other government sectors. A more detailed population needs analysis is outlined in Appendix A.

Primary Health Care

The New Zealand Public Health and Disability Act 2000 gives DHBs overall responsibility for assessing the health and disability needs of communities in their regions, then managing the resources and service delivery to best meet those needs consistent with the Government's Better, Sooner More Convenient Primary Care² policy.

To achieve this, the Central Region and its primary care partners are moving towards an integrated environment that will require a greater level of collaboration in the planning and implementation of services. This integration will create a quality primary health service that is aligned with the Triple Aim approach, with services delivered closer to home, providing better health outcomes through earlier and simpler interventions, and making New Zealanders healthier.

Primary health services in the Central Region include services that are provided in the community as a first point of contact – services such as general practice and nursing services and other community health services, for example pharmacy, family planning, midwifery, dental therapy, sexual health and physiotherapy. Such services focus on better health for a population and actively work to reduce health inequalities between different groups. A strong primary health system encourages community participation that gives a greater sense of involvement in the planning and delivery of localised services.

Comprehensive, accessible primary health services promote better population health status. Consequently demand for more expensive secondary care services are managed through

- effective management of long-term (chronic) health conditions through early interventions and supporting patient self-care,
- effective management of the demand for costly hospital services by providing alternative community-based packages of care, ensuring that patient referrals to specialist services are consistently appropriate and lowering rates of hospitalisation for ambulatory, 'care-sensitive' conditions and
- effective use of the workforce by making prudent use of scarce staff with appropriate reimbursement incentives.

² Ministry of Health 2011 *Better, Sooner, More Convenient Health Care in the Community*. Wellington.

RSP Linkages

In the Central Region, primary care provided by general practitioners (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 in Capital & Coast*,
- one in Hutt Valley*,
- one in MidCentral,
- one in Hawke's Bay,
- two in Whanganui** and
- one in Wairarapa.

(* = one shared PHO across both Capital & Coast DHB and Hutt Valley DHB, ** = one PHO that has practices across several DHBs nationally)

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:

- Information Technology
 - Development of integrated systems to allow access to clinically appropriate patient records with the *Central Region Information Systems Plan* (CRISP) programme of work.
- Health of Older People Regional Programme
 - Dementia care and the development of dementia pathways.
 - Multi-sector approach to developing Advance Care Planning (ACP) for individuals.
 - Multi-disciplinary approach to managing polypharmacy.
- Māori Health Regional Programme
 - Integration to reduce inequalities of access throughout the region.
- Cancer Regional Programme
 - Development of initiatives to support the identification of high suspicion of cancer.
 - Tools and education programme to assist in the detection of prostate cancer.
- Cardiac Regional Programme
 - Development of access criteria and clinical pathways for an integrated 'heart team'.
- Electives Regional Programme



- Development of pathways such as the orthopaedic pathway and referral systems.
- Mental Health and Addictions Regional Programme
 - Support and education to facilitate the transitioning of some services back into the community.
 - Co-location of primary care liaison services with specialist staff in some areas.
- Diagnostic Imaging Regional Programme
 - Development of cost-effective and accessible, community-referred radiology.
 - Development of clinical treatment pathways.
- Workforce Regional Programme
 - Understanding the capability and capacity of the workforce to extend scope of practice to ensure fully integrated primary and secondary services.
 - Development and planning of workforce to address issues of vulnerability within the continuum of care.
- a greater clinical and management focus on key issues.

A further national work programme, the Community Pharmacy Services Agreement, also has a strong linkage to the integration of pharmacy services through information technology (IT) systems, polypharmacy and behavioural change brought about by the agreement's new funding arrangement. Sub-regional and individual DHB initiatives continue to evolve throughout the region, with a strong focus on integrating care services within communities.

Regional Collaboration

Our approach acknowledges that regional collaboration is not an end in itself but a means to delivering services more effectively and efficiently, to improve the quality of health and disability services in a sustainable way and within fiscal constraints. It is at the centre of our approach to achieving our goals for the region.

For the Central Region DHBs, the primary benefit of regionalisation is to achieve improvements in line with our strategic intentions through:

- a standardisation of clinical practice and administrative functions,
- shared best practice,
- the optimal use of scarce resources, for example workforce, equipment and facilities and

SECTION TWO

The Central Region's Response

Strategic Direction for the Central Region

The vision for the Central Region is defined as:

There will be a regionally integrated system of health service planning and delivery that will lead to on-going improvements in the sustainability, quality and accessibility of health services.

Better integrated, more convenient and patient-centred services are being provided to improve the experience for patients. These changes aim to help manage the demand for higher-cost hospital-based care, decrease the average cost per intervention and make better use of our specialist workforce and expensive technologies.

Alignment with DHB annual plans across the region helps to achieve the Government's aim for a health and disability system that is managed and delivered in a sustainable way. The following objectives underpin our developments for the next three to five years.

1. Improving Quality and Safety – the Essence of the Triple Aim³

The Triple Aim is the basis of the Central Region's clinical governance framework, that provides direction at a regional level to deliver sustainable, patient-focused, high-quality care.

The following principles inform the Triple Aim approach, which is illustrated in Figure 2.

- Quality and safety will be the goal of every clinical and administrative initiative.
- The most effective use of resources occurs when clinical leadership is embedded at every level of the system.
- Clinical decisions at the closest point of care will be encouraged.
- Clinical reviews of administrative decisions will be enabled.
- Clinical governance will build on successful initiatives.

Figure 2: The New Zealand Health Quality and Safety Commission Triple Aim



2. Sustainable Service Models

Changes in service design reflect the changing health needs and population size of the Central Region. In particular, an ageing population and the increasing diversity of need and poorer health outcomes for Māori and Pacific peoples will require new models of care. Service models and the need to focus on sustainable services inform the current and future investment in the workforce, capital and information. For example, investments in IT systems such as shared electronic records will enable improved co-ordination between secondary and primary care services. Medium to major capital decisions are being tested regionally to ensure that the expected benefits of collaboration are maximised.

3. System Integration and Service Transformation

Health professionals, service providers and DHBs are being supported to better co-ordinate and integrate care by placing patients and carers at the centre of service delivery, while reducing waste, harm and unjustified variations in the quality of care and service performance. Our integrated approach relies on a strong primary care platform to support service transformation and provides us with opportunities to better manage demand and develop a more sustainable health system. DHBs are already working with alliance leadership teams to strengthen the integration at district level with primary care. Greater collaboration across the government sector is helping to promote a whole-of-system integration approach by improving

³ The New Zealand Health Quality and Safety Commission

outcomes for some of our more vulnerable populations, such as vulnerable children⁴.

4. 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 input on service design and implementation.

5. Ensuring that Services are Supported by Appropriate Infrastructure and Enablers

We operate in a challenging environment. It is critical that capital infrastructure and enablers fully support service delivery and the desired level of change to deliver quality improvement to populations, individuals and the public health system.

The on-going development of regional IT systems will enhance patient care by enabling clinicians from one DHB to have access to medical records from another, thus improving patient outcomes through faster access to medical histories.

6. 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 2014/15 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 2014/15.

7. Increasing Productivity while 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.

8. Managing the Impacts of the Development of Major Services

All key pieces of work that affect patients in the region will need to consider the best funding models and mechanisms to support them. Possible service changes may result in people needing to travel, leading to travel and accommodation requirements that will need to be incorporated into the way services are delivered. A whole-of-system approach is being led by DHB clinicians and managers to integrate and transform the Central Region health system. The regional, sub-regional and local DHB work programmes for 2014/15 are being more closely aligned with the strategic drivers and intentions set out in this RSP.

Structure of the RSP 2014/15

The RSP 2014/15 contains both the strategic vision and priorities as articulated by the Central Region's Regional Governance Group and other implementation planning elements. In doing so it identifies each DHB involved in each aspect of the RSP.

The RSP 2014/15 has been approved by the individual boards of the six Central Region DHBs. It outlines the intentions and focus of the Central Region for the period 1 July 2014 to 30 June 2015.

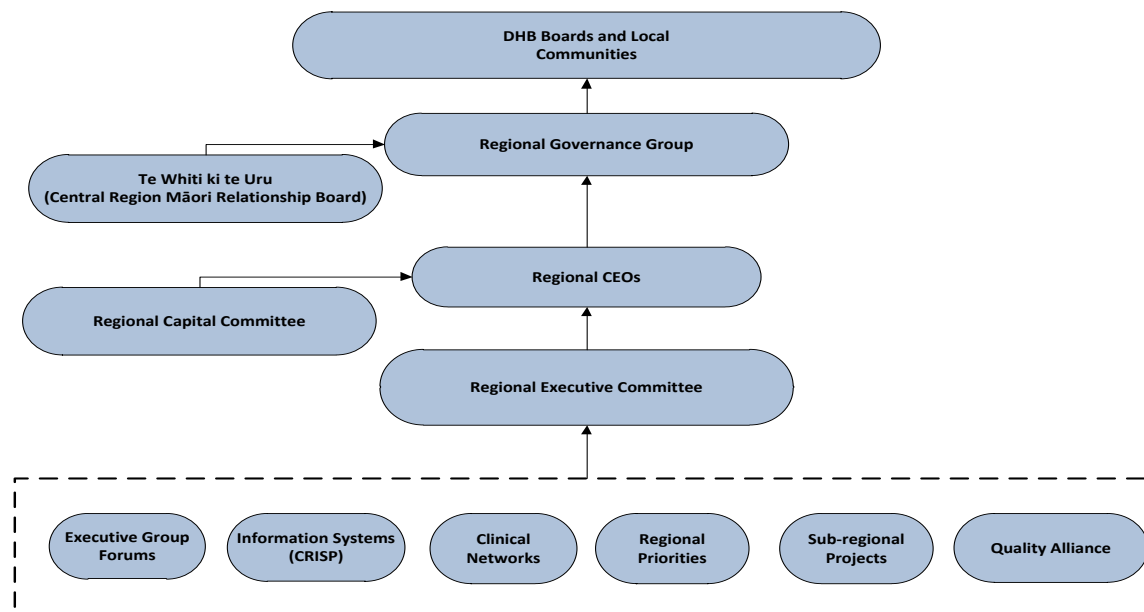
The RSP 2014/15 is consistent with the National Health Board's planning guidelines for 2014/15 and the Minister of Health's Letter of Expectations 2014/15.

⁴ The White Paper for Vulnerable Children, 2012

Central Region Leadership Framework

The Central Region DHBs reviewed their regional governance framework during the 2012/13 year. The revised framework is outlined below in Figure 3.

Figure 3 – Regional Governance Framework



(Appendix B outlines the responsibility and accountability matrix for the Central Region RSP)

Governance Groups

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

1. 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 and
- act as an escalation point for matters of strategic importance.

2. 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

- ensure a common approach to non-TAS issues.

- 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 and
- collaborate and identify synergies within the Central Region.

3. The Central Region CEOs

This group comprises the six CEOs (chief executives) 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 and

4. 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). The 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 General Managers 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 successful delivery,
- 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 forums and
- ensure strong engagement between management and clinicians.

These governance groups are supported by the following:

1. Quality and Safety Alliance

Quality, safety and clinical leadership is essential. In addition to the REC a Regional Quality and Safety Alliance (RQSA) is being established. Members will include the Chief Medical Officer, the Director of Nursing, the Director of Allied Health, the 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

that optimises health outcomes, including the reduction of health disparities. 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,
- enhance clinical governance and reporting across all health care settings and service levels so that health service consumers experience a consistent quality of care,
- 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, and establish an appropriate collection and reporting mechanism and
- ensure the sustainability of tertiary services by working with the REC to consider how best to deliver regional services safely.

2. 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 MoH and the Capital Investment Committee early in the capital planning process and

- provide regional scrutiny for individual business cases costing over \$500,000, and
- 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 and
 - reducing service vulnerability risks.

3. Regional ICT Governance

A Health Informatics Strategic Advisory Group is being established and will provide oversight and governance across regional information and communications technology (ICT) initiatives. The group will be chaired by the lead CEO for ICT and include multi-disciplinary representatives. 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 under performance against plan and
- develop and implement a communications and clinical engagement strategy.

CRISP 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 national infrastructure plan.

CRISP Phase One is governed by a steering group and has appropriate clinical and management representation from DHBs. The programme also has a Clinical Reference Group.

4. 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

Assessing the Impacts of the RSP

DHBs are expected to deliver against the national health sector outcomes: "all New Zealanders lead longer, healthier and more independent lives" and "the health system is cost effective and supports a productive economy". They are also expected to achieve the Government's 'Better, Sooner, More Convenient Health Services' guidance. To demonstrate the effectiveness of regionalisation and the added value, the outcomes framework will enable success to be measured by assessing the impacts of regional service planning on the achievement of the national health sector outcome expectations.

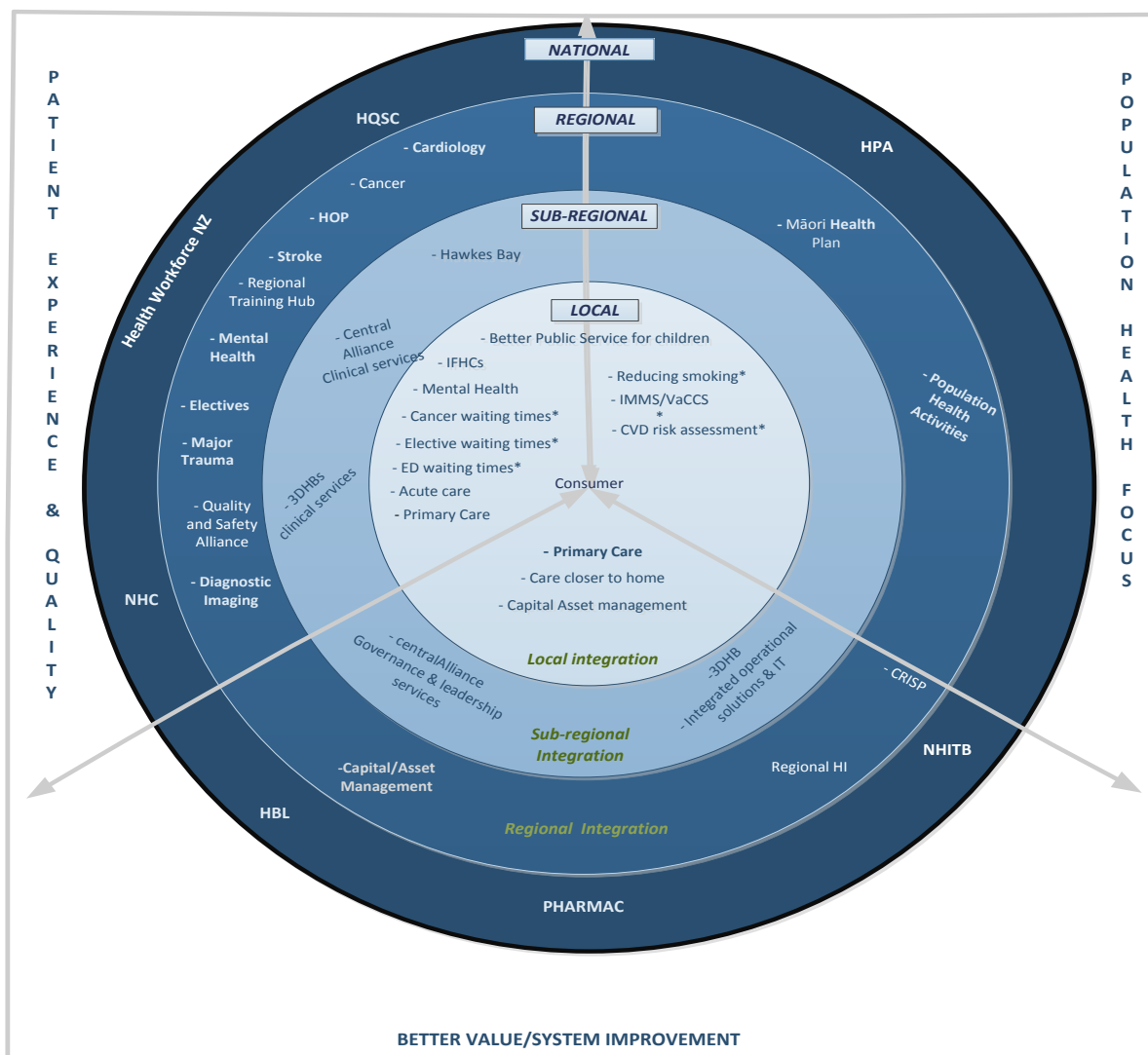
Background

Regional service planning will deliver added value to the Central Region's DHBs by way, in part, of a positive impact on and benefits for individual DHBs, sub-regional alliances and the Central Region as a whole. These benefits are expected to come about through reduced costs, reduced growth in costs, increased sustainability of services, reduced vulnerability in services, and improved access and patient care quality. These are all principles of the Triple Aim, as represented in Figure 2. The Triple Aim framework is consistently applied across all six of the Central Region's DHBs.

To understand the impacts on and benefits or downsides of the projects within the RSP programme of work, each project has been assessed for its contribution to making a positive impact on the three principles of the Triple Aim, as outlined in Figure 4.

Figure 4 – Line of Sight and Benefit Mapping

Initiative Mapping: Line of Sight of Local, Sub-regional, Regional and National



KEY

Local: activity focused within DHBs – focus of annual plans.

Sub-regional: activity/initiatives where two or three DHBs collaborate.

Regional: activities/initiatives where greater benefit is gained from collaborative working by six DHBs.

Better Public Services for Children

Reducing rheumatic Fever

Prime Minister's Youth Mental Health Projects

Children's Action Plan

Whānau Ora

SECTION THREE:

Implementation Plans 2014/15

Introduction to the RSP 2014/15

The RSP 2014/15 builds on our achievements in 2013/14. It addresses new areas from which improvements will be delivered to the population of the Central Region through collaborative activity at either a regional or sub-regional level. The RSP 2014/15 articulates the longer-term strategic intentions for the Central Region and the shorter-term actions to address national and regional priorities. The RSP 2014/15 also provides stronger linkages to the annual plans prepared by each of the DHBs, and in doing so strengthens the line of sight between local, sub-regional, regional and national integration efforts.

The Central Region Priorities for 2014/15

The priorities for the Central Region DHBs for 2014/15 have remained relatively unchanged from those of 2013/14 and are informed by national expectations, the Minister of Health's Letter of Expectations 2014/15 and the health needs assessment. The 2013/14 RSP provided a firm foundation for change, enabling the RSP 2014/15 to progress specific actions to reduce service vulnerability, reduce costs and improve the quality of care to patients. In 2014/15 the Major Trauma Network and Health of Older People (Dementia Care) were added as national priorities. This year we have organised our plans into four distinct portfolios.

- **Population health focus** – includes plans focusing on population health and vulnerable populations within our communities.
- **Managing long-term conditions** – includes plans responding to the growing demand placed on the sector by chronic illnesses and other long-term conditions.
- **Specialist/Acute services including diagnostics** – includes plans relating mainly to specialist hospital services.
- **Regional enablers** – includes plans that enable the environment for service transformation to exist.

Population Health Focus – Regional and National Priorities

1. Quality and Safety, including Patient Experience

The quality and safety of services is the top priority for 2014/15. The region is committed to working on the Health Quality and Safety Commission's (HQSC's) 'Open for Better Care' campaign. With the Central Region Patient Safety Campaign Steering Group and the establishment of the RQSA, the region is already taking positive steps towards enhancing patient outcomes in the region.

2. Population Health

The Central Region believes that a whole-of-system approach to the delivery of integrated services must include community-based preventive services. Investments in preventive measures and the promotion of positive health choices will, over time, help to maintain and potentially improve people's health standards, reduce pressure on health care services and avoid hospital admissions. The approach to population health at the regional level is focused mainly on areas of shared learning to progress work already underway.

Increasing rates of obesity and chronic disease, combined with an ageing population, are commonly present in most developed countries. Investments in preventive measures will contribute to achieving four of the Government's Health Targets:

- Shorter stays in emergency departments.
- More timely and equitable access to elective surgery.
- Better diabetes and cardiovascular services.
- Shorter waiting times for cancer treatment.

The remaining two targets, better help for smokers to quit and increased immunisation are important public health initiatives that are economically efficient and cost effective.

The Health Act 1956 (as amended by the Health [Drinking Water] Amendment Act 2007) requires that operators of community drinking-water supplies comply with the Drinking-Water Standards (2008). This includes the requirement to develop and implement an effective public health risk management plan (now termed a 'water safety plan'). The timeframes for meeting this requirement depend on the size of the population

supplied, with operators of smaller supplies given longer to demonstrate compliance.

There are a relatively large number of smaller suppliers, meaning that workloads will increase over time, affecting the limited specialist workforce. The volume of work required is difficult to assess, and requires some further modelling.

A whole-of-system approach to the delivery of integrated services must include community-based prevention services and recognise the importance of linking these to the rest of the health sector. Clinical leadership, a focus on quality and safety, and the co-ordination of services are fundamental to improving health outcomes and reducing health inequalities for populations.

The Central Region Public Health Clinical Network was established in 2011 to share learning and innovation, and support local public health unit activity where this makes sense. The approach to population health at the regional level is focused mainly on areas of shared learning to progress work already underway.

Common public health priorities agreed for the Central Region in 2014/15 are:

- Implement the agreed action in *Making Connections: Auahi Kore/Tupeka Kore Central Region 2013-2015*, the Central Region Smokefree plan.
- Facilitate the focus on consistent emergency management responses across the Central Region's public health services, increase capacity for response via an annual emergency management meeting and one annual shared training opportunity.
- Evaluate the implementation of the DHB-specific pilot projects from the *Central Region Gastroenteritis Plan* for reducing gastroenteritis hospitalisation rates for zero- to four-year-olds, and share learning/successes and
- Develop an effective model to predict future drinking-water workloads across the Central Region so as to ensure that the capacity exists to support communities to demonstrate compliance with the drinking-water legislation.

3. Māori Health

A reduction in health inequalities must remain a core focus of our regional work. This focus will ensure that our DHBs pool their resources and understanding of how to reduce health

inequalities. The implementation of a monitoring plan for health inequalities is to be addressed at all organisational levels. Our *Regional Māori Health Plans* prioritise improving Māori health and reducing Māori health outcome disparities by focusing on the key indicators where the health inequalities experienced are the greatest between Māori and non-Māori.

4. Health of Older People

HOP has been a Central Region priority for three years. In 2014/15 there is an expectation that all regions prioritise improving services for people with dementia. Regions are expected to work across the sector and support the implementation of DHB dementia care pathways through shared learning and resources.

5. Vulnerable Children

Early intervention can prevent ill health and reduce morbidity for children and young people. Healthy behaviours in childhood and the teenage years can affect health outcomes in adulthood. Continued support for positive child health outcomes means that society as a whole will improve its overall health status.

While the Central Region's RSP programme of work does not have a specific focus on children and young people, several of the regional programmes have actions for different aspects of child health and wellbeing.

- The Mental Health and Addictions Network's on-going focus on maternal and perinatal mental health and wellbeing, and youth forensic services.
- The *Regional Māori Health Plan's* on-going focus on Māori health indicators, including Tamariki Ora.
- The *Central Region Gastroenteritis Plan* for reducing gastroenteritis hospitalisation rates for zero- to four-year-olds.

Managing Long-Term Conditions – Regional and National Priorities

1. Cancer Services

The Central Cancer Network (CCN) involves stakeholders working across organisational and service boundaries to

- reduce the incidence and impacts of cancer,
- address inequalities with respect to cancer and
- improve the experience and outcomes for people with cancer.

The CCN *Strategic Plan 2009-2014* guides the implementation of the strategic direction.

2. Cardiac Services

The objectives for cardiac services in 2014/15 are to demonstrate on-going improvements in access to cardiac services, including

- improved and timelier access to cardiac services,
- patients with similar needs receive comparable access to services, regardless of where they live,
- more patients survive acute coronary events and
- patients with Acute Coronary Syndrome (ACS) receive seamless, co-ordinated care across the clinical pathway.

3. Stroke Services

The region has established a Stroke Network to facilitate the implementation of the *New Zealand Guidelines for Stroke Management 2010*. The aim of the Stroke Network is to ensure that risks are reduced and improvements are made in the provision of acute and rehabilitation stroke services in the Central Region. The regional objectives for 2014/15 include

- stroke prevention improvement,
- stroke event survival,
- reduction in subsequent stroke events and
- improved access to organised acute and rehabilitation services.

