





# Northern Region Health Plan

## 2016/17

# Foreword

This is our sixth 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, equity, and health of older people for particular attention. In addition, we place 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 2016/17.

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

# Office of Hon Dr Jonathan Coleman

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


07 JUL 2016

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 2016/17 Regional Service Plan**

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

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

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

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

**Regional Service Plan Agreement**
Approval of your RSP is currently conditional on the Region providing a refreshed prioritised list of IT investments in quarter 2 of 2016/17.

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

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

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

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

Yours sincerely

Hon Dr Jonathan Coleman
**Minister of Health**

cc DHB Chairs and Chief Executive Officers in the Northern Region


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

# Table of Contents

**Appendices**

# Executive Summary

## Introduction

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

The Northern Region Health Plan is intended to improve health outcomes and reduce disparities for the 1.76 million people living in the Northern Region.

It places emphasis upon selected actions that will be progressed in a joined up manner across the 4 Districts in our Region. These are actions that it makes sense to progress once, in a collaborative and consistent manner, rather than independently by each DHB. 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 2016/17.

The Northern Region Health 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. It 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.

***Building on past success***

This is the sixth 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.

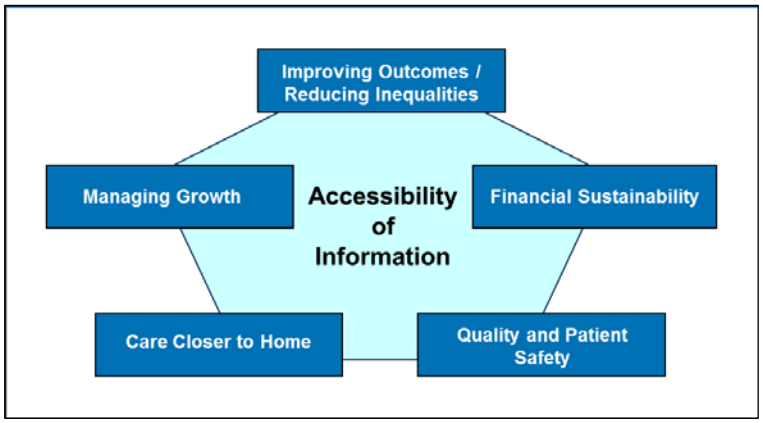
Successful innovations are shared and adopted more quickly across the region. Our clinical leaders are driving strategic service change. These improvements give us the confidence that we are focussing on the right things to really make a difference for our population.

## The Northern Region Context

***Six key drivers of change***

The Northern Region is facing significant environmental pressures which are recognised as key drivers of change. We also recognise the enabling resource 'Information Accessibility and Sustainability' as the sixth driver of change for our region.

**Figure 1 : Northern Region - Key Drivers for Change**




***Innovative investment is required to meet demand growth***

"Managing Growth' is a particularly significant force for change in the current environment.

Our Region's population is expected to grow by nearly 550,000 people over the next 20 years. Rapid demographic change and growing demand requires investment in new solutions and new capacity to serve. The solution requires new ways of thinking and better information and connectivity across the health sector.

The relentless demand on health services, particularly from demographic change, the growth in chronic diseases and the health needs of our aging population, poses a major challenge in a fiscally constrained environment.

The demand impacts on service utilisation rates and available capacity across our region. If the future service delivery mix was to be similar to that currently delivered, then our region would need approximately 75 -100 additional beds per annum over the next 20 years The way we currently deliver services is not sustainable. Wise and innovative investment is required in our Region.

***Regional Informatics work is a priority for our Region***

Regional informatics remains a 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]. Enabling our regional workforce to share and use information across the care continuum is critical to the effective and efficient delivery of services and touches upon every area of health care.

***Meeting The Minister's expectations***

The Northern Region operates as part of the national health system. The recently finalised New Zealand Health Strategy provides a vision to guide the future provision of health services. There are five 'visioning' themes to the national strategy:

- People Powered
- Care Closer to Home
- High Value and Performance
- One Team
- Smart System

The Minister expects that DHBs and regions will focus on:

- Aligning any new initiatives to the five themes of the draft New Zealand Health Strategy
- Fiscal discipline and management of health services
- Supporting cross agency work that delivers outcomes for children and young people, including reducing unintended teenage pregnancies
- Achieving the National Health Targets, particularly the Faster Cancer Treatment target
- Reducing the incidence of obesity, with emphasis upon preventing and managing obesity in children and young people
- Integration of Primary and Secondary Care, including moving services closer to home
- Planning and design for the Health IT programme 2015-2020.

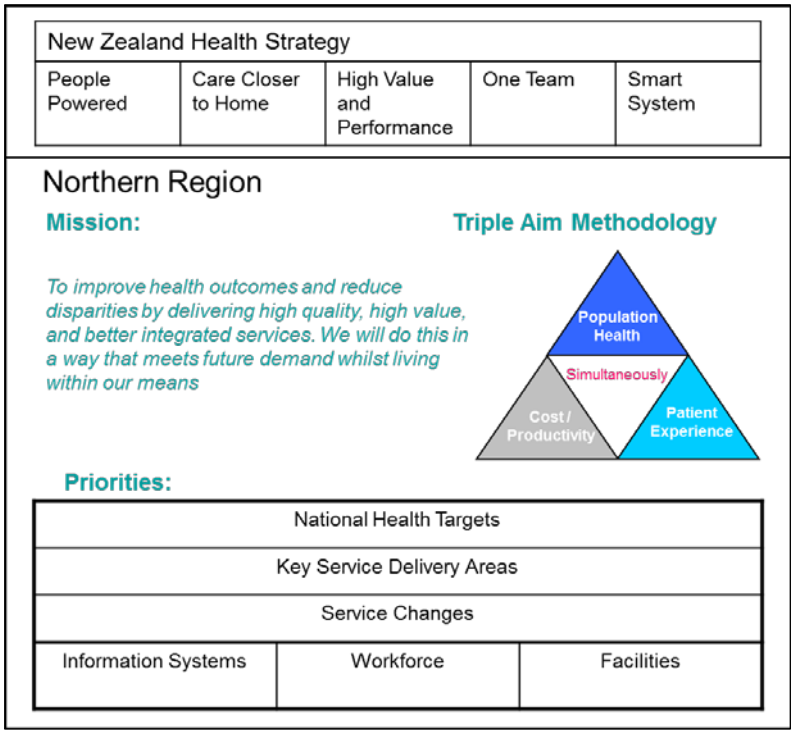
## Our Direction

Our Region's vision as detailed in the Northern Region Charter is well aligned to the vision and themes outlined in the New Zealand Health Strategy as well as the Minister of Health's expectations.

Our Regional interventions during 2016/17 are intended to:

1. Meet our Regional Charter's objectives
2. Achieve gains across the Triple Aim Framework:
    - Population health: Lifting the health outcomes of the 1.76 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.
3. Reflect the themes of the New Zealand Health Strategy.

**Figure 2 : Northern Region Direction**




We will maintain our 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.

***As a region we will focus on a small number of areas where we can make a real difference***

To facilitate regional delivery we have grouped our regional priorities into four categories. These provide the priority areas of focus for 2016/17 and include:

1. Supporting achievement of the National Health Targets

2. Progressing the Northern Region clinical networks' focus areas for 2016/17. These remain largely the same as in previous years. There will be a particular regional emphasis to achieve gains in Child Health; and Health of Older People. We will also prioritise equity issues through our regional clinical network mechanisms, as well as maintaining our focus on quality and safety across all areas of regional work. Northern Region clinical network focus areas are:

    - Child Health; to progress work under the themes of:
        - '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

    - Health of Older People; with effort focussed on initiatives which have proven to be effective at reducing demand, including:
        - Ensuring consistent assessment processes for people requiring long term support
        - Concentrating on disease specific initiatives, such as dementia and psychogeriatric care to best meet the growing demand and better support people in the community
        - Strengthening care in ARRC and Home Based Care
        - Working to prevent health deterioration by disease prevention and information sharing initiatives

    - Equity (which will be an emphasis across each clinical network area of work) involving identification of equity issues in the areas of priority regional focus, and developing plans to address the gaps identified

    - Regional collaborative work to achieve national targets, enhance outcomes, develop new models of care, and drive process consistency by means of Regional Clinical Networks for:

        - Cancer
        - Cardiovascular Disease
        - Diabetes
        - Major Trauma
        - Mental Health and Addiction
        - Stroke
        - Youth Health

3. Regional service changes and other regional service planning with a particular emphasis on:
   - The implementation of a supra regional Eating Disorders Services (EDS) Hub
   - The new national Hepatitis C initiative to implement a clinical care pathway, assessment and treatment services across the region
   - Local oncology service delivery where we will investigate the options for transitioning some high volume Medical Oncology service elements between service providers
   - Hyper-acute stroke services; improvements to models of care and service implementation plans
   - Electives service delivery, and maintaining achievement of the reduced elective services wait time target
4. 'Enablers' of service delivery with emphasis on:
   - Information Systems
   - Workforce
   - Facilities (and Long term Investment Planning).

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

## Achieving Our Targets

We are committed to achieving ten targets which will measure our success in achieving our priority goals.

**Table 1 : Top 10 Patient-Focussed Regional Commitments for 2016/17**

| | |
|---|---|
| 1. | Achieve and maintain the National Health Targets |
| 2. | Child Health continue to reduce SUDI deaths to ≤ 0.4 SUDI Deaths per 1,000 Maori live births |
| 3. | 75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months |
| 4. | 85% of patients receive their first cancer treatment or other management within 31 days from decision to treat |
| 5. | Lift proportion such that 30% of bowel investigations are CTC; consistent with the Regional Colonoscopy Plan and Bowel Investigations Programme Business Case |
| 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. | 80% of diabetes patients to have good or acceptable glycaemic control (HbA1c≤64) |
| 8. | 90% of discharges from adult mental health services receive post discharge community care (within 7 days) |
| 9. | 80% of patients who have a stroke are treated in a stroke unit |
| 10. | Reduce unintended teen pregnancies |

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

## Governance and Leadership

***System wide engagement and alignment of goals with strong governance underpins delivery of the plan***

Delivery of the initiatives outlined in this plan requires strong governance and the participation of a wide range of stakeholders and organisations. The success of the priorities outlined in this plan will also depend on primary care to implement new initiatives and ways of working. We continue to work with our primary care Alliance Partners, primary care and community representatives who participate in our clinical networks and other regional workgroups to ensure alignment of plans and actions.

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
- Regional 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 recently established Regional Patient Safety Network will provide regional oversight of quality and safety initiatives undertaken at both the regional and local level. The network will promote ongoing reduction of avoidable healthcare associated harm and agree on key patient safety and patient experience areas for regional collaboration and alignment with national priorities. It will promote the use of data to drive learning regionally and assess progress made on improvement efforts
- 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 progress 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 outlined in this plan.

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

***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 requires 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

## The Purpose of the Northern Region Health Plan

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

This Northern Region Health Plan provides an overall framework for regional work to demonstrate how the Government's objectives and the region's priorities will be met during 2016/17 and beyond.

The intent of the regional plan is to emphasise selected actions that will be progressed in a joined up manner across the 4 Districts in our Region.

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. The 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.

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 the national expectations of regional planning***

Six areas of emphasis for regional planning are detailed in the MoH guidance:

1. Strategic context within which the plan has been developed, including:
    a. Progress to date
    b. Identifying significant changes from earlier years
    c. Identifying the direction of travel for 2016/17 and beyond
    d. A strategic context that is consistent with DHB's Statement of Intent and the Strategic Intentions of the DHB Annual Plans
2. Reflect the recently finalised New Zealand Health Strategy's direction and to deliver actions in line with the draft Strategy roadmap, as an overarching goal
3. Regional governance, leadership and decision making, with detail of the specific governance and leadership approaches that support regional collaboration
4. Clinical leadership to champion change is strongly emphasised, as is the development and support of regional clinical networks
5. Health equity and reduction in gaps between different groups. The Guidance places emphasis upon:
    a. The identification of disparities evident in each of the Regional Service Plan priority areas detailed in the guidance
    b. The identification of activities to reduce these disparities
6. Line of sight to clarify the alignment between the Regional plan and DHB Annual Plans and the implementation plan to deliver the priorities, including:
    a. The Region's priorities and specific actions and timeframes for implementation, and the inputs required
    b. Governance arrangements.

The Ministry of Health (MoH) has also identified key approaches and outcomes that regional plans are required to support. These national expectations for regional plans signal regional planning priorities for 2016/17 that are largely a continuation of those identified for 2015/16.

These are to:

- Achieve the Health Targets
- Progress System integration
- Progress nationally identified Regional Service Plan priorities (specifically relating to Elective Services, Cardiac Services, Mental Health and Addictions, Stroke, Health of Older People, Major Trauma, Hepatitis C, Information Technology, and Workforce)
- Implement the priorities of the New Zealand Cancer Plan: Better, faster cancer care 2015-2018.

The MoH also places planning emphasis upon linkages to national entities and national work, including:

- The National Health IT Plan
- Health Workforce New Zealand
- the Health Quality and Safety Commission

Our region is committed to working with these agencies and implementing their recommendations.

## The Planning Approach

***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 to address some of the biggest challenges we face; such as:

- Chronic and long term conditions
- Our ageing population
- How to ensure information is shared and available when needed in the delivery of care.

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 focus is due to a desire to keep the regional 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.

***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.

Broad membership, together with emphasis on a 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 consumers, the community, and clinical leaders in work to improve health services delivery across the sector.

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 2016/17 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[2]. Some key highlights include:

***Achievement Highlights***

- Achievement of 2015/16 national targets with regional results of:
    - On track for ED waiting patients seen within 6 hours
    - On track for delivery against agreed 2015/16 electives volume schedule
    - Good progress towards the July 2016 target of 85% of Cancer patients receiving their first treatment (or other management) within 62 days of being referred with high suspicion of cancer (December 2015 = 71.2%) .
    - On track to achieve 95% of eight month olds and two year olds are fully immunised (Mar 16 = 93%)
    - On track to achieve target for 95% of public hospital patients who smoke receive advice to quit
    - On track for 90% of the eligible population will have had their CVD risk assessed (Sept 15 = 91.6%)
- Grade 3 & 4 pressure injuries (the more serious injuries) have reduced to a sustained low rate so they are now regarded as rare events
- Measures associated with Sudden Unexpected Death of an Infant (SUDI) indicate a drop in death rates equivalent to a 41% reduction in deaths, adjusted for population, in the Northern Region. Over the past five years, there have been a total of 53 fewer SUDI deaths (133 down to 80), in the Northern region, with 40 fewer deaths among Māori families, compared to the five years to 2009
- Older persons falls initiatives extended into community and homecare environments with a pilot for people who do not require transport to hospital to enable direct referral to specialist services for further assessment. The pilot has been undertaken together with St John Ambulance
- 83.1% acute stroke patients were admitted to a stroke bed or unit (Dec 2015 result)
- Development and publication of cognitive impairment education and training resources for primary health care professionals

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

- Improvements to systems to ensure patients with myocardial infection can have their electrograph ECG transmitted from ambulances in the region to the nearest hospital
- Implementation of new Acute and Intensive Perinatal and Infant Mental Health Services and commencement of workforce development activity
- Development of a revised Eating Disorders Services Service Delivery Model.

## Engagement and Leadership

***Region wide commitment to the directions set out in this plan***

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 particular 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 our Regional Plan.

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

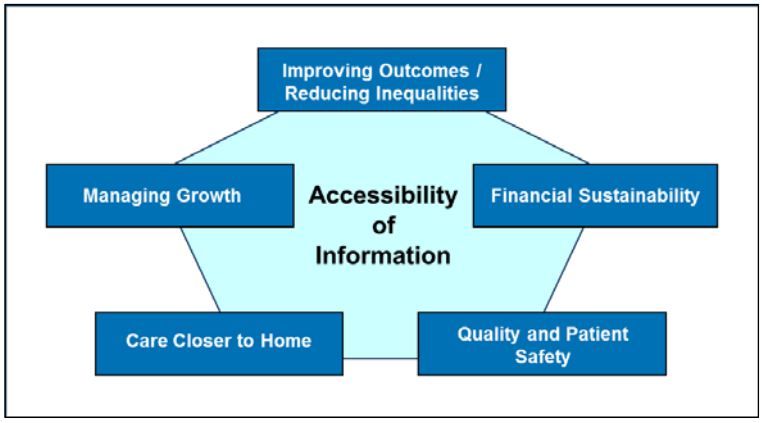
# 2. The Northern Region Context

## 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. The sixth, 'information accessibility and sustainability' has been increasingly recognised as a driver of change for our region.

**Figure 3 : Northern Region - Key Drivers of Change**




The five key 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.

### Managing Growth

***Rapid change impacts on capacity and utilisation***

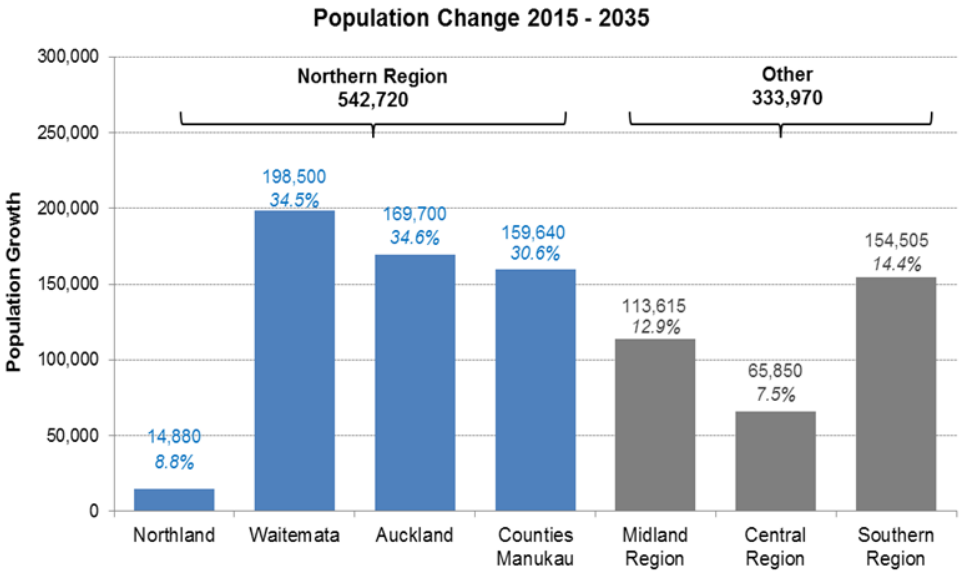
The rapid demographic growth being experienced in our region is already having an impact on service capacity and service utilisation levels. Our Region has already implemented many innovative solutions to deliver services outside the traditional hospital setting and to avoid or to defer significant capital investment in facilities and infrastructure on hospital campus settings. The pressures currently experienced in service delivery areas are expected to grow in future as demographic change continues.

