Northern Region

Health Plan

2014/15

Foreword

Over the past four years the clinical networks and services which fall under the Northern Region Health Plan have exceeded expectations. We can demonstrate real improvements with our patients getting better access to health care and more efficient and safer care while using our services. These achievements give us the confidence we have the right foundations in place to shape a health system that is fit for the future.

This year we will dedicate our resources to primarily implement the step changes needed to drive sustainable improvements in the areas we have already selected. We have highlighted child health, inequalities in health outcomes, and health of older people for intensified attention this year. We believe we need to make accelerated gains in these areas and a regional approach will be more effective than working as individual DHBs. To achieve meaningful gains in many of our focus areas will require greater integration across the community-hospital interface. Our Alliance Partners will remain critical to the successful delivery of the Northern Region Health Plan.

The 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 2014/15.

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Office of Hon Tony Ryall
Minister of Health
Minister for State Owned Enterprises

2 JUL 2014

Mr Geraint Martin
Chief Executive Officer
Lead Chief Executive Officer for Northern Region District Health Boards
Counties Manukau District Health Board
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Dear Geraint

2014/15 Regional Services Plan

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

As greater integration between regional DHBs supports more effective use of clinical and financial resources, I expect DHBs to make significant progress in implementing their RSPs during 2014/15. Improving the alignment between DHB Annual Plans and RSPs is an important planning priority and I understand the alignment is better than in 2013/14, however we must continue to strengthen this alignment if we are to achieve the best use of resources.

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

Regional Service Plan Agreement
Your region has described your Information Systems Strategic Plan, with some costed initiatives and actions aimed at improving information management. My agreement of your RSP is on condition that a fully costed regional IT plan with milestones is provided by the end of quarter one 2014/15. I understand that you will continue to work closely with the Ministry to produce an acceptable IT plan.

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

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

by your DHBs. Approval for equity or new lending is also managed through the annual capital allocation round.
Finally, please ensure that a copy of this letter is attached to the copy of your signed RSP held by each DHB Board and to all copies of the RSP made available to the public.

Yours sincerely

Hon Tony Ryall
Minister of Health

cc: DHB Chairs and Chief Executive Officers in the Northern region

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Executive Summary

Introduction

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

The Northern Region Health Plan is designed to improve health outcomes and reduce disparities for the 1.7 million people living in the Northern Region. Developed by the Region's four District Health Boards and primary care Alliance Partners, the Northern Region Health Plan involves working together as a region to provide health care that makes best use of available resources, is sustainable, and improves access to services.

This is the fourth regional plan. Over the past few 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 new innovations are adopted more quickly across the region, and our clinical leaders are driving strategic service change. These improvements give us the confidence that we have the right foundations in place, and are focussing on the right things to really make a difference for our population.

At the same time we are acutely aware we have significant challenges ahead. The relentless demand on health services, particularly from the growth in chronic diseases and the health needs of our aging population, poses a major challenge in a fiscally constrained environment.

The Northern Region Context

Meeting Minister's expectations

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

- **Better Public Services**: leading the effort to increase immunisation, reduce the incidence of rheumatic fever, and reduce violent assaults against children
- **National Health Targets**: committing to achieve the six national health targets.
- **Care closer to home**: better integration and coordination of health services between the community and hospitals particularly for management of long term conditions, and for the health of our older people to support their independence
- **Regional and national collaboration** to leverage the financial and clinical gains to be derived from working together
- **Living within our means** to support the Government's goal to return to surplus in 2014/15.

Five key drivers of change

The Northern Region is facing significant pressures which will require substantive change in the way we work in the future.

Figure 1 : Northern Region - Key Drivers for Change

It is not sustainable to continue to deliver health services as we do currently

The way we currently deliver services is not sustainable. Our estimates indicate that the region's population will grow by around 500,000 people over the next 20 years. We will need an additional 75 -100 beds per annum just to accommodate demographic growth. This does not include an allowance for improved service to population groups which have high levels of deprivation nor the continuing growth in long term conditions.

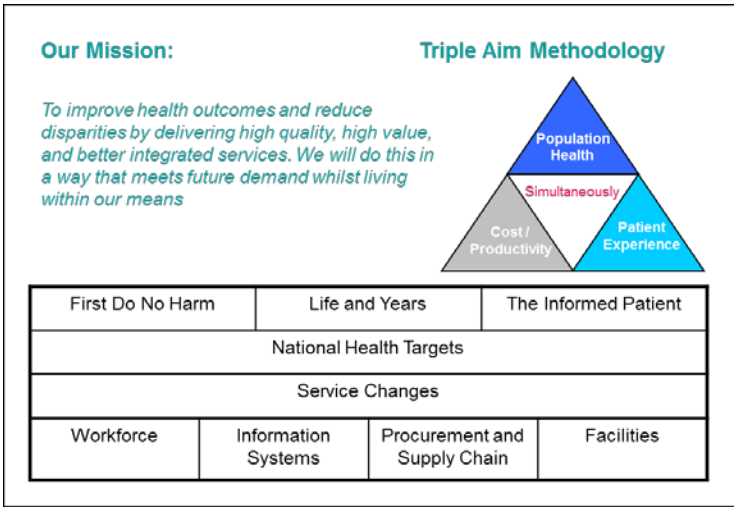
We have the foundation blocks in place with clinical networks and clinical leaders appointed to lead the work around our priority goals. The focus is now on achieving gains for the health of our population, in line with regional and national directions.

Our Direction

As a region we will need to think and act differently

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

Figure 2 : Northern Region Direction



Focusing on a small number of areas where we can make a real difference

The Northern Region Health Plan outlines the prioritised programme of work for the region to achieve in 2014/15. It builds on a strong history of regional collaboration in which the four DHBs have invested over the last decade.

As a region we have prioritised a small number of areas where we believe we can make the greatest impact. By getting these areas right, we will be in a better position to assure the sustainability of our health system over the next 10 to 20 years.

Our Priority Goals

We will continue to work on previously agreed 'key areas' for gains

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

- Goal One - First, Do No Harm: Reducing harm and improving patient safety
- Goal Two - Life and Years: Reducing disparities and achieving longer, healthier and more productive lives
- Goal Three - The Informed Patient: ensuring patients are better informed about care and treatment choices and healthcare providers are better informed about patient's care preferences, particularly around end of life care.

Goal One: First Do No Harm

A single strategy to improve the safety of patients in our care

Patient safety, under the banner of the *First, Do No Harm* campaign, is a priority for the Northern Region. There is clear evidence that certain interventions, if systematically applied, will save lives and money and prevent harm to patients. The *First, Do No Harm* campaign is focussed on improving the quality and safety of our health system. Over 2014-15 the focus of activities will be on:

- Reducing pressure injuries and harm from falls in hospitals and residential aged care
- Reducing healthcare associated infections
- Improving medication safety, and
- Reducing peri-operative harm.

There is close alignment of activities between *First, Do No Harm* and the Health Quality & Safety Commission's *Open for better care* patient safety campaign. The *First, Do No Harm* campaign will continue to build on its work to develop a safety culture across hospital and residential aged care facilities, and strengthen its partnerships with consumers and clinical staff.

