Northern Region

Health Plan

2015/16

Foreword

This is our fifth regional plan. Over past years we have seen demonstrable improvements in our health services, with more patients getting better access to care, and care which is more consistent across our region as well as being safer and more efficient. Successful innovations are shared and adopted more quickly across our region. Our clinical leaders are driving strategic service change. These improvements give us the confidence that we are focussing on the right things to really make a difference for our population.

This year we continue to highlight child health, inequalities in health outcomes, and health of older people for particular attention. In addition, we have placed a strong focus upon regional informatics in this year's work plan. Our intent is to further align DHB IS plans and to clarify the path to achieve a Northern Electronic Health Record.

Many of our focus areas will require greater integration across the community-hospital interface. As in prior years, our Alliance Partners will remain critical to the successful delivery of the Northern Region Health Plan.

Our Regional Governance Group is committed to the regional process and applauds the gains made so far. We are proud of the work and dedication shown by our clinical networks and clinical leaders and commit our ongoing support to them as we work to achieve the ambitious targets set for 2015/16.

Geraint Martin
Chief Executive
Counties Manukau District Health Board
NRHP Executive Sponsor

Margaret Wilsher
Chief Medical Officer
Auckland District Health Board
NRHP Clinical Sponsor

Tony Norman
Chair
Northland District Health Board

Lester Levy
Chair
Waitemata District Health Board
Auckland District Health Board

Lee Mathias
Chair
Counties Manukau District Health Board

Nick Chamberlain
Chief Executive
Northland District Health Board

Dale Bramley
Chief Executive
Waitemata District Health Board

Ailsa Claire
Chief Executive
Auckland District Health Board

Mr Geraint Martin
Lead Chief Executive Officer for Northern Region District Health Boards
Counties Manukau District Health Board
Private Bag 94052
Manukau 2240

Dear Mr Martin

Northern Region 2015/16 Regional Service Plan

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

Good progress has been made with regional planning this year, particularly in relation to the alignment between the DHB Annual Plans and RSPs. However, we must continue to strengthen this alignment in the future if we are to achieve the best use of resources.

As greater integration between regional DHBs supports more effective use of clinical and financial resources, I expect DHBs to make significant progress in implementing their RSPs during 2015/16 and to continue to work together to ensure service sustainability within the Region.

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

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

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

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc   DHB Chairs and Chief Executive Offices in the Northern Region

Contents

Appendices

Executive Summary

Introduction

The Northern Region Health Plan is intended to improve health outcomes and reduce disparities for the 1.7 million people living in the Northern Region.

Developed under our regional governance structure, with significant contributions from the Region's clinical networks, clinical governance groups and other regional workgroups, the Northern Region Health Plan represents the thinking of clinicians and managers from both our hospital and community settings. This plan is founded upon working together as a region to provide health care that makes best use of available resources, is sustainable, and improves access to services.

This is the fifth regional plan. Over past years we have seen demonstrable improvements in our health services, with more patients getting better access to care, and care which is more consistent, safer and efficient. Successful innovations are shared and adopted more quickly across the region. Our clinical leaders are driving strategic service change. These improvements give us the confidence that we are focussing on the right things to really make a difference for our population.

At the same time we continue to have significant challenges ahead. The relentless demand on health services, particularly from the growth in chronic diseases and the health needs of our aging population, poses a major challenge in a fiscally constrained environment. Enabling our regional workforce to share and use information across the care continuum is also critical to the effective and efficient delivery of services and touches upon every area of health care.

This plan outlines a series of initiatives for the next three years with a particular focus on those actions we expect to deliver in each quarter of 2015/16. Regional informatics is a major focus in this year's work plan; to further align DHB IS plans and to clarify the path to achieve a Northern Electronic Health Record [NEHR].

The informatics programme of work is ambitious. We are fully committed to:

- Meeting national informatics expectations as outlined in the Ministry Guidance for Regional Plans
- Progressing our regional priority informatics initiatives.

The Northern Electronic Health Record Implementation Planning Study [IPS], due to report initial findings by December 2015, will clarify the potential impacts of an implementation upon existing plans. This includes areas where a NEHR implementation could touch upon any informatics areas that we have flagged in this Northern Region Health Plan as needing attention over the next three to five years. Until the NEHR IPS is completed, and an approval decision is taken to proceed with a NEHR implementation, it is premature to try to detail the potential impacts; other than to note that IS/IT projects focussed on development work that cross multiple systems and interfaces may well be affected. Our regional informatics workplan has taken this into account, in terms of:

- Not prioritising areas of investment for 2015/16 in areas that that we currently understand are highly likely to be affected by a NEHR implementation
- Establishing a Regional Informatics Governance Group that will:
  - Review the regional informatics plan on a quarterly basis, to ensure that the informatics priorities reported in our IS/IT work plans remain valid as work progresses on the NEHR IPS project

     o   Ensure that any questions regarding the appropriateness of any planned investments are identified and addressed as we gain greater clarity through the NEHR IPS work.

The Northern Region Context

Meeting Minister's expectations

The Northern Region operates as part of the national health system. Our plan reflects national priorities and the Minister of Health's expectations of continuing the focus on shaping services to deliver care closer to home within constrained funding increases. The Minister expects that DHBs and regions will focus on:

- Fiscal discipline and management of health services
- Strong clinical leadership and engagement in service design and budgeting
- Integration between Primary and Secondary Care
- National Health Targets
- Tackling key drivers of morbidity
- A renewed focus on strategic direction.

Five key drivers of change

The Northern Region is facing significant pressures which are reflected as five key drivers of change. Information accessibility and sustainability has increasingly become recognised as a 'sixth' driver of change for our region.

Figure 1 : Northern Region - Key Drivers for Change
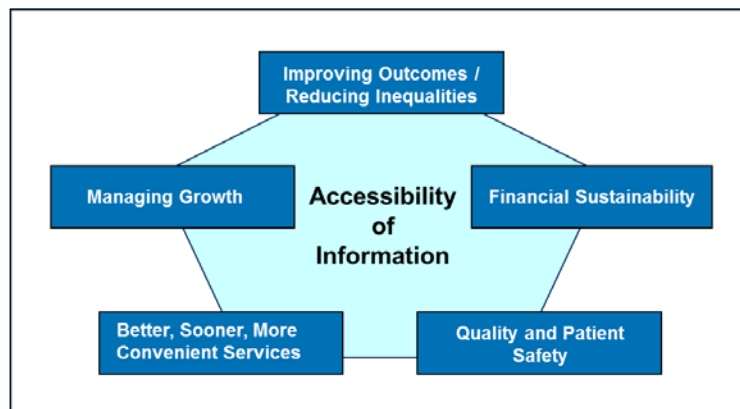
It is not sustainable to continue to deliver health services as we do currently

The way we currently deliver services is not sustainable. Our estimates indicate that the region's population will grow by around 500,000 people over the next 20 years. To serve this demographic growth, our region would need approximately 75 -100 additional beds per annum over the next 20 years if the future service delivery mix was to be similar to that currently delivered. The solution requires new ways of thinking and better information and connectivity across the health sector.

Our Direction

The agreed direction for our region is set out in the Northern Region Charter.

Figure 2 : Northern Region Direction
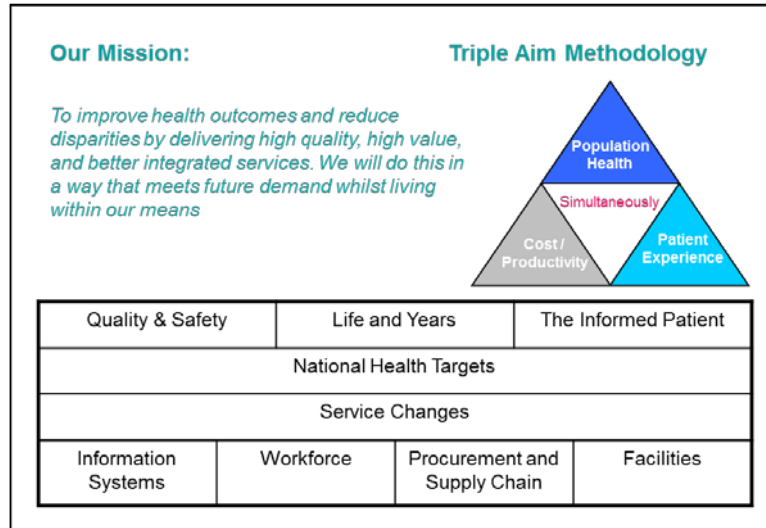
This plan builds on a strong history of regional collaboration in which our four DHBs have invested over the last decade. We have the foundation blocks in place, with clinical networks and clinical leaders appointed to lead the work associated with our priority goals. The emphasis is on achieving gains for the health of our population, in line with regional and national directions and ensuring the 'enablers' of service delivery (information systems, workforce, procurement and supply chain and facilities) are aligned with the direction of our regional travel.

This regional plan focusses on a small number of areas where we believe we can make the greatest impact. By getting these areas right, we will be in a better position to assure the sustainability of our health system over the next 10 to 20 years.

Our Priority Goals

This year we will be placing special emphasis upon regional planning with regard to information systems as an 'enabler' of services and, in particular, undertaking work to:

- Update the regional strategic plan for information systems development,
- Undertake an Implementation Planning Study [IPS] regarding the Northern Regional Electronic Health Record [NEHR].

There will also be a strong focus on clinical integration between, and within, hospital and community based services. Our clinical networks will continue to be critical to clinical engagement as we progress the regional work. The clinical networks are a key regional mechanism to drive change, and to design and implement new initiatives. They also provide a point of engagement to contribute to the regional information systems work.

The success of the priorities outlined in this plan will also depend on primary care to implement new initiatives and ways of working. We are continuing to work with our primary care Alliance Partners and networks to align strategic intentions.

The Northern Region clinical network focus areas, signalled in this plan, remain largely the same as in previous years. There will be a continuing strong regional focus to achieve gains in three priority service delivery areas: Child Health; Inequities and Inequalities; and Health of Older People.

In this year's NRHP we will continue to progress three key goals for Regional gains:

- Goal One - Quality and Safety; Reducing harm and improving patient safety

- Goal Two - Life and Years: Reducing disparities and achieving longer, healthier and more productive lives

- Goal Three - The Informed Patient: Ensuring patients are better informed about care and treatment choices and healthcare providers are better informed about patient's care preferences, particularly around end of life care.

Goal One: Quality and Safety

A strategy to improve the safety of patients in our care

Quality of service and patient safety is a priority for the Northern Region. There is clear evidence that certain interventions, if systematically applied, will save lives and money and prevent harm to patients.

The Northern Region has been progressing a regional campaign of *First, Do No Harm,* focussed on improving the quality and safety of our health system. Our work plan has been aligned with the Health Quality & Safety Commission's patient safety campaign *Open for better care.*

We will work collaboratively with our DHB and HQSC partners to transition from the *First, Do No Harm* campaign to a sustainable structure for continuing a regional systems approach, involving consumers as partners in this work, and targeting areas of high incidence of harm.

Over 2015/16 the focus of activities to achieve our Regional Quality and Safety Goal will be on:

- Sustaining improvements already achieved
- Developing structure and process to support regional collaboration
- Delivering the national campaign objectives.

Goal Two: Life and Years

Targeted approaches to address the incidence of diseases on our population

We are adopting a targeted approach with specific initiatives to improve health outcomes for our most vulnerable populations.   The achievements we expect from this approach are to:

- Reduce the wide inequalities in health status and life expectancy, particularly for Māori and other groups

- Slow the growth in incidence of disease and ill health in our population, and with that, the demand on our health services

- Reduce the acute demand growth in our hospitals and increase services provided in primary and community settings

- Improve the consistency in access, quality of care, and safety

- Utilise our region's intellectual and physical resources more effectively.

Three particular areas of work will be emphasised by the Northern Region this year:

- **Child Health**

  The 2015/16 plan for Child Health focuses on themes where regional activity will create significant gain, often across more than one priority health area.

  Key themes include:

  - o 'Knowing every child': enhancing systems of enrolment for effective engagement with universal healthcare
  - o Informing families: using consistent health promoting messages regionally
  - o Enabling clinical teams: to deliver health care to those with highest need through supporting models of care and evidence-based approaches
  - o Advocating for the child: through coordinated regional approach and active inter-sectoral relationships

  Work streams under each of these themes will improve child health outcomes.

- **Inequities and inequalities amongst Māori, Pacific, and other groups**

  Our population is made up of many ethnicities, however not all our population groups have equitable access to health and disability services, and there are significant inequalities in the health status of particular groups. Past efforts by health services have resulted in some improvement in health for Māori, but have not closed the gap between Māori and non-Māori. This year we will continue the increased regional focus on inequalities and support DHBs and our clinical networks by:

  - Enhancing the reporting against the Māori health dashboard

  - Focussing on three areas for local and regional action for Māori:

    - o Workforce development; to support more Māori and Pacific into health careers, professional development for potential leaders and training of our workforce in cultural competency

    - o Diabetes, cardiovascular disease, oral health and childhood obesity

    - o Tobacco control.

  Equality in health remains a goal of our health services. Achievement of this longer term goal will depend on addressing the upstream determinants of health while encouraging at-risk populations to access health services and to make personal changes that will impact upon their own health status.

- **Health of older people**

  The demand that older people place on our health system is enormous and growing. Older people comprise between 11%-18% of the population

in our DHBs. In our region about 28% of patients discharged from our hospitals are over 65 but about 41% of our hospital inpatient beds are typically occupied by patients over 65 years old. There are significant differences in how we deliver care for our older people. Furthermore, the way we currently care for our older people does not always best meet their needs, nor are services always delivered in a way they would prefer.

This year, we will refocus our efforts on initiatives which have proven to be more effective at reducing demand. This includes:

- o Concentrating on disease specific initiatives, such as dementia and psychogeriatric care to best meet the growing demand and better support people in the community
- o Implementing more quality and safety initiatives across aged residential care and acute hospitals to reduce the incidence of falls and pressure injuries
- o Strengthening clinical governance for residential care and InterRAI.

We are emphasising these three areas of work as we believe we can make significant gains by working together as a region. All aspects of these workstreams will have strong regional oversight aligned to the heightened regional emphasis. Our overarching goal is to support our older people to be well and to live healthy independent lives.

Seven other regional workstreams will also deliver improved outcomes for our population

Work will also continue on the seven other workstreams which fall within the Life and Years goal category. The focus of each of these areas is:

Cancer: Implement the Northern Region Cancer Strategy to support a tumor stream approach, achieve faster cancer treatment, improve the functionality and coverage of multi-disciplinary meetings, progress a regional non-surgical patient management system, and develop services for specific cancer care such as colonoscopy, radiation and chemotherapy treatments, and continue to support the bowel screening pilot.

Cardiovascular disease: Continue to provide oversight of cardiac surgical waiting list and maintain the delivery of surgery measures already achieved. Improve access to echo-cardiogram and implementation of Accelerated Chest Pain pathways (as per the Minister's Health report).

Diabetes: Increase the capability of the Region to detect untreated diabetes patients in the community, including identification of diabetic patients through the CVD risk assessment tool, better management of high-risk feet and working with primary care to improve the rate of insulin initiation. Progress improvements by Regional Public Health initiatives including the Regional Obesity project.

Major Trauma: Continue to build on progress for this new priority to implement a formal trauma system in the Northern region. The network will strengthen clinical governance, improve data collection and analysis, and the consistency of care across pre-hospital and hospital services.

Mental Health and Addiction: Progressively implement changes to the eating disorders model of care, improve capacity and responsiveness of: adult and youth forensic services; and services for people with high and/or complex needs

Stroke: Strengthen regional efforts to improve timely access to acute and post-

acute stroke services, develop and implement pathways for patients at risk of stroke, and progress stronger cross sector collaboration amongst providers of primary and secondary stroke service.

Youth Health: Explore new ways of working to provide more youth friendly services and the workforce to deliver these services. With a particular focus on: mental health (aligned to the Prime Minister's Youth Mental Health Project); school based health services and access to primary care services.

All workstreams will monitor and report against performance measures to demonstrate health gains for our population.

Clinical leadership and partnership to enable gains

With strong clinical leadership and focus, and the participation of our primary care partners, we expect to realise material improvements in health outcomes for our population:

- **In the short to medium term** to achieve greater consistency and broader adoption of initiatives which have been effective in one or two DHBs. This is expected to improve the 'process' performance measures

- **In the longer term** to embed new ways of working to slow the rate of growth, so that actual demand is lower than the projected demand, acknowledging that the impact of the initiatives implemented now will be observed over a 10-20 year timeframe.

We recognise that our ability to achieve lower rates of disease and admission to hospitals will rely on a number of factors, some of which are within health services control, and some of which are broader societal influences such as socioeconomic status and education. We will focus on the factors which are within our control, such as delivering leading practice and consistent health care, and continue to advocate for changes in the other areas in line with national directions.

Goal Three: The Informed Patient

Engaging with our patients in a different way to enable them to make choices about their care

The objective of this goal is to achieve greater patient participation and improved health care through patients being better informed across the full health spectrum; from prevention and early diagnosis to better treatment of disease. Effective consumer engagement and health literacy are both seen as important in this context.

Enabling and encouraging patient and whānau self-directed care extends throughout all areas of our plan. The themes of enhancing self-directed care, individual ownership and responsibility are being developed within our regional work areas, particularly those relating to:

- Goal Two - Life and Years

- Enablers - IS/IT.

In addition we are targeting Advance Care Planning as one specific regional action against Goal Three.

Advance care planning aims to ensure patients and whānau/families are better informed about future care and treatment choices and healthcare providers are better informed about patient's care preferences, particularly around end of life care. This year we intend to continue to increase the number of advance care plan conversations that take place in our region. Training of the health workforce will also continue. We plan to increase public and health staff awareness of Advance Care Planning with consumer and wider community engagements being

scheduled during the coming year.

These initiatives will support patients and their whānau/families to make choices about their care.   We expect this to enable a greater and more meaningful level of engagement. We also expect more patients, and their families to be able to plan how and where they die.

We are committed to achieving our Top 10 targets in 2013/14

Achieving Our Targets

We have identified and are committed to achieving ten targets which measure our success in achieving our priority goals.

Table 1 : Top 10 Patient-Focussed Regional Commitments for 2015/16

All Interventions

1. Achieve and maintain the Minister's health targets

Quality and Safety

2. Maintain falls causing major harm in the acute sector to a rate of less than or equal to 0.10 per 1000 patients days

Life and Years

3. Consistent clinical measurement tool for child health growth and obesity available across the region (establish consistent baseline measurement)
4. 95% of General Practices will be enabled to utilise the Northern Region Cognitive Impairment Pathway (baseline measurement of the % application of the pathway to be progressed alongside the roll-out)
5. 80% of patients who have a stroke are treated in a stroke unit
6. 80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes[1]
7. 85% of patients receive their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016. (in 2015/16 demonstrable improvement towards July 2016 target of 85%)
8. Establish consistent measures and baselines for access to youth forensic services for each of the three service elements – court liaison, CYF youth justice residences and community
9. 37,000 patients undergo retinal screening

The Informed Patient

10. A 20% increase on the 2014/15 end of year ACP conversations documented by each of the four DHBs

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[1] There may be some variation for patients from NDHB due to geographical isolation and dependence on emergency helicopter transport.

Service Planning

A service planning framework has been developed to support decisions around the configuration of services across the region. We will continue to progress work to improve regional collaboration for two particular services:

- Radiology: Addressing the Sonography workforce shortage is a key priority with several initiatives planned and underway to increase trainee numbers and recruitment. We will continue to develop and embed service models for sub-speciality services. Development of a regional radiology information systems strategic plan, aligned to other IS planning taking place in the region is also a priority.

- Elective services: Our region will maintain the gains in the efficiency and productivity of the region's elective services, including patients receiving first specialist appointments and treatment within 120 days of referral and decision to treat, respectively.

In addition to these particular service areas, we will also continue to progress other service development work to shape how our services are structured and delivered within an environment of greater regional co-operation. During the 2015/16 year this service development workplan will:

- Complete the successful transition to a single location of service for acute spinal cord impairment,

- Progress the Sexual Health Review implementation.

Enablers

We need to strengthen regional collaboration emphasising four key enablers.

Information Systems

Information systems are fundamental to the Northern Region's ability to deliver a whole of system approach to health service delivery.

A key clinical driver for our region is to improve the continuity of care for patients across primary, secondary and tertiary care. This relies on consistent and reliable access to core clinical information for all clinicians involved in a patient's care; an electronic health record.

Our information system developments will align with national and regional information strategies and be a key enabler for us to achieve our clinical and business objectives.

The region has been progressively implementing IT capital investment plans. Multi-year capital investment plans have been developed for:

- The ICT (ICT Capital Spend) maintenance and replacement programme of work progressed by healthAlliance (within depreciation and 'carry forward' funding plus 'top-up' funds)
- Business transformation (Non ICT Capital Spend) programmes progressed by the region as new 'strategic' investment.

The development of an integrated Northern Electronic Health Record is a

particularly significant IS/IT initiative for our region.

The immediate aim of the Electronic Health Record project is to identify the best way to progress the *'person-centric, regional electronic health record that will be shared by, and will integrate between the key stakeholders in a person's care'[2]*.

At a forum held in February 2015 senior DHB, healthAlliance, NRA, Primary Care and Consumer stakeholders sought to align common opportunities across various strategic IT initiatives and concluded that:

- We need to accelerate progress towards implementing a Regional Electronic Health Record
- A new approach to implementing whole of system regional informatics capability is required across the region
- A key component of the new approach is an Integrated Regional Electronic Health Record (consolidation of existing PAS and Clinical Systems with interfaces to a limited number of specialised systems) to support significant business and technology drivers across the region
- The integrated approach represents a change from an incremental specialised system approach previously adopted by the region.

In order to ensure there is robust governance and streamlined decision making over IS regionally, the Northern Region is implementing a revised IS governance framework. A Regional Informatics Governance Group (IGG) comprising senior representatives from each DHB, health Alliance, primary care and consumers will report directly to the Northern Region CEO/CMO Forum.

The Northern Region DHBs and healthAlliance are committed to working closely with the National Health IT Board to ensure that regional capital investment plans are aligned with national priorities and programmes of work.

Workforce

We need to develop support and strengthen our workforce to meet the long term needs of our region

The total combined clinical, technical, clerical and other workforce in our region is around 27,000 employees representing 36% of the total workforce across all DHBs. The 2015/2016 Workforce plan has seven objectives aligned to both HWNZ strategies and local DHB activity:

- Strengthen clinical leadership and management capability throughout the workforce
- Grow the capacity and capability of our Māori and Pacific workforce
- Increase the flexibility and affordability of the workforce to manage rising demand
- Build and align the capability of the workforce to deliver new models of care
- Optimise the pipeline and improve the sustainability of priority workforces
- Adopt a regional approach to developing an engaged and capable workforce.
- Optimise the capacity and capability of the RMO workforce

In addition, we will continue to develop the Workforce and Training Hub to better support the post graduate workforce aligned with the health sector. The initiatives undertaken by the Northern Regional Alliance and DHBs have an immediate focus to resolve short term issues, and a long term focus to ensure the region has a workforce which is sustainable and fit for purpose.

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[2] As outlined in the RIS 10-20 vision

Procurement and Supply Chain

Procurement will generate value and savings for the Northern Region through economy of scale and negotiation of deals with suppliers. The focus will be to strengthen the category management approach, common data structures and common data banks. This will enable optimised gains and leverage the scale of the Northern Region.

We will also continue to progress clinical product coordination support ensuring that all products entering the hospital meet regulatory requirements.

Facilities and Capital

We understand the implications of recent economic signals and are planning our capital developments accordingly. We will continue to strengthen our regional mechanisms to ensure rigorous challenge of our capital plans. We will invest in capital developments that fit within a framework of change that prioritises changes to models of care and the better use of information and technology. As part of our renewal and replacement we will ensure decisions make the best use of regional resources.

During the coming year we will undertake regional work to:

- Refine DHB capital plans with a particular emphasis on IS/IT capital budgets
- Meet the capital planning requirements of the Ministry of Health and The Treasury and will work with both these entities on the Health Capital Review
- Progress DHB proposals for capital projects in line with National Health Board Capital Investment Committee [NHB CIC] and Treasury's Better Business Case requirements.

The Way Forward

Delivery of the initiatives outlined in this plan requires strong governance and the participation of a wide range of stakeholders and organisations. Leadership will ensure an integrated approach to the delivery of services and close alignment of different organisation's goals. Broadly, this means that:

- DHBs will continue to take the lead in assessing the health needs of their populations and funding services to meet their needs. They will continue to deliver predominantly hospital and community specialist services. DHBs will also support whole of system planning and integration in partnership with locality groups, primary care Alliances, and non-government organisations [NGOs]. DHBs also have a role providing oversight of the regional work program

- Clinical Networks will drive strategic and tactical planning with regard to specific areas of their clinical subject matter expertise and will deliver, and support others to deliver, the priority regional initiatives as outlined in this plan. The Networks cross DHB boundaries and engage with community partners, NGOs and consumers. The Networks will monitor key performance measures

- The three District Strategic Alliances that have been established to strengthen relationships with primary care and enhance service delivery integration are critical to the delivery of the plan. The District Strategic Alliance Partners and locality teams, including NGOs, will be the key mechanism to drive changes to clinical practice in primary care and

across the community setting. This will include delivering a greater breadth of services locally and supporting high-needs patients to prevent acute and unplanned admissions, and for older people to live independently

- The District Strategic Alliances will develop more clinical pathways and will implement initiatives that align with the key goals of reducing acute demand, supporting the development of clinical pathways and better management of targeted individuals

- The Northern Regional Alliance will lead the delivery of the health service, and workforce regional activities as outlined in this plan

- The Regional Informatics work to develop the plan for the Electronic Health Record will be managed as a specific project of work with close engagement of the NRA, DHBs, and hA via their CIOs and executive teams

- healthAlliance will lead the work associated with enhancements to delivery of core information, communication and technology [ICT] systems as well as progressing the Procurement & Supply Chain enablers as outlined in this plan.

A strong programme management framework is in place to ensure effective delivery of this plan.

As a sector we also need to develop our collective ability to more accurately assess what works and provides value for money. This particularly applies to the achievement of health gains for the whole population; but especially for our Māori, Pacific and other high need groups at the preventative, early identification and management end of the continuum of care.

Region wide engagement and commitment to this plan

We commit to achieving better outcomes for our population

The region is committed to this plan. Implementation will require strong leadership and confidence across all sectors and regional agencies. The region's leading clinicians have prioritised those plan initiatives where significant gains can be made, and which are feasible to achieve and measure.

The Northern Region is committed to meeting national expectations as outlined in the Ministry Guidance for Regional Plans.

1. Introduction

Addressing National and Regional Requirements

This plan is consistent with accountability frameworks and the Minister's expectations

This Northern Region Health Plan provides an overall framework for regional work and builds on previous years' gains to demonstrate how the Government's objectives and the region's priorities will be met during 2015/16 and beyond.

The plan has been developed under our Regional governance structure with significant contributions from the Region's clinical networks, clinical governance groups and other regional workgroups. This Northern Region Health Plan represents the thinking of clinicians and managers from both our hospital and community settings. This plan is founded upon working together as a region to provide health care that makes best use of available resources, is sustainable, and improves access to services.

The Planning Environment

This plan is consistent with the planning, funding and accountability frameworks that apply across the public sector.

Under the New Zealand Public Health and Disability Amendment Bill (2010), Regional Service Plans are the medium term (5 - 10 years) accountability documents for DHBs. Regional Service Plans are designed to provide a mechanism for DHBs to document regional collaboration efforts and to align service and capacity planning in a deliberate way.

It aligns to key Government outcomes applied at national, regional and district levels

The Ministry of Health (MoH) has identified key approaches and outcomes that regional plans will support. These apply at national, regional and district levels. These are to:

- Place emphasis on Better Sooner More Convenient Services, as an overarching goal
- Achieve the Health Targets
- Progress System integration
- Progress Regional Service Plan priorities (specifically relating to Elective Services, Cardiac Services, Mental Health and Additions, Health of Older People, Major Trauma, Information Technology, and Workforce).

It aligns to the national expectations of regional planning

The national expectations for regional plans signal that the priorities for 2015/6 are largely a continuation of those identified for 2014/15. Three main areas of emphasis are detailed in the MoH guidance:

1. Regional governance, leadership and decision making, with detail of the specific governance and leadership approaches that support regional collaboration. Strong clinical leadership to champion change is strongly emphasised
2. Strategic context within which the plan has been developed, including:
   o Progress to date
   o Identifying significant changes from earlier years
   o Identifying the direction of travel for 2015/16 and beyond

- The strategic context is also expected to be consistent with DHB's Statement of Intent and the Strategic Intentions of the DHB Annual Plans

3. Implementation plan to deliver the priorities, including:
   - The region's priorities and specific actions and timeframes for implementation, and the inputs required
   - Line of sight to clarify the alignment between the Regional plan and DHB Annual Plans
   - Governance arrangements.

Emphasis is also placed upon linkages to national entities and national work, including the Health Quality and Safety Commission, Health Workforce NZ, the National Health Information Technology Board (NHITB) and the National Health Committee. Our region is committed to working with these agencies and implementing their recommendations.

Developing the Regional Plan

A whole of system approach is the key strategic platform driving change

Our region has adopted a whole of system approach to drive change. Taking a perspective across hospital, primary and other community care services is vital for addressing some of the biggest challenges we face; such as chronic and long term conditions, our ageing population and how to ensure information is shared and available when needed in the delivery of care. This whole of system view helps us to determine the most efficient models of service delivery and to ensure service planning is not done in silos. It also supports the active engagement of the community and clinical leaders in health services delivery across the sector.

Building on the successes and learning over the past years

Over past years, we have established many of the foundation blocks to support regional collaboration in agreed key areas. We have expanded the original focus areas and refined the directions. We have seen the establishment of new clinical networks and have appointed clinical leaders.

Our networks have built on a strong foundation of leadership, membership and clear strategic directions and are fully focussed on activities which will have an impact on improving the health outcomes for our region's population.

This 2015/16 plan leverages the work that the region has previously undertaken. Our Region's community and hospital based workforce working with clinical networks, supported by clinical leadership, have accomplished significant improvements in the health of our patients and made good progress to improve the consistency and the quality of care for our population[3]. Some key highlights include:

- Exceeded all national targets with regional results of:
  - Electives reaching 107.5% of target volume and reduced waiting time from referral to assessment and treatment
  - ED wait 95.2% of patients seen within 6 hours
  - 96.6% patients who smoke receive advice to quit
  - 90.8% patients at risk of CVD and diabetes receive health checks
  - 91.8% of our children are fully immunised
  - 100% of our cancer patients receive treatment within 4-weeks

  - Grade 3 & 4 pressure injuries (the more serious injuries) have

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[3] The main achievements of each workstream are detailed in Appendix A.2

reduced to a sustained low rate so they are now regarded as rare events

- Development and publication of a Northern Region dementia services guidelines document

- Over 40,000 school aged children have access to school based primary care for the identification and treatment of Group A Streptococcal throat infections and skin infections

- 100% critical results in lab tests are phoned through to the referring clinician in under 1 hour

- Clinical pathways have been implemented for accelerated chest pain diagnosis and management; Skin infections, cellulitis and abscesses; trans-ischaemic attacks; diabetes, dementia and cognitive impairment

- Patients with myocardial infection can now have their electrograph ECG transmitted from many ambulances in the region to the nearest hospital

- More than 20% increase in Advance Care Plan conversations have been held with patients as they plan their end of life care (recorded across the region compared with the prior year's final conversation number of 6,536)

- 65.4% acute stroke patients transferred to rehabilitation within 10 days.

Areas of Focus

Priority areas identified to address sustainability and inequalities

This plan intentionally does not attempt to address every challenge related to service delivery across our region. The intent has been to identify a few priority areas to address which are of significant concern to our region. These are priority areas due to issues such as clinical or financial sustainability, inequalities, and high and growing demand.

We have selected areas of focus where:

- We believe we can make a real difference in patient outcomes by collaborative work as a regional health system

- The region particularly wants to see improvement in current service arrangements and where working regionally will enable this to happen

- Our region hopes to improve value for money or to achieve productivity gains by working across services and organisations.

This is due to a desire to keep the plan to a manageable and achievable set of initiatives, and to enable learning by testing ideas and concepts in largely discrete areas of service delivery.

Emphasis for 2015/16

This year we will be placing special emphasis upon regional planning with regard to information systems as an 'enabler' of services and, in particular, undertaking work to:

- Update the regional strategic plan for information systems development,
- Undertake an Implementation Planning Study [IPS] regarding the Northern Regional Electronic Health Record [NEHR].

There will also be a strong focus on clinical integration between, and within, hospital and community based services. Our clinical networks will continue to be critical to clinical engagement as we progress the regional work. The clinical networks are a key regional mechanism to drive change, and to design and implement new initiatives. They also provide a point of engagement to contribute to the regional information systems work.

This year we continue to place emphasis upon three areas of service delivery where we will apply a strong regional focus to achieve gains:

- Child Health

- Inequities and inequalities, particularly for our Māori population

- Health services for older people.

This means that all aspects of these work streams will have a strong regional oversight and resourcing aligned to the raised regional emphasis.

Smarter use of our workforce will be critical to sustainable service delivery.

Region Wide Engagement

The directions and actions set out in this plan have been agreed as priorities by a wide range of key stakeholders.

In our planning process we have placed emphasis upon ensuring clinical and management engagement, and the engagement of senior executive leadership in various planning fora. We have leveraged our relationships and contact points with a broad range of stakeholders across DHBs, our clinical networks, primary care alliance partnerships, NGOs and hospital services to develop and deliver on this plan.

A list of people who have particularly assisted with the development of this plan is included at Appendix A.1.

The Regional Governance Group, the CEO/CMO Forum and Clinical Leaders Forum have guided the development of the elements of this Second Draft plan and the priority initiatives developed by each of the workstreams.

The Final Draft Northern Region Health Plan will be provided to each of the four Northern region DHB Board Chairs for endorsement prior to submission to the MoH by 19th June.

2.   The Northern Region Context

National Direction

National directions provide one context for regional planning

Meeting The Minister's Expectations

The Northern Region operates as part of a national health system and, as such, our overall direction is set by the Minister's expectations for the sector.

Figure 3 : The Minister's Expectations

The Government's key expectations for the public health service in 2015/16 are:

- Fiscal discipline / management of the health portfolio to ensure budgeting and operation within allocated funding. This includes seeking efficiency gains and improvements in operations and service delivery.

- Strong clinical leadership and engagement in all aspects of service. Clinically driven system changes are encouraged where these make sense for patients and are positive system changes

The Minister has articulated a strong emphasis on:

- Integration between Primary and Secondary Care. To deliver better management of long term conditions, mental health, an aging population and patients in general.