***A growing and aging population gives rise to significant additional demand for health services***

We serve a population of over 1.76 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 4 : Population Change 2015 - 2035**[3]




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 (21.8% in the next 5 years),is likely to generate disproportionate demand for health services
- High growth in the Asian population, with a 23.0% increase expected in the metro Auckland DHBs in the coming 5 years
- Significant unmet health needs in the Māori, Pacific, Asian and MELAA populations
- Large numbers of births. The region accounts for more than 40.4% of all births in New Zealand (with 40.8% of all New Zealand women of birthing age living in our region
- 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.

[3] Based on Census 2013 data. Projections produced in 2015 by Statistics New Zealand according to assumptions specified by the Ministry of Health.

Revised models of care must be developed and implemented to sustain the health system in response to this change. Ongoing investment in health service capacity and capability is required, both in the hospital and the community setting.

***Social services also need to respond to population growth***

Perhaps more importantly, the population growth in our region continues to 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.

## Outcomes / Inequalities

***Improving health outcomes and reducing inequalities for, Māori, Pacific and those with high health needs***

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, 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%[4] of the Northern Region's population, with the highest proportion in Northland DHB (34.1%). 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
- **Pacific people** comprise 11.9% of the Northern Region's population, with the highest proportion in Counties Manukau (21.2%). 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

[4] All ethnicity percentages of population in this section derived from June 2015 period projections produced in 2015 by Statistics New Zealand according to assumptions specified by the Ministry of Health (Census 2013 as the base year)

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 22.2% of the Northern Regions population with the highest proportion in the Auckland District (29.6%). 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.

***We will focus on health conditions associated with high need and health disparity***

The Regional focus will be on conditions where these populations experience the highest need and where the greatest disparity in health exists:

- Child and Youth

  Inequalities in health outcomes for children and youth can be clearly seen across a range of measures. Childhood obesity and oral health are areas of concern, with likely long term impact on health outcomes for children in this category. Despite significant 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.

- 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.

- 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.

- 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.

## 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

***Improving the patient journey through the system, and patient safety will be key drivers***

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.

Providing opportunity for learning from consumers by engaging with patients and whanau, during service design and process improvement, delivers an improved patient journey and enhances patient centred care.

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, are key drivers of future models of care across all health services and a particular focus for the Clinical Networks.

## Financial Sustainability

***Financial pressures are significant as costs grow at an unsustainable rate***

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
  - Additional costs arising from a growing population with increasing health needs and increasing demand for services
  - New treatment methods and enabling improvements arising from technological advances (including diagnostics and IT/IS to enable change)
  - Labour cost pressures
  - Capital costs related to maintenance (and deferred maintenance) and the replacement of assets at the end of their useful life
  - Capital costs to provide new assets
- Revenue pressures
  - Constrained growth in revenue streams, with little sign of this changing due to the economic outlook
- Capital funding pressures
- Limited available health capital budget.

***Planning affordable services for our region is paramount***

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 Investor Confidence Rating and Long Term Investment Planning work being led by The Treasury as well as regional governance of investment decisions. An understanding of the interrelationships between change initiatives and all service delivery mechanisms, including 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 foundations that will enable us to progressively deliver services in a fundamentally different way in the future. We will work within the context of national direction and regional drivers.

# 3. Our Direction

## The NZ Health Strategy and The Minister's Expectations

The Northern Region operates as part of the national health system. Our plan reflects national priorities as outlined in the New Zealand Health Strategy and immediate priorities as set out in the Minister's letter of expectations.

The New Zealand Health Strategy provides a vision to guide the future provision of health services. There are five 'visioning' themes to the national strategy:

- People Powered
- Care Closer to Home
- High Value and Performance
- One Team
- Smart System.

***The Minister's Expectations provide one context for regional planning***

### Meeting The Minister's Expectations

Our direction for 2016/17 is set by the Minister's expectations for the sector.

**Figure 5 : The Minister's Expectations**

The Government's key expectations for the public health service in 2016/17 are:

- That new initiative work will align to the 5 themes of the New Zealand Health Strategy and that outcomes will be clearly linked to the intent of the draft Strategy
- Strong 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.
- Support for cross agency work that delivers outcome for children and young people and work to reduce unintended teenage pregnancies
- Achieving and improving performance against the national health targets; particularly the Faster Cancer Treatment health target as a priority

The Minister has also articulated a strong emphasis on:

- Actions to reduce the incidence of obesity; particularly the new childhood obesity package of initiatives
- 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 Health IT programme 2015-2020 and the importance of co-design involving DHBs, PHO and Primary Care representatives.

*From December 2015 Letter of Expectations 2016/17*

The Northern Region is committed to:

- Supporting the achievement of the Minister's expectations
- 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.

## Northern Region 'Future Landscape'

***The Northern Region's Vision for the future is aligned to the themes of the New Zealand Health Strategy***

Our Regions 'Future Landscape' sets a vision for the future where each stakeholder in the health system adopts a behaviour which is more planned and collaborative.

**Figure 6 : Vision for Stakeholder Behaviour**

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

These future behaviours will support progression of the strategic directions signalled by the New Zealand Health Strategy, 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.

***Engage patients and their families in decisions about care***

### Patient Participation and Engagement in Health Improvement

We will achieve greater patient participation and improved health care through patients being better informed, and better able to contribute, across the full health spectrum; from prevention and early diagnosis to better treatment of disease. We increasingly expect to have the consumer view represented in regional work that relates to the patient journey or work to enhance patient centred care. We also want to emphasise the concepts of being 'partners in care' and 'self-directed care'.

The outcomes we want to achieve from this work include:

- An improved patient journey through our health service process
- 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.

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.

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
- Northern 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

***Health gains for Māori is a critical step we need to achieve***

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

***Aligning our key enablers to our future models of care***

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
- 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.
- 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. Investment will still be required in different care settings. The Long term Investment Planning process will help to define requirements.

## Clinical Leadership

***Clinical leadership will shape future service delivery and drive innovation***

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 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 will expand and 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.

## Northern Region Charter

***Our Region's Vision informs our Aims as set out in the Northern Region Charter***

The Northern Region Charter clarifies that 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:
    - Effectively engaging clinicians and the wider healthcare workforce in decision making, service design and leadership of change
    - Delivering the health and disability system that our populations need within a long term sustainable funding allocation
    - 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.

# 4. Our Intervention Logic and Regional Targets

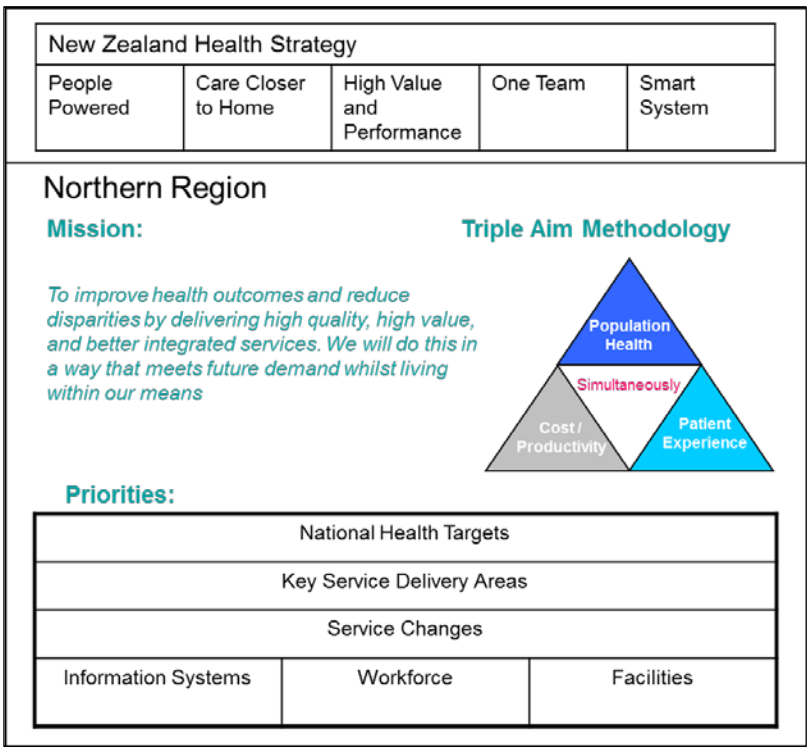
## The Northern Region Intervention Logic

***Our Interventions relate to strategic objectives***

This Northern Region Health Plan details regional interventions that are intended to:

1. Meet our Regional Charter's objectives (summarised as the regional Mission).
2. Achieve gains across the Triple Aim Framework:
    - Population health: Lifting the health outcomes of the 1.76 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.
3. Reflect the themes of the New Zealand Health Strategy.

**Figure 7 : Northern Region Intervention Logic**




***Our interventions are grouped into key priority areas to assist with operational implementation***

To facilitate regional delivery we have grouped our planned regional priorities into four categories (as outlined in Figure 7 : Northern Region 'Northern Region Intervention Logic' above). These are:

- National Health Targets
- Key Service Delivery Areas
- Service Changes
- Enablers (Information Systems, Workforce, and Facilities)

The priorities are discussed in greater detail under these category headings in the remainder of this section of the Regional Health Plan.

The alignment of our regional direction and initiatives with the New Zealand Health Strategy 'themes' 'directions' and 'route map', will be further developed and strengthened during 2016/17 now that the New Zealand Health Strategy is finalised.

Our intervention logic provides a focus on a number of priority areas for realisation of gains through selected interventions. It is not intended that our selected interventions will address all the possible areas for action in our region. We expect to make best progress by prioritising a few areas to align our expertise and resource.

These areas provide points of focus where there is evidence and regional consensus that gain can be achieved. The regional priorities 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:
  - Benefits are likely to be material
  - The health sector has the main role to play in affecting change
  - 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.
- Consideration of the New Zealand Health Strategy intent and directions.

***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. We expect benefits by focussing on these priority areas including:

- 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.

***Ensuring the sustainability of services in the future***

We recognise that our ability to achieve lower rates of disease and admission to hospitals will rely on a number of factors, some within health services control, and some 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.

The region will still need to build more beds and service capacity across care settings , but not as much as would be required if we continue to deliver services as we do now.

During 2016/17, we will continue to progress work across our region and across the full continuum of care in relation to each of the priority areas. 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 element of our health system contributes to achieving regional objectives. We will continue to clarify this 'line of sight' within our planning processes and as we progress work across our region and across the full continuum of care.

# National Health Targets

***We are committed to achieving the National Health Targets***

As a region, we have made significant progress towards achieving the National Health Targets since they were introduced. The National Health Targets for 2016/17 are shown in the table below:

**Table 2 : National Health Targets: 2016/17**

| Health target | Target goal |
|---|---|
| **Shorter stays in Emergency Departments** | 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. |
| **Improved access to elective surgery** | Delivery against agreed elective volume schedule including minimum number of elective discharges by the Northern Region in 2016/17 |
| **Faster cancer treatment** | 90 percent of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by June 2017. |
| **Increased immunisation** | 95 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. |
| **Better help for smokers to quit** | • 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months<br>• 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking |
| **Childhood obesity** | By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. |

## Regional Targets for 2016/17

During 2016/17 we are committed to achieving the regional targets set out below:

Table 3 : Top-10 Patient Focussed Regional Commitments for 2016/17

| | |
|---|---|
| 1. | Achieve and maintain the National Health Targets |
| 2. | Continue to reduce SUDI deaths to ≤ 0.4 SUDI Deaths per 1,000 Maori live births |
| 3. | 75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months |
| 4. | 85% of patients receive their first cancer treatment or other management within 31 days from decision to treat |
| 5. | Lift proportion such that 30% of bowel investigations are CTC; consistent with the Regional Colonoscopy Plan and Bowel Investigations Programme Business Case |
| 6. | 80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes[5] |
| 7. | 80% of diabetes patients to have good or acceptable glycaemic control (HbA1c≤64) |
| 8. | 90% of discharges from adult mental health services receive post discharge community care (within 7 days) |
| 9. | 80% of patients who have a stroke are treated in a stroke unit |
| 10. | Reduce unintended teen pregnancies |

The Top 10 targets listed above are drawn from the implementation action plans developed for the regional priority areas and detailed in Appendix A2

## Key Service Delivery Areas

***We have ten clinical service priorities, of which three are areas of particular emphasis during 2016/17***

Our clinical service priority areas have a focus on achieving gains by reducing disparities across our region and achieving longer, healthier and more productive lives for our population.

Three areas of regional work continue to be particularly emphasised for accelerated gains

- Child Health
- Health of Older People
- Equity (which crosses each clinical service area and also aspects of the enabler services )

The other identified priority areas for regional collaborative work in the regional category of ‘Service Delivery Areas’ are:

- Cancer
- Cardiovascular Disease
- Diabetes
- Major Trauma
- Mental Health and Addiction
- Stroke
- Youth Health

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

These priority areas

- Represent 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.
- 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 areas of particular emphasis for our Region during 2016/17.

Detail of these priority service delivery area's implementation plans is provided in Appendix A.2.

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.

***Quality and Safety is woven throughout this plan***

Regional initiatives to improve quality, to drive consistency of care, and to increase patient safety are woven throughout this regional health plan. Our quality initiatives are intended to contribute to improvements in one or more of the dimensions of quality, namely:

- Safety
- Effectiveness
- Equity
- Patient experience
- Efficiency
- Access / Timeliness

The regional 'joined up work' on quality will be led by those Clinical Networks and Regional Working Groups according to the initiatives in their implementation plans. Regional oversight of quality initiatives across the region and DHB's will be led by the Patient Safety Network. The regional network plans demonstrate the actions and quarterly milestones with regard to the regionally led work; some of these plans explicitly identify initiatives relating to the involvement of consumers, others identify projects that will require consumer representation as part of the supporting work plan.

***Consumer input is valued and expected as part of our regional***

The region values consumer input and expects appropriate involvement of patients, and family, in work to improve the patient experience. This is reflected in the plans of the various networks and by means of consumer representation and focus groups at the initiative working group level. The representation is intended to help share experiences or to define requirements at key stages of individual initiative or project work.

The regional governance approaches that ensure regional and local leadership of the work in this plan, including the patient safety and quality initiatives, are outlined in the Governance section of this plan. The regional patient safety network is the key regional mechanism for developing and maintaining regional leadership to support quality and safety and to build capability for improvement.

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.

*Child health is our first particular area of emphasis*

## 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 2016/17 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 have been established under each of these themes to improve child health outcomes. For example, the workstream for 'Integrated enrolment in health services' will be progressed under the theme, 'Knowing every child'. Achievement of full enrolment rates will necessitate a coordinated focus on children who are 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:

- Improved information capture relating to integrated enrolment
- Implementation of developed strategies for injury prevention though home visiting programmes particularly aimed at communities of high risk
- Improved skin infection management through targeted information developed for families of 0-5 years olds (via early childhood centres)
- Consistent clinical measurement of growth and obesity across the northern region
- 'Development of a regional clinical pathway for pre-school obesity'
- Continued implementation of the regional SUDI Action Plan
- Improved oral health by monitoring the implementation of the ARDS and NDHB pre-school oral health strategy
- 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 the 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 2016/17 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; builds on work completed; and that the network has the capacity to successfully implement.

***Our Second 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, with a newborn female expected to live to 83.2 years and a newborn male 79.5 years[6].
- The proportion of New Zealanders in the 85-plus age bracket is growing rapidly, and is projected to double by 2063[7].

Despite improvement in longevity, health expectancy is likely to be adversely impacted by the rapidly growing population of older people. Increasing numbers will require increasing support from health and other services:

- By 2043, 24%, or one in five, of the NZ population will be aged 65 years and over (up from 14% in 2013)
- Older people currently account for 32% of hospitalisations across NZ DHBs[8] but the proportion of hospital inpatient beds typically occupied by patients over 65 years old, is higher.
- About 30,000 older people live in Age Related Residential Care (ARRC) in NZ.
- In the last year, Northern Region DHBs spent $527 million on the 200 Age Related Residential Care providers, and numerous Home and Community Based Care services[9].
- The burden of disease and injury in the over 65 year age group will continue to rise due to population growth.
- Dementia is a significant and growing healthcare challenge with an estimated 53,000 people in NZ affected. This number is forecast to triple to around 150,000 by 2050.
- Falls are the predominant cause of injury-related health loss for older people, with femoral fracture the major contributor for which subsequent decline in health is well demonstrated.

The way we currently care for our older adults does not always best meet their needs.

- There is good evidence that people who continue to live in their own home (with personal care and home support if necessary), experience greater health and well-being. Most older adults prefer to stay in their own home, and this arrangement is usually less expensive than residential care.
- Admitting people to acute hospitals can have negative impacts on their independence and mental health, and raise risk of further decline.

Initiatives that have been shown to be effective at improving outcomes (including risk of hospital admission) include:

---

[6] Based on the 2012–14 period; Statistics NZ

[7] Compared with the current population in 2013; Statistics NZ

[8] Publicly Funded Hospital Discharges - 1 July 2012 to 30 June 2013, Ministry of Health

[9] Northern Region Health of Older Person Service Utilisation Report, NRA, September 2015

- Integrated community care programmes (e.g. Alzheimers, St John Ambulance)
- Improved flexible home and community based care options (e.g. standard assessment tools)
- Dementia pathway improvements (e.g. primary care support & education)
- Targeted disease programmes (e.g. hip fractures)
- Targeted ARRC programmes (e.g. pressure injury reduction initiatives).

***What we want to achieve***

Our key performance measures include:

- GP "hits" on static Northern Region Cognitive Impairment Pathway will increase by 50% over next 12 months
- Increasing number of people with dementia living at home, are registered on the Northern Region Cognitive Impairment Pathway
- Increased uptake of the programmes to reduce falls and pressure injuries in ARRC facilities, from 30% of facilities to 40% of facilities
- 100% of Northern Region DHBs will have implemented the ANZHFR
- 100% of ARRC residents have been assessed using interRAI LTCF
- % of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first LTCF assessment.
- 75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months.

***How we will achieve these outcomes***

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).

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

- Ensuring consistent assessment processes for people requiring long term support by:
  - Promoting the use of InterRAI assessment tools in the ARRC and HBSS sectors and analysing data to inform clinical improvements
  - Increasing the number of people undergoing reassessment of needs

- 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 national suite of education resources in collaboration with other regions for primary healthcare professionals e.g. e-learning.
  - Undertaking a stocktake of education resources available to informal caregivers
  - Support collaboration between clinical specialties, health organisations and other external agencies e.g. National Hip Fracture Registry

- Strengthening care in ARRC and Home Based Care by:
  - Increasing support to ARRC by specialist services and education/training
  - Rolling out targeted programmes in ARRC such as pressure injury reduction
  - Ensuring consistent high quality care across a range of community settings e.g. dementia unit care & design

- Preventing future deterioration by:
  - Identifying and implementing disease prevention programmes e.g. falls prevention
  - Supporting information sharing and transfer to progress these initiatives e.g. InterRAI.