Goal Two: Life and Years

Targeted approaches to address the incidence of diseases on our population

Our historical broad approaches have done little to halt acute demand growth or address disparities in health outcomes. We are therefore adopting a targeted approach with specific initiatives to improve health outcomes for our most vulnerable populations. The achievements we expect from this approach are to:

- Reduce the wide inequalities in health status and life expectancy, particularly for Maori 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.

Stronger regional focus will be applied to three areas to achieve accelerated gains

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

- **Child Health**

  Child Health has a stronger regional focus this year.

  Our children are one of our most disadvantaged groups, yet if we get it right now we will have a lifetime of payback. Child health is a Ministerial priority through the Better Public Service Targets. Inter-sectoral and inter-agency work to address the upstream determinants of health is being encouraged at the highest levels of Government. Northland DHB has many innovative initiatives such as the Children's Team which we can leverage across the region.

  This year the child health network will continue to develop the five priority areas to reduce the incidence, particularly in Maori and Pacific children of:

  - Sudden unexpected death of an infant (SUDI)
  - Rheumatic fever
  - Accidental injuries
  - Skin infections
  - Respiratory tract conditions.

  The network will lead key health initiatives with the Auckland and Northland Councils and other agencies, particularly to improve immunisation and to reduce rheumatic fever. Population health approaches for children will also be strengthened across community and hospital care, so that the most high needs children are supported with targeted health and social initiatives. This includes strengthening the Healthy Housing initiatives in the metro area to enable children and their whanau at high risk of rheumatic fever and other conditions to receive priority referral to better housing options.

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

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

  - Reporting against the Maori health dashboard
  - Three areas for focus for local and regional action for Maori: youth health, oral health, and reducing tobacco consumption
  - Further developing the workforce to support more Maori and Pacific into health careers, professional development for potential leaders and training of our workforce in cultural competency.

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

- **Health of older people**

  The demand our older people place on our health system is enormous and growing. Older people comprise between 5%-25% of the population in our DHBs which is a significant variance regionally. There are also significant variances in how we deliver care for our older people. It is not sustainable to continue to grow our facilities and workforce to manage the growing demand. Furthermore, the way we currently care for our older adults does not always best meet their needs, nor are services always delivered in a way they would prefer.

  With a stronger regional focus this year, we will refocus our efforts on initiatives which have proven to be more effective at reducing demand. This includes:

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

  Our overarching goal is to support our older people to be well and to live healthy independent lives.

We are emphasising these three areas of work as we believe we can make significant gains by working together as a region. All aspects of these workstreams will have strong regional oversight aligned to the heightened regional emphasis.

We will continue seven other workstreams

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

Cancer: faster cancer treatment, improving the functionality of multi-disciplinary meetings, implementing national medical oncology models of care and the tumour standards, progressing a regional non-surgical patient management system, and developing services for specific cancer care such as the bowel screening pilot, Bone Marrow Transplants, and prostate cancer.

Cardiovascular disease: review cardiac surgery to ensure sufficient capacity to meet demand, supporting primary care to better manage cardiovascular disease, implementing new models of care to better meet demand and more consistent care, improving access to echo-cardiogram and implementation of Accelerated Chest Pain pathways (as per the Minister's Health report).

Diabetes: implement revised diabetes self-management education to empower patients with Type 2 diabetes to have more control over their care, support primary care to improve the rate of insulin initiation and better management of high-risk feet, and identification of diabetic patients through the CVD risk assessment tool.

Major Trauma: this is a new priority for 2014/15 in line with the Minister's intent to implement a more formal trauma system in each region. The network will strengthen regional governance, improve data collection and analysis, and update the pre-hospital destination protocols.

Mental Health and Addiction: implement changes to the Eating Disorders model of care, establish secure inpatient capacity for people with high and/or complex needs and enable access to services, develop the youth forensic framework, and establish acute perinatal and infant mental health service options.

Stroke: strengthen regional efforts to improve timely access to acute and post-acute stroke services, develop and implement pathways for patients at risk of stroke, and stronger cross sector collaboration amongst providers of primary and secondary stroke service.

Youth Health: develop standards of care for school based and primary care services, and update standards for youth in secondary services.

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

Clinical leadership and partnership to enable gains

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

- **In the short to medium term** to achieve greater consistency and broader adoption of initiatives which have been effective in one or two DHBs. This is expected to improve the 'process' performance measures
- **In the longer term** to embed new ways of working to slow the rate of growth, so that actual demand is lower than the projected demand, acknowledging the impact of the initiatives implemented now will be observed over a 10-20 year timeframe.

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

Goal Three: The Informed Patient

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

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

Advance care planning aims to ensure patients are better informed about future care and treatment choices and healthcare providers are better informed about patient's care preferences, particularly around end of life care. This year training of the health workforce will continue. Consumer and wider community engagements will also be strengthened.

These initiatives signal a very different approach to supporting patients and their whanau/families to make choices about their care. We expect this to enable a greater and more meaningful level of engagement. We also expect more patients, and their families to be able to plan how and where they die.

Enabling and encouraging patient and whanau self-directed care extends throughout our work and underpins all areas of our plan.

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

Achieving Our Targets

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

Table 1 : Top 10 Patient-Focussed Regional Commitments for 2014/15

All Interventions 1. Achieve and maintain the Minister's health targets
First, Do No Harm 2. Reduction in falls causing major harm in the acute sector to a rate of less than 0.07 per 1,000 bed days
Life and Years 3. 86% of Well Child Tamariki Ora core checks in first year all completed by December 2014 (rising to 95% by June 2016) 4. % of ARRC residents with completed InterRAI assessment and associated care plan 5. 80% of patients who have a stroke are treated on a stroke unit 6. 80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes, 7. Improvement in the % of patients referred urgently with a high suspicion of cancer receiving their first cancer treatment (or other management) within 62 days from date of referral (achievement of the 85% Health Target by July 2016) 8. 1.25% of young people aged between 12 and19 years old are accessing specialist Alcohol and Other Drug (AOD) services (quarter 4) 9. 37,000 patients undergo retinal screening
The Informed Patient 10. A 20% increase on the 2013/14 end of year ACP conversations documented by each of the four DHBs
We will investigate the opportunity to analyse these measures by ethnicity and, where feasible and value adding, data collection mechanisms will be put in place to progress the inequities and inequalities workstream.

We will improve collaboration

Service Planning

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

- Laboratory - priority is being placed on ensuring a smooth transition for community referred services, working towards more standardised access levels and processes regionally and building resilience and future proofing the laboratory system to cater for changes in clinical practice and demand
- Radiology: addressing the Sonography workforce shortage is a key priority with several initiatives planned and underway to increase trainee

numbers and recruitment. New service models for sub-speciality services will be developed. Collaboration with healthAlliance on key radiology IS initiatives is also a priority

- Pharmacy: to continue support for the implementation of the next stage of the national pharmacy agreement which is designed to provide more patient centred care in community pharmacies and benefit high-needs patients. Focus is also on medication safety improvements across the sector
- Elective services: Implementation of initiatives to improve the efficiency and productivity of the region's elective services, regional reporting, and a service plan for Urology services. A common clinical prioritisation tool for at least two surgical services will also be developed.

Developing services to meet a dynamic and changing context

Service Planning and Development

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

Ongoing work will progress regional services development with regard to:

- Acute spinal cord impairment to implement a single location of service
- Maxillo facial surgery to support a small and fragmented workforce
- Rehabilitation to ensure that plans are based on consistent assumptions regarding patient flows and models of care.
- Sexual Health Review with work initially focusing on Waitemata and Auckland DHBs

In addition Auckland DHB will be reviewing the specification and costing of tertiary services. Findings may impact on the configuration and scope of some services.