4. Mental Health and Addiction Services

The Mental Health and Addictions Network leads regional planning and service delivery to reduce inequalities in outcomes for mental health and addictions (MH&A). The regional objectives for 2014/15 are to improve:

- access to the range of eating disorder services,
- adult forensic service capacity and responsiveness,
- youth forensic service capacity and responsiveness,
- the availability of perinatal and maternal mental health service options and
- MH&A service capacity for people with high and complex needs.

5. End-of-Life Care

End-of-life care has been identified as an area of focus for the Central Region as there is a growing recognition of the need to have an engaged and informed discussion on end-of-life care. As the population ages and more people enter the last years of life there is an expressed need to consider solutions to address the issues proactively. An integrated approach to the care of the frail elderly and people who are in the last years of life will provide a better quality of care and a more appropriate use of current services. Likewise, addressing end-of-life care requires a 'cradle to the grave' approach as advances in medical technology enable people of all ages with life-threatening conditions to live longer and indeed survive into old age.

This RSP does not have a specific work plan on end-of-life-care. However, there are obvious linkages to ACP, the HOP Network, the Palliative Care Plan and CCN, with an integrated, cross-boundary approach involving the main areas where people live and die: in their community (primary, community care), in care homes and hospices, and in hospitals (acute care).

Specialist/Acute Services including Diagnostics – Regional and National Priorities

• Elective Services

Elective surgery has the ability to make an immediate impact on quality of life, reducing pain and discomfort and improving independence and wellbeing. Yet some patients still experience long waits before receiving treatment. The region's DHBs are working together to ensure they will be able to meet the elective targets in the future and move towards a four-month waiting time by December 2014.

• Major Trauma

A major trauma is defined as

- an event requiring the treatment of two or more injuries generally relating to the head or spine, or
- an Injury Severity Score greater than 15.

Nationally there are approximately 2,000 major trauma events per year. On average each event attracts a 15-day stay in an intensive care unit and one to two years of rehabilitation. Major trauma mortality rates range between 5% and 10%. The establishment of the Major Trauma National Clinical Network (MTNCN) is a quality initiative aimed at improving outcomes from major trauma.

• Diagnostic Imaging (Radiology)

The opportunity exists to take a regional approach to radiology services within the Central Region. A working group is guiding standardisation in the prioritisation of, and access criteria to, radiology services across the region. This group is also working with the CRISP team to implement the Picture Archiving and Communication System Archive (PACS) and Radiology Information System (RIS).

Regional Enablers

1. Regional IT and CRISP

CRISP moves the DHBs to a suite of shared, standardised and fully integrated information systems that will enhance clinical practice, drive administrative efficiencies, enable the regionalisation of services and reduce current operational risks.

A General Manager Health Informatics has recently been appointed to design, develop and implement a business model to accelerate progress toward regionalisation of an integrated approach to ICT and Health Informatics investment. Currently a regional audit is being undertaken to identify and provide detail on all local, regional and national IT projects underway and planned for the next three years. This will attempt to ensure there is a common view across the region as to:

1. Treatment of CAPEX/OPEX
2. Identify potential duplicated investment/work effort
3. Ensure adequate planning is taking place to make the local DHB's ready to adopt CRISP deliverables
4. Understand and ensure benefits are clear and understood

It is envisaged the detail outputs of this process will be provided before the end of Q1 2015.

2. Capital Asset Management

A regional approach to capital investment is more likely to secure a sustainable approach to service and capacity development as well as manage the on-going operational costs. This is especially relevant for any future service change. Capital asset planning will be undertaken within the context of service planning, with a regional overview to ensure that the expenditure aligns with service plans. The development of this RSP sees a stronger focus on how regional service priorities affect both capital and operational costs – to give a clear line of sight back to the DHBs' accountability documents and vice versa.

The establishment of the Regional Capital Committee will enable better linkages to capital planning. The primary purpose of the Committee is to improve capital planning and decision making to ensure that current assets are well managed, future proposals are justified and that they are aligned to fit the strategic intentions of the Central Region. The Committee's objectives include ensuring regional peer review of capital projects so that it provides strong and critically appraised business cases. The Committee also aims to agree a regional approach to national capital and deficit equity support requests and to inform the national process of regional issues.

Other On-going Regional Work

Following are the sub-regional work programmes included in the RSP.

1. Sub-regional Activity

Key alliances have developed at the sub-regional level where individual DHBs see benefits in acting collaboratively. These are:

- the centralAlliance of the MidCentral and Whanganui DHBs and
- the 3DHB health service development alliance of the Capital & Coast, Hutt Valley and Wairarapa DHBs (the 3DHBs).

2. centralAlliance

Strategic Intent

The centralAlliance between the MidCentral and Whanganui DHBs aims to achieve improved health outcomes for their DHB populations. Through the alliance, clinically-led, collaborative health services and more effective and efficient shared support services are developed.

Current Situation

Under the centralAlliance, a number of services and processes are provided on a sub-regional basis (see below). In 2013/14 women's health services moved to a sub-regional model of care. This was the first significant clinical service development. Implementation will continue during the planning period.

The two DHBs also agreed to develop a strategic plan to guide further integration across all DHB functions. This work is underway and a discussion document will be issued for public consultation in 2014/15. The following table shows the focus of this plan.

3. The 3DHBs

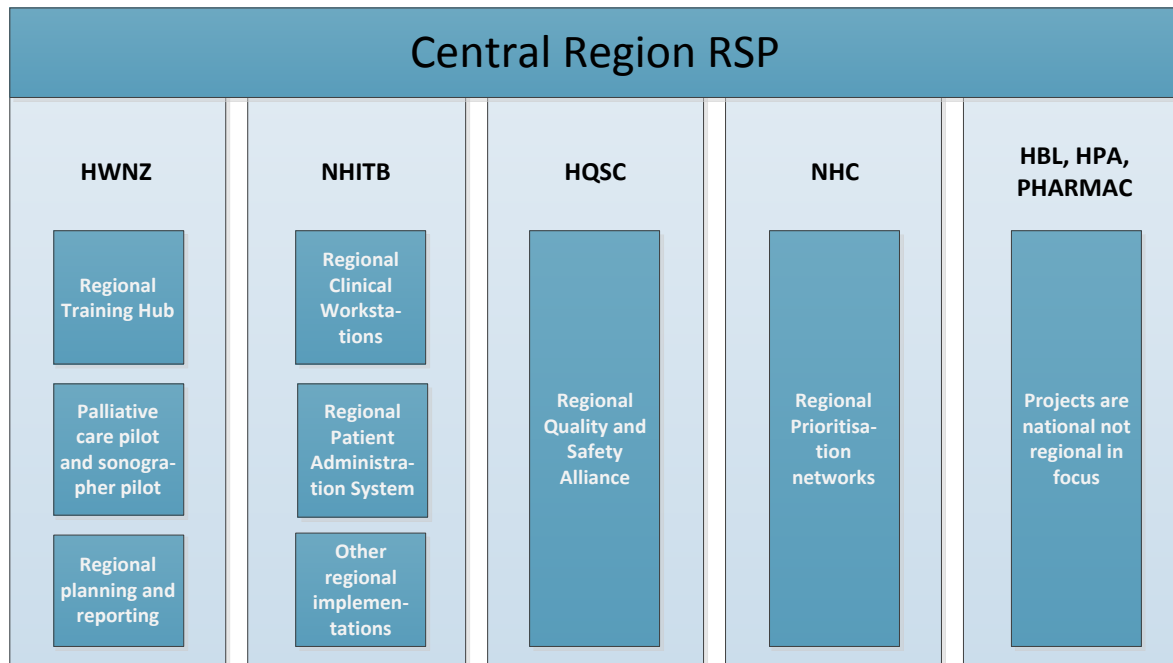
The 3DHB health service development programme continues to progress clinical service alignment and integration across the three DHBs. In 2013/14 the programme continued to align the clinical service for gastroenterology, ear, nose and throat (ENT), orthopaedics, general paediatrics, radiology and laboratory services. An agreed sub-regional model of care for the treatment of non-melanoma skin cancer is under discussion. A number of programme enablers were progressed, along with a comprehensive review of the operational changes required to progress integrated clinical services operating on multiple DHB sites. In addition, the sub-region has selected and begun the implementation of health pathways as a sub-regional platform for whole-of-system integration.

The 3DHB health service development work plan for 2014/15 will focus on progressing clinical service alignment across the 3DHBs, as well as a number of key enablers such as more integrated IT solutions and clinical pathways. The 3DHB health service development programme will also comprise fluid programmes of work as the 3DHBs continue to work collaboratively to achieve the Triple Aim.

Linkages with Other National Entities

The regional work programme is well connected to the work of the HQSC at various levels. The role of the other national entities, including Health Benefits Limited (HBL) and the National Health Committee (NHC), will be considered throughout the year as part of the execution of regional plans.

Clinical Services	Shared Leadership and Governance	Support Services
<ul style="list-style-type: none"> • Cancer services • Renal services • Specialist medicine – neurology, respiratory, sleep apnoea • Specialist surgical – vascular • Public health services – health protection • Specialist women's health services • Urology services 	<ul style="list-style-type: none"> • Common board members • Joint Allied Health director • Joint midwifery adviser • Joint professional adviser, occupational therapy • Joint human resources and organisational development • Child health network • Child and youth mortality review co-ordination • Joint maternity quality co-ordination • Autism spectrum disorder service co-ordination • Medical credentialing processes • Clinical policies and procedures 	<ul style="list-style-type: none"> • Bio-medical engineering • Cleaning services • Facilities' management, engineering and maintenance • Food services, including dietetics • Grounds maintenance • Laundry services • Orderly services • Security services • Transport and fleet management



The regional work programme is connected to the national entities Health Workforce New Zealand (HWNZ), the NHITB and the HQSC at various levels. There are a number of projects being worked on regionally with HWNZ. These include:

- the Central Region Training Hub's work on aligning with the HWNZ strategic plan,
- adapting the Northern Region sonography pilot to the Central Region in the next three years,
- undertaking regional reporting on the 70/20/10% funding criteria and medical trainee career planning, improving access to ACP training,
- developing and implementing the *Health and Disability Workforce Plan*,
- implementing the Palliative Care Managed Clinical Network pilot,
- CRISP working with the NHITB to deliver regional clinical workstations and
- Implementing a regional patient administration system (PAS) by June 2015 and
- Establish a RQSA with HQSC.

Linkages with the NHC are expected at a regional level when contributions are required for prioritisation networks to prioritise service improvements, and for assessments of new technologies. The region is committed, through all of its DHBs, to working on National Health Committee recommendations. HBL, PHARMAC and the Health Promotion Agency (HPA) are working on national projects and there are no regional

work streams at present. The region's DHBs are individually contributing to

- HBL's national finance, procurement and supply chain programme,
- development of a detailed business case for food services, linen and laundry and a national infrastructure platform,
- an indicative case for a human resource management system to assist regional prioritisation networks prioritise service improvements and assessment of new technologies.

DHBs are locally contributing to PHARMAC projects on hospital medical device interim procurement and the development of the hospital pharmaceuticals schedule.

The region also has linkages with other national bodies including

- the National Clinical Stroke Network's Leadership Group,
- the Stroke Foundation of New Zealand,
- the National Cardiac Network and
- MoH – National Forensic Network

SECTION FOUR

Implementation

Central Region Implementation Plans 2014/15

The following action plans focus on outlining the specific tangible and measurable actions to be undertaken in 2014/15 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 Action Plans

1	Health of Older People (HOP)
2	Māori Health
3	Cancer Services
4	Cardiac Services
5	Stroke Services
6	Mental Health and Addictions
7	Electives
8	Major Trauma
9	Diagnostic Imaging
10	Information Technology
11	Regional Capital Investment Approaches
12	Workforce
13	Quality and Safety

Vulnerable Populations

Health of Older People (HOP)

The proportion of older people aged 65 years and over in New Zealand is projected to grow steadily to 19% by 2021. By 2026 approximately one-fifth of the New Zealand population is expected to be over 65 years and this growth will be seen across all DHBs in the Central Region.

The greatest need and the highest health care costs are amongst those over 85 years, and the number of people aged 85-plus in the Central Region is expected to double by 2026.

Older people are the most frequent users of primary care services; accounting for 30% of all GP and nurse consults. Those aged over 65 years are also high users of secondary care services, with 35% of all hospitalisations in the Central Region⁵.

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 on-going 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.

Integrated care is not indicated for all older people, but is appropriate 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 requires higher levels of service integration.

⁵ Health Needs Assessment for the Central Region DHBs, October 2008

A health system that functions well for HOP is one that

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

Strategic direction changes from the 2013/14 RSP

The 2013/14 RSP for HOP noted that the HOP Network would consider findings from the Hawke's Bay DHB nutrition project and assess the feasibility of establishing nutrition risk screening for older people living in the community. However, this is not a regional priority for 2014/15.

An evaluation of the Multi-interventional Approach to Polypharmacy (MiAP) has been deferred to 2014/15 to enable sufficient numbers of patients to be referred to the Specialist Medicine Advisory Service.

The HOP Network was formed in July 2011 to provide oversight and governance to HOP work streams that support the RSP. The CEO sponsor and Chair is Julie Patterson (Whanganui DHB).

The HOP Network has representation from six DHBs. The focus of the HOP Network in 2014/15 is on:

- Dementia pathways
- ACP
- MiAP and
- HOP workforce capacity.

To Achieve the Following Outcomes

Regional Objectives HOP

- To ensure that older people and their families/whānau are valued partners in an integrated health and social support system that supports them throughout their journeys to maintain and maximise their abilities, optimise their sense of wellbeing and have control over their circumstances
- The focus for 2014/15 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 Primary Healthcare Organisations,
 - provide representation at a national level when requested by MoH (approximately twice a year) to provide an overview of the DHB development and implementation of dementia care pathways and share learning and ideas nationally,
 - raise awareness among consumers, primary care providers, community agencies and health professionals of the importance and relevance of ACP to them,
 - raise awareness among consumers of the risks associated with polypharmacy, providing consumers with medicine-adherence support to enable self-management and reduce the risks of adverse events and interactions and
 - develop an understanding of the capacity of the specialist HOP workforce to meet current and future service models

Regional Milestones and Measures

Dementia measures

- To report quarterly to MoH on regional activity that supports DHB dementia care pathway development and implementation
- To report six-monthly on the development and commencement of dementia awareness and responsiveness education programmes in primary health care (as set out in the CFA variations)
- Represented at national dementia meetings when required by MoH
- ACP measures
- Implement the Central Region ACP Framework
- MiAP
- Develop recommendations for the Central Region regarding regional implementation of MiAP

Workforce

- Determine the capacity of the HOP workforce to meet the needs of a rapidly ageing population
- Consider the strategic intents in sectors such as primary care, palliative care and aged care to reduce the likelihood of workforce fragmentation

Sponsor: Julie Patterson

Clinical Lead: Dr Elaine Plesner (tbc)

1. Dementia Pathway

In November 2013 MoH launched the New Zealand Framework for Dementia Care 2013 with the expectation that significant improvements in dementia health and support services will be achieved in the coming five years. It was also created to provide national consistency, with a degree of flexibility so that DHBs can adapt it to meet local priorities and be innovative in their approaches.

The framework aims to help people with dementia and their families/whānau to maximise their independence and wellbeing by reducing stigmas and providing clear, comprehensive information

and an integrated, holistic approach to dementia care and support. The framework encourages different health and social services to work together to provide people with integrated care. Early diagnosis by health professionals for people with dementia is highlighted so that people can get the help they need as soon as possible.

The Central Region DHBs, under the guidance of the HOP Network, will progress the development of their dementia pathways to meet the expectations outlined in the framework. The work for the 2014/15 year is outlined below.

Key Actions – 2014/15

Key Actions– Dementia Pathway	Milestone/Measurement	Leads
<ul style="list-style-type: none"> Identify gaps in services for people with dementia, including older people, younger onset and people with intellectual disabilities, by benchmarking against the New Zealand Framework for Dementia Care. The following will take place in 2014/15: <ul style="list-style-type: none"> Identify the regional components Develop the Dementia Pathways Working Group (and if necessary increase the membership) into a Regional Dementia Care Network to share learning and resources across the region Provide representation at a national level when requested by MoH (approximately twice a year) to provide an overview of DHB development and implementation of dementia care pathways and share learning and ideas nationally 	<ul style="list-style-type: none"> Project scoping document completed – 15 August 2014 Project scoping document agreed by Central Region Mental Health and Addiction Network(MHAN)/HOP – 25 August 2014 Gap analysis methodology identified – 31 September 2014 Regional components identified – 30 November 2014 On-going quarterly reporting to June 2015 Potential network membership identified – 31 August 2014 Quarterly network meetings – dates and times identified – 31 August 2014 Regional representation to MoH twice a year as requested 	<ul style="list-style-type: none"> Dementia Pathways Working Group Regional delivery
<ul style="list-style-type: none"> Hawke's Bay DHB to lead in the delivery of two education packages (for each DHB) for primary care – general practices, to improve confidence in the timely diagnosis and treatment of dementia, in the next two years 	<ul style="list-style-type: none"> Education package, and providers identified – 30 September 2014 Primary care health professionals are surveyed to identify their level of confidence and knowledge in the diagnosis of dementia – September 2014 (re-survey at the end of June 2016) Evaluation of the education packages developed – October 2014 Record and report the numbers attending education sessions 	<ul style="list-style-type: none"> Lead DHB: Hawke's Bay All regional DHBs Dementia Working Group to co-ordinate

Key Actions– Dementia Pathway	Milestone/Measurement	Leads
	<ul style="list-style-type: none"> Six-monthly reporting to MoH to June 2015 Interim progress report to MHAN/HOP – 24 November 2014 Final report to MHAN/HOP – May 2015 	
<ul style="list-style-type: none"> Support the implementation of ‘Walking In Another’s Shoes’ across local DHBs in the Central Region 	<ul style="list-style-type: none"> Home-based support demonstration in Capital & Coast DHB by June 2015 Whanganui DHB, Wairarapa DHB and MDHB in aged residential care by June 2015 Interim progress report to MHAN/HOP – 24 November 2014 Final report to MHAN/HOP – May 2015 	<ul style="list-style-type: none"> Local delivery supported by DBSA role All regional DHBs – Dementia Working Group to co-ordinate
<ul style="list-style-type: none"> HOP E-resource (HOPE). On-going active promotion with 100 new registrations from across the primary, community and secondary sectors in the Central Region. This will become business as usual (BAU) and embedded in local DHB workforce training June 2016 	<ul style="list-style-type: none"> Promotion plan designed – 30 September 2014 Quarterly reporting on utilisation of HOPE tool Interim progress report to MHAN/HOP – 24 November 2014 Final report to MHAN/HOP – May 2015 	<ul style="list-style-type: none"> All regional DHBs – Dementia Working Group to co-ordinate

2. Multi-interventional Approach to Polypharmacy (MiAP)

Sponsor: HOP Network

Clinical Lead: Dr Ian Hosford, Psychogeriatrician (Hawke’s Bay DHB)

It has long been known that elderly people are particularly prone to the adverse effects of medicines and are vulnerable to sometimes unpredictable interactions between medicines. The more medications an elderly person is taking, the more likely they are to have adverse events and interactions.

The compartmentalisation of health care contributes to the problem. Elderly people with multiple conditions are often seen by a number of specialists, all treating each condition in the correct ‘evidence-based’ way. There are no ‘evidence-based guidelines’ on stopping medicines in these circumstances. Because each person has a unique set of circumstances and symptoms, past efforts to address this problem with protocols and simple guidelines have not been successful.

In November 2012 the MiAP approach was endorsed by the REC. Whanganui DHB committed to act as a demonstration site.

MiAP provides a three-point approach to addressing polypharmacy:

- A campaign to raise awareness of polypharmacy among consumers and their family/whānau as patients and of their families’/whānau need to be well informed with quality, readily available information on polypharmacy and the negative impacts it can have. Patients and their families/whānau should drive the demand for change.
- A campaign to raise awareness of polypharmacy among prescribers, encouraging a considered approach to prescribing in the specialist and primary care settings.
- The development of a Specialist Medicine Advisory Service to assist in complex medicine reviews, and support to GPs and other prescribers by giving them somewhere to go for other opinions if they need assistance to reduce patients’ medications.

MiAP was launched on 1 September 2013 as a collaborative effort between the Whanganui DHB and the Whanganui Regional Health Network.

Key Actions – 2014/15

Key Actions – MiAP	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Evaluation of demonstration site at Whanganui DHB 	<ul style="list-style-type: none"> Prospective evaluation of outcomes of patients who have been referred to the Specialist Medicine Advisory Service (75 people) Retrospective evaluation of effectiveness of awareness-raising campaign with consumers and prescribers February 2015 	<ul style="list-style-type: none"> MiAP Project Team (regional)
<ul style="list-style-type: none"> Report to the REC regarding evaluation outcomes and regional implementation of MiAP 	<ul style="list-style-type: none"> May 2015 	<ul style="list-style-type: none"> MiAP Project Team
<ul style="list-style-type: none"> Develop master class programme to expand knowledge of and capabilities in identifying and supporting persons with a high risk of polypharmacy 	<ul style="list-style-type: none"> Develop master class programme content – October 2014 Develop business case for the delivery of master classes – November 2014 Business case signed off by REC – December 2015 Pending agreement of business case, master classes occur sub-regionally – June 2015 	<ul style="list-style-type: none"> HOP Network

3. Advance Care Planning

Sponsor: HOP Network

Clinical Lead: Dr Kirsten Holst, Physician and Geriatrician (MDHB)

ACP assists in the provision of quality health care. It 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 the 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.

Organisations and health care professionals need to be prepared to talk about ACP. They need to be capable of asking about and understanding what matters most to the person, and respecting their end-of-life wishes.

The National ACP Co-operative is a national collective of people driving a collaborative approach to the design and implementation of ACP in New Zealand. ACP training is an important component of the co-operative's strategy and is supported by HWNZ. There are two levels of

training designed to build a health care professional's understanding of ACP. Level 1 is module-based e-learning, which is available free from the National ACP Co-operative website. It is designed for health care workers interacting with people and their families/whānau who need to improve their understanding of ACP. Level 2 is practitioner level and is aimed at health care professionals who want to improve their communication skills and ACP documentation.

For a sustained adoption of ACP, social change needs to occur across the community and in the health sector. Social change needs to occur across a diverse audience, where the central message is the same but requires different approaches.

In 2013/14 an ACP project team produced *Advance Care Planning – A Framework for the Central Region*. The implementation of the quality improvements identified in the framework will be supported by a regional ACP project with governance from the HOP Network.

Key Actions – 2014/15

Key Actions – Advance Care Planning	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Establish ACP leads and governance groups at local or sub-regional level to support the local implementation of the ACP framework 	<ul style="list-style-type: none"> DHBs identify ACP leads – January 2015 Local or sub-regional governance groups established – March 2015 	<ul style="list-style-type: none"> Locally implemented
<ul style="list-style-type: none"> Deliver community training programmes to facilitate raising awareness of ACP among the wider public 	<ul style="list-style-type: none"> June 2015 	<ul style="list-style-type: none"> Locally implemented
<ul style="list-style-type: none"> Train 20 health professionals in ACP Level 2 (ACP practitioners) across the Central Region 	<ul style="list-style-type: none"> Governance groups establish relationship with Regional Training Hub – April 2015 Governance groups support ACP applications – June 2015 	<ul style="list-style-type: none"> Locally implemented
<ul style="list-style-type: none"> 120 people from the Central Region complete ACP Level 1 online modules 	<ul style="list-style-type: none"> Promotion of Level 1 online training modules – December 2014 120 people utilise ACP Level 1 tool by June 2015 	<ul style="list-style-type: none"> Locally implemented

4. Health of Older People Workforce Capacity

Sponsor: HOP Network

In November 2013 the HOP Network surveyed regional executive groups and clinicians to inform the development of the HOP component of the RSP. A theme from this survey was that the specialist HOP workforce needed to be fit for purpose to support the delivery of the services required for an increasingly complex and ageing population.