- Care closer to home

- The development of pathways to achieve better coordinated health and social services; supported in both community and hospital settings

- Earlier intervention and population-based initiatives delivered in the community

- Achieving the national health targets

- Tackling key drivers of morbidity with an emphasis upon how DHBs can contribute to the reduction of obesity in New Zealand

In addition, health services are expected to support Government priorities with particular mention of cross agency work that delivers outcomes for children across a range of dimensions: health, education social and justice.

The Government is signalling modest increases in health expenditure in 2014/15. DHBs must contribute by living within our means and keep tight control on equity and capital expenditure.

From December 2014 Letter of Expectations

17

The Minister's expectation is that during 2015/16 there will be a renewed focus on strategic direction for the NZ health sector. This will be led by the Ministry of Health undertaking an update and refresh of the New Zealand Health Strategy four year plan. This is intended to help clarify strategic direction and to provide a road map for delivery of health services to New Zealanders into the future.

The Northern Region is committed to:

- Supporting the achievement of the Minister's expectations
- Participating in the consultation and refresh of the national strategy
- Aligning with work programs of national entities such as Health Workforce NZ, Health Quality & Safety Commission, Pharmac and the National Health Commission
- Demonstrating a clear line of sight of key initiatives across the regional plans, DHB Annual Plans and the DHB Māori Health Plans.

Drivers for Change

Our regional analysis has identified key drivers of change

The Northern Region continues to face significant pressures that require substantive changes in the way we work. Five key drivers of change have underpinned regional work in prior years. In addition 'information accessibility and sustainability' is increasingly becoming recognised as a 'sixth' driver of change for our region.

Figure 4 : Northern Region - Key Drivers of Change
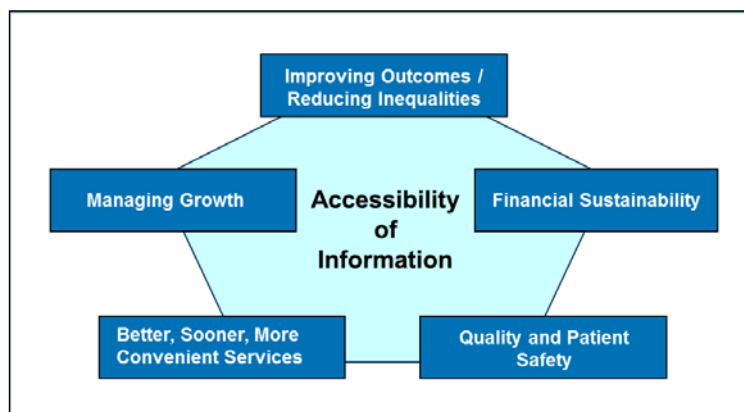
The five drivers of change are detailed below. The importance of the sixth driver of change 'accessibility of information' is outlined in the Enablers section relating to information systems and technology.

Outcomes / Inequalities

Significant health inequities are present in our region. Inequities result from complex socio-cultural, socio-economic and historical factors, which influence the determinants of health and health services. Within health services some population groups, particularly Māori, do not receive equal:

- Opportunity of access to the socio-economic determinants of health,
- Access to healthcare
- Quality of care.

Māori and Pacific populations experience significant inequities in health outcomes. For example, a substantial gap in life expectancy persists for Māori and Pacific populations, and, while the gap has reduced in Northland in recent years, it has increased in Waitemata and plateaued in Auckland and Counties Manukau. The life expectancy gap ranges from 7-11 years for Māori and 7-8 years for Pacific.

Health outcomes differ between population groups across the region:

- **Māori** comprise 13.6% of the region's population, with the highest proportion in Northland DHB (33.8%). Health outcomes for Māori are worse compared with other ethnicities across a range of indicators, and are closely associated with poor socioeconomic status. Past effort by health services has resulted in some improvement in health for Māori, but has not closed the gap between Māori and non-Māori. Chronic conditions, smoking, obesity, and childhood illnesses are the key health problems for Māori. The Māori Health Dashboard commenced in 2014/15 will be further enhanced in 2015/16 to provide a monitoring framework to influence improvements and areas of focus

- **Pacific people** comprise 12% of our population, with the highest proportion in Counties Manukau (21.4%). Pacific peoples are a diverse group of people with unique culture, language and practices distinct to each Island. Generally, health outcomes for Pacific are better than for Māori, but still poorer than for non-Māori and non-Pacific. Diabetes, smoking, obesity, and childhood illnesses are the key health problems for Pacific people

- **Asian people** comprise 22.9% of the Auckland region's population. Health concerns among Asian populations include stroke and CVD (Indian and other Asian groups); diabetes prevalence, including gestational diabetes, child oral health (all Asian groups), low cervical screening coverage (all Asian groups) and low access to primary care for Chinese populations.

- **Middle Eastern, Latin American, and African** (MELAA) groups are a small proportion of our population consisting of extremely diverse cultural, linguistic and religious groups and characterised by high and complex health needs.

More action is required to address inequalities in health outcomes by health services but also by other social sector agencies to address the broader determinants of health, such as housing, employment and education.

In the 2015/16 year the focus will be on conditions where these populations experience the highest need and where the greatest disparity in health exists, including:

- CVD, Diabetes and Cancer

  The largest differences in life expectancy are from causes such as cardiovascular disease (CVD), smoking-related diseases, diabetes and cancer. These diseases account for a significant proportion of the lost years and life expectancy gap.

- Child Health and Youth Health

  Inequalities in health outcomes for children and youth can be clearly seen across a range of measures. Childhood oral health and obesity are areas of concern, with likely long term impact on health outcomes for children in this category. Despite recent gains, our region still has unacceptably high rates of Sudden Unexpected Death of an Infant (SUDI) and Rheumatic Fever. Māori children and other high needs groups suffer disproportionately high incidence with significant impact on their chances of survival and long term outcomes.

- Health of Older People

  Our older people have a burden of disease that is higher within our more deprived communities and there are other inequalities in terms of access to care for older people across our region. The number of people with dementia is expected to double in the next 20 years. Supporting our older people to live independently and in good health is a key priority.

- Mental Health

  An estimated 200,000 adults living in the region will experience a mental health disorder in the next 12 months. A small proportion will have a serious disorder requiring intensive input from mental health services. Māori have a higher rate for serious mental health and/or addictions than other groups. The prevalence is higher still amongst youth who have offended. Our youth suicide rate is amongst the highest in the OECD.

- Stroke

  Nearly 2,500 people in this region will have a stroke each year, of which over a quarter will die. Māori and Pacific people will on average have a stroke 10 years younger than others. This has a significant impact on the quality of life for the individual, their whānau and family.

Each of the above areas is also highlighted in each DHB's Annual and/or Māori Health Plan. The Māori Health Plan, in particular, identifies priorities within each district to reduce the inequalities of health for Māori.

Managing Growth

Developing models of care for a growing and aging population

We serve a population of over 1.7 million and our population is growing at a rate much higher than elsewhere in New Zealand. Predictions indicate that:

- Over the next 20 years the Northern Region population growth will account for two out of every three additional people in New Zealand

- The scale of our region's population growth expected over this period is greater than the current population of any other DHB

- The scale of the population growth in any of our metro DHBs is larger than the expected population growth in any other region.

Figure 5 : Population Change 2014 - 2033[4]

Population Change 2014 - 2033
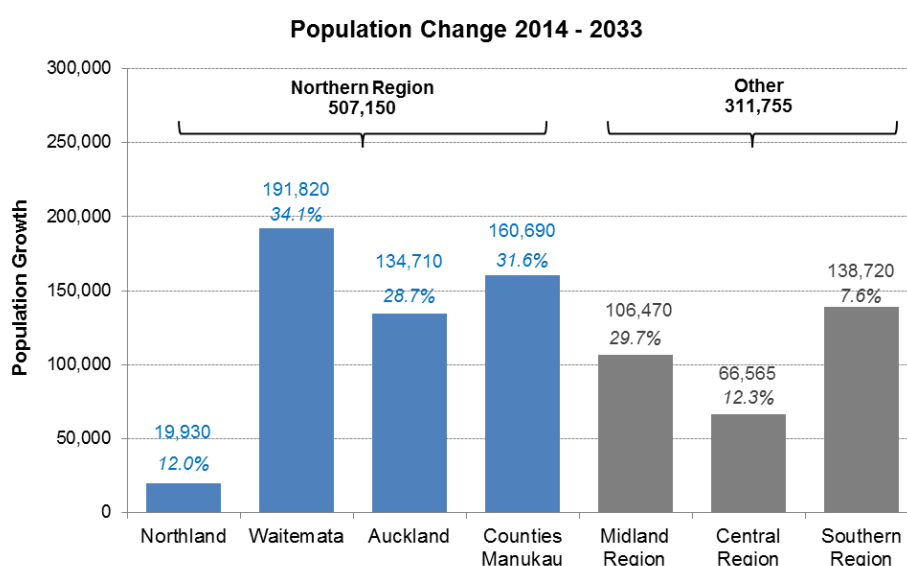
Demographic changes will generate significant demand for health services

The expected demographic changes will generate additional demand for health services in the Northern Region, particularly due to:

- High growth in the older population. The high proportion of the 65+ age group, particularly in Waitemata DHB (23.2% in the next 5 years),is likely to generate disproportionate demand for health services

- High growth in the Asian population, with a 22.3% increase expected in the metro Auckland DHBs in the coming 5 years

- Significant unmet health needs in the Māori, Pacific, Asian and MELAA populations

- High birth rates. The region accounts for more than 40.8% of all births in

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[4] Based on Census 2013 data. Projections produced by Statistics New Zealand according to assumptions specified by the Ministry of Health.

New Zealand

- Ongoing and increasing demand particularly on acute health services associated with the leading causes of morbidity and mortality in our region: cancer, cardiovascular disease, diabetes, mental health and respiratory disease.

Revised models of care must be developed and implemented to sustain the health system in response to this.

Social services also need to respond to population growth

Perhaps more importantly, the population growth in this region will impact the wider determinants of health such as housing, employment and education. Social service agencies need to plan and implement strategies and initiatives to ensure there is sufficient safe and affordable housing, employment opportunities and schools. There is a wealth of empirical evidence to show that health outcomes can be improved, in a significant and sustainable way, by meeting these basic needs.

Demand for certain health services is significantly higher than population growth

In addition to the demographic driven growth, the demand for certain health services is growing at a rate significantly higher than the population growth. The services experiencing the greatest pressure are those which are focused on providing care for people with chronic diseases. The services with high demand include Emergency Departments, acute medicine, surgical services, rehabilitation, radiology, cancer and cardiology.

Care Closer to Home

A whole system approach will support care closer to home

Providing care close to home is a key driver which underpins many aspects of this regional plan. It is designed to enable people living with chronic conditions and our older population to have better access to healthcare and live more independently. We want to deliver services to patients more proactively, which means fewer acute and unplanned admissions and faster care at the early stages of disease and ill health.

A key principle of providing care closer to home is the clinical integration of primary care with other parts of the health service, such as secondary services and community based services. The ability to share information is a key enabler of clinical integration.

NGOs have a key role to play in delivering care and support in the community. A strong multidisciplinary approach will mean better coordinated health, disability and social services to support our most vulnerable. Care will be more consistent through the implementation of care pathways for the most common conditions. A whānau ora approach is also a key feature, where individuals and their family / whānau are supported to achieve their maximum health and well-being.

The principles driving care closer to home are threaded through all levels of this plan. There is greater emphasis on broadening the scope of services delivered in primary care and other providers in the community. Locality-based health networks provide a mechanism for lateral and vertical integration of services.

Quality and Patient Safety

There are substantial human and financial costs to our community associated with failures in health and disability services. It is estimated that nearly 13% of hospital admissions involve some form of harm caused by medical treatment. More than a third of these are preventable.

There is compelling evidence that fully integrated health systems significantly improve the delivery of care for patients. They will improve access, quality of life and health outcomes at the same time as reducing costs.

The Northern Region focus on improving quality and patient safety is aligned to the Health Quality and Safety Commission's work, particularly with regard to falls, medication safety and healthcare-associated infections.

Improving the patient journey through the health system, and addressing issues relating to patient safety, will be key drivers of future models of care across all health services and a particular focus for the Clinical Networks.

Financial

Financial pressures have always been a major consideration in the planning of health services. The cost of providing publicly funded health services has been growing at an unsustainable rate. Available health funding has been squeezed by the pressures arising from the current fiscal environment and by other demands for national funding.

The key financial drivers influencing regional planning at this time manifest as:

- Cost pressures
  - o Additional costs arising from a growing population with increasing health needs and increasing demand for services
  - o New treatment methods and enabling improvements arising from technological advances (including diagnostics and IT/IS to enable change)
  - o Labour cost pressures
  - o Capital costs related to maintenance (and deferred maintenance) and the replacement of assets at the end of their useful life
  - o Capital costs to provide new assets

- Revenue pressures
  - o Constrained growth in revenue streams, with little sign of this changing due to the economic outlook

- Capital funding pressures

- Limited available health capital budget.

We must implement new service delivery approaches to ensure the affordability and sustainability of the services we deliver. We must focus on innovation, service integration, improved efficiency and reduced waste to allow ongoing provision of high quality care.

We need to improve productivity and share capability and resources across our region, including the private sector.

Our region is committed to developing plans that map out the best pathway forward to deliver affordable services to a growing population with increasing health needs.

Managing and planning change in a fiscally responsible manner

The focus on change and improving the affordability of services means that we need strong financial controls around any proposed changes. One regional area of focus is the governance of investment decisions and the capability of our workforce to apply analytical frameworks such as the Treasury Better Business Case methodology. An understanding of the interrelationships between change initiatives and all service delivery mechanisms, as well as the timing of any change related costs is critical.

We operate within a resource constrained environment (workforce, facilities and financial). Our regional capacity to deliver services is strongly influenced by the historic location of facilities and diagnostics support services, together with historic patterns of workforce availability. Affordability factors in different localities also drive variation in service expenditure and can reinforce existing disparities.

We are building a foundation now that will enable us to progressively deliver services in a fundamentally different way over the next five years. We will work within the context of national direction and regional drivers.

3.   Our Direction

The Northern Region DHBs have a strong history of working together. This section outlines the regional charter and the strategic direction to which the region has committed.

Northern Region Charter

Our Region's direction is set out in the Northern Region Charter

Our Mission:

To improve health outcomes and reduce disparities by delivering high quality, high value, and better integrated services. We will do this in a way that meets future demand whilst living within our means

Triple Aim Methodology

Population Health

Simultaneously

Cost / Productivity

Patient Experience

Quality & Safety	Life and Years	The Informed Patient
National Health Targets		
Service Changes		

Information Systems	Workforce	Procurement and Supply Chain	Facilities

Everything we do must aim to:

- Improve health outcomes and reduce inequalities in health outcomes for our population groups

- Support services aimed at delivering improvements in outcomes for Māori, Pacific and high needs families/whānau

- Ensure our eligible populations have affordable access to a strong public health and disability system which provides excellent care

- Enable the component parts of the health and disability system to operate effectively together as a more unified system while recognising and leveraging the unique capabilities of the different providers

- Plan public health and disability services to reflect the models of care and service configurations most likely to sustain a high quality health service across the region into the future

- Effectively apply information technology, workforce, and facilities to create the right level and mix of public capacity. These, along with the private capacity available in the region, can meet demand in a sustainable manner over the medium and longer term

- Ensure the ongoing clinical and financial sustainability of the public health

and disability system by:

- o Effectively engaging clinicians and the wider healthcare workforce in decision making, service design and leadership of change
- o Delivering the health and disability system that our populations need within a long term sustainable funding allocation
- o Effectively engaging with our service users, their families and whānau to play a greater role in staying healthy and managing their healthcare needs

- Optimise the use of regional resources and capability by standardising processes and systems and reducing duplication, particularly in back office functions

- Leverage the strengths of each DHB while recognising the context of working with four autonomous DHBs

- Honour our commitments to The Treaty of Waitangi and our memorandum of understanding with Iwi.

Te Tiriti o Waitangi Statement

Recognition of the relationship between Crown and Iwi

The Northern Region DHBs recognise and respect Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. It provides a framework for Māori development, health and wellbeing. The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes to enable Māori to participate in, and contribute towards, strategies to improve Māori health outcomes.

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

Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the DHB's provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with manawhenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHB's activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Our Intervention Logic

Our interventions must achieve our Mission within the Triple Aim Framework

In everything we do, we need to demonstrate gains across the Triple Aim Framework:

- Population health: Lifting the health outcomes of the 1.7 million people living in this region and reducing health inequalities

- Service cost productivity: Ensuring we have the capacity to meet demand whilst living within our means

- Patient experience: Delivering better services and improving performance.

To achieve these gains we have prioritised our directions to focus on a select few interventions. Each particular goal area is expected to deliver across all the areas where we need to demonstrate achievement of our Mission and Triple Aim objectives. We will apply a whole of system approach to each area of focus.

Three key priority goals shape our direction

The region has identified three goals. These are:

- Quality and Safety - Reducing harm and improving patient safety

- Life and Years - Reducing disparities and achieving longer, healthier and more productive lives

- The Informed Patient - Ensuring patients and their whānau get care, information and support appropriate to their context.

Achievement of these goals will be supported by having effective and efficient 'Enablers'. This year information systems will be a particular focus of attention.

Emphasising regional performance against National Health Targets

In addition to these three key goal areas, we also place emphasis upon regional performance against National Health Targets and ensuring that our services meet future demand and are sustainable.

The regional priority goals have been identified by consideration of:

- Determinants of health and risk factors in our region

- Morbidity and mortality rates in our populations

- Evidence that change can be achieved and that:
  o Benefits are likely to be material
  o The health sector has the main role to play in affecting change
  o There is likely value in terms of cost/benefit relationship as a consequence of change

- Opportunity to achieve some 'quick wins' to motivate staff while also addressing the significant challenges facing our region.

By working together as a region in the identified, specific, areas we can pool our intellectual and physical resources more effectively to achieve real change.

The common achievements we expect by focussing on these areas are:

- Closing the wide inequalities in health status and life expectancy, particularly for Māori and Pacific people

- Greater consistency, quality and safety

- Slowed growth in morbidity in our patients, and with that, demand on our health services

- More involvement of our patients in their care and easier access to care as they navigate through different services

- Wise investment decisions

- Clinical workforce developed in different ways to deliver innovative models of care

- Slowed financial cost growth of health services.

The three priority goals are intended to provide focus on specific areas where there is evidence and significant clinical and management consensus that gain can be achieved. It is not intended that they will address all the possible areas for action in our region.

Our success will depend on working together and aligning our expertise and resource to progress a few priority areas

During 2015/16, we will continue to progress work across our region and across the full continuum of care in relation to each of the areas previously identified. Some work will be best co-ordinated and delivered by local agencies ie DHBs or PHO Alliance Partners. Other work will be progressed by regional resources.

We will also focus on the specific performance targets each priority area has identified. These are designed to focus attention on the areas which really matter, and to demonstrate achievement of changes in patient outcomes.

Clear line of sight of contribution to regional objectives

In this plan we indicate the linkages across the program of work to demonstrate how each entity in our health system contributes to achieving regional objectives. We will continue to clarify this 'line of sight' as work continues within our planning processes and as we progress work across our region and across the full continuum of care.

Ensuring the sustainability of services in the future

Our overall intention is to improve health outcomes and deliver services in ways that reduce demand on hospitals. The region will still need to build more beds, but not as many as would be required if we continue to do what we currently do. We will continue to support our clinicians, as well as the wider workforce, to implement the changes signalled here. This will put the region in a better position and assure the sustainability of services in the future.

Future Landscape

Adopting a new approach to healthcare provision

We need to think and act quite differently about how we provide care if we are going to have a clinically and financially sustainable health system in the future.

Our vision for the future is one where each stakeholder in the system adopts a new behaviour which is more planned and collaborative.

Figure 7 : Vision for Stakeholder Behaviour

Stakeholder	Past Behaviours	Future Behaviours
Patients	Reactive Dependent	Proactive Independent, self-directed
Clinicians	Reactive / Episodic Independent Focus on individuals	Proactive / Planned Team based Individual and population care
PHOs	Competitive GP Focussed	Collaborative Multi-disciplinary
DHBs	Contract / Hospital oriented	Alliance / Whole of System oriented

These new behaviours will be underpinned by the new strategic directions signalled in DHB and regional plans and the primary care Alliance Partnerships.

At a high level strong, cross-sectoral, governance will drive and sustain change, supported by a performance framework which incentivises optimal performance. New models of care that optimise self-directed care for patients and whānau/families will progressively be introduced across community care, supported by multi-disciplinary teams.

Better Integration Across Services

Continuing the journey to provide a broader range of care closer to home

We will continue the journey to integrate care between community and hospital services. Our intention is that more patients will be managed and supported locally without needing to present to hospital. The primary care Alliance Partnerships, supported by an effective electronic health record, will play a key role as one building block for the delivery of integrated clinical care.

Figure 8 : Integration Across Services
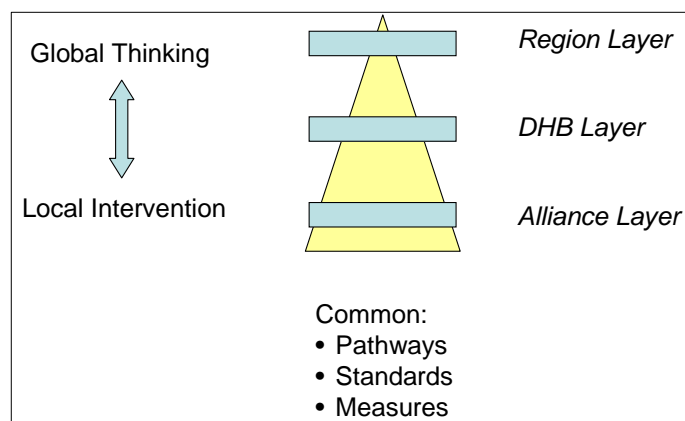
The key mechanisms we are using to support better integration across services will be further enhanced:

- Locality planning: Local multidisciplinary networks are established to plan and deliver services which best meet the local needs. These networks provide a framework for horizontal and vertical integration of services and provide a mechanism to engage with all service providers to a community

- Integrated Family Health Centres: health centres positioned in community 'hubs' to provide a comprehensive range of health services, including some secondary services such as outpatient clinics and care for patients with complex conditions

- Clinical networks: A number of clinical networks established by the region, to build relationships and to drive change and improve health outcomes for diseases and conditions which have a significant impact on our population and on our health services

- Electronic Health Record: Work will progress under the regional Informatics work to clarify how technology can best facilitate shared information across the continuum of care in our Region.

Relationships to influence upstream determinants of health

Relationships with other agencies and service providers will continue to be strengthened to address the upstream determinants of health, such as housing, education, and building resilient communities. This is in line with efforts to progress the better public service goals and the Children's Action Plan.

Improving Health Gains for Māori

While health outcomes for Māori have in general improved, progress to reduce disparities is unacceptably slow.

In the future landscape our Māori population will be more involved in decision making about their health choices and Māori youth in particular will have a greater sense of awareness of their ability to influence their future health.

There will be an increase in the regulated Māori health workforce to more closely reflect the community we live in, and they will play a key role in responding more effectively to the health literacy needs of Māori patients.

The effort made today to encourage good health behaviour to support Māori babies and children will pay dividends with more children fully immunised and participating in before school checks, and with better nutrition. The number of new smokers will significantly reduce. Māori living with chronic health conditions will participate more in their planning of care and will have more choice.

Aligning Enablers

We will progressively strengthen our key enablers through business support and operational functions. This includes:

- Implementing an enhanced and accessible IS and IT in all care settings to support the delivery of integrated models of care. As part of the Regional informatics work the region will revisit the regional strategy to clarify the development direction for key enabling information systems; cognisant of the national IT strategy

- Planning facility developments to support changed models of care. Our current hospitals will grow more slowly in the future as models of care change to support the integration of services and the management of patients in other care settings

- Being smarter about how we use our workforce such as supporting staff to work at full scope, developing new and hybrid roles to better manage rising demand and optimising capacity particularly for our vulnerable workforces. Our workforce and training hub will drive workforce development in the region.

- Leveraging opportunities in the Procurement and Supply Chain to realise cost savings together with greater consistency of product and more efficient processes.

Clinical Leadership

Our clinical leaders and the clinical networks will continue to be given strong mandates to shape and deliver services in partnerships with management. This will build on the significant achievements to date and will continue to play a lead role in shaping their services to meet future health needs. Consistency of care and cost effective care will continue to be key drivers for the networks.

Innovation will be strongly supported to ensure we stay at the forefront of new advances in medicine and service delivery. Successful initiatives will be picked up quicker and promulgated across the region. This will be achieved through the work of the clinical networks and by the alliances we have formed between the health sector and the tertiary education sector. New models such as working collaboratively with the private sector may also be explored.

Maturing Partnerships

Continuing to harness the strength of our intellectual and physical resources

We will continue to evolve the robust regional governance arrangements in place across business services and clinical services. We have already delivered significant achievements in this sphere, and will continue to progress regional governance arrangements as we learn and adapt our approaches.

The Alliance Partnerships between DHBs and primary care partners will grow and evolve over time, with closer alignment of priorities and continuing integration of care across primary, community and hospital services.

The Clinical Networks and the Regional Clinical Leaders Forum are driving changes in clinical services across the region, and will continue to evolve. A stronger focus on consumer engagement and supporting patients and whānau determined health will be a key trend in coming years.

Regional services will continue to be planned together in partnership with other DHBs. Where it makes sense to do so, they will be delivered locally with the support of specialist expertise and local clinicians with special interests.

Stronger partnerships with other sectors and NGOs will be fostered, with a particular focus on progressing initiatives to address the upstream determinants of child health and mental health. Health will become more involved in addressing housing issues to improve functional and structural overcrowding, and to ensure that vulnerable children and their families live in warm, safe homes. Initiatives such as the Vulnerable Children's Teams will grow to provide better whole of system care for children.

We will continue to strive for safe, sustainable and equitable services for our population regardless of location, or social and ethnic barriers. We will work together on activities such as health needs analysis and finding solutions to manage long term conditions. This will enable us to harness the strength of our intellectual and physical resources to find simple and innovative ways to improve our population's health.

4.   Our Priority Goals

Key focus areas signalled in the 2015/16 Plan

This plan states the region's priorities for 2015/16.

This year the region will be placing special emphasis upon information systems and, in particular:

- The opportunity to strengthen our regional strategic planning for information systems development,
- How best to progress the Electronic Health Record concept in our regional environment, across the continuum of care.

The service delivery focus areas remain the same as previously with a continuing strong regional focus to achieve accelerated gains in three priority areas: child health, inequities and inequalities, and health of older people.

Our clinical networks will continue to be critical to clinical engagement as we progress the regional work. The clinical networks are a key regional mechanism to drive change, and to design and implement new initiatives. They also provide a point of engagement to contribute to the regional information systems work.

The success of the priorities outlined in this plan will also depend on primary care to implement new initiatives and ways of working. We are continuing to work with our primary care Alliance Partners and networks to align strategic intentions.

In this year's NRHP we will continue to progress established workstreams across the regionally agreed three key areas for gains:

- Goal One – Quality and Safety:
  - Reducing harm and improving patient safety

- Goal Two - Life and Years:
  - Reducing disparities and achieving longer, healthier and more productive lives

- Goal Three - The Informed Patient:
  - Ensuring patients get care, information and support appropriate to their context.

We have three particular areas of service delivery emphasis during 2015/16

Three particular areas of work are being emphasised by the Northern region. There will be a strong regional focus placed on three service delivery priority areas:

- Child Health

- Inequities and Inequalities

- Health of Older People.

All aspects of these three work streams will have a strong regional oversight aligned to the heightened regional emphasis. These three areas of particular emphasis all fit within the regional second key area for gain; 'Life and Years'.

The following table summarises all the Regional work priorities by key area of gain, highlighting the three particular areas of regional emphasis for 2015/16.

Table 2 : Priorities by Key Areas of Gain

Key Area for Gain	Focussed Work Priorities (work streams)
Quality and Safety	*First, Do no Harm*
Life and Years	Northern Region 2015/16 three areas of particular emphasis: • Child Health • Inequities and Inequalities • Health of Older People Cancer Cardiovascular Disease Diabetes Major Trauma Mental Health and Addiction Stroke Youth Health
The Informed Patient	Advance Care Planning

Goal One: Quality and Safety

Regional partnership and collaboration in the reduction of healthcare-associated harm

Patient safety, under the banner of *First, Do No Harm,* has been a priority area for the Northern Region over the last three years. There is clear evidence that certain interventions, if systematically applied, will save lives and money and prevent harm to patients.

By supporting a regional approach we aim to achieve improved quality and safety of our health system. Opportunities exist for organisations to work collaboratively to enhance the consistency of care and to improve the safety and quality of service delivery.

Our work plan has been aligned with the Health Quality and Safety Commission's (HQSC) national patient safety campaign, *Open for better care,* and we have worked in partnership to support the patient safety objectives of the national campaign in the Northern Region. With the national campaign coming to an end in June 2016, the regional *First, Do No Harm* campaign will also cease. The 2015/16 year will provide a transition from activity coordinated by NRA, to supporting the Northern Region DHBs to: sustain the safety improvement gains achieved; ensure there is a process to support regional collaboration on key patient safety areas; and maintain the national campaign objectives.

What we want to achieve

Our objectives for 2015/16 are to support the Northern Region DHBs' patient safety initiatives through:

o   Maintaining a regional communication strategy
o   Supporting partnership with consumers, clinical staff and networks - 'safer care together'
o   Supporting the use of an effective measurement dashboard to track regional improvements
o   Supporting the development of improvement science capacity and capability in key areas (clinical change champions)
o   Supporting the momentum of a safety culture
o   Updating change packages

We will work collaboratively with our DHB and HQSC partners to transition from the *First, Do No Harm* campaign to a sustainable structure for continuing a regional systems approach, involving consumers as partners in this work, and targeting areas of high incidence of harm. Our objective during this transition period is to:

- Sustain improvements achieved
  - Report patient outcome measures and support learning from the data.
  - Support the spread of strategies to address harm
- Support regional collaboration to strengthen planning and delivery of services in partnership with residential aged care
  - Support alignment with other work programmes and agency initiatives (e.g. Health of Older People Clinical Network, Health Quality & Safety Commission, Ministry of Health) including the implementation of national patient safety campaign activities
  - Provide opportunity for consumer participation to reduce healthcare associated harm
- Maintain the national campaign objectives
  - Utilise various communication channels to promote sector-wide engagement in key campaign areas
  - Support national medication safety activities.

Goal Two: Life and Years

Ten 'Life and Years' priorities, of which three are areas of particular emphasis during 2015/16

Goal Two; 'Life and Years' has a focus on achieving gains by reducing disparities and achieving longer, healthier and more productive lives for our population.

The priority work areas covered by this goal present our region's greatest opportunities for gain, in terms of the significant numbers of people impacted now and in the foreseeable future, and the subsequent pressure on all health services. They also account for a substantive proportion of the inequalities in health outcomes for our Māori and Pacific and other high needs populations.

An overview of each priority work area is outlined below, commencing with the three areas of particular emphasis for our Region during 2015/16.

Further detail of the priority work area's implementation plans is provided in Appendix A.2. Embedded into the relevant work areas are the National Health Targets and additional areas for improvement identified by the Minister.

Child health is our first particular area of emphasis during 2015/16

Child Health

The Northern Region is committed to lifting the health of children in the region by reducing disparity and targeting populations where the distribution of poor health is marked by socio-economic and ethnic difference. The 2015/16 plan for Child Health focuses on themes where regional activity will create significant gain, often across more than one priority health area.

Project themes include:

- Knowing every child: enhancing systems of enrolment for effective engagement with universal healthcare
- Informing families: using consistent health promoting messages regionally
- Enabling clinical teams: to deliver health care to those with highest need

through supporting models of care and evidence-based approaches
- Advocating for the child: through coordinated regional approach and active inter-sectoral relationships.

Work streams under each of these themes will improve child health outcomes across a range of health outcomes that incorporate previous plans' health themes. For example, 'Knowing every child' work stream will progress integrated enrolment in health services for all children. Achievement of full enrolment rates will necessitate a coordinated focus on children currently missing out to ensure well child, primary care, immunisation and dental health care, and prevent poor health outcomes.

What we want to achieve

> This year we want to achieve:
>
> - A strategic business case on integrated enrolment
> - Strengthened injury prevention activity of home visiting programmes particularly in communities of high risk
> - Key messages developed to help families prevent skin infection and models of care that improve skin infection management progressed for populations at high risk
> - Consistent clinical measurement of growth and obesity across the northern region
> - Continued implementation of the regional SUDI Action Plan
> - Systems for head injury follow-up of children hospitalised with head injury mapped and implemented
> - Effective advocacy for child health and well-being in the Northern Region

How we will achieve these outcomes

The Child Health Plan aligns with DHB Annual Plans. It identifies areas where regional activity makes a difference and avoids duplication of activity already underway in the region. Existing DHB investments in promoting smoke free environments, and relationship with programmes to improve eating and increase physical activity, are recognised for their importance for child and family health. Strong linkage with these programmes will fit within the remit of a number of the work streams and will also contribute to the development of future plans for more specific related regional actions in coming years. This 2015/16 plan has prioritised activity that the Child Health Network considers: is achievable; will be widely beneficial; has regional participation and commitment for action; links to DHB planning; that builds on work completed; and that the network has the capacity to successfully implement.

Inequities and Inequalities

Our population is made up of many ethnicities, however not all our population groups have equitable access to health and disability services, and there are significant inequalities in the health status of particular groups.

Our region is committed to accelerating health outcomes and access. We will have a focus on those populations with poor health outcomes and inequitable access to health care, or whose housing, income and education is inadequate to support good health. This applies particularly to Māori and Pacific people. We will also continue to progress initiatives to address the needs of other disadvantaged groups such as non-English speaking background populations from Asian, Middle Eastern, Latin American and African groups.

The focus of this Plan in 2015/16 is to deliver on the regional commitment.

'Inequities and inequalities' has explicit linkages across local, regional and national initiatives

Broad initiatives underway to improve the equity and equality of health include:

- **Regional** commitment to focus on three areas for Māori:

  - Workforce development

  - Diabetes, cardiovascular disease, oral health, childhood obesity

  - Tobacco control.

  This commitment is signalled through this plan to measure performance and support local and regional initiatives.

- **Local commitment** to implement the Māori Health Plans across community, primary care and secondary care services. These initiatives are aligned to the three regional areas and the national requirements and are tailored to meet the local health needs within the context of each district.