The refreshed Health of Older People Strategy will also provide a road map for future improvements to health services for older people over the next 10 to 15 years.

## Equity

***Our third particular area of emphasis is a focus on those significant components of our population who suffer poorer health than others***

Our regional population is made up of many different groups, 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. Equity issues cross all elements of service and health outcomes and impact on different groups reflecting ethnicity, deprivation, age, gender, disability and location.

The World Health Organization defines equity as

> *'The absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically'.*

Our region is committed to improving 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 in our Region. 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.

We will focus on the factors which are within health services 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

***'Maori and Pacific health initiatives***

Broad initiatives already underway and continuing in 2016/17 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.
- **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 local commitment includes working with agencies to help progress 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.

***What we want to achieve***

We will progress equity improvement work by two regional mechanisms. We will

1. Continue to progress equity work and planned actions in each clinical network, as detailed in the clinical network plans 2016/17; eg:
    - 90% of eligible patients will have had their cardiovascular risk assessed in the last five years
    - 90% of diabetic patients who have microalbuminuria are on an ace inhibitor or Angiotensin Receptor Blocker
    - 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
2. Identify and undertake local and regional initiatives to improve diabetes, cardiovascular disease, childhood obesity and tobacco control for Māori

***How we will achieve these outcomes***

We will strengthen the regional coordination of our systematic planning cycle aimed at reducing gaps in health outcomes between different groups (based on ethnicity, deprivation, age, gender, disability and location). This will focus on improvement work relating to equity underway within each of our regional clinical network areas. Working with and through selected networks and key stakeholders we will:

- Drive equity improvement work through the systematic identification of:
    - Disparities evident in each priority area
    - Relevant activities to reduce these disparities in order to achieve health equity for those populations.
- Complement and enhance the existing planning mechanisms and ensure appropriate engagement and alignment of regional and local equity planning frameworks, and actions to enhance equity of outcomes.

## Cancer Services

***Cancer is a significant and growing issue for our region***

Cancer continues to be a leading cause of death for both males and females in New Zealand, accounting for nearly a third 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, 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 by 2030).
- $295m per annum estimated cost for cancer care in this region, expected to rise nationally by $117million by 2030.
- Sustainable delivery of faster cancer treatment goals and tumour stream pathways require innovative changes to models of care and reconfiguration of services accordingly.

***What we want to achieve***

**Health Targets & Indicators**

- Compliance with the National Health Target aiming for 85% of patients receiving their first treatment within 62 days of referral.
- Continued strong performance against the FCT 31 day indicator, consistently getting patients treated within 31 days from when the decision to treat was made.
- Meet or make significant progress against the National Colonoscopy indicators for Urgent, Non-Urgent & Surveillance procedures.
- Continue meeting the radiation therapy and medical oncology timeliness of treatment targets.

**Faster Cancer Treatment**

- Sustainable systems changes that, although generated by improvements focused on FCT achievement, benefit all cancer patients in the Region. Includes improvements to logistical, diagnostic, and treatment pathways within and across DHBs.
- Successful delivery of the FCT2 project deliverables for this timeframe.

**Regional Cancer Strategic Plan**

- Progressive implementation of Tumour Stream model according to regional priority areas.
- Completion of the Local Delivery of Oncology Regional Plan.
- Completion of the required number of reviews against the National Standards, and to ensure the results of those reviews directly inform the workplans of the Tumour Stream groups.

***How we will achieve these outcomes***

We will continue to develop and implement work which has been designed regionally and nationally. We will build upon our history of strong Regional governance frameworks.

This year we will increase and/or maintain focus on:

- Progressive implementation of the Northern Region Cancer Strategic Plan 2015 - 2020 priorities
- Reviewing regional progress toward nominated national tumour standards, and prioritising service delivery model changes where indicated
- Faster cancer treatment health target achievement, particularly focusing on sustainable process and practice improvements that benefit all cancer services patients
- Support of DHB initiatives to provide equitable breast and cervical screening rates for Maori, Pacific, and Asian women
- Review of current regional Cancer Equity reporting and creation of a plan for developing robust regional equity goals, in partnership with clinicians and DHBs
- Considering future Models of Care that align with the five strategic themes of the NZ Health Strategy, based on a regional Tumour Stream structure
- Service development for specific cancer care:
    - Considering Local Delivery of Oncology future direction
    - Continuing to support the bowel screening pilot, and preparing for a National Bowel Screening Programme roll-out
    - Continue to work regionally to support DHBs in identifying and implementing improvements in colonoscopy services
- Other regional priorities as they arise.

***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:

- Reducing variation in both access and timeliness of access to core cardiology assessment, investigation and management across the primary-secondary continuum
- Reducing variation in CVD outcomes by socio-economic status and ethnicity. Our focus this year will be to work toward ensuring these groups meet accepted intervention rates and health outcomes
- Developing useful reporting to primary care. The reporting infrastructure to measure activity and support improvement initiatives has been developed for secondary care and we are now focusing on applying this to primary care.

***What we want to achieve***

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 4 months of referral
- All DHBs to have implemented Accelerated Chest Pain pathways.

***How we will achieve these outcomes***

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
  - Progress the Regional Primary PCI service developed in collaboration with St John Ambulance Services and Emergency Departments to support more rapid transit of ST elevation MI patients direct to a PCI centre
- 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
- Continue to improve access to Echo-cardiogram to support diagnosis of Heart Failure and other conditions including those requiring cardiac surgery
- 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 further CVD pathways, including dynamic heart failure pathway (Static – [Health Pathways] and dynamic [NEXXT]) and promote their use.

Areas with a new focus for 2016/17 include the following:

- Work with The National AED and Bystander CPR Working Group's (CARENZ) to develop and implement AED and Bystander CPR project
- Develop and implement the out-of-hospital STEMI pathway in conjunction with NZ STEMI group
- Increase existing rates for medicine adherence in both primary and secondary care by 5% over the next two years
- Implement use of agreed core components of the Cardiac Rehab Programme across the region.

## Diabetes

***Diabetes has a lifetime impact***

Diabetes is a chronic condition which impacts patients and their whanau over a lifetime. It can lead to disability through problems such as blindness, amputation of limbs, heart attacks and renal failure, and as a consequence can shorten life expectancy.

Despite greater awareness about the risk factors for development of Type 2 Diabetes and the interventions required to achieve good control (which reduces complication risk), the attention and resources being allocated to diabetes 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:

- Approximately 128,000 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.

***What we want to achieve***

Our key performance measures are:

- 90% of eligible patients will have had a cardiovascular risk assessment in the last 5 years
- Refine and develop new reporting whilst continuing existing KPI 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.

***How we will achieve these outcomes***

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 Primary Care to develop key diabetes clinical indicators, 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 DHBs to develop diabetes services in line with the MOH diabetes Strategy, 'Living Well with Diabetes'.

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 contemporary, formal trauma system will save lives and support effective use of resources across pre-hospital, hospital and rehab services***

Each year there are approximately 500 cases of major trauma and 4,200 of non-major trauma in the Northern Region. Many patients are transferred between DHBs to receive definitive care for their injuries.

The Northern Region Trauma Network has a goal to introduce a more formal system for managing trauma patients. The initiatives we are implementing are in line with other jurisdictions which have demonstrated significant reduction in in-hospital mortality rates, improved recovery from injuries, and cost savings to the health system. Our work is aligned to the Major Trauma National Clinical Network to build a robust and consistent national system across New Zealand.

We are introducing a range of initiatives to introduce contemporary, quality care for major trauma patients in this region. Optimisation of pre-hospital and inter-hospital transfer systems and in-hospital management practices will deliver better overall trauma care and cost savings in the form of improved resource utilisation and shorter hospital stays. A case review process is being established to identify and address regional systemic issues.

***What we want to achieve***

This year we will

- Measure KPIs in line with the national KPIs, including:
  - GCS <9 and intubated pre-hospital
  - Time of injury to
    - 1st facility arrival
    - Definitive care hospital
  - Time of 1st observations to
    - ED entry and exit
    - Index CT
    - Procedures: laparotomy, craniotomy etc.
  - In-hospital mortality rate
  - Injury diagnosis after 48 hours.
- Recognise the importance of gaining information from patients and their families about their experience of trauma care

***How we will achieve these outcomes***

The broad areas of focus this year include:

- Strengthening the linkages with pre-hospital and rehabilitation services
- Clinical audit to identify and address systemic and regional issues
- Training sessions for Registrars and other trauma staff to encourage shared learning and networking
- Establishing a feedback loop from the analysis of major trauma data to areas of focus and identifying opportunities for improvement.
- Ensuring the patient voice is heard

We will also continue to leverage the recent introduction of initiatives such as:

- Single point of contact at Auckland City Hospital set up to expedite the transfer of patients from other hospitals in the region
- Pre-hospital destination protocols so that ambulance services take the patient to the hospital for definitive care first time
- Inter-hospital transfer guidelines.

## Mental Health and Addictions

***Mental health and wellbeing is everyone's business***

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 8 : 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 2016/17 Planning Priorities for Regional Service Plans. Initiatives in the plan will consider a systems level approach, including DHBs, PHOs, NGOs and other community and inter-sectoral organisations as appropriate, and identify opportunities to address inequities within the activity undertaken.

Our objectives for 2016/17 are to improve:

- Access to the range of eating disorders services
- Mental health and addiction service capacity for people with high and complex needs
- Youth forensic service capacity and responsiveness
- Perinatal and maternal mental health acute service options across a service continuum
- The physical health of people with low prevalence disorders

***How we will achieve these outcomes***

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

- Progress the implementation of the service change proposal for the delivery of supra regional eating disorder services
- Progress the development of a detailed business case for an inpatient minimum secure service for people with high and complex needs
- Review the investment in additional services to better address the needs of people requiring access to acute perinatal and maternal health services
- Strengthen our workforce capability by completing the development of a regional Suicide Prevention Training Framework and progressing its implementation.

## 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 2,500 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 2016/17 we want to achieve further gains in preventing stroke and to improve the quality of care we provide for people who have had strokes. Specifically we want to achieve:

- 8% of potentially eligible stroke patients are thrombolysed 24/7 (MOH target = 6%)
- 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
- 60% of people with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute stroke admission
- 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

***We will focus on our most vulnerable youth to improve their potential in life***

The Northern Region is committed to lifting the health of 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 quality youth-friendly primary care
- Access to developmentally appropriate secondary 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
- Further develop KPI reporting with regard to Youth Health
- Refine and support implementation of the 'Standards for the Delivery of Care for Youth':
    - Priorities for improvement of School-based Health services
    - Services in other primary care settings.
    - Delivery of developmentally appropriate care for young people in secondary care, including the interface with primary care.

***How we will achieve these outcomes***

We will:

- Continue to develop, refine and report clinical outcome measures for Youth Health reporting
- Determine key areas requiring support amongst School based Health services
- Review, further develop and support implementation of standards of care for services and clinicians working in other primary care settings
- Review, further develop and support implementation of 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 as part of Prime Ministers Youth Mental Health Project.

# Service Changes and Other Service Planning

## Service Changes

***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 continuing to focus on 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.

The key regional service change that has been signalled in prior years, is the implementation of a Supra Regional Eating Disorders Services (EDS) Hub. Key changes that will be implemented in 2016/17 include:

- ADHB will progress co-location of services comprising the fully integrated ADHB-managed EDS Hub which will result in seamless transitions for clients between services
- A comprehensive training and support schedule will support supra regional workforce development and enhance local service delivery
- Exploring the use of technology to enhance client access to specialist support
- Extending the range of services where there is evidence of effectiveness (e.g the introduction of multi-family therapy).

In 2016/17, key services being considered for change include:

- Hepatitis C with development and implementation of a single clinical pathway for hepatitis C care across the region, in order to provide consistent services to maximise the wellbeing of our population living with hepatitis C. This aligns with the national initiative and recent guidelines (Further detail in Appendix A3)
- Local oncology service delivery where we will investigate the options for transitioning some high volume Medical Oncology service elements away from the Northern Region Tertiary centre (Auckland DHB), and into regional secondary and community based delivery. Locations/facilities to be considered are within Northland, Waitemata and Counties Manukau DHBs
- Hyper-acute stroke services are also a considered area of change. This work is being progressed as part of the longer term workplan of the Stroke Network.

***Collaborative service development models***

We will also 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.

## Other Services -Elective Services

***Ensuring timely access to elective surgery***

Elective service improvements are a national priority and a particular focus for medium to longer term regional work

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 continued to prioritise an increase of elective surgery output and the maintenance of reduced elective wait times.

The key challenges in our region include:

- Maintaining the reduced waiting 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
- Ensuring continuity of service when access to specialised expertise is reduced
- 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 elective surgery discharges to meet targets agreed with the MoH
3. Working across Cancer and Elective services to develop consistent pathways and clinical protocols for tumour streams
4. Pursuing fair and equitable access to elective surgery
5. Improving service interfaces by engaging with and supporting the implementation of e-referrals projects.

***How will we achieve these outcomes***

This year we will focus on:

- Monitoring wait-time, length of stay and discharge targets attainment to identify any issues and to enable regional identification of solutions should issues occur
- Delivery of the agreed elective surgical volumes, (including the required volumes of additional elective orthopaedic and general surgery discharges first announced in Budget 2015)
- Ensuring linkages, alignments and sharing of elective service good practice between DHBs
- Elective services workflow to support the Cancer Network to progress the development of 'Faster Cancer Treatment' pathways and protocols for tumour streams.
- Regional collaboration to contribute to:
    - Implementation of system improvements, including:
        - e-referrals (including service interface improvements)
        - National Patient Flow concepts
    - Monitoring of standardised intervention rates to understand areas of need to improve equity of access
    - Implementation of clinical prioritisation tools across the region, once they are agreed as clinically appropriate
- Sub Regional work to support:
    - Bariatric surgery for the Northland community by means of a collaborative approach between NDHB and WDHB
    - Calendar management systems to optimise utilisation of theatre and staffing availability
    - Improved access to Ophthalmology for the CMDHB population.

Regional work on urology will be focussing on Faster Cancer Treatment objectives and waiting times. The region will be continuing work to apply consistent processes to address workflow issues, and to strengthen coordination of systems and processes across the region.

# 5. 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 three 'enabling' resources groups:

- Information Systems
- Workforce
- Facilities / Capital.

## Information Systems

***Health IT is a key enabler***

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 are a key enabler for us to achieve our clinical and business objectives. It is recognised that health IT plays an increasingly significant role in today's environment by enabling the delivery of high quality, timely and cost-effective health care.

***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 for 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 at the midway point in delivering RIS 10-20. Progress has been made over the last five years to implement RIS 10-20 however the region recognises the need to accelerate progress towards implementing a '*person-centric, regional electronic health record that will be shared by, and will integrate between the key stakeholders in a person's care'*[10].

In 2016/2017 we will continue the work to refresh and further develop a Regional Information Systems Strategic Plan (ISSP) so that there is a clear and appropriate framework to guide our information system investment decisions over the next decade. This will also support the implementation of comprehensive e-Health capability across the Northern

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

Region, and ensure alignment with relevant health service and business plans, major transformation and investment programmes and key national initiatives, such as the National Infrastructure Programme.

The Regional ISSP will consider the future regional business operating model and how IT might enable this. It will include an enterprise architecture framework and an implementation roadmap, and an indication of the likely scale and timing of the required investment programme to deliver the Regional e-Health Vision and Strategy.

The Regional ISSP will also align with the following strategic key themes from the National Health Strategy, to guide planning priorities and ensure focus on the critical areas to drive change:

- People powered
- Care closer to home
- High value and performance
- One team
- Smart system

***Northern Electronic Health Record Programme***

The Northern Electronic Health Record (NEHR) Programme is a key regional initiative to identify the best way for us 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].

The NEHR Programme commenced in 2014, and the current phase of the programme will continue in 2016/2017 to complete the following deliverables:

- An Implementation Planning Study (IPS) with the region's preferred IPS vendor for an integrated regional electronic health record. A key output of the study will be confirmed functional requirements and an implementation framework for a "person-centric" regional electronic health record
- An indicative programme-level business case, following the Treasury Better Business Case process, including a full options analysis and assessment of the feasibility and affordability of various options to implement a "person centric" regional electronic health record.

Consideration of the business case will provide a 'go/no-go' gateway control point before any decision is made on the way forward. This work will be pivotal in setting the future road map for our clinical and business application investments.

All parties involved in the NEHR programme, including the four northern region DHBs and private hospital and primary care representatives, are committed to completing the NEHR current phase of work. This will clarify our Region's future direction and the DHB IS/IT budget impacts.

***Ongoing investment in IT Infrastructure and Services***

The Northern Region DHBs and healthAlliance (our shared services provider) are committed to continuing to work closely with the National Health IT Board to ensure that regional capital investment plans are aligned with national priorities and programmes of work.

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

In 2016/17 we will continue to work with our shared services provider to ensure that our investment in IT infrastructure and services is prioritised to address underlying service risks in the following areas:

- 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
- IE11 implementation to upgrade the default browser and remediate applications as required to operate in this environment.
- Replacement of the Spark paging system before it is decommissioned.
- Investment in regional mobility solutions.
- Increased capacity and capability in our regional IT service, with a focus on responsiveness, programme delivery and value.

A particular area of focus will be the Digital Foundation Programme that will put in place the foundation needed to help us accelerate our regional digital transformation. These changes are aimed at helping move hA and our DHBs into the digital realm. The three pillars of work underway include:

- Building the Enterprise Mobility Management infrastructure that will enable staff across the region to safely and responsibly use smartphone, tablet devices and apps anytime, anywhere
- Investing in upgrading our Integration Engine which is needed to enable clinical applications to work together seamlessly.
- Planning is also underway to modernise our Data Management Framework, including architecture, to ensure we make better use of data and start sharing data insights at a regional level.

***Information systems investment plan for 2016/17 aligned to national priorities***

The Northern Region information systems investment plan for 2016/2017 comprises the following on-going, multi-year programmes:

- National Patient Flow Phase 3
- eReferrals Phase 3: Intra & Inter DHB Referrals
- ePrescribing and Administration (ePA)
- eOrders
- Regional Radiology/PACS
- Clinical Pathways (continued rollout)
- Shared Care (continued rollout).

CMH will continue to utilise the National Maternity System in community settings. It will cease using it for acute care as a number of critical issues need to be addressed before it can be effectively used in these settings. In discussion with the Ministry, it has been agreed that further roll out of the product out will be put on hold until there is confidence that the system can reliably meet clinical requirements in an acute setting. CMDHB clinicians have committed to working with the Ministry to try to address these clinical requirements. The Northern Region has revised its plans to align with this decision, putting on hold implementation planning until there is a clear consensus that the product is fit for purpose in an acute setting.