This project will determine the capacity of the HOP workforce to meet the needs of a rapidly ageing population and consider the strategic intents in sectors such as primary care, palliative care and aged care to reduce the likelihood of workforce fragmentation.

Key Action – 2014/15

Key Action – HOP Workforce	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Undertake specialist HOP workforce stocktake to assist in planning service delivery and models to meet the needs of an ageing population 	<ul style="list-style-type: none"> Develop project scope for workforce review – October 2014 Recruit project members – December 2014 Undertake Central Region stocktake – April 2015 Report findings of stocktake to HOP Network – June 2015 	HOP Network

Linkages to Other Work Programmes

Dementia Pathways	ACP
<ul style="list-style-type: none"> • Linkages to Regional Training Hub • Dementia Behaviour Support Advice role • Mental Health and Addictions Network • ACP • MiAP 	<ul style="list-style-type: none"> • CRISP • Regional ICT • Regional Training Hub • Dementia Pathways
MiAP	HOP Workforce Capacity
<ul style="list-style-type: none"> • Regional Training Hub 	<ul style="list-style-type: none"> • Regional Training Hub

High-level Key Actions – 2015-2017

Dementia Pathways 2015-2017

The work of the Dementia Pathways Group in the next two years will follow on from the work completed in the 2014/15 year. Work will continue to be developed in line with the principles and

objectives enshrined in the New Zealand Framework for Dementia Care 2013, and ensuring a collaborative approach with primary care and social services.

Māori Health

Māori have poorer health outcomes, die younger and have higher rates of chronic disease (such as cardiovascular disease and respiratory diseases) than other New Zealanders. There is a growing body of evidence showing that poorer access to health services for Māori relative to health need is one of the contributing factors to the inequalities in outcomes. Improving access to services will lead to a reduction in the health inequalities between Māori and other New Zealanders. Therefore improving health outcomes for Māori is one of the objectives of the New Zealand Public Health and Disability Act 2000. Improving the health outcomes and life expectancy of Māori and reducing health inequalities must remain a core focus of the work in the Central Region. It is vital that the Central Region DHBs remain steadfast in their commitment to pool their resources and capabilities to reduce health inequalities. The Central Region's overarching strategic *Regional Māori Health Plan, Tū Ora*, has included indicators to enable a measurement of the Central Region's progress in improving Māori health and reducing inequalities.

A strong primary health care system is also essential to improving the health of New

Zealanders, and to removing inequalities in health. The vision for an integrated primary, secondary and tertiary health care system will help to ensure that Māori (as a population group) participate in easily accessible local primary health care services that improve their health, keep them well and co-ordinate their on-going care. This integration is consistent with the Whānau Ora programme, which is a cross-government work programme that aims to integrate the provision of health, education and social services. It is an approach that places family/whānau at the centre of service delivery, requires the health sector to work in a more seamless way with other parts of the social sector, and expects improved outcomes and results for New Zealand families. A Central Region Whānau Ora Framework is essential to maximise opportunities to align and progress initiatives across all Central Region DHBs.

The Māori health programme is sponsored by Julie Patterson (CEO, Whanganui DHB) and led by Riki Nia Nia (Director of Māori Health). The Steering Group comprises all of the general managers Māori, directors of Māori health and advisors for Central Region DHBs (CRMM).

To Achieve the Following Outcomes

Regional Objectives

- The Central Region DHBs will continue to work with iwi to improve Māori health by reducing health disparities among Māori. We will:
 - continue processes that enable Māori to participate in and contribute to strategies for Māori health improvement,
 - continue to 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 and
 - reduce health inequalities, which will remain a core focus of our regional work, ensuring that our DHBs pool their 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.

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.
- Hold and evaluate a Tū Kaha biennial Central Region Māori conference – measured through evaluation and feedback following the conference.
- Accelerate performance regionally against the annual *Regional Māori Health Plan* indicators – measured through quarterly reporting.

Sponsor: Julie Patterson

Executive Lead: Riki Nia Nia

Key Actions – 2014/15

Key Actions – Māori Health	Milestone/Measurement	Lead
<ul style="list-style-type: none"> • Implement the <i>Central Region Whānau Ora Framework and Action Plan</i> 	<ul style="list-style-type: none"> • Successful implementation of Whānau Ora Framework by 30 June 2015 	<ul style="list-style-type: none"> • DHBs
<ul style="list-style-type: none"> • Implement the <i>Central Region Māori Health Workforce Development Plan</i> 	<ul style="list-style-type: none"> • Successful implementation of Whānau Ora Framework by 30 June 2015 	<ul style="list-style-type: none"> • DHBs
<ul style="list-style-type: none"> • Provide quarterly consolidated reporting of the National Māori Health Indicators 	<ul style="list-style-type: none"> • Develop and successfully implement best practice for quarterly reporting of Regional Māori Indicators – report by 30 June 2015 	<ul style="list-style-type: none"> • TAS
<ul style="list-style-type: none"> • Tū Kaha, the biennial Central Region Māori Health Development Conference, to be held 	<ul style="list-style-type: none"> • Deliver and evaluate Tū Kaha, the biennial Central Region Māori Health Development Conference, by 30 June 2015 	<ul style="list-style-type: none"> • Hawke's Bay GM Māori is the lead, supported by C&CDHB
<ul style="list-style-type: none"> • Identify best practice principles for iwi governance of Māori health 	<ul style="list-style-type: none"> • Document best practice principles by 30 June 2015 	<ul style="list-style-type: none"> • Child Health, Māori Health and DHBs
<ul style="list-style-type: none"> • Work together to improve child health for Māori in the areas of immunisation, breastfeeding, ambulatory sensitive hospitalisation rates, sudden unexpected death of an Infant and oral health 	<ul style="list-style-type: none"> • Achieve compliance performance indicators by 30 June 2015 	<ul style="list-style-type: none"> • DHBs
<ul style="list-style-type: none"> • Evaluate the Central Region Māori Cultural Training Programme 	<ul style="list-style-type: none"> • Produce an evaluation report on the Central Region Māori Cultural Training Programme by 30 June 2015 	<ul style="list-style-type: none"> • C&CDHB

Linkages to Other Work Programmes

Workforce	
<ul style="list-style-type: none"> • Work in partnership with Regional Training Hub • Strengthen the new-to-entry-practice-nursing (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	
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Create intelligence about accelerating annual <i>Regional Māori Health Plan</i> indicator performance in Central Region A central repository information system is maintained, ensuring that all documents remain up to date
Child Health	
<ul style="list-style-type: none"> Connection to child health priorities of <ul style="list-style-type: none"> - immunisation, - breastfeeding, - ambulatory sensitive hospitalisation rates and - oral health Identifying regional child health priorities 	<ul style="list-style-type: none"> Monitoring performance in these areas and sharing best practice <p>Project resources to be utilised to facilitate collaboration between respective parties to improve outcomes in priority areas</p>
Capital and Operational Budget	
<ul style="list-style-type: none"> No capex requirements 	DHBS to fund group membership through the release 'in kind' to cover operational resource expenses

High-level Key Actions – 2015-2017

CRMM in partnership with WKTU has identified four key Māori health priority areas for the Central DHB region. The following actions are planned for each priority moving forward:

1. Child Health

- Work collaboratively to improve regional performance in annual *Regional Māori Health Plan* indicator areas relating to child health.

2. Māori Health Development

- Implement the Tū Kaha, the biennial Central Region Māori Health Development Conference
- Implement the Central Region Māori Health Development Plan.

- Pilot and evaluate Regional Māori Capability training programme.
- Identify principles of best practice in effective iwi/Māori health governance.

3. 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.

4. Whānau Ora

- Implement regional Whānau Ora Framework.
- Proactive support of Whānau Ora provider collectives.

Managing Long-term Conditions – Regional and National Priorities

Cancer Services

Better, Sooner, More Convenient Health Services for New Zealanders in relation to cancer means that all New Zealanders can easily access the best services, in a timely way, to improve overall cancer outcomes. In New Zealand

- cancer is the country's leading cause of death (29.8%),
- cancer is a major cause of hospitalisation and a significant driver of cancer health care cost,
- the overall 'risk' of developing cancer is decreasing, while the number of people diagnosed with 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 to 2016,
- cancer continues to have inequalities, with a higher Māori incidence (20% higher) and a higher Māori mortality rate (80% higher) than non-Māori, 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 increases in survival between 1994 and 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 rates than residents of less deprived areas and
- 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 2013.

- 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 (FCT) indicators have been reported quarterly since Quarter 3 2012/13. Regional results for Quarter 2 2013/14:
 - 63% of patients referred urgently with high suspicion of cancer received their first cancer treatment (or other management) within 62 days from date of referral.
 - 57% of patients referred urgently with high suspicion of cancer had their first specialist assessment (FSA) within 14 days.
 - 81% of patients referred urgently with a high suspicion of cancer who received their first cancer treatment (or other management) within 31 days of decision to treat.
- Development of regional radiation and medical oncology plans, aligned with the national plans.
- Review of services against the bowel national tumour standard.
- DHB implementation of the Global Rating Scale to improve colonoscopy services.
- Continued implementation of the new Cancer Nurse Co-ordinator roles.
- Continued development of Multi-disciplinary Meetings (MDMs) to increase patient access to MDM opinions.
- Publication of two provisional national tumour team standards, hosted nationally from 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:

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

Regional Milestones and Measures

Milestones

- Priorities in the regional radiation and medical oncology plans identified by July 2014 and implemented by June 2015
- Ministry-funded FCT projects completed
- Service reviews against lung, gynaecological and breast national tumour standards completed by June 2015
- Priorities identified from service review against the bowel national tumour standard completed by June 2015
- High suspicion of cancer e-referral processes in place by June 2015
- Identified DHBs implement ProVation by June 2015 (regional business case currently in process)
- Service assessment against the national specialist palliative care service specifications completed by December 2014

Measures

- Current Health Target – All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy, reported monthly (this will revert to a Policy Priority (PP30) on 1 October 2014)
- FCT Indicators reported against quarterly.
 - New cancer Health Target from the 1 October 2014 with quarterly public reporting from 1 January 2015: Faster tests and Cancer Treatment: 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.
 - % 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% of 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 patients accessing MDMs (by DHB and ethnicity) will be reported quarterly
- Progress updates in the RSP quarterly reporting

This programme of work will be led within the region by a lead CEO and facilitated and co-ordinated by CCN.

To note, CCN also covers Taranaki DHB for the purposes of cancer services.

1. Shorter Waiting Times for Cancer Treatment

National and regional radiation and medical oncology plans were developed in late 2013/14 and identified priorities require implementation to

ensure that non-surgical cancer treatment services in the region develop in line with national direction and the region continues to meet the current

Key Actions – 2014/15

Health Target: all patients ready for treatment wait less than four weeks for radiotherapy or chemotherapy.

Key Actions – Cancer	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Report against the shorter waits for cancer treatment target on a monthly basis 	<ul style="list-style-type: none"> All patients ready for treatment wait less than four weeks for radiotherapy or chemotherapy, reported monthly 	<ul style="list-style-type: none"> DHBs
<ul style="list-style-type: none"> Implement priority areas for the year identified in the regional radiation oncology capital and service plan 	<ul style="list-style-type: none"> Implementation priorities identified by July 2014 Priorities completed by June 2015 	<ul style="list-style-type: none"> C&CDHB/MDHB
<ul style="list-style-type: none"> Continue implementation of the priority areas for each year identified in the <i>Medical Oncology Models of Care National Implementation Plan 2012/13</i>, including: <ul style="list-style-type: none"> continue to implement e-prescribing into both cancer centres and implement Senior Medical Officer (SMO) workforce priorities as identified by the national plan Implement national priorities from the Nursing Knowledge and Skills Framework 	<ul style="list-style-type: none"> Implementation priorities identified by July 2014 Priorities completed by June 2015 	<ul style="list-style-type: none"> C&CDHB/MDHB

2. Implement the Faster Cancer Treatment Work Programme

Focus areas for the FCT work programme for 2014/15 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 impacts of the Cancer Nurse Co-ordinator roles and developing primary care initiatives to support the identification of high suspicion of cancer.

MoH ran a Request for Proposal (RFP) funding round for DHBs in February/March 2014 to identify projects for funding relating to DHBs achieving the 62-day waiting time indicator and implementing the national tumour standards. \$5.2 million nationally is available for this first round of funding for 2013/14 and 2014/15. Decisions on successful projects and contracts are expected to be made in Quarter 4 2013/14.

Key Actions – 2014/15

Key Actions – Cancer	Milestone/Measurement	Lead
Ministry FCT RFP projects <ul style="list-style-type: none"> CCN and DHBs implement funded projects that aim to support DHBs to meet the 62-day Health Target and implement the tumour standards 	<ul style="list-style-type: none"> Milestones in identified projects met 	DHBs/CCN
FCT indicators <ul style="list-style-type: none"> DHBs to complete implementation of MoH-funded projects to improve FCT data collection and reporting, including: 	<ul style="list-style-type: none"> Identified initiatives completed by Oct 2014 FCT Indicators reported against quarterly: 	DHBs

Key Actions – Cancer	Milestone/Measurement	Lead
<ul style="list-style-type: none"> - DHB FCT IT projects implemented, including transitioning to new solutions as enabled by CRISP • FCT trackers identify and implement processes to move DHBs towards BAU 	<ul style="list-style-type: none"> - New cancer Health Target from the 1 October 2014 with quarterly public reporting from 1 January 2015: Faster tests and Cancer Treatment: 85 per cent 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. - % 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) 	
MDM development <ul style="list-style-type: none"> • Complete phased implementation of the regional <i>MDM Implementation Plan</i> within allocated funds for each DHB. Priority activities: <ul style="list-style-type: none"> - Review current MDMs to ensure they meet National MDM Standards - Review current MDM access criteria against nationally developed criteria and adjust as required 	<ul style="list-style-type: none"> • PP24 reported quarterly – improvements to the coverage and functionality of MDMs, including expenditure against identified funding • Number of patients accessing MDMs (by DHB and ethnicity) will be reported by CCN quarterly • Reviews completed by December 2014 	MDM chairs
Tumour standards <ul style="list-style-type: none"> • Undertake the following actions to support the implementation of the tumour standards: <ul style="list-style-type: none"> - Undertake and analyse reviews of the lung, gynaecological and breast tumour standards to inform regional service improvement initiatives - Implement the regional service improvement initiatives that were identified by the review of the bowel tumour standards in 2013/14 • CCN to provide clinical teams with regularly updated environmental scans against the standards across all tumour streams • Develop a co-ordinated approach to cancer pathway development via Map of Medicine/Health Pathways projects 	<ul style="list-style-type: none"> • Tumour standard reviews completed by June 2015 • Implementation priorities identified by August 2014 with priorities completed by June 2015 • Environmental scans updated quarterly • Approach developed by August 2014 	DHBs/CCN
Care co-ordination <ul style="list-style-type: none"> • Implement Cancer Nurse Co-ordinators' professional development plans, including attendance at national and regional training and mentoring forums • Progress the ORION solution for patient tracking and MDM management subject to successful Proof of Concept exercise in 2013/14 	<ul style="list-style-type: none"> • National forum attended by June 2015 • Next steps identified and implemented 	DHBs CCN
Primary care <ul style="list-style-type: none"> • Implement nationally developed e-referral criteria for referrals of patients with high suspicion of cancer from primary care as enabled by CRISP 3.0 	<ul style="list-style-type: none"> • E-referral processes in place by June 2015 	CCN/CRISP

3. Prostate Cancer

The Prostate Cancer Awareness and Quality Improvement Programme includes a set of actions to provide a system-wide improvement in prostate cancer detection and treatment, including consumer resources, tools for primary care,

education for GPs and pathologists, guidelines and standards, monitoring, research and evaluation. The programme has a budget of \$4.3 million over four years, commencing in 2013/14.

Key Action – 2014/15

Key Action – Cancer	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Priorities identified in the national <i>Prostate Cancer Awareness and Quality Improvement Plan</i> implemented 	<ul style="list-style-type: none"> Identified initiatives completed by June 2015 	DHBs/CCN

4. Improved Waiting Times for Diagnostic Services (Colonoscopy)

The National Endoscopy Quality Improvement Programme includes a set of actions to improve access to, and the efficiency of, colonoscopy

services, including rolling out the New Zealand Global Rating Scale product, endoscopy workforce development and national governance structures

Key Actions – 2014/15

Key Actions – Cancer	Milestone/Measurement	Lead
<ul style="list-style-type: none"> DHBs to take a co-ordinated 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"> Improved waiting times for colonoscopy (PP29): <ul style="list-style-type: none"> Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within two weeks (14 days) – target 75% Percentage of people accepted for a diagnostic colonoscopy who receive their procedure within six weeks (42 days) – target 60% Percentage of people waiting for a surveillance colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date – target 60% 	DHBs
<ul style="list-style-type: none"> Identified DHBs implement the regional ProVation solution (endoscopy reporting system) – regional business case in progress May 2014 	<ul style="list-style-type: none"> Identified DHBs implement ProVation by June 2015 	Identified DHBs

5. Palliative Care

Whilst palliative care services are identified in and primarily supported by the cancer programme, it is recognised that palliative care is wider than cancer. CCN, TAS and the Central Region Palliative

Care Network will 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 2015/16 planning.

Key Actions – 2014/15

Key Actions – Cancer	Milestone/Measurement	Lead
<ul style="list-style-type: none"> DHBs to work with specialist palliative care providers (hospices and hospital palliative care teams) to implement the national Specialist Palliative Care Service Specifications 	<ul style="list-style-type: none"> Service assessments completed by October 2014 	DHBs
<ul style="list-style-type: none"> Three-year HWNZ pilot of the Lower North Island Palliative Care Managed Clinical Network across C&CDHB, HVDHB and WaiDHB districts commenced 	<ul style="list-style-type: none"> Identified initiatives for the first year of the pilot completed by June 2015 	C&CDHB, HVDHB, WaiDHB
<ul style="list-style-type: none"> CCN, TAS and the Central Region Palliative Care Network to explore developing a more strategic approach to service planning and delivery across the region to inform 2015/16 planning 	<ul style="list-style-type: none"> Strategic approach developed by November 2014 	CCN
<ul style="list-style-type: none"> 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 November 2014 	<ul style="list-style-type: none"> Implementation plans developed by June 2015 	DHBs

6. Clinical Leadership

Clinical leadership is viewed as a key enabler in ensuring the success of the cancer programme. CCN directly contracts regional nursing and social

work director roles. Medical leadership is currently demonstrated across the many project groups and at the governance level.

Key Action – 2014/15

Key Action – Cancer	Milestone/Measurement	Lead
<ul style="list-style-type: none"> CCN continues to engage with and support clinical leaders across cancer programme areas to lead and contribute to pre identified projects. Clinical leaders include: <ul style="list-style-type: none"> regional cancer nurse directors, the Regional Oncology Social Work Director and medical leads who engage with project groups and governance 	<ul style="list-style-type: none"> Director work plans developed by August 2014 and completed by June 2015 Medical leadership evident in all work programmes 	CCN

7. Māori Leadership

Cancer continues to have inequalities, with a higher Māori incidence (20% greater) and higher Māori mortality rate (80% higher) than non-Māori. Māori are also 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 that we meet the goals of the *Cancer Control Strategy*. Regional and national leadership is viewed as a key enable.

Key Actions – 2014/15

Key Actions – Cancer	Milestone/Measurement	Lead
<ul style="list-style-type: none"> CCN will support, facilitate and co-ordinate Māori cancer leadership in the Central Region in partnership with national, regional and local partners including: <ul style="list-style-type: none"> working in partnership with Hei Ahuru Mowai 	<ul style="list-style-type: none"> Quarterly reporting of regional and national engagement 	CCN

Key Actions – Cancer	Milestone/Measurement	Lead
<p>(HAM) Māori Cancer Leadership Aotearoa; to develop and deliver the national work programme</p> <ul style="list-style-type: none"> - Engagement with Tumu Whakarae – DHB General Manager Maori leadership 		
<ul style="list-style-type: none"> • CCN will lead a regional programme to analyse and address DHB system barriers in cancer care for Maori including: • Develop an audit tool to identify areas for system improvement • CCN will continue to monitor improvements relating to ethnicity data and reporting, including ensuring a focus on the 62 day target • Engaging with service providers and researchers to implement research findings related to Maori and cancer • Explore in partnership with the Cancer Society and DHBs to deliver Kia Ora E Te Iwi Cancer Support Programme 	<ul style="list-style-type: none"> • Process evaluation of audit tool completed • Progress report • Report on integration of research into practice • Project reporting 	CCN
<ul style="list-style-type: none"> • DHBs achieve, exceed or at the minimum sustain national targets for breast and cervical screening rates for Māori 	<ul style="list-style-type: none"> • 70% coverage rate target for Breast Screening • 80% coverage rate for Cervical Screening 	DHBs/BreastScreen Coast to Coast/BreastScreen Central/DHB Māori managers

8. System Integration and Service Collaboration

CCN facilitates meetings and education opportunities for a range of regional service and professional groups. Cancer consumer representatives are important partners in the

delivery of the cancer programme and CCN facilitates the recruitment, training and deployment of cancer consumer representatives across the region.

Key Action – 2014/15

Key Action – Cancer	Milestone/Measurement	Lead
<ul style="list-style-type: none"> • CCN supports the network's collaborative groups to progress their individual work plans. Network groups include: <ul style="list-style-type: none"> - Central Region Palliative Care Network, - Regional Oncology Social Workers Group, - Cancer Consumers Representatives Forum and - Cancer Nurses Forum 	<ul style="list-style-type: none"> • Work plans developed by August 2014 • Priorities completed by June 2015 	<ul style="list-style-type: none"> • CCN

Linkages to Other Work Programmes

Linkages
<ul style="list-style-type: none"> • CRISP
<ul style="list-style-type: none"> • Local cancer network plans
<ul style="list-style-type: none"> • <i>Maori Health Plans</i> including <i>Tumu Whakarae Regional Māori Health Monitoring Plan</i>
<ul style="list-style-type: none"> • Diagnostic and elective surgery services
<ul style="list-style-type: none"> • Sub-regional plan i.e. 3DHB and centralAlliance

High-Level Key Actions – 2015-2017

- Continue implementing the regional radiation and medical oncology plans.
- FCT programme.
- Further service reviews completed against national tumour standards and resultant service improvement plans implemented.
- Cancer Nurse Co-ordinator national evaluation completed.
- Develop RFPs for the second round of MoH funding for 2015/16 and 2016/17 (\$6 million) and implement successful projects.
- Continue implementing the national Prostate Cancer Awareness and Quality Improvement Programme.
- Implement a more strategic approach to palliative care and end-of-life planning.
- Continue to address inequalities, especially those experienced by Māori.

Cardiac

Cardiovascular diseases are a leading cause of death in New Zealand and are responsible for 27.4% 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, where ischaemic heart disease is a major cause of all deaths and the rate of hospital admissions for heart failure is nearly four times that of non-Māori. Males have a consistently higher age-standardised mortality rate from ischaemic heart disease than females, with the 2010 male age-standardised rate being 85.3% higher than the female rate⁶.

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. It is estimated that 80% of the population have three or more of the risk factors, such as smoking, physical inactivity, poor diet and being overweight. 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 in most need is reducing.

The Central Region Cardiac Network (CRCN) is a programme of work led by CEO sponsor Murray Georgel (CEO, MidCentral DHB) and Clinical

Director Andrew Aitken (Interventional Cardiologist, Capital & Coast DHB). It has a strong history of engaging clinical leaders in service improvement and works closely with the National Cardiac Network. The CRCN comprises the seven clinical leads from the represented DHBs and a primary care representative, the seven being the six Central Region DHBs along with Nelson Marlborough due to patient travel and service flow alignment.

The goal of the 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 and
- influencing policy decisions at a national level for cardiac issues.

The Central Region has performed below Ministerial expectations in all areas of angiography and angioplasty and all cardiovascular standardised population intervention rates. The CRCN 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, and to ensure there is appropriate access to cardiac diagnostic and specialist assessments, 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 and
- a flow-on effect to lower mortality rates as a result of heart disease.