- The Government's **Whānau Ora program** which has developed the Whānau Ora and Fanau Ola holistic approaches to health and wellbeing that acknowledge Māori and Pasifika paradigms. The intent is to work with both the Māori and Pasifika commissioning agents Te Pou Matakana and Pasifika Futures to identify opportunities for co-investment and service co-design and collaborate with commissioning agents to support whānau ora collectives, their development and specific initiatives which will deliver outcome goals that enable whānau and families to be self-managing and empowered to live healthy lifestyles and participate in society. There is a strong emphasis on participating in Te Ao Māori (the Māori world) and being economically secure and resilient.

This year we will measure and work to achieve targets across key areas:

- 95% of Maori women are smokefree at two weeks postnatal.

- 95% Preschool Oral Health Enrolments for Māori

- 90% of the eligible population – Maori and Pacific – will have had their cardiovascular risk assessed in the last five years

- 90% of the eligible population – Maori and Pacific– will have had their diabetes risk assessed

- Grow the capacity and capability of the Maori and Pacific workforce

- Continue implementing Cultural and Linguistically Diverse (CALD) training for our staff.

- Continue implementing Primary Health Interpreter Services to improve access to Primary health services for non-English speaking communities in metro Auckland

Key activities we will undertake over the year to reach these objectives include:

- The Māori health dashboard will be implemented to track progress against our National Health targets, Māori Health Plan indicators and a set of regional health indicators

- Local and regional workforce development will continue to support more Māori and Pacific into health careers, and professional development for potential leaders, and cultural competency training

- Local and regional initiatives to improve diabetes, cardiovascular disease, childhood obesity and tobacco control for Māori

- Identify opportunities for co-investment and service co-design and collaborate with commissioning agents to support whānau ora collectives their development and tailored initiatives to implement whānau ora.

*Our third area of
particular emphasis
is Health of Older
People*

Health of Older People

Older people in New Zealand are healthier than they have ever been and more active within their communities. Longevity is increasing and the proportion of New Zealanders in the 85-plus age bracket is growing rapidly[6].

However, the rapidly growing population of older people means that increasing numbers will require support from health and other services. New Zealand population projections suggest that by 2031 one in five New Zealanders will be

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[6] Average life expectancy for New Zealanders at their 65th birthday is now 21 years for females and 19 years for males.

aged over 65 years[7]. Older people comprise between 11%-18% of the population in our DHBs. In our region about 28% of patients discharged from our hospitals are over 65, but about 41% of our hospital inpatient beds are typically occupied by patients over 65 years old.

Approximately $505 million[8] is spent each year on Northern Region health services specifically for older people (with approximately 200 Age Related Residential Care providers, and numerous Home and Community Based Care services)[9].

The way we currently care for our older adults does not always best meet their needs. We know that admitting people to acute hospitals can have negative impacts on their independence and mental health. Initiatives that have been shown to be effective at improving outcomes (including risk of hospital admission) include:

- Integrated community care programmes
- Improved flexible home and community based care options
- Dementia pathway improvements (including care options)
- Targeted disease programmes (e.g. fracture liaison services)
- Targeted ARRC programmes (e.g. falls prevention programmes).

The key drivers that are creating challenges for our region's health care services that support the older age group are:

- High demand on hospital services, including acute admissions (65% of the projected grown in acute inpatient beds is for older people)
- Increasing need for community based services such as residential care, home based care and pharmaceutical expenditure
- Varying standards of quality of care.

A regional approach is required, as many of our services for older people are delivered in the community; where DHB boundaries are artificial (and, at times, can be a hindrance to good care delivery).

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[7] In 2013 there were 191,000 people aged over 65 years living in the northern region (12.2% of the total population), of those, 22,500 were aged 85 years or over - Statistics NZ.

[8] This amount excludes the cost of acute and elective inpatient care in public hospitals for this age group.

[9] Northern Region Health of Older Person Service Utilisation Report, NRA, June 2014

Our key performance measures include:

- 95% of General Practices will be enabled to utilise the Northern Region Cognitive Impairment Pathway (baseline measurement of pathway application will also be progressed alongside the roll-out).
- 20% reduction in falls causing major harm in those age-related residential care (ARRC) facilities that have implemented a programme.
- 20% reduction in pressure injuries in those ARRC facilities that have implemented a programme
- Proportion of ARRC facilities that have implemented a falls & pressure injury reduction programme will increase from 35-50%
- 100% of ARRC residents have a completed InterRAI LTCF assessment.
- 75% of clients receiving long term Home Based Support Services (HBSS)have an InterRAI clinical assessment within the previous 24 months

We will continue to build on the progress already achieved, with focus on:

- Ensuring consistent assessment processes for people requiring long term support by:
  - Supporting use of InterRAI information in the ARRC and HBSS sectors
  - Increasing the number of people on supports undergoing reassessments of needs e.g. psychogeriatric care.

- Planning for growth in demand for dementia and acute services by:
  - Rolling out region wide dementia diagnosis and management programme for primary care e.g. integrated dementia care pathways
  - Developing a suite of education resources for healthcare professionals to use e.g. e-learning in collaboration with other regions.

- Strengthening care in ARRC and Home Based Care by:
  - Increasing support to ARRC by specialist services and building closer relationships with the ARRC & HBSS sectors e.g. contracting
  - Rolling out targeted programmes in ARRC such as Falls Reduction.
  - Ensuring consistent high quality care across a range of community settings e.g. psychogeriatric care.
  - Collaborating with other programmes and agency initiatives e.g. National Hip Fracture Registry.

- Prevent future deterioration by:
  - Identifying and implementing disease prevention programmes e.g. Fracture Liaison Services.
  - Supporting information sharing and transfer to progress these initiatives e.g. InterRAI.

Cancer Services

Cancer was the leading cause of death for both males and females in New Zealand in 2010, accounting for 30% of all deaths. The impact on people diagnosed with cancer and their whānau can be devastating. A whole of system approach via tumour streams is improving access to services and waiting times for patients, with strong multidisciplinary expertise and standard care pathways.

Notwithstanding the success of our approaches to date, cancer remains a significant concern for our population and health services, largely due to:

- A population that is both ageing and growing (Northern Region cancer registrations are predicted to increase from 6,000 to 9,000 in 15 years)

- $295million per annum estimated cost for cancer care in this region, expected to rise nationally by $117million over the next 15 years

- Sustainable delivery of faster cancer treatment goals and tumour stream pathways require innovative changes to models of care and reconfiguration of services accordingly.

Faster Cancer Treatment - proportion of patients referred urgently with high suspicion of cancer receive

- First Treatment within 62 days from referral to first cancer treatment (or other management). Health Target achievement rate of 85% by 1 July 2016.
- First Treatment (or other management) within 31 days from when the decision to treat was made.

Cancer Treatment – 100% of patients receive treatment within four weeks of referral for policy priorities:

- Radiation therapy.
- Chemotherapy treatment.

Improving Wait Times for Colonoscopy

- 75% % of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive), 100% within 30 days..
- 65% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days), 100% within 120 days.
- 65% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days.

How we will achieve these outcomes

We will continue to develop and implement work which has been designed regionally and nationally. This year we will increase the focus on:

- Implementing the Northern Region Cancer Strategic Plan priorities, including reviewing regional progress toward nominated national tumour standards, and prioritising service delivery model changes where indicated

- Faster cancer treatment, specifically working toward health target achievement by July 2016

- Colonoscopy policy priorities to further analyse the production planning requirements and develop/implement strategies to meet wait time targets for colonoscopy

- Improving the functionality and coverage of multi-disciplinary meetings (MDMs)

- Service development for specific cancer care:
  o Delivering Faster Cancer Treatment service improvement projects
  o Identifying and implementing regional priorities for prostate cancer
  o Continuing to support the bowel screening pilot
- Working nationally and regionally to progress a regional non-surgical patient management system.

*We will reduce the
growth and burden
of cardiovascular
disease*

Cardiovascular Disease

Cardiovascular Disease (CVD) is a significant disease nationally. There is variation in both access and timeliness of access to core cardiology assessment, investigation and management across the primary-secondary continuum. There are also variations in CVD outcomes by socio-economic status and ethnicity with the effect that some population groups do not meet accepted intervention rates and health outcomes.

Key challenges related to cardiovascular disease include:

- Cardiovascular disease as the second leading cause of death has disproportionately high rates in Māori and those from low socio-economic areas
- Many of the CVD events in younger patients are preventable.

Our measures this year are to:

- Maintain the nationally agreed cardiac surgical delivery and waiting list management targets.
- 95% of out-patient coronary angiogram waiting time to <3 months.
- 70% of patients presenting with an acute coronary syndrome who are referred for angiography receive it within 3 days of admission (day of admission being day 0)
- 80% of patients presenting with ST elevation MI and referred for PCI will be treated within 120 minutes. (There may be some variation for patients from NDHB due to geographical isolation and dependence on emergency helicopter transport).
- 80% of all outpatients triaged to chest pain clinics to be seen within 6 weeks for cardiology assessment and if an ETT is considered appropriate it will be undertaken at that time.
- 90% of eligible patients will have had their CVD risk assessed in the last 5 years
- Over 95% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge
- 95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection.

We will also aim for:

- 95% of outpatient echocardiograms to have been completed within 5 months of referral
- The Accelerated Chest Pain pathways to be implemented in phases by quarter by DHB

We will continue to build on the progress made over the past year. This year's plan will focus on:

- Current measures to meet cardiac surgery across the region will be continued and closely monitored to ensure the appropriate capacity is available

- Managing CVD across the continuum of care, in line with the CVD Risk Recommendations document

- Implementing new models of care to better meet demand and improve better quality of care across the continuum
  - Host an Allied Health regional forum focusing on Cardiac rehabilitation
  - Progress the Regional Primary PCI service developed in collaboration with St John's Ambulance Services and Emergency Departments to support more rapid transit of ST elevation MI patients direct to a PCI centre.
  - Finalise the regional plan for Electrophysiology Services

- Continue to provide on-going support for use of ANZACS QI reporting and ACS quality improvement throughout the region

- Review data entries (target achievement) per DHB and in conjunction with each DHB determine barriers to reaching this target (for ANZACS QI ACS and Cath/PCI registry data collection.)
- Work with DHBs to make changes which will allow them to meet this target.
- Two DHBs will be meeting or exceeding target (ANZACS QI ACS and Cath/PCI registry data collection.)

- Continue to improve access to Echo-cardiogram to support diagnosis of Heart Failure and other conditions including those requiring cardiac surgery

- Work directly with NDHB in support of their planned phased implementation for ACCP in September 2015

- Standardised Intervention Rates, patient prioritisation and waiting lists for secondary services (ACS) and cardiac surgery will be reported quarterly from quarter 1. The reported SIRs will be:
  - 6.5 per 10,000 population for cardiac surgery,
  - 12.5 per 10,000 for percutaneous revascularisation
  - 34.7 per 10,000 for coronary angiography

- Support / development of dynamic primary care pathways.

Areas of new activity for 2015/16 include the following:

- Cardiac Rehab
- Implementation of ACCP pathways
- improved data collection and reporting for ACS and Cardiac Surgery
- Increase in existing rates for Medicine adherence in both primary and Secondary care by 5% over the next two years
  Audit of current measures used to ensure appropriate capacity is available to meet cardiac surgery across the region.

Diabetes

Diabetes is a chronic disease that impacts patients and their whānau over a lifetime. It leads to disability through blindness, amputation of limbs, heart attacks and renal failure, and it shortens lifespan.

While the last decade has seen greater attention and resources being allocated to diabetes, our efforts have not always been systematic and coordinated. We need to be at the forefront of innovations to test new strategies to slow the growing incidence, and the impact, of diabetes on our populations.

Key challenges for diabetes include:

- 115,000 people in the region have diabetes

- A fast growing pre-diabetic population means that the diabetes population roughly doubles every 10 years

- Certain ethnic groups experience higher rates of the disease, particularly Māori, South Asian and Pacific

- The conservative estimated costs of diabetes in this region are approximately $365million annually, excluding primary care costs and are mainly due to treatment of complications

- Greater than 80% of diabetic complications are preventable through good management.

Our key performance measures are:

- 90% of eligible patients will have had a cardiovascular risk assessment in the last 5 years
- Continue existing KPI reporting whilst refining and developing new reporting
- Develop the capability to highlight patients who are not on treatment to GPs in order to achieve improved outcomes (such as those listed here).
  - Improve the percentage of diabetes patients:
    - On diabetic medications
    - On lipid lowering medication
    - On blood pressure medication
    - Being monitored for HbA1c levels and treated to target (HbA1c <64)
    - Tested for microalbuminuria and on ACE or ARB
  - Improve the percentage of CVD patients with diabetes on appropriate medications as per cardiac network report
- Reduction in (to be agreed) proportion of patients with Hba1c >64,80,and 100mmol/mol
- 37,000 people undergo retinal screening
- Provide a single reporting mechanism to primary care (in conjunction with the Cardiac Clinical Network).

We will continue to build on the progress made over the past years. Key activities will be:

- Support regional work to improve the quality of Diabetes self-management (DSME) resources and the implementation and evaluation of DSME standards and curriculum

- Agree effective strategies and interventions to support the early detection and management of diabetes and pre-diabetes

- Work with communities and community partners to identify and implement culturally appropriate and effective strategies to reduce diabetes related health disparities e.g. in Māori and Pacific Island Populations and in adolescents and young adults with diabetes

- Work with the MOH to access live NHIs and develop an agreed process for reporting to Primary care which will enable GPs to identify those patients who are not on appropriate treatment. (This is in support of achieving Patient Outcome Measures)

  Support the implementation of the Ministry Quality Standards and others as published; Gestational Diabetes Guidelines, NZSSD High Risk Foot Pathway, 20 Quality standards (Diabetes Care toolkit 2014)

- Support the development and implementation of guidelines for a consistent in-hospital care approach for patients admitted with diabetes

- Support improvements by Regional Public Health initiatives; including the Regional Obesity project

In support of these key activities we will collect and use data that captures process and clinical improvements providing a view across the continuum of care. Quality Improvement strategies will be utilised and progress will be monitored to assess improvements in patient outcomes and workforce capability and capacity.

Major Trauma

A formal trauma system will save lives and will ensure our resources are used most effectively

Each year in the Northern Region of New Zealand there are approximately 500 cases of major trauma and 4,200 of non-major trauma. Most cases are young males aged between 15-44 years, and Māori are over-represented in the statistics. Our data is incomplete, but indications are that the average length of stay is 8 days, with a mortality rate of around 10%. While these figures are within range of international benchmarks, we believe we can make further improvements.

Historically, we have operated a model based on care at individual hospitals, with referral to tertiary centres when required.

Through the formation of a regional trauma network the intent is to introduce a more formal and organised system for trauma care. The regional work program is aligned to the National Major Trauma Clinical Network and is a new priority area for the Region.

This year we will:
- Introduce a trauma registry
- Have the capability to monitor several process indicators to establish baseline measures; including as a minimum to measure:
  o Death in hospital
  o Proportion of patients discharged to residential rehabilitation facility
- Develop further KPIs (with alignment to national work) for progression as measures only this year with a view to determining targets later.

In this second year as a regional priority, we will focus on three key areas:
- Strengthening clinical governance through focussing on regional and systemic issues including variation in care, case reviews and supporting the clinical leads and trauma coordinators in each DHB
- Implement Regional Trauma Registry to provide good quality trauma data which is tailored to meet the needs of the region and links to the National Major Trauma Registry
- Implement guidelines and protocols to support consistency of care across pre-hospital and hospital services.

Mental Health and Addictions

Mental health and addiction issues can have a range of impacts and effects across the life span. The social determinants of health (employment, housing, social engagement) are important factors in people's ability to demonstrate resilience and achieve recovery. Mental illness and addiction issues carry one of the highest disease burdens for people, their families, their whānau and our communities.

Key challenges associated with mental illness and addictions include:

- Stigma and discrimination within and outside of health services

- Poor physical health and wellbeing, including in a reduction in life span of 20-30 years compared with the general population

- A youth suicide rate that is one of the highest in the OECD

- The impact of severe mental illness or addiction issues affecting people's ability to fully engage in relationships, in employment, to maintain housing, and be active participants in their communities

- The complexity of co-existing problems, including mental health and addiction issues, and mental health and physical health problems.

The Ministry of Health Service Development Plan, 'Rising to the Challenge', sets out the national strategy and plan for mental health and addiction services.

Figure 9 : Rising to the Challenge

The Ministry of Health Mental Health and Addiction Service Development Plan creates a vision whereby:

"All New Zealanders will have the tools to weather adversity, actively support each other's wellbeing, and attain their potential within their family and whanau and communities. Whatever our age, gender or culture, when we need support to improve our mental health and wellbeing or address addiction, we will be able to rapidly access the interventions we need from a range of effective, well-integrated services. We will have confidence that our publicly funded health and social services are working together to make best use of public funds and to support the best possible outcomes for those who are most vulnerable."

What we want to achieve

The Northern Region Health Plan encompasses the five objectives identified in The Ministry of Health's 2015/16 Planning Priorities for Regional Service Plans, a number of objectives carried forward 2014-15, and some regionally agreed priorities. Initiatives in the plan will consider a systems level approach, including DHBs, PHOs, NGOs and other community and intersectoral organisations as appropriate, and identify opportunities to address inequities within the activity undertaken.

Our objectives for 2015/16 are to:

- Increase capacity and improve responsiveness of mental health and addiction services for people with high and/or complex needs, including
  - Improve capacity and responsiveness of adult and youth forensic services
  - Improve availability of and access to the range of eating disorder services
  - Improve access to and experience of perinatal and infant mental health service options across a service continuum
  - Improve secondary service support to primary care settings
  - Improve secondary service support to primary and community care settings
  - Identify opportunities for regional alignment on suicide prevention and postvention initiatives.

We will work collaboratively to strengthen resilience and support recovery, with key areas of focus being:

- Addressing the needs of people with high and/or complex needs
- Ensuring the agreed Eating Disorders Services service delivery model is implemented
- Suicide prevention
- Improving the health of people in the criminal justice system and their families/whanau.

Stroke

Stroke is a significant cause of death and disability

The impact of stroke on individuals and their whānau/family is significant. There is a very high risk of death. For those who survive, the disability caused by the stroke often has a major impact on their ability to work and live independently. The disability often requires high level support from family and external assistance at significant emotional and financial cost. Strokes in the under-65 age group are particularly challenging because of loss of income and impact on young families.

Yet strokes are largely preventable and transient ischemic attack's [TIA's] often provide good warning that a stroke is imminent. Good care of an acute stroke patient will improve the chances of survival and recovery.

Key challenges:

- Stroke is the third largest killer in New Zealand (about 2500 people every year). Around 10% of stroke deaths occur in people under 65
- Stroke is largely preventable yet every day about 24 New Zealanders have a stroke. A quarter occur in people under 65
- Stroke is the major cause of serious adult disability in New Zealand.
- On average, Māori and Pacific people suffer strokes 10 years younger, and have worse outcomes, compared to New Zealand Europeans.

Key aspects of service delivery:

- Acute stroke sufferers should be seen urgently at designated stroke centres and considered for acute clot treatment (e.g. thrombolysis, clot retrieval)
- Acute stroke sufferers should be admitted to acute stroke units.
- Stroke victims should be considered for stroke rehabilitation programmes both in hospital and in the community including early supported discharge
- Stroke (and TIA) victims should be investigated and offered timely stroke prevention interventions.

There are an estimated 60,000 stroke survivors in New Zealand. Many are disabled and need significant daily support. However, stroke recovery can continue throughout life.

What we want to achieve

All DHBs will continue to provide stroke services in line with the New Zealand Clinical Guidelines for Stroke and in collaboration with the regional group and the national network.

In 2015/16 we want to achieve further gains in preventing stroke and improve the quality of care we provide for people who have had strokes. Specifically we want to achieve:

- 8% of acute ischaemic stroke patients are thrombolysed
- 80% of patients who have had an acute stroke are treated in a stroke unit
- Proportion of people with acute stroke who are transferred to inpatient rehabilitation services
- Proportion of the above who are transferred within 10 days of acute stroke admission – target 70%.
- Less than 10% of patients will be coded as Acute Unspecified Stroke

How will we achieve these outcomes

The Northern Region Stroke Network Executive was established in 2014 and works in partnership with the Northern Region Stroke Network Group – the latter is a multidisciplinary clinical group which has been a major catalyst for improving stroke services across the region. Members have been active participants in national stroke initiatives along with contributing to the NZ Clinical Guidelines for Stroke Management (2010) which underpin the way stroke services are provided.

In addition to local efforts to improve outcomes for stroke patients, we will strengthen our regional focus to:

- Improve timely access to acute and post-acute stroke services
- Continue developing and implementing consistent protocols and pathways for patients who are at risk and/or have had strokes e.g. TIAs, hyper-acute interventional management and rehabilitation
- Strengthen collaboration between primary, secondary and tertiary stroke services
- Review ways to strengthen in-hospital and community, rehabilitation stroke services
- Align access to stroke services and models of care across the region, consistent with national guidelines
- Assess impacts on Māori and other ethnic groups, and instigate actions to address inequities.

Youth Health

The Northern Region is committed to lifting the health of the young people within the region. While most young people born or living in the region enjoy good health, some do not, with the distribution of poor health marked by significant socio-economic and ethnic differences. Inequities can be clearly seen across a range of measures. Māori young people and Pacific young people experience poorer health than other young people.

Key areas youth health will focus on are:

- Mental health (aligned to the Prime Minister's Youth Mental Health Project);
- School based health services
- Access to primary care.

This year, we will continue to develop new ways of working to provide more youth-friendly services and the workforce to deliver these services.

What we want to achieve

This year we aim to:

- Support implementation of the Prime Minister's Youth Mental Health Project
- Achieve KPI reporting with regard to Youth Health
- Refine standards for the delivery of care for youth:
  - Priorities for improvement of School-based Health services
  - Delivery of developmentally appropriate care for young people in secondary care, including the interface with primary care
  - Services in other primary care settings.

- Improve workforce training options

How we will achieve these outcomes

We will

- Work with the Northern Region Mental Health and Addictions Network to progress the Prime Minister's Youth Mental Health Project
- Develop clinical outcome measures for youth and instigate reporting once development has been completed
- Determine key areas requiring support amongst School based Health services
- Review and further develop standards of care for services and clinicians working in other primary care settings
- Review and further develop standards of care for delivery of developmentally appropriate care for young people in secondary care settings
- Support improved access to mental health services – both in secondary and primary care
- Explore workforce training options by identifying what is currently in existence and gaps which are evident.

Goal Three: The Informed Patient

The objective of this goal is to achieve greater patient participation and improved health care through patients being better informed across the full health spectrum; from prevention and early diagnosis to better treatment of disease. We want to emphasise the concepts of being 'partners in care' and 'self-directed care'.

The outcomes we want to achieve from this work include:
- A greater sense of individual ownership and responsibility toward health
- Reduction of unplanned care and avoidance of acute presentations at hospital emergency departments
- Increased patient compliance with treatments and care plans
- Involvement of patients and their whānau in decisions about care options
- Increased health literacy, awareness and knowledge among our population to ensure early decisions to seek diagnosis and care.

The themes of enhancing self-directed care, individual ownership and responsibility are being developed within our regional work areas; particularly those relating to:
- Goal Two - Life and Years
- Enablers - IS/IT.

In addition we are targeting Advance Care Planning as just one specific regional action against Goal Three.

Engaging patients and their whānau in decision about care

Advance Care Planning (ACP)

Advance care planning aims to ensure patients are better informed about future care and treatment choices and healthcare providers are better informed about patient's care preferences, particularly around end of life care.

Key Challenges

The key challenges with regard to advance care planning are:
- Rapidly growing ageing population
- Increasing burden of disease
- Medical advances can result in extension of life but not necessarily quality of that life
- Death is often viewed as a failure of a health system geared to cure patients
- There are societal barriers around thinking and talking about dying.

As a result of the above, patients and whānau/family are often not given the opportunity to participate in planning their end-of-life care.

What we want to achieve

Our aim is to improve communication between patients and whānau/families and clinicians around their end-of-life care and treatment. Patients and their whānau require more, and clearer, information to enable them to make informed choices. This year our key performance measures are:

- A 20% increase in patients having ACP conversations (measured against the respective DHBs total number of conversations in 2014/15)
- Health workforce training in the Northern Region including:
  - Delivering 10 ACP Level 2 ACP Practitioner training courses
  - Training 95 Level 2 ACP Practitioners (95% attendance at 10 courses).

A second aim of the programme is to increase both public and healthcare staff awareness of and need for ACP. We are planning to deliver:

- An ACP consumer awareness raising campaign, with a recurring, annual, Conversations That Count Day (CtC) each year on April 16th. This will be delivered in partnership with the National ACP Cooperative.
- Two 'CtC Communicator' courses (where members of the general public attend two days training learning to lead community education sessions on ACP)
- One CtC Trainer course (using a train-the-trainer approach we will teach select CtC Communicators to deliver the CtC Communicator training).

Meet our Health Workforce New Zealand (HWNZ) contract deliverables which include:

- Review of the current ACP Level 2 Practitioner course with a plan to reduce it to two days duration
- Develop a one day ACP course
- Work with a pedagogy expert to review the training (this will include a written report to be submitted to HWNZ)
- Prepare a business and marketing plan to explore self-sustainability for the programme.

How we will achieve these outcomes

We will continue to build on the progress made and will:

- Train and raise awareness in ACP for the health workforce including primary care
- Strengthen consumer and wider community engagement through:
  - Awareness of ACP and its benefits in the wider community
  - Resources development to meet the specific needs of Māori, Pacific and Asian consumers
- Develop the programme infrastructure model to support on-going continuous quality improvement initiatives such as evaluation tools, production of communications material and measurement processes
- Strengthen planning and delivery of services through supporting:
  - Local DHB ACP deployment teams
  - Development of DHB policies and procedures.

National Health Targets

As a region, we have made significant progress towards achieving the National Health Targets since they were introduced. The regional priorities we have developed for 2015/16 are aligned and complementary to our focus on health targets. The National Health Targets as stated for 2015/16 are shown in the table below:

Table 3 : National Health Targets

Shorter stays in emergency departments	95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours.
Improved access to Elective surgery	Delivery against agreed volume schedule including a minimum of 65,631 elective discharges by the Northern Region in 2015/16
Faster cancer treatment	85% of patient receive their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016
Increased immunisation	95% of eight month olds and two year olds will be fully immunised by July 2015. 90% of four year olds will be fully immunised by age 5 by June 2016
Better help for smokers to quit	Brief advice and support to quit smoking will be offered to: • 95% of patients who smoke and are seen by a health practitioner in public hospitals; and • 90% of patients who smoke and are seen by a health practitioner in primary care; and • 90% of pregnant women (who identify as smokers at confirmation of pregnancy in GP or booking with a lead maternity Carer) By 2025 less than 5% of each DHBs population will be a current smoker.
More heart and diabetes checks	90% of the eligible population will have had their cardiovascular risk assessed in the last five years.

Top 10 Patient-Focused Regional Commitments for 2015/16

During 2015/16 we are committed to achieving the key targets set out below:

Table 4 : Top-10 Patient Focussed Regional Commitments for 2015/16

All Interventions

1. Achieve and maintain the Minister's health targets

Quality and Safety

2. Maintain falls causing major harm in the acute sector to a rate of less than or equal to 0.10 per 1000 patients days

Life and Years

3. Consistent clinical measurement tool for child health growth and obesity available across the region (establish consistent baseline measurement)
4. 95% of General Practices will be enabled to utilise the Northern Region Cognitive Impairment Pathway (baseline measurement of the % application of the pathway to be progressed alongside the roll-out)
5. 80% of patients who have a stroke are treated in a stroke unit
6. 80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes[10]
7. 85% of patients receive their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016. (in 2015/16 demonstrable improvement towards July 2016 target of 85%)
8. Establish consistent measures and baselines for access to youth forensic services for each of the three service elements – court liaison, CYF youth justice residences and community
9. 37,000 patients undergo retinal screening

The Informed Patient

10. A 20% increase on the 2014/15 end of year ACP conversations documented by each of the four DHBs

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[10] There may be some variation for patients from NDHB due to geographical isolation and dependence on emergency helicopter transport.

5.   Service Planning

Implementing a whole of system approach with a staged change process

From the outset of the regional planning process, the Northern Region made the commitment to a whole of system approach which crosses a number of organisational boundaries. The approach has required, and continues to require:

- Agreement on the principles and rules by which we work as one region

- Testing of new ideas

- Embedding of new ways of working, one step at a time.

Building on previous work, certain services are a particular focus for medium to longer term regional work:

- Radiology

- Elective Services

In addition to these services 'other' regional work is planned with a short to medium time horizon. The overall aim for work in this 'other' category is to support: clinical collaboration and advancements; cost-efficiency; improved access and timeliness of care; and alignment across clinical services models of care.

The progress expected by service category is detailed below. The implementation plans for the services groups is provided in Appendix A3.

Radiology

Radiology is critical to patient care and to achieving efficiency across the health system

By providing diagnostic information at critical points in the patient journey, imaging services rationalise the need for intervention and help target where it will have the greatest benefit.

Key challenges for radiology services include:
- Acute shortage of sonography workforce
- High annual growth in demand for Ultrasound, Magnetic Resonance Imaging, and Computed Tomography
- Service productivity dependence on Radiology IS performance
- Long waiting times for some imaging, particularly MR and Ultrasound.

What we want to achieve

The Radiology targets for 2015/16 are:

- 75% of reports validated within 24 hours
- 95% wait time less than 6-weeks for CT
- 85% wait time less than 6 weeks for MR
- Measure of CTCA and CTC activity

How we will achieve these outcomes

This year the Regional Clinical Radiology Network will closely align its work program to the National Radiology Advisory Group, along with a focus on:
- Addressing the Sonography workforce shortage through:
  - Continuing the 12-week intensive training pilot

- - Engaging in cross-sector collaboration to address training, recruitment and retention strategies
  - Continue to develop and embed service planning for sub-specialities
  - Develop a regional Radiology Information Systems Strategic Plan
  - Refresh the Radiology Asset Management Plan
  - Support the development of cancer follow-up, surveillance, and incidental findings to be led by the National Cancer team
  - Implement regional oncology imaging CT and MR protocols and cancer staging imaging pathways to support Faster Cancer Treatment targets.

Elective Services

Ensuring timely access to elective surgery

Elective surgery has the ability to make an immediate impact on quality of life by reducing pain or discomfort, and improving independence and wellbeing. The Minister of Health has prioritised an increase of elective surgery output and the maintenance of reduced elective wait times.

The key challenges in our region include:

- Maintaining the reduced wait time targets for First Specialist Appointment and treatment (ESPI 2 and ESPI 5) such that all patients wait 120 days or less for first specialist assessment and treatment

- Incorporating the required flexibility to meet the urgent needs of Faster Cancer Treatment patients while maintaining effective and efficient elective work schedules to sustain the reduced elective wait-times

- Population aging and patients with long term conditions will substantially increase the demands on elective and planned care across all settings

- Increasing pressure on acute beds impinging on our ability to deliver elective volumes.

What we want to achieve

The Region is committed to:

1. Maintaining the reduced elective services wait time target of
   - 100% of patients receiving First Specialist Appointment within 120 days of referral

   - 100% of patients receive treatment within 120 days once the decision to treat has been made

2. Delivery of at least 65,631 elective surgery discharges.
3. Working across Cancer and Elective services to develop consistent pathway and clinical protocols for tumour streams
4. Pursuing fair and equitable access to elective surgery
5. Improving information by engaging with and supporting the implementation of e-referrals projects within elective services

How will we achieve these outcomes

This year we will focus on:

- Monitoring wait-time and discharge targets attainment to identify any issues and to enable regional identification of solutions should issues occur

- Ensuring linkages, alignments and sharing of elective service good practice between DHB
- Elective service workflow to support the Cancer Network to progress the development of 'Faster Cancer Treatment' pathways and protocols for tumour streams; with a particular focus on enabling urgent and surveillance colonoscopy work
- Regional collaboration to:
  - contribute to the implementation of system improvements, including e-referrals, and National patient flow concepts
  - Improve standardised intervention rates and gain a better understanding of catchment and demand arising within demographic areas
  - Sustain and broaden the implementation of the learnings and principles of the Enhanced Recovery after Surgery [ERAS] project; including sharing good practice as DHBs apply the model to different specialities
  - Reduce DNA rates and progressing "patient focussed booking" initiatives
  - Implement clinical prioritisation tools across the region, once they are agreed as clinically appropriate.
- Sub Regional work to deliver:
  - Bariatric surgery for the Northland community by means of a collaborative approach between NDHB and WDHB
  - Ophthalmology to the WDHB population by the ADHB provider delivering clinics at Waitakere Hospital.

Other Service Planning

Developing services to meet a dynamic and changing context

Health services are continually evolving. Having a strong regional focus has successfully reduced the number of services identified as 'vulnerable' in terms of workforce, capacity, and demand. We are changing the focus toward service planning and development to reflect the support given by DHB Chairs, clinical leaders and management to shape how services are structured and delivered in an environment of greater regional co-operation.

Services of regional importance identified for attention during 2015/16, include:

- Complete the successful transition to a single location of service for acute spinal cord impairment,

- Progress the Sexual Health Review implementation.

Auckland DHB will complete its tertiary services review and will progressively implement recommendations which may impact on the configuration and scope of some services.

In addition, during 2015/16 we will be working with the Ministry of Health to develop regional Hepatitis C services and we will be developing a plan for implementation of the service. The implementation plan will focus on the identification of people at risk of, or with, Hep C and the development and delivery of treatment services for these people. The plan will consider the best options for:

- Recruitment (or identification) of a Hep C clinical specialist (nurse) to provide oversight of the services,
- Support to other clinicians and undertake clinical care as indicated
- How DHBs will provide Fibroscanning as part of triage for their region
- Adopting/adjusting pilot clinical pathways for Hep C to suit the region's needs.

There is an expectation that the services will commence by 1 April 2016.

Collaborative service development models

We will continue to work in the direction set by the DHB Chairs, that our region will promote rational regional service distribution to:

- Strengthen the region overall

- Create the opportunity for certain services to be delivered locally

- Not destabilise any particular DHB.

The moratorium on service repatriation will continue. In the place of service repatriation we will ensure a service distribution process that is rational, collaborative, enabling and able to be achieved in as short a time as possible.

The vision is that the current service providers will continue to hold the funding (through IDFs) and the key staff for the service mix currently being delivered for different DHB populations but will provide the service in an appropriately agreed and distributed way for each of our DHBs.

6.   Enablers

Four 'enablers' particularly impact on our ability to deliver services

For our plan to be successful we need to strengthen regional collaboration with a particular emphasis on four 'enabling' resources groups:

- Information Systems
- Workforce
- Procurement and Supply Chain
- Facilities / Capital.