Collaborative service development models

In a new initiative being led by the DHB Chairs, our region will promote rational regional service distribution that strengthens the region overall, creates the opportunity for certain services to be delivered locally and does not destabilise any particular DHB. To this end the plan is to set in place a moratorium on service repatriation and, in the place of service repatriation, to have 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 inter-district flows [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. Immediate areas of focus are the services of:

- Ophthalmology service provision in the Waitemata District
- Chemotherapy outpatient treatment service provision in the Counties Manukau District.

Enablers

Ensuring the four enablers support our strategic direction

We need to strengthen regional collaboration emphasising four key enablers.

Workforce

The total combined clinical, technical, clerical and other workforce in our region is around 27,000 employees. Indicative workforce projections suggest that by 2021 the demand for labour will grow by 52%, but supply of labour will grow by just 29% creating increased labour shortages unless workforce training is aligned to potential future models of care.

The region has identified six workforce objectives which are aligned to new models of integrated care and a greater level of care in the community:

1. Enable workforce flexibility and affordability to manage rising demand
2. Build and align the capability of the workforce to deliver new models of care
3. Grow the capacity and capability of our Maori and Pacific workforce
4. Build a workforce that engages effectively with the community it serves
5. Promote advanced practise roles and working at top of scope
6. Adopt a stronger regional HR approach.

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

Information Systems

Information systems are fundamental to the Northern Region's ability to deliver on the whole of system approach to health service delivery that is embedded throughout this plan. Good information is required to improve the continuity of care for patients in our region across primary, secondary and tertiary care. This relies on consistent and reliable access to core clinical documents and facts for all clinicians involved in a patient's care.

Consistent with the direction set by the National Health IT Board and the Northern Region's IS plans, the focus in 2014-15 will be to continue implementing the

infrastructure upgrades and enhancement of the resilience and security of IS. The Northern Region DHBs began to address this in 2013/14 and this will continue in 2014/15, with investment in the following areas:

- Microsoft software upgrades in infrastructure
- Clinical and business systems upgrades to ensure systems remain on supportable versions and can realise the potential available with later versions
- Clarification of DHB service requirements and realignment of IS services to better support the Northern Region within available funding
- Improved resilience and security of IS systems to improve system availability, access and data integrity.

Prioritisation of the above areas is a fundamental pre-requisite for maintenance of current IS services and investment in our future systems. The regional plan also supports a five yearly computer replacement cycle to ensure these are regularly updated and fit for purpose.

The region is strengthening its governance of information systems and information management. The Northern Region CIO Group is accountable to the CEO/CMO Forum for advice and assurance on all information system and information management matters. It will work closely with the Regional IS Clinical Leadership Group and with CIOs in each DHB to ensure prioritised IS business requirements are delivered.

Procurement and Supply Chain

The region has agreed a procurement and supply chain savings target for the next five years, contributing to the $700 million target of Health Benefits Limited. The foundation work has been put in place to change historical practices and introduce more streamlined and standardised processes. This year the focus will be to:

- Procurement will strengthen its category management approach, and build on its supplier relationship management program to enable a more proactive approach with key suppliers, and improve the overall performance of the procurement process
- Supply Chain will establish an Auckland distribution centre, and extend the Oracle inventory management system more broadly across the region. The first iteration of the region's Procurement & Supply Chain Business Plan will reconfirm the direction and roadmap for activity over the next three years. Work will continue on implementing the current road map.

Facilities and Capital

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

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

During the coming year we will:

- Meet the capital planning requirements of the Ministry of Health and The

Treasury and to work with both these entities on the Health Capital Review 2014/15

- Progress the CMDHB immediate proposals for capital projects in line with Treasury's Better Business Case requirements
- Work to refine DHB capital plans with a particular emphasis on:
    - IS/IT capital budgets
    - Children's services
    - Inpatient rehabilitation service and mental health services
    - Other service areas with potential for greater regional co-ordination
    - Identifying and implementing capital planning process improvements

The Way Forward

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. 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 primary care Alliances and oversight of the regional work program
- Clinical Networks will drive strategic planning and deliver, and support others to deliver, the priority initiatives outlined in this plan. They will also monitor key performance measures
- The three District Strategic Alliances that have been established to strengthen relationships with primary care and enhance service delivery integration are critical to the delivery of the plan. The Strategic Alliance Partners and locality teams will be the key mechanism to drive changes to clinical practice in primary care. This will include delivering a greater breadth of services locally and supporting high-needs patients to prevent acute and unplanned admissions, and older people to live independently
- The District Alliances will develop more clinical pathways and implement initiatives that align with key goals of reducing acute demand, supporting the development of clinical pathways and better management of targeted individuals
- Northern Regional Alliance will lead the delivery of the health service and workforce activities as outlined in this plan
- healthAlliance will lead the delivery of the Information System and Procurement & Supply Chain enablers as outlined in this plan.

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

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

We commit to achieving better outcomes for our population

Region wide engagement and commitment to this plan

The region is committed to this plan and believes it is achievable. Its implementation will require strong leadership and confidence across all sectors. The region's leading clinicians have prioritised initiatives where significant gains can be made, and are feasible to achieve and measure. Detailed implementation planning and setting patient outcome measures and targets are developed to ensure we make the gains proposed.

1. Introduction

Addressing National Requirements

This Northern Region Health Plan has been developed by the four DHBs and reflects contributions from our primary care Alliance Partners. It provides an overall framework for regional planning and builds on previous years' work to demonstrate how the Government's objectives and the region's priorities will be met over 2014/15 and beyond.

The Planning Environment

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

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

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

This year the Government's expectation is that the regional plans and DHB Annual Plans demonstrate more clearly the contributions by regions and DHBs to achieve objectives.

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

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

- Make best use of available resources
- Strengthen clinical and financial sustainability
- Increase access to services.

Development of the Northern Region Health Plan is an iterative process aligned with the development of DHB Annual Plans and Maori Health Plans.

It aligns to the national expectations of regional planning

The National Health Board (NHB) has outlined expectations for regional plans detailing three main areas of emphasis:

1. Regional governance, leadership and decision making, with detail of the specific governance and leadership approaches that support regional collaboration. Strong clinical leadership to champion change is strongly emphasised
2. Strategic context within which the plan has been developed, including:
   - Progress to date
   - Identifying significant changes from earlier years
   - Identifying the direction of travel for 2014/15 and beyond
   - The strategic context is also expected to be consistent with DHB's Statement of Intent and the Strategic Intentions of the DHB Annual Plans
3. Implementation plan to deliver the priorities, including:

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

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

Developing the Regional Plan

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

The clinical and managerial leadership of the four District Health Boards have engaged with primary care Alliance Partners and worked together to develop this regional plan. This plan is the overarching document defining the region's strategic direction.