The service model that CRCN supports in the Central Region involves integration and

⁶ Ministry of Health, *Mortality and Demographic Data* (2010) www.health.govt.nz/publication/mortality-and-demographic-data-2010

collaboration between primary, secondary and tertiary service providers and the merging of tertiary cardiology and cardiac surgery into 'heart teams'. This facilitates better flow through the system for cardiac patients. Also important is the

development of hybrid operating theatres/angiography suites. These facilitate combined percutaneous and surgical procedures and innovation.

To Achieve the Following Outcomes

Regional Objectives

- The focus for 2014/15 will be on continuing to improve access to cardiac services, including
 - improved and timelier access to cardiac services,
 - patients with a similar level of need receive comparable access to services, regardless of where they live,
 - more patients survive acute coronary events, and the likelihood of subsequent events is reduced and
 - patients with suspected ACS receive seamless, co-ordinated care across the clinical pathway.
- This will ensure that:
 - more patients survive acute coronary events, cardiac damage from these events is minimised, and the likelihood of subsequent cardiac events is reduced and
 - patients with suspected ACS receive seamless, co-ordinated care across the clinical pathway

Regional Milestones and Measures

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

- Standardised intervention rates:
 - Cardiac surgery: 6.5 per 10,000 of population (C&CDHB 6.2 per 10,000)
 - 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
 - No patients wait longer than five months for cardiac surgery during 2014, and waiting times are reduced to a maximum of four months by the end of December 2014
 - Each region will have established measures of ACS risk stratification and time to appropriate intervention
- To work towards a nationally consistent reporting framework, all regions are required to report:
 - 70% of high-risk patients will receive an angiogram within three days of admission ('Day of Admission' being 'Day 0') and
 - over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days

Key Actions – 2014/15

Key Actions – Cardiac Services	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Monitor, report and make assessments of the achievement of key performance indicators (KPIs) in managing a regional acute coronary syndrome service for the Central Region 	<ul style="list-style-type: none"> Monitoring of KPIs with recommendations for assistance in the removal of barriers to efficient performance and/or improvement in service initiatives Monthly exception reporting to regional CEOs and Regional Governance Group Full quarterly reporting to regional chief operating officers (COOs) Monitoring of all Central Region DHBs' use of and contribution to ANZACS-QI reporting. Working with DHBs to ensure effective utilisation and removing barriers to data capture as required 	<ul style="list-style-type: none"> CRCN and DHBs
<ul style="list-style-type: none"> Continue to work with DHBs locally, sub-regionally and regionally, the regional cardiac clinical networks and, when appropriate, the New Zealand Cardiac Network to implement actions to improve outcomes for people with suspected cardiac symptoms. This will be achieved through the delivery and implementation of a regional plan for cardiac services, with a focus on ensuring appropriate access to cardiac surgery, percutaneous revascularisation and coronary angiography and sustained performance against cardiac surgery waiting list time expectations. Such plan to answer the question of, 'What are the requirements for a regional cardiology service in the Central Region for the next 10 years?' 	<ul style="list-style-type: none"> Finalise full regional service review being undertaken in the 2013/14 year by 31 July 2014 Develop implementation plan and roadmap by 30 September 2014 Commence implementation of the service plan, to agree and design implementation of regionally agreed protocols, processes and systems to ensure prompt local risk stratification and management of suspected ACS patients, by 30 September 2014 All cardiac surgery patients are prioritised and treated in accordance with assigned priority and urgency timeframes, by 31 December 2014 The MoH-recommended principles for an Accelerated Chest Pain Pathway will be adopted, which will assist in implementing such a pathway in all emergency departments in the Central Region by 31 December 2014 	<ul style="list-style-type: none"> CRCN and DHBs
<ul style="list-style-type: none"> Support the review and on-going development of regionalised training for vulnerable workforce components, initially with physiologist technicians at C&CDHB as the tertiary provider 	<ul style="list-style-type: none"> Seek assurance from 3DHB and centralAlliance that cross-boundary DHB patient servicing within these constructs will be done on the basis of patient need, not location, by 30 September 2014 Assist and promote regional recruitment for the vulnerable workforce components as an on-going position 	<ul style="list-style-type: none"> CRCN and DHBs

Linkages to Other Work Programmes

Sub-regional	
<ul style="list-style-type: none"> 3DHB (Wairarapa, Hutt Valley and Wellington hospitals) centralAlliance (Whanganui and MidCentral DHBs) Hawke's Bay DHB 	<ul style="list-style-type: none"> Incorporate sub-regional requirements as part of the full regional service review that is being undertaken in the 2013/14 year, by 31 July 2014 Incorporate sub-regional development, implementation of the plan and roadmap into a full regional service review by 30 September 2014
Information Technology	
<ul style="list-style-type: none"> Resourcing requirements to implement and integrate ANZACS-QI into the future CRISP environment will require full scoping and assessment 	<ul style="list-style-type: none"> Work with TAS, CRISP, Regional ICT, the General Manager of Infometrics 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
Māori Health	
<p>The Central region approach to improving Maori health and reducing inequalities is contained in its Regional Maori Health Plan, Tu Ora. Tu Ora includes indicators to enable performance measurement.</p> <ul style="list-style-type: none"> Where cardiac data is available by ethnicity, this is included in indicator reports. In both the Maori Indicator report and the Cardiac KPI report, CVD risk assessment is 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 Maori. 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. 	

High-Level Key Actions – 2015-2017

The main activities for this time period will be:

- 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 and
- an involvement in MDMs for case management and learning.

Stroke Services

Better, Sooner, More Convenient Health Services for New Zealanders in relation to stroke services means 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 costs New Zealand over \$450 million every year. If current trends in stroke incidence and morbidity continue, the number of stroke survivors will reach 50,000 by 2015, with overall annual costs of more than \$700 million. 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 established organised stroke services, but dedicated stroke units exist in only four. Within these four DHBs beds are generally not ring-fenced and are frequently insufficient to support the admitted number of stroke patients. Rapid-access TIA pathways exist in all DHBs; however, organisation and diagnostic access could be

improved. Thrombolysis is offered in some fashion at all six DHBs, but in many areas service provision is ad hoc, often provided by non-stroke physicians or with stroke physician telephone back-up only (neither being evidenced-based practices), and without adequate quality assurance in place. In addition, while access may be quite reasonable in Wellington and surrounds, regional centres struggle significantly with after-hours' service provision, and patients residing in rural areas often have no way to reach hospitals providing this service within the required timeframes.

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 is a continuation of the stroke services work programme in the 2013/14 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

- Better, Sooner, More Convenient Health Services for New Zealanders in relation to stroke services means improved and more timely access to 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 a stroke
- Develop regionally agreed work plans for stroke improvements
- Establish regionally agreed protocols, processes and systems to ensure that people with a 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:
- 8% of potentially eligible stroke patients thrombolysed
- Progress towards 80% of stroke patients admitted to a stroke unit. (Note that in small DHBs, stroke patients would be admitted to an organised stroke service, with a demonstrated stroke pathway)
- Proportion of patients with acute stroke who are transferred to in-patient rehabilitation service, and;
- Proportion of people with acute stroke who are transferred to in-patient rehabilitation service within 10 days of acute stroke admission. Target 60%

Sponsor: Murray Georgel

Clinical Lead: Anna Ranta

Key Actions – 2014/15

Key Actions – Stroke	Milestone/Measurement	Lead
Organised acute stroke services		
<ul style="list-style-type: none"> • Stroke data is collected and reported. This data includes: <ul style="list-style-type: none"> - total number of strokes - percentage of stroke patients admitted to an organised stroke unit - percentage of ischaemic stroke patients thrombolysed - stroke patients who are 65-plus years of age and - percentage of Māori and Pacific (broken down into total number of strokes, thrombolysed and seen by a stroke service) 	<ul style="list-style-type: none"> • Reported quarterly 	<ul style="list-style-type: none"> • All DHBs
<ul style="list-style-type: none"> • Trend analysis of 2013/14 acute stroke data 	<ul style="list-style-type: none"> • By 31 December 2014 	<ul style="list-style-type: none"> • Central Region Stroke Steering Group
Stroke Rehabilitation Services		
<ul style="list-style-type: none"> • Regional rehabilitation data collected. This data includes: <ul style="list-style-type: none"> – Proportion of patients with acute stroke who are transferred to in-patient 	<ul style="list-style-type: none"> • Reported quarterly 	<ul style="list-style-type: none"> • All DHBs

Key Actions – Stroke	Milestone/Measurement	Lead
<ul style="list-style-type: none"> rehabilitation service, and; – Proportion of people with acute stroke who are transferred to in-patient rehabilitation service within 10 days of acute stroke admission. Target 60% 		
<ul style="list-style-type: none"> Continue work on regional rehabilitation definitions and measures to access adequacy of stroke rehabilitation across the patient journey 	<ul style="list-style-type: none"> Report progress quarterly 	<ul style="list-style-type: none"> Central Region Stroke Steering Group
Transient Ischaemic Attacks		
<ul style="list-style-type: none"> Develop a regional TIA strategy to improve consistency of TIA services 	<ul style="list-style-type: none"> Progress reported quarterly Regional strategy developed 31 December 2014 	<ul style="list-style-type: none"> Developed by Central Region Stroke Steering Group. Implemented by all DHBs
Thrombolysis		
<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> Reported quarterly 8% of patients presenting with ischaemic strokes thrombolysed across the region by 30 June 2015 	<ul style="list-style-type: none"> Central Region Stroke Steering Group
<ul style="list-style-type: none"> Implement 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"> – MDHB, HBDHB and WhaDHB by TeleStroke (Northern sub-region) – CCDHB, WaiDHB and HVDHB by Telephone or TeleStroke (Southern sub-region) 	<ul style="list-style-type: none"> Progress reported quarterly TeleStroke equipment purchased for Northern sub-region by 31 December 2014 Telephone backup set up in Southern sub-region by 31 December 2014 Sub-Regional Stroke thrombolysis networks implemented by 30 June 2015 	<ul style="list-style-type: none"> Developed by Central Region Stroke Steering Group. Implemented by all DHBs
<ul style="list-style-type: none"> Promote integrated thrombolysis services with emergency and ambulance services 	<ul style="list-style-type: none"> On-going attendance at quarterly Stroke Steering Group meetings Formal update to emergency and ambulance services on Thrombolysis access by 30 June 2015 	<ul style="list-style-type: none"> Central Region Stroke Steering Group
Workforce		
<ul style="list-style-type: none"> Regional stroke service workforce strategy and education plan developed 	<ul style="list-style-type: none"> Investigate regional stroke workforce issues and resourcing and training needs and develop a regional workforce strategy by 31 March 2015 	<ul style="list-style-type: none"> Central Region Stroke Steering Group
<ul style="list-style-type: none"> Continuing Stroke Education 	<ul style="list-style-type: none"> Two Central Region stroke education days held by 30 June 2015. 	<ul style="list-style-type: none"> Central Region Stroke Steering Group
<ul style="list-style-type: none"> On-going Thrombolysis Education plan developed 	<ul style="list-style-type: none"> Plan developed by 30 June 2015 	<ul style="list-style-type: none"> Central Region Stroke Steering Group

Linkages to Other Work Programmes

Information Technology	
<ul style="list-style-type: none"> Regionally accessible PACS 	<ul style="list-style-type: none"> By 31 July 2014

High-Level Key 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 2015. If none is required the Central Region Stroke Steering Group will be disestablished.

Mental Health and Addictions

The Central Region Mental Health and Addiction Network's (MHAN's) vision is to deliver 'Better, Sooner, More Convenient mental health and addiction services'. This RSP is informed by the national document, *Rising to the Challenge 2012-2017: The Mental Health and Addiction Service Development Plan (SDP)* and the Government's Additional Health Target for 2014/15. The SDP clearly articulates prioritised service development plans for the next five years. The SDP ensures that across the spectrum of health promotion, primary treatment, specialist treatment and support services, access and responsiveness will be enhanced and integration will be strengthened while improving value for money and delivering improved outcomes for people using services. The SDP focus is on intervening at critical points in the lives of people with MH&A issues. This has heavily influenced the identification of priority groups, as follows, which is a continuation of the 2012/13 and 2013/14 RSP programmes of work.

- People with low-prevalence conditions and/or high needs.
- Infants, children and youth with high-prevalence conditions.
- Adults with high-prevalence conditions.
- Older people with high-prevalence conditions.

There has been a significant transformation in MH&A services in the past two decades. However, the challenge is to ensure that health services work alongside families/whānau and communities. This is to ensure that young people have a healthy beginning and can subsequently flourish, and that people with MH&A issues can recover rapidly. If local delivery is not sustainable, service delivery will involve regional service arrangements. This means that the majority of services will be delivered locally within single DHB areas or in some cases sub-regionally. There are, however, some services that are better suited to regional or national delivery.

The emerging model of care for the Central Region, therefore, is a sustainable, integrated continuum of care based on local delivery wherever possible. A co-design approach to working with mental health patients continues to be a strong principle behind future multi-disciplinary teams for patient care and service development. With the Government focus on

providing better public services, the challenge for the foreseeable future is to continue to forge stronger links with other public sector services. This work has commenced with MH&A services (forensics) having memoranda of understanding with the Ministry of Justice and Department of Corrections. There are opportunities to develop further relationships in the areas of education, housing, the Ministry of Social Development and employment.

Sitting alongside this is the drive by the Central Region CEOs to integrate further service delivery with appropriate primary care practitioners. In the coming years it is anticipated that an increasing number of MH&A services will be delivered through primary care. This has the ability to increase the level of involvement by service users and family/whānau in service planning and delivery.

MHAN has a responsibility to facilitate primary and hospital service integration through the influence of DHB members inclusively within the network. Individual DHBs will continue to be responsible for leading local initiatives in the development of treatment pathways to ensure a seamless transition for patients across boundaries, e.g. in relation to mild to moderate mental health issues and maternal health screening for early signs of depression.

MHAN is clinically led by Dr Alison Masters (Capital & Coast DHB) and represented in the region by Julie Patterson (CEO, Whanganui DHB). MHAN will also contribute to the review of guidelines for HOP and the CRISP programme, to ensure an integrated approach to actions, and the on-going monitoring of regional services to ensure they offer the best value for money, and continue to support integration with local services.

The programme is divided into the following projects:

- Low prevalence/high needs:
 - Youth forensic
 - Adult forensic
 - Residential addictions
 - Regional rehabilitation
- Maternal and perinatal
- Eating disorders
- Workforce

To Achieve the Following Outcomes

Regional Objectives

The main objectives for 2014/15 are 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,
- maternal and perinatal mental health service options as part of a service continuum, and
- MH&A service capacity for people with low prevalence conditions and/or high needs

Regional Milestones and Measures

The substantive milestones for the 2014/15 year are as follows:

Low prevalence and/or high needs

- Development of a Youth Forensic Pathway across the continuum of care
- Design of an implementation plan to improve integration across the continuum of care for low-prevalence and/or high-needs clients
- Design of implementation plan for the reconfigured Central Region Residential Addiction Service
- Implementation of the community rehabilitation and recovery capacity and capability plans

Maternal and perinatal

- Review of respite options
- Review of perinatal screening
- Report on the continuum of acute services

Eating disorders

- Develop an implementation plan based on the 2013/14 service review

Workforce planning

- Work with Regional Training Hub and Te Pou to develop regional workforce plan

These will be measured as follows:

- Quarterly progress reports on status of all reviews and planning, together with numerical reporting on the following DHB volumes:
 - A reduction in waiting lists and times for people in prisons requiring assessments in forensic services
 - Increased access to community youth forensic services and availability of liaison officers in court
 - Increased access to perinatal and maternal mental health services

1. Low-Prevalence/High-Needs

1.1 Youth Forensic Services

In the SDP 2012-2017 MoH outlines work that it will lead to develop comprehensive, youth-focused forensic mental health services. The RSP focus for 2014/15 will be to utilise data collected in the

2013/14 stocktake to inform the development of a five-year action plan to assist in the delivery of non-stigmatising and developmentally and culturally appropriate services for youth

Key Action – 2014/15

Key Action – Youth Forensics	Milestone/Measurement	Lead
<ul style="list-style-type: none"> • Based on the outcome of the 2013/14 service stocktake, a five-year action plan will be developed, including: 	<ul style="list-style-type: none"> • Interim Progress report by 28 February 2015 • Develop draft action plan by June 	Lead C&CDHB Youth Forensic

Key Action – Youth Forensics	Milestone/Measurement	Lead
<ul style="list-style-type: none"> - links to SDP youth-focused forensic mental health services - youth forensic MH&A services with in-reach into Child, Youth and Family youth justice residences and youth units within prisons, and transitional support back to local child and adolescent mental health services and/or primary care 	2015 <ul style="list-style-type: none"> • Develop evaluation plan on implementation by June 2015 	Working Group to co-ordinate

1.2 Adult Forensic Services

This RSP continues work commenced in the 2013/14 year to improve the service user journey across the continuum of care. The plan will also contribute to the objectives outlined in the SDP

2012-2017 to develop an approach to identify and meet the needs associated with mental health issues for people within prisons.

Key Action – 2014/15

Key Action – Adult Forensics	Milestone/Measurement	Lead
<ul style="list-style-type: none"> • Based on the outcome of the 2013/14 review of the <i>Central Region Forensic Plan 2007</i>, an action plan will be developed to improve integration across the continuum of care for low-prevalence and/or high-needs clients: <ul style="list-style-type: none"> - Improve the pathways of care so that they are clearly identified across the continuum of care - Increase the number of service users from the forensic services accessing general MH&A services to ensure they are responsive and timely 	<ul style="list-style-type: none"> • Interim Progress report by 28 February 2015 • Develop draft action plan by June 2015 • Develop evaluation plan on implementation by June 2015 	Lead: C&CDHB Adult Forensics Working Group to co-ordinate

1.3 Residential Addictions Services

A low utilisation of the Central Region residential addiction beds was identified, and in 2013/14 a comprehensive review of services was completed, resulting in recommendations to MHAN. The

following plan is based on an engagement and decision-making process that will lead to the development of an implementation plan for agreed service changes.

Key Action– 2014/15

Key Action – Residential Addiction	Milestone/Measurement	Lead
<ul style="list-style-type: none"> • Services – engagement and decision-making phase: <ul style="list-style-type: none"> - Finalisation and sign-off of recommendations from the 2013/2014 review of residential addiction services - Design an implementation plan based on the agreed recommendations of the 2013/14 Central Region residential addiction services review - Design evaluation criteria for the reconfigured services 	<ul style="list-style-type: none"> • Draft implementation plan designed by 31 October 2014 • Draft evaluation plan designed by 31 December 2014 • 2014 final report to MHAN by July 2014 • Project phase completed and closed – June 2015 	Lead: C&CDHB Working Group to co-ordinate

1.4 Regional Rehabilitation

This RSP continues a project that commenced in 2011/12. The focus is on improving the transition of service users from regional rehabilitation units

to their DHBs of origin, ensuring that local DHBs and NGO services have both the capacity and capabilities to sustain the reintegration.

Key Actions 2014/15

Key Actions – Regional Rehabilitation	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Implement the reintegration of Regional Rehabilitation and Extended Care (RREC) service users to their DHBs of origin/ including recovery, capacity and capability building and reviewing recommendations Enhance the care pathways between RREC services in partnership with the local DHBs and NGO community MH&A services Enhance the capacity and capabilities of local DHBs and NGO services to meet the needs of service users returning from RREC services to their places of origin/choice e.g. through systems and processes and workforce development 	<ul style="list-style-type: none"> Implementation plan designed, including quarterly reporting by 31 December 2014, Project complete and closed – June 2015 	Lead: HVDHB All regional DHBs

2. Maternal and Perinatal

This project is to improve the provision of acute mental health services to women in the perinatal period within the Central Region. In October 2013 MoH raised an RFP for the Midland and Central Region regarding service delivery options for

women experiencing acute mental health issues in the perinatal period. The outcome of this RFP is awaited and will contribute to actions within the RSP for 2014/15.

Key Actions – 2014/15

Key Actions– Maternal and Perinatal	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Complete implementation of the 2013/14 recommendations to improve the provision of maternal and perinatal service models across the region Establish a perinatal mental health network for the Central Region Develop and implement workforce training packages for respective DHB requirements Develop 'packages of care' options across the Central Region and support implementation and monitoring 	<ul style="list-style-type: none"> Regional perinatal clinical network established by August 2014 Training packages developed and implementation underway by January 2015 Packages of care developed by DHB by June 2015 	Lead: C&CDHB All regional DHBs

3. Eating Disorder Services

This is a continuation of work commenced in the 2013/14 year, when services were reviewed against the 2009 *Central Region Strategic Plan for*

the Development of Eating Disorders. Access to a range of eating disorder services has been identified as a priority area by MoH.

Key Actions – 2014/15

Key Actions – Eating Disorders	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Finalisation and sign-off of recommendations from the 2013/14 review of Central Region Eating Disorder Services (CREDS) Design an implementation plan based on the agreed recommendations of the 2013/14 CREDS review 	<ul style="list-style-type: none"> Interim progress report to MHAN – 24 November 2014 Draft implementation plan developed by 31 December 2014 Final report to MHAN – 25 May 2015 	Lead: HVDHB All regional DHBs
<ul style="list-style-type: none"> Continued regional provision of eating disorder inpatient services to ensure sustainable inpatient and community services: <ul style="list-style-type: none"> Enhance the agreed 'hub and spoke' model of care, including pathways between CREDS and local DHBs, NGOs, primary care services and families/whānau Implement service recommendations within the existing funding 	<ul style="list-style-type: none"> Interim progress report to MHAN by 24 November 2014 Final report to MHAN by 25 May 2015 	Lead: HVDHB All regional DHBs

4. Workforce

In 2013 TAS and Te Pou formed a partnership to complete workforce actions in the Central region.

Key Actions – 2014/15

Key Actions – Workforce Planning	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Work with training hub and Te Pou to develop a regional approach to planning 	<ul style="list-style-type: none"> Quarterly monitoring until June 2015 	Lead: TAS/Regional Training Hub
<ul style="list-style-type: none"> National Workforce Stocktake Mental Health and Addictions 'More than Numbers' 	<ul style="list-style-type: none"> Stocktake report available to sector by December 2014 	Te Pou/all regional DHBs
<ul style="list-style-type: none"> National Employer Survey 	<ul style="list-style-type: none"> Report to MHAN by 28 February 2015 	Te Pou/all regional DHBs
<ul style="list-style-type: none"> National Workforce Employee Census 	<ul style="list-style-type: none"> Progress reported quarterly Draft report completed by Te Pou by 30 June 2015 	Te Pou/all regional DHBs
<ul style="list-style-type: none"> Analyse data to assist with Mental Health and Addictions team planning, including: <ul style="list-style-type: none"> unregulated workforce numbers, scoping of training available and identify access to training issues 	<ul style="list-style-type: none"> Progress reported quarterly Final report completed by 30 June 2015 	Te Pou/all regional DHBs

Linkages to Other Work Programmes

Maori Mental Health

“As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand” (Ministry of Health. 2013. <http://www.health.govt.nz/our-work/populations/maori-health>. Wellington: Ministry of Health)

In alignment to the Central regional approach to improving service capability for Maori Health, MHAN will:

1. Continue processes that enable Māori to participate in and contribute to strategies for Māori health improvement
2. Continue to foster the development of Māori capacity for participating in the health and disability sector
3. Continue to provide for the needs of Māori providing relevant information to Māori for the purposes above.

A specific area of focus for 2014/15 will be the development a monitoring framework which includes NHI level data analysis. This will assist to identify and agree service gaps for Māori and other ethnic groups. The Regional Portfolio Manager will assist to facilitate agreement via MHAN on opportunities to target actions within each service priority to improve Maori Health outcomes.

Data analysis to NHI level across all 6 Central Region DHBs for each workstream will begin 2014/15 to gauge levels of service utilisation and level of access for respective services by DHB for Maori populations. This will include utilisation of the PRIMHD data to be collated on a regional basis with regular reporting back to DHBs to assist monitoring of service utilisation, and to enable effective capability to measure Maori Health efficacy of services, which include the following 14/15 service priorities:

- 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

maternal and perinatal mental health service options as part of a service continuum, and MH&A service capacity for people with low prevalence conditions and/or high needs

The development of IT enablers is a dependency for the MH&A programme of work. These linkages are summarised as follows:

Low Prevalence/High Needs

IT

- MHAN will continue to work with HOP and the CRISP programme to ensure an integrated approach to actions on IT integration

CRISP

- Ensure MHAN involvement in all regional working groups involved in the development of regional applications
- Implementation of version 1.5 in MidCentral DHB
- Gathering further requirements for V2-required functionality for HBDHB and WhDHB (then C&CDHB, WaiDHB and HBDHB)
- Developed and implemented WebPas for MDHB, WhDHB and HBDHB

CAPEX

- Local DHB requirements for integration with CRISP clinical portal (outside the expenditure noted for CRISP)

High-Level Key Actions – 2015-2017

For the 2015-2017 years key 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) and
- Central Region priorities delivered regionally, sub-regionally or 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 and
- be delivered in local hospitals, communities and people's homes.