The work we are doing in Phase Two of our Northern Electronic Health Record Programme, is aligned with national priorities, including regional Patient Administration System implementation, and IT investment in the following new national priority areas:

- A single longitudinal electronic health record over the next five years; and
- Hospital electronic medical records based on a digital hospital blueprint.

The Region is committed to working regionally to ensure participation on advisory groups to progress the National Electronic Health Record, and a plan to integrate with the national system.

The Northern Region will recognise SNOMED CT as the standard system of clinical terminology for all point of care applications, and will develop a roadmap for delivery of this capability.

In addition, the Region will prioritise IT investment in the following other national priority initiatives signalled to be commissioned over the next twelve months:

- A national health prevention IT platform to support screening and immunisation
- Data to support health and social investments.

Appendix A4 provides detail of key deliverables for the priority programmes and projects for FY 2016/17. This prioritised list of IT investment will be updated for the Q2 report 2016/17.

## 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 27,400 employees[12], representing 36% of the total workforce across all DHBs.

The Northern Region has four priority areas for workforce development in the 2016-2017 plan; increasing and strengthening the Māori and Pacific workforce, building clinical leadership and management capability throughout the workforce, supporting the unregulated workforce, and developing advanced practice roles, particularly those which deliver new models of care.

Increasing the size of our Māori and Pacific health workforce in particular continues to be an area of high priority. We are committed to achieving a health workforce that reflects the population we serve. To do this, we have set our targets and committed to a series of intentional actions to make a difference in 2016-17. We 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.

[12] DHB Shared Services. (2015). DHB Employed Workforce Quarterly Report 1 July to 30 September 2015.

In addition to medical, nursing, midwifery, allied health, scientific and 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 is working together to strengthen clinical leadership and establish a management development framework to support and grow our own 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 advanced practice roles, and to build capability across our unregulated, Kaiawhina workforce.

***Five objectives support the direction for implementation in 2016/17***

The region has identified five 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. We will strengthen cultural competency across our leadership and establish a regional health management development pathway.
2. **Grow the capacity and capability, and the size of our Māori and Pacific workforce:** We will widen the pipeline and improve recruitment strategies and candidate support to increase our Māori and Pacific workforce, with a particular focus on nursing. We will provide opportunities for our potential leaders to aspire to senior roles, continue to support Māori and Pacific students to graduate and navigate their entry into the health workforce, and improve ethnicity data quality and intelligence.
3. **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 advanced practice for allied health in key areas. We will support the development of specialist roles such as new palliative care specialist nurses, nurse practitioners, clinical nurse specialists and educators.
4. **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 provide development opportunities to the unregulated and low-paid workforces.
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.

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

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 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.

## Facilities / Capital

***Our Region has 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 about $3.3 billion.

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

About 6.7% 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 with a book value of about $132.5m.

***We have a need to invest, but limited available funds***

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

- **Population Growth** - Over the next 20 years the Northern Region population will grow by over 500,000. This growth will exceed the current population of any other DHB and, assuming current models of care are unchanged, will result in the need for significant investment in acute hospital facilities in the Northern Region. The Northern Region also has the fastest rate of growth in the 65+ population, a group who place heavy demands on health services.
- **IT and IS investment** - Our Region recognises that information systems 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 maintain functionality and keep abreast of developments in software and technology.
- **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 still need to be addressed.

- **Replacement burden** - The region has a large 'fleet' of clinical equipment that requires regular replacement to support delivery of services. In 2015/16 the region expects to spend about $125 million on 'baseline maintenance and renewals' in our region
- **Affordability** - The financial pressures on all DHBs in the region are substantial which impacts the region's ability to fund and finance capital investments.

***We need to live within our means***

The Northern Region understands the importance of prudent financial management and the need to proactively contain cost growth to operate within previously agreed budgetary parameters.

***We have a process to ensure capital investment is aligned to regional needs***

The Northern Region currently applies an iterative approach to capital investment planning. This process will be reviewed in 2016/17 as the region responds to increasing focus on long term investment planning and management as a result of the Treasury's Investment Management and Asset Performance framework.

The existing process integrates the following activities:

- 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.

***Anticipated Capital Investment Committee timeline***

The business cases currently anticipated for submission from the Northern Region to the Capital Investment Committee during 2016/17 are outlined in the following table.

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

**Table 4 : Anticipated Submissions to Capital Investment Committee, July 2016- June 2017**

| DHB | Strategic Assessment | Indicative Business Case | Detailed Business Case |
|---|---|---|---|
| **Northland DHB** | | | |
| NDHB – ED/AAU | Aug 16 | Dec 16 | May 17 |
| **Waitemata DHB** | | | |
| ESC building Expansion | | Q3 2016 | |
| Mason Clinic Remediation project update | | Q2 2017 | |
| Waitemata 2025 Programme business case | TBC | | |
| Medical Tower | | | TBC (dependent on programme) |
| **Auckland DHB Projects**[14] | | | |
| Northern Region Electronic Health Record (NEHR) | Implementation Planning Stage (IPS) complete by Sep-16 | Program Business Case complete by Sep-16 | TBA |
| Integrated Cancer Centre | Complete but to go through the approval processes, Sept-16 | Q2 17 | TBA |
| Renal Service Reconfiguration | Complete but to go through the approval processes, Sept -16 | Mar-17 | TBA |
| Stroke Services Reconfiguration | Business case being developed: submission to CIC, Feb-17 | Q3-17 | TBA |
| Facilities Infrastructure Remediation Program | Business case being developed: submission to CIC, Dec-16 | Q1-17 | Q3-17 |
| **Counties Manukau DHB** | | | |
| Radiology at Manukau | Nov 2016 | Feb 2017 | June 2017 |
| Elective Surgery at Manukau | Feb 2017 | May 2017 | Dec 2017 |
| Specialised Rehab & Community Wellbeing | June 2016 | October 2016 | June 2017 |
| Community Hub Programme Case and/or single stage cases for individual hubs | Procurement approach and Business Case type TBC | | |
| Relocation/expansion of Middlemore Radiology | Procurement approach and Business Case type TBC | | |

***We are working to implement Treasury's Investment Management and Asset Performance***

The regional capital planning process is ongoing, aligned Treasury and MoH requirements. During 2016/17 the Region is undertaking extensive work to participate in the first tranche of health organisations to implement the Treasury's new Investment Management and Asset Performance framework (IMAP). The DHBs and healthAlliance will each undertake a comprehensive assessment of investment planning, asset

[14] Auckland DHB plans are in draft and subject to confirmation by the ELT as scope and costs are still being considered. ADHB indicates NEHR submissions to CIC as part of this draft plan. Other DHBs are committed to completion of the NEHR current phase of work and await clarification of the future direction and DHB IS/IT budget impacts.

***framework***

management and benefits realisation capability. A Long Term Investment Plan (LTIP) outlining the DHBs' rationale for their 10 year investment planning approach will be a key output and ultimately contribute to central agency visibility of investment intentions across the state sector.

This assessment process will also result in an Investor Confidence Rating which will inform Treasury and Ministry of Health actions in response to cases submitted to both for approval.

***Specific areas for further regional capital planning work***

In addition to the IMAP process DHBs will continue to 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 stated milestones.

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

- Meeting the investment planning and management 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.

***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.

***We are committed to ensure effective utilisation of our assets***

The Northern Region is 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:
  - Focusing on demand management activities that will reduce hospital admissions
  - Considering whether activity can be channelled to a lower cost setting without compromising clinical or workforce sustainability
  - 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 the likelihood of realising the benefits described in the business case
- 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.

# 6. Governance and Leadership

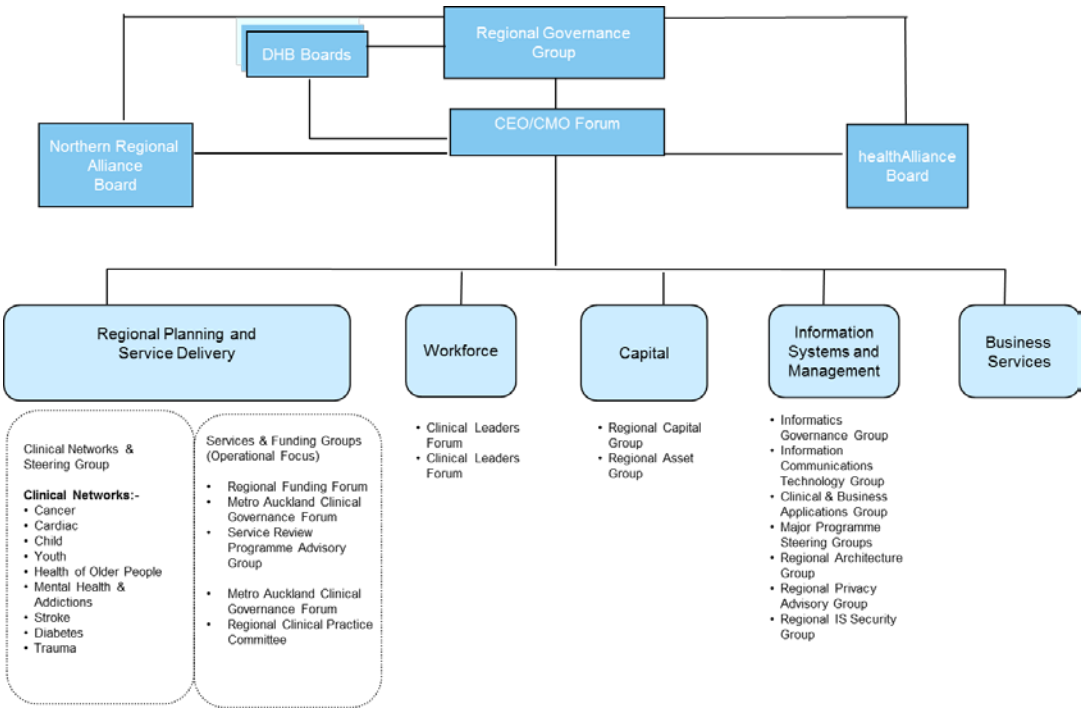
The prioritised programme of work mapped out in this plan builds on a strong history of regional collaboration over the last decade. It is only by working together across all care settings that we will be able to address the challenges of the future.

***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 9 : 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
- Monitor performance against plans
- Approve allocation of resources/budgets for regional organisations and programmes
- 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, clinical 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 agreed service developments, 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 NZ Limited 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 NZ Board which comprises seven directors including one representative from each DHB and two independent directors.

healthAlliance leads the delivery of the business services, including Information Systems as outlined 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 2016/17 they will continue to be instrumental in creating a trusting and collegial regional culture and promoting leading practice and innovation in clinical care.

***The Northern region Patient Safety Network will play a regional role improving patient experience and reducing harm***

The Northern Region has established a Patient Safety Network with the purpose to improve the patient experience by reducing avoidable healthcare associated harm through a regionally collaborative approach.

The Network is expected to:

- Promote ongoing reduction of avoidable healthcare associated harm
- Agree on key patient safety and patient experience areas for regional collaboration and align with national priorities
- Ensure key metrics to assess patient safety are being monitored in the region and in the sector
- Promote use of data to drive learning regionally
- Assess progress on improvement efforts.

The initial activities will focus on

- Development of a Northern Region patient safety strategy for the next five years
- Reviewing current regional patient safety activities and priorities for ongoing work, including opportunities for collaboration
- Agreement on leadership structure, representation on the network; including consumers and cross sector representation
- Collaboration with HQSC in supporting patient safety programmes

- Support and overview of collaborative activities by regional networks and other groups with a patient safety focus, eg Infection Prevention and Control network, Medication Safety network.

The primary focus of the Network is to establish leadership that will:

- Support national patient safety programmes and provide an overarching view and support of networks/ programmes.
- Drive and support the co-ordination of regionally agreed improvement areas with the DHB leads and to foster collaboration among care providers that improves the patient experience.
- Develop the regional plan.

Membership will comprise one senior quality / patient safety leader from each DHB and a representative from HQSC. The regional CMO lead for patient safety will be the Network Leader and the initial Chair of this group.

## Funding Mechanisms for Work to Deliver the Regional Health Plan

The Northern Region Alliance manages the operational budget for supporting the delivery of the health service and workforce components of the Northern Region Health Plan. The Northern Region DHBs fund the NRA for this service on a PBFF basis.

The work to progress the IS/IT priorities is the responsibility of health Alliance. hA is funded by the DHBs to the level determined by the deprecation associated with the DHB assets that have been transferred from DHBs to hA books. Additional funding may be agreed from DHBs as part of the annual IS/IT planning and budgeting cycle dependent upon priorities and requirements associated with annual IS/IT development plans.

Additional resources are contributed to the delivery of the regional plan by many northern region entities and individuals across the continuum of care. This contribution is usually in the form of time participating in workshops and regional meetings and also includes development or review of workstream deliverables. This cost of this time is met by those organisations and individuals.

The Regional priorities and work pla**n**s are developed and endorsed by regional clinical networks, regional work groups and DHB Boards. The Regional Governance Group provides oversight and the governance for this process delivered by both the NRA and hA. The resource requirements are identified in parallel with the finalisation of the regional plans:

- The NRA undertakes a budgeting process under the governance of the NRA Board
- Health Alliance undertakes a budgeting process under the governance of the hA Board.

Regional activity that needs capital funding follows the guidance of the capital investment committee. Individual DHB funding requirements are identified as part of a business case process and capital approvals follow local DHB, regional capital committee, and national approval processes and comply with national investment approval guidelines.

# 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:

  - Active participation of clinicians and managers in networks and the delivery of DHB and regional priorities
  - Supporting the development of locality networks and Integrated Family Health Centres
  - Aligning funding to the Northern Region Health Plan and DHB priorities
  - 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:
  - The strategic direction and prioritised initiatives across primary, community and hospital care
  - Performance targets and adjusting resources and workplans to improve health outcomes and patient experience for the population
  - 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:

- System outcomes to design and implement optimal performance and incentive framework
- New models of care that optimise self-directed care at home and in the community
- Developing fit for purpose practice models that deliver proactive patient centered care
- Information infrastructure to enable integrated and self-directed care
- Governance to drive and sustain the change agenda.

These areas of PHO focus, align with the Northern Region Health Plan. During 2016/17, 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**

  Linkages with other social agencies are 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 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:

  - Health Workforce 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.

# 7. 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.

***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.

# Implementation Risks

***This plan has risks, and only some can be regionally managed***

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 5 : 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.<br><br>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 2016/17 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, information systems 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 it can be hard to sustain long term work plans due to the capacity of key individuals to support multiple workstreams. |

# 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 |
| NEHR | Northern Region Electronic Record |
| 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 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | DHBS | | | | Primary | |
| **Regional Governance Group** | | 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 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | DHBS | | | | Primary | |
| **CEO / CMO Forum** | | 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 | |
| | | Team Member | Medical | Nursing | Allied Health & Technical | Other | Clinical | Other |
| **Regional Capital Group** | NDHB | Meng Cheong | | | | X | | |
| | | Mike Cummins | | | | X | | |
| | WDHB | Robert Paine | | | | X | | |
| | | Rosemary Chung | | | | X | | |
| | | Chris Watson | | | | X | | |
| | ADHB | Rosalie Percival | | | | X | | |
| | | Auxilia Nyangoni | | | | X | | |
| | CMDHB | Ron Pearson | | | | X | | |
| | | Pauline Hanna | | | | X | | |
| | hA | Dean Cross | | | | X | | |
| | | Kevin Robinson | | | | X | | |
| | NRA | Sarah Prentice | | | | X | | |
| | | Tony Phemister | | | | X | | |

| | REGIONAL FUNDING FORUM | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | DHBS | | | | Primary | |
| | | Team Member | Medical | Nursing | Allied Health & Technical | Other | Clinical | Other |
| **Regional Funding Forum** | NDHB | Joyce Donaldson | | | | X | | |
| | | | | | | | | |
| | WDHB/ ADHB | Debbie Holdsworth | | | | X | | |
| | | Simon Bowen | | | | X | | |
| | | | | | | | | |
| | CMDHB | Benedict Hefford | | | | X | | |
| | | Margie Apa | | | | X | | |
| | | | | | | | | |
| | NRA | Sarah Prentice | | | | 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<br>- *Human Resources* | | | | X | | |
| | | | | | | | | |
| | WDHB | Andrew Brant | X | | | | | |
| | | Jocelyn Peach | | X | | | | |
| | | Tamzin Brott | | | X | | | |
| | | Jean McQueen | | | | | X | |
| | | Fiona McCarthy<br>- *Human Resources* | | | | X | | |
| | | | | | | | | |
| | ADHB | Margaret Wilsher | X | | | | | |
| | | Margaret Dotchin | | X | | | | |
| | | Sue Waters | | | X | | | |
| | | Fiona Michel<br>- *Human Resources* | | | | X | | |
| | | | | | | | | |
| | CMDHB | Gloria Johnson | X | | | | | |
| | | Denise Kivell | | X | | | | |
| | | Martin Chadwick | | | X | | | |
| | | Campbell Brebner | | | | | X | |
| | | Thelma Thompson | | X | | | | |
| | | Beth Bundy<br>- *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 |
| | | | | | | | | |
| | hA | Myles Ward | | | X | | | |
| | | Kevin Robinson | | | X | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **CANCER** | | | | | | | |
| | | | DHBS | | | | Primary | |
| | | Team Member | Medical | Nursing | Allied Health & Technical | Other | Clinical | Other |
| | Northern Region Cancer Governance Board | Andrew Brant (Chair) (CL) | X | | | | X | |
| | | Ailsa Claire (deputy Chair)X | | | | X | | X |
| | | Wilbur Farmilo | X | | | | X | |
| | | Vanesse Geel | | | | X | | X |
| | | Richard Sullivan | X | | | | X | |
| | | Cath Cronin | | | | X | | X |
| | | Jo Brown | | | | X | | X |
| | | Margaret Dotchin | | X | | | X | |
| | | Phillip Balmer | | | | X | | X |
| | | | | | | | | |
| | | Benedict Hefford | | | | X | | X |
| | | | | | | | | |
| | Network Tumour Stream Clinical Chairs | Richard Sullivan (CD) | X | | | | X | |
| | | Richard Sullivan/Wilbur Farmilo | X | | | | X | |
| | | David Moss | X | | | | X | |
| | | Lois Eva | X | | | | X | |
| | | Paul Dawkins | X | | | | X | |
| | | Rowan Collinson | X | | | | X | |
| | | Richard Doocey | X | | | | X | |
| | | | | | | | | |
| | Regional Oncology Operations Group | Richard Sullivan (Chair) | X | | | | X | |
| | | | | | | | | |
| | Regional FCT Group | Richard Sullivan (Chair) | X | | | | X | |
| | | Ada Schuler (NDHB) | | | | X | | X |
| | | Andrew Potts (NDHB) | | | | X | | X |
| | | Anne-Marie Wilkins (CMDHB) | | X | | | X | |
| | | Annette Becker (NDHB) | | | | X | | X |
| | | Barbara Cox (ADHB) | | | | X | | X |
| | | Deirdre Maxwell (ADHB) | | | | X | | X |
| | | Jonathan Koea (WDHB) | X | | | | X | |
| | | Penny Impey (ADHB) | | | | X | | X |
| | | Richard Small (CMDHB) | | | | X | | X |
| | | Roz Sorensen (ADHB & WDHB) | | | | X | | X |
| | | Sandra Sheene (WDHB) | | X | | | X | |
| | | Michelle Sutherland (WDHB) | | | | X | | X |
| | | Wilbur Farmilo (CMDHB) | X | | | | X | |
| | | | | | | | | |
| | Cancer Control Steering Group Chairs | Andrew Potts (NDHB) | | | | X | | X |
| | | Jonathan Koea (WDHB) | X | | | | X | |
| | | Richard Sullivan (ADHB) | X | | | | X | |
| | | Richard Small | | | | X | | X |