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

Building on the successes and learning over the past years

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

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

This 2014/15 plan leverages the work that the region has previously undertaken. Our 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[1]. Some key highlights include:

- Exceeded all national targets with regional results of:
  - Electives reaching 106.8% of target volume
  - ED wait 95.4% of patients seen within 6 hours
  - 96.2% patients who smoke receive advice to quit
  - 75.9% patients at risk of CVD and diabetes receive health checks
  - 89.7% of our children are fully immunised
  - 100% of our cancer patients receive treatment within 4-weeks
- Grade 3 & 4 pressure injuries (the more serious injuries) have reduced significantly so they are now regarded as rare events

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

- 95% children and adolescents referred to mental health services are seen within eight weeks of referral
- 30,000 school aged children have access to school based primary care for the identification and treatment of Group A Streptococcal throat infections and skin infections
- 100% critical results in lab tests are phoned through to the referring clinician in under 1 hour
- The vulnerable Sonography workforce is being actively supported through cross sector work and securement of funding to implement a 12 week intensive clinical programme pilot
- Since 2012 over 9,000 advance care planning discussions have been held with patients as they plan their end of life care
- 7% stroke patients thrombolysed
- 13% increase in patients with acute coronary syndrome who receive angiography within three months
- ECG transmission in ambulances has been successfully piloted with broader roll out planned.

Areas of Focus

Priority areas identified to address sustainability and inequalities

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

We have selected areas of focus where:

- We believe we can make a real difference in patient outcomes by working as a regional health system
- The region particularly wants to see improvement in current service arrangements and where working regionally will enable this to happen
- Our region hopes to improve value for money or to achieve productivity gains by working across services and organisations.

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

Key changes are signalled in this 2014-15 plan

Key changes for 2014/15

This year we have identified three areas where we will apply a stronger regional focus to achieve accelerated gains:

- Child Health
- Inequities and inequalities, particularly for our Maori population
- Health services for older people.

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

A new additional regional priority this year is Major Trauma. This is in line with national efforts to build a more structured and robust approach to major trauma.

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

Region wide commitment to the directions set out in this plan

Region Wide Engagement

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

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

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

Commitment and endorsement from leadership within the region

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

This Northern Region Health Plan has been submitted to each of the four DHB Boards for sign-off prior to submission to the MoH.

2. The Northern Region Context

National Direction

National directions provide one context for regional planning

Meeting The Minister's Expectations

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

Figure 3 : The Minister's Expectations

The Government's key expectations for the public health service in 2014/15 are:

- Achieving the national health targets
- Shorter wait times for surgery, diagnostics, cardiac and cancer care

In addition, health services are expected to support the Prime Minister's key result areas to support vulnerable children, through:

Achieving the immunisation target,

- Reducing the incidence of Rheumatic Fever, and
- Reducing violent assaults against children.

The Minister has articulated a strong emphasis on care closer to home to better manage people living with chronic conditions and older people. His expectations are this will be supported through:

- More integrated care between primary and hospital clinicians
- Primary care direct referral for diagnostics
- Clinical pathways
- Sharing of patient controlled health records.

DHBs and regions are expected to strongly support the implementation of the key Health Benefits Ltd savings programs, and work closely with key national agencies to achieve further gains in quality and efficiency.

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

From January 2014 Letter of Expectations

The Minister's expectation in 2014/15 is that DHBs will:

- Demonstrate a clear line of sight of key initiatives across the regional plans, DHB Annual Plans and the DHB Maori Health Plans
- Align closely with work programs of national entities, such as Pharmac, Health Workforce NZ, Health Quality & Safety Commission, and the National Health Commission.

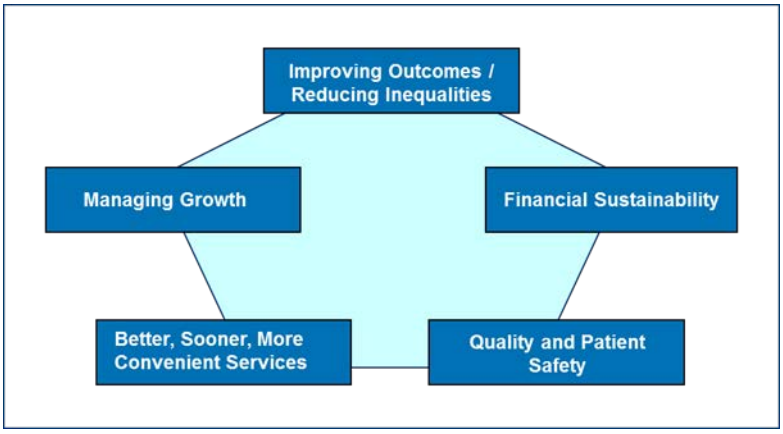
The Northern Region is committed to doing this and has set out in this plan an agenda that will achieve this over the three year horizon of the plan.

Drivers for Change

Our regional analysis has identified five key drivers of change

The Northern Region continues to face significant pressures that require substantive changes in the way we work. The key drivers of change are detailed in the diagram below:

Figure 4 : Northern Region - Key Drivers of Change



Outcomes / Inequalities

Improving health outcomes and reducing inequalities for, Maori, 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 Maori, do not receive equal:

- opportunity of access to the socio-economic determinants of health,
- access to healthcare
- quality of care.

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

life expectancy gap ranges from 7-11 years for Maori and 7-8 years for Pacific.

Health outcomes differ between population groups across the region:

- **Maori** comprise 13% of the region's population, with the highest proportion in Northland DHB (33%). Health outcomes for Maori 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 Maori, but has not closed the gap between Maori and non-Maori. Chronic conditions, smoking, obesity, and childhood illnesses are the key health problems for Maori
- **Pacific people** comprise 13% of our population, with the highest proportion in Counties Manukau (23%). Pacific peoples are a diverse group of people with unique culture, language and practices distinct to each Island. Generally, health outcomes for Pacific are better than for Maori, but still poorer than for non-Maori and non-Pacific. Diabetes, smoking, obesity, and childhood illnesses are the key health problems for Pacific people
- **Asian** comprise 22.5% of the Auckland regions population. Health concerns among Asian populations include stroke and CVD (Indian and other Asian groups); diabetes prevalence, including gestational diabetes, child oral health (all Asian groups), low cervical screening coverage (all Asian groups) and 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 affirmative 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

In the 2014/15 year the focus will be on conditions where these populations experience the highest need and where the greatest disparity in health exists, including:

- CVD, Diabetes and Cancer

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

- Child and Youth Health

  Inequalities in health outcomes for children and youth can be clearly seen across a range of measures. This region has unacceptably high rates of Sudden Unexpected Death of an Infant (SUDI) and Rheumatic Fever. Maori children and other high needs groups suffer disproportionately high incidence with significant impact on their chances of survival and long term outcomes.

- Health of Older People

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

- Mental Health

  An estimated 200,000 adults living in the region will experience a mental health disorder in the next 12 months. A small proportion will have a serious disorder requiring intensive input from mental health services. Maori 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. Maori 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 whanau and family.

Each of the above areas is also highlighted in each DHB's Maori Health Plan. These plans identify priorities within each district to reduce the inequalities of health for Maori.