Specialist/Acute Services including Diagnostics – Regional and National Priorities

Electives

The Central Region DHBs continue to focus on improving the delivery of elective surgical services, as set out in the previous two RSPs⁷.

Elective surgery has the ability to make an immediate impact on quality of life, reducing pain and discomfort and improving independence and wellbeing, yet some patients still experience long waits before receiving treatment. The six DHBs in the Central Region continue to work together to ensure they meet the elective targets in the future through collaborative regional actions.

The operational challenges of delivering elective services are not insignificant. DHBs are experiencing increased demand for elective services due to the ageing population and the increasing availability of specialised services. While there is an overall reduction in the demand for acute surgical services, some specialties are experiencing an increase in acute demand, resulting in the cancellation of elective procedures. The milestone identified by the Minister of Health to further reduce waiting times for access to elective FSAs and specialist treatment is a maximum of four months by December 2014. To achieve this milestone and meet these conflicting demands, DHBs must find the most efficient ways to deliver effective services.

We anticipate high-level benefits in line with the Triple Aim benefits defined in section 2 of this document.

Other benefits of a regional approach to elective services' delivery are becoming apparent as the outcomes from the clinical pathways developed through service improvement programmes are shared with DHBs. Improved equity of access, reduced waiting times and greater clarity will enhance the patient experience. Improved financial and service sustainability will be achieved through increased productivity. A regional approach will address some of the key issues

facing the Central Region. The regional planning and delivery of services for a population of fewer than one million allow the provision of nearly all modern-day health services, with the necessary critical mass for the effective operation of those services. There are a small number of exceptions where a national approach is preferable, and in most instances such an approach is already in place, albeit in need of strengthening in some particular instances. A regional approach can provide necessary efficiencies in terms of high-cost facilities, technologies and the use of professional staff – both clinical and support – to address service sustainability for a range of services in parts of the Central Region, and in addressing persistent inequities in access to quality services for some of our disadvantaged communities.

The CEO sponsor for regional electives is Dr Kevin Snee (CEO, Hawke's Bay DHB), with Chris Lowry (COO, Capital & Coast CDHB) as the lead executive.

⁷ Central Region DHBs' RSPs 2012/13 and 2013/14

To Achieve the Following Outcomes

Regional Objectives
<ul style="list-style-type: none"> Improve access to elective services Reduce waiting times for elective FSAs and treatment Improve equity of access to services, so patients receive similar access regardless of where they live
Regional Milestones and Measures
<p>Milestones</p> <p>The following actions will improve access to elective services, reduce waiting times and improve equity of access:</p> <ul style="list-style-type: none"> Developing a regional delivery plan that supports the achievement of: local intervention rates, maximised regional capacity, optimal use of specialist resources and sub-specialist capabilities, increased access to less complex surgery, local Health Target delivery, consistent pathways, access criteria, and clinical protocols for individual services Developing consistent pathways, access criteria and clinical protocols for orthopaedics, ENT and another service to be identified Establishing and delivering sub-regional agreements to facilitate cross-boundary patient care where appropriate Implementing sub-regional referral management and scheduling systems where appropriate Deliver actions agreed in regional Elective Services Productivity and Workforce Programme (ESPWP) contract Identify regional and sub-regional opportunities to increase the number of surgical procedures performed by developing different service delivery models Identify excellent performers in management and clinical service delivery and utilise these people as change facilitators within DHBs <p>Measures</p> <p>For the 2014/15 year it is expected that:</p> <ul style="list-style-type: none"> the Central Region's electives Health Target will be met no patients will wait more than four months for FSAs or elective treatment by the end of December 2014 a maximum waiting time of four months will be maintained from January 2015 onwards (Elective Services Performance Indicator [ESPI] 2 and ESPI 5)

Sponsor: Dr Kevin Snee (CEO, HBDHB)

Executive Lead: Chris Lowry (COO, C&CDHB)

Key Actions – 2014/15

To achieve the objectives of the regional electives project, the following actions will be undertaken:

Key Actions – Electives	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Health Target discharges and waiting times indicator targets (Stage 4⁸) for four-month waiting times' milestone are achieved. The actions to achieve this target are listed below 	<ul style="list-style-type: none"> 31 December 2014 ESPI 2 Elective Services Performance Indicator compliance – no-one waiting more than four months for FSA ESPI 5 compliance – no-one waiting more than four months for elective surgery treatment 	Central Region DHBs
<ul style="list-style-type: none"> Continue work on the waiting list and capacity management⁹ actions as follows: <ul style="list-style-type: none"> Reporting on weekly regional waiting lists available to COOs 	<ul style="list-style-type: none"> On-going 	Central Region DHBs

⁸ Continuation of previous stages in RSP 2013/14

⁹ Actions to deliver from RSP 2013/14

Key Actions – Electives	Milestone/Measurement	Lead
<ul style="list-style-type: none"> - Enhance existing escalation system for outlier waiting lists in each DHB - Agreed actions are implemented to address early identification of problems and variations in performance - Effective capacity management systems are identified and their implementation is encouraged in all DHBs 		
<ul style="list-style-type: none"> • The Central Region will have a consolidated regional annual production plan 	<ul style="list-style-type: none"> • Approved by 31 May each year 	C&CDHB
<ul style="list-style-type: none"> • All DHBs have systems, including theatre systems, in place to manage the acute impacts on elective activity 	<ul style="list-style-type: none"> • 10% reduction in acute displacement of elective surgery by 31 June 2015 	Central Region DHBs
<ul style="list-style-type: none"> • The region agrees on a managed approach to the engagement of the private sector in delivering publicly funded elective services 	<ul style="list-style-type: none"> • An agreement or alliance with the main private providers in the region by 30 June 2015 • Less than 1% variation in delivering the consolidated production plan targets • Financial performance of elective services in each DHB is achieved within allocated funds 	Central Region DHBs
<ul style="list-style-type: none"> • Standardised processes are implemented for equitable management of the surgical services waiting list for the Central Region 	<ul style="list-style-type: none"> • Consistent application of access prioritisation criteria across all services • Annual increases in elective surgery discharge volumes are achieved across the region 	Central Region DHBs
<ul style="list-style-type: none"> • A regional pathway is developed for elective Orthopaedic services; this will reflect working sub-regional plans 	<ul style="list-style-type: none"> • Pathways are defined and agreed by 30 September 2014 • Agreed pathway in place by 30 31 March 2015 • Pathway implementation is reviewed by 30 June 2015 	Central Region Electives Project Board
<ul style="list-style-type: none"> • A regional pathway is developed for a second elective service (possibly ENT) reflecting working sub-regional plans 	<ul style="list-style-type: none"> • Pathways are defined and agreed by 30 September 2014 • Agreed pathway in place by 30 31 March 2015 • Pathway implementation is reviewed by 30 June 2015 	Central Region Electives Project Board
<ul style="list-style-type: none"> • A regional pathway is developed for one other surgical specialty, reflecting working sub-regional plans 	<ul style="list-style-type: none"> • Pathways are defined and agreed by 30 September 2014 • Agreed pathway in place by 30 31 March 2015 • Pathway implementation is reviewed by 30 June 2015 	Central Region Electives Project Board

Key Actions – Electives	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Productivity opportunities of tele-health application are identified and budgeted in one DHB 	<ul style="list-style-type: none"> One DHB has a pilot for elective services in place by 31 December 2014 Number of full-time-equivalent (FTE) specialist medical officer hours using tele-health application 	Participating DHBs
<ul style="list-style-type: none"> Specialists share best practice and agree means to deliver elective services through regular collaborative regional or sub-regional forums 	<ul style="list-style-type: none"> ESPWP annual regional forums 	Central Region clinical leads
<ul style="list-style-type: none"> Elective services managers share effective business systems and processes through regular collaborative regional forums 	<ul style="list-style-type: none"> Attendance at monthly forums 	Central Region electives managers
<ul style="list-style-type: none"> Options to further improve access to elective services are identified by DHBs and other provider partners 	<ul style="list-style-type: none"> Number of proposals approved Attendance at quarterly forums 	Central Region DHBs

Linkages to Other Work Programmes

Information Technology
<ul style="list-style-type: none"> It is suggested that a regional oversight role be established to ensure that any actions required to contribute to or implement the National Patient Flow collection are regionalised where possible National Patient Flow: all DHBs have implemented phase 2 of National Patient Flow Diagnostic waiting times indicator targets
Workforce
<ul style="list-style-type: none"> The ESPWP will identify opportunities to utilise resources differently to maximise productivity. This may involve up-skilling of the therapist, nurse and GP workforce. At this stage in the project there are no formal workforce plans
Māori Health
<ul style="list-style-type: none"> Improved access as a result of improved waiting times
Sub-regional Work
<ul style="list-style-type: none"> 3DHB work programme centralAlliance work programme HBDHB work programme

High-Level Key Actions – 2015-2017

The Central Region ESPWP concludes on 31 December 2015. The focus in the closing months of the programme will be on supporting DHBs in the implementation of changes in clinical pathways to align with the regional pathways, including new models of service delivery where these are agreed. The final report will be developed and will describe in detail the processes

used and the outcomes of the programme. This will assist DHBs to continue to keep a regional focus while developing clinical pathways by utilising resources in the Central Region and working collaboratively at a regional or sub-regional level to maximise the effectiveness of elective services.

Major Trauma

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 15. Nationally there are approximately 2,000 major trauma events per year. On average each event attracts a 15-day stay in an intensive care unit, and one to two years of rehabilitation. Mortality rates for major trauma range between 5% and 10%.

The establishment of the MTNCN is a quality initiative arising from the assumption that outcomes from major trauma can be improved

The clinical lead for MTNCN visited all DHBs in the Central Region and met with CEOs and interested clinicians. These visits have supported the engagement of DHBs to progress the objectives of the MTNCN.

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 will build on the 7 March Central Region Clinical Symposium by formalising the Central Region Major Trauma Working Party. With the inclusion of management, this clinically led team will identify key personnel in each Central Region DHB and progress the development of a three-year *Central Region Major Trauma Plan*.

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.

The CEO sponsor and lead executive for the MTNCN has yet to be agreed.

To Achieve the Following Outcomes

Regional Objectives
<ul style="list-style-type: none"> Designated DHB clinical leads, co-ordinators and a regional clinical lead are identified A process is established to collect and report the data required to implement a national register 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
Regional Milestones and Measures
<p>Milestones</p> <ul style="list-style-type: none"> Identify the actions that the region will undertake to support DHBs' engagement with the MTNCN. Develop a three-year regional action plan that will deliver: <ul style="list-style-type: none"> the collection and reporting of a nationally consistent major trauma dataset and the implementation of local and regional major trauma systems <p>Measures</p> <ul style="list-style-type: none"> For the 2014/15 year it is expected that processes for enabling the measuring of, and the commencement of reporting on, the full New Zealand Major Trauma Dataset (NZMTMD) will be established

Sponsor

Clinical Lead

Key Actions – 2014/15

Key Actions – Major Trauma	Milestone/Measurement	Lead
<ul style="list-style-type: none"> The Central Region Major Trauma Working Party will be 	<ul style="list-style-type: none"> 31 July 2014 	Chris Lowry

Key Actions – Major Trauma	Milestone/Measurement	Lead
established		
<ul style="list-style-type: none"> Terms of reference for the Central Region Major Trauma Working Party will be defined 	<ul style="list-style-type: none"> 31 July 2014 	Chris Lowry
<ul style="list-style-type: none"> An approved major trauma work plan will be developed for year one and priorities established for years two and three, including: <ul style="list-style-type: none"> the national collection and reporting of a nationally consistent major trauma dataset the implementation of local and regional major trauma systems 	<ul style="list-style-type: none"> 31 December 2014 	Chris Lowry
<ul style="list-style-type: none"> The three-year <i>Regional Major Trauma Plan</i> is completed and approved 	<ul style="list-style-type: none"> 30 June 2015 	Chris Lowry
<ul style="list-style-type: none"> Each Central Region DHB will identify a designated clinical lead for major trauma 	<ul style="list-style-type: none"> 1 July 2014 	
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 1 July 2014 	
<ul style="list-style-type: none"> C&CDHB pilot patient identification and data collection system 	<ul style="list-style-type: none"> Commenced by 1 August 2014 Completed by 31 December 2014 	
<ul style="list-style-type: none"> Central Region DHBs pilot patient identification and data collection system 	<ul style="list-style-type: none"> Commenced 1 October 2014 	
<ul style="list-style-type: none"> Central Region DHBs roll out patient identification and data collection system 	<ul style="list-style-type: none"> 1 March 2015 	
<ul style="list-style-type: none"> The Central Region DHBs align local trauma definitions with those used in NZMTMD 	<ul style="list-style-type: none"> 1 July 2015 	
<ul style="list-style-type: none"> The regional plan for collection and reporting of a nationally consistent dataset is implemented 	<ul style="list-style-type: none"> 31 December 2015. Datasets received by NZMTMD from the Central Region's DHBs support the collection and reporting of a nationally consistent major trauma dataset 	

High-Level Key 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.

Diagnostic Imaging

Better, Sooner, More Convenient Health Services for New Zealanders 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 access, quality, sustainability and affordability of services as well as increasing demand. While not named as a Ministerial priority, diagnostic imaging in the Central Region has been identified as a vulnerable service as a result of these tensions. This is unsustainable from both a capacity and financial perspective. 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.

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 their 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.

The Central Region's DHBs currently operate their diagnostic imaging services in relative isolation (although there is co-operation). There is no commonality of systems employed and the implementation process adopted by each DHB has resulted in inconsistent applications of functions

and patient prioritisation. Images and reports are not always available to clinicians at the points of care due to incompatible IT systems. Workforce recruitment, retention and profession shortage issues are present within all professions, in particular radiologists and sonographers.

There is a need to look at the diagnostic imaging service as a whole, including the primary sector. Each DHB has disparate private imaging service utilisation. This is compounded by a lack of cohesion in sub-regional and regional contracting relationships with these 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 and behavioural change.

Existing constraints need to be overcome to achieve this, including 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 key performance measures and wait times indicators may not be met.

The Central Region programme of work for diagnostic imaging is led within the region by lead CEO and sponsor Graham Dyer (Hutt Valley DHB and Wairarapa DHB), chaired by Chris Lowry (COO, Capital & Coast DHB) 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 Objective
<ul style="list-style-type: none"> The regional objective will be to continue to focus on the regional work programme managed by the Central Region Radiology Steering Group, in consultation with appropriate sub-regional groups, and include: <ul style="list-style-type: none"> regionalisation: overall regionalisation of diagnostic imaging services in the Central Region, stage one being the 3DHB Radiology Programme IT infrastructure: supporting the development and installation of a regional PACS and regional RIS solution through the CRISP programme of work workforce: improving the workforce to become regionally sustainable in the future clinical indicators: standardising clinical indicators and developing appropriate access criteria across the Central Region to improve equitable and timely access to diagnostic imaging and developing a cost-effective and accessible primary care radiology service through improvements in community referrals and clinical pathways
Regional Milestone and Measures
<p>The substantive milestone for diagnostic imaging across the Central Region</p> <ul style="list-style-type: none"> to create a patient-focused, high-quality, timely and affordable regionalised radiology service by 2016. This will be measured by: <ul style="list-style-type: none"> achieving monthly national wait indicators for CT and MRI and developing a plan for delivering the future regional diagnostic imaging service by 30 June 2016

Sponsor: Graham Dyer (CEO Wairarapa DHB and Hutt Valley DHB)

Clinical Lead: Dr James Entwisle

Key Actions – 2014/15

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 2014/15 year are detailed as follows:

Key Actions – Diagnostic Imaging	Milestone/Measurement	Lead
KPIs <ul style="list-style-type: none"> Work with all DHBs to ensure that they have systems in place to manage and improve their individual DHB CT and MRI waiting time indicator performance, while ensuring patient safety and improving the access for all patient groups, including elective procedures and colorectal cancer 	Quarterly Reporting <ul style="list-style-type: none"> KPIs and reporting on key performance indicators to the Central Region's COOs including recommendations for assistance in the removal of barriers to efficient performance and/or improvement in service initiatives. 	Central Regional Radiology Group and DHBs
Service vision <ul style="list-style-type: none"> Work with all DHBs and their sub-regional constructs to ensure that service delivery is consistent with the aims of the regional 	<ul style="list-style-type: none"> Work with the 3DHBs' programme office to support its delivery of service reconfiguration across 	Central Regional Radiology Group and DHBs

Key Actions – Diagnostic Imaging	Milestone/Measurement	Lead
radiology vision for the Central Region namely - a patient-focused and regionalised diagnostic imaging service that is high quality, timely, affordable and therefore sustainable	3DHBs. This will include attendance at regular 3DHB meetings and taking lessons learned back to the regional table <ul style="list-style-type: none"> Work with the centralAlliance programme office to assist and align the centralAlliance service review with the regional vision 	
Workforce development <ul style="list-style-type: none"> Work with Health Workforce New Zealand (HWNZ), the Regional Training Hub and DHBs to develop a strategy to address the vulnerable workforce issues of Diagnostic Imaging 	Quarter 1 – Clarifying Roles <ul style="list-style-type: none"> Clarify the role of HWNZ and the Central Region Training Hub with regards to development of recruitment, retention and development strategy for imaging workforce Quarter 2 – Recruitment and Retention <ul style="list-style-type: none"> Work with HWNZ and the Central Region Training Hub to develop a regional strategy for recruitment, retention and workforce development for imaging workforce. 	Central Regional Radiology Group, HWNZ and Regional Training Hub
Governance and Programme Structure <ul style="list-style-type: none"> Operationalise and maintain the necessary governance, business as usual and change control systems to deliver the regional work programme, including the systems delivered by CRISP (Regional PACS/RIS) 	Quarter 1 - Define scope <ul style="list-style-type: none"> Define what we understand is required to govern regional systems once implemented Quarter 1 - Structure recommendations <ul style="list-style-type: none"> Write paper for approval on appropriate work programme group structure and membership Quarter 2 – Implement structure <ul style="list-style-type: none"> Work with individual DHB operational teams to implement and maintain the necessary structure for managing the RSP work programme including the systems delivered by CRISP (Regional PACS/RIS) 	Central Regional Radiology Group, COOs and GMs P&F, REC

Linkages to Other Work Programmes

Sub-regional	
<ul style="list-style-type: none"> 3DHBs centralAlliance 	<ul style="list-style-type: none"> 30 June 2015 Delivery of 3DHB service reconfiguration 30 June 2016 Delivery of lessons learned from centralAlliance service review

Information Technology	
<ul style="list-style-type: none"> Operationalise and maintain the necessary governance, BAU and change control systems to manage the IT systems delivered by CRISP (RIS/PACS) 	<ul style="list-style-type: none"> 30 June 2015 Work with TAS, CRISP, Regional ICT and individual DHB operational teams to maintain the necessary structure for managing regionalised radiology IT systems
Māori Health	
<ul style="list-style-type: none"> There are no specific actions targeted at Māori or other unique populations 	

High-Level Key Actions – 2015-2017

Actions	Milestone/Date
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 30 June 2016 Waiting time indicators for CT and MRI are achieved
<ul style="list-style-type: none"> Develop a plan for delivering the future regional diagnostic imaging service 	<ul style="list-style-type: none"> 30 June 2016 Future service development plan
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 30 June 2016 Regionalised recruitment, training and retention
<ul style="list-style-type: none"> Utilise the lessons learned from the centralAlliance service review to inform the region of the proposed future service model for the region 	<ul style="list-style-type: none"> 30 June 2016 Delivery of lessons learned from centralAlliance service review

High-Level Key Actions – 2016/17

The main focus for diagnostic imaging for 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 future 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 future service vision.

Regional Enablers – Regional and National Priorities

Information Technology

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 healthcare 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 2014/15 include:

- regional clinical workstation called the clinical portal and clinical data depository
- replacement of legacy PAS
- National Patient Flow and
- finance procurement and supply chain

The priorities provide the foundation to support regional initiatives in community and hospital information and shared care.

The first two IT priorities will be regionally delivered. National Patient Flow will create a further requirement for the implementation of a regional PAS and CWS.

To Achieve the Following Outcomes

Regional Objectives

- **CR Clinical Applications** – the Central Region DHBs clinicians have access to patient information wherever they may be situated
- **Regional Network** – the Central Region DHBs establish a region-wide area network that can enable all health care providers in the region to access common information
- **Regional e-Pharmacy** – the Central Region DHBs implement a single hospital pharmacy solution

Regional Milestones and Measures

CRISP

- At the end of phase one of the CRISP programme the Central Region DHBs will have:
 - a clinical portal accessible by DHB users
 - a RIS for all DHBs
 - a PAS for 3DHBs
 - a regional network
 - a regional e-Pharmacy

1. CRISP

Sponsor: Julie Patterson

Key Actions – 2014/15

Key Actions – CRISP	Milestone/Measurement	Lead
Regional clinical portal and clinical data repository <ul style="list-style-type: none"> • Implement a clinical portal and a clinical data repository using the Orion Concerto suite of products integrated to national, regional and local systems • Complete implementation in the remaining 	<ul style="list-style-type: none"> • By June 2015 Clinical portal is able to be accessed by 30% of authorised clinicians in the region • Clinicians are able to view their patient information sourced 	CRISP programme to lead the development of regional systems.

central region DHBs other than MDHB • A regional view of common clinical information enabled	regionally • A single regional clinical portal is available at 2 DHBs	DHB to lead local changes
Replacement of legacy PAS • Implement a regional PAS using CSC suite of products • A single regional PAS is implemented for HBDHB, MDHB and WDHB	• By June 2015 a Regional WebPAS is implemented on a regional platform.	TAS/DHBs
Transfer of Care • Implement transfers of care (e-referrals and e-discharges) using the regional clinical applications • A common standards-based system for transfers of care between all providers is enabled	• Standard transfer-of-care processes used at all DHBs for referral triage and patient scheduling as part of the regional Clinical Portal roll out.	TAS/DHBs
Regional Radiology Information System • Implement a single RIS using the Carestream product	• By June 2015 100% of DHB radiology staff able to utilise the regional RIS.	TAS/DHBs

2. Regional Network

Key Action – Regional Network	Milestone/Measurement	Lead
• Based on an approved business case implement a regional network linking all health care providers based on the Regional Network Architecture	• By June 2015 25% of the region's DHBs utilising the regional network	DHBs

3. Regional e-Pharmacy

Key Action – Regional e-Pharmacy	Milestone/Measurement	Responsibility
• Based on an approved business case, DHBs will implement e-Pharmacy system	• By June 2015 25% of the region's DHBs utilising e-Pharmacy	DHBs

Linkages to Other Work Programmes

CRISP – Regional governance, leadership and decision-making
• Capital Asset Management • Cardiac • Cancer • Diagnostic Imaging (Radiology) • Elective Services • MHAN • Central Region Consumer Forum

CRISP
National Health IT Plan update 2013/14 National Patient Flow



High-Level Key Actions – 2015/16

1. CRISP programme – Complete the implementation of the regional PAS for Hawkes Bay DHB, MidCentralDHB and Wairarapa DHB including National Patient Flow requirements – Dec 2015.
2. Regional network – Implement across the remaining DHBs who are in the region wide area network (WAN) – December 2015.

Regional Capital Investment Approaches

Regional services' planning requires DHBs to work together and with other health providers in a more integrated way. The RSP outlines how DHBs will plan, fund and deliver individual service priority areas to reduce service vulnerability, reduce costs and improve the quality of care.