Information Systems

Our Regional focus is to support continuity of patient care

Information systems are fundamental to the Northern Region's ability to deliver a whole of system approach to health service delivery.

A key clinical driver for our Region is to improve the continuity of care for patients across primary, secondary and tertiary care. This relies on consistent and reliable access to core clinical information for all clinicians involved in a patient's care.

Our information system developments will align with national and regional information strategies and are a key enabler for us to achieve our clinical and business objectives.

Our vision and direction is detailed in our Regional Information Strategy

The Northern Regional Information Strategy 2010 to 2020 (RIS 10-20: Progressing and Transforming Health) provides the strategic direction on information management, systems and services in the Northern Region.

It aligns with national, regional and district information strategies and is a key enabler for primary, community and secondary care organisations to achieve their clinical and business objectives. An underlying core principle of RIS10-20 is that it will deliver single, regional DHB systems to support common clinical and business processes in the region, with primary and community care organisations actively encouraged and supported to use these systems.

The Northern Region is now at the midway point in delivering RIS 10-20 and while progress has been made over the last five years across the six focus areas (Person Centred Health Information, Population Health Information, Knowledge Management, Workforce Information, Business Information and IT Infrastructure & Services), we recognise the need to accelerate progress for the Person Centred Health Information and IT Infrastructure & Services Strategies.

IT Infrastructure and Services have been strengthened; but planning remains very challenging

In 2015/16 information systems investment will be prioritised to address underlying service risks in the following areas:

- Back end software and infrastructure upgrades to keep licensing at formally supported levels

- Clinical and business systems upgrades to ensure systems can operate in these upgraded infrastructure environments ready for migration to the National Infrastructure Platform, whilst also improving resilience, security,

system availability, access and data integrity

- Refresh of the information systems service catalogue and service level agreements with the Northern Regional DHBs and healthAlliance to clarify roles and responsibilities, service provision and performance measures

- Improve user support services to include self-service options to reduce demand, ensure better use of resources and introduce service delivery management

- Investment in Regional mobility solutions.

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We have multiyear information system investment plans that will continue to be implemented during 2015/16

The region has been progressively implementing IT capital investment plans. Multi-year capital investment plans have been developed for:

- The ICT (ICT Capital Spend) maintenance and replacement programme of work progressed by healthAlliance (within depreciation and 'carry forward' funding plus 'top-up' funds)
- Clinical and Business programmes progressed by the region as new 'strategic' investment.

Further details of these investment plans and other activities and the current implementation plan with deliverables and measures are provided in Appendix A4.

Key highlights include:

- ePrescribing and Administration (ePA)
- Regional Patient Administration System / Northern Electronic Health Record (NEHR) Implementation Planning Study & Business Case Development
- Radiology/PACS
- Clinical Pathways
- eOrders for Laboratory & Radiology
- eReferrals Phase 3: Intra & Inter DHB Referrals
- Patient Portal Integration Strategy
- Shared Care Integration
- National Maternity
- National Patient Flow.

We need a new approach to achieve a single integrated Northern Region electronic health record

The development of an integrated Northern Electronic Health Record is a particularly significant IS/IT initiative for our region.

The immediate aim of the Electronic Health Record project is to identify the best way to progress a *'person-centric, regional electronic health record that will be shared by, and will integrate between the key stakeholders in a person's care'*[11].

At a forum held in February 2015 senior DHB, healthAlliance, NRA, Primary Care and Consumer stakeholders sought to align common opportunities across various strategic IT initiatives and concluded that:

- We need to accelerate progress towards implementing a Regional Electronic Health Record

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[11] As outlined in the RIS 10-20 vision

- A new approach to implementing whole of system regional informatics capability is required across the region

- A key component of the new approach is an Integrated Regional Electronic Health Record (consolidation of existing PAS and Clinical Systems with interfaces to a limited number of specialised systems) to support significant business and technology drivers across the region

- The integrated approach represents a change from an incremental specialised system approach previously adopted by the region.

Work is now underway to refresh our RIS 20-10

RIS 10-20 is being refreshed during 2015/16 to:

- Reflect the noted changes

- Inform the IS programme of work in the Northern Region

- Set the strategic context for the next phase of the Northern Electronic Health Record (NEHR) Project.

The refresh of RIS 10-20 will include an:

- Update, reflecting how new business and technology drivers have emerged across the region to support the need to implement a Regional Electronic Health Record

- Emphasis on integration of information, with provision of this information in a timely, appropriate manner in order to improve quality of care

- Update, describing how the key strategic IT initiatives have come together (WDHB's Leapfrog, CMH's Project SWIFT and the Northern Regional Electronic Health Record (NEHR) Project) to inform the change in approach to implementing a Regional Electronic Health Record. The broader vision, strategy and supporting principles for Person Centred Health Information that the region aspired to in RIS 10-20 still apply today.

Three work streams will be managed by the NEHR Project in 2015/16

The Northern Electronic Health Record (NEHR) Project will progress three work streams, during May 2015 to February 2016, as part of the next phase of work:

- Conduct an Implementation Planning Study (IPS) with the Region's preferred vendor for an Integrated Regional Electronic Health Record. A key output of the study will be an implementation framework for an Integrated Regional Electronic Health Record

- Develop an indicative business case (continuing to follow the Treasury Better Business Case process) including a full options analysis and assessment of the feasibility and affordability of an Integrated Regional Electronic Health Record implementation

- Complete further updates to RIS 10-20 as more information becomes available e.g. the detailed scope, approach and timeframe for implementation of an integrated Regional Electronic Health Record.

These will help the Northern Region to define its requirements in detail and to assess the affordability and resource implications of the NEHR on the IS initiatives and work streams outlined in the current regional IS plan. While the preferred vendor solution will be investigated in most detail, the business case work will also ensure that a range of different options are considered including, for example:

1. Maintenance of the status quo

2. Progressive development, increased investment and increased regional leadership, applying evolutionary principles to what we have
3. Transformational change, using Epic to achieve the transformation
4. Transformational change using another (as yet undetermined) product.

Consideration of the business case will provide a 'go/no-go' gateway control point before any move to progress implementation of the electronic health record. This work will be pivotal in setting the future road map for clinical and business applications in the Northern Region.

Regional IS Governance at both the strategic and operational / project level is being strengthened

In order to ensure there is robust governance and streamlined decision making over IS regionally, the Northern Region is implementing a revised IS governance framework. A Regional Informatics Governance Group (IGG) comprising senior representatives from each DHB, health Alliance, primary care and consumers will report directly to the Northern Region CEO/CMO Forum. It will be accountable for:

- Ensuring there is a regionally agreed informatics strategy that is aligned with regional clinical and business drivers
- Ensuring that the regional work plan and investments are aligned to deliver solutions that are affordable and have been through a robust prioritisation process
- Overseeing and providing guidance and support to the delivery of key regional programmes of work
- Receiving regular updates on ICT and non ICT work plans and service delivery
- Acting as a point of escalation for issues and risks.

The Informatics Governance Group will:

- Seek technical advice from three key regional advisory groups (architecture, privacy and security) that will support all informatics work regionally
- Be supported in its work by:
  o Steering Groups for key regional projects/programmes of work, with the three key programmes in 2015/16 being the Northern Region Electronic Health Record (NEHR), Care Connect and the National Infrastructure Project (NIP)
  o A Clinical and Business Applications Group
  o An ICT Group.

This regional framework has been aligned with healthAlliance NZ Ltd's roles and responsibilities as the performance of our shared services support agency is fundamental to the achievement of our objectives. Work is progressing with health Alliance to ensure that there are robust processes in place to:

- Define the business requirements of the Northern Region DHBs with regard to IS shared services

- Monitor the performance of IS shared services in line with regional priorities and requirements

- Prioritise the regional ICT programme of work, ensuring that resilience and security risks are appropriately addressed

- Prioritise national, regional and local capital IS projects

- Monitor the performance of key projects.

We have commitment to National Alignment

The Northern Region DHBs and healthAlliance are committed to working closely with the National Health IT Board to ensure that regional capital investment plans are aligned with national priorities and programmes of work.

healthAlliance (as the Northern Region Shared Services provider) is also committed to supporting the direction set by the Ministerial Committee on Government ICT. This Committee proposes a framework to ensure ICT can be used effectively across Government to achieve the performance improvements Government is seeking. Agencies need to align ICT management and investment with the following five directions:

- Provide clear leadership and direction
- Support open and transparent government
- Improve integrated service delivery
- Strengthen cross-government business capability
- Improve operational ICT management.

healthAlliance demonstrates support for this direction by:

- Providing a leadership role in the definition and implementation of a common electronic workspace (desktop) environment in collaboration with Department of Internal Affairs and the Office of the Government CIO
- Actively supporting HBL's programme of work to establish a national (health) IT infrastructure.
- Continuously improving operational IS Service Management and the effectiveness of shared services.

Workforce

Our health workforce is a key resource in delivering health services to our growing population

The workforce is the health sector's most valuable resource, and our region is committed to supporting its health workforce to provide care that is of high quality and meets the needs and expectations of our community.

The total combined workforce in the Northern Region DHBs is around 27,000 employees[12], representing 36% of the total workforce across all DHBs.

The Northern Region has four priority areas for workforce development in the 2015/2016 plan; strengthening the Māori and Pacific workforce, building clinical leadership and management capability throughout the workforce, supporting the unregulated workforce, and developing new and hybrid roles to deliver new models of care.

Strengthening the Māori and Pacific health workforce in particular continues to be an area of high priority. We aspire to achieve a health workforce that reflects the population we serve. Actions relating to our Māori and Pacific health workforce development have been guided by the Waitemata – Auckland DHB Māori Health Workforce Development Strategy 2014-2017 (Te Runanga o Ngati Whatua) and the Counties Manukau Health Pacific Health Plan 2015/16 – 2019/20.

In addition to medical, nursing, midwifery, allied health, scientific & technical staff, we are also dependent on a large number of management and support staff to ensure that we deliver high quality, safe services in the most appropriate setting for our population. The Northern Region plans to work together to strengthen clinical leadership and establish a management training framework to support and develop our managers.

Future health service delivery is challenged by an ageing population with increasing health needs, a global shortage of highly skilled and experienced health professionals and a changing demographic in the workforce and the local population. New models of care will also require us to deploy our workforce in different ways and in different settings, explore possibilities to establish innovative blended and hybrid roles, and to advance our unregulated, Kaiawhina workforce.

Seven objectives support the direction for implementation in 2015/16

The region has identified seven workforce objectives which align our regional priorities, national HWNZ strategies and local DHB activity. These are:

1. **Strengthen clinical leadership and management capability throughout the workforce:** Although our focus is on clinical leadership, we also recognise that effective leadership is important across both our clinicians and managers. We will harness our regional resources to raise the visibility and value of leadership in health and build the capability of our leaders and the wider management workforce. This includes the development of a regional health management training pathway.

2. **Grow the capacity and capability of our Māori and Pacific workforce:** To support the pipeline of Māori and Pacific employees, we will work to align existing Māori and Pacific workforce development strategies regionally, support Māori and Pacific students and graduates, promote leadership initiatives, and improve ethnicity data quality.

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[12] DHB Shared Services. (2014). DHB Employed Workforce Quarterly Report 1 July to 30 September 2014.

3. **Build and align the capability of the workforce** to deliver new models of care: We need to develop a workforce with more generic skills, which is flexible to work across both hospital and community settings. To do this, we will identify opportunities to and to support the unregulated and low-paid workforces.

4. **Increase the flexibility and affordability of the workforce** to manage rising demand: We will continue to develop and implement regional strategies to increase the flexibility of the workforce to better utilise our workforce regionally, by extending the scope of practice for particular roles and developing new and hybrid roles.

5. **Optimise the pipeline and improve the sustainability of priority Workforces**: We will identify priority workforces, and develop strategies to ensure the future sustainability of vulnerable workforce groups. This will be assisted by improving our ability to model and forecast workforce requirements.

6. **Adopt a regional approach to developing an engaged and capable workforce:** We will take a regional approach on specific workforce initiatives to strengthen our efficiency and effectiveness. In particular, we will continue to share e-learning modules, develop regional policies, procedures and processes and continue to strengthen workforce cultural competency.

7. **Optimise the capacity and capability of the RMO workforce**: We will continue to support DHBs to recruit and retain an RMO workforce aligned with service delivery and training requirements, and to support the HWNZ Medical Workforce programme.

Accountability for the delivery of the workforce elements of the plan will be shared between the DHBs, the clinical networks (which work regionally) and the Northern Regional Alliance, which encompasses the Northern Region Training Hub.

The workforce operations, training and development hub has an important role

The workforce and training hub has an important role in supporting workforce development for all post entry workforces. The hub will also collaborate with the other regional training hubs and HWNZ to share ideas and initiatives that can be rolled out to other professional groups and hubs. This will be achieved by participating in national and regional fora and continuing to work closely with our workforce partners at all levels.

Procurement and Supply Chain

Achieving best value for money

Procurement is undertaken to generate significant value and savings for the Northern Region DHBs by leveraging economies of scale. This enables negotiation of better deals with new and existing suppliers to save money for the health sector.

The region is making good progress around procurement value delivery through its business support agency healthAlliance. The National Procurement Service, operated by healthAlliance became operational on 1 July 2014. This is the first stage of Implementing the Finance, Procurement and Supply Chain Business Case.

The overarching procurement strategy and service goals for the region include:

- Transforming procurement practice in the Health Sector

- Delivery of agreed procurement activity to unlock further significant financial value once the new contract is fully imbedded across DHBs

- Managing procurement risk through policy, probity and best practice procurement

- Delivering a strong customer and partner experience supported by robust relationships and processes

- Ensuring quality in all outcomes, interactions, decisions, information and advice.

Evolution of the Finance, Procurement and Supply Chain (FPSC) solution is a key enabler for the service. It is our intention to be an early implementer in all HBL programmes within the Auckland region. Being at the forefront of these solutions is a significant leap for our region; we are committed to improving the efficiency of our operations so more money can be invested where it is needed most – providing better health care to New Zealanders.

Work is also focused on developing a common catalogue, common data structures and common data banks. These are critical in leveraging the true scale of the Northern Region network, and will help to optimise the benefits. Our collective performance in managing and leveraging our current contracts continues to demonstrate sustainable results; establishing a robust foundation to grow our realised benefits. These products contribute to building Procurement as an essential, fundamental discipline within the health sector; a discipline that is valued across all key stakeholders and communities.

Each DHB will continue to benefit from Clinical Product Co-ordination [CPC] support; ensuring that all products entering a hospital meet stringent regulatory requirements. The CPC commitment to clinical outcomes and patient well-being is reflected in their on-going local co-ordination, management and advice.

A national approach to maximise gains

Work is underway to enhance the procurement service specification to include co-ordination of the National Catalogue and Data Hub from 1 July 2015.

Benefit realisation in 2014/15 has been greater for the Northern Region than for the other regions. This is probably attributable to the Northern Region having had a shared procurement service prior to establishment of the national service.

During the 2015/16 year the Northern Region DHBs and healthAlliance will continue to work with the other DHBs to implement the national Finance, Procurement and Supply Chain Information System. This system will be completed and tested during 2015/16, and implementation into the Northern Region will take place in 2016/17 as part of the overall staged implementation.

Having a critical mass of DHBs on a national system will enable greater procurement benefits to be realised.

We are well placed to proceed with the identified initiatives

The Northern Region will continue to gain sustainable value through its partnership with healthAlliance Procurement as the team builds on the established foundation of governance to grow realised benefits.

Key procurement initiatives that will contribute to this success include:

- Developing a sustainable annual planning framework that delivers to the needs of the DHBs, the Ministry and healthAlliance

- Working with DHB's to map DHB lead and lag processes with healthAlliance procurement processes, with a view to developing a standard blueprint for the Region

- Working with supply chain to evolve a common catalogue, common data structures and common databanks

- Effective management of key supplier relationships to unlock innovation, value and drive efficiencies

- Refine the detailed service schedule with each DHB through the Annual Operating Plan process

- Improved utilisation of the Managed Service Centre to manage DHB queries and responses**.**

Facilities / Capital

A large value of assets, most of it hospital based

The Northern Region DHBs, have approximately $2.4 billion worth of assets on their books, with a replacement cost valuation of $3.3 billion.

The majority (90%), of the Northern Region's building and plant value is centered on six main hospital campuses in the region.

About 6% of our asset base is in clinical and other equipment; with large amounts invested in certain higher cost assets supporting services such as radiology and oncology. healthAlliance owns the Northern Region information system assets.

A need to invest, but limited funds

The key challenges that our region faces with respect to capital planning include:

- **IT and IS investment** - Our Region recognises that IT and IS are key enablers of change and wants to invest capital in clinical systems that support changes to models of care. Equally there is a pressing need to renew existing systems to keep abreast of developments in software and technology.

- **Growth** - Over the next 20 years the Northern Region population will grow by nearly 500,000. This will exceed the current population of any other DHB and will account for two out of every three additional people in New Zealand. It also has the fastest rate of growth in the 65+ population who

place heavy demands on health services.

- **Pressure on main acute sites** - All acute facilities in the region are operating at occupancy rates well above the 85% 'good practice' benchmark. Demand continues to place pressure on hospital beds despite initiatives to manage demand and increased delivery of care in the community setting.

- **Facilities issues** - There are a number of facilities in our region that are not fit for purpose and require substantial investment. About 17%[13] of our buildings are ranked 'poor' or 'very poor'. There are also buildings with seismic issues that will need to be addressed.

- **Replacement burden** - The region has a large 'fleet' of clinical equipment that requires regular replacement to support delivery of services. Regionally around $125million is planned to be spent on 'baseline maintenance and renewals' during 2015/16.

- **Affordability** - The financial pressures on all DHBs in the region are substantial which impacts the region's ability to fund and finance capital investments.

Clarity regarding the Minister's expectations

Equity and capital remain constrained. The Minister's expectations are very clearly stated with regard to the need to prioritise capital and to fund capital from internal resources.

A process to ensure Capital investment is aligned to regional needs

The Northern Region applies an iterative approach to capital investment planning:

- Longer term capital intentions are signaled via the annual planning process. These ensure long term visibility of potential expenditure enabling good communication between stakeholders, strong alignment of potential spend with strategic direction and prioritisation of capital projects from a regional perspective

- A 'top-down' approach is used to clarify indicative DHB financial envelopes for 'affordable' capital expenditure (this includes assessment of DHB ability to seek external funding)

- A 'bottom-up' approach is used to identify asset requirements based on an asset management planning approach within individual DHBs. This approach reflects existing asset lifecycles, local, regional and national strategic directions and changing models of clinical care

- A region wide view is ensured by the annual capital planning approach and reinforced by the Region (and DHB) business case challenge process. This also requires the consideration of regional network opinion when challenging or regionally approving capital expenditure proposals

- The Treasury 'Better Business Case' philosophy has been regionally adopted. This requires that individual business cases for capital expenditure are complete, well argued, and follow an iterative planning and development approach that ensures prioritisation of proposals by appropriate stakeholders.

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[13] % of insured asset $ value rated, 'Poor' or 'Very Poor' (score 4 or 5)

Capital Investment plans that sum to approximately $248m per annum

As a region, the planned overall capex expenditure profile equates to an average of $248 million per annum over the five years 2015/16 to 2019/20.

Figure 10 : Northern Region Planned Capital Expenditure
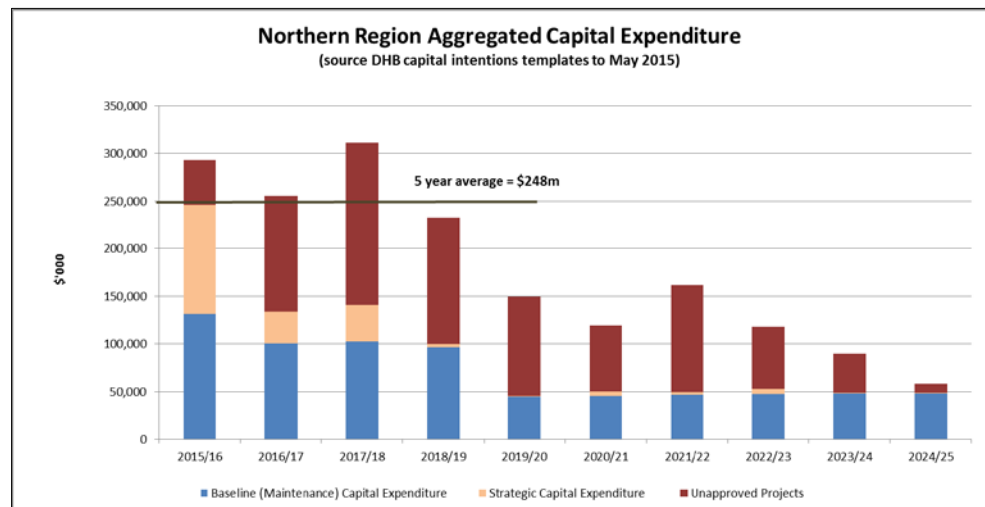
Source : DHB draft AP financial templates at 26 May 2015
Note : The above regional aggregated view of capital expenditure excludes hA IT expenditure. hA expenditure is outlined in the Regional IS/IT outline provided in Appendix 4.

Note that this regional summed view of capex excludes the IT/IS expenditure that occurs in healthAlliance (regional IS/IT). The IT/IS assets were transferred off the DHB books to healthAlliance in 2012. hA and our DHBs work together to plan for the upgrade of essential information systems across the Region and the prioritisation of investment within affordable parameters.

An ongoing planning process with key projects planned across our Region

The regional capital planning process is ongoing. Some of the more significant facility capital projects currently signaled in the Northern Region include:

- *Northland DHB's key projects* include
    - Whangarei new ED and Acute Assessment Unit (which is strongly linked to the rebuild of the Kitchen and the CSU due to location and physical relationships)
    - Redevelopment of the Bay of Islands hospital with an Integrated Family Health Unit(a co-location of services in a rural setting)
    - Maternity Unit and upper shell (currently underway and nearing completion, maternity opening November 2015)
    - An additional Operating Theatre and Endoscopy Suite for Whangarei
    - Informatics work focuses on the Web Patient Administration system implementation

  Northland
    - Has a number of other smaller projects (≤ $5m) underway or planned, including:
        - a training facility to meet the needs for undergraduate and graduate training
        - A refurbished paediatric ward
        - Expanded laboratory
        - Is progressing a potential 'sell & leaseback' capital funding arrangement for the Whangarei office building.

- *Waitemata DHB's main capital projects* include:
    - Medical Tower on the North Shore campus – This is a priority

71

replacement of the existing 1960's tower block which has wards that are unfit for purpose. This project will also add additional capacity to meet the rapid population growth in the Waitemata region.

- o Repair and upgrade of poor condition facilities at the Mason Clinic – This project addresses risks to health and safety of patients and staff. It also provides additional capacity at the request of the MoH.
- o Ambulatory Centre currently comprising Breast Screening and Servicing, Haematology/Oncology and associated infrastructure
- o Waitakere Maternity facility upgrade
- o Surgical Tower on the North Shore campus.

- • **Auckland DHB's key capital projects** during the planning horizon include:
  - o Auckland City Hospital [ACH] Integrated Cancer Service Facility
  - o Renal dialysis unit rebuild
  - o ACH Accident and Emergency Department Expansion
  - o Expansion of endoscopy suites at ACH and Greenlane
  - o The Northern Region Electronic Health Record [NEHR] is a high priority informatics project for ADHB
  - o Other signalled projects and placeholders include:
    - ▪ Mental Health beds
    - ▪ New radiotherapy capacity
    - ▪ Additional medical bed capacity for growth
    - ▪ Additional car parking capacity.

- • **Counties Manukau DHB itemised capital projects:**
  - o The most significant currently signalled include:
    - ▪ Adult Mental Health Services and Facilities
    - ▪ Spinal Rehabilitation facilities
  - o Other key points of note include:
    - ▪ Medical Oncology
    - ▪ Endoscopy developments in support of colonoscopy targets
    - ▪ Urology development proposals (early thinking with potential for regional impacts)
    - ▪ Diagnostics (Laboratory and Radiology developments)
    - ▪ The Women's Health development is still proposed with a potential start date in 2020/21.
    - ▪ In order to recommend an integrated investment direction for the next ten years, the investment business case process is focused on aligning future strategic investment objectives with other Counties Manukau Health programmes and projects such as:
      - • Development of localities and Community hubs (early thinking concepts)
      - • The 20,000 bed days project
      - • Strategy refresh 2020

      "Investment" in this context does not just mean capital; some initiatives require significant operational investment (including borrowing costs for any new facilities).

The major facility projects planned in the Region and their indicative costs over the next 10 years as of March 2015 are listed in Appendix A.4.

Capital Investment Committee timeline

The following table outlines business cases currently anticipated for submission from the Northern Region to the Capital Investment Committee during 2015/16.

Table 5 : Proposed Business Case Submissions to NHB CIC July 2015- June 2016

DHB – Project	Strategic Assessment	Indicative Business Case	Detailed Business Case
NDHB – ED/AAU	Nov-15	May-16	Nov-16
WDHB - Mason Clinic 15 bed unit additional works	Oct-15	TBC	TBC
WDHB - comprising Breast Screening and Service Centre. Haematology /Oncology and associated infrastructure	Sep-15	TBC	TBC
WDHB – North Shore Hospital Medical Tower	Sep-15	TBC	TBC
ADHB – (NEHR)	Jun-15	Likely Dec -15	Likely Aug -16
ADHB - ACH Integrated Cancer Centre	Business case being developed: submission to CIC tbc		
ADHB - A&E	Business case being developed: submission to CIC tbc		
ADHB - Renal Dialysis	Business case being developed: submission to CIC tbc		
CMDHB – Acute Mental Health*	Complete	Complete	Apr-15
CMDHB – Specialist Rehab	Complete	May-14	To be confirmed
CMDHB - Swift	Business case being developed: submission to CIC tbc		
CMDHB – Diagnostics (Radiology)	Single Stage Business Case: submission to CIC tbc		

*Note: the CMDHB Acute Mental Health project was approved and announced by the Minister in May 2015

During 2015/16 the Region will contribute to, and support, DHB work to develop the Strategic Assessments, Indicative Business cases and detailed Business Cases as required for NHB-CIC, with a particular focus on:

- Achieving greater clarity regarding IT capital planning and national approval requirements

- Ensuring involvement of key stakeholders (eg Regional Clinical networks) and completion of appropriate local governance stages (eg Regional Capital Group review) in a timely manner to support achievement of the milestones reported above.

Regional work over the coming year to clarify capital investment requirements will be focused on:

- Meeting the capital planning requirements of the Ministry of Health and The Treasury

- Ensuring appropriate regional oversight, review and endorsement of DHB capital development plans and business cases by the Regional Capital Group

- Achieving a view on the most appropriate capital plans for certain specific areas in relation to Regional service planning, namely:
  o Information Systems;
    - Regional informatics is a major focus this year; aligning DHB IS plans and clarifying the path to achieve an Northern Electronic Health Record [NEHR]. The informatics programme of work is ambitious
    - Refresh of the Regional Information Strategy 2010-2020
    - Undertake an implementation planning study [IPS] regarding the Northern Electronic Health Record [NEHR]
    - Further clarifying and confirming a short to medium term capital budget and prioritised work plan for ICT Infrastructure and non-ICT Business Transformation projects and the impact on DHB financial plans

  o Cancer services (in support of faster cancer treatments)

  o Endoscopy services
    - Facilities and infrastructure
    - Workforce planning

  o Radiology services
    - Asset management plan refresh
    - ISSP work

  o healthAlliance procurement / supply chain initiatives

  o Business support initiatives
    o Food services (kitchens)
    o Linen and laundry services
    o National infrastructure programme.

The above provide the main focus for on-going regional work and complement the local, DHB-led, work on capital planning.

Regional Governance of Capital Planning

The regional governance for capital planning is centred upon the Regional Capital Group with escalation mechanisms to the CEO/CMO forum as required. The Regional Capital Group comprises:

- The CFOs of each DHB
- One other attendee from each DHB; business or clinical focus as determined by the DHB CFO
- The CEO and CFO of healthAlliance
- The GM of Northern Regional Alliance [NRA] (Chair)
- Secretariat service to the RCG is provided by the NRA
- Each DHB has one vote on agenda items hA and NRA are non-voting/ in-attendance.

The role of the Regional Capital Group is to ensure that due process has been followed with regard to capital planning, that appropriate regional stakeholder groups and clinical networks have been involved in decision making and that a regional view has been considered and applied within the logic of business cases.

The Regional Capital Group ensures that appropriate awareness of capital projects is achieved across the region; at all levels in the planning process.

Commitment to ensure effective utilisation of our assets

We are committed to exploring alternative models of care and different approaches. This will help us to meet our fiscal challenges and to ensure that the region's asset base is effectively utilised. Our actions include:

- Proactively challenging models of care in all planning processes
- Rigorous challenge around 'best location' for service provision, including:
  o Focusing on demand management activities that will reduce hospital admissions
  o Considering whether activity can be channelled to a lower cost setting without compromising clinical or workforce sustainability
  o Whether there is spare capacity elsewhere which could practically be used rather than investing in additional capacity
- Partnering with private, where appropriate, to develop an alternative means of accessing facilities or equipment which may include public private partnership models
- Exploring ways to increase throughput by improving productivity within current working hours as well as extending operating hours
- Working regionally to smooth the investment profile
- More aggressive use of joint procurement processes
- Ensuring that investments are challenged around value for money
- Managing projects effectively to ensure that they are delivered within budget and on time.

Our region will continue to promote strong clinical engagement in all aspects of our planning and to ensure that redesigns of models of care are clinically led.

7.   The Way Forward

The prioritised programme of work mapped out in this plan builds on a strong history of regional collaboration over the last decade. It is only by working together across all care settings that we will be able to address the challenges of the future.

Accountability for delivering our plan will depend on strong governance

The Regional Governance Manual sets out the DHBs' regional governance arrangements. It describes how the different regional entities and groups relate to each other and summarises how they will work together to improve health outcomes and reduce disparities by delivering better, sooner, more convenient services.

Our governance model is outlined below.

Figure 11 : Regional Governance Model
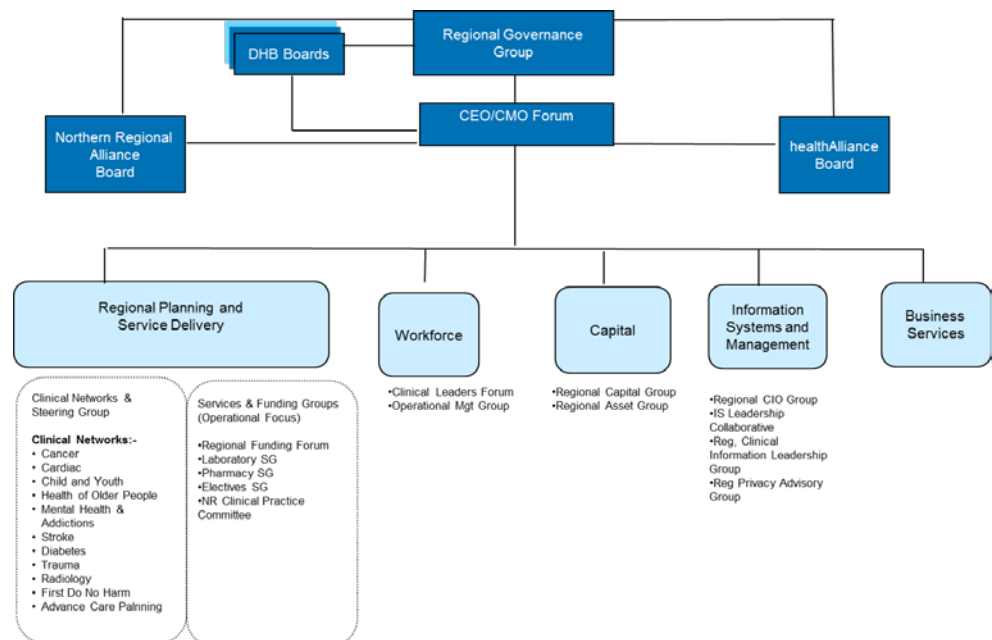
Two key governance groups oversee all clinical and business services activities. These are:

The Regional Governance Group has oversight across all clinical and business service activities, with other groups providing more detailed support and guidance

- **Regional Governance Group** that comprises Chairs, CEOs and CMOs. The key accountabilities are to:
  - Approve regional strategy
  - Shape thinking on the regional direction, particularly in relation to long-term planning of regional health service
  - Monitor progress and performance against regional plans and drive the regional collaboration agenda
  - Act as an escalation point for matters of strategic importance

- **Regional CEO/CMO Forum** that has the following key accountabilities:
  - Determine regional strategy and provide leadership for the regional agenda
  - Agree annual and three year strategic priorities and plans

77

- o Monitor performance against plans
- o Approve allocation of resources/budgets for regional organisations and programmes
- o Act as a first point of escalation for issues that cannot be resolved through other regional forums.

The Northern Regional Alliance Board will oversee regional health service delivery and workforce activities

The Northern Regional Alliance (NRA) works in conjunction with the four Northern DHBs to achieve the Minister's and region's priorities and to support the effective implementation of policy directions and objectives. In particular, the NRA will support the four Northern DHBs in areas where there is benefit from working regionally. The NRA leads the delivery of the health service and workforce activities as outlined in this Plan.

Broadly, NRA's scope of services includes:

- Workforce development, training and RMO operations

- Regional health service planning, coordination and delivery

- Corporate and business support.

The NRA also supports links with the Health Workforce New Zealand (HWNZ) and Health Quality and Safety Commission to ensure that the regional and national priorities are aligned.

The Regional Planning and Service Delivery cluster comprises steering groups, networks and service groups established to:

- Provide visible and credible leadership to the region for health service planning including Northern Region Health Plan development, oversight and embedding activity in business as usual operation

- Develop regional strategy and oversee the 3 year regional planning cycle

- Provide Clinical network and regional service delivery oversight

- Strengthen whole of systems clinical engagement in health service planning and delivery oversight

- Oversee population health analysis and the development of an appropriate regional performance reporting framework and processes to support the implementation of this framework

- Oversee the development of future models of care and configuration of services, ensuring the clinical and financial sustainability of services and the region's workforce

- Sponsor key regional health service projects including laboratory services, radiology services, service reviews, vulnerable services etc.

- Monitor and receive updates on key regional strategic initiatives

- Act as point of escalation for regional health services issues that require urgent progress or resolution.