CL – Clinical Lead

| | CARDIOVASCULAR DISEASE | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | DHBS | | | | Primary | |
| | | Team Member | Medical | Nursing | Allied Health & Technical | Other | Clinical | Other |
| | Region | Tony Scott (WDHB) (CL) | X | | | | | |
| | | Helen McKenzie | | | | X | | |
| | | Tony Phemister | | | | X | | |
| | | | | | | | | |
| | NDHB | Aniva Lawrence | | | | | X | |
| | | Lucille Wilkinson | | | | X | | |
| | | Peter Wood | | | | X | | |
| | | Stephen Jennison | X | | | | | |
| | | Raj Nandra | X | | | | | |
| | | Neil Beney | | | | X | | |
| | | | | | | | | |
| | WDHB | Barbara O'Shaughnessy | | | | X | | |
| | | Kim Bannister | | | | | X | |
| | | Jo Brown/ Lorraine Bailey | | | | X | | |
| | | | | | | | | |
| | ADHB | Jim Kriechbaum | | | | | X | |
| | | Jim Stewart | X | | | | | |
| | | Mark Webster | X | | | | | |
| | | Chris Occleshaw | X | | | | | |
| | | Joy Farley | | | | X | | |
| | | Mark Edwards | X | | | | | |
| | | Peter Ruygrok | X | | | | | |
| | | | | | | | | |
| | CMDHB | Brad Healey | | | | X | | |
| | | Helen Liley | | | | | X | |
| | | Paul Hewitt | | | | 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 |
| | Region | Timothy Jelleyman | CL | | | | | |
| | | Pam Henry | | | | X | | |
| | NDHB | Roger Tuck | X | | | | | |
| | | Nick Chamberlain | | | | X | | |
| | | Jacqui Westren | | | | X | | |
| | | Jeanette Wedding | | | | X | | |
| | WDHB | Andrew Brant | X | | | | | |
| | | Linda Harun | | | | X | | |
| | | Meia Schmidt- Uili | X | | | | | |
| | ADHB | Sarah Little | | X | | | | |
| | | Alison Leversha | X | | | | | |
| | | Emma Maddren | | | | X | | |
| | | Mike Shepherd | X | | | | | |
| | ADHB/WDHB | Ruth Bijl | | | | X | | |
| | CMDHB | Phillipa Anderson | X | | | | | |
| | | Wendy Walker | X | | | | | |
| | | Carmel Ellis | | | | X | | |
| | | Nettie Knetsch | | | | X | | |
| | NHC | David Jansen | | | | | X | |
| | Procare | Lorraine Hetaraka-Stevens | | | | | 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 | | | | | X | |
| | | Therese Rongonui | | | | X | | |
| | | | | | | | | |
| | ADHB | Ruth Bijl | | | | X | | |
| | | Alison Leversha | X | | | | | |
| | | Rachael Harry | X | | | | | |
| | | Heidi Watson | X | | | | | |
| | | | | | | | | |
| | CMDHB | Julia Shaw | | | | X | X | |
| | | Carmel Ellis | | | | X | | |
| | | Simon Denny | X | | | | | |
| | | Paul Vroegop | X | | | | | |
| | | | | | | | | |
| | Region | Bridget Farrant ( CL) | X | | | X | | |
| | | Helen McKenzie | | | | X | | |
| | | Jan Tew | | | | X | | |
| | | Andrew Brant (CMO) | X | | | | | |

CL – Clinical Lead

| | DIABETES | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | DHBS | | | | Primary | |
| | | Team Member | Medical | Nursing | Allied Health & Technical | Other | Clinical | Other |
| | Region | Catherine McNamara (CL) | X | | | | | |
| | | Helen McKenzie | | | | X | | |
| | | Tony Phemister | | | | X | | |
| | | | | | | | | |
| | NDHB | Carolyn Jones | | | | | | 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 | |
| | | Carl Eagleton | X | | | | | |
| | | Rochelle Bastion | | | | X | | |
| | | | | | | | | |
| | CVD | Tony Scott | X | | | | | |
| | | Helen McKenzie | | | | X | | |

| | HEALTH OF OLDER PEOPLE | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | DHBS | | | | Primary | |
| | | Team Member | Medical | Nursing | Allied Health & Technical | Other | Clinical | Other |
| | Region | Alan Davis (NDHB)(CL) | X | | | | | |
| | | Chris Pegg | | | | X | | |
| | | | | | | | | |
| | NDHB | Sandie Kirkman | | X | | | | |
| | | | | | | | | |
| | WDHB | John Scott | X | | | | | |
| | | Rob Butler | X | | | | | |
| | | Martin Connolly | X | | | | | |
| | | Janet Parker | | X | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | ADHB | Richard Worrall | X | | | | | |
| | | Maree Todd | X | | | | | |
| | | Jane Lees | | X | | | | |
| | | | | | | | | |
| | | Kate Sladden | | | | X | | |
| | | | | | | | | |
| | CMDHB | Geoff Green | X | | | | | |
| | | Kathy Peri | | X | | X | | |
| | | Dana Ralph-Smith | | | | | | |
| | | | | | | | | |
| | 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 |
| | Region | Ailsa Claire (ADHB) | | | | X | | |
| | | Michael Roberts (NDHB) | X | | | | | |
| | | Siobhan Isles PM | | | | X | | |
| | | | | | | | | |
| | St John Ambulance | Tony Smith | X | | | | | |
| | | | | | | | | |
| | NDHB | Andrew McClelland | X | | | | | |
| | | | | | | | | |
| | WDHB | David Lang | X | | | | | |
| | | Helen Hogan | | X | | | | |
| | | | | | | | | |
| | ADHB | James Hamill | X | | | | | |
| | | Alex Ng | X | | | | | |
| | | Rhondda Paice | | X | | | | |
| | | Rangi Dempsey | | | | X | | |
| | | Mark Friedrickson | X | | | | | |
| | | | | | | | | |
| | CMDHB | Murray Cox | X | | | | | |
| | | Sylvia Boys | X | | | | | |
| | | Kevin Henshall | | X | | | | |

CL – Clinical Lead, PM = Programme Manager

| | MENTAL HEALTH & ADDICTIONS | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | DHBS | | | | Primary | |
| | | Team Member | Medical | Nursing | Allied Health & Technical | Other | Clinical | Other |
| | Regional | Gloria Johnson (CMDHB) Regional Lead CMO* | X | | | | | |
| | | Dale Bramley (WDHB) Regional Lead CEO* | | | | X | | |
| | | Portfolio Manager (NRA) | | | | | | |
| | | Lyndy Matthews (NRA) | X | | | | | |
| | | | | | | | | |
| | NDHB | John Wade | | | | X | | |
| | | Verity Humberstone | x | | | | | |
| | | Planning and Funding rep TBC | | | | X | | |
| | | | | | | | | |
| | WDHB | Murray Patton | X | | | | | |
| | | Ian McKenzie | | | | X | | |
| | | Jean-Marie Bush | | | | X | | |
| | | Jeremy Skipworth | X | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | ADHB | GM MH&A - TBA | | | | X | | |
| | | Clive Bensemann | X | | | | | |
| | | | | | | | | |
| | CMDHB | Tess Ahen | | | | X | | |
| | | Abi Bond* | | | | X | | |
| | | Peter Watson | X | | | | | |

*Not a member of the RSP meeting.

| | STROKE | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | DHBS | | | | Primary | |
| | | Team Member | Medical | Nursing | Allied Health & Technical | Other | Clinical | Other |
| | 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 | | | | |
| | | | | | | | | |
| | Consumer | Kylie Head | | | | | | X |

CL – Clinical Lead

| | ELECTIVES | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | DHBS | | | | Primary | |
| | | Team Member | Medical | Nursing | Allied Health & Technical | Other | Clinical | Other |
| | Region | Mark Harris | | | | X | | |
| | | | | | | | | |
| | NDHB | Andrew Potts | | | | X | | |
| | | | | | | | | |
| | WDHB | Michelle Sutherland | | | | X | | |
| | | | | | | | | |
| | ADHB | Tara Argent | | | | X | | |
| | | | | | | | | |
| | CMDHB | Gillian Cossey | | | | X | | |

# Appendix A.2:

# Our Priority Goals – Implementation Plan Matrices

# 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 and Pacific children experience poorer health than non-Māori, non-Pacific children. Children living in poorer neighbourhoods also have poorer health.<br><br>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.<br><br>In 2016/17 we will continue to progress the current workstream with an additional emphasis on working with key partners to reduce obesity and improve oral health. The Ministry of Health have released a new target that by December 2017, 95% of obese children identified in the Before School Check programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. |

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

- √ Regional agreement has been achieved about the preferred model of an Integrated Newborn Enrolment system. Counties Manukau will continue to develop Kidslink Plus while Auckland, Waitemata and Northland DHBs develop and implement the National Child Information Platform.
- √ SUDI rates per 1000 births have dropped from 1.06 to 0.63 in the years 2005-2009 compared to 2010-2014. This is a 41% reduction in deaths, adjusted for population, in the Northern Region. Over the past five years, there have been a total of 53 fewer SUDI deaths (133 down to 80), in the Northern region, with 40 less deaths among Māori families, compared to the five years to 2009.
- √ The Northern Region skin infection prevention working group are working with the Ministry of Education to review Nga Kupu Oranga – Health Messages, a resource for early childhood education teachers. This will align with the existing activity to develop consistent key messages including skin infection prevention for families of pre-school children and in early education setting with particular attention to Māori, Pacific and High Needs populations
- √ There is regional agreement to purchase the Sysmex Electronic Growth tool. This will provide consistency and meets the new Ministry of Health WHO standard.
- √ The pathway for childhood head injury management in primary care will be mapped by the end of June with an implementation plan in place.
- √ An intervention logic to reduce home injury for children is agreed across services and sector engagement achieved to progress to regional implementation.

## 2016/17 Implementation Plan

| Item | Child Health : Process/Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| | **Patient Outcome Measures** | | | |
| 1 | 95% of eight months olds and two year olds are fully immunised | Q2 & Q4 | √ | √ |
| 2 | Meet 2016/17 targets for first episode rheumatic fever hospitalisations (Northern Regional Rate of 3.0/; Number 52)<br>• Report regional view of progress to CEO/CMO group in alignment with DHB reports from MoH<br>o MoH will forward previous end of calendar year report in February (Q3 to report previous year)<br>o MoH will forward previous financial year report in August (Q1 to report previous financial year) | Q3<br><br>Q1 | √ | √ |
| | **THEMES** | | | |
| | **1. Know Every Child** | | | |
| | **Integrated enrolment:** | | | |
| 3 | Ensure region preparedness to implement the National Child Health Information Platform (NCHIP).<br>• Develop the business case for NCHIP implementation.<br>• Report progress to Child Health Steering Group 6 monthly | Q4 | √ | √ |
| | **2. Informed Families** | | | |
| | **Injury prevention** : | | | |
| 4 | Work with sector partners to strengthen focus of home visiting programmes particularly in communities of high risk for injury<br>• Agree the process to deliver a regionally consistent home visiting programme that will be effective at reducing injury in and around the home, particularly in high risk populations (model of care, recommended roles, responsibilities and intersectoral working arrangements).<br>• Report progress to Child Health Steering Group 6 monthly. | Q4 | √ | √ |
| | **Skin Infection**: | | | |
| 5 | 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<br><br>• Secure funding for regional application of resource packs<br>• Agree delivery model<br>• Agree priority population for implementation | <br><br>Q4<br>ongoing<br>Q4 | | |
| 6 | • Long term: Rates for admission of skin infections regionally reduced in under 5 year olds | | | √ |
| | **Obesity**: | | | |

| Item | Child Health : Process/Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| 7 | Consistent clinical measurement approachfor child health growth and obesity available across the region (with implementation plan for 2016/17).<br>• Develop regionally consistent guideline for B4SC providers re referral pathways for overweight and obese children<br>• Develop regionally consistent messages to be delivered by health care professionals that are culturally appropriate<br>• Working with Primary Care to ensure growth charts consistent with the Ministry of Health's advice are being used in primary care patient management systems. Undertake a stocktake of current physical activity and nutrition programmes available in the region, and review evidence of effectiveness for such programmes. | Q4 | √ | √ |
| | **3. Enabled Clinical Teams** | | | |
| | **SUDI**: | | | |
| 8 | Continue to implement the regional SUDI action plan<br>• 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 | √ | √ |
| 9 | Continue to develop a consistent systematic process for risk assessment of SUDI in primary care at the time of the 6 week check<br>• Develop the plan and associated business case (if required) with allocated resource | Q4 ongoing | | |
| | **Injury Management**: | | | |
| 10 | Enhance regional consistency for childhood head injury management and follow-up for children<br>• Implement the primary care pathway for head injury follow-up | Q4 ongoing | | |
| | **Oral Health:** | | | |
| 12 | Monitor the implementation of the ARDS and NDHB pre-school oral health strategy with a particular focus on equity. | Q4 ongoing | | |
| | **4. Advocacy for the Child** | | | |
| 13 | Make advocacy a Standing Agenda item, with CHSG oversight | ongoing | | |
| 14 | Report on advocacy activities to Child Health Steering Group 6 monthly | ongoing | | |

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

## Key achievements

Now, in its fifth 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, Regional Mental Health Network, FDNH & HQSC) to ensure alignment with national and regional programmes.
- √ Extending falls initiatives into community and homecare environments. The pilot with St John Ambulance Officers has resulted in direct referral of those people who do not require transport to hospital, to DHB specialist services for further assessment.
- √ Piloting the national Hip Fracture Registry in the Northern Region – the positive evaluation significantly influenced the decision to roll-out to all DHBs across NZ.
- √ Leading the development and production of a suite of national education and training resources for primary health care professionals (in partnership with the other three regions). This has also enabled additional GP seminars and strengthened relationships outside of the Northern Region.
- √ Drafting the minimal requirements for new builds/renovations of dementia units in the Northern Region, which is complementary to the MOH national guidelines development.
- √ The pilot of the Nexxt Cognitive Impairment Pathway Decision Support Tool across the Northern Region has had excellent uptake from GPs. Feedback from the 92 Practices (363 GPs) in the pilot is very positive about the Cognitive Impairment Pathway, they appreciate the decision support functionality of the Nexxt tool.
- √ Enhanced understanding of interRAI capability and challenges, particularly in a clinical context. It is also beneficial having a HOP network member appointed to the interRAI NZ Governance Board.

## 2016/17 Implementation Plan

| Item | Health of Older People: Process/Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| | **1. Patient Outcome Measures** | | | |
| | GP "hits" on static Northern Region Cognitive Impairment Pathway will increase by 50% over next 12 months (baseline = 276 views in HealthPathways) | Ongoing to Q4 | | |
| | Increasing number of people with Dementia living at home, are registered on the Northern Region Cognitive Impairment Pathway (baseline will be established 2017/18) | Q1-Q4 | √ | √ |
| | Increased uptake of the programmes to reduce falls and pressure injuries in ARRC facilities, from 30% of facilities to 40% of facilities | Q1-Q4 | √ | |
| | 100% of Northern Region DHBs will have implemented the ANZHFR | Q1-Q4 | | |
| | 100% of ARRC residents have been assessed using interRAI LTCF | Q1-Q4 | √ | √ |
| | % of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first LTCF assessment (MoH baseline yet to be established) | Q1-Q4 | √ | √ |
| Top 10 | 75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months | Q1-Q4 | √ | √ |
| | **2. Process Activity** | | | |
| | **2a. Models of care and service** | | | |
| | **Cognitive Impairment & Associated Conditions** | | | |
| 1 | Regional Dementia Working Group provides oversight & expert advice for regional & national initiatives. | Ongoing to Q4 | √ | √ |
| 2 | Continue to collaborate with other regions to further develop & roll-out education resources for primary care health professionals | Q1-Q4 | | |
| 3 | Administer & report on regional Dementia funding & activities for primary care education & training | Q1 & Q4 | √ | |
| 4 | Review SLA & volumes in Regional Mental Health: Long Stay Older People Unit & provide findings/recommendations | Q2 | | |
| 5 | Support development of national guidelines for dementia units | Ongoing to Q4 | | |
| 6 | Publish & implement Northern Region guidelines for dementia/PG units | Q1 | | |
| 7 | Undertake a stocktake with DHBs, of current education & support groups available to informal carers, evaluating effectiveness, access & consistency. | Q1-Q3 | | |
| 8 | Feedback findings, & together with DHBs, develop recommendations to improve education & support programmes for informal carers | Q4 | | |
| 9 | Develop a Depression in Older People Clinical Pathway for Primary Care Clinicians | Q2-Q3 | | |
| 10 | Develop a Delirium Clinical Pathway for Primary Care Clinicians | Q3-Q4 | | |
| | **Quality & Safety** | | | |
| 11 | Support DHBs, ARRC, HBSS & other providers to reduce harm for older adults, particularly from falls & pressure injuries in partnership with DHB Patient Safety & ARRC Teams & HQCS. | Ongoing to Q4 | √ | √ |
| 12 | Engage ARRC sector teams in regional Falls and Pressure Injuries collaboratives which include; education & training, benchmarking, | Ongoing to Q4 | √ | √ |
| 13 | Develop a sustainable model for monitoring outcomes in ARRC eg harm from falls & pressure injuries | Ongoing to Q4 | √ | √ |
| 14 | Support ACC, DHBs, PHOs & others, with community falls initiatives | Ongoing to Q4 | √ | √ |
| 15 | Support DHBs in the roll-out of the Hip Fracture Registry | Ongoing to Q4 | √ | √ |

| Item | Health of Older People: Process/Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| 16 | Increase consumer engagement in respect to Q&S by appointing a representative on to the HOP network, who can also be available to DHBs | Q1 | √ | √ |
| | **Age Related Residential Care Sector (ARRC)** | | | |
| 17 | Analyse rates of admission to ARRC by DHB & regionally | Q2 | √ | √ |
| | **Home Based Support Services** | | | |
| 18 | Report & benchmark KPIs at regional, DHB & provider level | Ongoing to Q4 | √ | √ |
| | **interRAI** | | | |
| 19 | Support clinician representation on NZ interRAI Governance Board & clinical reporting working group | Ongoing to Q4 | √ | √ |
| 20 | Continue to expand regional measures for categories of interRAI assessments in line with national guidelines & DHB initiatives | Ongoing to Q4 | √ | √ |
| 21 | Analyse & report interRAI data across the continuum of care, with focus on quality & safety, & equity. | Q2-Q4 | √ | √ |
| | **2b. Workforce** | | | |
| 22 | Facilitate training & education to primary care clinicians on specific dementia initiatives | Ongoing to Q4 | √ | |
| 23 | Support pilot for ARRC RNs in dementia training & education | Q3-Q4 | | |
| 24 | Conduct at least 2 workshops with ARRC staff focusing on quality improvement & resident safety iniatives, in partnership with FDNH/DHB Patient Safety Team & HQSC. | Ongoing to Q4 | | |
| | **2c. Information Systems** | | | |
| 25 | Support the use of the dynamicCognitive Impairment Clinical Pathway Tool to all GPs participating in the NEXXT Programme | Q1-Q4 | √ | |
| 26 | Support the roll-out of the Depression in Older People Clinical Pathway Tool to GPs | Q4 | √ | |
| 27 | Assist DHBs to implement the national hip fracture registry, and analyse the data to inform service improvement | Ongoing to Q4 | √ | √ |
| 28 | Participate in the design of the national EHR as required, & ensure future IT systems can be integrated | Ongoing to Q4 | √ | √ |