Capital investment planning needs to be linked to both DHB annual planning processes and regional service planning. This link has been rather tenuous in the past, with RSPs not clearly signalling to DHBs any forthcoming indicative capital requirements and any expected reductions or increases in on-

going operating costs. The annual capital planning undertaken within DHBs is currently very much DHB-centric and does not fully permit the required regional involvement to explore service opportunities and priorities requiring capital investment regionally and ensure that decisions are well informed.

The development of the 2014/15 RSP has seen mechanisms and processes put in place to ensure that RSP capital requirements are fed back to the regional DHBs for inclusion in their annual plans and capital planning documents.

To Achieve the Following Outcomes

Regional Objectives
<ul style="list-style-type: none"> That DHBs' annual plans fully show the 2014/15 regional service planning capital requirements Long term, that DHB regional capital plans be informed by local and regional service planning and DHB facility assessments That the region has processes in place to prioritise capital intentions over 10 years That the region can engage with the Capital Investment Committee on the long-term capital intention planning process That the regional DHBs have processes to ensure quality asset management planning
Regional Milestone and Measure
<ul style="list-style-type: none"> Establishment of a Regional Capital Committee

Sponsor: Julie Patterson

Key Actions – 2014/15

Key Actions – Capital Investment	Milestone/Measurement	Lead
<ul style="list-style-type: none"> Establishment of a Regional Capital Committee, including secretariat support 	<ul style="list-style-type: none"> 1 July 2014 	Lead CEO
<ul style="list-style-type: none"> Development of a strategy and work plan for regional capital engagement 	<ul style="list-style-type: none"> 30 November 2014 	Lead CEO
<ul style="list-style-type: none"> Work with MoH and Treasury on the Health Capital Review, which will include a work plan in 2014 on asset management 	<ul style="list-style-type: none"> TBA (to be agreed) 	Lead CEO
<ul style="list-style-type: none"> Identify the 2015/16 regional process for the preparation of a <i>Regional Capital Plan</i> for 2015/16 	<ul style="list-style-type: none"> 1 November 2014 	Lead CEO

Linkages to Other Work Programmes

Regional Service Priority Areas
<ul style="list-style-type: none"> All regional service priority areas to consider capital investment implications of their respective projects

Workforce

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 27 workforce priorities for 2014/15. 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 Training Director working in conjunction with the Central region DHBs (particularly the general managers of human resources (GMsHR)), 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.

To Achieve the Following Outcomes

Regional Objective
<ul style="list-style-type: none"> Support the HWNZ mission to ensure a health workforce in New Zealand that is both sustainable and fit for purpose
Regional Milestones and Measures
<p>Milestones</p> <ul style="list-style-type: none"> Implement a shared e-learning hosting platform in four of the six Central Region DHBs to enable sharing of learning modules Develop a database of postgraduate health training/information to enable information and education packages to be available Complete and implement a regional recruitment action plan to reduce vacancies in hard-to-staff areas Maintain, evaluate and evolve a sole practitioner register and support mechanisms available Ensure a sustainable and supported diabetes prescribing workforce Ensure a sustainable and supported graduate workforce for NETP, mental health nursing (nursing entry to specialist practice [NESP]) and graduate midwifery and address the ageing nursing, mental health nursing and midwifery workforce Increase the Pacific workforce regionally Increase the Māori workforce regionally in nursing, midwifery, medicine, allied and technical staff Complete and implement the Regional Māori Capability Programme to develop a culturally competent workforce Develop a database of multi-professional innovations to enable a centralised information system to be available Centralise strategic planning and the implementation of Resident Medical Officer pipeline workforce planning

Regional Milestones and Measures

- Implement actions to support the Medical Council of New Zealand's (MCNZ's) national initiatives for Postgraduate Year 1 (PGY1) and PGY2 programmes
- Establish ACP leads and governance groups at local or sub-regional level to support the local implementation of the ACP Framework, with a regional increase of a minimum of 20 health care sector employees Level 2 competency trained
- Support the development of the national Kaiāwhina project and regional Allied Health Assistants programme
- Ensure a workforce fit for purpose to support the moving of CRISP to a suite of shared, standardised and fully integrated information systems
- Development of Cancer Nurse Co-ordinator roles, including implementing professional development
- Commence implementation of the national cancer nursing knowledge and skills framework
- Complete regional plan to increase SMO workforce capacity aligned with national medical oncology models of care
- Support the review and on-going development of regionalised training for vulnerable workforce components within diagnostic imaging services
- Regional workforce planning and development for cardiology and physiology technicians
- Complete a regional stroke service workforce strategy and education plan
- Complete a strategic regional workforce plan to build workforce capacity for MH&A services
- Ensure dementia care education provision and resources for regulated/unregulated workforce
- Develop a dementia awareness and responsiveness education programmes for primary health clinicians
- Undertake a specialist health stocktake of the older people workforce to assist in planning service delivery and models to meet the needs of the ageing population
- Complete workforce resource for the development and delivery of polypharmacy master class
- Complete and implement a regional plan to share management and leadership development programmes

Measures

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

Sponsor: Graham Dyer

Lead: Roy Pryer

The following key actions have been identified as the strategic workforce priorities for the 2014/15 RSP. Capacity, capability and change leadership are

the fundamental themes under which strategic workforce sustainability will be achieved through a cohesive and collaborative regional approach.

Key Actions – 2014/15

Key Actions – Workforce	Milestone/Measurement	Lead
Capacity – Consolidation of Training and Education Resources and Sharing of Practices		
<ul style="list-style-type: none"> • Implement a shared e-learning hosting platform in four of six DHBs to enable sharing of learning modules 	<ul style="list-style-type: none"> • Q1: Complete a regional e-learning strategy with DHB alignment on approach and direction • Q2: Progressively implement regional e-learning strategy and approach • Q3: Sign up three out of six DHBs to e-learning hosting platform and sourcing of current utilised health e-modules • Q4: Sign up four out of six DHBs to e-learning hosting platform with modules accessible to staff • Q4: Share agreed e-/blended/other learning modules 	Regional development: <ul style="list-style-type: none"> • Regional Training Hub Regional implementation: <ul style="list-style-type: none"> • DHBs' education and development managers

Key Actions – Workforce	Milestone/Measurement	Lead
	across Central Region	
<ul style="list-style-type: none"> Develop a database of postgraduate health training/information to enable information and education packages to be available 	<ul style="list-style-type: none"> Q1: Source an IT package to support common platform Q2: Complete and progressively implement a regional database of staff training and education providers Q3: Access to database given to identified health sector staff in order to facilitate sharing of training information Q4: Share current training information, resources and practices where feasible Q4: Evidence of collaborative projections for future training requirements based on current training workforce data (refer to minutes from Training Hub network meetings and develop, where appropriate, through working groups) 	Regional development: <ul style="list-style-type: none"> Training Hub, Regional Director of Training and GMsHR Regional implementation: <ul style="list-style-type: none"> DHBs
Capacity – Recruitment and Retention of the Regulated Workforce		
<ul style="list-style-type: none"> Complete and implement a regional recruitment action plan to reduce vacancies in hard-to-staff areas 	<ul style="list-style-type: none"> Q1: Continue to maintain regional register of hard-to-staff areas Q2-4: Complete and implement regional recruitment action plans for current hard-to-staff areas with reduced percentage of vacancies in same areas Q3-4: Utilise current workforce initiative 'Grow our own' where feasible in health workforce population across the Central Region (refer minutes in GMsHR meetings and developed where appropriate through working groups) 	Regional development: <ul style="list-style-type: none"> GMsHR, Regional Director of Training and RSP radiology, RSP cancer and RSP cardiac Regional implementation: <ul style="list-style-type: none"> DHBs
<ul style="list-style-type: none"> Maintain, evaluate and evolve sole practitioner register and support mechanisms available 	<ul style="list-style-type: none"> Q1-4: On-going maintenance of sole practitioner register Q3: Stocktake of support mechanisms available to sole practitioners Q4: Review and evaluate stocktake of support mechanisms available to sole practitioners Q4: Complete a regional action plan to address identified peer support gaps 	Regional development: <ul style="list-style-type: none"> GMsHR Regional implementation: <ul style="list-style-type: none"> GMsHR
Capability (Innovation) – Supporting Training for Best Practice for Vulnerable Groups		
<ul style="list-style-type: none"> Ensure a sustainable and supported diabetes prescribing workforce 	<ul style="list-style-type: none"> Q1-4: Continue to provide education support to staff undertaking the required clinical supervision for diabetes prescribing Q1-2: Undertake stocktake of current staff completing/completed diabetes prescribing Q3-4: Complete a workforce plan for providing further diabetes prescribers within identified high-need areas within 2015/16 period 	Regional development: <ul style="list-style-type: none"> GMsHR, Regional Director of Training and professional leads Regional implementation: <ul style="list-style-type: none"> Professional leads and Director of Training
<ul style="list-style-type: none"> Ensure a sustainable and supported graduate workforce for 	<ul style="list-style-type: none"> Q1: Undertake regional stocktake of current and available NETP, NESP and graduate (hospital employed) midwifery positions 	Regional development: <ul style="list-style-type: none"> DHB directors of nursing, directors of



Key Actions – Workforce	Milestone/Measurement	Lead
NETP, mental health nursing (NESP) and graduate midwifery (MFYOP) to address the ageing nursing, mental health nursing and midwifery workforce	<ul style="list-style-type: none"> Q1: Undertake regional stocktake of vacancies in nursing, mental health nursing and midwifery outside graduate scope Q2: Analyse current regional workforce data obtained from regional stocktakes and national Tertiary Education Organisation pre-registration nursing data, in conjunction with NETP, NESP and graduate midwife workforce, including identification of hard-to-staff areas including aged and primary care Q2-3: Complete a regional strategic model and process/es to increase regional recruitment to NETP, NESP and graduate midwifery programmes, aligning regional priorities with national workforce initiatives through Office of the Chief Nurse and Nursing Council of New Zealand and Midwifery Council of New Zealand (individual DHB recruitment percentage increase TBA on result from stocktake) Q3-4: Undertake a regional scoping exercise to identify and develop potential new areas within region for new NETP, NESP and graduate midwifery placements for 2015-2017 period Q4: Implement regional model with collaborative plan for identification of future NETP, NESP and graduate midwifery workforce planning for 2015-2017 period as part of national three-year vision for graduate workforce (evaluation of regional model and processes to be undertaken within 2015/16 period) 	<p>midwifery, nurse directors of mental health and other associated nurse leaders</p> <p>Regional implementation:</p> <ul style="list-style-type: none"> DHB directors of nursing, directors of midwifery, nurse directors of mental health and other associated nurse leaders
<ul style="list-style-type: none"> Increase Pacific workforce regionally (supported by regional GMsHR) 	<ul style="list-style-type: none"> Q1-4: Increase contact rate with school-age Pacific population through delivery and monitoring of Health Science Academy workshops and other identified workshops in three out of six DHBs with six-monthly reporting from directors of Pacific health through Training Hub and GMsHR Q2: Complete a scoping exercise of existing Pacific cultural competence programmes Q2-4: Increase opportunities for Pacific population recruitment into health sector through engagement of directors of Pacific health with all professional leaders in recruitment processes Q2-4: Increase attendance for PDRP development and extend to three out of six DHBs for Pacific multi-professional health workforce through workforce initiatives and support, as reported by directors of Pacific health Q3-4: Complete a regional Pacific plan with health sector educators to increase percentage of health sector workforce receiving Pacific cultural competence education, with utilisation reported in 2015/16 period Q4: Complete a Pacific health workforce plan to 	<p>Regional development:</p> <ul style="list-style-type: none"> Directors of Pacific health, GMsHR, professional clinical leads and health sector educators <p>Regional implementation:</p> <ul style="list-style-type: none"> GMsHR and directors of Pacific health, professional clinical leads and health sector educators

Key Actions – Workforce	Milestone/Measurement	Lead
	regionally increase recruitment of Pacific population in health sector by 10% seen post-implementation in 2015/16 period	
<ul style="list-style-type: none"> Increase Māori workforce regionally in nursing, midwifery, medicine, allied and technical staff (supported by regional GMsHR) 	<ul style="list-style-type: none"> Q1-4: Continue to support and monitor Kia Ora Hauora outcomes with monthly reporting through Kia Ora Hauora delivery statistics and monitoring of cadetship programme development by Kia Ora Hauora through directors of Māori health Q1-4: Continue to utilise the performance monitoring framework for the development of the Māori health workforce and implement six-monthly reports to the REC by regional directors of Māori health Q2: Continue to develop regional strategy to implement <i>Māori Health Workforce Development Plan</i> by GMsHR and directors of Māori health Q3-4: Implement the <i>Māori Health Workforce Development Plan</i> leading to regional increase in 10% Māori population recruited within 2015/16 period 	Regional development: <ul style="list-style-type: none"> Directors of Māori health, GMsHR Regional implementation: <ul style="list-style-type: none"> GMsHR, directors of Māori health and professional clinical leads
<ul style="list-style-type: none"> Complete and implement Regional Māori Capability Programme to develop a culturally competent workforce (supported by regional GMsHR) 	<ul style="list-style-type: none"> Q1-2: Implement pilot for Regional Māori Capability Programme at C&CDHB and Wairarapa DHB for Māori Capability Framework Q3: Evaluate pilot and produce report for Regional Māori Capability Programme Q3-4: Revise programme as required and develop regional approach to implement Q4: Implement Regional Māori Capability Programme through all six DHBs and associated PHOs 	National and regional development: <ul style="list-style-type: none"> Directors for Māori health and GMsHR Regional implementation: <ul style="list-style-type: none"> Directors of Māori health, GMsHR and DHB and PHO educators
<ul style="list-style-type: none"> Develop a database of multi-professional innovations to enable centralised information system to be available 	<ul style="list-style-type: none"> Q1: Source an IT package to support common platform Q2: Complete and progressively implement innovations database with communication tools to allow for online discussion groups Q3: Access to database for identified health sector personnel Q4: Evidence of multi-professional, regional innovation sharing and collaboration within discussion groups and database 	Regional development: <ul style="list-style-type: none"> Director of Training and Training Hub Regional Implementation: <ul style="list-style-type: none"> DHBs and PHOs
Capability (Innovation) – Workforce Development/Sector Transformation		
<ul style="list-style-type: none"> Central strategic planning and implementation of Resident Medical Officer pipeline workforce planning 	Quarterly reporting on 70/20/10% criteria through DHBs on: <ul style="list-style-type: none"> Q1-4: 100% of HWNZ-funded medical trainees develop and implement career plans Q1-4: All trainees are provided with links to website for career planning advice, supported by the opportunity to discuss with supervisors or other clinicians Q1-4: Confirmed regional satisfaction level and feedback survey results with Resident Medical 	National development: <ul style="list-style-type: none"> HWNZ Regional development: <ul style="list-style-type: none"> GMsHR, Intern Supervisor Group and Regional Director of Training Regional implementation: <ul style="list-style-type: none"> DHBs and PHOs



Key Actions – Workforce	Milestone/Measurement	Lead
	<p>Officer Units</p> <ul style="list-style-type: none"> - Q1-4: Work with HWNZ on national initiatives – Medical Workforce Taskforce - Q1: Identification of regional events and initiatives to support medical vocational trainee evenings and postgraduate education fairs • Q1-2: Complete a plan to standardise identified PGY 1 and 2 programmes, liaising with other regions to reduce duplication and mapping across professions where possible. Four programmes identified as (may be changed as required): <ul style="list-style-type: none"> - communication, - prescribing, - patient consent and - e-portfolios • Q3: All health professional trainees have access to career events and initiatives • Q3: Implement plan for four programme standardisations • Q3: Conduct a stocktake of current contracted and established DHB SMO positions • Q3-4: Align contracted FTE to establishment FTE for PGY3 with no more than 15% variance • Q4: Identify further four PGY1 and PGY2 programmes to be standardised within 2015/16 period, mapping across professions where possible • Q4: Complete and implement an action plan to address collaboration on development of plans for Medical Workforce Taskforce recommendations for 2015/16 period with emphasis on regional increase in New Zealand-trained SMOs (percentage TBA on result of regional SMO stocktake) 	
<ul style="list-style-type: none"> • Implement actions to support the MCNZ national initiatives for PGY1 and PGY2 programmes 	<ul style="list-style-type: none"> • Q1-2: Scope and identify workforce initiatives in conjunction with MCNZ for PGY1 and PGY2 curriculum • Q3-4: Complete a regional plan with MCNZ representatives on identified workforce initiatives 	<p>National development:</p> <ul style="list-style-type: none"> • MCNZ <p>Regional development:</p> <ul style="list-style-type: none"> • Regional Director of Training, Training Hub and GMsHR <p>Regional implementation:</p> <ul style="list-style-type: none"> • Regional health system
<ul style="list-style-type: none"> • Establish ACP leads and governance groups at local or sub-regional level to support the local implementation of the ACP Framework, with a regional increase of a minimum of 20 	<ul style="list-style-type: none"> • Q1-2: Source IT packages and implement ACP database to allow central register of staff who have undertaken training and levels of competency in Central Region • Q1-2: Regional DHBs to identify ACP leads • Q1-2: Quarterly report to National Health Board for numbers completing Level 2 training in Central Region • Q2-3: Implement regional ACP Framework 	<p>Regional development:</p> <ul style="list-style-type: none"> • GMsHR, Training Hub and Regional Director of Training <p>Regional implementation:</p> <ul style="list-style-type: none"> • DHBs and PHOs



Key Actions – Workforce	Milestone/Measurement	Lead
health care sector employees Level 2 competency trained	<ul style="list-style-type: none"> Q2-3: Establish local or sub-clinical governance groups Q4: Stocktake of regional uptake of ACP Level 2 training in 2014/15 period 	
<ul style="list-style-type: none"> Support the development of the national Kaiāwhina project and regional Allied Health Assistants programme 	<ul style="list-style-type: none"> Q1-4: Participate in national initiatives in formulating the national and regional unregulated workforce training structure (Kaiāwhina project) Q2-4: Further develop and implement regional Allied Health Assistant programme in five out of six DHBs to increase allied health assistants acquiring NZQA Level 3 Q3-4 Complete regional action plan to address unregulated workforce development needs 	<p>National development:</p> <ul style="list-style-type: none"> HWNZ and Careerforce <p>Regional development:</p> <ul style="list-style-type: none"> GMsHR, professional groups, Regional Director of Training, Training Hub in collaboration with other health groups <p>Implemented regionally:</p> <ul style="list-style-type: none"> TBA
<ul style="list-style-type: none"> Ensure a workforce fit for purpose to support moving of CRISP to a suite of shared, standardised and fully integrated information systems across Central Region 	<ul style="list-style-type: none"> Q3-4: Complete a workforce plan to ensure workforce capability and capacity to support CRISP and informatics strategy Q4: Implement workforce plan to ensure capability and capacity to support CRISP and informatics strategy 	<p>Regional development:</p> <p>TAS</p> <p>Regional implementation:</p> <ul style="list-style-type: none"> Chief information officers and regional DHBs
<ul style="list-style-type: none"> Development of Cancer Nurse Co-ordinator roles, including implementing professional development plans 	<ul style="list-style-type: none"> Refer to regional cancer services programme, workforce section 	<p>Refer to regional cancer services programme, workforce section</p>
<ul style="list-style-type: none"> Commence implementation of the national cancer nursing knowledge and skills framework 	<ul style="list-style-type: none"> Refer to regional cancer services programme, workforce section 	<p>Refer to regional cancer services programme, workforce section</p>
<ul style="list-style-type: none"> Development of regional plan to increase SMO workforce capacity aligned with national medical oncology models of care 	<ul style="list-style-type: none"> Refer to regional cancer services programme, workforce section 	<p>Refer to regional cancer services programme, workforce section</p>
<ul style="list-style-type: none"> Support the review and on-going development of regionalised training for vulnerable workforce components within diagnostic imaging services 	<ul style="list-style-type: none"> Refer to regional diagnostic imaging services programme, workforce section 	<p>Refer to regional diagnostic imaging services programme, workforce section</p>
<ul style="list-style-type: none"> Regional workforce planning and 	<ul style="list-style-type: none"> Refer to regional cardiology services programme, workforce section 	<p>Refer to regional cardiology services</p>



Key Actions – Workforce	Milestone/Measurement	Lead
development for cardiology and physiology technicians		programme, workforce section
<ul style="list-style-type: none"> Development of regional stroke service workforce strategy and education plan 	<ul style="list-style-type: none"> Refer to regional stroke services programme, workforce section 	Refer to regional stroke services programme, workforce section
<ul style="list-style-type: none"> Complete a strategic regional workforce plan to build workforce capacity for MH&A services 	<ul style="list-style-type: none"> Q1-2: Quarterly reporting on stocktake progress Q1-2: Facilitate 'More Than Numbers' MH&A services workforce stocktake Q3-4: Identify MH&A workforce in DHBs Q3-4: Promote use of 'Let's get Real' tools to inform workforce planning for DHBs Q4: Introduction of workforce planning systems in DHBs Q4: Scope unregulated MH&A workforce 	<p>National development:</p> <ul style="list-style-type: none"> Te Pou <p>Regionally developed:</p> <ul style="list-style-type: none"> Te Pou, Mental Health and Addiction Network and MH&A workforce planning lead <p>Regional implementation:</p> <ul style="list-style-type: none"> MH&A workforce planning lead
<ul style="list-style-type: none"> Ensure dementia care education provision and resources for regulated/unregulated workforce 	<ul style="list-style-type: none"> Refer to regional HOP services programme <i>Dementia Pathway Action Plan</i> 	Refer to regional HOP services programme <i>Dementia Pathway Action Plan</i> section
<ul style="list-style-type: none"> Collaborative development of dementia awareness and responsiveness education programmes for primary health clinicians 	<ul style="list-style-type: none"> Refer to regional HOP services programme <i>Dementia Pathway Action Plan</i> 	Refer to regional HOP services programme <i>Dementia Pathway Action Plan</i> section
<ul style="list-style-type: none"> Undertake specialist health stocktake of older people workforce to assist in planning service delivery and models to meet the needs of ageing population 	<ul style="list-style-type: none"> Q1-4: Quarterly report on progress through Training Hub Q2: Develop project scope for workforce review Q2: Recruit project members Q4: Undertake Central Region stocktake Q4: Report findings of stocktake to HOP Network 	<p>Regional development and implementation:</p> <ul style="list-style-type: none"> HOP Network
<ul style="list-style-type: none"> Development of workforce resource for development and delivery of polypharmacy master class 	<ul style="list-style-type: none"> Refer to regional HOP services programme, workforce section 	Refer to regional HOP services programme, workforce section
Change leadership – Leadership and Management Programmes		
<ul style="list-style-type: none"> Complete and 	<ul style="list-style-type: none"> Q1: Stocktake of current leadership programmes 	<ul style="list-style-type: none"> Regional

Key Actions – Workforce	Milestone/Measurement	Lead
implement a regional plan to share management and leadership development programmes	<ul style="list-style-type: none"> Q2: Develop a regional plan for sharing of current leadership programmes to enable increasing utilisation Q3-4: Implement a regional plan for sharing of current leadership programmes Q4: Monitor regional uptake of existing leadership programmes and develop regional plan for future leadership and development programmes 	development: <ul style="list-style-type: none"> GMSHR Regional implementation: <ul style="list-style-type: none"> DHBs and PHOs

Linkages to Other Work Programmes

Stroke
<ul style="list-style-type: none"> Refer to regional stroke services programme, workforce section
Mental Health and Addictions
<ul style="list-style-type: none"> Refer to regional MH&A services programme, workforce section
Health of Older People
<ul style="list-style-type: none"> Refer to regional HOP services programme, workforce section
Diagnostic Imaging
<ul style="list-style-type: none"> Refer to regional diagnostic imaging services programme, workforce section
Cancer
<ul style="list-style-type: none"> Refer to regional cancer services programme, workforce section
Cardiology
<ul style="list-style-type: none"> Refer to regional cardiology services programme, workforce section
Māori
<ul style="list-style-type: none"> Refer to regional Māori services programme, workforce section
CRISP
<ul style="list-style-type: none"> CRISP workforce training

High-Level Key Actions – 2015-2017

The focus in the workforce arena will stay firmly on continued collaboration across the Central Region in relation to shared learning and development. This will include the continued development of regional/national standardised e-learning resources and modules across DHBs, available to PHOs and NGOs where appropriate.