The healthAlliance Board will oversee business services activity	healthAlliance is the regional business services agency for the four DHBs. The key service activities are finance (transactional processing), procurement, supply chain, information services, and Regional Internal Audit Services. The activities of this organisation are governed by the healthAlliance Board which comprises five directors including one representative from each DHB and one representative from Health Benefits Limited. This reinforces the commitment between HBL and hA to ensure there is strong alignment between their priorities and work programmes.
	healthAlliance leads the delivery of the business services, including Information Systems and Procurement and Supply Chain as outline in this Plan.
Chief Executive Officer and clinical leadership is embedded in all regional activity	Our CEOs and clinical leaders are at the forefront of leading and being involved in regional activity.
	Our CEOs have each taken a lead role on different aspects of the Northern Region Health Plan. Clinical governance of the overall Northern Region Health Plan is provided by the Chief Medical Officers who provide networks with support and leadership, and are the key link between networks and other senior management.
	Clinical leaders are appointed to lead the networks and are the key people on point for their services. The leaders work in partnership with the multidisciplinary members of the network to identify and progress the specific initiatives. Clinical membership on networks typically comprises doctors, nurses and allied health from across the primary and secondary sector, and the non-governmental sector.
	Much of the successes over the past three years can be attributed to our senior executive commitment and our clinical leaders. Over 2014/15 they will continue to be instrumental in creating a trusting and collegial regional culture and promoting leading practice and innovation in clinical care.

Whole of System Implementation

A whole of system plan with accountability for delivery shared between all signatories	There is a reasonably complex array of organisations involved in the implementation of the initiatives highlighted in this plan. In some instances one organisation will lead an initiative, and others will contribute and participate to supporting the lead. In a number of instances all organisations will have shared accountability for delivery and performance.
	The following articulates, at a high level, the alignment of the role and the accountability each organisation has in the delivery of this plan:

- **District Health Boards**

  DHBs will continue to take the lead on assessing the health needs of populations and funding services to meet these needs. They will also continue to deliver predominantly hospital and community specialist services. DHBs will continue to sponsor the governance groups and, in partnership with the signatories of this plan, will provide oversight of performance against the priority goals and achieving improvements in patient outcomes.

  DHBs will also take greater responsibility and accountability for integration and the performance of primary care in their districts. This is expected to be achieved by continuing to build local partnerships through collaboration and forming alliance agreements.

Other DHB activities will include:

- o Active participation of clinicians and managers in networks and the delivery of DHB and regional priorities
- o Supporting the development of locality networks and Integrated Family Health Centres
- o Aligning funding to the Northern Region Health Plan and DHB priorities
- o Supporting primary care partners and the BSMC Whānau Ora providers.

- **Clinical Networks**

  The focus of clinical networks will continue to be collaborative planning and monitoring across levels of care and organisations. Networks will be the key mechanism to drive:
  - o The strategic direction and prioritised initiatives across primary, community and hospital care
  - o Performance targets and adjusting resources and workplans to improve health outcomes for the population
  - o Engagement with primary, community and secondary care providers and the users of services.

- **Alliance Partnerships in Primary Care**

  Primary care providers are critical to the delivery of the plan. PHOs will be the key mechanism to drive changes to clinical practice associated with delivering a greater breadth of services locally. They will have a stronger focus on planned care for high-needs populations to prevent acute and unplanned admissions, and supporting older people to live independently.

  The seven Auckland PHOs have five key areas of focus:
  - o System outcomes to design and implement optimal performance and incentive framework
  - o New models of care that optimise self-directed care at home and in the community
  - o Developing fit for purpose practice models that deliver proactive patient centered care
  - o Information infrastructure to enable integrated and self-directed care
  - o Governance to drive and sustain the change agenda.

  Ten priority areas support these areas of PHO focus, which largely align to the Northern Region Health Plan. During 2015/16, work will continue to progress initiatives in these areas, to provide a much stronger and more concerted effort to address the priorities.

  The Northland PHOs have similar focus areas to the Auckland PHOs and continue to develop their own planning intentions in a collaborative manner with the Northland DHB.

- **Other Social Sector Agencies**

  Linkage with other social agencies important in the delivery of this plan, particularly with regard to Child Health. The health outcome for many of the children in the care of health services depends on addressing the upstream determinants of health. Children with, or at risk of, rheumatic fever and respiratory conditions will receive preferential access to housing services to address structural and functional overcrowding and to enable warmer houses. Initiatives such as the Vulnerable Children's Teams will involve collaboration with agencies such as Child, Youth and Family, education providers, and Ministry of Social Development to deliver whole of system care to the most vulnerable children and their families.

- **Aged Residential Care**

  Aged Related Residential Care (ARRC) comprises a number of operators who provide residential care for our elderly. The operators range from having strong commercial concerns to those with a social care philosophy. Cooperation and collaboration with the range of ARRC providers will be important in the implementation of activities to reduce acute presentations from residential care and increase advanced care planning activities, and to improve the safety of patients from falls and pressure injuries.

- **Non-Governmental Organisation (NGO) sector**

  This sector is very important to many aspects of this plan, particularly Health of Older People, Mental Health and Addictions, Cancer, and Child Health. In each of these workstreams, linkages exist or are being strengthened to share information and align activities. These relationships are important to ensure consistent messages are being provided, regardless of where our population seeks help.

- **National Organisations**

  Alignment with a number of national organisations is also signalled, particularly:
  - HealthWorkforce New Zealand on workforce initiatives which are being driven nationally. This will impact the regional workforce initiatives as well as those identified in individual workstreams
  - Health Safety and Quality Commission
  - National Health IT Board to maintain the alignment between the national and regional priorities
  - National Health Committee to ensure our decision making is aligned with prioritised new and existing technologies and interventions. Our region is committed to working with the NHC and implementing their recommendations. Our region has established a Regional Clinical Practice Committee.

The strength of the whole of system approach is best illustrated by consideration of the continuum of care. The diagram below summarises the key areas of focus and interventions that require multiple agency co-operation and collaboration to implement and embed change.

Figure 12 : Whole of System - Areas of Focus that Require Multiple Agency Cooperation Across the Continuum of Care

Key implications for primary care

Prevention	Early detection	Diagnosis	Treatment	Rehab	End of life
Use of Global Trigger Tool	Roll-out of Rheumatic Fever and skin clinics in schools	Faster cancer treatment and tumour standards		Strengthened community cardiac rehab	
Child health initiatives: nutrition immunisation, smoking, safe sleep	CVD and diabetes Risk assessments	Chronic and long term conditions Acute demand management		Stroke rehab services	
Support upstream determinants of health: housing, education, family support	Timely access to diagnostic imaging and pathology	New pathways and models of care` : ■ Dementia ■ Psychogeriatric ■ Chronic cough and asthma ■ High risk foot			More tools available for Advance Care Planning
Alternative options for care for older people		Increased access to youth forensic and alcohol & drug services			

Enablers			
Change to primary care nursing models: Nurse prescribing, Nurse led clinics, Primary/secondary integration	Primary care Alliance Partners		Shared care IS to enable primary to tertiary clinical teams and the patient to share care planning.
Grow workforce to reflect new models and the community we serve	Locality networks.		

Implementation Plan

Oversight across all workstreams will be required to ensure the region delivers the plan

At a regional level, we will be monitoring progress against the activities that have been committed to as part of this plan.

The initiatives outlined in relation to the three priority goals are the main focus of our work over the next year. In addition, there are a number of other initiatives outlined with regard to each of the key enablers and radiology, laboratory and other service planning priorities. The following roadmap provides an overview of the key initiatives being planned in these areas.

Figure 13 : Implementation Plan Roadmap
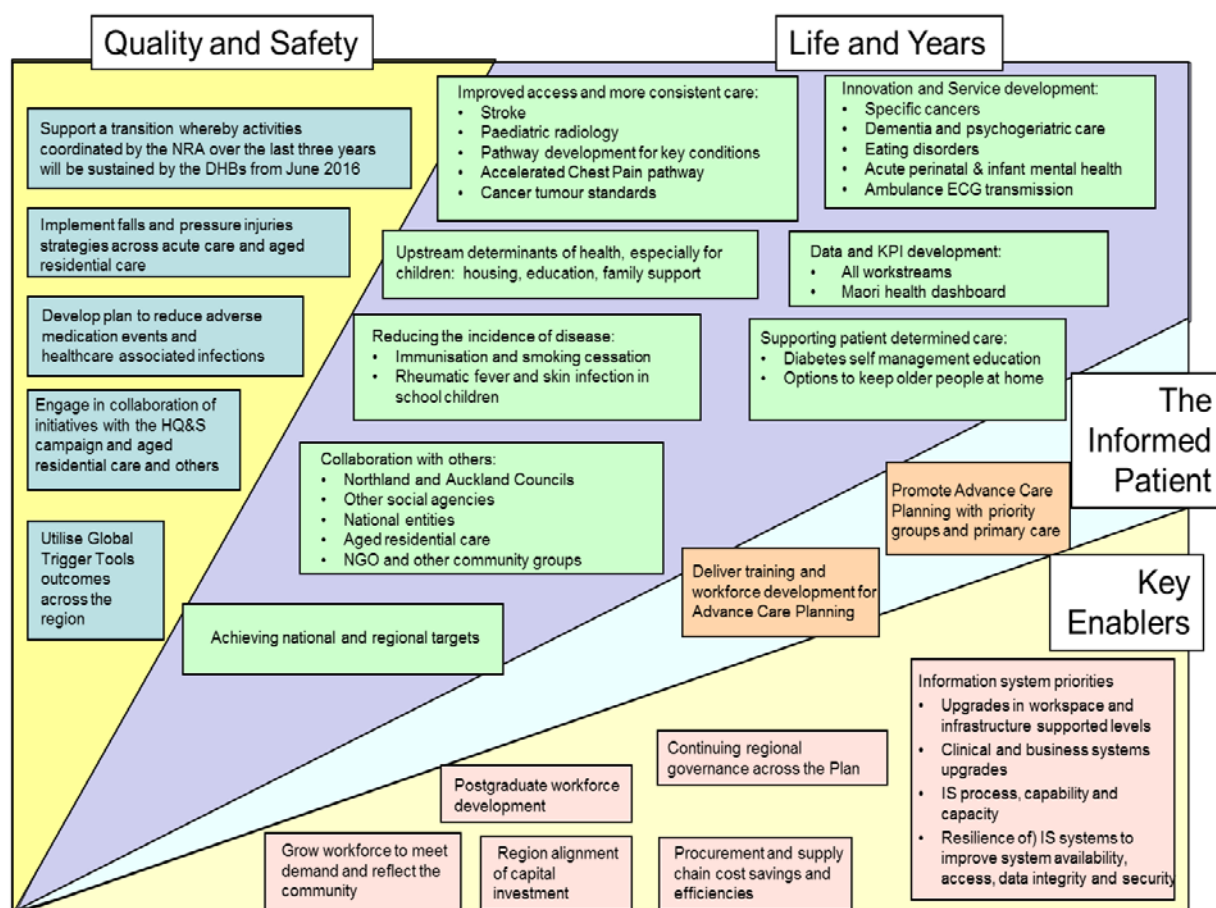
Implementation Risks

This plan maps out an ambitious work programme. There is strong agreement regionally that the direction is right. Our plan is not without risk, however only some of this risk can be managed regionally.

Table 6 : Implementation Risks

Risk	Description
Impact on primary health care	There is significant cumulative change on primary care arising from the directions articulated in this plan. Common themes suggest that patients are more proactively managed in the community and new models of care are being developed. Primary care comprises a large group of doctors, nurses and allied health and other people. Therefore there are a number of challenges associated with communicating the key directions, managing the changes, and evaluating the impacts of the changes. Time and effort will be needed to support primary care providers to implement the changes.
Implementation costs	All DHBs in the region are actively working to reduce their deficits. This plan requires ongoing funding. Some funding may be managed by internally shifting resource, and some will require funding in 2015/16 for a later pay back. The region's governance structures will continue to have challenging prioritisation discussions to ensure the region can deliver on this Plan in a fiscally constrained environment.
Affordability	The operating cost of current models of care and the capital investment required to maintain these models is of particular concern to the region. Facilities in the region are working to capacity. Substantial investment is required in staff, facilities and key equipment if waiting times and service levels are to be met and demographic growth accommodated. It will take 5 - 10 years before changes outlined in this plan can be expected to have a significant impact on slowing growth in demand for hospital based services.
Information systems	Information systems are critical to support many of the proposed changes in models of care. It will however take several years to deliver on the prioritised initiatives. This may be slowed further by access to capital funding and affordability of proposed investments.
Workforce	Time is needed to grow the workforce to work in new fields, and expanded roles. Until the workforce role changes occur it will be hard to build momentum around some initiatives where current staff is already stretched to deliver in their current roles.
Interdependencies with other work	Concurrent work is being undertaken at local, regional and national levels. There is strong alignment but the cumulative change agenda is significant and will require careful management at a regional level. The leaders and change agents within our region are frequently asked to champion or participate in many concurrent work areas. As priorities change is can be hard to sustain long term work plans due to the capacity of key individuals to support multiple workstreams.

Commitment to Achieving Better Outcomes for Our Population

This plan signals our commitment to work together to achieve our goals

In this plan we have outlined the goals and initiatives we have committed to this year. It continues to be an ambitious programme of work; however we are confident we have the right foundations in place to achieve our goals.

The level of commitment shown to this plan from the four DHBs and our primary care and community partners gives us confidence that we can embed the changes required across all levels of our health system. To realise our goals we will continue to develop the relationships we have established, particularly across primary, community and hospitals services. This will achieve a level of integration which is both meaningful and productive.

Our clinical networks and steering groups are leading the transformation in our health system, and the incremental steps being undertaken will progressively improve patient health outcomes and increase efficiency across the health system. These steps will add up to significant benefits and will transform our health system to be fit for the future.

Glossary of Terms

ACP	Advance Care Planning
ADHB	Auckland District Health Board
AH+	Alliance Health Plus
ALT	Alliance Leadership Team
AOD	Alcohol or Other Drug
ARRC	Aged Related Residential Care
BSMC	Better, Sooner, More Convenient (Primary Care)
CEO	Chief Executive Officer
CDR	Clinical Data Repository
CLAB	Central Line Acquired Bacteraemia
CMDHB	Counties Manukau District Health Board
CME	Continuing Medical Education
CMO	Chief Medical Officer
CNE	Continuing Nursing Education
COPD	Chronic Obstructive Pulmonary Disease
CSSD	Central Sterile Supply Department
CT	Computed Tomography
CVD	Cardiovascular Disease
CWS	Clinical Workstation
DAH	Director of Allied Health
DHB	District Health Board
DNA	Do Not Attend
DON	Director of Nursing
ED	Emergency Department
FAST	Face, Arm, Speech Test
FSA	First Specialist Assessment

FTE	Full Time Equivalent
GP	General Practitioner
GTT	Global Trigger Tool
hA	healthAlliance
HBL	Health Benefits Ltd
HCP	Health Capital Budget
HOP	Health of Older People
HWNZ	HealthWorkforce New Zealand
IFHC	Integrated Family Healthcare Centre
IS	Information Systems
IT	Information Technology
KPI	Key Performance Indicator
MDM	Multi-disciplinary Meeting
MELAA	Middle Easterm Latin American and African
MPT	Mama, Pepi and Tamariki
MRI	Magnetic Resonance Imaging
NASC	Needs Assessment Service Coordination
NDHB	Northland District Health Board
NGO	Non-Government Organisations
NHC	National Hauora Coalition
NHI	National Health Index
NRA	Northern Regional Alliance
NRHP	Northern Region Health Plan
OKT	Oranga Ki Tua
PAH	Potentially Avoidable Hospitalisations
PAS `	Patient Administration System
PGY	Post Graduate Year
PHO	Primary Healthcare Organisation
PMH	Primary Mental Health

RF   Rheumatic Fever

RIS   (Northern) Regional Information Strategy

RMO   Resident Medical Officer

ROOG   Regional Oncology Operations Group

RVU   Relative Value Unit (Radiology)

SMO   Senior Medical Officer

STEMI   ST Elevation Myocardial Infarction

SUDI   Sudden Unexplained Death of an Infant

TIA   Transient Ischemic Attack

TOP   Terminations of Pregnancy

WDHB   Waitemata District Health Board

Appendix A.1:

Northern Region Health Plan - Development Phase Contributors

Regional Governance Group	REGIONAL GOVERNANCE GROUP							
					DHBS		Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	NDHB	Tony Norman				X		
		Nick Chamberlain				X		
		Mike Roberts	X					
	WDHB	Lester Levy				X		
		Dale Bramley				X		
		Andrew Brant	X					
	ADHB	Lester Levy				X		
		Ailsa Claire				X		
		Margaret Wilsher	X					
	CMDHB	Lee Mathias				X		
		Geraint Martin				X		
		Gloria Johnson	X					

CEO/CMO Forum	CEO/CMO FORUM							
					DHBS		Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	NDHB	Nick Chamberlain				X		
		Mike Roberts	X					
	WDHB	Dale Bramley				X		
		Andrew Brant	X					
	ADHB	Ailsa Claire				X		
		Margaret Wilsher	X					
	CMDHB	Geraint Martin				X		
		Gloria Johnson	X					

		REGIONAL CAPITAL GROUP						
					DHBS		Primary	
Regional Capital Group		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	NDHB	Meng Cheong				X		
		Mike Cummins				X		
	WDHB	Robert Paine				X		
		Chris Watson				X		
		Jo Brown				X		
	ADHB	Rosalie Percival				X		
		Auxilia Nyangoni				X		
	CMDHB	Ron Pearson				X		
		Pauline Hanna				X		
	hA	Pat Richards				X		
		Ross Chirnside				X		
		Rosemary Chung				X		
	NRA	Sarah Prentice				X		
		Tony Phemister				X		

		REGIONAL FUNDING FORUM						
					DHBS		Primary	
Regional Funding Forum		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	NDHB	Joyce Donaldson				X		
	WDHB/ ADHB	Debbie Holdsworth				X		
		Simon Bowen				X		
	CMDHB	Benedict Hefford				X		
		Margie Apa				X		
	NRA	Sarah Prentice				X		
	Primary Care	Tim Wood						X
		Campbell Brebner						X
		Stuart Jenkins						X
		Louise McCarthy						X

		CLINICAL LEADERS FORUM - WORKFORCE						
			DHBS				Primary	
	Team Member	Medical	Nursing /Midwifery	Allied Health & Technical	Other	Clinical	Other
NDHB	Mike Roberts	X					
	Margareth Broodkoorn		X				
	Pat Hartung - *Human Resources*				X		
WDHB	Andrew Brant	X					
	Jocelyn Peach		X				
	Jenny Parr			X			
	Jean McQueen					X	
	Fiona McCarthy - *Human Resources*				X		
ADHB	Margaret Wilsher	X					
	Margaret Dotchin		X				
	Sue Waters			X			
	Maggie O'Brien		X				
	tbc - *Human Resources*				X		
CMDHB	Gloria Johnson	X					
	Denise Kivell		X				
	Martin Chadwick			X			
	Campbell Brebner					X	
	Thelma Thompson		X				
	Beth Bundy - *Human Resources*				X		

INFORMATICS GOVERNANCE GROUP							
		DHBS				Primary	
	Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
NDHB	Nick Chamberlain	X					
WDHB	Andrew Brant	X					
ADHB	Ailsa Claire				X		
CMDHB	Gloria Johnson	X					
Primary Care	Steve Boomert						X
Consumer	Jo Fitzpatrick						X

	FIRST DO NO HARM (Steering Group Members)						
		DHBS				Primary	
	Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Region	Karen O'Keeffe(NDHB)(CL)		X				
	Peter Leong				X		
	Kelly Fraher				X		
	Gael Panama				X		
	Lyndsay Fortune				X		
NDHB	Alan Davis	X					
	Cristina Rood				X		
WDHB	Penny Andrew	X					
	Jenny Parr		X				
	Kim Bannister					X	
ADHB	Andrew Jull		X				
	Colin McArthur	X					
	Jane Lees		X				
	Sally Roberts	X					
CMDHB	Gloria Johnson	X					
	David Hughes	X					
	Jacqueline Ryan				X		
HQSC	Karen Orsbom						X
	Liz Price						X
Consumer	Judith Lunny						X
	Renee Greaves						X

First Do No Harm

CL – Clinical Lead

			CANCER					
				DHBS			Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Northern Region Cancer Governance Board	Andrew Brant (Chair) (CL)	X					
		Ailsa Claire				X		
		Wilbur Farmilo	X					
		Vanesse Geel				X		
		Richard Sullivan	X					
		Cath Cronin				X		
		Deirdre Maxwell				X		
		Margaret Dotchin		X				
		Kim Tito				X		
		Aroha Haggie				X		
		Benedict Hefford				X		
	Network Tumour Streams	Richard Sullivan (ADHB) (CL)	X					
		Deirdre Maxwell				X		
		Chris Lewis/Paul Dawkins	X					
		Rowan Collinson	X					
		Richard Doocey	X					
	Regional Oncology Operations Group	Richard Sullivan (Chair)	X					
	Faster Cancer Treatment Technical Group	Ian Butler (Chair)				X		
	Cancer Control Steering Group Chairs	Nick Chamberlain (NDHB)	X					
		Jonathan Koea (WDHB)	X					
		Richard Sullivan (ADHB)	X					
		Richard Small				X		

CL – Clinical Lead

| | | | CARDIOVASCULAR DISEASE | | | | | | |
| | | | DHBS | | | | Primary | |
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Tony Scott (WDHB) (CL)	X					
		Helen McKenzie				X		
		Tony Phemister				X		
	NDHB	Ada Schuler		X				
		Andrew Potts				X		
		Peter Wood				X		
		Stephen Jennison	X					
	WDHB	Barbara O'Shaughnessy				X		
		Hamish Hart	X					
		Kim Bannister					X	
		Jo Brown/ Lorraine Bailey				X		
	ADHB	Jim Kriechbaum					X	
		Jim Stewart	X					
		Mark Webster	X					
		Samantha Titchener				X		
		Joy Farley				X		
		Mark Edwards	X					
		Peter Ruygrok	X					
	CMDHB	Brad Healey				X		
		Helen Liley					X	
		Leanne Elder				X		
		Andrew Kerr	X					
		Selwyn Wong	X					
		Patrick Kay	X					
		Wing Cheuk Chan	X					
	Diabetes	Catherine McNamara	X					

CL – Clinical Lead

| | | | CHILD HEALTH | | | | | |
| | | | DHBS | | | | Primary | |
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Timothy Jelleyman	CL					
		Pam Henry				X		
		Tony Phemister				X		
		Deb Christiansen				X		
		Mark Harris				X		
		Anna Blackwell				X		
		Aroha Haggie				X		
	NDHB	Roger Tuck	X					
		Jacqui Westren				X		
		Shane Stanners				X		
		Jeanette Wedding				X		
	WDHB	Andrew Brant	X					
		Stephanie Doe		X				
		Patsy Prior				X		
		Marianne Cameron		X				
		Helene May			X			
		Natalie Desmond				X		
		Linda Harun				X		
		Wai Vercoe				X		
		Satha Kanagaratnam	x					
		Patricia Bolton	X					
		Meia Schmidt- Uili	X					
	ADHB	Kathy Peacock				X		
		Alison Leversha	X					
		Emma Maddren				X		
		Mike Shepherd	X					
		Linda Haultain			X			
		Heather Roberton			X			
		Mike Butcher			X			
	ADHB/WDHB	Ruth Bijl				X		
	CMDHB	Phillipa Anderson	X					
		Christine McIntosh	X				X	
		Wendy Walker	X					
		Christine McKay				X		
		Marianne Scott				X		
		Michelle Nicholson- Burr		X				
		Nettie Knetsch				X		
	NHC	David Jansen					X	
	University of Auckland	Dianna Lennon	X					
		Innes Asher	X					
	Alliance Health Plus	Pauline Sanders-Telfer		X				
	Auckland PHO	Barbara Stevens					X	
	Te Hononga	Jo Peterson					X	
	Procare	Alan Moffitt					X	
		Nicola Young					X	
		Lorraine Hetaraka- Stevens					X	
	Well Child Tamariki Ora Provider	Tui Makoare-lefala					X	
		Jess Beauchamp					X	

CL – Clinical Lead

		YOUTH					
		DHBS				Primary	
	Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
NDHB	Jessica Kimberly	X					
	Michael Sullivan				X		
	Aniva Lawrence					X	
	Trish Palmer		X				
	Meryl Frear				X		
WDHB	Tracey Walters				X		
	Fionna Bell						
	Therese Rongonui				X		
	Sione Feki				X		
ADHB/WDHB	Ruth Bijl				X		
	Alison Leversha	X					
	Rachael Harry	X					
	Heidi Watson						
CMDHB	Julia Shaw				X	X	
	Carmel Ellis				X		
	Simon Denny	X					
	Paul Vroegop	X					
Region	Bridget Farrant (CL)	X			X		
	Helen McKenzie				X		
	Andrew Brant (CMO)	X					

CL – Clinical Lead

		Team Member	DHBS				Primary	
DIABETES			Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Catherine McNamara (CL)	X					
		Helen McKenzie				X		
		Tony Phemister				X		
	NDHB	Catherine Turner						X
		Andrea Taylor		X				
		Rose Lightfoot						X
	WDHB	Michele Garrett			X			
		Andrew Brant	X					
		Jean McQueen		X				
		Simon Young	X					
		Kim Bannister					X	
		Jagpal Benipal				X		
	ADHB	Jim Kriechbaum					X	
		Paul Drury	X					
	CMDHB	Brandon Orr-Walker	X					
		Helen Liley					X	
		Carolyn Jones				X		
	CVD	Tony Scott	X					
		Helen McKenzie				X		

		HEALTH OF OLDER PEOPLE						
				DHBS			Primary	
	Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Alan Davis (NDHB)(CL)	X					
		Chris Pegg				X		
		Tony Phemister				X		
	WDHB	John Scott	X					
		Rob Butler	X					
		Martin Connolly	X					
		Janet Parker		X				
		Sandie Cherrington		X				
	ADHB	Richard Worrall	X					
		Maree Todd	X					
		Jane Lees		X				
		Trina Johnson			X			
		Kate Sladden				X		
	CMDHB	Geoff Green	X					
		Kathy Peri		X		X		
		Dana Ralph-Smith						
	Oceania	Barbara Sangster					X	
	CHT	Liz Webb					X	
	Presbyterian Support North	Andrea McLeod					X	
	The Selwyn Foundation	Bart Nuysink					X	
	Consumer	Margaret Willoughby						X

CL – Clinical Lead

		MAJOR TRAUMA						
				DHBS			Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Ailsa Claire (ADHB)				X		
		Michael Roberts (NDHB)	X					
		Siobhan Isles PM				X		
	St John Ambulance	Tony Smith	X					
		Jo Goodfellow			X			
	NDHB	Andrew McClelland	X					
	WDHB	David Lang	X					
		Helen Hogan				X		
	ADHB	James Hamill	X					
		Alex Ng	X					
		Rhondda Paice	X		X			
		Rangi Dempsey				X		
	CMDHB	Murray Cox	X					
		Sylvia Boys	X					
		Kevin Henshall		X				

CL – Clinical Lead, PM = Programme Manager

		MAORI, PACIFIC AND INEQUALITIES						
				DHBS			Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	NDHB	Kim Tito				X		
		Ellie Berghan						
	WDHB	Aroha Haggie				X		
		Sue Crengle	X					
		Nina Scott	X					
	WDHB & ADHB	Lita Foliaki				X		
	ADHB	Marty Rogers				X		
		Sue Crengle	X					
		Nina Scott	X					
	CMDHB	Riki Niania				X		
		Tania Wolfgram				X		
		Elizabeth Powell				X		

		MENTAL HEALTH & ADDICTIONS						
				DHBS			Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Regional	Gloria Johnson (CMDHB)	X					
		Lyndsay Fortune				X		
						X		
	NDHB	John Wade				X		
		Verity Humberstone	x					
		Patricia Palmer				X		
	WDHB	Murray Patton	X					
		Ian McKenzie				X		
		Jean-Marie Bush				X		
		Jeremy Skipworth	X					
						X		
	ADHB	Maria West				X		
		Clive Bensemann	X					
	CMDHB	Tess Ahem				X		
		Abi Bond				X		
		Peter Watson	X					

		STROKE						
				DHBS			Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Chris Pegg				X		
	NDHB	Alan Davis CL	X					
	WDHB	Dean Kilfoyle	X					
		Debra Hogan		X				
	ADHB	Alan Barber	X					
		Anna McCrae			X			
	CMDHB	Geoff Green	X					
		Pauline Owen		X				

CL – Clinical Lead

			ADVANCE CARE PLANNING					
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
The Informed Patient	Region	Barry Snow (ADHB)	X					
		Leigh Manson (ADHB)				X		
		Shona Muir (ADHB)				X		
		Melanie Coleman (ADHB)				X		
	NDHB	Margareth Broodkoorn		X				
		Stephen Jennison	X					
		Jessica O'Donnell				X		
	WDHB	Andrew Brant	X					
		Janet Liang	X					
		Peter Groom		X				
	ADHB	Ian D'Young				X		
		Marg Dotchin		X				
	CMDHB	Richard Small				X		
		Clinical Lead - TBC						
		Karlynne Earp				X		
		Sarah Christophers				X		
		Karen Long		X				
		Meg Goodman		X				
	NRA	Sarah Prentice				X		
		Tony Phemister				X		

Services		RADIOLOGY						
				DHBS			Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	Region	Kate Aitken (WDHB) CL	X					
		Gloria Johnson	X					
		Siobhan Isles				X		
	NDHB	Kim Shepherd	X					
		Andrew Howes			X			
		Ada Schuler				X		
	WDHB	David Cranefield	X					
		Sue Miller			X			
	ADHB	David Milne	X					
		Sally Vogel	X					
		Raewyn Curin			X			
		David Perry	X					
	CMDHB	Gloria Johnson	X					
		Sally Urry	X					
		Paul Hewitt			X			
		Stuart Barnard	X					
	Primary Care	Barnett Bond					X	

CL – Clinical Lead

Services		ELECTIVES						
				DHBS			Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	Region	Tony Phemister				X		
	NDHB	Andrew Potts				X		
	WDHB	Elizabeth Hollier				X		
	ADHB	Tara Argent				X		
	CMDHB	Gillian Cossey				X		

Appendix A.2:

Our Priority Goals – Implementation Plan Matrices

First, Do No Harm

Context
The development of the Northern Region's *First, Do No Harm* patient safety campaign, launched at the beginning of 2012, acknowledged the need for focused effort on improving the quality and safety of our health system and raising the profile of patient safety. *First, Do No Harm* is a clinically-led campaign involving the four Northern Region district health boards (DHBs) (Auckland, Counties Manukau, Waitemata and Northland DHBs). The campaign reflected one of three strategic priorities of the Northern Region Health Plan.   In May 2013 the Health Quality & Safety Commission (the Commission) launched the national patient safety campaign, *Open for better care*. The focus of this campaign included areas that the Northern Region had identified as priorities. The *First, Do No Harm* team has developed a partnership with the Commission to support the achievement of the national campaign outcomes at a regional level. First Do No Harm has continued with the campaign's original focus areas and aligned with the national campaign's activities. The *Open for better care* campaign is expected to cease mid-June 2016. A programme of work in the falls area is expected to continue to 2018.   This plan will focus on a transition over the next 12 months to the NRA supporting the Northern Region DHBs to sustain the safety improvement gains achieved, and ensuring there is a process to support regional collaboration on key patient safety areas and maintain the national campaign objectives.

Objectives	Linkages
First, Do No Harm will support the Northern Region DHBs' patient safety initiatives through: • Maintaining a regional communication strategy • Supporting partnership with consumers, clinical staff and networks - 'safer care together' • Supporting the use of an effective measurement dashboard to track regional improvements • Supporting the development of improvement science capacity and capability in key areas (clinical change champions) • Supporting the momentum of a safety culture • Updating change packages	• Health Quality & Safety Commission • Health of Older People (HOP) Clinical Network • District health boards • Residential aged care sector • Primary care networks • Consumer networks

Key achievements

Since the launch of the *First, Do No Harm* campaign activities in February 2012, the campaign has primarily focused on building the will, ideas and ability to execute the changes that will result in the reduction of harm. The strength of the campaign to date has been in bringing the region together to focus on particular patient safety topics and providing space and opportunity to learn and share how to achieve sustainable process improvements and changes. A key component of improving harm-free care has been supporting teams in using a formal improvement process to undertake and spread effective change concepts.

Key achievements over the 2014/15 year include:
  √ Regular First, Do No Harm e-newsletters and updates to website highlighting patient safety information, learning and activities happening across the Northern Region
  √ Provision of learning sessions, workshops, training and coaching, including Frances Healey and Jim Bagian and a regional learning session for medication safety

- √ Supported clinical staff in use of data for improvement work and improved collection of falls and pressure injuries data from residential aged care sector
- √ Strong linkages with other work programmes (i.e. Health Quality and Safety Commission, Health of Older People Clinical Network) to ensure alignment with national and regional patient safety programmes and priorities
- √ Certificate of participation for aged residential care providers launched
- √ Regional reductions in pressure injury rates.
- √ Recruitment of ARRC facilities participating in improvement programmes
- √ Established links with regional infection prevention and control teams
- √ Supported and facilitated learning at Global Trigger Tool workshop

2015/16 Implementation Plan

Item	*First, Do No Harm* - Process / Action	2015/16 Quarter completed by
	1. *First, Do No Harm* Measures	
	Maintain falls causing major harm in the acute sector at a rate of less than or equal to 0.10 per 1000 patient days	Q1-Q4 ongoing
	Establish a baseline for falls causing major harm in those age-related residential care (ARRC) facilities that have implemented a programme	Q1-Q4 ongoing
	Reduction in hospital acquired pressure injuries Grades 3 and 4 to 'never events' in the acute sector	Q1-Q4 ongoing
	20% reduction in pressure injuries in those ARRC facilities that have implemented a programme	Q1-Q4
	Review regional quality and safety marker [QSM] to support sharing and learning for improvement	Q1-Q4 ongoing
	Medication safety QSM process and outcome measures to be confirmed	Q1-Q4 ongoing
	2. Process Activity	
	Reduce harm from falls	
1	Support HOP Clinical Network to investigate regional solution for residential aged care falls data capture and reporting	Q1-Q4
2	Implement strategy to incorporate reducing harm from falls initiatives into a regional network approach	Q4
3	Link with national patient safety campaign quality and safety marker for falls	ongoing to Q4
4	Update change packages for Falls – with an ARRC focus	Q4
	Reduce harm from pressure injuries	
5	Support HOP Clinical Network to investigate regional solution for residential aged care pressure injuries data capture and reporting	Q1-Q4
6	Support the development of an ongoing monitoring process for pressure injuries to ensure sustainability	Q4
	Support national initiatives	
7	Support national programme initiatives at regional level, including: • Medication safety • Healthcare associated infections	ongoing to Q4
	Workforce	
	Develop a quality improvement culture	
8	Provide learning events and coaching to improve capacity and capability for improvement activities	ongoing to Q4
9	Support consumer participation in regional patient safety activities and planning	ongoing to Q4
10	Support transition from a campaign focus to a regional network to work on patient safety issues and improvements	Q4

Child Health

Context
Most children born or living in the region enjoy good health, but some do not, with the distribution of poor health marked by significant socio-economic and ethnic differences. Inequities can be clearly seen across a range of measures. Māori children and Pacific children experience poorer health than non-Māori, non-Pacific children. Children living in poorer neighbourhoods also have poorer health.
The determinants of child health outcomes extend beyond the traditional boundaries of the heath sector. The health outcomes of our children are affected in a very real way by issues such as the quality of housing, maternal mental health, parental smoking, nutrition, income, employment status of caregivers, and urban design which challenge us to think more broadly about solutions. Problems such as overcrowded and unhealthy housing contribute to unacceptable rates of diseases such as respiratory infection, skin sepsis and rheumatic fever.