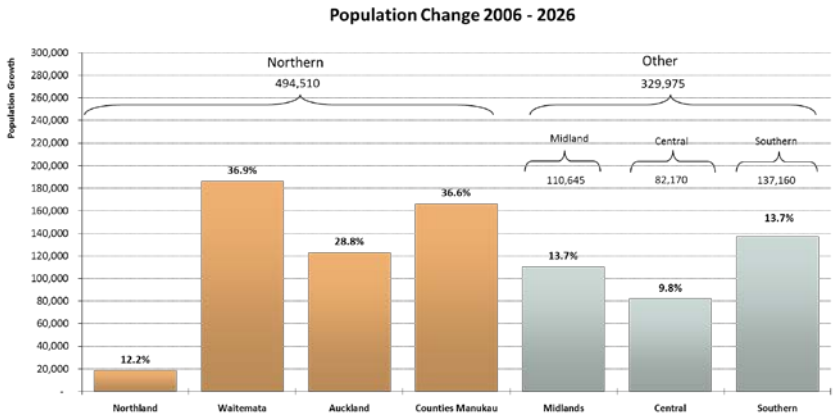
Managing Growth

Developing models of care for a growing and aging population

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

- Over the next 20 years the Northern Region population growth will account for two out of every three additional people in New Zealand
- The scale of our region's population growth expected over this period is greater than the current population of any other DHB.
- The scale of the population growth in any of our metro DHBs is larger than the expected population growth in any other region

Figure 5 : Population Change 2006 - 2026[2]



[2] Sourced from Statistics New Zealand Population Projection for 2006 and 2026 (2013 Update)

Demographic changes will generate significant demand for health services

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

- High growth in the older population. The high proportion of the 65+ age group, particularly in Waitemata DHB, is likely to generate disproportionate demand for health services
- High growth in the Asian population, with a 30 % increase in the metro Auckland DHBs over the past 5 years
- Significant unmet health needs in the Maori, Pacific, Asian and MELAA populations
- High birth rates. The region accounts for more than 40% of all births in New Zealand
- Ongoing and increasing demand particularly on acute health services associated with the leading causes of morbidity and mortality in our region: cancer, cardiovascular disease, diabetes, mental health and respiratory disease.

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

Social services also need to respond to population growth

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

Demand for certain health services is significantly higher than population growth

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

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 manage 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 for example pharmacists. A strong multidisciplinary approach will mean better coordinated health 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 whanau ora approach is also a key feature, where individuals and their family / whanau are supported to achieve their maximum health and well-being.

The Alliance Partnerships are at the forefront of this approach. Over the course of the year they will develop new models of care and work towards alignment of the workforce to fit the new approach.

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 the community. This will take the form of locality-based health networks to 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.

The northern region focus to improve quality and patient safety is aligned to the Health Quality and Safety Commission's work, particularly around falls, medication safety and healthcare-associated infections. Improving the patient journey through the system, and addressing issues relating to patient safety across all health services, will be key drivers of future models of care. Further development of the DHB Quality Account mechanism and the alignment of DHB approaches will support this focus on quality and patient safety.

Financial

Financial pressures are significant as costs are growing 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
- Very 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. An understanding of the interrelationships between change initiatives and all service delivery mechanisms, as well as the timing of any change related costs is critical.

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

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

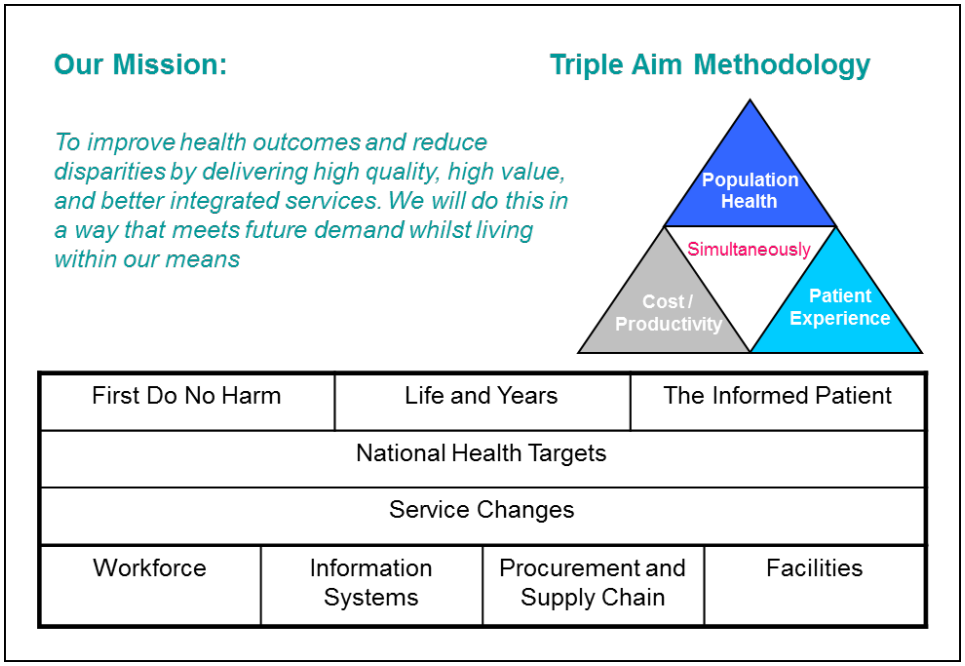
3. Our Direction

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

Northern Region Charter

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

Figure 6 : Northern Region Direction



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 Maori, Pacific and high needs families/Whanau
- 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
- Invest in workforce, information technology 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 Whanau 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

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

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

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

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

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

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

Our Intervention Logic

Our interventions must achieve our Mission within the Triple Aim

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

- Population health: Lifting the health outcomes of the 1.7 million people

Framework

living in this region and reducing health inequalities

- Service cost productivity: Ensuring we have the capacity to meet demand whilst living within our means
- Patient experience: Delivering better services and improving performance.

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

Three key priority goals shape our direction

The region has identified three goals. These are:

- First, Do No Harm - Reducing harm and improving patient safety
- Life and Years - Reducing disparities and achieving longer, healthier and more productive lives
- The Informed Patient - Ensuring patients and their whanau get care, information and support appropriate to their context.

Emphasising regional performance against National Health Targets

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

The regional priority goals have been identified by consideration of:

- Determinants of health and risk factors in our region
- Morbidity and mortality rates in our populations
- Evidence that change can be achieved and that:
  - 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.

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

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

- Closing the wide inequalities in health status and life expectancy, particularly for Maori and Pacific people
- Greater consistency, quality and safety
- Slowed growth in morbidity in our patients, and with that, demand on our health services
- More involvement of our patients in their care and easier access to care as they navigate through different services
- Wise investment decisions
- Clinical workforce developed in different ways to deliver innovative models of care
- Slowed financial cost growth of health services.

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

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

During 2014/15, we will continue to progress work across our region and across the full continuum of care in relation to each of the areas previously identified. Some work will be best co-ordinated and delivered by local agencies ie DHBs or PHO Alliance Partners. Other work will be progressed by regional resources.

We will seek greater emphasis on the actions which will achieve significant improvements in patient outcomes. We will do this by supporting and challenging the clinical networks and clinical leaders to prioritise the initiatives which will have the greatest impacts.

We will also focus more on the specific performance targets each priority area has identified. This is designed to focus our attention on the areas which really matter, and to demonstrate the changes in patient outcomes.

Clear line of sight of contribution to regional objectives

This year we will indicate more clearly the linkages across the program of work to demonstrate how each entity in our health system contributes to achieving regional objectives. This 'line of sight' clarification work will continue within our planning processes as we progress work across our region and across the full continuum of care.