Identified professional development programmes for midwifery, nursing, allied health, scientific and

technical professionals will be standardised across the Central Region.

We will align our work programme to work being undertaken with the unregulated workforce in the health and disability sector by HWNZ and Careerforce. This includes the establishment of essential training and education standards, programmes and associated quality assurance processes. This strategic focus will become part of the *Health and Disability Workforce Plan's* '20-year vision'.



Strategic regionalised workforce planning will continue within specialist fields, namely MH&A services and care of the elder population. The scope of this will include better integration between primary and secondary services, ensuring that the workforce is fit for purpose. Workforce planning will continue to focus on challenges presented by the ageing and vulnerable workforce.

The workforce programme will continue to support the workforce capacity and capability requirements of changing models of care, new technology and innovation.

There will be a planned and sustained focus on clinical leaders and clinical leadership across to sector to help them shape and guide the future direction of our health system.

Quality and Safety

Clinical leadership is internationally recognised as a fundamental driver of improved care and maintaining patient safety.

There is widespread recognition that the management of quality and safety systems within health care benefits from a consistent, systematic approach. The aim for the Central Region is to achieve a culture of quality improvement whereby clinicians lead improvements in health care with a patient-centred strategy and with support from the systems and the management teams.

To help achieve this aim the RQSA is being established to lead this work in the Central Region. It will work to achieve consistent standards of quality of care and positive patient experiences regardless of where they enter the Central Region health system. The RQSA will strive to ensure the clinical safety of health care consumers and the ethical and efficient use of resources to align with the Triple Aim.

The principal purpose of the RQSA will be to provide strong clinical leadership across the continuum of care that optimises health outcomes, including the reduction of health disparities. 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 information and regional learning that supports a regional perspective on patient safety issues and
- develop, prioritise and monitor regional activities, aligned to prioritised goals and the delivery of outputs. These will have an overall strategic focus for regional quality and safety development.

The RQSA will also work to support and provide oversight to the Central Region Patient Safety Campaign

To Achieve the Following Outcomes

Regional Objectives
<ul style="list-style-type: none"> • Promoting the embedding of a clinical governance framework at all levels across the region and advising on the strategic direction. This will assist in providing a vision for health services to incorporate quality and safety goals into strategic plans and relevant agreements • Promoting the direction of quality and safety in line with policy and that is evidence-based. DHBs need to have aligned quality plans and risk management structures
<ul style="list-style-type: none"> • Maximising clinical governance and reporting to be embedded at all directorate and service levels so that the health service user experiences consistent, quality care. • Providing leadership in 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 sharing learning from adverse events. • Providing input to planning at a regional level where objectives for the improvement of quality and safety are incorporated, including vulnerable and isolated services. • Defining a core set of quality and safety measures based on national evidence. Establishment of an appropriate collection and reporting mechanism.

Sponsor: Julie Patterson

Key Actions – 2014/15

Key Actions – Quality and Safety	Milestone/Measurement	Lead
<ul style="list-style-type: none"> • To establish a fit-for-purpose RQSA 	<ul style="list-style-type: none"> • Terms of reference agreed and work 	TAS and regional



within the Central Region	programme developed by 31 August 2014	quality and safety clinical lead
<ul style="list-style-type: none"> To review regional quality indicators 	<ul style="list-style-type: none"> A trend analysis of Central Region quality indicators by 31 March 2015 	TAS and the RQSA

Linkages to Other Work Programmes

<ul style="list-style-type: none"> Central Region Patient Safety Campaign Central Region Quality Managers Forum

High-Level Key Actions – 2015-2017

Work programme yet to be established.

Links to the DHBs' Annual Plan

Action plans	C&CDHB	HBDHB	HVDHB	MDHB	WaiDHB	WhaDHB
HOP	Module 2.3.13	Module 2	Module 2.3.13		Module 2.3.13	Module 2
Māori Health		Module 2				Module 2
Cancer	Module 2.3.14	Module 2	Module 2.3.14	Chapter 2.1.7	Module 2.3.14	Module 2
Cardiac	Module 2.3.10	Module 2	Module 2.3.10	Chapter 2.1.3	Module 2.3.10	Module 2
Stroke	Module 2.3.12	Module 2	Module 2.3.12		Module 2.3.12	Module 2
Mental Health and Addictions	Module 2.3.3	Module 2	Module 2.3.3		Module 2.3.3	Module 2
Electives	Module 2.3.9	Module 2	Module 2.3.9	Chapter 2.1.3/2.1.8	Module 2.3.9	Module 2
Major Trauma		Module 2				Module 2
Diagnostics	Module 2.3.8	Module 2	Module 2.3.8	Chapter 2.1.6	Module 2.3.8	Module 2
Information Technology						
Regional Capital Investment						
Workforce	Module 2.4.1	Module 2	Module 2.4.1	Chapter 2.1.8	Module 2.4.1	Module 2



APPENDICES



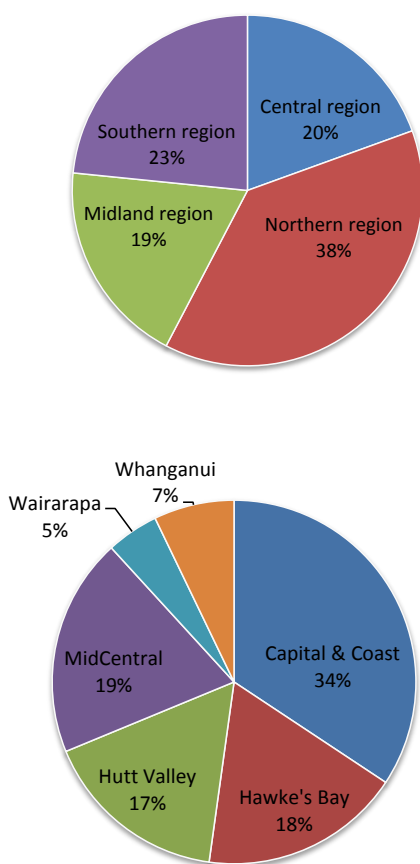
Appendix A – The Central Region

Demographic Overview

The Central Region is made up of six DHBs who service a population of just under 879,000¹⁰. This represents approximately 20% of New Zealand's total population. The region covers an area of 39,482 square kilometres. Capital & Coast DHB services the region's largest population base. This is 7.4 times that of Wairarapa DHB, the region's smallest.

It is projected that in the next 10 years the region's overall population will grow by 4.1%. Most of the region's growth will be within the current Capital & Coast DHB catchment area. This is projected to grow by 7.2% during the same 10-year period. The only DHB expected to experience negative growth in the next 10 years is Whanganui DHB (a decrease of 2.4%). The number of people living within the boundaries of Wairarapa DHB is expected to grow by less than 1%, while the other three DHBs should experience growth of between 2.2% and 4.7%.

Figure 1: Central Region Population Distribution by Region and DHB (2014)



Population Distribution

The Central Region is sparsely populated, with the majority of the population clustered in several urban areas. Approximately 80% of the region's population are urban dwellers (compared with 86% nationally). Capital & Coast and Hutt Valley are the most highly urbanised at 99% and 98% respectively. At 24% Wairarapa has the greatest proportion of rural inhabitants.

Age Distribution

The age distribution amongst the various DHBs varies. Wairarapa has the highest proportion of people aged over 65 years, representing 21% of its population. This is considerably higher than the Central Region and national proportions (both 15%) and Capital & Coast (12%). However, Wairarapa's 65-plus population accounts for 6% of the region's population in this age bracket, with Capital & Coast residents aged 65-plus accounting for 28%.

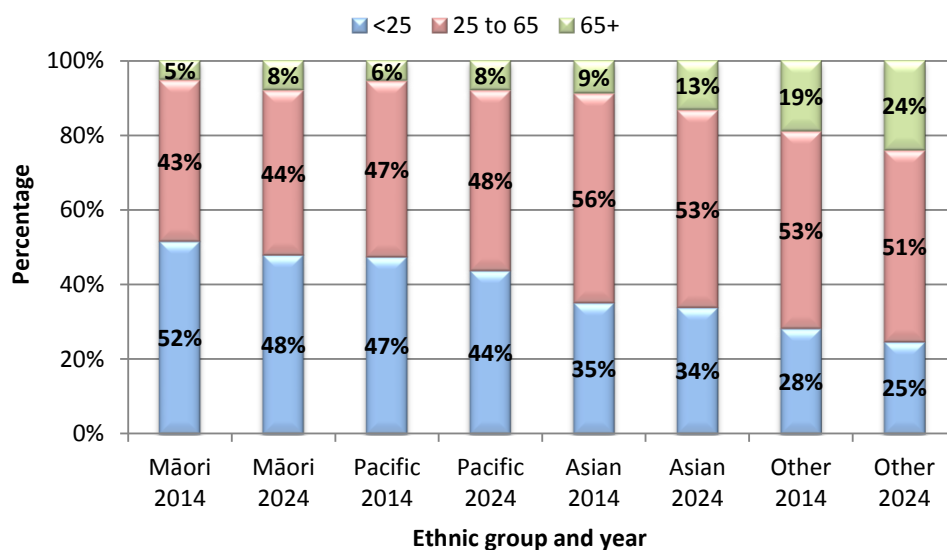
Māori and Pacific peoples have predominantly younger populations than other ethnicities. In 2014 approximately half of the Māori and Pacific peoples' population in the region is under the age of 25 years, compared with 35% for the Asian¹¹ population and 28% for all 'Other' ethnicities. Projections to 2024 suggest

¹⁰ Demographic data is based on population projections released in October 2013 based on the 2006 Census (projections produced by Statistics New Zealand according to assumptions specified by MoH) Unless otherwise specified, data is for the estimated 2014 resident population

¹¹ The Asian ethnicity group is made up of the following ethnicities as defined within the Ethnicity Data Protocols for the Health and Disability Sector 2004: Filipino, Vietnamese, Chinese, Indian, Sri Lankan, Japanese, Korean and Fijian Indian

that the Māori and Pacific peoples populations will continue to be younger compared with the non-Māori and non-Pacific populations.

Figure 2: Central Region Population Distribution by Age Group and Ethnicity (2014 and 2024)



Ethnicity Distribution

The Central Region has a slightly higher proportion of Māori than New Zealand overall (18% and 15% respectively). One in four people in Whanganui and Hawke's Bay is Māori, while the largest proportions of Pacific peoples and Asians reside in the Hutt Valley and Capital & Coast districts. There is a greater number of Asians than Pacific peoples in the region, although the Central Region has a smaller percentage of Asians than New Zealand as a whole (7% versus 12% respectively). The region's Asian population is projected to increase by 26% in the next 10 years; this represents the largest increase amongst all the ethnic groups. The Māori and Pacific peoples' populations are expected to increase by 10% and 8% respectively, while the population group 'Other' will remain steady.

Table 1: Ethnicity Distribution by DHB (2014)

DHB	Māori	Pacific peoples	Asian	Other
Capital & Coast DHB	11%	7%	12%	69%
Hawke's Bay DHB	26%	3%	3%	68%
Hutt Valley DHB	18%	8%	9%	65%
MidCentral DHB	19%	3%	5%	73%
Wairarapa DHB	16%	2%	2%	81%
Whanganui DHB	26%	2%	2%	70%
Central Region total	18%	5%	7%	70%
New Zealand	15%	7%	12%	66%

Gender Distribution

The Central Region has slightly more females than males (51% and 49% respectively). Projections to 2024 indicate a continuation of this trend across the six DHBs and the rest of New Zealand.

Deprivation Distribution

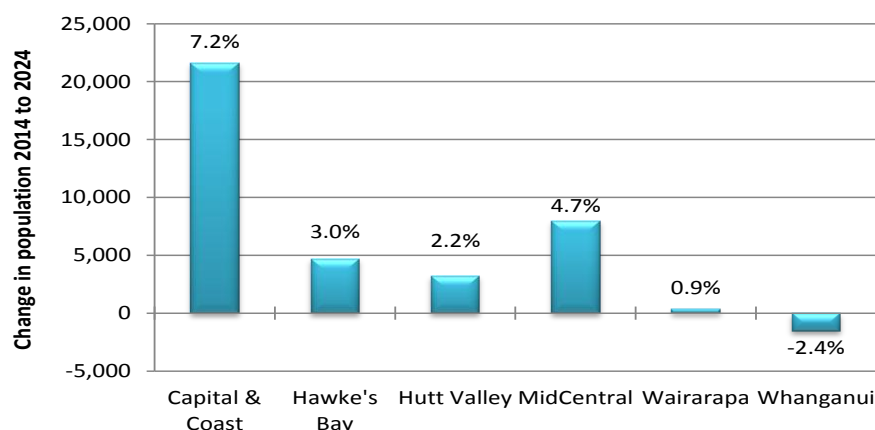
Socio-economic deprivation can be measured via the New Zealand Deprivation (NZDep) Index¹². The contrast between the proportions of people in each DHB area who live in the least deprived quintile (1) and those who live in the most deprived quintile (5) is significant.

Of the six DHBs in the region, Capital & Coast has the highest percentage (31) of people living in quintile 1 (least deprived) and the lowest percentage (15) living in quintile 5 (most deprived). In comparison, 35% of the population in Whanganui DHB live in the most deprived quintile (5). Māori are particularly overrepresented – 53% of all Māori in Whanganui reside in quintile 5. Across all DHBs there are higher proportions of Māori and Pacific peoples in the two most deprived quintiles (4 and 5).

Population Growth

Between 2014 and 2024 the Central Region population is expected to grow by 4.1% to approximately 915,000. This is less than the national projected growth rate of 9.2% and is the lowest of the four regions. Capital & Coast will experience the greatest growth (7.2%) followed by MidCentral (4.7%), Hawke's Bay (3.0%), Hutt Valley (2.2%) and Wairarapa (0.9%). Population numbers are expected to decline by 2.4% in Whanganui.

Figure 3: Projected Change in Population Numbers by Central Region DHB (2014-2024)



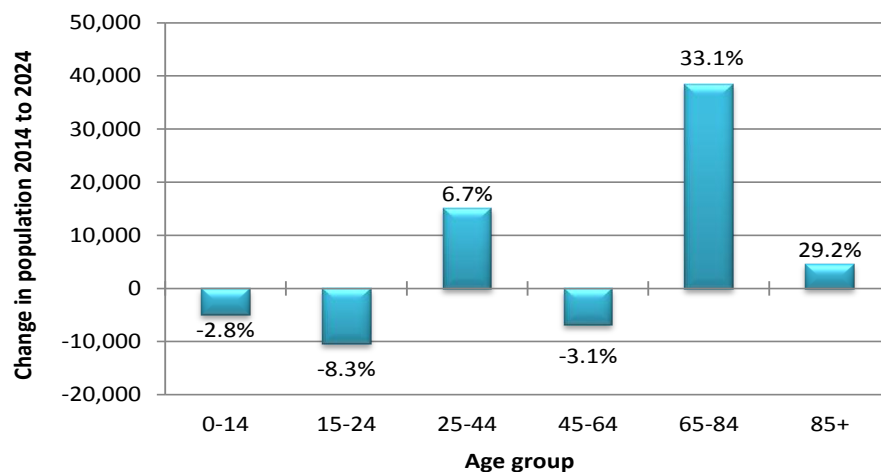
There are marked age group changes of which DHBs need to be aware. There will be more elderly and fewer young people and these trends are expected in each of the region's DHBs. However, changes for the region as a whole differ slightly from those expected nationally.

The age group 65-84 years is expected to grow by 33.1% across the region (this compares with 39.3% nationally) and represents an increase of approximately 38,500 people. The 85-plus age group is projected to increase by 29.2% (4,600 people). There will be 2.8% fewer young people under 15 years of age (approximately 4,900), which is in contrast to the 2.2% increase expected nationally for this age group. The other age group to experience a decrease regionally but increase nationally is 45- to 64-year-olds.

¹² NZDep is derived from variables contained in the Census about factors such as income and employment. All deprivation data in this report is based on NZDep2006

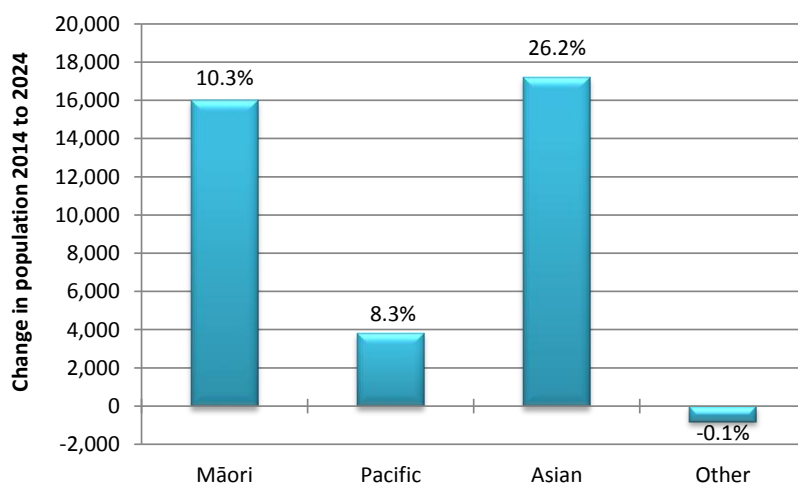
Both regionally and nationally there will be a decrease in people aged 15-24 years. The region's decrease of 8.3% is over twice that projected nationally (3.7%). The region's population aged 25-44 years is expected to experience a percentage increase that is half that expected nationally (6.7% versus 12.7%).

Figure 4: Projected Changes to the Age Distribution, Central Region (2014-2024)



The ethnic composition of the region will become more diverse and there will be more Māori, Pacific peoples and Asians in all six DHBs. The region's Māori population is expected to increase by approximately 16,000 in the next 10 years, a 10.3% increase. The biggest percentage increase will be in our Asian population, 26.2%, representing approximately 17,000 people. The number of Pacific peoples in our region is projected to increase by 8.3% (approximately 3,800). The rest of the population is expected to remain steady.

Figure 5: Projected Changes to the Population by Ethnicity (2014-2024)



Disparities and Inequalities

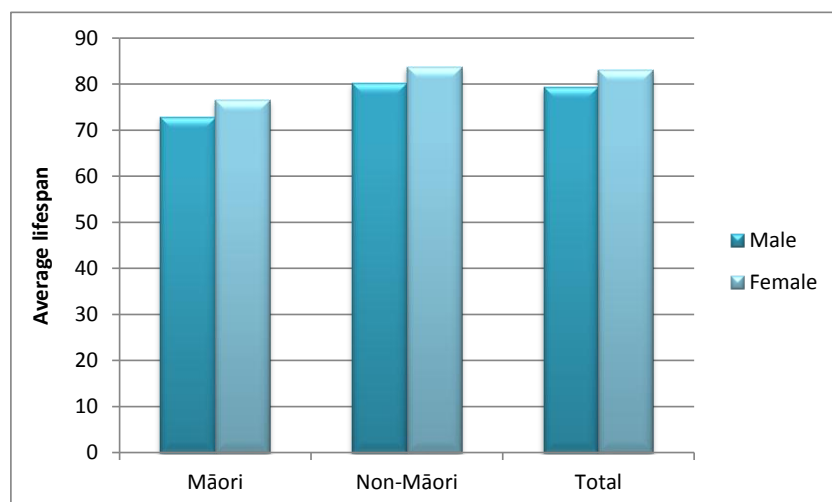
Inequalities in health status exist across our region and relate to age, ethnicity and socioeconomic deprivation. There are variations between different population groups' expectations of (and demands for) health services. We need to improve population health outcomes and reduce inequalities affecting population groups, especially older adults, those with high needs and disabilities, Māori and Pacific peoples and those on low incomes.

An 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 counterparts¹³.

Recent life expectancy data (Statistics New Zealand) shows that while life expectancy continues to improve, gaps remain significant, with a gap of 7.3 years in life expectancy between Māori and other New Zealanders.

Figure 6: Life Expectancy at Birth, 2012



Source: Statistics New Zealand – NZ Period Life Table 2010-12

An 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 expect to live 8.8 years longer than males in the most deprived areas.

Compared with the national population, Māori and Pacific peoples have higher incidences of cardiovascular disease, smoking-related diseases, diabetes and cancer. The national incidence rates illustrated below show the importance of targeted health prevention and promotion to at-risk populations, for example encouraging Māori and Pacific women to participate in breast-screening programmes as well as the need for smoking cessation programmes for the whole population.

Table 2: Selected National Chronic Disease Incidences (per 10,000 population per year)

	Pacific	Māori	Other	Total
Ischaemic heart disease	419	364	331	340
Stroke	318	238	170	179
Diabetes	370	218	79	97
COPD	290	285	102	120
Asthma	135	101	41	51
All cancer	561	617	623	624
Lung cancer	50	84	31	35
Breast cancer	43	56	38	40

Source: NZHS for Ministry of Pacific Island Affairs report on health and Pacific peoples in New Zealand, *Pacific Progress*, October 2011

¹³ *Health Loss in New Zealand: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016* (MoH 2013)

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 Causes

- 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 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 was 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.
- On-going 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.

Appendix B – The Central Region DHB Roadmap Towards 2017

The table summarises the roadmap of the Central Region RSP in the next three years. The focus is on joining up the region's clinicians, clinical systems and pathways to become a more regionally integrated health service. The roadmap has an implementation 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.