Objectives	Linkages
Five main objectives are to: • Optimise health outcomes for infants and children, including improved equity • Use a regional voice to advocate for improvements in the upstream determinants of child health • Co-ordinate resources with other sectors more effectively • Achieve greater consistency and quality of care for children through workforce development and systems improvement • Foster a regional approach to child health monitoring and research, influencing future planning and strategic development	• Children's Action Plan • Better Public Services • Local authorities, social development, housing, transport • Rheumatic Fever programme • Regional groups for maternity, youth, primary care, etc • Education and schools • Tamariki Ora Well Child providers • District Annual Plans • Child Health Implementation Plan

Note: Children are defined as 0 – 14 years for the purposes of the Child Health Plan (there is a recognised overlap with the youth age band to reflect the blurred transition from 'Child' issues and 'Youth' Issues affecting younger people)

Key achievements over the past two years

The Northern Region Child Health Network was established in July 2012. In 2014 a re-structure of governance occurred to streamline regional collaboration, ensure regional participation and strengthen leadership. Key achievements include:

√ Over 40,000 children receive better access to primary care through the school based program to identify and treat Group A Streptococcus (to prevent Rheumatic fever) and skin infections. In the metro Auckland region rapid response sore throat clinics have been established in a number of primary care settings including GP practise, pharmacies and secondary schools. Between March 2014 and December 2014 12,997 eligible 4 -19 year olds have accessed rapid response services.

√ Implementation of the regional 'Sudden Unexpected Death of an Infant' (SUDI) strategy and policy continues. All DHBs in the region have established safe sleep enabler programmes for high risk populations. There are early indications that SUDI rates are dropping.

√ Northern Regional Clinical Paediatric Pathways have been published for Skin and Respiratory Conditions.

√ Links have been developed intersectorally with Auckland Council to strengthen injury prevention

015/16 Implementation Plan

Item	Child Health : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	1. Patient Outcome Measures			
1	95% of eight months olds and two year olds are fully immunised	Q2 & Q4	√	√

2	Meet 2015/16 targets for first episode rheumatic fever hospitalisations (Northern Regional Rate of 3.0; Number 52)
	• Report regional view of progress to CEO/CMO group in alignment with DHB reports from MoH
	  o MoH will forward previous end of calendar year report in February (Q3 to report previous year)
	  o MoH will forward previous financial year report in August (Q1 to report previous financial year)
		Q3
		
		Q1
			√	√

	1. Know Every Child			
	Integrated enrolment:			
3	Establish regional working group on integrated enrolment for new-borns in the Northern region to progress universal health care services: oral health, immunisation, Well Child-Tamariki Ora checks, and primary care	Q2		
4	Ensure region preparedness to implement the National Child Health Information Platform (NCHIP). Report progress to Child Health Steering Group 6 monthly	Q3	√	√
	2. Informed Families			
5	Establish regional working group to agree key health messages selected across health themes and initiate regional communications	Q2		
	Injury prevention :			
6	Strengthen focus of home visiting programmes particularly in communities of high risk for injury • Consistent messages established • Report progress to Child Health Steering Group 6 monthly.	Q4	√	√
	Skin Infection:			
8	Develop consistent key messages including skin infection prevention for families of pre-school children and in early childhood education settings, targeted particularly for populations at highest risk • Phase One 2015/16: Key messages developed and endorsed by the Child Health Steering Group • Implementation Plan is endorsed by the Child Health Steering Group • Implementation Plan is endorsed by the Metro Clinical Governance Group and Northland Primary Care PHO	Q3 Q4 Q1		
9	• Long term: Rates for admission of skin infections regionally reduced in under 5 year olds			√
	Obesity:			
10	Consistent clinical measurement tool for child health growth and obesity available across the region (with implementation plan for 2016/17).	Q4	√	√

Item	Child Health : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	3. Enabled Clinical Teams			
11	Establish regional working group to implement selected activities that inform and re-orientate workforce to improve health outcomes for children	Q1		
	SUDI:			
12	Continue to implement the regional SUDI action plan • Report progress 6 monthly to the Child Health Steering Group (includes regional reporting from SUDI audit tool developed for secondary and primary birthing units to the Child Health Steering Group).	Q2&Q4	√	√
13	Continue to develop a consistent systematic process for risk assessment of SUDI in primary care at the time of the 6 week check • Develop the plan and associated business case (if required)	Q4 ongoing		
	Injury Prevention:			
14	Enhance regional consistency for childhood head injury management and follow-up for children • Systems for head injury follow-up of children hospitalised with head injury mapped • Implementation plan endorsed by Child Health Steering Group	Q3 Q4		
	Skin Infection:			
15	Develop model of care to implement Skin Clinical Pathway, enhancing care particularly for populations at highest risk • Business case developed • Business case endorsed by Child Health Steering Group • Business Case tabled at Primary Care governance groups regionally (Metro Clinical Governance Group and in Northland)	Q4 Q4	Q1	
	4. Advocacy for the Child			
16	Establish working group to plan and advance advocacy activity for child health and well-being in the Northern Region	Q3		
17	Report on advocacy activities to Child Health Steering Group 6 monthly		Q1	

Inequalities / Disparities

Context
Our historical broad approaches have done little to address inequalities in health outcomes. As a region we recognise that we need to adopt a targeted approach with specific initiatives to improve health outcomes for our most vulnerable populations. This year we will continue the focus on exploring new ways to engage with Māori, Pacific and other high needs populations by building on existing work and challenging the clinical and health expertise in the region to address priorities which will have the greatest impact for these groups. Many of the initiatives to address inequalities and disparities will be progressed as part of Clinical Network and regional workforce initiatives

Objectives	Linkages
The key drivers to reduce disparities and inequalities are: • Close the wide disparity in health status and life expectancy • Accelerate Māori and Pacific health gain. • Slow the growth in incidence of disease and ill health in our population • To meet national and local targets and related ethnicity measures that reduce disparities and accelerate health gain • A health system that is whānau ora oriented and works in a seamless and integrated way with other parts of the social sector • A health workforce that can operate and respond to the needs of patients and their families /whānau • Improve ethnicity data quality across all health services in the northern region • Build and maintain mature, resilient providers with appropriate capacity and capability	• District Health Boards (DHBs) • Regional Clinical Networks • Ministry of Health • Whānau Ora Providers and Commissioning Agents • Māori and Pacific Health Providers • Primary Healthcare Organisations (PHOs)

2015-16 Implementation Plan

Item	Inequalities Disparities : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	1. Patient Outcome Measures			
	90% of the eligible population – Māori and Pacific – will have had their cardiovascular risk assessed in the last five years	Q1 – Q4 ongoing	√	√
	95% of Māori women are smoke free at two weeks postnatal.	Q1 – Q4 Ongoing	√	√
	90% of the eligible population – Māori and Pacific– will have had their diabetes risk assessed	Q1 - Q4 ongoing	√	√

Item	Inequalities Disparities : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	95% Preschool Oral Health Enrolments for Māori	Q1 - Q4 ongoing		
	2. Process activity			
	2a. Models of care and service			
	Disparities and inequalities			
1	Report on Māori Dashboard indicators	Q2		
	Māori Health Needs Analysis			
2	Complete a regional analysis to understand where disparities exist, and to enable targeted interventions	Q3		
3	Report the regional analysis to the regional CEO/CMO Forum and Clinical Networks	Q4	√	√
	2b. Workforce			
	Grow the capacity and capability of our Māori and Pacific Workforce			
	Refer Workforce Plan (Appendix A4)			

Health of Older People

Context
While the proportion of people aged 65+ living in the region is still relatively low, the rate of projected growth is very high over the next 20 years. This is significant because this age group is strongly associated with high admission rates, longer lengths of stay, high residential and community costs, prevalence of dementia doubling, and likelihood of more severe injuries/accidents.

Objectives	Linkages
The key drivers for Health of Older People (HOP) are to: • Plan for projected growth in the population of older people including management of acute demand • Provide informed choice for older people in their care, minimise dependence and protect the vulnerable aged population • Improve service coordination and deliver whole of system care through enhancing cooperation with primary, community and ARRC sectors	• District Health Boards (DHB) • Age-Related Residential Care sector (ARRC) • Home Based Support Services (HBSS) • Metro Auckland Clinical Governance Forum • Alzheimer's NZ • St John Ambulance • National Dementia Cooperative • Health, Quality & Safety Commission • Ministry of Health

Key achievements

Now, in its fourth year, the clinical network is cohesive and stable, and clearer about the need to concentrate effort on fewer, high priority areas. Key achievements include:

√ Strong linkages with other work programmes (i.e. National Dementia Cooperative, FDNH & HQSC) to ensure alignment with national and regional programmes.
√ Retention of a majority of founding members on the network.
√ Recruitment of Consumer & Māori representation on network.
√ Supporting FDNH, DHBs and many ARRC providers to be involved in a cross-sector collaboration for falls and pressure injuries.
√ Extending falls initiatives into community and homecare environments. For example, a new initiative has been developed for St John Ambulance Officers to refer patients directly to DHB specialist service.
√ Facilitating Fracture Liaison Service coordination for the region.
√ Piloting the national Hip Fracture Registry in the Northern Region
√ Publication of a Northern Region Dementia Services Guidelines Document.
√ Regional collaboration around Dementia Care Pathway development and rollout of proof of concept. The dementia and cognitive impairment pathway is the first to be piloted in 11 GP practices across the region.
√ Active participation across national dementia initiatives.
√ A review of Psycho-Geriatric Beds across the Northern Region and implementation of recommendations identifying more appropriate care for clinically stabilised patients, or too frail psycho-geriatric patients.
√ Adoption of a regionally consistent Transfer of Clinical Information process ("Yellow Envelope").
√ Building regional consistency for GP e-Referrals into HOP services.
Enhanced understanding of interRAI capability and challenges, establishing a regional data repository and developing reporting parameters. All NASC and ARRC providers now use InterRAI.

Item	Health of Older People: Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	1. Patient Outcome Measures			
	95% of General Practices will be enabled to utilise the Northern Region Cognitive Impairment Pathway	Q1-Q4		
	20% reduction in falls causing major harm in those age-related residential care (ARRC) facilities that have implemented a programme.	Q1-Q4	√	
	20% reduction in pressure injuries in those ARRC facilities that have implemented a programme	Q1-Q4	√	
	Proportion of ARRC facilities that have implemented a falls & pressure injury reduction programme will increase from **35-50%**	Q1-Q4	√	
	100% of ARRC residents have a completed InterRAI LTCF assessment.	Q4	√	√
	75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months	Q4	√	√
	2. Process Activity			
	2a. Models of care and service			
	Cognitive Impairment			
1	Regional Dementia Working Group provides oversight & expert advice for regional & national initiatives.	Ongoing to Q4	√	√
2	Support development of DHB models of care for dementia across the region	Ongoing to Q4	√	√
3	Participate in national working group to develop primary care education & training	Q1–Q4	√	
4	Administer & report on regional Dementia funding & activities for primary care education & training	Q1 & Q4	√	
5	Finalise guidelines for Dementia/PG unit design & publish to DHBs/ARRC providers	Q1	√	√
6	Evaluate literature for ethnicity and inequalities >65 and assess impacts for Northern Region		√	√
	Quality & Safety			
7	Engage ARRC sector teams in regional Falls and Pressure Injuries Collaborative in partnership with First Do No Harm (FDNH) & HQCS August Falls Campaign	Ongoing to Q4	√	√
8	Support ARRC in the measurement and reporting of harm from falls & pressure injuries	Q4	√	√
9	Work with HQSC to confirm national definitions for falls & pressure injuries	Q1		
10	Provide coordination for Fracture Liaison Services across the region	Ongoing to Q4	√	
11	Support DHBs in the roll-out of the Hip Fracture Registry	Ongoing to Q4	√	√
12	Evaluate St John, DHBs & PHOs in the roll-out of Falls initiatives	Ongoing to Q4	√	√
13	Finalise Community Acquired Pneumonia Pathway for ARRC	Q3		
14	Partner with FDNH/HSQC on Medication Safety initiative/s in ARRC	Q1-Q4		
15	Support the MOH/ACC NZ Hospital to Home Rehabilitation review	Q1-Q3		
16	Increase consumer engagement in respect to Q&S	Q2	√	√
	Age Related Residential Care Sector (ARRC)			
17	Analyse rates of admission to ARRC by DHB & regionally	Q2	√	√

Item	Health of Older People: Process/Action	2015/16 Quarter completed by	2016/17	2017/18
18	Implement process for palliative care funding in ARRC	Q2		
	Home Based Support Services			
19	Establish regional KPIs in line with national guidelines & initiatives	Ongoing to Q4	√	√
20	Report KPIs at regional & DHB level	Ongoing to Q4	√	√
	interRAI			
21	Facilitate clinician access to information including representation on NZ interRAI Governance Board	Ongoing to Q4	√	√
22	Support pilot / demonstration sites for interRAI	Q1-Q4		
23	Establish Q & S KPI Reporting	Ongoing to Q4	√	√
24	Develop KPIs & baseline s for HBSS & ARRC across DHBs	Q1-Q4		
	2b. Workforce			
25	Facilitate training & education to primary care clinicians on specific dementia initiatives	Ongoing to Q4	√	
26	Promote CALD Older People training & HOPE - Health of Older People E-resource (Mental Health Services for Older People) to HOP workforce	Q1-4		
27	Analyse & understand composition of HBSS workforce to inform future workforce planning	Q1-4		
	2c. Information Systems			
28	Support the roll-out of the Cognitive Impairment Electronic Pathway Tool	Q1-Q4	√	
20	Support the roll-out of the triage process associated with e-Referrals	Q3-4	√	
	2d. Capital and other expenditure			
30	Inform & participate in regional /national rehabilitation planning	Ongoing to Q4	√	√

Cancer Services

Context
Cancer was the leading cause of death for both males and females in New Zealand in 2010, accounting for 30% of all deaths. The impact on people diagnosed with cancer and their whanau can be devastating for months and sometimes years. A whole of system approach via tumour streams is improving access to services and waiting times for patients, with strong multidisciplinary expertise and standard care pathways. Notwithstanding the success of our approaches to date, cancer remains a significant concern for our population and health services.

Objectives	Linkages
• To continue to meet national and local health targets and related measures • To progress Faster Cancer Treatment indicator measurements and service improvements • To progress tumour stream-related improvements including standards implementation, models of care work and others	• Information systems strategic management and support • Workforce development • Diagnostic services

Key achievements since July 2014

Last year the sector achieved all the following outcomes as planned:

√   100% of patients requiring radiation therapy receive this within four weeks.
√   100% of patients requiring chemotherapy receive this within four weeks.
√   Faster cancer treatment indicators, regional achievements
   –   52.5% of patients referred urgently with high suspicion of cancer receive their first cancer treatment (or other management) within 62 days from date of referral (as at Q2 2014/5).
   –   86.9% of patients referred urgently with a high suspicion of cancer receive their first cancer treatment (or other management) within 31 days of decision to treat.
√   Commissioning the new Northern Region Haematology & Bone Marrow Transplant Unit (ADHB, August 2014), and the Jim Carney Cancer Treatment Centre (NDHB, November 2014).
√   Development of a new Strategic Plan for cancer in the region.
√   Commencement and implementation of 8 Faster Cancer Treatment projects, both regional and local as a result of successful national RFP process.
√   Continued successful implementation of the Bowel Screening Programme at Waitemata DHB.
√   Review of the national bowel cancer, gynaecology oncology, and upper GI standards within the Northern region.
√   Continued regional and local work to understand and improve Faster Cancer Treatment times, including a bowel cancer audit to confirm baseline cohort consistency with national definitions.
√   Significant regional and local DHB work to increase colonoscopy capacity consistent with Ministry requirements, including outsourcing, understanding current and future CT colonography provision as examples.
√   Continued implementation of Care Coordinator work within DHBs.

2015/16 Implementation Plan

Item	Cancer Services: Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	1. Patient Outcome Measures			
	62 day indicator – Improvement in percentage of patients referred urgently with a high suspicion of cancer (without a confirmed pathological diagnosis of cancer at referral), and where the triaging clinician believes the patient needs to be seen within two weeks, receiving their first treatment (or other management) for cancer within 62 days from date of referral. Achievement of the 85% health target by July 2016.	Ongoing	√	√
	31 day indicator – percentage of patients referred urgently with a high suspicion of cancer (irrespective of how they were initially referred) who receive their first cancer treatment (or other management) within 31 days of decision to treat (Policy priority).	Ongoing	√	√
	100% of patients requiring radiation therapy will receive this within four weeks (Policy priority).	Ongoing	√	√
	100% of patients requiring medical oncology treatment will receive this within four weeks (Policy priority).	Ongoing	√	√
	75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive), 100% within 30 days.	Ongoing	√	√
	65% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days), 100% within 120 days..	Ongoing	√	√
	65% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days.	Ongoing	√	√
	2.Process activity			
	2a. Models of care and service			
	Regional Health Targets			
1	Regional service to work collaboratively through ROOG process to continue achievement against health targets and policy priorities, including maintaining timeliness of access to radiotherapy and chemotherapy.	Ongoing	√	√
2	All DHBs to progress and resolve capacity and resourcing issues around achievement of colonoscopy indicators.	Ongoing	√	√
	Faster Cancer Treatment			
3	Continue to provide regional support for regional and local DHB round one FCT projects (including sustainable provision of improvements), and plan for round two consistent with agreed regional process.	Ongoing	√	√
4	Continue to develop FCT measurement capacity and improvements in cancer pathways for all cancers, across all DHBs by tumour stream. Regional process to support DHBs to improve data quality, consistency and target achievement.	Ongoing	√	√
5	Engage with DHBs through the tumour stream approach to agree service improvements in lung, bowel and colonoscopy access and timeliness to treatment, reflecting progress against targets. To include the implementation of prioritised actions as a result of previous tumour stream reviews.	Ongoing	√	√
6	Continue national tumour stream(s) standards of service provision by working regionally to prioritise phased implementation across	Q4		

Item	Cancer Services: Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	nominated tumour streams, to include an audit of a further two tumour standards.			
	Delivering Whole of System Care			
7	Work with the Ministry of Health to agree, and in time implement the priority areas identified in the National Medical Oncology Models of Care projects, within available resources. To include increased standardisation of processes, procedures and workforce across the region.	Ongoing	√	√
8	Improve the functionality and coverage of MDMs across the region to include the development of electronic MDM templates for up to 2 additional tumour streams and work regionally to improve the effectiveness of MDMs. Report % of patients presented to MDM by tumour streams with electronic templates, consistent with national recommendations concerning which patients are to be presented, when determined through national process.	Q4		
9	Implement the priorities identified in the Prostate Cancer Quality Improvement Plan including ensuring that appropriate clinicians such as urologists and radiation oncologists receive the guidance on the use of active surveillance treatment for prostate cancer, including the updating of care pathways and other proformas to include guidance on the use of active surveillance treatment for prostate cancer.	Ongoing	√	√
10	Provide regional support for the ongoing activities of the Waitemata DHB Bowel Screening Pilot.	Ongoing	√	√
11	Continue to work with the Ministry of Health to support GRS as part of the National Endoscopy Quality Improvement Programme.	Ongoing	√	√
12	Continue to work regionally to support DHBs in identifying and implementing improvements in colonoscopy services, consistent with the Regional Colonoscopy Plan, including monitoring CT colonography as a subset of the Ministry of Health CT indicators that state TBC% of accepted referrals for CT scans will receive their scan within 6 weeks (42 days).	Ongoing	√	√
13	Present an annual equity assessment, with a focus on Māori, to include FCT indicators for lung cancer, % presentation at MDM for lung cancer by ethnicity, and colonoscopy indicators.	Q4		
14	As a region support the Ministry in the development and implementation of Budget 2014 initiatives, for example Supportive Care, and Quality Clinical Information.	Q4		
15	Implement the activities contained within the Northern Region Cancer Strategy, as sanctioned by the Cancer Governance Board.	Q4		
	2b. Workforce			
16	Support the commitment of the region and DHBs to train and provide professional development to cancer nurse coordinators, including attendance at national and regional training and mentoring forums.	Ongoing	√	√
17	Establish a Registered Nurse Expanded Practice Training and Credentialing Programme, in support of increased colonoscopy provision in the region's DHBs.	Q4		
	2c. Information Systems			
18	Ensure work is progressed to develop an appropriate electronic health record that caters for the needs of cancer patients	Ongoing	√	√

Cardiovascular Disease

Context
Improving access to cardiac services will help our population to live longer, healthier, and more independent lives. The Northern Region's Cardiac Clinical Network has identified the following issues with CVD management in the Northern Region; • There is variation in both access and timeliness of access to core cardiology assessment, investigation and management across the primary-secondary continuum. • Variations in CVD outcomes by socio-economic status and ethnicity have been identified and our focus this year will be to work toward ensuring these groups meet accepted intervention rates and health outcomes. • The reporting infrastructure to measure activity and support improvement initiatives has been developed for secondary care and we are now focusing on developing useful reporting to primary care.

Objectives	Linkages

We plan to focus on:
• Managing CVD across the continuum of care in line with the CVD Risk Recommendations document.
• Ensuring current measures to meet Cardiac Surgery across the region continue to be closely monitored to ensure the appropriate capacity is available.
• Regionally consistent monitoring and auditing of investigations, management and outcomes across the four DHBs including primary care.
• Continuing to provide on-going support for use of ANZACS QI reporting and ACS quality improvement across the region and in line with National practice.
• Implementing of better models of care to meet demand and improve better quality of care across the continuum by:
   o Reducing waiting times for First Specialist Appointments.
   o Ensuring appropriateness and timeliness of follow up visits.
   o Providing better support for discharged patients.
   o Reducing age standardised CVD admission rates.
	• Diabetes Network
	• District Health Boards (DHBs)
	• National Cardiac Network
	• DHB Shared Services
	• Auckland Metro & Northland PHOs
	• National Heart Foundation
	• National Health Committee
	• Metro Clinical Governance Group
	• St John Ambulance
	• National IT Board
	• MOH

Key achievements since July 2014

Last year the Northern Region's Cardiac Clinical Network met the following objectives for the 2014/15 Regional Service Plan.

√ Strengthened the Northern Region's Cardiac Clinical Network by;
– Providing continuing support for the consistent and effective use of ANZACS-QI in all four DHBs.
– The CVD Risk Registry continues to be progressed with development of the reporting requirements underway. It is anticipated diabetes patients will now be included within the registry

- Initiated development of a pathway for prompt transfer of acute patients for transfer to ACH for angiography within 24 hours from Northland.
- Initiated development of 'Accelerated Chest Pain Pathways in ED' in each DHB as per MOH directive

√ Further refined   the reporting of Regional KPIs. Cardiac KPI reports including details by ethnicity and inclusion of ANZACS QI reporting. Reporting continues with regard to:
- Summary report for all KPIs
- Cardiac Surgery
- Primary Care Adherence
- Cardiology First Specialist Appointment Waiting times including chest pain FSAs and follow ups
- Inpatient Coronary Angiography for ACS
- Outpatient Angiography
- Door to Balloon for Primary PCI
- ACS and PCI form completion
- CVD risk assessment
- Trans-thoracic Echocardiography
- National Medicine Adherence Report
- Electrophysiology
- Medicine adherence for PHO & practise-level report
- PHO medicine adherence comparison for DHBs
  Recent changes include
  - The addition of CVD Risk Assessment Indicator
  - Utilising the data from ANZACS reports for cath lab and door to balloon KPIs

Age standardised rates by ethnicity are now being reported for all secondary KPIs

√ Developed:
- Three primary care pathways have been developed and development of a dynamic pathway is underway
- After hours Primary PCI- 'ECG transmission by ambulance process continues to be further developed and refined. This is likely to be incorporated within a national model during the coming year.
- CVD Risk Management has been maintained by further progressing CVD risk assessments within the hospital and the community. PHOs have engaged with DHBs to work together toward the national target.
- Clinical Guidelines for Echocardiogram ('first referral' and 'repeat Echo') have been developed and agreed regionally. These are now in use and will be used for development of a nationally agreed set of guidelines.

Item	Cardiovascular : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	1. Patient Process Measures			
	80% of all outpatients triaged to chest pain clinics to be seen within 6 weeks for cardiology assessment and if an ETT is considered appropriate it will be undertaken at that time.	Q2		
	95% of out-patient coronary angiogram waiting time to <3 months.	Q1		
	70% of patients presenting with an acute coronary syndrome who are referred for angiography receive it within 3 days of admission (day of admission being day 0)	Q1		
	80% of patients presenting with ST elevation MI and referred for PCI will be treated within 120 minutes. (There may be some variation for patients from NDHB due to geographical isolation and dependence on emergency helicopter transport.)	Q2		
	Maintain the nationally agreed cardiac surgical delivery and waiting list management targets.	Q1		
	Standardised Intervention Rates (SIRs), patient prioritisation and waiting lists for secondary services (ACS) and cardiac surgery will be reported quarterly from quarter 1. Regional SIRs will be reported against the following standards: • 6.5 per 10,000 population for cardiac surgery, • 12.5 per 10,000 for percutaneous revascularisation • 34.7 per 10,000 for coronary angiography	Q1		
	90% of eligible patients will have had their CVD risk assessed in the last 5 years	Q1		
	95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection.	Q3		
	Review data entries (target achievement) per DHB and in conjunction with each DHB determine barriers to reaching this target (for ANZACS QI ACS and Cath/PCI registry data collection.)	Q1		
	Work with DHBs to make changes which will allow them to meet this target Two DHBs will be meeting or exceeding target (ANZACS QI ACS and Cath/PCI registry data collection.)	Q2		
	Three DHBs will be meeting or exceeding target (ANZACS QI ACS and Cath/PCI registry data collection.)	Q3		
	Over 95% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge	Q3		
	1. Increase dispensing of triple therapy (BP lowering and statin and anti-platelet/anti-coagulant) in those with prior CVD. 2. Increase dispensing of double therapy (BP lowering and statin) high risk primary prevention (>=20%) over 2 years. Change from baseline will be assessed using the regional CVDRA registry linkage to national dispensing data. • Target for secondary prevention: - increase in existing rates by absolute 5% over next 2 years. • Target for primary prevention: - increase in existing rates by absolute 5% over next 2 years. The target is to achieve this in the overall cohort eligible for CVD risk assessment and in the Maori and Pacific groups • Report dispensing rates for Maori and Pacific Island (PI) patients. • Reduce the gap in dispensing rates between Maori and PI patients and the rest of the population.	Q4		

Item	Cardiovascular : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	2a. Models of care and service			
1	Agree to a workforce plan for Electrophysiology, arrhythmia and pacing for the medium to long-term. This to include SMO and technical staff with a regional perspective.	Q4		
2	In collaboration with St John Ambulance and ED staff, continue to progress and monitor the ECG transmission by ambulance process in order to support more rapid transit of ST elevation MI patients direct to a PCI Centre.	Q2 on-going		
3	All patients will wait less than four months for a cardiology first specialist assessment, or for cardiac surgery	Ongoing		
4	Current measures will be continued and closely monitored to ensure the appropriate capacity is available to meet cardiac surgery across the region. Audit will be undertaken to ensure measures are applied consistently and reliably.	on-going		
5	All patients will be scored using the national cardiac surgery CPAC tool, and treated in accordance with assigned priority. Audit will be undertaken to ensure measures are applied consistently and reliably	on-going		
6	Support collaborative improvement process for CVD Risk Management in primary care and monitor those processes as measured by the medicine adherence reports.	on-going		
7	Support development of the 'Atrial Fibrillation "dynamic primary care pathway and pilot.	Q3		
8	Continue to improve access to Echo to support diagnosis of Heart Failure and other conditions including those requiring cardiac surgery. Aim for 95 % of outpatient Echos to have been completed within 5 months of referral.	Q4		
9	Implement the Accelerated Chest Pain pathways phased by quarter for each DHB	Q4		
10	Work directly with NDHB in support of their planned phased implementation in September 2015	Q1		
11	Two DHBs will have implemented the ACCP pathway	Q2		
12	Three DHBs will have implemented the ACCP pathway	Q3		
13	Four DHBs will have implemented the ACCP pathway	Q4		
14	Ensure that 'increasing equity of access across the region' for Maori and Pacific Islanders in particular, underpins all activities. Progress work to ensure measurement reflects ethnicity, evaluation of inequalities by closing the gap for medicine adherence and by better understanding the reasons for these inequalities.	on-going		
	2b. Workforce			
15	Host a further Allied Health/ Advanced Cardiac Nurses regional forum focusing on Cardiac rehab across the region.	Q2		
16	Agree minimum core components of Cardiac Rehab programme (regionally)	Q3		
17	Agree best method of data reporting for Cardiac Rehab across the region	Q4		
	2c. Information Systems			
18	Continue to provide on-going support for use of ANZACS QI KPI reporting and ACS quality improvement throughout the region.	Q4		
19	Support the population of the CVD Risk Registry	Q4		
20	Support better integration of ECG transmission by ambulance	On-going		
	2d. Capital and other expenditure			
21	Develop a regional view of capacity and demand for Cardiac Catheter lab services to inform future planning and time frames.			

Diabetes Implementation Plan 2014/15

Context
Diabetes is a chronic disease that impacts patients and their whanau over a lifetime. It leads to disability through blindness, amputation of limbs, heart attacks and renal failure, and it shortens lifespan.   While the last decade has seen greater attention and resources being allocated to diabetes, our efforts have not always been systematic and coordinated. We need to be at the forefront of innovations to test new strategies to slow the growing incidence, and the impact, of diabetes on our populations.   To prevent / minimise the co morbidities early detection and treatment that targets retinopathy, the high risk foot, renal failure and cardiovascular disease is critical. The bulk of this activity occurs within primary care settings, rather than in hospitals. The primary care workforce needs assistance to build its capacity and capability to manage increasingly numbers of complex patients in community settings. More effective utilisation of allied health and nursing workforces and alternative care models are needed.

Objectives	Linkages
There are three key drivers to this priority area • Cost –115,000 people in the region have diabetes and a fast growing pre-diabetic population means that the diabetes population roughly doubles every 10 year. The conservative estimated costs of diabetes in this region are approximately $365m annually, excluding primary care costs and are mainly due to treatment of complications. • Secondary services will not grow at the same rate that the diabetes population is expected to grow. Early detection and treatment in primary care is critical. • Certain ethnic groups experience higher rates of the disease, particularly Māori, South Asian and Pacific. • Greater than 80% of diabetic complications are preventable through good management	• Northern Region Cardiac Network • Internal Stakeholders – Planning and Funding, Alliance Leadership, Long Term Conditions Groups, DHB staff • External Stakeholders – Primary care, PHO's, Diabetes NZ, Ministry of Health • Metro Clinical Governance Group

Key achievements

The Northern Diabetes Network is committed to providing regional clinical leadership on diabetes prevention and management across the health system with the aim of achieving system wide integration and improvement for the improved health of at risk populations.

Implemented:
   √   Developed Indicator set and report format

√ Undertook stock take of diabetes activity across the region
√ Developed and published 2 algorithms to support the implementation of the NZ Guideline on Diabetes Management in Primary Care.
√ Developed a "Key Tips Sheet" for GPs on Diabetes Management
√ Conducted regional consultation on the replacement on Diabetes Get Checked programme
√ Obtained approval for the use of Test Safe diabetes data for quality improvement
√ Developed the Quality Improvement Teams model in primary care as the preferred care model with commitment gained from DHB's to pilot
√ Undertook a regional revision of the Diabetes Self Management Education (DSME) to refine and standardise content, standards and evaluation

√ Started delivery of
– Indicator reporting
– Embedding of NZ Guideline on Diabetes Management in Primary Care
– Implementation of one Quality Improvement Team (NDHB)
– Publication of two pathways on Type 2 Diabetes Management and Insulin Initiation in primary care.