Ensuring the sustainability of services in the future

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

Future Landscape

Adopting a new approach to healthcare provision

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

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

Figure 7 : Vision for Stakeholder Behaviour

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

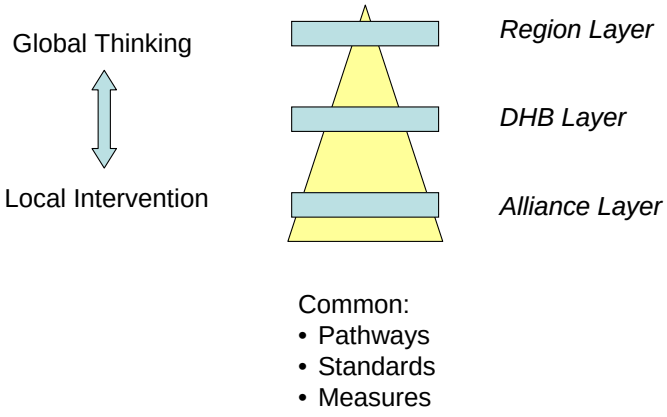
These new behaviours will be underpinned by the new strategic directions signalled in DHB and regional plans and the primary care Alliance Partnerships. At a high level strong, cross-sectoral, governance will drive and sustain change, supported by a performance framework which incentivises optimal performance. New models of care that optimise self-directed care for patients and whanau will progressively be introduced across primary care, and 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 will play a key role as the building block for the delivery of integrated care.

Figure 8 : Integration Across Services



The three 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. The networks provide a framework for horizontal and vertical integration of services
- 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 are established by the region to drive change and improve health outcomes for diseases and conditions which have a significant impact on our population and on our health services.

Upstream determinants of health will be a key focus

Relationships with other agencies 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 Maori

Health gains for Maori is a critical step we need to achieve

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

In the future landscape our Maori population will be more involved in decision making about their health choices and Maori 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 Maori 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 Maori patients.

The effort made today to encourage good health behaviour to support Maori 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. Maori 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. The region will continue to implement the NHITB and Regional Information Strategies
- Planning facility developments to support changed models of care. Our current hospitals will grow more slowly in the future as models of care change to support the integration of services and the management of patients in other care settings
- Being smarter about how we use our workforce, so that our staff is supported to work at the top of their scope, and we share resources to better manage after-hours rosters and spread the expertise of the highly specialised workforce across the region. Our training hub will drive workforce development in the region
- Leveraging opportunities in the Procurement and Supply Chain to realise cost savings together with greater consistency of product and more efficient processes.

Clinical Leadership

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 their services to meet future health needs. Consistency of care and cost effective care will continue to be key drivers for the networks.

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

Maturing Partnerships

Continuing to harness the strength of our intellectual

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

and physical resources

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

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

4. Our Priority Goals

Key changes signalled in the 2014/15 Plan

This plan states the region's priorities for 2014/15. The focus areas remain the same as previously, with the addition of Major Trauma. However, a key change this year is the stronger regional focus to achieve accelerated gains in three priority areas: child health, inequities and inequalities, and health of older people.

This year there will also be greater clarity around the 'line of sight' of actions and targets between the DHB Annual Plans and this regional plan.

Our clinical networks will continue to be the key mechanism to drive change and design and implement new initiatives. There will be a stronger focus on clinical integration between hospital and community based service, and the success of the priorities outlined in this plan will 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.

We will continue to work on previously agreed 'key areas' for gains

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

- Goal One - First, Do No Harm:
  - Reducing harm and improving patient safety
- Goal Two - Life and Years:
  - Reducing disparities and achieving longer, healthier and more productive lives
- Goal Three - The Informed Patient:
  - Ensuring patients get care, information and support appropriate to their context.

We have three particular areas of emphasis during 2014/15

Three particular areas of work will be emphasised by the Northern region this year. There will be a strong regional focus placed on three priority areas:

- Child Health
- Inequities and Inequalities
- Health of Older People.

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

The following table summarises all the Regional work priorities by key area of gain, highlighting the three particular areas of regional emphasis for 2014/15.

Table 2 : Priorities by Key Areas of Gain

Key Area for Gain	Focussed Work Priorities (work streams)
First Do no Harm	*First, Do no Harm*
Life and Years	Northern Region 2014/15 three areas of particular emphasis: • **Child Health** • **Inequities and Inequalities** • **Health of Older People** Cancer Cardiovascular Disease Diabetes Major Trauma Mental Health and Addiction Stroke Youth Health
The Informed Patient	Advanced Care Planning

Goal One: First, Do No Harm

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

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

By adopting a regional approach to certain initiatives we aim to achieve a focussed effort on improving the quality and safety of our health system. Opportunities exist to work across organisation boundaries to enhance the consistency of care and to improve the safety and quality of service delivery.

Our work plan is aligned with the national patient safety campaign *Open for better care* in the Northern Region and we will work in partnership to support the patient safety objectives of the national campaign in the Northern Region. The national campaign will also enhance the current regional initiatives.

Since 2013, our DHBs have been required to publish a Quality Account to provide a view of how quality health care is being delivered in our region.

What we want to achieve

Our targets for 2014/15 are:

- Monitor regional performance on national patient safety campaign, *Open for better care*, quality and safety markers
- Reduction of falls causing major harm in the acute sector to a rate of less than 0.07 per 1000 bed days
- 20% reduction in falls causing major harm in those age-related residential care (ARRC) facilities that have implemented a programme
- Percentage of ARRC facilities implementing a falls and pressure injuries reduction programme will move from 40% to 75%
- Reduction in pressure injuries grades 3 and 4 to zero ('never events') in the acute sector
- 20% reduction in pressure injuries in those ARRC facilities that have implemented a programme.

How we will achieve these outcomes

We will build on the progress made over the previous period by broadening implementation within key areas to address a whole of systems approach, involve consumers as partners in this work, and target areas of high incidence of harm.

- Improved patient outcomes
  - Track patient outcome measures and support learning from the data.
  - Support the spread of falls and pressure injury strategies
  - Utilise the region's Global Trigger Tool data to support quality improvement activities and knowledge
  - Develop the plan and detail initiatives to reduce adverse medication events in conjunction with national medication safety activities
  - Focus on healthcare-associated infection as a leading cause of harm
- Whole of system care
  - Engage with consumers to reduce healthcare associated harm
  - Utilise various communication channels to promote sector-wide engagement in key campaign areas
  - Progress regional work on reducing falls and pressure injuries
  - Strengthen planning and delivery of services in partnership with residential aged care
  - Align with other work programmes and agency initiatives (i.e. Health of Older People Clinical Network, Health Quality & Safety Commission, Ministry of Health) including the development of national patient safety campaign activities
  - The national Quality and Safety Markers (QSMs) will be incorporated into the KPIs for the regional programme
  - Regional improvement is facilitated through regional learning events and communication channels such as First Do No Harm website, e-newsletter and overseen by First Do No Harm Steering Group

Goal Two: Life and Years

Ten 'Life and Years' priorities, of which three are areas of particular emphasis during 2014/15

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

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

An overview of each priority work area is outlined below, commencing with the three areas of particular emphasis for our Region during 2014/15.

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

We will also introduce Major Trauma as a regional workstream during 2014/15; in accordance with national directions and regional needs.