# Cancer Services

| Context |
|---|
| Cancer continues to be the most common cause of death for both males and females in New Zealand, accounting for nearly a third 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. Cancer remains a significant concern for our population and health services. |

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

## Key achievements since July 2016

√ 100% of patients requiring radiation therapy receive this within four weeks
√ 100% of patients requiring chemotherapy receive this within four weeks
√ Regional progress toward achievement of Faster Cancer Treatment indicators (MoH Q3 15/16 data):
√ 73.3% of patients referred urgently with high suspicion of cancer receive their first cancer treatment or other management within 62 days from date of referral
√ 86.6% of patients received their first cancer treatment or other management within 31 days of decision to treat, irrespective of how they were initially referred
√ Progressed implementation of the Cancer Regional Strategic Plan priorities through establishing regional governance groups for Haematology, Gynaecological Oncology, and Sarcoma Tumour Streams
√ Completed reviews of Sarcoma, Myeloma and Lymphoma performance against National Standards
√ Completion of extensive modelling, procedure and demand analysis for Regional Bowel Investigations
√ Completion of Regional Indicative Business Case to support indicator achievement and forward planning for National Bowel Screening Programme rollout
√ Commencement of Faster Cancer Treatment service improvement fund Round 2 project to further develop and streamline regional Tumour Streams in support of FCT health target achievement
√ Implemented reporting of % Bowel Investigations performed by CTC
√ Regional agreement and implementation of optimized Lung Cancer pathway
√ Continued successful operating of the Bowel Screening Pilot
√ Establishment of the Oncology Psycho-Social initiative within our DHBs which sees increased Social Worker and Psychologist resources available for cancer patient and whanau support
√ Completion of the project: Northern Region readiness to deliver Nurse Endoscopy – registered nurse expanded practice training and credentialing
√ Establishment of a Regional project to create the framework, regional agreements, and impact analysis required to move toward local delivery of oncology services

| Item | Cancer Services: Process/Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| | **1. Measures** | | | |
| A | Health Target: 62 day indicator – Achievement of 85% by 1 July 2016.<br>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. | Ongoing | √ | √ |
| A1 | Health Target: 62 day indicator – Improved performance against the faster cancer treatment health target. 90% 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 June 2017. | Progress Toward | Q1 | √ |
| B | Policy Priority 30, part A: 31 day indicator – 85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat. | Ongoing | √ | √ |
| C | Policy Priority 30, part B: 100% of patients requiring radiation therapy will receive this within four weeks . | Ongoing | √ | √ |
| D | Policy Priority 30, part B: 100% of patients requiring medical oncology treatment will receive this within four weeks . | Ongoing | √ | √ |
| E | Policy Priority 29: 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive), 100% within 30 days. | Ongoing | √ | √ |
| F | Policy Priority 29: 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days), 100% within 90 days. | Ongoing | √ | √ |
| G | Policy Priority 29: 70% 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 Approach to Targets & Policy Priorities** | | | |
| 1 | Regional service to work collaboratively through ROOG process to continue achievement against national 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 | √ | √ |
| 3 | Continue regional focus on Cancer Multidisciplinary Meetings, ,working with DHBs to drive improvements in their coverage and functionality | Ongoing | √ | √ |
| | **Faster Cancer Treatment** | | | |
| 4 | Continue to provide regional support for FCT Round 1 Projects, including sustainable provision of improvements. Implement FCT Round 2 project consistent with agreed regional process. | Ongoing | √ | √ |
| 5 | 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.[1] | Ongoing | √ | √ |

[1] This includes regional FCT work on urology.

| | | | | |
|---|---|---|---|---|
| 6 | Engage with DHBs through the tumour stream approach to agree service improvements in priority areas. To include the implementation of prioritised actions as a result of previous Tumour Stream reviews against National Provisional Standards (Lung, Bowel, Gynae, Lymphoma, Myeloma, Sarcoma, Upper GI). | Ongoing | √ | √ |
| 7 | Complete reviews of performance against a further two National Provisional Tumour Standards. Breast and Melanoma provisionally prioritised as the next two to be completed by the region.<br>Continue to facilitate implementation of the Standards through prioritised, phased approach as agreed by regional governance mechanisms. | Completed by Q4 | √ | √ |
| | **Delivering Whole of System Care** | | | |
| 8 | Progress the regional planning elements required to move toward a Local Delivery of Oncology model which is aligned to the National Medical Oncology Models of Care projects. To include increased standardisation of processes, procedures and workforce across the region. | Ongoing | √ | √ |
| 9 | 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. | Ongoing | √ | √ |
| 10 | Support DHBs identified actions to implement the prostate cancer management and referral guidance | Ongoing | √ | √ |
| 11 | Provide regional support for the ongoing activities of the Waitemata DHB Bowel Screening Pilot. Assist where needed with analysis and support for rollout of National Bowel Screening Programme. | Ongoing | √ | √ |
| 12 | Continue to work regionally to support DHBs in identifying and implementing improvements in colonoscopy services, consistent with the Regional Colonoscopy Plan and Bowel Investigations Programme Business Case. Monitor CTC usage within the region. | Ongoing | √ | √ |
| 13 | Support DHB initiatives to provide equitable breast and cervical screening rates for Maori, Pacific, and Asian women | Ongoing | | |
| 14 | 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 | √ | √ |
| 15 | As a region support the Ministry in the development and implementation of Budget 2014 initiatives including Supportive Care and Quality Clinical Information. | Ongoing | √ | √ |
| 16 | Implement the activities contained within the Northern Region Cancer Strategy, as sanctioned by the Cancer Governance Board. | Q4 | √ | √ |
| 17 | Create a plan for developing robust regional equity goals in partnership with clinicians and DHBs | Q4 | | |
| | **2b. Workforce** | | | |
| 18 | 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 | √ | √ |
| 19 | Continue work to support a Registered Nurse Expanded Practice Training and Credentialing Programme, in support of increased colonoscopy provision in the region's DHBs. | Ongoing | √ | √ |
| 20 | Support regionally consistent training of nurses for local chemotherapy delivery. | Ongoing | √ | √ |
| | **2c. Information Systems** | | | |
| 21 | Ensure work is progressed to develop an appropriate electronic health record that caters for the needs of cancer patients | Ongoing | √ | √ |
| 22 | Implement process to ensure all new cancer related information initiatives align with the New Zealand Cancer Health Information Strategy | Q4 | √ | √ |

# 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:<br>• There is variation in both access and timeliness of access to core cardiology assessment, investigation and management across the primary-secondary continuum.<br>• 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.<br>• 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:<br>• Ensuring current measures to meet Cardiac Surgery across the region continue to be closely monitored to ensure the appropriate capacity is available.<br>• Regionally consistent monitoring and auditing of investigations, management and outcomes across the four DHBs including primary care.<br>• 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.<br>• Implementing of better models of care to meet demand and improve better quality of care across the continuum by:<br>o Reducing waiting times for First Specialist Appointments.<br>o Ensuring appropriateness and timeliness of follow up visits.<br>o Providing better support for discharged patients.<br>o Reducing age standardised CVD admission rates.<br>• To focus on heart failure including continuing to improve access to Echo and to develop the heart failure dynamic care pathway.<br>• Support DHBs in the implementation and continued use of accelerated chest pain pathways. | • Diabetes Network<br>• District Health Boards (DHBs)<br>• National Cardiac Network<br>• Auckland Metro & Northland PHOs<br>• National Heart Foundation<br>• National Health Committee<br>• Metro Auckland Clinical Governance Forum (MACGF)<br>• St John Ambulance<br>• National IT Board<br>• MOH<br>• NZ Cardiac Society<br>• NZ Resuscitation Council |

## Key achievements since July 2015

Last year the Northern Region's Cardiac Clinical Network met the following objectives for the 2015/16 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.
- Engagement with DHB planners and funders.

- The CVD Risk Registry continues to be progressed with diabetes patients now 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.
- 'Accelerated Chest Pain Pathways in ED' implemented across 3 DHBs as per MOH directive and in advance of the 2015/16 target.
- CVD Risk Management has been maintained. All 4 DHBs are consistently above the 90% target.
- In general, all DHBs have achieved the target for completion of Cath/PCI data for 95% of patients under 30 days.
- CTCA service has been implemented at Northland DHB, supported by Metro Auckland DHB including:
    - Double screening of initial 68 cases
    - Agreed a regional clinical model of care including reporting indicators.
    - Videoconference meetings for joint correlation and review of cases are ongoing with WDHB and NDHB

√ Further refined and continued reporting of Regional KPIs. Recent improvements include the addition of diabetes status to the report.

√ Developed:
- Dynamic pathway for Atrial Fibrillation
- 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.
- Minimum core components for Cardiac Rehab have been developed based on the data collected from the Cardiac Rehab Regional Forum. Further work in place to develop recording/reporting of minimum data sets.
- Reporting of interventionist call-outs for the cardiac catheter lab.
- St John Ambulance continues to upgrade ambulances by installing Wi-Fi hubs and replacing defibrillators which significantly improves ECG transmission by ambulance.

√ Long Term Projects Initiated and Underway:
- A significant national project has been undertaken and is being led by the Northern Region. This is in support of automated external defibrillator (AED) and bystander CPR. This involved the identification and comparison of existing Apps to be developed for NZ. We are working closely with St John Ambulance to map prior Out of Hospital Cardiac Arrests (OHCA) to determine the best locations for new AEDs in NZ.
- Development of the National STEMI pathway has been supported by the Northern Region, in conjunction with St John Ambulance, with a focus on:
    - ECG criteria for STEMI;
    - Drug regime ;
    - SpO2 threshold for oxygen;
    - Transport times,
    - Regimen for pre-hospital thrombolysis;
    - ECG transmission by ambulance and activation of the Cardiac Catheter lab.
- Regional Cath Lab review and capacity planning is underway; a draft scoping document has been noted at the SRPAG group and will be further developed. A regional capacity planning model is to be developed.

| Item | Cardiovascular : Process/Action | **2016/17**Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| | **1. Patient Process Measures** | | | |
| 1. | 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. | Q1 | | |
| 2. | 95% of out-patient coronary angiogram waiting time to <3 months. | Q1 | | |
| 3. | 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 | | |
| 4. | 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.) | Q1 | | |
| 5. | Maintain the nationally agreed cardiac surgical delivery and waiting list management targets, (<10%) | Q1 | | |
| 6. | Continue to monitor the standardised Intervention Rates<br>Regional SIRs will be reported against the following standards:<br>• 6.5 per 10,000 population for cardiac surgery,<br>• 12.5 per 10,000 for percutaneous revascularisation<br>• 34.7 per 10,000 for coronary angiography | Q1 | | |
| 7. | 90% of eligible patients will have had their CVD risk assessed in the last 5 years | Q1 | | |
| 8. | Monitor the data to ensure 95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography continue to have completion of ANZACS QI ACS and Cath/PCI registry data collection. | Q1 | | |
| 9. | All patients will wait less than four months for a cardiology first specialist assessment, or for cardiac surgery | Ongoing | | |
| 10. | Continue to improve access to Echo to support diagnosis of Heart Failure and other conditions including those requiring cardiac surgery.<br>Aim for 95 % of outpatient Echos to have been completed within 4 months of referral. | Q4 | | |
| 11. | 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 | | |
| 12. | 1. Increase dispensing of triple therapy (BP lowering and statin and anti-platelet/anti-coagulant) in those with prior CVD.<br>2. Increase dispensing of double therapy (BP lowering and statin) high risk primary prevention (>=20%) over 2 years.<br>Change from baseline will be assessed using the regional CVDRA registry linkage to national dispensing data.<br>• Target for secondary prevention: - increase in existing rates by absolute 5% over next 2 years.<br>• Target for primary prevention: - increase in existing rates by absolute 5% over next 2 years.<br>The target is to achieve this in the overall cohort eligible for CVD risk assessment and in the Maori and Pacific groups<br>• Report dispensing rates for Maori and Pacific Island (PI) patients.<br>• Reduce the gap in dispensing rates between Maori and PI patients and the rest of the population. | Q4 | | |
| | **2a. Models of care and service** | | | |
| 13. | 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<br>on-going | | |

| Item | Cardiovascular : Process/Action | 2016/17Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| 14. | 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 | | |
| 15. | 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 | | |
| 16. | Support collaborative improvement process for CVD Risk Management in primary care and monitor those processes as measured by the medicine adherence reports. | on-going | | |
| 17. | Support development of further CVD pathways, including dynamic heart failure pathway (Static – [HealthPathways] and dynamic [NEXXT]) and promote their use. | Q4 | | |
| 18. | Work with The National AED and Bystander CPR Working Group's (CARENZ) to develop and implement AED and Bystander CPR project | Q4 | | |
| 19. | Develop and implement the out of hospital STEMI pathway in conjunction with NZ STEMI group. | Q4 | | |
| 20. | Monitor the use of ACCP Pathway via DHB self-audit. | Q4 | | |
| 21. | Implement use of agreed core components of the Cardiac Rehab Programme across the region | Q3 | | |
| 22. | Implement/Initiate data reporting for Cardiac Rehab as agreed regionally. | Q4 | | |
| 23. | 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** | | | |
| 24. | Agree a plan for the EP workforce, including physiologists; the interventional and diagnostic angiography cardiology clinical workforce and those clinicians responsible for pacemaker/ ICD implantation. This will be for the medium to long term and is to include SMO and technical staff, from a regional perspective | Q3 | | |
| | **2c. Information Systems** | | | |
| 25. | Continue to provide on-going support for use of ANZACS QI KPI reporting and ACS quality improvement throughout the region, with improved use in primary care setting. | Q4 | | |
| 26. | Support the population of the CVD Risk Registry | Q4 | | |
| 27. | Support better integration of ECG transmission by ambulance | On-going | | |
| | **2d. Capital and other expenditure** | | | |
| 28. | Develop a regional plan for cardiac catheter and EP lab services. Undertake a regional review of capacity and demand for cardiac catheter lab services to inform future planning. | Q4 | √ | |

# Diabetes

## Context

Diabetes is a chronic condition which impacts patients and their whanau over a lifetime. It can lead to disability through problems such as blindness, amputation of limbs, heart attacks and renal failure, and as a consequence can shorten life expectancy.

There are approx. 128,000 people in the region with diabetes and a fast growing pre-diabetic population means that the diabetes population roughly doubles every 10 years. This puts ever increasing demands on an already stretched health system. Despite greater awareness about the risk factors for development of Type 2 Diabetes and the interventions required to achieve good control (which reduces complication risk); the attention and resources being allocated to diabetes have not always been systematic and coordinated.

The conservative estimated costs of diabetes in the Northern region are approximately $365m annually, excluding primary care costs and are mainly due to treatment of complications. We need to be at the forefront of innovation to test new strategies, to slow the growing incidence and the impact of diabetes on our population.

It is vital to prevent or minimise the co-morbidities of retinopathy, high risk foot, renal failure and cardiovascular disease. 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 increasing numbers of complex patients in community settings. More effective utilisation of allied health and nursing workforces and alternative care models are needed. Central to this is the realisation that the patient with diabetes or prediabetes must be empowered to self-manage safely and effectively. To this end the patient's needs should be at the forefront of all service redesign.

| Objectives | Linkages |
|---|---|
| There are key drivers to this priority area<br>• Secondary services cannot grow at the same rate that the diabetes population is expected to grow. Early detection and practice management in primary care is critical. Secondary Care services need to evolve to provide mentoring and support in a community setting.<br>• Certain ethnic groups experience higher rates of the disease, particularly Māori, Asian and Pacific. Specialist services which are culturally appropriate need to be developed in order to serve these population groups properly. The role of peer support and health coaches needs to be explored as a matter of urgency.<br>• Greater than 80% of diabetic complications are preventable through good management. Health Care Providers need to be up-skilled to provide timely assessments of patients with diabetes and implement proactive management plans which involve the patient. Regional Guidelines on all aspects of Diabetes Management should be available with a focus on Care Planning for all patients with diabetes. | • Northern Region Cardiac Network.<br>• Internal Stakeholders – Planning and Funding; Long Term Conditions Groups; DHB staff.<br>• External Stakeholders – Primary care, PHO's, Diabetes NZ, Ministry of Health.<br>• Metro Auckland Clinical Governance Group.<br>• Diabetes Service Level Alliance Leadership Teams. |

## 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 in health outcomes for at risk populations.

Implemented:

- √ Closer working relationship with Northern Cardiac Clinical Network
- √ Improved Indicators for reporting
- √ Ongoing involvement with Service Level Alliances at WDHB/ADHB
- √ Involvement with Metro Auckland Clinical Governance Forum
- √ Ministry of Health Quality Standards for Gestational Diabetes, High Risk Foot Pathway and "20 Quality Standards" are in place across the network and being incorporated into the regional pathways.
- √ 2 Podiatry Indicators for the management of High Risk Foot have been developed.
- √ CVD Risk Assessment process has been formalised and is monitored quarterly.
- √ Retinal screening data recorded monthly, includes ethnicity.
- √ Quality Standards and Audit tool for DSME have been developed
- √ DSME Curriculum.
- √ Diabetes Nurse-led clinic guidance for primary care.