2015/16 Diabetes Implementation Plan

Item	Diabetes : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	1. Patient Outcome Measures			
A	90% of eligible patients will have had a cardiovascular risk assessment in the last 5 years.	Q1		
B	Continue existing Diabetes KPI reporting whilst further refined reporting is under development.	Q1		
C	Develop the capability to be able to highlight patients who are not on treatment and advise this to GPs in order to achieve outcome measures such as those listed here. Improve the percentage of Diabetes patients: • on diabetic medications • on lipid lowering medication • on blood pressure medication • being monitored for HbA1c levels and treated to target (HbA1c<64) Improve the percentage of Diabetes patients tested for microalbuminuria and on ACE or ARB (N.B. measures may vary from those listed here after further development work has been undertaken)	Q4		
D	Improve the percentage of CVD patients with Diabetes who are on appropriate medications as per the Cardiac report	Q4		
E	37,000 patients undergo retinal screening NB: Achieving this number is dependent on the results of a review currently being undertaken by WDHB/ADHB in order to understand key issues relating to lower screening volumes and to gain clarity around reporting programmes.	Q4		
F	Reduction in (to be *agreed*) proportion of patients with HbA1c above 64, 80 and 100 mmol/mol.	Q4		
G	Collaborate with Cardiac network to provide a single reporting mechanism to primary care for both Diabetes and Cardiac.	Q2		

Item	Diabetes : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	2 Models of care and service			
	Promote early detection of pre-diabetes and diabetes, and proactive patient management			
1.	Agree effective strategies and interventions to support the early detection and management of diabetes and pre-diabetes.	Q3		
2.	Support the development and implementation of guidelines for a consistent in-hospital care approach for patients admitted with diabetes.	Q4		
	Promote and develop models of care which support proactive care at practice level & utilise community resources			
3.	Promote greater utilisation of Nurse Led Clinics in primary care and develop GP and practice nurse Diabetes Champions.	Q2		
	Promote and support patients with diabetes or pre-diabetes across the life span through collaboration with health systems and communities			
4.	Support regional work to improve the quality of Diabetes self-management (DSME) resources and the implementation and evaluation of DSME standards and curriculum.	Q2		
5.	Support effective strategies and interventions to encourage patients with obesity to lose weight and adopt healthy lifestyles to prevent the onset of type 2 diabetes, whilst maintaining acceptable glycaemic control and managing HbA1c levels.	Q4		
	Target Populations with Increased Risk of Diabetes and Related Complications (access equality)			
6.	Work with communities and community partners to identify and implement culturally appropriate and effective strategies to reduce diabetes related health disparities e.g. in Māori and Pacific Island Populations and in adolescents and young adults with diabetes.	Q4		
	Diabetes related complications			
7.	Develop strategies to support the proactive recall of screening to ensure the early identification of diabetes related complications (retinal, foot, renal, CVD).	Q3		
8.	Align with Cardiac network to ensure eligible patients are receiving a cardiovascular risk assessment.	Q2		
	Monitor, support and evaluate quality improvement initiatives in primary and secondary care			
9.	Support the implementation of DCIP and work with the MoH to ensure effective and appropriate use of DCIP funds.	Q2		
10.	Support the implementation of the Ministry Quality Standards and others as published; Gestational Diabetes Guidelines, NZDSS High Risk Foot Pathway, 20 Quality standards (Diabetes Care toolkit 2014).	Q3		
	3. Workforce			
11.	Support the development of skills in diabetes within health professional groups and promote professional education opportunities on risk factor assessment, behaviour change counselling skills, diabetes prevention and control, and cultural competency.	Q3		
12.	**4. Information Systems**			
13.	**Improve the capture and visibility of diabetes related data**			
14	Work with the MOH to access live NHIs and develop an agreed process for reporting to Primary care which will enable GPs to identify those patients who are not on appropriate treatment. (This is in support of achieving Patient Outcome Measures).	Q2		

Item	Diabetes : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
15	Enhance the current indicator set to allow for the capture, reporting and analysis of trends in diabetic and pre-diabetic patients.	Q3		
16	Establish the regions capability to report on patients HbA1c ranges and implement effective strategies to provide capability where missing.	Q3		
17	Develop podiatry indicators that capture the management of the High Risk Foot.	Q3		
18	Enhance regional retinal screening volumes reporting to include ethnicity breakdown.	Q2		
19	Utilise TestSafe data to obtain and share primary care data for quality improvement purposes.	Q4		

Major Trauma

Context
Each year in the Northern Region of New Zealand there are approximately 500 cases of major trauma and 4,200 of non-major trauma.   The historical model is to provide care at individual hospitals, with referral to tertiary centres when required. While the trauma care provided in the region is of a high standard, a more organised and formal trauma system is required in order to deliver optimal and equitable care to our patients, in line with best practice internationally. The National Major Trauma Clinical Network was established for this purpose. Aligned with this, a Northern Regional Trauma Network (NRTN) has subsequently been formed to improve the quality of trauma care at a regional level. The purpose of the NRTN is to implement a more organised and formal system to improve trauma care in the region, recognising the special geographical and organisational requirements of the northern region. Optimisation of prehospital and interhospital transfer systems and in-hospital management practices will deliver not only better overall trauma care, but also cost savings in the form of improved resource utilisation and shorter hospital stays.

Objectives	Linkages
The key drivers to this priority area are to establish a formal trauma system through: - Strengthening regional collaboration and clinical governance - Data analysis - Delivering the patient to the right hospital for definitive care at the right time	- National major trauma network - St John Ambulance - ACC

Key achievements over the past year

The Major Trauma Clinical Network was established at the end of 2013 with cross DHB and ambulance service representation. Since inception, key achievements include:
- √ Data collection underway in all 4 DHBs
- √ Clinical leads and coordinators in place in each DHB
- √ Stock take of current guidelines done, and work started on developing a regionally consistent set of guidelines for the region
- √ Funding approved for the regional registry with implementation expected by mid-2015
- √ Pre-hospital triage tool developed and destination protocols for the region agree, with implementation pending national endorsement

2015/16 Implementation Plan

Item	Process/Action	2015/16 Quarter due for completion	2016/17	2017/18
	1. Major Trauma measures			
	The following measures align with the national trauma network and in this first year will be measured only with no targets assigned.			
	• Death in hospital	Q2		
	• Proportion of patients discharged to residential rehabilitation facility	Q2		
	2. Foundation Activity			
1	Succession plan for clinical lead	Q1		
2	Review requirement for a data manager for when the new regional registry is implemented	Q1		
	3. Models of care and service			
	Clinical guidelines			
3	Lead the regional trauma clinical guidelines for prioritised conditions to guide clinical management and where patients are best managed in the region: • Develop and agree • Communication • Publication and promulgation • Implement	Ongoing to Q4	√	√
4	Develop process to update guidelines and audit use	Q3		
	Clinical Governance			
5	Continue to strengthen clinical governance with a focus on regional and system issues including: • Variation in care • Supporting clinical leads in DHBs • Peer audit and case reviews • Review regional trauma data	Ongoing to Q4	√	√
6	Develop and monitor trauma KPIs	Ongoing to Q4	√	√
7	Support partners to fill gaps in the regional trauma system	Ongoing to Q4	√	√
	Pre-hospital destination protocols			
8	Support the implementation of the updated triage tool which includes which patients go where	Q1		
9	Evaluate the impact of the new protocols	Q4		
	Data analysis			
10	Support the collection and input of quality data including • Training on the 2008 AIS scoring system • Accuracy and timeliness	Ongoing to Q4	√	√
11	Analyse regional data	Ongoing to Q4	√	√
12	Provide regional data to national collection	Ongoing to Q4	√	√
	Communications			
13	Develop and distribute communications to inform others of the progress of the network	Ongoing to Q4	√	√

Item	Process/Action	2015/16 Quarter due for completion	2016/17	2017/18
	4. Workforce			
	Develop a workforce training plan which encompasses: • Training opportunities • Supporting staff especially in smaller centres to train and get more experience in trauma	Ongoing to Q4	√	√
	5. Information Systems			
15	Implement the new regional data registry across all four DHBs	Q1		
16	Review progress of the ePRS and any implications for DHBs	Ongoing to Q4		

Mental Health and Addictions

Context
Rising to the Challenge, the Mental Health and Addiction Service Development Plan, articulates the priority service development actions through until 2017. The Ministry of Health's 2015-16 Planning Priorities for Regional Service Plans identifies five key objectives, and the Northern Region will carry forward a number of objectives from 2014-15. Initiatives in the plan will consider a systems level approach, including DHBs, PHOs, NGOs and other community and intersectoral organisations as appropriate, and identify opportunities to address inequities within the activity undertaken.

Objectives	Linkages
• Increase capacity and improve responsiveness of mental health and addiction services for people with high and/or complex needs, • Improve capacity and responsiveness of adult and youth forensic services • Improve availability of and access to the range of eating disorder services • Improve access to and experience of perinatal and infant mental health service options across a service continuum • Improve secondary service support to primary care settings • Identify opportunities for regional alignment on suicide prevention and postvention initiatives	• The Ministry of Health Rising to the Challenge – Mental Health and Addiction Service Development Plan 2012-2017, and Blueprint II • The Ministry of Health Regional Services Plan Guidelines (2015-16), and 2015/16 Planning Priorities for Annual Plans and Regional Service Plans • DHB Action Plans 2015-16

Key achievements since July 2014

Increasing sector responsiveness to children and youth at risk
- √ Increased numbers of young people being seen by Youth Forensics services
- √ Increasing the percentage of young people being seen by specialist AOD services

Increasing service capability to respond more flexibly to support recovery
- √ Launched a peer support worker competency framework in collaboration with Midland region and the national workforce centre, Te Pou

Developing mental health and addiction capacity in Primary Care settings
- √ Pilot on capturing information on consultation to primary care yielded results for methodology and process to support a comprehensive roll-out across Child and Youth, Adult and Older Adult services

Developing capability in services for vulnerable populations
- √ Implementation of new Acute and Intensive Perinatal and Infant Mental Health services, and commencement of workforce development activity
- √ Developed a revised of Eating Disorders Services Service Delivery Model with recommendations for change in respect of changed funding model, and revised clinical service models

2015/16 Implementation Plan

Item	Process/Action	2015/16 Quarter due for completion	2016/17	2017/18

1	**Youth Forensic Services**
	• Measure and report improved access to youth forensic services – court liaison, CYF youth justice residences and community
	   o Baseline access rates to be determined
	   o Increased access rates reported
		Q2
		Q4		

2	**Adult Forensic Services** *A reduction in waiting lists and time for people in prisons requiring assessment in forensic services, measured by:* • The percentage of mentally unwell prisoner admissions to Forensic inpatient services that meet the agreed Prison Model of Care acute and sub-acute targets is maintained or increased	Q1 – Q4		
3	**Perinatal and maternal mental health services** *Increased access to P&MMHS, measured by:* • X (current numbers) to be increased to y with progress measured each quarter TBC- (awaiting Ministry advice regarding this measure)	Q1 – Q4		
	2. Service Delivery			

4	**Services for people with high and/or complex needs**
	
	Increase minimum secure capacity within the Northern Region through:
	• Progressing options analysis and business case development for regional minimum secure inpatient service :
	   o Strategic business case
	   o Indicative business case
	   o Detailed business case
	
	Adult forensic services
	• Contribute to the national network of forensic inpatient services through contribution to Ministry of Health's development of National Forensic Framework
	
	Youth Forensic Services
	• Develop quality indicators and a reporting framework that will support a future assessment of the impact of the additional investment in Youth Forensic services in alignment with the national KPI activities
	• Develop and agree service user pathways into and out of local, regional and national Youth Forensic services inclusive of key interfaces with local health services and other agencies
	• Develop a minimum clinical documentation set and regionally consistent service policies/protocols
		Q4
		
		Q1
		Q2
		Q4
		
		Q1 – Q4
		Aligned to MOH process
		
		Q1
		
		Q2
		
		Q3		

5	**Eating Disorders Services** Commence implementation of the agreed EDS service delivery model • Provide a service change proposal for supra-regional eating disorders to the Ministry for approval • Develop working draft service delivery framework • Implement agreed service reconfiguration	Q1 Q1 Q4		

Item	Process/Action	2015/16 Quarter due for completion	2016/17	2017/18
6	**Perinatal and Maternal Mental Health Acute Service Options**			
	• Implement the Northern Region Perinatal and Infant Mental Health Model of Care Guideline	Q1 –Q4		
	• Increase access to perinatal and infant mental health services by ensuring a coordinated and consistent response to service access, delivery and after hours support across the region and the North Island	Q1-Q4		
	• Evaluate the services within the continuum, and the continuum as a whole o Contract for evaluation service o Commence three year evaluation process	Q1 Q1 –Q4		
7	**Offender health**			
	• Determine opportunities to intervene to improve the health of people in the criminal justice system and their families/whanau (TBC)	Q1 – Q4		
8	**Suicide prevention/postvention**	Q1-Q4		
	• Identify opportunities to align and coordinate local suicide prevention initiatives, including evaluation and sharing of learning			
9	**Child and Youth Service Review**			
	• Undertake utilisation review of Child and Family Unit • Map the current range and utilisation of local, regional and supra-regional child and youth mental health and addiction services	Q2 Q4		
10	**Integrated mental health care**			
	• Commence implementation of consult-liaison reporting across the range of mental health and addiction services • Agree a regionally consistent metabolic screening tool • Increase information sharing and support shared care through development of regionally agreed technology solutions	Q2 Q3 Q4		
11	**NGO sector sustainability**			
	• Commence a collaborative process to: o Review services ensuring NGO services form part of the MHAS continuum o Support the sustainability of the NGO sector	Q4		
12	**Smokefree**	Q1-Q4		
	• Support the achievement of smokefree objectives within the region			
	3. Workforce			
13	• Develop a regional Suicide Prevention Training Framework	Q2		
14	• Identify workforce requirements to support the implementation of : o Perinatal and maternal mental health o Emerging Framework for a Youth Forensics Model of Care	 Q1 Q2		
15	• Identify and implement agreed recommendations from the Māori Mental Health and Addiction Workforce stocktake	Q4		
	4. Information Systems			
16	• Ensure work being progressed around regional consistency for e-referrals and forms is aligned with electronic Health Record IPS	Q1 – Q4		

Stroke

Context
The impact of strokes and Transient Ischemic Attacks (TIAs) on individuals and their whanau / family is significant. There is a very high risk of death, and for those that survive, the disability caused by the stroke can impact on the ability to work and live independently. The disability often requires support from family and external help to support the person at significant emotional and financial cost. Strokes in the under-65 age group is particularly challenging because of the loss of income and impact on young families.

Strokes are largely preventable with improvements to lifestyle such as blood pressure control, stopping smoking, limiting alcohol intake and having a balanced diet with low salt. TIA's may also provide a good warning sign that a stroke is imminent. Good care of an acute stroke event will improve the chances of survival and recovery. |

Objectives	Linkages
Strengthening the regional focus on stroke is designed to build on the improvements made in this region over the past few years. This is aimed at stroke prevention and improving health and social outcomes for patients who have suffered a stroke.

The key drivers to this priority area:

• Strengthen the regional focus on stroke services in three key areas; thrombolysis, inpatient & rehabilitation stroke care
• Using the region's intellectual and physical resources to improve stroke care in conjunction with NZ Stroke Guidelines | District Health Boards (DHB)
NZ Stroke Foundation
Metro Auckland Clinical Governance Forum
Rehabilitation/NGO sector
Ministry of Health |

Key Achievements over the past three years

Key achievements include:

- √ Progress against thrombolysis, admission to stroke unit, and time to rehabilitation, targets
- √ Dashboard of Northern Region Stroke indicators developed
- √ Regional and national alignment of TIA Pathway
- √ Reporting and analysis around rehabilitation phase for patients
- √ Participation in regional rehabilitation planning principles
- √ Implementation of national thrombolysis database
- √ Improved data quality with respect to clinical coding of strokes
- √ Strong linkages and input into national work programmes facilitated by NZ Stroke Foundation.

Item	Stroke - Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	1. Stroke Measures			
	2015/16 targets			
	8% of acute ischaemic stroke patients are thrombolysed	Ongoing toQ4	√	√
	80% of patients who have an acute stroke are treated in a stroke unit	Ongoing toQ4	√	√
	Proportion of people with acute stroke who are transferred to inpatient rehabilitation services	Ongoing toQ4	√	√
	Proportion of the above who are transferred within 10 days of acute stroke admission – target 70%	Ongoing toQ4	√	√
	Less than 10% of patients will be coded as Acute Unspecified Stroke	Ongoing toQ4	√	√
	2. Models of care and service			
1	Evaluate membership of the Stroke Network Executive to ensure there is adequate representation from DHB/NGO/Primary & Community sectors	Q1	√	√
2	Develop and agree a Northern Region Stroke Plan	Q2	√	√
3	Review & update "Stroke Dashboard" 6 monthly	Q2,Q4	√	√
4	Report outcomes for Māori & Pacific Island people with stroke in alignment with Northern Region Māori Dashboard	Q2,Q4	√	√
5	Establish future baselines for Māori, Pacific Island & other vulnerable ethnic groups following release of ARCOS report	Q1	√	√
6	Work towards a door-to-needle time (thrombolysis) of less than 1 hour for at least 50% of patients	Q4	√	√
7	Participate in national stroke rehabilitation group and implement agreed regional actions	Ongoing toQ4	√	√
8	Work with national rehabilitation group to establish KPI & target for patients transferred to community rehabilitation.	Ongoing toQ4	√	√
9	Work with national rehabilitation group to establish KPI & target for patients discharged directly home with community rehab follow up.	Ongoing toQ4	√	√
	3. Workforce			
10	Calculate % of nursing & allied health staff who have completed a stroke care competency programme	Q4	√	√
11	Establish thrombolysis credentialing programme for medical staff		√	√
12	Report on stroke training/education events	Ongoing toQ4	√	√
13	Review & update Northern Region section (for health professionals) on NZ Stroke website, 6 monthly	Ongoing toQ4	√	√
14	Support national workforce initiatives and roll-out regionally eg thrombolysis workforce plan	Q1-Q4	√	√
	4. Information systems			
15	Explore options to improve use of TIA Pathway by GPs	Q1-Q4	√	√

Informed Patient: Advance Care Planning

Context
We want to achieve greater patient participation and improved health care through patients being better informed across the full health spectrum; from prevention and early diagnosis to better treatment of disease. Advance care planning (ACP) will ensure: • Patients are better informed about future care and treatment choices • Healthcare providers are better informed about patient care preferences; particularly around end-of-life care.

Objectives	Linkages
The key objectives are to: • Improve patient and whanau access to ACP • Increase health workforce awareness of, and competence in, ACP and communication skills • Increase access to efficient and accurate health information for health providers and the general public.	• National ACP Cooperative • Regional and national ACP Tools Tasks teams – across primary, secondary and tertiary care • Regional and national ACP Project Teams – across primary, secondary and tertiary care • Relevant non-government organisations (NGO's) • Disability representatives • Regional Training Leads • South Island Alliance Programme Office (SIAPO) • Health Workforce New Zealand (HWNZ) • Health Quality Safety Commission (HQSC) • Health and Disability Commissioner (HDC) • Local ACP champions across NZ.

Key achievements since July 2014

Key achievements include:

√   Workforce Training:
   – 378 candidates registered for Level 1 eLearning modules and we estimate 176[1] have completed all four (via www.advancecareplanning.org.nz website)
   – Achieved a 96% uptake of Level 2 training spaces from across primary, secondary and tertiary care, and supported development of ACP and communication skill improvement in the regional and national healthcare workforce.
   – Continuous quality improvement of the Level 1, Level 2, Level 3 and actor training components of the programme
   – Development of Level 4 training programme
   – Continued to record statistically significant pre and post Level 2 training confidence score increases in delegates self-reported abilities

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[1] The data included prior to Learning Management System (before mid Sept 2014) is based on module 2 as the data available is unable to be filter by completion of all four modules by one person.

- – Development of the Level 3 Facilitator skill base at an annual two day training camp and through ongoing Professional Development Plans
- – Consolidate the competencies of the Level 3 Facilitator team (there are now ten L3's for the country, four of whom are from within the Northern Region). One Level 3 remains in training.
- – Consolidate the competencies of the Level 4 Trainer team (there are two Level 4 Trainers - both are from the South Island)
- – Retained 11 professional actors (actors based in Auckland, Wellington or Christchurch)
- – Confirmed a lead actor (to train new actors)
- – Delivered 11 Northern Region[2] and 20 non-Northern Region ACP L2 Practitioner courses nationally
- √ Consumer:
  - – More than a 20% increase in ACP conversations recorded across the Region (measured against the previous year's final conversation number of 6,536)
  - – More than a 5% increase on the annual number of hits recorded for the website[3] www.advancecareplanning.org.nz, as measured against the previous year's final website hit number of 23,178.
  - – Engaged with consumers through the co-design process to translate the two ACP leaflets and the ACP Guide and Plan into Korean.
  - – Conversation that Count (CtC) Communicator training commenced. CtC Communicators now running community education interventions in three of the four Northern region DHBs
  - – The national Conversation That Count Day 2015 (to raise awareness of ACP) led by Northern Region staff and involving representation from each of the four regions.
- √ Cultural engagement
  - – Māori consumer tools team relaunched by Northland DHB
  - – Asian consumer tools team work included ACP team consultation and input to an online resource supporting ACP engagement for the Asian community (Led by Waitemata DHB). As noted above, translation of ACP leaflets into Korean. Work also commenced on translating resources into Japanese and Chinese.
  - – Initiation of a Pacific Tools Task Team (lead by Counties Manukau DHB)
- √ Information systems
  - – IT solution Collaborative Care Management System (CCMS) for the recording, reporting and sharing of ACP conversations and plans is live in ADHB and CMDHB.

Other: Awards

- – Conversations that Count (CtC) poster won first prize in the APAC conference (August 2014), consumer engagement section
- – CtC Day 2014 won the CEO's Award at Auckland District Health Board Health Excellence Awards (December 2014).

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[2] One of these courses was delivered prior to June 2014. This was required to meet the training needs of the Level 3 Facilitators and Level 4 Trainers.

[3] A mix of consumer and healthcare staff, we are unable to differentiate further.

2015/16 Implementation Plan – Year 4 of ACP Programme

Item	Informed Patient - Advanced Care Planning: Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	1. Consumer Awareness and Support Measures			
	1a. Consumer awareness			
	Increase consumer access to ACP conversations			
1.	A 20% increase in the 2014/15 end of year ACP conversations documented by each of the four DHBs	Q4	√	√
2.	Deliver 2 CtC Communicator training courses.	Q4	√	√
	Increase consumer awareness of ACP and/or CtC			
3.	ACP website 'hit' recorded as a proxy measure of consumer awareness and interest in ACP	Quarterly	√	√
4.	Record the number of consumer resources (leaflets & ACP Guides) distributed by DHB	Quarterly	√	√
5.	Record the hits on the Conversations That Count website	Q4	√	√
6.	Record the 'Likes' on the Conversations That Count FaceBook page	Q4	√	√
7.	Record the number of followers on Twitter (@CtC_NZ)	Q4	√	√
8.	Complete a communication strategy evaluation	Q4	√	√
9.	Record the number of sessions each DHB CtC Communicator spends promoting ACP to consumers	Quarterly	√	√
10.	Record the number of consumers who attend CtC sessions	Quarterly	√	√
	1b. Consumer support measures			
	Ongoing engagement and development of ACP and/or CtC resources in partnership with consumers			
1.	Engage and include the views of the disability community	Ongoing	√	√
2.	Continue the development the national ACP website with consumers.	X	√	X
3.	Review ACP consumer resources.	Q4	X	√
	2. Workforce Awareness and Support Measures			
	2a. Workforce awareness measures			
	Increase workforce awareness of ACP			
1.	Annual measurement of ACP and CtC awareness in the 4 DHBs workforce	Q4	√	√
	Active participation in the promotion and development of the Conversations that Count programme			
2.	Each DHB to support the volunteers delivering the CtC Communicator programme (e.g. for providing mentorship and petrol/travel expense).	Q2	√	√
3.	Each DHB to ensure a minimum of 10 community CtC sessions are held	Q4	√	√
4.	Active participation in the national CTC day (April 16th)	Q4	√	√
	3b. Workforce support measures			
	Standard of care			
1.	Annual audit of the ACP policy and/or processes across each regional DHB	Q4	√	√

Item	Informed Patient - Advanced Care Planning: Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	Support of ACP competency development and roll out			
2.	Each DHB to update their plan on how they will: • Increase the uptake of the Basic Level training	Q1	√	√
	• Achieve a 25% increase in the 2014/15 end of year L1 trained staff	Q1	√	√
3.	Increase by 20% the number of staff who have completed all four ACP Level 1 modules (measured against 2014/15 figures).	Quarterly	√	√
4.	Review the content of the ACP Level 2 course and reduce from 2.5 days to two days. Pilot & evaluate the two day course.	Q4		
5.	Deliver 10 Level 2 two day courses across the Northern region. Training space allocation on a population based funding calculation.	Q4	√	√
6.	Develop, pilot and evaluate a one day ACP course	Q4		
7.	Pilot 6 one day ACP courses	Q4	√	√
8.	Achieve a 95% attendance rate or higher at the one day and Level 2 courses	Q4	√	√
9.	75% of ACP Level 2 Practitioners to undertake a minimum of 2 ACP conversations a month (24 conversations in the year).	Ongoing		
10.	Each DHB with Level 3 Facilitator/s to update their plan demonstrating how the L3s will be supported to deliver a specified number of one day ACP courses and ACP Level 2 courses in a year	Q1	√	√
	Engage cultural teams			
11.	Continue to work with Māori teams and consumers at local, regional and national level to understand and develop resources which meet the needs of these consumers. **Note:** Northland DHB are leading this work.	Ongoing	√	√
12.	Continue to work with Asian services and Asian consumers to develop resources which meet the needs of these consumers **Note:** WDHB Asian Health services leading this work	Ongoing	√	√
13.	Continue to work with the Pacific tools team and consumers at local, regional and national level to understand and develop resources which meet the needs of these consumers **Note:** CMDHB ACP Team are leading this work.	Ongoing	√	√
	3. Information Systems			
1.	Each DHB has system/s to accurately record and report on workforce ACP activity	Q4	√	√

Youth Health

Context
New Zealand has a poor record when it comes to young people's health and wellbeing. Rates of youth suicide, death from motor vehicle injuries, unintended pregnancy and drug and alcohol use are among the highest in the Western world.
The distribution of poor health marked by significant socio-economic and ethnic differences. Inequities can be clearly seen across a range of measures
The determinants of youth health outcomes extend beyond the traditional boundaries of the heath sector. The health outcomes of our youth are affected by wider contexts comprising families, schools and communities, where issues such as poverty, disengagement from school and availability of alcohol are examples of risks which impact of the health and wellbeing of young people.
The future of Auckland as a vibrant and economically healthy city depends on our young people being prepared to contribute to their families and communities in a rapidly changing and technology sophisticated world. This requires young people to be healthy, emotionally resilient and engaged in education and training with access to high quality health and social services.

Objectives	Linkages
Six main objectives are to: • Optimise health outcomes, including reducing inequities in health outcomes • Use a regional voice to advocate improvements in the upstream determinants of youth health • Target our interventions at those who need them most • Improve the capability and capacity of our workforce so that a young person receives quality care regardless of where they present, • Pool health and other social agency resources more effectively • Achieve greater consistency and quality of care for young people	• Northern Region Mental Health and Addictions network, and its focus on youth forensics • Youth health action plan • Youth development strategy • Auckland Council and its intersectoral groups • Northland Council and its intersectoral groups • Regional groups for maternity, youth, primary care, etc. • Child Health Network

Note: Youth are defined as 12 – 24 years, for the purposes of this document

2015-16 Implementation Plan

Item	Youth Health : Process/Action	2015/16 Quarter completed by	2016/17	2017/18
	1. Patient Outcome Measures			
	Develop clinical outcome measures and instigate reporting on the following once development is complete:	Q4		
	• PHO Enrolment • Smoking status • Teen Birth Rate • Access to Primary Mental Health (in line with MoH PP6 criteria) • Youth elective termination of pregnancy • Suicide numbers • GP practices offering free service to <18 year olds. • Secondary Mental health care access rates	Q1 Q1 Q1 Q2 Q2 Q3 Q1 Q4		
	2. Models of care and service			
	Youth Mental Health			
	Support regional mental health network, and local development and implementation, of the 'prime ministers initiative' for youth mental health.	On going		
	School based health services			
	Determine key areas requiring support amongst School based Health services. This will be based on responses to the survey recently undertaken by the Youth Health Network.	Q2		
	Youth appropriate primary care			
	Review and develop/ refine standards for delivery of care (aspects of service design and clinician skills) for youth in other primary care settings	Q4		
	Youth appropriate secondary care			
	Support /progress youth health services and transitions in secondary care, including the interface with primary care.	on-going		
	Workforce			
	Explore workforce training options- develop a landscape to identify what is currently in existence and gaps which are evident.	Q3		

Appendix A.3:

Services – Implementation Plan Matrices

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Supporting Material

Radiology

Context
Radiology provides screening, diagnostic and treatment imaging support to other clinical services. Imaging is an integral part of healthcare. By providing diagnostic information at critical points in the patient journey, and the option of image-guided minimally invasive interventional procedures, imaging services rationalise the need for intervention and target where it will have the greatest benefit. Interventional radiology procedures allow minimally invasive procedures to be performed and often avoid the need for more invasive surgery

Clinical practice is changing for radiology, driven by new models of care which see health care increasingly being delivered in the community, and the introduction of new targets and pathways, particularly for cancer.

It is a capital intensive service, particularly in high tech/high cost modalities such as CT and MR. The tight current fiscal environment means we will need to work differently to afford the projected future demand

There are also significant workforce shortages in key areas (e.g. Sonographers). |

Objectives	Linkages
The key drivers to this priority area: • A sustainable workforce in all Radiology related professional groups • Matching capacity to demand, and maximising productivity of radiology resources • Improving equitable and timely access to high quality imaging • More efficient and accurate access to health information by health providers and the public	• National Radiology Advisory Group • Regional and national PET-CT Variance Committees • Northern Region Cancer Network • Regional Capital Group

Key achievements over the past three years

The Radiology Clinical Network was established at the end of July 2011 with cross DHB and later primary care representation. Since inception, achievements in Radiology in the region include:
- Consistent KPIs implemented, with improvements across most measures
- Continuing investment in imaging with 3 new MR and 6 new CT scanners
- Cross-sector work to address Sonography shortage, including public and private providers, training institutions and others. An intensive training pilot scheme has started to improve the work-readiness of trainees and reduce the training burden on DHBs
- Regional Paediatric Radiology Service Standard and Plan developed
- Introduction of new PET-CT referrals and contracts, and expansion of indications
- Radiology regional access criteria developed and rolled out in Care Connect e-referrals
- Lead role in development of set of national access criteria for DHB funded community radiology
- Regionally consistent pricing model implemented for inter-DHB Radiology charging
- Establishment of functional working groups to develop regional service planning and strategy for neuroradiology, nuclear medicine, radiology IS and obstetric imaging

2015/16 Implementation Plan

Item	Process/Action		2015/16 Quarter due for completion	2016/17	2017/18
	1. Radiology Measures				
	75% validated reports completed within 24 hours		Q1-Q4 Ongoing	√	√
	95% patients receive CT scan within 6-weeks of referral		Q1-Q4 Ongoing	√	√
	85% patients receive MR scan within 6-weeks of referral		Q1-Q4 Ongoing	√	√
	Measure of CTCA and CTC activity		Q1-Q4 Ongoing	√	√
	2. Foundation Activity				
	Foundation in place, no further activity				
	3. Process activity				
	3a. Models of care and service				
	Regional Radiology service planning and improvement				
1	Further development and implementation of regional service plans for : - Paediatrics - Nuclear Medicine - Neuroradiology		Q1-Q4 Ongoing	√	√
2	Further development of cross sector Obstetric Imaging quality improvement		Q1-Q4 Ongoing	√	√
3	Establish a regional Oncology imaging group to promote QA of Oncology imaging, ensure regional consistency of access and delivery and appropriate resource use The group will act as reference group for the regional Cancer network		Q1-Q4 Ongoing	√	√
4	Explore new opportunities to drive radiology quality and productivity improvements		Q1-Q4 Ongoing	√	√
	National service improvement				
4	Support the implementation of the NHB service improvement toolkit		Q1-Q4 Ongoing	√	√
	Greater Regional Consistency		Q3-Q4		
5	Support the Cancer network in implementation of standards for Oncology follow-up and surveillance imaging		Q1-Q4 Ongoing	√	√
6	Support the development of standard imaging protocols for follow up of incidental findings		Q4		
7	Lead the implementation of regional oncology imaging protocols for CT and MR imaging pathways to support FCT targets.		Q4		
	Strengthen linkages with others				
8	Develop and align relationships with other Community Radiology service delivery organisations		Q2		
9	Continue to strengthen linkages between regional PET-CT variance committees		Q1-Q4 Ongoing	√	√
10	Continue to support National Radiology Advisory Group through: • Chair and clinical leadership • Developing national initiatives in key areas		Q1-Q4 Ongoing	√	√
11	Continue to liaise with other groups on radiology issues, e.g. cancer network, cardiac network		Q1-Q4 Ongoing	√	√
	3b. Workforce				
12	Support DHBs to increase the number of Sonography trainees		Q1-Q4 Ongoing	√	√
13	Continue to lead cross sector work to address the shortage of Sonographers		Q1-Q4 Ongoing	√	√

Item	Process/Action		2015/16 Quarter due for completion	2016/17	2017/18
14	Support the new intensive training program for Sonographers		Q1-Q4 Ongoing	√	√
15	Continue to engage with HWNZ to support the funding and training of Sonographer trainees		Q1-Q4 Ongoing	√	√
16	Engage with the MRTB to facilitate international recruitment for Sonographers, MR technicians and Nuclear Medicine		Q1-Q4 Ongoing	√	√
17	Support the development of the radiology workforce including joint appointments		Q1-Q4 Ongoing		
	3c. Information Systems				
18	Support the functioning and key initiatives of the Regional Radiology IS Steering Group		Q1-Q4 Ongoing	√	
19	Plan for the implementation of the ISSP in alignment with other key strategic IS work		Q1		
19	Engage DHBs to secure funding for IS projects		Q2		
20	Progressively implement the ISSP		Q3-Ongoing	√	√
21	Support national Radiology IS initiatives through representation on clinical advisory group of NHITB and in key initiatives		Q1-Q4 Ongoing	√	
	3d. Capital and other expenditure				
22	Refresh the 10 year Radiology Capital and Asset plan		Q1		
23	Continue to support business case development, asset planning, and procurement processes		Q1-Q4 Ongoing	√	√
24	Continue engagement with hA to improve procurement processes for radiology equipment		Q1-Q4 Ongoing	√	√

Electives implementation plan

Context
National directions place emphasis upon elective services as a regional area of focus. Over the past three years the wait time targets for elective FSA and treatment has progressively been reduced from 6 months in 11/12, to 5 months in 12/13 and 4 months by the end of December 2014. In addition, DHBs are working to increase the number of elective surgery cases being done.

While the Northern Region DHBs have achieved their electives targets in the past, it will continue to be a challenge to maintain these targets in the future. Constraints on capital funding limit our ability to build additional capacity. To be able to continue to meet our targets our DHBs have actively sought new ways to improve elective productivity within existing resources.

We are progressively standardising access and care through the development of pathways so that most people who require elective services receive fast and consistent decisions. We have implemented a range of initiatives to improve productivity and efficiency.