Child health is our first particular area of emphasis during 2014/15

Child Health

The Northern Region is committed to lifting the health of the young people in the region. Most children born or living in the region enjoy good health, but some do not. The distribution of poor health is marked by significant socio-economic and ethnic differences. Those children who experience significant deprivation often have the highest health needs limiting their social, educational and physical potential. These children grow into adults with lower life expectancy and greater burden of diseases.

Key challenges for child and youth health include:

- Around 62% of infants who die because of Sudden Unexpected Death of an Infant (SUDI) are Maori
- The rate of rheumatic fever in the region is the highest in the country, with Counties Manukau and Northland most affected
- Socially disadvantaged children are more likely to be hospitalised for chronic respiratory tract conditions
- The rate of hospitalisation for skin infections in New Zealand children has doubled in the last 10 years and is double the rate observed in Australia and the US.

Unintentional injury is the leading cause of mortality in New Zealand children, with motor vehicle accidents the leading cause of death.

What we want to achieve

This year we aim to achieve:

- 10% reduction in first episode hospitalisation for Rheumatic Fever
- Over 40,000 school children receive better access to primary care for Group A Streptococcal throat infections, and skin infections
- Implementation of a regional SUDI Action Plan
- 40% reduction in hospitalisation rate of serious skin infections for children aged 5-14
- Clinical guidelines and algorithms for skin infections and LRTIs implemented in 50% of GP practices.

How we will achieve these outcomes

This year the Child Health Network will continue to develop the five priority areas to reduce the incidence, particularly in Maori and Pacific children of:

- Sudden unexpected death of an infant (SUDI)
- Rheumatic Fever
- Accidental injuries
- Skin infections
- Respiratory Tract Conditions.

In addition, the network will lead key health initiatives within the Auckland and Northland Councils for immunisation and rheumatic fever, and support work around more early childhood education and protecting children with high health needs. This work is in line with the effort to deliver on the Better Public Services initiatives. Northland DHB will be an early adopter of the Children's Team concept in line with the Child Action Plan. Population health approaches for children will also be strengthened across primary and secondary care, so that the most high needs children are supported with targeted health and social initiatives.

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

Inequities and Inequalities

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

Our region is committed to improving health outcomes and access. We will have a focus on those populations which experience poor health outcomes and unequal access to health care, or whose housing, income and education is inadequate to support good health. This applies particularly to Maori and Pacific peoples. 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.

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

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

- **Regional** commitment to focus on three areas for Maori: youth health, oral health and tobacco control. This commitment is signalled through this Plan to measure performance and support local and regional initiatives. **Local commitment** to implement the Maori 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 meet the local health needs within the context of each district.

- The Government's **Whanau Ora program** which has developed the Whanau Ora and Fanau Ola holistic approaches to health and wellbeing that acknowledge Mâori and Pasifika paradigms. The intent is to work through commissioning agents to deliver outcome goals that enable whanau and families to be self-managing and empowered to live healthy lifestyles and participate in society. There is a strong emphasis on participating in teao Maori (the Maori world) and being economically secure and resilient. Two agents are appointed: Te Pou Matakana and Pasifika Futures to increase capability across a range of areas including income generation, literacy for health and technology, effective parenting and supporting cultural language and customs. This region will develop relationships and common priorities with the commissioning agents, and augment DHB specific activities with other providers who deliver whanau ora services.
- **Auckland Region Settlement Strategy** improves access for non-English speaking groups and culturally and linguistically diverse background communities to health and disability services and supports in the Auckland region. Areas of focus include: the Primary Health Interpreting Service to support non-English speakers to access primary care and engage effectively with their clinician, and the Culturally and Linguistically Diverse Cultural Competency training for health staff to support equitable access to clinically and culturally appropriate health services.

The focus of this Plan in 2014-15 is to deliver on the regional commitment.

What we want to achieve

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

- 95% of smokers who are hospitalised and 90% of enrolled patients who are seen by a health practitioner are offered brief advice and support to quit
- Access rates for Maori and Pacific to Youth Forensic service tracked
- 1.25% of those aged between 12 &19 years old accessing specialist AOD services
- 86% of pre-school children enrolled in DHB-funded oral health services
- 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

How we will achieve these outcomes

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

- The Maori health dashboard will be implemented to track progress against our National Health targets, Maori Health Plan indicators and a set of regional health indicators
- Local and regional workforce development will continue to support more Maori and Pacific into health careers, and professional development for potential leaders, and cultural competency training.
- Local and regional initiatives to improve oral health, youth health, and tobacco control for Maori
- Develop relationships and share common priorities with the Whanau Ora Commissioning agents to implement whanau ora

Our third area of particular emphasis is Health of Older People

Health of Older People

New Zealand population projections suggest that by 2031 one in five New Zealanders will be aged over 65 years. Longevity is increasing and the proportion of New Zealanders in the 85-plus age bracket is growing rapidly. Average life expectancy for New Zealanders at their 65th birthday is now 21 years for females and 19 years for males. In 2013 there were 191,000 people aged over 65 years living in the northern region (12.2% of the total population), of those, 22,500 were aged 85 years or over[4].

Older people in New Zealand are healthier than they have ever been and more active within their communities. However, the rapidly growing population of older people means that increasing numbers will require support from health and other services.

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

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

Approximately $500 million is spent each year on Northern Region health services specifically for older people (approximately 200 Age Related Residential Care providers, and numerous Home and Community Based Care services)[5]. This amount excludes the cost of acute and elective inpatient care in public hospitals for this age group.

Varying standards of residential care have come under the spotlight in recent years with opportunities to improve quality. Research also shows that 75% of older people in institutional care in New Zealand do not want to be there[6].

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

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

A regional approach is required, as:

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[4] Statistics NZ

[5] Northern Region Health of Older Person Service Utilisation Report, NRA, June 2013

[6] Parsons et al, ASPIRE Study, MoH 2006

- These challenges affect all our DHBs.
- Most 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).

What we want to achieve

Our key performance measures include:

- % of primary care clinicians utilising the electronic dementia care pathway
- 20% reduction in falls causing major harm in those age-related residential care (ARRC) facilities that have implemented a programme
- 20% reduction in pressure injuries in those ARRC facilities that have implemented a programme
- Proportion of ARRC facilities that have implemented a falls and pressure injury reduction programme will increase from 30% to 75%
- % of ARRC residents with completed InterRAI LTCF assessment.
- 65% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 12 months.

How we will achieve these outcomes

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

- Supporting consistent assessment processes for people requiring long term support by:
  - Supporting implementation of interRAI to ARRC sector
  - Increasing the number of people on supports undergoing reassessments of needs eg psychogeriatric care.
- Planning for growth in demand for dementia and acute services by:
  - Developing region wide dementia diagnosis and management programmes for primary care
  - Developing alternative assessment and treatment options aimed at keeping people well and supported in their communities for longer eg integrated dementia care pathways
  - Develop a suite of resources for Healthcare professionals to use eg electronic pathways
- Strengthening care in ARRC and Home Based Care by:
  - Increasing support to ARRC by specialist services and building closer relationships with the ARRC sector eg contracting
  - Rolling out targeted programmes in ARRC such as Pressure Injury prevention.
  - Ensuring consistent high quality care across a range of community settings eg psychogeriatric care.
  - Collaborating with other programmes and agency initiatives eg Falls prevention
- Prevent future deterioration by:
  - Identify and implement disease prevention programmes eg Fracture Liaison Services
- Support information sharing and transfer to support these initiatives eg interRAI.