## 2016/17 Diabetes Implementation Plan

| Item | Diabetes : Process/Action | **2016/17** Quarter completed by | **2017/18** | **2018/19** |
|---|---|---|---|---|
| | **1. Patient Outcome Measures** | | | |
| 1. | Continue work to ensure '90% of eligible patients will have had a cardiovascular risk assessment in the last 5 years'. | Q1 | | |
| 2. | Diabetes reports continue to be developed and refined to provide better, more usable data. | Q1 | | |
| 3. | Develop the capability to be able to highlight patients who are not on treatment and advise this to primary care teams in order to achieve outcome measures. | Q4 | | |
| 4. | 80% of diabetic patients should have good or acceptable glycaemic control (HbA1c≤64) | Ongoing | Ongoing | Q4 |
| 5. | 90% of patients with diabetes who have microalbuminuria are on an ACE inhibitor or Angiotensin Receptor Blocker | Ongoing | Q4 | |
| 6. | 70% of patients with known CVD are on triple therapy (Statin + BP lowering agent + Aspirin) | Ongoing | Ongoing | Ongoing |
| 7. | 70% of patients with 5 year cardio-vascular risk ever recorded >20%, (excluding those with a previous CVD event) are on dual therapy (statin + BP Lowering agent) | Ongoing | Ongoing | Ongoing |
| 8. | Agreed target number of patients undergoes retinal screening across the region.<br>MOH guidance indicates '90% of the population with diabetes (PWD) are to receive retinal screening'. We will target this proportion, with the first step being to convert this % to an annual eligible number of patients. This target number will be identified by Q1 (work already commenced) | Q1 - Q4 | | |
| 9. | Demonstrate a trend in reduction of proportion of patients with HbA1c levels over 100 mmol/mol. | Q4 | | |
| 10. | Continue to develop podiatry indicators that capture the management | | | |

| Item | Diabetes : Process/Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| | of the High Risk Foot. | Q3 | | |
| | **2 Models of care and service** | | | |
| | **Promote early detection of pre-diabetes and diabetes, and proactive patient management** | | | |
| 11. | Support the development and implementation of guidelines for a consistent in-hospital care approach for patients admitted with diabetes. | Q4 | | |
| 12. | Work with MACGF to identify a reporting mechanism to demonstrate 80% of patients with diabetes (aged 15 – 74 years) have systolic blood pressure of <140 | Q4 | | |
| | **Promote and develop models of care which support proactive care at the practice level & utilise community resources** | | | |
| 13. | Promote greater utilisation of Nurse-led Clinics in primary care and develop GP and practice nurse Diabetes Champions. | Q2 | | |
| 14. | Support the development of Diabetes HealthPathways and promote their use in primary care. | Ongoing | | |
| | **Promote and support patients with diabetes or pre-diabetes across the life span through collaboration with health systems and communities** | | | |
| 15. | Provide clinical advice and support to the working groups developing DSME and lifestyle programmes. | Q4 | | |
| | **Target Populations with Increased Risk of Diabetes and Related Complications (access equality)** | | | |
| 16. | Support the identification and implementation of 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 | | |
| 17. | Support the implementation of integrated diabetes foot services throughout the Northern Region. | Q4 | | |
| | **3. Workforce** | | | |
| 18. | 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 | | |
| | **4. Information Systems** | | | |
| | **Improve the capture and visibility of diabetes related data** | | | |
| 19. | This will be reflected in the updated Medication Prevention reports along with improved distribution and commentary available to PHOs and GPs | Q2 | | |

# Major Trauma

| Context |
|---|
| Each year there are approximately 500 cases of major trauma and 4,200 of non-major trauma in the Northern Region. Many patients are transferred between DHBs to receive definitive care for their injuries.<br><br>The Northern Region Trauma Network has a goal to introduce a more formal system for managing trauma patients. The initiatives we are implementing are in line with other jurisdictions which have demonstrated significant reduction in in-hospital mortality rates, improved recovery from injuries, and cost savings to the health system. Our workplan is aligned to the Major Trauma National Clinical Network to build a robust and consistent national system across New Zealand.<br><br>Optimisation of pre-hospital and inter-hospital 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. A case review process is being established to pinpoint where intra-regional systemic issues have occurred and make recommendations for change. We are introducing a range of initiatives to introduce contemporary, quality care for major trauma patients in this region |

| Objectives | Linkages |
|---|---|
| The key drivers to this priority area are to establish a formal trauma system through:<br>• Strengthening regional collaboration and clinical governance<br>• Data analysis<br>• Consistency in prehospital and hospital care | • National major trauma network<br>• St John Ambulance<br>• ACC |

## Key achievements to date

The Northern Region Trauma 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
- √ Upload to NZ Major Trauma Registry in each DHB
- √ Pre-hospital destination protocols agreed
- √ Clinical audit process established to identify and address regional and systemic issues
- √ Single Point of Contact introduced at Auckland City Hospital

## 2016/17 Implementation Plan

| Item | Process/Action | 2016/17<br><br>Quarter due for completion |
|---|---|---|
| | **1. Major Trauma measures** | |
| | Measure national KPIs for the region and review additional KPIs specific for the region, including<br>• GCS <9 and intubated pre-hospital<br>• Time of injury to<br>o 1st facility arrival<br>o Definitive care hospital<br>• Time of 1st observations to<br>o ED entry and exit<br>o Index CT<br>o Procedures: laparotomy, craniotomy etc<br>• In-hospital mortality rate<br>• Injury diagnosis after 48 hours. | Q1 |
| | **2. Foundation Activity** | |
| 1 | Succession plan for clinical lead | Q1 |
| | **3. Models of care and service** | |
| | **Regional trauma system** | |
| 2 | Build on Clinical Guidelines developed by ACH for regional use and publish and distribute | Q2 |
| 3 | Clinical audit process – strengthen this initiative to identify and address issues which have regional systemic impacts, to build a picture of issues and work with stakeholders to address, including pre-hospital and rehabilitation | Ongoing |
| 4 | Single Point of Contact at ACH – support implementation set up to support efficient and easy transfer of patients to Auckland, and review to identify improvements | Ongoing |
| 5 | Inter-hospital guidelines - Support the implementation particularly with junior medical staff | Ongoing |
| 6 | Pre-hospital destination protocols - Support the implementation with pre-hospital ambulance services which includes which patients go where | Ongoing |
| 7 | Scope a review of trauma rehabilitation capacity and capability to identify opportunities for improvement | Q3 |
| | **Trauma Data** | |
| 8 | Continue the collection and upload of major trauma data to the NZ Major Trauma Registry in all 4 DHBs | Ongoing |
| 9 | Establish data analysis process and feedback loops to inform areas of focus to improve the trauma system | Q1 |
| | **Communications** | |
| 10 | Communicate to key stakeholders on the intent and activities of the network | Ongoing to Q4 |
| | **4. Workforce** | |
| 11 | Establish regional trauma training days for registrars and other staff working in trauma to build competency and capability in the sector, aiming for two sessions each year | Q2 |
| 12 | Proactively share training courses which are held locally and in Australasia | Q1 |

| Item | Process/Action | 2016/17<br><br>Quarter due for completion |
|---|---|---|
| | **5. Information Systems** | |
| 13 | Continue to work in collaboration with Waikato DHB IS as host for the NZ Major trauma Registry | Ongoing |
| 14 | Review the ePRS to suggest changes to better meet the requirements for trauma patients in collaboration with St John Ambulance | 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. Our focus is on initiatives that align with the Ministry of Health's 2016/17 Planning Priorities. We 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 |
|---|---|
| • Improve access to the range of eating disorders services<br>• Improve mental health and addiction service capacity for people with high and complex needs<br>• Improve youth forensic service capacity and responsiveness<br>• Improve perinatal and maternal mental health acute service options across a service continuum<br>• Improve the physical health of people with low prevalence disorders | • The Ministry of Health Rising to the Challenge – Mental Health and Addiction Service Development Plan 2012-2017, and Blueprint II<br>• The Ministry of Health Regional Services Plan Guidelines (2016/17), and 2016/17 Planning Priorities for Annual Plans and Regional Service Plans<br>• DHB Action Plans 2016/17 |

**Key achievements since July 2015:**

**Increasing sector responsiveness to children and youth at risk**

√ Establishment of Mother and Baby Unit, enhancement of maternal mental health services, and increase in community respite and packages of care for perinatal and maternal mental health

√ Increased number of people seen by youth forensic services

√ Utilisation and service level agreement review of regional CFU services

**Developing capability in services for vulnerable populations**

√ Progressed service change to implement an EDS service hub for the Supra region.

√ Service Delivery Model developed for supra-regional Eating Disorders Services

√ Developed indicative business case for minimum secure services for people with high and/or complex needs

**Developing capacity and responsiveness of adult and youth forensic services**

√ Increased service capability through the development of training framework

## 2016/17 Implementation Plan

| Item | Process/Action | 2015/16<br><br>Quarter due for completion | 2016/17 | 2017/18 |
|---|---|---|---|---|
| | **1. Patient Outcome Measures** | | | |
| 1 | **Adult Forensic Services**<br>• 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 | | |
| 2 | **Youth Forensic Services**<br>• Access rates to youth forensic services are maintained or improved for:<br>o Court liaison services<br>o Child Youth and Family Residences<br>o Community based services | Q2 & Q4 | | |
| 3 | **Perinatal and maternal mental health services**<br>• Regional access rates to P&MMHS are maintained or improved in terms of<br>o Bed days provided,<br>o Individual patient contacts. | Q1 – Q4 | | |
| 4 | **Adult mental health services**<br>• 90% of discharges from adult mental health services receive post discharge community care (within 7 days) | Q1 – Q4 | | |
| | **2. Service Delivery** | | | |
| 1 | **Eating Disorders Services**<br>Progress the implementation of the service change proposal for the delivery of supra regional eating disorder services with key activities including<br>• ADHB will progress co-location of services comprising the fully integrated ADHB-managed EDS Hub which will result in seamless transitions for clients between services.<br>• A comprehensive training and support schedule will support supra regional workforce development and enhance local service delivery<br>• Explore the use of technology to enhance client access to specialist support | Q1 – Q4<br><br>Q1 – Q4<br><br>Q1 - Q4 | | |
| 2 | **Services for people with high and/or complex needs**<br>Increase minimum secure capacity within the Northern Region by:<br>• Progressing the development of a Detailed Business Case for an Inpatient Minimum Secure Service | Q1 – Q4 | | |
| 3 | **Youth Forensic Services**<br>• 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<br>• Complete the development of a minimum clinical documentation set and regionally consistent service policies/protocols<br>• Finalise and implement a regionally agreed youth | Q2<br><br>Q3<br><br>Q4 | | |

| Item | Process/Action | 2015/16<br><br>Quarter due for completion | 2016/17 | 2017/18 |
|---|---|---|---|---|
| | forensic model of care | | | |
| 4 | **Perinatal and Maternal Mental Health Acute Service Options**<br>• Support regional coordination and oversight of service delivery and models of care that support an integrated response to acute care<br>• Increase access to perinatal and infant mental health services by ensuring a coordinated and consistent acute specialist response to service access, delivery and after hours support<br>• Grow the expertise (through active clinical networks) of the workforce to support consistent delivery of services regionally<br>• Complete a review of PIMH services funded through the CFA to inform decisions about service provision options in 2016/17 and out years | Q1 - Q4<br><br>Q1 - Q4<br><br>Q1 - Q4<br><br>Q2 | | |
| 5. | **Improve physical health for people with low prevalence disorders**<br>• Increase information sharing and support shared care through development of regionally agreed technology solutions<br>• Support improved access to primary care for people with long term mental health conditions (low prevalence), contributing toward ensuring that all New Zealanders have access to a medical home.<br>• Develop a strategic framework to progress the implementation of Equally Well.<br>• Progress the implementation of shared metabolic screening between primary care and secondary mental health services. | Q1-Q4 | | |
| | **3. Workforce** | | | |
| 1 | • Support regional suicide prevention initiatives by:<br>o Completing the development of a regional Suicide Prevention Training Framework<br>o Implementing the Framework | Q2<br>Q4 | | |
| 2 | • Support the implementation of the Youth Forensics Regional Training Framework within the Youth Forensics Service Development Report | Q4 | | |
| 3 | • Design and implement a regional Smokefree Training and Development framework | Q4 | | |
| | **4. Information Systems** | | | |
| 1 | • Progress work to support e-referrals and uptake<br>• Progress work associated with metabolic screening tool implementation<br>• Progress alignment with other national initiatives such as eMedicine Reconciliations and Shared Care | 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.<br><br>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.<br><br>The key drivers to this priority area:<br>• Strengthen the regional focus on stroke services in three key areas; thrombolysis/clot retrieval, inpatient & rehabilitation stroke care<br>• Using the region's intellectual and physical resources to improve stroke care in conjunction with NZ Stroke Guidelines | District Health Boards (DHB)<br>NZ Stroke Foundation<br>St John Ambulance<br>Metro Auckland Clinical Governance Forum<br>Rehabilitation/NGO sector<br>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
- √ Hyper-acute Stroke Pathway Project for Northern Region progressing according to plan and in alignment with proposed Clot Retrieval Service.
- √ Utilising a co-design approach has resulted in the engagement of several hundred consumers in collaboration with the Stroke Foundation.
- √ TIA Pathway completed and available to GPs.
- √ 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 | 2016/17<br>Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| | **1. Stroke Measures** | | | |
| | **2016/17 targets** | | | |
| | 8% of potentially eligible stroke patients are thrombolysed 24/7 (MOH target = 6%) | 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 | √ | √ |
| | 60% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission | Ongoing toQ4 | √ | √ |
| | Less than 10% of patients will be coded as Acute Unspecified Stroke | Ongoing to Q4 | √ | √ |
| | **2. Models of care and service** | | | |
| 1 | The Stroke Network Executive provides oversight & expert advice for local, regional & national initiatives. | Q1 | √ | √ |
| 2 | Update the Northern Region Stroke Plan to reflect the 3x phases of stroke improvement (hyper-acute, inpatient & rehabilitation) | Q2 | √ | √ |
| 3 | Finalise the implementation plan for the Hyper-acute Stroke Pathway and support St John Ambulance & DHBs in the roll-out. | Q1-Q4 | | |
| 4 | Support ADHB in the establishment of their regional Clot Retrieval Service | Q1-Q4 | √ | √ |
| 5 | Develop detailed project plan for 2nd phase of Northern Region Stroke Plan – Acute Stroke Inpatient Phase of Care | Q2 | √ | √ |
| 6 | Commence Acute Stroke Inpatient Pathway Project | Q3-Q4 | √ | |
| 7 | In conjunction with the MOH FAST campaign, undertake additional activities in the Northern Region to heighten public awareness | Q2-Q3 | √ | √ |
| 8 | Strengthen collaboration with consumers around co-design of strategies & initiatives' specified in the Northern Region Stroke Plan. | Q1-4 | √ | √ |
| 9 | Review & update "Stroke Dashboard" 6 monthly | Q2,Q4 | √ | √ |
| 10 | Report outcomes for Maori & Pacific Island people with stroke in alignment with Northern Region Maori Dashboard | Q2,Q4 | √ | √ |
| 11 | Work towards a door-to-needle time (thrombolysis) of less than 1 hour for at least 50% of patients | Q4 | √ | √ |
| 12 | Participate in national stroke rehabilitation group and implement agreed regional actions | Ongoing toQ4 | √ | √ |
| 13 | Work with national rehabilitation group to establish KPI & target for patients discharged directly home with community rehab follow up. | Ongoing toQ4 | √ | √ |
| | **3. Workforce** | | | |
| 14 | Report on stroke training/education events in Northern Region | Ongoing toQ4 | √ | √ |
| 15 | Review & update Northern Region section (for health professionals) on NZ Stroke website, 6 monthly | Ongoing toQ4 | √ | √ |
| 16 | Support national workforce initiatives and roll-out regionally eg thrombolysis credentialling programme for medical staff | Q1-Q4 | √ | √ |
| | **4. Information systems** | | | |

| Item | Stroke - Process/Action | 2016/17<br>Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| 17 | Support the use of the dynamic Trans Ischaemic Attack (TIA) Clinical Pathway Tool to all GPs participating in the NEXXT Programme | Q1-Q4 | √ | √ |
| 18 | Participate in the design of the national EHR as required, & ensure future IT systems can be integrated | Ongoing to 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.<br><br>The distribution of poor health is marked by significant socio-economic and ethnic differences. Inequities can be clearly seen across a range of measures.<br><br>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.<br><br>The future of the Northern Region as a vibrant and economically healthy area 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:<br><br>• Optimise health outcomes, by reducing inequities.<br>• The Northern Regional Youth Network will advocate for improvements in the upstream determinants of youth health.<br>• Target our interventions at those who need them most especially Maori and Pacific Island youth.<br>• Improve the capability and capacity of our workforce so that a young person receives quality care regardless of where they present.<br>• Pool health and other social agency resources more effectively<br>• Achieve greater consistency and quality of care for young people | • Northern Region Mental Health and Addictions network, and its focus on youth forensics<br>• Youth health action plan<br>• Youth development strategy<br>• Auckland Council and its intersectoral groups<br>• Northland Council and its intersectoral groups<br>• Regional groups for maternity, youth, primary care, etc.<br>• Child Health Network |

Note: Youth are defined as 12 – 24 years, for the purposes of this document

## Key Achievements since July 2015

√ KPIs agreed, produced and distributed for:

- PHO enrolment by Age Band and Ethnicity
- GP Practice information including top 10 practices and fees
- Smoking Status
- Teen Birth rates
- Access to Mental Health Services by DHB, Age and Ethnicity

√ Draft version of 'Standards for Quality Care for Adolescents and Young Adults in Secondary or Tertiary Care' completed.