We have identified a number of regional initiatives in areas where we can make the most gain by working regionally, with a strong focus on building on the work which has been done locally. We also acknowledge that elective services are managed differently in each DHB and so have focussed on initiatives which have a universal impact across our region. |

Objectives	Linkages
The objectives of the regional work are to: • Maintain reduced waiting times for elective first specialist assessments and treatment • Improve access to elective services; including equitable access to services; for our population • Support the development of new models of care	Capital planning National targets Alignment to Elective Services Productivity and Workforce contract between the NHB and NRA

2015/16 Implementation Plan

Item	Electives : Process/Action		2015/16 Quarter completed by	2016/17	2017/18
	1. Patient Outcome Measures				
	Maintain ESPI 2 targets - 100% of patients receive FSA within 120 days of referral		Q1 ongoing		
	Maintain ESPI 5 targets - 100% of patients receive treatment within 120 days once the decision to treat has been made		Q1 ongoing		
	The region will deliver at least 65,631 Elective Services discharges in 2015/16		Q4		
	2. Process activity				
	2a. Models of care and service				
	Maintain the monthly Service Manager Forum, and Promote good practice and awareness by DHBs hosting regional showcase – 'sharing' sessions - Reducing DNA rates and progressing "patient focussed booking" initiatives - The implementation of the learnings and principles of the Enhanced Recovery after Surgery [ERAS] project, as DHBs apply the model to different specialities - Process and progress to Improve standardised intervention rates including work to gain a better understanding of catchment and demand arising within demographic areas		Monthly One per quarter		
	Progress bariatric surgery for the Northland community by means of a collaborative approach between NDHB and WDHB		Q4		
	Progress the implementation of ophthalmology services to the WDHB population by the ADHB provider delivering clinics in the WDHB Waitakere Hospital;		Q4		
	Develop and Implement Pathways and protocols				
	Work with cancer services to develop consistent pathways and protocols for tumour streams (refer Appendix 2 Cancer plan, particularly 2a.2, 2a.4, 2a.5)		Q4	X	X
	Pursue fair and equitable access criteria				
	Implement clinical prioritisation tools across the region, once agreed as clinically appropriate, with a focus on : - Ophthalmology for cataracts - Plastic surgery - Orthopaedics - General surgery (as these tools become available for use)		Q4		
	Identify and remove barriers to access for Maori and PI to bariatric surgery at WDHB and ADHB		Q1 toQ4		
	2c. Information Systems				
	Support the eReferrals inter and intra DHB implementation within elective services		As per ESPWP contract		
	Implement National patient flow concepts, in line with MoH guidance and data collection expectations		Q4		
	2d. Capital and other expenditure				

Item	Electives : Process/Action		2015/16 Quarter completed by	2016/17	2017/18
	Support DHBs capital planning		ongoing		

Appendix A.4:

Enablers– Implementation Plan Matrices

Regional Information Systems Implementation Plan
Northern Region Priority Programmes/Projects FY2015/2016 – Key Deliverables - Status as at 12 June 2015

Projects	Deliverables 2015/2016								Deliverable 2016-2017	Deliverable 2017-2018
	Q1 July - September		Q2 October - December		Q3 January - March		Q4 April - June			
CareConnect Programme										
eReferrals Phase Two (2.3/2.4) (Intra and Inter Hospital Referrals)	Regional business case approved	G	Development complete and system ready for go-live	G	System go-live & regional implementation commenced	G	Regional implementation ongoing - 50% completed for intra-DHB and inter-DHB referrals	G	Regional implementation ongoing - 75% completed for intra-DHB eReferrals and inter-DHB referrals	
					NDHB: Migration Planning commenced	G			NDHB: Migration completed	
Patient Portal Integration Strategy	Patient Portal Integration Strategy drafted & PHOs agreed to sign up	G	Patient Portal Integration Strategy agreed & implementation commenced	G	Patient Portal Integration Strategy implementation ongoing	G	Patient Portal Integration Strategy implementation complete	G		
Shared Care Development & Integration	CareConnect Technical Integration Plan drafted	G	CareConnect Technical Integration Plan agreed; procurement process commenced	G	CareConnect Technical Integration procurement process completed (preferred vendor selected)	G	CareConnect Technical integration commenced	G	CareConnect Technical integration completed	
Clinical Pathways			Pilot evaluation completed & stop gate decision made; further primary care implementation ongoing	G	Integration with secondary care commenced	G	Integration with eReferrals & Testsafe completed	G	Integration with secondary care completed; 50% implementation completed	

Projects	Deliverables 2015/2016				Deliverable 2016-2017	Deliverable 2017-2018
	Q1 July - September	Q2 October - December	Q3 January - March	Q4 April - June		
eMedicines Programme						
Hospital ePharmacy			NDHB: regional implementation completed **G**		CMH: implementation completed	WDHB: implementation completed
ePrescribing and Admin'n (ePA)				WDHB: ePA Phase 3 rollout completed **G**		
	ADHB: ePA Phase 1 implementation planning commenced **G**	ADHB: ePA Phase 1 implementation ongoing **G**	ADHB: ePA Phase 1 Implementation completed **G**		ADHB: ePA Business case for Phase 2 Implementation approved & implementation commenced	ADHB: ePA Phase 2 Implementation completed
	CMH: ePA Early Adopter planning commenced **G**	CMH: ePA Early Adopter implementation commenced **G**		CMH: Business case for ePA Implementation Phase 1 approved **G**	CMH: ePA Implementation Phase 1 completed	CMH: ePA Implementation Phase 2 completed
				NDHB: Business case for ePA Implementation Phase 1 approved **G**	NDHB: ePA Implementation Phase 1 completed	NDHB: ePA Implementation Phase 2 completed
NZ Formulary (NZF)			NDHB: NZF and ePharmacy implementation completed **G**		CMH: implementation of ePharmacy and Reference viewer upgrade completed	WDHB: implementation of ePharmacy and Reference viewer upgrade completed

Projects	Deliverables 2015/2016								Deliverable 2016-2017	Deliverable 2017-2018
	Q1 July - September		Q2 October - December		Q3 January - March		Q4 April - June			
National Solutions										
National Patient Flow			Phase 2 agreed functionality delivered	**G**	Phase 3 Plan agreed	**G**	Phase 3 functionality delivered	**G**	Phase 4 functionality agreed and delivered	
National Maternity	CMH: Phase 2 Implementation planning completed	**G**	CMH: Phase 2 Implementation commenced	**G**			CMH: Phase 2 Implementation completed	**G**		
							WDHB: Business Case approved	**G**	WDHB: Implementation completed	
									NDHB: Business Case approved and Implementation complete	
										ADHB: Business Case approved and Implementation complete

Projects	Deliverables 2015/2016								Deliverable 2016-2017	Deliverable 2017-2018
	Q1 July - September		Q2 October - December		Q3 January - March		Q4 April - June			
Other Regional Initiatives										
Regional Patient Administration System	Implementation Planning Study and (Indicative) Business Case development ongoing	G	Implementation Planning Study and (Indicative) Business Case development ongoing	G	Implementation Planning Study completed; (Indicative) Business Case approvals process commenced	G	(Indicative) Business Case approved	G	(Full) Business Case development and approvals phase completed	Implementation phase commenced
Radiology PACS			Regional infrastructure upgrade completed and test environment delivered	G	Auckland metro PACS Platform implemented ; CMH & WDHB Upgrade to IMPAX 6.6 completed	G			ADHB migration to metro PACS completed	
eOrders for Laboratory & Radiology			WDHB: implementation of eOrders (Rad/Lab) commenced	G	WDHB: implementation of eOrders (Rad/Lab) ongoing	G	WDHB: implementation of eOrders (Rad) completed	G	WDHB: implementation of eOrders (Lab) completed	
			ADHB: eOrders (Lab) business case approved	G	ADHB: implementation of eOrders (Lab) commenced	G	ADHB: implementation of eOrders (Lab) ongoing	G	ADHB: implementation of eOrders (Lab) completed	
					CMH: eOrders Strategy confirmed & milestones defined	G				
					NDHB: eOrders Rad/Lab) Business case completed	G	NDHB: implementation of eOrders (Rad/Lab) commenced	G	NDHB: implementation of eOrders (Rad/Lab) completed	

Workforce implementation plan

2015/16 Implementation Plan

Item	Regional Workforce: Process / Action	2015/16 Quarter completed by	2016/17	2017/18
	Strengthen clinical leadership and management capability throughout the workforce			
1	Harness our regional resources to raise the visibility and value of leadership in health and build the capability of our leaders and the wider management workforce. – Identify the range of clinical leadership development initiatives across the northern region. – Create opportunities at the regional level to support shared learning and sharing of resources for the development and deployment of clinical leadership. Support the national GMs HR / HWNZ Leadership Domains Framework, commencing with the pilot implementation of the Framework at Waitemata DHB. – Develop a Health Management Training Pathway – engage with DHBs to determine agreed model and develop implementation plan.	Q2 Q3 Q1 – Q4 Q3	✔	✔
	Grow the capacity and capability of our Maori and Pacific Workforce			
2	Implement local, regional and national initiatives to support a "pipeline" or student driven approach to workforce development such as "Grow our Own" initiatives through secondary, tertiary, and/or "second chance" learners' programmes, opportunities for work experience placements and exposure to health care settings, and scholarships for tertiary study. – A minimum of a 200 Maori and 200 Pacific students enrolled in high school based health career programmes – A minimum of 200 Maori and 200 Pacific students offered • Gateway programmes, or • work experience placements, or • work exposure in a DHB. – 50 Maori and 50 Pacific people offered scholarships for tertiary health studies. Implementing nationally based Kia Ora Hauora initiatives: – Recruit a minimum of 200 Maori students to a health study pathway in this region – Support at least 20 Maori into first year tertiary study.	Q1 – Q4 Q1 – Q4	✔ ✔	✔ ✔
3	Build our workforce to reflect the communities we service, prioritising Maori and Pacific workforces. – Work with Tertiary Education Commission (TEC) and tertiary education providers to improve Maori and Pacific undergraduate completion rates. – Implement a dedicated regional recruitment and retention strategy (end to end support) for Maori and Pacific staff – Monitor progress by reporting on ethnicity of the health workforce against the regional and local population on a 6-monthly basis.	Q1 – Q4 Q2 Q2 – Q4	✔ ✔	✔ ✔

	Ensure that available funding is joined up to maximise impact and value for the Maori and Pacific workforces. – Undertake stocktake of various MoH funding sources for workforce programmes in DHB (Year 1) – Explore new funding opportunities for primary healthcare clinical placements for Maori and Pacific undergraduate students.	Q1 – Q2 Q1 – Q4		
4	Promote and support the development of Maori and Pacific Clinical and Cultural Leaders.	Q1 – Q4	✔	✔
	Increase the flexibility and affordability of the workforce to manage rising demand			
5	Develop a regional workforce programme for the introduction of nurses performing endoscopies.	Q1 - Q4	✔	✔
	Develop new and hybrid roles to increase flexibility to work across hospital and community settings, including – Roles that support the functions of care-co-ordination / navigation. – Hybrid / blended roles across the Allied Health, Scientific and Technical professions	Q1 – Q4	✔	✔
	Actively support and contribute to the HWNZ Nursing Workforce Programme as initiatives are clarified, such as: – Support the creation of new palliative care specialist nurses and educators. – Refocus the role of nurse practitioners and clinical nurse specialists.	Q1 – Q4	✔	✔
	Build and align the capability of the workforce to deliver new models of care			
6	Identify opportunities to better utilise and support the non-regulated workforce: – Undertake a stocktake of existing support programmes for the unregulated workforce in each DHB. – Identify new opportunities and existing initiatives that could be expanded, e.g. investigate the feasibility of formalising existing informal interpreting services already provided by staff. – Increase access to education and training pathways, e.g. by providing formal qualifications to Orderlies, Kitchen Assistants, and Healthcare Assistants.	Q1 Q2 Q3 – Q4	✔	✔
	Identify initiatives for implementation/support arising from the Kaiawhina Workforce Action Plan.	Q2 – Q4	✔	✔
	Identify opportunities to better support our low paid workforce through: – Determine who our low paid workforces are. – Identify new opportunities and existing initiatives that could be expanded to increase access to education and training pathways.	Q1 Q2 - Q4	✔	✔
	Optimise the pipeline and improve the sustainability of priority Workforces			
7	Undertake a workforce "scan" utilising key indicators including the National Workforce Intelligence and Planning Framework to identify at least two priority workforces for attention.	Q1 – Q4	✔	✔
	Implement existing and new initiatives: – Sonographer Trainee pilot – AP Scientific & Technical workforce plan (continuance)	Q1 – Q4		

	Adopt a regional approach to developing an engaged and capable workforce.			
8	Jointly identify, develop and implement policies and procedures / processes across the region for: – Employment Application Form – Health and Safety Policy (including workforce wellbeing)	 Q3 Q3 – Q4		
9	Strengthen the regional development and implementation of e-learning modules. – Share and consolidate existing courses; regionalise 3 mandatory courses per year. – Expand access and reach into the primary and community sector. – Work towards implementation of e-passport capability, by investigating the feasibility of aligning the e-learning platforms and training records.	Q2 - Q4	✔	✔

10	Continue building on the cultural competency training to all staff:
	– Tikanga and Pacific cultural training is included as part of mandatory training schedule for all staff:
	– Evaluate the process and impact of the Tikanga and Pacific cultural training programmes regionally.
	
	– 400 per DHB for CMDHB / ADHB / WDHB staff and 50 for NDHB enrolled in Culturally and Linguistically Diverse (CALD) courses annually
	
	Improve workforce cultural competency to support our migrant workforce especially our large migrant Asian workforce:
	– Increase the uptake of Managers and their Teams completing the CALD programmes:
	    o "Managing Culturally Diverse Teams
	    o "Working in Culturally Diverse Teams"
		
		Q4
		
		Q2 – Q3
		
		Q1 – Q4
		
		Q2 – Q4
			
			✔
			
			✔
				
				✔
				
				✔

	Optimise the capacity and capability of the RMO Workforce			
11	Provide an effective regional RMO service to support DHBs recruit and retain an RMO workforce aligned with service delivery and training requirements. Lead the development of consistent approaches of minimum standards for RMO education and training across the region, consolidating training resources and standardising at least four PGY 1 / 2 programmes annually (aligned with national and regional service needs). Support Medical trainees to develop and implement career plans, providing access to career guidance and mentoring services for RMOs.	Q1-Q4 Q1-Q4 Q1-Q4	✔ ✔ ✔	✔ ✔ ✔
12	Support the HWNZ Medical Workforce programme. – Provide reporting and analysis of regional workforce trends. – Maximise the placement of NZ graduates who are New Zealand Citizens or New Zealand Permanent Resident. – Develop 7 primary care/community based positions for PGY 2s in line with the MCNZ requirements for General Registration. – DHB placement for GPEP trainees to support integration between primary and secondary care.	Q1-Q4	✔	✔

The table below outlines regional workforce initiatives to be progressed by the Regional Clinical Networks.

Regional Programmes and Clinical Networks	2015/16 Quarter Completed by			
	Q1	Q2	Q3	Q4
First Do No Harm				
Provide learning events and coaching to improve capacity and capability for improvement activities	✔	✔	✔	✔
Support consumer participation in regional patient safety activities and planning	✔	✔	✔	✔
Child Health				
Enabled Clinical Teams: Establish regional working group to implement selected activities that inform and re-orientate workforce to improve health outcomes for children				
Health of Older People				
Facilitate training & education to primary care clinicians on specific dementia initiatives	✔	✔	✔	✔
Promote CALD Older People training & HOPE - Health of Older People E-resource (Mental Health Services for Older People) to HOP workforce	✔	✔	✔	✔
Analyse composition of HBSS workforce	✔	✔	✔	✔
Cancer				
Support the commitment of the region and DHBs to train and provide professional development to cancer nurse coordinators, including attendance at national and regional training and mentoring forums.	✔	✔	✔	✔
Establish a Registered Nurse Expanded Practice Training and Credentialing Programme, in support of increased colonoscopy provision in the region's DHBs.				✔
Cardiovascular Disease				
Follow up agreed actions from Allied Health and Cardiac nurses cardiac rehab forum		✔		
Diabetes				
Support the development of skills in diabetes within health professional groups and promote professional education opportunities on risk factor assessment, behaviour change counselling skills, diabetes prevention and control, and cultural competency.			✔	
Major Trauma				
Develop a workforce training plan which encompasses: • Training opportunities • Supporting staff especially in smaller centres to train and gain more experience in trauma	✔	✔	✔	✔
Stroke				
Calculate % of nursing & allied health staff who have completed a stroke care competency programme				✔
Establish thrombolysis credentialing programme for medical staff				
Report on stroke training/education events	✔	✔	✔	✔
Review & update Northern Region section (for health professionals) on NZ Stroke website, 6 monthly	✔	✔	✔	✔
Support national workforce initiatives and roll-out regionally e.g. thrombolysis workforce plan	✔	✔	✔	✔
Advance Care Planning				
Increase health workforce awareness of, and competence in, ACP and communication skills.	✔	✔	✔	✔
Mental Health				
Develop a regional Suicide Prevention Training Framework		✔		
Identify workforce requirements to support the implementation of • Perinatal and maternal mental health • Emerging framework for a youth forensics model of care		✔ ✔		
Identify and Implement agreed recommendations from the Maori Mental Health and Addiction Workforce stocktake.	✔	✔	✔	✔

Regional Programmes and Clinical Networks	2015/16 Quarter Completed by			
	Q1	Q2	Q3	Q4
Long Term Services – Chronic Health Conditions (LTS - CHC)				
Undertake professional development workshop for the Northern Region's LTS CHC DHB and DSS NASCs on specialist assessments that support the Northern Region's Specialist Rehabilitation Model of Care.	✔	✔		
Youth Health				
Explore workforce training options- develop a landscape to identify what is currently in existence and gaps which are evident.			✔	
Radiology				
Support DHBs to increase the number of Sonography trainees	✔	✔	✔	✔
Continue to lead cross sector work to address the shortage of Sonographers	✔	✔	✔	✔
Continue to engage with HWNZ to support the funding and training of Sonographer trainees including the new intensive training program for Sonographers.	✔	✔	✔	✔
Engage with the MRTB to facilitate international recruitment for Sonographers, MR technicians and Nuclear Medicine	✔	✔	✔	✔
Support the development of the radiology workforce including joint appointments	✔	✔	✔	✔

Facilities / Capital

The major facility projects planned in the Region and their indicative costs over the next 10 years (as at 19 June 2015) are listed in the following tables (*note that these will be updated as work is progressed with the DHBs on the Regional Capital Plan for submission in August 2015*).

Northland DHB

10 Year Cash and Debt Forecast ($'000)	Intentions / Approved	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	Total
		Preliminary Capital 1516										
Opening Cash												
Opening Debt												
Cash generated from Operations												
Add Surplus												
Cash generated from Donations												
Capital Intentions:												
Land, Buidings & Plant												
Baseline Replacement Capital	Intention	2,380	2,800	2,900	3,000	3,000	3,000	3,000	3,000	3,000	3,000	29,080
Maternity Building	Approved	7,000	5,356									12,356
Whangarei Energy Centre - Boiler House Upgrade	Approved	315										315
Site Wide Infrastructure	Approved	4,000	1,402									5,402
Office Building	Approved	9,804										9,804
Maunu House Fitout	Approved	1,159										
Carparking	Approved	2,177										2,177
CT Scanner building	Approved	1,076										1,076
MRI Building	Approved		500									500
CSSD Reconfiguration	Intention			1,000								1,000
Mental Health Extend capacity	Intention							4,000				4,000
Dargaville replace Boiler House	Intention			1,200								1,200
Campus Wide Power Generation	Intention			2,800								2,800
Whangarei ED/AAU & Kitchen	Intention		5,000	13,000	13,000							31,000
Whangarei ED/AAU Shell 2nd floor	Intention			4,833								4,833
Bay of Islands rebuild & Integrated Family Health Centre	Intention		9,000									9,000
Whangarei Additional Theatre & Endoscopy Suite	Intention		3,000									3,000
Whangarei Clinical Traning Centre	Intention		5,200									5,200
Whangarei New Theatres and Endoscopy Suite	Intention								10,000	15,700		25,700
Whangarei Relocation Paediatrics to Maternity	Intention			2,000	2,000							4,000
Whangarei Relocation of Laboratories	Intention			2,000	2,000							4,000
Whangarei Wards	Intention								20,000	30,000	22,000	72,000
Whangarei Multilevel Carpark	Intention										9,500	9,500
												0
Clincial Equipment												
Baseline Replacement Capital		1,912	3,800	3,800	3,876	3,954	4,033	4,113	4,196	4,279	4,365	38,327
CT Scanner	Approved	2,100							2,200			4,300
MRI	Approved		1,860							2,000		3,860
CSU Equipment Upgrade	Intention		1,500						1,600			3,100
Patient Acuity Monitoring System	Intention				0	2,500						2,500
ICU Monitoring System	Intention		1,500						1,600			3,100
CSSD Equipment	Intention			1,300								1,300
Theatre Tables	Intention		130	130	130	130	130	130	130	130	130	1,170
Anaesthetic Machines	Intention		250	250	250	250	250	250	250	250	250	2,250
Anaesthetic Monitors	Intention		100	100	100	100	100	100	100	100	100	900
												0
Other Equipment												0
Baseline Replacement Capital			300	300	300	300	300	300	300	300	300	2,700
												0
ICT												0
WebPAS Project	Approved	2,500	2,000									4,500
Pharmacy Information System	Intention	3,737	996									4,733
Misc Other	Intention											0
												0
Vehicles												0
Baseline Replacement Capital		20										20
												0
Investments												0
healthAlliance												0
Health Benfits Ltd												0
Total Capital Expenditure		38,179	44,694	35,613	24,656	10,234	7,813	11,893	40,176	58,959	39,645	310,703
Existing Debt Repaid												
New debt repaid												
New Debt (project)												
Closing Cash												
Closing Debt												

(all values shown as $'000)

Waitemata DHB

Project	Status	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	10 Year total
Land, Buildings and Plant												
Mason Clinic remediation programme	Approved	0.50	3.53	2.00	-	-	-	-	-	-	-	6.03
Mason Clinic 15 Bed Unit	Approved	4.90	4.57	-	-	-	-	-	-	-	-	9.47
Waitakere ED	Approved	6.50	-	-	-	-	-	-	-	-	-	6.50
Waitakere ED Mental Health and Emerging Diseases	Approved	2.00	-	-	-	-	-	-	-	-	-	2.00
WTH Maternity - Redesign	Approved	0.89	-	-	-	-	-	-	-	-	-	0.89
Level 3 Dept of Med	Approved	1.12	-	-	-	-	-	-	-	-	-	1.12
Awhina (Campus) Stage 1	Approved	7.03	2.34	-	-	-	-	-	-	-	-	9.37
44 Taharoto - cash flow funding	Approved	19.00	-	-	-	-	-	-	-	-	-	19.00
Theatres	Approved	5.60	-	-	-	-	-	-	-	-	-	5.60
Discharge lounge	Approved	1.08	-	-	-	-	-	-	-	-	-	1.08
Bridge to ESC	Approved	5.30	-	-	-	-	-	-	-	-	-	5.30
Car Park Crown Loan Repayment	Approved	1.00	1.00	1.00	1.00	-	-	-	-	-	-	4.00
Programme of works - WTH Energy and Infrastructure	Intention	1.00	1.50	2.50	2.00	2.00	2.00	2.00	2.00	-	-	15.00
Programme of works - NSH Energy and Infrastructure	Intention	1.00	1.50	2.50	2.00	2.00	2.00	2.00	2.00	-	-	15.00
NSH Ground Floor redevelopment	Intention	4.40	4.50	0.50	-	-	-	-	-	-	-	9.40
NSH Heliport and Hyperbarich chamber	Intention	0.10	2.00	2.90	-	-	-	-	-	-	-	5.00
Community Building 5 refurbishment	Intention	4.00	5.00	-	-	-	-	-	-	-	-	9.00
SCBU	Intention	1.50	3.50	-	-	-	-	-	-	-	-	5.00
Ambulatory Centre - Breast service and Screening	Intention	2.00	6.00	1.00	-	-	-	-	-	-	-	9.00
Ambulatory Centre - Haematology/Oncology	Intention	0.10	0.50	7.00	1.40	-	-	-	-	-	-	9.00
Ambulatory Centre - Car Park	Intention	-	-	0.50	10.00	8.90	-	-	-	-	-	19.40
Orthopaedic clinic expansion	Intention	0.10	2.90	-	-	-	-	-	-	-	-	3.00
Wahanu accommodation	Intention	0.10	1.00	1.90	-	-	-	-	-	-	-	3.00
WTH Maternity - Stage 2	Intention	0.40	0.50	7.00	20.00	11.10	-	-	-	-	-	39.00
NSH and WTK Clinical Support Services	Intention	0.10	1.70	4.00	3.50	2.90	-	-	-	-	-	12.20
Medical Tower	Intention	0.50	5.00	30.00	29.50	5.00	-	-	-	-	-	70.00
Awhina Stage 2	Intention	-	0.50	2.00	4.00	4.00	1.10	-	-	-	-	11.60
NSH Tower Refurbishment	Intention	-	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	9.00
Surgical Tower	Intention	-	-	-	0.50	3.50	13.00	29.00	29.00	15.00	-	90.00
Marae	Intention	-	-	0.20	0.50	0.30	-	-	-	-	-	1.00
Baseline Replacement	Intention	0.85	3.83	3.96	4.10	4.24	4.39	4.55	4.72	4.89	5.07	40.60
Non strategic assets	Intention	0.15	2.63	2.72	2.81	2.91	3.02	3.13	3.24	3.37	3.49	27.47
Clinical Equipment												
Stryker Power Tools Deal - 7 Year deal	Approved	0.26	0.26	0.26	0.26	0.26	0.07	-	-	-	-	1.36
Patient Beds Pool Replacement programme	Intention	0.89	0.89	0.89	-	-	-	-	-	-	-	2.67
Baseline Replacement	Intention	8.30	5.59	5.78	5.97	6.18	6.40	6.64	6.88	7.13	7.40	66.27
Non strategic assets	Intention	2.23	4.29	4.44	4.60	4.76	4.93	5.11	5.30	5.50	5.71	46.88
Other Equipment												
Baseline Replacement		1.70	0.48	0.50	0.51	0.53	0.55	0.57	0.59	0.61	0.63	6.67
Non strategic assets		0.59	0.33	0.34	0.35	0.36	0.38	0.39	0.41	0.42	0.44	4.00
ICT												
E Prescribing	Approved	1.95	-	-	-	-	-	-	-	-	-	1.95
Programme of works - Leapfrog	Intention	1.00	-	-	-	-	-	-	-	-	-	1.00
Regional Patient Admin System	Intention	-	2.50	2.50	2.50	2.50	-	-	-	-	-	10.00
Baseline Replacement	Intention	1.73	5.27	5.45	5.63	5.83	6.04	6.26	6.48	6.72	6.98	56.39
Non strategic assets	Intention	7.95	3.61	3.74	3.87	4.01	4.15	4.30	4.46	4.63	4.80	45.52
Motor Vehicles												
Baseline - Replacement	Intention	3.46	0.80	0.83	0.85	0.88	0.91	0.95	0.98	1.02	1.06	11.74
Non strategic assets	Intention	0.09	0.09	0.09	0.09	0.10	0.10	0.10	0.11	0.11	0.11	0.98
Investments												
Commitment to hA	Approved	2.50	2.50	2.50	2.50	2.50	2.50	2.50	-	-	-	17.50
HBL	Approved	-	-	-	-	-	-	-	-	-	-	-
Total		103.84	81.60	99.98	109.45	75.77	52.55	68.50	67.17	50.40	36.70	745.95

(all values shown as $'000)

Auckland DHB

ADHB	Intentions / Approved / Placeholder	Prior Years Costs (specific Projects)	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Capital Intentions:													
Land, Buildings & Plant													
Baseline Replacement Capital	Intention		16,402	11,767	10,000	10,000	25,000	21,142	24,000	16,770	17,632	31,446	184,159
Purchase of Procare Building, Grafton	Approved		7,720										7,720
Starship Theatres	Approved	2,445	5,356	1,500									6,856
Anatomical Pathology Lab	Approved		786	2,514									3,300
PC3 Lab	Approved	588	1,730	5,122									6,852
Lab Expansion Shell	Approved	364	5,230	2,546									7,776
ACH Car Park Top Level Expansion	Approved		2,333										2,333
Hybrid Operating Room	Approved	115	5,286										5,286
DML Cytology Fitout	Approved		1,055										1,055
Child and Family Unit (CFU) Upgrade	Approved	373	773	554									1,327
CFU Mother and Baby Unit	Approved		822										822
Theatre lights	Approved		500										500
PACU & PreOp Expansion	Approved	138	1,262										1,262
Directorate Office expansion	Approved	124	974										974
Ernst and Marion Davis Library Refurb	Approved		1,399										1,399
Haematology & Bone Marrow Unit Ward	Approved	4,774	3,011										3,011
ACH Comprehensive Cancer Centre and Brachytherapy Unit	Intention		600	500	6,800	8,700							16,600
Accident and emergency Department Expansion	Intention			1,000	2,000								3,000
Fraser McDonald Unit Redevelopment	Intention		200	800	1,500	1,500							4,000
Dialysis Unit Rebuild	Intention			2,000	4,000	4,000							10,000
Expansion of Endoscopy Suite at ACH and Greenlane	Intention				5,000	5,000	5,000						15,000
Inpatient Bed Growth	Intention								5,000	25,000	25,000		55,000
New Radiotherapy Capacity	Intention							22,501					22,501
Greenlane Clinical Centre- new Car Park Building	Intention										5,000	5,000	10,000
ACH additional car parking capacity	Intention					10,000							10,000
Mental Health 30 new acute & extended care beds for growth	Intention								14,850				14,850
Clinical Equipment													
Baseline Replacement Capital	Intention		12,173	19,763	10,000	10,000	13,623	9,980	12,920	15,000	9,138	20,499	133,096
Anaesthetic Monitors Fleet Replacement	Approved		1,844	1,666	1,220								4,730
Patient Monitors Fleet Replacement	Approved		4,000	2,133									6,133
Ventilator	Approved		874	580									1,454
Linear Accelerator	Approved		800	3,200									4,000
Heart Lung Machine	Approved			582									582
DML Business Equipment	Approved		1,100										1,100
CIU Room II Replacement	Approved		1,000										1,000
Heart Lung Machines	Approved		1,807										1,807
Bi Plane Catheter Lab	Approved		1,800										1,800
Fluoroscopy Room upgrades	Approved		1,600										1,600
Gamma Camera	Approved		1,200										1,200
CT Scanners	Approved		2,630										2,630
GCC MRI 3.7 Tessla	Approved	52	4,448										4,448
Ultrasound Machines	Approved		2,500										2,500
Beds	Approved		504										504
Bulk Instruments	Approved	802	1,098										1,098
Echo Machines	Approved		660										660
Camera Towers	Approved		500										500
Operating Room Tables	Approved		500										500
Other Equipment													
Baseline Replacement Capital	Intention		4,000	4,053	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	18,093
Access CCTV & Monitoring	Approved		1,552	884									2,436
Information Technology (IT)													
Baseline IT	Intention		9,605	6,193	264	191							16,253
Patient Administration System (PAS)	Intention		1,000	5,000	18,000	10,000	10,000						44,000
Rostering RiTA	Intention	1,576	354	469									824
Trendcare	Intention	606	237										237
CSSD Single Instrument Tracking	Intention		240	958									1,198
ePrescribing	Intention		550	650									1,200
National Cancer Information System	Intention		650	350									1,000
Vehicles													
Baseline Replacement Capital	Intention	211	660	446	675	650	675	675	675	675	675	500	6,306
Capital Program		12,168	115,326	75,230	60,714	61,296	55,553	55,553	58,700	58,700	58,700	58,700	670,639
Investments													
healthAlliance (additional, not funded by depreciation of transferred assets)													0
Health Benefits Ltd	Intention	11,858	542	2,000	2,000	1,000							5,542
Total Capital Expenditure		24,026	115,868	77,230	62,714	62,296	55,553	55,553	58,700	58,700	58,700	58,700	664,014
Financing Sources:													
Opening Cash Balance			87,076	19,433	0	0	0	0	0	0	0	0	87,076
DHB Cash from Depreciation			41,916	46,298	48,489	52,353	52,353	52,353	55,500	55,500	55,500	55,500	515,762
Balance sheet cash release				2,500	7,025	4,743							14,268
National Infrastructure programme asset sales				2,500	2,000								4,500
Lease financing (Iin Acc or CTs)				2,300									2,300
Donations			6,308	4,200	5,200	5,200	3,200	3,200	3,200	3,200	3,200	3,200	40,108
Crown Debt / Equity Required			0	0	0	0	0	0	0	0	0	0	0
Total Funds Available for Capital			135,300	77,231	62,714	62,296	55,553	55,553	58,700	58,700	58,700	58,700	664,014
Surplus / (Shortfall) on Total Capital Intentions			19,433	0	0	0	0	0	0	0	0	0	0

Summary			2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Land			0	0	0	0	0	0	0	0	0	0	0
Buildings & Plant			55,439	28,303	29,300	39,200	30,000	43,643	43,850	41,770	47,632	36,446	395,583
Clinical Equipment			41,038	27,924	11,220	10,000	13,623	9,980	12,920	15,000	9,138	20,499	171,342
Other Equipment			5,552	4,937	1,255	1,255	1,255	1,255	1,255	1,255	1,255	1,255	20,529
Information Technology			12,637	13,620	18,264	10,191	10,000	0	0	0	0	0	64,712
Motor Vehicles			660	446	675	650	675	675	675	675	675	500	6,306
Investments (HBL)			542	2,000	2,000	1,000	0						5,542
Total Capital Expenditure			115,868	77,230	62,714	62,296	55,553	55,553	58,700	58,700	58,700	58,700	664,014

(all values shown as $'000)

Counties Manukau DHB

CMDHB	Intentions / Approved	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	Total
		$000										
Capital Intentions:												
Land, Buidings & Plant												
Baseline Replacement Capital	Intention	(6,600)	(6,780)	(9,975)	(10,170)	(7,371)	(7,577)	(7,789)	(8,007)	(8,231)	(8,461)	(80,961)
Acute Mental	Approved		(3,000)	(17,000)	(33,000)							(53,000)
Specialised Rehabilition	Unapproved			(20,000)	(35,000)	(1,000)						(56,000)
Southern Car Park ($19.0m)	PPP											-
Diagnostics Laboratory	Approved	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(10,000)
Womens Health Building	Unapproved						(20,000)	(30,000)	(10,000)			(60,000)
Clinical Equipment												
Baseline Replacement Capital		(9,696)	(13,461)	(14,040)	(10,527)	(10,822)	(11,125)	(11,437)	(11,757)	(12,086)	(12,086)	(117,037)
project 1	Intention											
project 2	Intention											
Other Equipment												
Baseline Replacement Capital		(6,780)	(6,975)	(7,170)	(7,371)	(7,577)	(7,789)	(8,007)	(8,231)	(8,461)	(8,461)	(76,822)
		-										
ICT		-										
Baseline		(120)	(126)	(130)	(134)	(138)	(142)	(146)	(150)	(154)	(154)	(1,394)
Intangibles		(612)	(634)	(652)	(670)	(689)	(708)	(728)	(748)	(769)	(769)	(6,979)
Project SWIFT ($40-100m)	under development											
Project NEHR	under development											
Vehicles												
Baseline Replacement Capital		(252)	(254)	(261)	(268)	(276)	(284)	(292)	(300)	(308)	(308)	(2,803)
Investments												
healthAlliance (IT not available pending hA 15/16 plan)												
Health Benfits Ltd (FPSC est only) Going forward is unclear as from July under hA		(1,500)	(1,800)									(3,300)
Total Capital Expenditure		(26,560)	(34,030)	(70,228)	(98,140)	(28,873)	(48,625)	(59,399)	(40,193)	(31,009)	(31,239)	(468,296)

(all values shown as $'000)