	2013/14
SERVICE MODELS AND INTEGRATION Designing new models of care that have a whole-of-system, integrated approach	<p>Integration</p> <ul style="list-style-type: none"> Whole-of-system, integrated care framework implementation commenced and monitored, helping the region to address health inequalities and improve the experience of patients in their care <p>Electives</p> <ul style="list-style-type: none"> Consolidated regional overview of elective waiting lists Regional elective services strategy implemented Acute/Elective pathways are scoped and implemented ESPI compliance targets met Commence implementation of elective pathway in four services <p>Cancer</p> <ul style="list-style-type: none"> Regional cancer services aligned Improved access to and shorter waiting times for cancer treatments; everyone requiring radiation or chemotherapy has treatment in fewer than four weeks <p>Cardiovascular</p> <ul style="list-style-type: none"> Adopt quality improvement software (ANZAC-QI) across the Central Region DHBs to improve service and outcomes from ACS Continue improvement in access to cardiac interventions (which will help towards reducing health inequalities) <p>Stroke</p> <ul style="list-style-type: none"> Improved access to high-quality stroke services: stroke services are credentialed Stroke services are organised to improve acute and rehabilitation stroke services <p>Mental Health</p> <ul style="list-style-type: none"> Service models are reviewed in line with national frameworks, including: youth and adult forensic services, maternal and perinatal health services, eating disorders, maternal and perinatal MH&A services, and older people's mental health services <p>Radiology</p> <ul style="list-style-type: none"> Regionalised approaches to radiology services improve waiting times for CT and MRI and improve the patient experience of care Further sub-regional services established
WORKFORCE Strengthen innovation, new ways of working and the development of sustainable workforces	<ul style="list-style-type: none"> Further review of roster arrangements for acute services Regional elective management teams established Regional Training Hub facilitating professional workforce development A single Resident Medical Officer Unit established – 3DHBs Standardised clinical policies and procedures implemented Clinical skills passports implemented
INFRASTRUCTURE AND ENABLERS Supporting health professionals to better co-ordinate and integrate care	<p>CRISP</p> <ul style="list-style-type: none"> A clinical portal and clinical data repository are implemented, allowing clinicians to access patient information across the region E-referrals and e-discharges facilitate transfers of care across the region E-medicine reconciliation enables GPs to receive medicine reconciliations as part of discharge summaries
QUALITY AND SAFETY Improving the quality of services as a region, reducing waste and harm and improving the patient experience	<ul style="list-style-type: none"> Extend credentialing of regional services Implement the Patient Safety Campaign: reducing harm from falls, medication safety, infection prevention and control, reducing pre-operative harm Embed a regional clinical governance framework within each DHB
GOVERNANCE Good leadership and governance to ensure that the sector is engaged and moving in the same direction	<ul style="list-style-type: none"> Revised regional governance embedded across the Central Region A governance and decision-making function developed for the following regional forums: <ul style="list-style-type: none"> Clinical Board Regional Training Hub Regional ICT Regional Capital Planning
FINANCE AND PRODUCTIVITY	<ul style="list-style-type: none"> Flexible funding models developed to support appropriate service delivery Consistent system approach in place for funding and monitoring regional services Regional IT service developed Regional facilities' management programme developed
	<p>Equity of access</p> <p>←</p>
	<p>Sustainability</p> <p>←</p>
	<p>Consumer participation</p> <p>←</p>
	<p>Clinical engagement</p> <p>←</p>



2014/15	2015-2017
<p>Integration</p> <ul style="list-style-type: none"> Continue to roll out the whole-of-system, integrated care strategy, helping the region to address health inequalities and improve the experience of patients in its care Interdisciplinary teams provide networked health care to people with complex needs <p>Electives</p> <ul style="list-style-type: none"> Regional electives Health Target met Zero patients wait more than four months for FSA or elective treatment by the end of December 2014 A maximum waiting time of four months is maintained from January 2015 onwards (ESIP 2 and ESPI 5) <p>Cancer</p> <ul style="list-style-type: none"> Health Target for patients ready for treatment met Improved waiting times for colonoscopy Strengthened regional relationships and improved service delivery within existing funding <p>Cardiovascular</p> <ul style="list-style-type: none"> More patients survive acute coronary events, cardiac damage from these events is minimised, and the likelihood of subsequent cardiac events is reduced Patients with suspected ACS receive seamless, co-ordinated care across the clinical pathway <p>Stroke</p> <ul style="list-style-type: none"> National consistency is achieved and the following targets met: <ul style="list-style-type: none"> 6% of potentially eligible stroke patients thrombolysed 80% of stroke patients admitted to a stroke unit <p>Mental Health</p> <ul style="list-style-type: none"> Improved access to the range of eating disorder services Improved adult forensic service capacity and responsiveness through the national forensic network Improved youth forensic service capacity and responsiveness Improved maternal and perinatal mental health service options as part of a service continuum Improved MH&A service capacity for people with high and complex needs <p>Major Trauma</p> <ul style="list-style-type: none"> Three-year regional action plan developed to deliver: <ul style="list-style-type: none"> collection and reporting of a nationally consistent major trauma dataset and implementation of local and regional major trauma systems <p>Health of Older People</p> <ul style="list-style-type: none"> Shared learning and resources with the dementia care pathways Raised awareness of the importance and relevance of ACP Raised awareness of polypharmacy with medicine adherence support to enable self-management and reduce risks of adverse events and interactions Developed understanding of the capacity of the specialist HOP workforce to meet current and future service models 	<p>Integration</p> <ul style="list-style-type: none"> There is a sustained focus on the whole-of-system, integrated care strategy, helping the region to address health inequalities and improve the experience of patients in its care <p>Electives</p> <ul style="list-style-type: none"> There is a sustained waiting time of less than four months for an elective procedure in the Central Region There is a tele-health option available and used for elective consultations in the region Waiting lists are managed at a regional or sub-regional level to maximise the total regional resources available <p>Cancer</p> <ul style="list-style-type: none"> Implementation of a bowel screening programme (subject to 2014/15 year) Cancer Nurse Co-ordinator roles developed to support people through the pathway of care and ensure timely access to services Cancer services performing well in line with FCT indicators <p>Cardiovascular</p> <ul style="list-style-type: none"> Services for ACS are organised across sub-regional areas to improve access and improve outcomes, and total capacity for cardiology is shared <p>Stroke</p> <ul style="list-style-type: none"> More people in the Central Region receive access to organised stroke services <p>Mental Health</p> <ul style="list-style-type: none"> There is an integrated service for youth forensic care in the region Addiction services are integrated with mental health services
<ul style="list-style-type: none"> Workforce initiatives that support and address Government priorities are implemented Training resources and shared areas of good practice are consolidated Clinical networks make best use of all skills and resources Plans developed and processes retained for older workers in the workforce Increased Māori and Pacific participation in the workforce Recruitment of hard-to-staff clinical specialties, geographical areas and communities Training settings for entry to practice are identified and implemented The unregulated workforce is developed Support provided to all DHBs to meet the funding criteria of post-entry training in medical disciplines as per 70/20/10% requirements 	
<p>Health facilities</p> <ul style="list-style-type: none"> Health facilities are utilised in line with integrated services <p>E-medicine</p> <ul style="list-style-type: none"> Roll out e-medication management 	<p>CRISP</p> <ul style="list-style-type: none"> One patient portal available for all clinicians <p>E-medicine</p> <ul style="list-style-type: none"> E-medication fully implemented across region
<ul style="list-style-type: none"> Regional network for consumer participation embedded Regional standards for quality audits in place Culture embedded to prevent patient harm and ensure continual quality improvement 	
<p>Electives</p> <ul style="list-style-type: none"> Standardised intervention rates across the region Regional facilities' management programme implemented 	<ul style="list-style-type: none"> Regional management of health facilities across the region progressed
<p>← Equity of access</p> <p>← Sustainability</p> <p>← Consumer participation</p> <p>← Clinical engagement</p>	

Appendix C – RSP 2014/15 Responsibility Matrix

The following responsibility assignment matrix, also known as RASCI matrix, describes the various roles of the Central Region Leadership Framework in completing tasks or deliverables in relation to the Central Region RSP.

R = Responsible

Those who do the work to achieve the task. There is at least one role with a participation type of *responsible*, although others can be delegated to assist with the work required.

A = Accountable

The governance level is ultimately answerable for the correct and thorough completion of the RSP and is the role that delegates the work to those responsible. In other words, an accountable role must sign off (approve) work that the responsible role provides. There must be only one accountable role specified for each task or deliverable.

S = Support

Resources allocated to the responsible role. Unlike consulted, who may provide input to the task, support helps to complete the task.

C = Consulted

Those whose opinions are sought, typically subject-matter experts; and with whom there is two-way communication.

I = Informed

Those who are kept up to date on progress, often only on completion of the task or deliverable; and with whom there is just one-way communication.

RASCI Matrix for RSP 2014/15

	Responsible	Accountable	Supportive	Consulted	Informed
RSP development and benefits' realisation	REC	Regional CEOs	TAS and regional groups and networks	Regional executives	MoH
RSP programme delivery and implementation	REC	Regional CEOs	TAS and regional groups and networks	Regional executives	MoH
RSP programme monitoring and reporting	REC	Regional CEOs	TAS and regional groups and networks	Regional executives	MoH

Appendix D – Unique Characteristics of each DHB

Capital & Coast DHB

Over one-third of the Central Region's population lives in the Capital & Coast area (more than 301,000 people). In the next 10 years most of the region's net growth will be in this catchment with a projected increase of 7.2%.

The DHB is home to 56% of the region's Asian population and this population is projected to grow in the next 10 years by 26%. Nearly half (48%) of the Pacific peoples in the region live in Capital & Coast DHB. While Māori make up 11% of the total population in this DHB, approximately a fifth of the region's Māori population resides within Capital & Coast boundaries. Only Hawke's Bay has a higher number of Māori.

Currently 12% of people living in the DHB are aged 65 and over, the lowest percentage in the region. However, because Capital & Coast is the most populous DHB in the region, 28% of those aged 65-plus across the whole region reside in Capital & Coast DHB.

Of the six DHBs in the region, Capital & Coast has the highest percentage (31) of people living in quintile 1 (least deprived) and the lowest percentage (15) living in quintile 5 (most deprived).

Women living in this DHB bear fewer children in their lifetimes than women in other Central Region DHBs. Life expectancy at birth for both males and females is slightly higher than it is for those in the other DHBs in the region.

Capital & Coast DHB is the region's tertiary referral centre. Its partnering sub-regional DHBs are Hutt Valley DHB and Wairarapa DHB. Capital & Coast and Hutt Valley have the same board chair.

Hawke's Bay DHB

Hawke's Bay DHB includes the Chatham Islands and occupies a land area of 13,543 square kilometres, making it the largest in the region. Its population of approximately 157,000 accounts for 18% of the region's population, and are spread across five territorial local authorities. Net population growth in the next 10 years is expected to be 3%.

With approximately 40,000 Māori people, Hawke's Bay has the largest number of Māori people in the region. People identifying as Māori make up just over a quarter of all people living in the DHB and also make up over a quarter of all Māori living in the Central Region.

17% of people living in Hawke's Bay DHB are aged 65 and over. In the next 10 years this is expected to increase to 22%. However, the percentage of the region's population in this age bracket who live in the Hawke's Bay region will remain steady at a fifth.

This DHB has 15% of its population living in the least deprived quintile, compared with 26% living in the most deprived quintile.

Women living in this DHB have fertility rates that are amongst the highest in the region. The average life expectancy at birth for both males and females is on par with those in most other DHBs in the region.

Hawke's Bay DHB forms sub-regional alliances for specific initiatives as appropriate.

Hutt Valley DHB

Nestled between Wairarapa DHB and Capital & Coast DHB is Hutt Valley DHB, with an area of 916 square kilometres and home to 17% of the region's population (approximately 146,000 people). In the next 10 years population growth is projected to be 2.2%.

By DHB, Hutt Valley has the highest percentage of Pacific peoples (8%) and second-highest percentage of Asians (9%). These two population groups are nearly equal in size (over 12,000). While Hutt Valley's Asian

population accounts for 19% of all Asians in the region, its Pacific population makes up 27% of all Pacific peoples residing in the region. 18% of the people who live in Hutt Valley identify as Māori, this represents 17% of all Māori people in the region.

14% of people living in Hutt Valley DHB are aged 65 and over. In the next 10 years this is expected to increase to 18%. Hutt Valley has approximately 15% of the region's 65-plus population within its boundaries.

This DHB has a quarter of its population living in the least deprived quintile (second-highest percentage in the region) and 22% living in the most deprived quintile.

Women living in this DHB have fertility rates that are the third lowest in the region. The average life expectancy at birth for both males and females is on a par with those in most other DHBs in the region.

Partnering sub-regional DHBs are Capital & Coast DHB and Wairarapa DHB. Hutt Valley and Wairarapa have the same CEO, while Hutt Valley and Capital & Coast have the same board chair.

MidCentral DHB

By land area MidCentral DHB is the third largest in the region and is home to 19% of the region's population (just under 171,000). Like Hawke's Bay it has five territorial local authorities. The number of people residing in this DHB is expected to increase by 4.7% in the next 10 years, the second-highest percentage increase after Capital & Coast.

With marginally fewer Māori than Capital & Coast, MidCentral DHB has the third-largest Māori population in the region. Māori people account for 19% of all people living in MidCentral, and 21% of all Māori in the region. 10% of the region's Pacific peoples reside in MidCentral and 14% of the region's Asian population.

21% of the region's population aged 65-plus reside in MidCentral DHB. In the DHB itself, this age group accounts for 17% of the population in 2014, but will increase to 21% by 2024.

This DHB has 16% of its population living in the least deprived quintile, compared with 22% living in the most deprived quintile.

Women living in this DHB have fertility rates that are the second lowest in the region. The average life expectancy at birth for both males and females is on par with those in most other DHBs in the region.

MidCentral's partnering sub-regional DHB is Whanganui DHB through the centralAlliance.

Wairarapa DHB

Wairarapa DHB is the most rural DHB in the region, with only 76% of the population considered urban. It also has the smallest number of inhabitants, approximately 5% of the region's population (nearing 41,000). Wairarapa's population is expected to increase by 0.9% in the next 10 years.

By DHB, Wairarapa has the highest percentage of people of 'Other' ethnicity (non-Māori, non-Pacific, non-Asian). People identifying as 'Other' make up 81% of all people living in the DHB but just 5% of all 'Other' living in the Central Region.

21% of the people living in Wairarapa DHB are aged 65 and over. This is the highest DHB-specific percentage in the region and is projected to rise to 28% by 2024. However, due to Wairarapa's smaller population, this accounts for just 6% of all 65-plus people in the region.

This DHB has 19% of its population living in the least deprived quintile, and 16% living in the most deprived quintile. While the percentage of people living in the most deprived quintile is the second lowest in the region, the DHB has by far the highest percentage of people living in quintile 4, the second most deprived (30%).

Women living in this DHB have fertility rates that are the highest in the region. The average life expectancy at birth for both males and females is on par with those in most other DHBs in the region.



Wairarapa is part of the 3DHB sub-region, which also includes Hutt Valley and Capital & Coast. Wairarapa and Hutt Valley DHBs have the same CEO.

Whanganui DHB

With a population nearing 63,000, Whanganui DHB is home to 7% of the region's population and occupies a land area that is 3.6 times greater than that of Capital & Coast DHB. This is the only DHB in the region projected to experience a decline in population in the next 10 years. Negative growth of -2.4% is projected.

Over a quarter of the people living in Whanganui DHB identify as Māori, accounting for 11% of the region's Māori population.

In Whanganui DHB the 65-plus age group accounts for 18% of the population in 2014, but will increase to 24% by 2024. 9% of the region's population aged 65-plus reside in Whanganui DHB.

Of the six DHBs in the region, Whanganui has the lowest percentage (11) of people living in quintile 1 (least deprived) and the highest percentage (35) living in quintile 5 (most deprived).

Women living in this DHB have fertility rates that are amongst the highest in the region. Life expectancy at birth for both males and females is slightly lower than it is for those the other DHBs in the region.

The partnering sub-regional DHB is MidCentral DHB through the centralAlliance.

Appendix E – Frequently Used Acronyms

Acronym	Definition
3DHB	Strategic alliance comprising the Capital & Coast, Hutt Valley and Wairarapa DHBs
ACP	Advance Care Planning
ACS	Acute Coronary Syndrome
ANZACS-QI	All New Zealand Acute Coronary Syndrome Quality Improvement
BAU	Business As Usual
BSCC	BreastScreen Coast to Coast
C&CDHB	Capital & Coast District Health Board
CCN	Central Cancer Network
CEO	Chief Executive Officer
COO	Chief Operating Officer
CRCN	Central Region Cardiac Network
CREDS	Central Region Eating Disorder Services
CRISP	Central Region Information Systems Plan
CT	Computed Tomography
DHB	District Health Board
ENT	Ear, Nose and Throat
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 of Human Resources
GP	General Practitioner
HBDHB	Hawke's Bay District Health Board
HBL	Health Benefits Limited
HOP	Health of Older People
HPA	Health Promotion Agency

Acronym	Definition
HQSC	Health Quality and Safety Commission
HVDHB	Hutt Valley District Health Board
HWNZ	Health Workforce New Zealand
ICT	Information and Communications Technology
IT	Information Technology
KPI	Key Performance Indicator
MCNZ	Medical Council of New Zealand
MDHB	MidCentral District Health Board
MDM	Multi-disciplinary Meeting
MH&A	Mental Health and Addiction
MHAN	Central Region Mental Health and Addiction Network
MiAP	Multi Interventional Approach to Polypharmacy
MoH	Ministry of Health
MRI	Magnetic Resonance Imaging
MTNCN	Major Trauma National Clinical Network
NCAMP	National Collections Annual Maintenance Project
NESP	Nursing Entry to Specialist Practice
NETP	New to Entry Practice Nursing
NGO	Non-Government Organisation
NHC	National Health Committee
NHITB	National Health IT Board
PACS	Picture, Archiving and Communication System
PAS	Patient Administration System
PGY	Postgraduate Year
PHO	Primary Health Organisation
REC	Regional Executive Committee
RFP	Request for Proposal
RIS	Radiology Information System
RQSA	Regional Quality and Safety Alliance
RREC	Regional Rehabilitation and Extended Care
RSP	Regional Service Plan

Acronym	Definition
SDP	<i>Rising to the Challenge 2012-2017: The Mental Health and Addiction Service Development Plan</i>
SMO	Senior Medical Officer
TAS	Central Region's Technical Advisory Services Limited
TBA	To be agreed
TIA	Transient Ischaemic Attack
WaiDHB	Wairarapa District Health Board
WhaDHB	Whanganui District Health Board

Appendix F – DHB ICT Initiatives

OUTCOMES: Whanganui DHB ICT initiatives to support delivery of national and regional strategies.			
MEASURED BY: Progress against the plan through Central Region RSP quarterly reporting.			
Projects	2014/15	2015/16	2016/17
Whanganui National Projects			
Finance, Procurement and Supply Chain (HBL)	✓		
Health Identity Programme	✓	✓	✓
Hospital e-Prescribing and Administration		✓	
Maternity Clinical Information System	✓		
National Collections Annual Maintenance Project (NCAMP)	✓	✓	✓
National Patient Flow	✓	✓	✓
Patient Portal			✓
WoG Functional Leadership Mandates			✓
Whanganui Regional Projects			
Hospital e-Pharmacy	✓		
Regional Portal	✓	✓	
Regional PAS	✓	✓	
Regional RIS	✓		
Regional Network	✓		
Whanganui Sub-regional Projects			
HR Performance Management System		✓	
Whanganui Local Projects			
Edge Switch Replacement	✓		
IT Asset Replacement Programme	✓	✓	✓
Ophthalmology System	✓		
Safer Sleep			✓
Electronic Board Papers	✓		
Server 2003 Upgrades	✓	✓	
e-referrals (Primary to Secondary)	✓		
Endoscopy (ProVation)			✓
Website Upgrade			✓
Dental Upgrade (Titanium Web)			✓
WAM/ED Common IT System		✓	
Data Warehouse		✓	
Care Capacity and Demand	✓	✓	
Clinical Care Pathway			✓
Integration with Primary Care Initiatives			✓

OUTCOMES: MidCentral DHB ICT initiatives to support delivery of national and regional strategies.			
MEASURED BY: Progress against the plan through Central Region RSP quarterly reporting.			
Project	2014/15	2015/16	2016/17
MidCentral National Projects			
NCAMP	✓	✓	✓
National Patient Flow	✓	✓	✓
Maternity System	✓		
Dental (CAOHP) – Clinical Software	✓		
e-Prescribing		✓	
Finance, Procurement and Supply Chain Management		✓	
e-Administration			✓
MidCentral Regional Projects			
CRISP – WebPAS	✓	✓	
Hospital e-Pharmacy	✓		
Regional Network	✓		
CRISP – Clinical Portal 1.5 (Core)	✓		
CRISP – Clinical Portal 2.0 (Core)	✓		
CRISP – e-Referrals	✓		
CRISP – Regional RIS	✓		
CRISP – Clinical Portal 2.5 (Enhanced)		✓	
CRISP – Clinical Portal 3.0 (Final)		✓	
MidCentral Sub-regional Projects			
HR Performance Management (centralAlliance)	✓		
MidCentral Local Projects			
Server Replacements	✓	✓	✓
Web Development: Yearly Changes	✓	✓	✓
Network, Telephony, Wireless	✓	✓	
Fibre, Cabling, Cabinets, UPSs	✓	✓	
Business Intelligence/Data Warehouse	✓		
Storage Area Network (2013)	✓		
Server Replacements: Physical to Virtual	✓		
Patient Flow Operations Centre	✓		
Sterile Services Tracking System	✓		
e-Chemotherapy	✓		
Web Development: DMS	✓		
e-Referrals – Primary to Secondary	✓		
Service Desk Upgrade	✓		
IT Building Alterations		✓	
Desktop Virtualisation			✓

OUTCOMES: Hawke's Bay DHB ICT initiatives to support delivery of national and regional strategies.			
MEASURED BY: Progress against the plan through Central Region RSP quarterly reporting.			
Project	2014/15	2015/16	2016/17
Hawke's Bay National Projects			
Common Operating Environment (Upgrade from Windows XP and Office 2003)			
Finance, Procurement and Supply Chain (HBL)		✓	✓
Health Identity Programme			
Hospital e-Prescribing and Administration	✓	✓	
Maternity Clinical Information System		✓	✓
NCAMP	✓	✓	✓
NPF	✓	✓	✓
Hawke's Bay Regional Projects			
CRISP Phase One	✓		
Provision of WebPAS to CRISP Phase One	✓		
Move to Regional WebPAS HBDHB			
Move to Regional WebPAS Whanganui and MidCentral	✓		
Clinical Portal 3	✓		
Move to Regional RIS Platform	✓		
Move to Regional PACS Archive	✓		
Hospital e-Pharmacy		✓	
Regional Network	✓	✓	✓
Hawke's Bay Local Projects			
Transform and Sustain Initiative Alignment	✓	✓	✓
CapPlan			
Hub Maintenance	✓	✓	✓
Hub Upgrade	✓	✓	✓
Network Infrastructure Upgrade	✓	✓	✓
Network Maintenance	✓	✓	✓
PC Replacement	✓	✓	✓
Server Replacement	✓	✓	✓
Wireless Upgrade			
Managed Mobility	✓	✓	✓
Voicedata Network Phase 1			
Videoconferencing Strategy Development and Implementation of Solutions	✓	✓	✓
COE Utilisation of New Tools and Processes	✓	✓	
Implementation of ProVation			
Support New Facility Builds, Wairoa, NHC, Mental Health, Maternity and Endoscopy Suite	✓	✓	
Clinical Care Pathway Implementation	✓		
Integrated Urgent Care Project	✓		
Integration with Primary Care Initiatives	✓	✓	✓

OUTCOMES: Capital & Coast DHB ICT initiatives to support delivery of national and regional strategies.			
MEASURED BY: Progress against the plan through Central Region RSP quarterly reporting.			
Projects	2014/15	2015/16	2016/17
Capital & Coast National Projects			
Common Operating Environment (Upgrade from Windows XP and Office 2003)	✓		
Exit Server 2003	✓		
Finance, Procurement and Supply Chain (HBL)	✓		
Cardiothoracic Database			
Hospital e-Prescribing and Administration		✓	✓
Maternity Clinical Information System	✓		
National Patient Flow	✓	✓	✓
NCAMP	✓	✓	✓
Capital & Coast Regional Projects			
CRISP Phase One (RIS & CP)	✓	✓	
Internal FSA	✓		
Emergency Department System Replacement (webPAS)	✓	✓	
Theatre System Replacement (webPAS)	✓	✓	
Pharmacy Information System	✓		
Regional Network	✓		
Security and Identity	✓		
Capital & Coast Sub-regional Projects			
Implementation of Ops Centre	✓	✓	✓
Winscribe Upgrade	✓		
Capital & Coast Local Projects			
Cath Lab XIMS Application Software/Hardware Upgrade	✓		
Disaster Recovery Programme	✓		
Local PACS Upgrade	✓		
Documents into Clinical Document Repository	✓		
Intranet Upgrade		✓	✓

OUTCOMES: Hutt Valley DHB ICT initiatives to support delivery of national and regional strategies.			
MEASURED BY: Progress against the plan through Central Region RSP quarterly reporting.			
Projects	2014/15	2015/16	2016/17
Hutt Valley National Projects			
National Patient Flow	✓	✓	✓
Finance, Procurement and Supply Chain (HBL)	✓		
Colposcopy	✓		
Endoscopy	✓		
Hutt Valley Regional Projects			
CRISP Phase One	✓	✓	
Ubook	✓		
e-Prescribing and Administration and e-Medicines Reconciliation		✓	✓
Pharmacy Information System	✓	✓	
Hutt Valley Sub-regional Projects			
3DHB Infrastructure Consolidation (Citrix Farm)	✓		
Common Operating Environment (Upgrade from Windows XP and Office 2003)	✓		
Implementation of Ops Centre	✓	✓	✓
Scanning to Clinical Data Repository	✓	✓	
NCAMP	✓	✓	✓
Exit Server 2003	✓		
Regional Public Health Programme	✓	✓	
Hutt Valley Local Projects			
District Nursing			
IBA/Concerto/Dental Interface			
MS SQL Upgrade	✓		
Community Radiology	✓	✓	✓



OUTCOMES: Wairarapa DHB ICT initiatives to support delivery of national and regional strategies.			
MEASURED BY: Progress against the plan through Central Region RSP quarterly reporting.			
Projects:	2014/15	2015/16	2016/17
Wairarapa National Projects			
Common Operating Environment (Upgrade from Windows XP and Office 2003)	✓		
Exit Server 2003	✓		
National Patient Flow	✓	✓	✓
Finance, Procurement and Supply Chain (HBL)	✓		
Hospital e-Prescribing and Administration		✓	✓
NCAMP	✓	✓	✓
Wairarapa Regional Projects			
CRISP Phase One	✓	✓	✓
Telehealth		✓	✓
Pharmacy Information System	✓	✓	
Wairarapa Sub-regional Projects			
PAS Replacement	✓		
Winscribe Upgrade	✓		