## 2016-17 Implementation Plan

| Item | Youth Health : Process/Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| | **1. Patient Outcome Measures** | | | |
| | Continue to monitor KPIs for:<br>• PHO Enrolment<br>• Smoking status<br>• Teen Birth Rate<br>• Access to Primary Mental Health ( in line with MoH PP6 criteria) and The Prime Minister's Youth Mental Health Project reporting.<br>• Youth elective termination of pregnancy<br>• GP practices offering free service to <18 year olds.<br>• Secondary Mental health care access rates | Ongoing | | |
| | Develop KPI reporting for :<br>• Suicide numbers<br>• PHO Utilisation data<br>• STI rates<br>• Re-referral rates to secondary care mental health services<br>• Mental health waiting times<br>• Alcohol and related presentation rates at ED | Q4 | | |
| | **2. Models of care and service** | | | |
| | **Youth Mental Health** | | | |
| | Support regional mental health network, and local development and implementation, of the Prime Minister's Youth Mental Health Project. | 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 implement standards for delivery of care (aspects of service design and clinician skills) for youth in all primary care settings | Q4 | | |
| | **Youth appropriate secondary care** | | | |
| | Support /progress youth health services and transitions in secondary care, including the interface with primary care.<br>Finalise and implement secondary care guidelines | Q4 | | |
| | **Teen Birth Rate** | | | |
| | National Priority for 2016/17 is to reduce unintended teen pregnancies – Awaiting guidance from MOH. | | | |

# Appendix A.3:

# Services – Implementation Plan Matrices

# &

# Supporting Material

# Electives implementation plan

## Context

National initiatives place emphasis on elective services as a regional area of focus. Previous DHB efforts to improve elective services patient flow have resulted in successfully meeting the target of less than 120 days waiting time for both FSA and access to treatment where indicated. In addition, DHBs continue to work on increasing the number of elective surgery cases being completed.

While the Northern Region DHBs have achieved their electives targets in the past, it will continue to be a challenge to maintain these targets. Constraints on capital funding limit our ability to develop additional capacity. To be able to continue to meet our targets our DHBs actively seek 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 gains by working collaboratively as a region. These initiatives demonstrate a strong focus on building on local DHB innovations and broadening their reach. We also acknowledge that elective services are managed differently in each DHB and so have focussed on initiatives which are likely to be successful in a range of settings and have a universal impact across our region.

| Objectives | Linkages |
|---|---|
| The objectives of the regional work are to:<br>• Maintain reduced waiting times for elective first specialist assessments and treatment<br>• Deliver the required elective surgical discharge volumes<br>• Improve access to elective services; including equitable access to services for our population<br>• Alignment between Elective and Cancer services to develop consistent pathways and clinical protocols for tumour streams<br>• Support the development of new models of care and improved service interfaces | Capital planning<br>National targets<br>Alignment to gains made during the Elective Services Productivity and Workforce Programme |

## 2016/17 Implementation Plan

| Item | Electives : Process/Action | | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|---|
| | **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 reach agreement with the MoH on the target number of Elective Services discharges to be delivered in 2016/17 (and will achieve this target by Q4) | | Q14 | | |
| | **2. Process activity** | | | | |
| | **2a. Models of care and service** | | | | |
| | Maintain the monthly Surgical Services Manager Forum, and promote good practice and awareness by DHBs hosting regional information exchange and 'sharing' sessions to:<br>• Monitor standardised intervention rates to understand areas of need and facilitate actions to improve equity of access<br>• Remain up to date with local DHB innovations and consider opportunities for spreading these to other settings<br>• Contribute to the implementation of other system improvements such as:<br>o Clinical Prioritisation tools<br>o Regional e-referrals<br>o National Patient Flow concepts | | Monthly<br><br>One per quarter | | |
| | Progress bariatric surgery for the Northland community by means of a collaborative approach between NDHB and WDHB | | Q2 | | |
| | Support local efforts to improve Ophthalmology access for the CMDHB population | | Q3 | | |
| | **Develop and Implement Pathways and protocols** | | | | |
| | Collaborate with cancer services to develop consistent pathways and protocols for 'Faster Cancer Treatment' tumour streams (refer Appendix 2 Cancer plan) | | 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 :<br>• Ophthalmology<br>• Cataract surgery<br>• Orthopaedics<br>• General surgery<br>• Plastics<br>(as these tools become available for use) | | Q4 | | |
| | **2c. Information Systems** | | | | |
| | Support the eReferrals inter and intra DHB implementation within elective services | | Q3 | | |
| | Implement National patient flow concepts, in line with MoH guidance and data collection expectations | | Q4 | | |
| | **2d. Capital and other expenditure** | | | | |
| | Support DHBs capital planning | | ongoing | | |

# Hepatitis C - Work plan

## Context

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

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

This change in approach was in part informed by a Pilot carried out by the Hepatitis Foundation between 2012- 2014. The Pilot focused on improvements to hepatitis C assessment in the four district health board (DHB) areas of Bay of Plenty, Capital & Coast, Hutt Valley and Wairarapa. The Pilot included education and awareness activity, targeted testing and identification, community-based assessment and support delivered by nurse specialists, and activity to improve disease surveillance and data collection.

Following the Minister's approval, the Ministry of Health (the Ministry) provided advice detailing the commitments requested from the regions regarding development and implementation of hepatitis C services during the 2015/16 financial year.

DHBs in the non-pilot Northern and Southern regions are required to identify how they will implement integrated services in their regions, informed by the experience of the Pilot DHBs. All four regions have committed to implementing integrated hepatitis C services in their regions by the end of the first quarter 2016/17 year.

Implementation of the diagnosis, management and treatment pathway will be carried out, assessed and refined to incorporate changes in treatment strategies and ensure equity of access and treatment.

| Objectives | Linkages |
|---|---|
| Work in the Northern Region will include:<br>• Refine the Hepatitis C clinical care pathway for the Region<br>• Identify clinical and mobile diagnostic capacity and capability requirements<br>• Develop an implementation plan for integrated service delivery across primary and secondary care within the region including awareness and education<br>• Detail service delivery options appraisal, and undertake analysis with the Ministry of Health; identifying the costs of undertaking this service in primary care across the Northern region<br>• Implement agreed service changes.<br>• Provide a quarterly narrative report on progress of the Key Actions<br>• Provide a six monthly report on the 6 key performance measures to the MOH | National targets |

| Milestone | Hep C Process / Action | Agreement Milestone Dates |
|---|---|---|
| **#1** | Development of a workplan for delivery and implementation of clinical pathway for hepatitis C | 4 March 2016 |
| **#2** | Development of an agreed clinical pathway | 31 March 2016 |
| **#3** | Development of service delivery options | 31 May 2016 |
| **#4** | Implementation planning completed. We will provide the MoH with a report on the planned deliverables, milestones and timeframes for implementation of services across the last 3 quarters of 2016/17 as part of this milestone deliverable | 30 June 2016 |

# Appendix A.4:

# Enablers– Implementation Plan Matrices

# Regional Information Systems Implementation Plan

## Northern Region Priority Programmes/Projects FY2016/2017 – Key Deliverables

**Note: This programme will be extended to a three year programme following the completion of the ISSP and the NEHR IPS and Business Case. The Northern Region will provide an updated prioritised list of IT investment as part of the Quarter 2 reporting process 2016/17.**

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July - Sep | | Q2 Oct - Dec | | Q3 Jan – Mar | | Q4 April - June | | | |
| **CareConnect Programme** | | | | | | | | | | |
| **eReferrals Phase Two (2.3/2.4) (Intra and Inter Hospital eReferrals) Implementation** | | | 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 eReferrals | G | Regional implementation completed for intra-DHB and inter-DHB eReferrals | |
| | | | NDHB: Gap analysis complete | G | NDHB: Planning complete | G | | | NDHB: Solution in place for Intra and Inter hospital eReferrals | |
| **Patient Portal Strategy** | | | Patient Portal strategy commenced | G | Patient Portal strategy and approach confirmed | G | | | | |
| **Shared Care Development & Integration** | CareConnect Technical integration commenced | G | | | CareConnect Technical integration completed | G | | | | |
| **Clinical Pathways Implementation** | Clinical Pathways implementation (primary & secondary care) ongoing | G | Clinical Pathways implementation (primary & secondary care) ongoing | G | Integration with eReferrals & Testsafe commenced | G | Integration with eReferrals & Testsafe completed | G | | |

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July - Sep | | Q2 Oct - Dec | | Q3 Jan - Mar | | Q4 April - June | | | |
| **eMedicines Programme** | | | | | | | | | | |
| **Hospital ePharmacy** | | | | | CMH: regional implementation completed | G | | | WDHB: regional implementation completed | |
| **ePrescribing and Admin'n (ePA)** | | | WDHB: ePA implementation completed | G | | | | | | |
| | ADHB: ePA Phase 1 Implementation completed | G | ADHB: Decision on further rollout pending outcome of NEHR Programme | G | | | | | | |
| | | | CMH: ePA Early Adopter implementation commenced | G | CMH: Business case for ePA Implementation approved | G | CMH: ePA Implementation commenced | G | | |
| | | | | | | | NDHB: Business case for ePA Implementation approved | G | NDHB: ePA Implementation commenced | NDHB: ePA Implementation ongoing |
| **NZ Formulary (NZF)** | | | | | CMH: implementation of ePharmacy and Reference viewer upgrade completed | G | | | WDHB: implementation of ePharmacy and Reference viewer upgrade completed | |

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July - Sep | | Q2 Oct - Dec | | Q3 Jan - Mar | | Q4 April - June | | | |
| **National Solutions** | | | | | | | | | | |
| **National Patient Flow** | Phase 3 functionality delivered | G | | | | | Phase 4 functionality agreed | G | Phase 4 functionality delivered | |
| **National Maternity** | All plans on hold until issues addressed and system is confirmed as being fit for purpose in acute care settings | | | | | | | | | |

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July - Sep | | Q2 Oct - Dec | | Q3 Jan - Mar | | Q4 April - June | | | |
| **Patient Management and Clinical Workstation** | | | | | | | | | | |
| **Clinical Workstation Upgrade** | CMH/WDHB: Clinical Workstation upgrade Commenced | G | | | | | | | CMH/WDHB: Clinical Workstation upgrade Completed | |
| | NDHB: Clinical Workstation upgrade business case completed | G | | | | | | | | |
| | | | ADHB: Decision on Clinical Workstation upgrade pending outcome of NEHR Programme | | | | | | | |
| **Patient Management System Upgrade** | CMH/WDHB: Patient Management System upgrade commenced | G | | | | | CMH/WDHB: Patient Management System upgrade completed | G | | |
| | | | ADHB: Decision on PAS replacement pending outcome of NEHR Programme | | | | | | | |
| | | | | | NDHB: WebPAS implementation completed | G | | | | |

| Projects | Deliverables 2016/17 | | | | | | | | Deliverable 2017-2018 | Deliverable 2018-2019 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 July - Sep | | Q2 Oct - Dec | | Q3 Jan - Mar | | Q4 April - June | | | |
| **eOrders Programme** | | | | | | | | | | |
| **Laboratory eOrders** | WDHB: Laboratory eOrders implementation commenced | G | | | WDHB: Laboratory eOrders implementation completed | G | | | | |
| | | | | | | | CMDHB: Laboratory eOrders implementation commenced | G | CMDHB: Laboratory eOrders implementation completed | |
| | | | ADHB: Decision on Laboratory eOrders pending outcome of NEHR Programme | | | | | | | |
| **Radiology eOrders** | WDHB: Radiology eOrders implementation completed | G | | | | | | | | |
| | CMDHB: Radiology eOrders implementation commenced | G | | | | | CMDHB: Radiology eOrders implementation completed | G | | |
| | | | | | | | | | NDHB: Radiology eOrders implementation commenced | |
| **Clinical Documentation** | | | | | | | | | | |
| **Nursing Notes** | WDHB: eVitals implementation completed | G | | | CMDHB: eVitals implementation commenced | G | | | CMDHB: eVitals implementation completed | |

# Workforce implementation plan

**2016/17**

| Item | Regional Workforce: Process / Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| | **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.<br><br>– Participate in and align our leadership development activities with the national leadership development programme.<br><br>– Strengthen cultural competency across all our senior leaders.<br><br>– Continue the development and implementation of a regional Health Management Development Pathway. | Q1 – Q4 | ✔ | ✔ |
| | **Grow the capacity and capability, and the size of our Maori and Pacific Workforce** | | | |
| 2 | We will increase the size of our Maori and Pacific workforces to reflect the communities we serve by 2025.<br>To achieve this we will:<br>Agree differential targets for our clinical and non-clinical workforces and develop related strategies to achieve these.<br><br>Increase the profile of our Maori and Pacific workforce and develop a more robust and consistent narrative about the importance of developing and recruiting the future Maori and Pacific health workforce.<br><br>Improve our data quality and intelligence by:<br><br>– Standardising our ethnicity data to align with the Ministry of Health and Census ethnicity data protocols/guidelines;<br>– Improving the completeness of our ethnicity data; and<br>– Generating intelligence to understand who our Maori and Pacific applicants are and their success rates for employment within the DHBs at the department/professional group level (including retention rates and length of service); and to inform our efforts to support population health need and human resources strategy.<br><br>Focus on increasing the numbers Maori and Pacific in our workforce by :<br><br>– Setting KPIs for hiring managers around the recruitment of new graduates.<br>– Working with our hiring managers and recruitment managers to align recruitment criteria to ensure the unique strengths the Maori and Pacific workforce bring to health care delivery are valued and recognised;<br>– Providing proactive support to all Maori and Pacific applications for employment;<br>– Commissioning and implementing initiatives to reduce unconscious & conscious bias in recruitment systems;<br><br>Increase mentoring and support to future workforce candidates to assist completion of their study and prepare them for employment in the health workforce. | Q1<br><br>Q1<br><br>Q2 – Q4<br><br>Q2 – Q4<br><br>Q1 – Q4 | ✔<br><br>✔ | ✔<br><br>✔ |

| Item | Regional Workforce: Process / Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| | – Undertake a regional Diversity Hui with tertiary partners focusing on allied health professions. Identify key transition points up to graduation and on to employment and implement targeted strategies to support students through into employment.<br><br>Widen the pipeline to grow our workforce by partnering with the Ministry of Social Development to advance specific and target innovations to increase Maori and Pacific applications for employment.<br><br>Review and strengthen our human resources strategy to support intentional and targeted approaches to achieve more equitable employment outcomes for Maori and Pacific. | Q2 – Q4<br><br>Q1 – Q4<br><br>Q2 | ✔<br><br>✔ | ✔<br><br>✔ |
| 3 | Identify and prioritise potential Maori and Pacific for leadership development and accelerated pathway opportunities to targeted senior level leadership roles. | Q1 – Q4 | ✔ | ✔ |
| | **Increase the flexibility and affordability of the workforce to manage rising demand** | | | |
| 4 | Monitor the first cohort's progress through the nurses performing endoscopy training and identify candidates for the second cohort.<br><br>Establish a regional view in regard to the local development of advanced practice roles, particularly those which increase flexibility to work across hospital and community settings.<br>– Advance the role of allied health in Emergency Care and in FSAs such as for orthopaedics, audiology and others.<br><br>Support nurses to provide chemotherapy through a hub and spoke model supported by the e-learning delivery of the Australasian chemotherapy standards. | Q1 – Q4<br><br>Q2 – Q3<br><br>Q1 – Q4 | ✔<br><br>✔ | ✔<br><br>✔ |
| | **Build and align the capability of the workforce to deliver new models of care** | | | |
| 5 | Identify opportunities to better utilise and support the non-regulated workforce:<br><br>– Create a common understanding on the assistant role.<br>– Enable career progression opportunities for the assistant workforce using the Careerforce qualification pathways.<br><br>Provide opportunities to better support our low paid workforce through:<br>– Targeted access to education and training pathways to support merit based steps to increase income.<br><br>– Develop primary care/community based positions for PGY 2s in line with the MCNZ requirements for General Registration. | <br><br>Q1<br>Q1 – Q4<br><br><br>Q1 – Q4<br><br><br>Q1 – Q4 | <br><br>✔<br><br><br>✔<br><br><br>✔ | <br><br>✔<br><br><br>✔<br><br><br>✔ |
| | **Optimise the pipeline and improve the sustainability of priority Workforces** | | | |

| Item | Regional Workforce: Process / Action | 2016/17 Quarter completed by | 2017/18 | 2018/19 |
|---|---|---|---|---|
| 6 | Develop a sustainable sonographer trainee pathway including options for an alternative training and supervision model that safeguards trainee places and ensures a steady trainee supply to meet future demand. | Q2 – Q4 | ✔ | |
| | Identify vulnerable workforces such as those which are small and highly technical and develop strategies to improve sustainably. | Q1 – Q4 | ✔ | |

**Regional workforce initiatives to be progressed by the Regional Clinical Networks**

| Regional Programmes and Clinical Networks | 2016/17 Quarter Completed by | | | |
|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 |
| **Child Health** | | | | |
| Skin Infection Prevention: Workforce training will be provided to support new initiative to reduce the rates of admission for skin infection for children aged 0-5 years. | Ongoing | | | |
| **Health of Older People** | | | | |
| Facilitate training & education to primary care clinicians on specific dementia initiatives | | ✔ | | ✔ |
| Support pilot for ARRC RNs in dementia training & education | | | | ✔ |
| Conduct at least 2 workshops with ARRC (aged related resident care) staff focusing on quality improvement & resident safety initiatives in partnership with FDNH/DHB Patient Safety Team & HQSC (Health Quality Safety Commission). | | ✔ | | ✔ |
| **Cancer Services** | | | | |
| Support the commitment of the region and DHBs to train and provide professional development to cancer nurse coordinators, including the attendance at national regional training and mentoring forums | Ongoing | | | |
| Continue work to support a Registered Nurse Expanded Practice Training and Credentialing Programme, in support of increased colonoscopy provision in the region's DHBs | Ongoing | | | |
| Support regionally consistent training of nurses for local chemotherapy delivery. | Ongoing | | | |
| **Cardiovascular Disease** | | | | |
| Agree a plan for the EP (electrophysiology) workforce, including physiologists; the interventional and diagnostic angiography cardiology clinical workforce and those clinicians responsible for pacemaker/ ICD (implantable cardioverter defibrillator) implantation. This will be for the medium to long term and is to include SMO and technical staff, from a regional perspective | | | | ✔ |
| **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** | | | | |
| Proactively share training courses which are held locally and in Australasia | ✔ | | | |
| Establish regional trauma training days for registrars and other staff working in trauma to build competency and capability in the sector, aiming for two sessions each year | | ✔ | | |
| **Mental Health and Addictions** | | | | |
| Support regional suicide prevention initiatives by:<br>- Completing the development of a regional Suicide Prevention Training Framework<br>- Implementing the Framework | | ✔ | | ✔ |
| Support the implementation of the Youth Forensics Regional Training Framework within the Youth Forensics Service Development Report | | | | ✔ |
| Design and implement a regional Smokefree Training and Development framework | | | | ✔ |
| **Stroke** | | | | |
| Report on stroke training/ education events in the Northern Region | | ✔ | | ✔ |
| Support national workforce initiatives and roll-out regionally e.g. thrombolysis credentialing programme for medical staff | ✔ | ✔ | ✔ | ✔ |