Cancer Services

Cancer is a significant and growing issue for our region

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

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

- A population that is both ageing and growing (Northern Region cancer registrations are predicted to increase from 6,000 to 9,000 in 15 years).
- $295m per annum estimated cost for cancer care in this region, expected to rise nationally by $117million over the next 15 years
- Major clinical workforce shortages
- Sustainable delivery of faster cancer treatment goals and tumour stream pathways will require innovative changes to models of care.

What we want to achieve

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

- Radiation therapy
- Chemotherapy treatment

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

- First Treatment (or other management) within 31 days from when the decision to treat was made
- First Treatment within 62 days from referral to first cancer treatment (or other management). New Health Target commences 1 October 2014 with the target achievement rate of 85% by 1 July 2016

Improving Wait Times for Colonoscopy

- 75% of people accepted for an urgent diagnostic colonoscopy receive their procedure within 14 days.
- 60% of patients accepted for a diagnostic colonoscopy receive their procedure within 42 days
- 60% of people waiting for a surveillance colonoscopy receive their procedure within 84 days.

How we will achieve these outcomes

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

- Faster cancer treatment
- Improving the functionality and coverage of multi-disciplinary meetings (MDMs)
- Implementing national medical oncology models of care where prioritised
- Reviewing regional progress against nominated national tumour standards, and prioritising service improvements
- Service development for specific cancer care:
  - Identify and implement regional priorities for prostate cancer
  - Continue to support the bowel screening pilot
  - Implement the Endoscopy Quality Improvement work
  - Support the implementation of the new Bone Marrow Transplant service
- Work nationally and regionally to progress a regional non-surgical patient management system
- Supporting DHBs with regard to Cancer Nurse Coordinators in professional development
- Telehealth to support the provision of oncology service
- Colonoscopy policy priorities to analyse the production planning requirements and develop strategies to support the region to meet its wait time targets for colonoscopy
- Conduct an equity assessment across faster cancer treatment, lung cancer and colonoscopy.

Cardiovascular Disease

We will reduce the growth and burden of cardiovascular disease

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

Key challenges related to cardiovascular disease include:

- Cardiovascular disease as the second leading cause of death has disproportionately high rates in Maori and those from low socio-economic areas
- Many of the CVD events in younger patients are preventable
- We spend around $440m each year on patients with CVD related diseases (excluding primary care costs).

What we want to achieve

Our measures this year are to:

- Maintain cardiac surgery to nationally agreed targets
- 90% of outpatient coronary angiograms to be seen within 3 months
- 70% of patients referred for angiography presenting with Acute Coronary Syndrome (ACS) to be seen within 3 days of admission
- 80% of patients presenting with ST elevation myocardial infarction [STEMI] referred for percutaneous coronary intervention [PCI] will be treated within 120 minutes
- 80% of all out-patients triaged to chest pain clinics to be seen within six weeks for cardiology assessment and stress test
- Aim for 95 % of outpatient echocardiograms to have been completed within 5 months of referral
- 90% of eligible patients will have had a cardiovascular risk assessment in the last five years.
- 95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection
- Aim for implementation of Accelerated Chest Pain Pathways (as per Minister's HealthReport)

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
  - Host an Allied Health regional forum to share existing models of care.
  - Develop a process to maintain ACS guidelines as a living document to allow for continuous improvement
  - Progress the Regional Primary PCI service developed in collaboration with St John's Ambulance Services and Emergency Departments
  - Develop a regional plan for Electrophysiology Services
- Implement ANZACS QI in NDHB and continue to provide ongoing support for use of KPI reporting and ACS quality improvement throughout the region
- Continue to improve access to Echo-cardiogram to support diagnosis of Heart Failure and other conditions including those requiring cardiac surgery
- Support / improve development of three primary care pathways.

Diabetes

We will reduce the growth and burden of diabetes

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

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

Key challenges for diabetes include:

- Nearly 82,000 people in the region have diabetes
- By 2026 this is expected to increase by 82%
- Certain ethnic groups experience higher rates of the disease, particularly Maori, South Asian and Pacific
- The conservative estimated costs of diabetes in this region are approximately $365m annually, excluding primary care costs
- A fast growing pre-diabetic population.

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
- Improving percentage of Diabetes patients on diabetic medications
- Improving percentage of Diabetes patients on lipid lowering medication
- Improving percentage of Diabetes patients on blood pressure medication
- Improving percentage of Diabetic patients being monitored for HbA1c levels
- Improving percentage of CVD patients with Diabetes on diabetes medications (all 3)
- Percentage of Diabetes patients tested for microalbuminuria and on ACE or ARB
- 37,000 people undergo retinal screening.

How we will achieve these outcomes

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

- Implementation of a revised Diabetes Self-Management Education (DSME) to better engage and empower patients with Type 2 diabetes
- Develop a referral pathway to improve DSME access especially for high risk groups
- Improve patient management in primary care settings to:
  - increase the rate of insulin initiation,
  - increase the rate of high-risk foot management
  - maximise the opportunities to identify and better manage diabetic patients via CVD risk assessment
- Workforce development across the sector will occur by supporting enhanced utilisation of the nurse and allied health workforce and supporting alternative models of care such as Nurse Led Clinics. This will occur in collaboration with key stakeholders e.g. Regional Professional Forums, Localities and local Networks, Workforce and training Hub, Health Workforce New Zealand (HWNZ), NZSSD

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

Introducing a systems approach to Major Trauma

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

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

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

What we want to achieve

We will be developing our key performance measures over the coming year.

How we will achieve these outcomes

In this first year as a regional priority, the intent to introduce a more formal and structured trauma system will focus on three key areas:

- Strengthen clinical governance through supporting the clinical leads and trauma coordinators in each DHB. Other activities will include auditing trauma cases, reviewing the trauma system, KPI development and implementing initiatives to improve consistency of care and efficiency
- Implement Regional Trauma Registry to provide good quality trauma data which is tailored to meet the needs of the region and links to the National Major Trauma Registry
- Implement pre-hospital destination protocols so that patients are taken to the right hospital for definitive care. This will focus on paediatrics initially and later for adults

Mental Health and Addiction Services

Mental health and wellbeing is everyone's business[7]

Mental Health & Addiction encompass a broad array of illnesses and conditions across the life course of people where social and environmental factors become implicated in both the illness progression and the recovery. The array of mental health & addiction illnesses carries one of the highest burdens for individuals, their families, their whanau and our communities.

Key challenges associated with mental health and addiction relate to:

- Adverse life events in childhood and adolescence driving the development of psychological issues and life course impacts
- The loss of functioning associated with severe mental illness limiting the capacity of people to fully engage in relationships, in employment and in society.
- The complexity that arises from the co-morbidities of psychological and physical health problems, and other complicating social factors.

One environmental challenge affecting the Northern Region Mental Health and Addiction services is that in 2015 a new Prison will open in Wiri, South Auckland. An increased prison muster of 960 people in the Northern region will require a response from both forensic and general mental health and addiction services, as well as physical health services.

[7] Mental Health Commission. 2012. *Blueprint II: How things need to be.* Wellington

The Ministry of Heath publication, 'Rising to the Challenge', sets out the development plan for Mental Health and Addiction Services.

Figure 9 : Rising to the Challenge

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

This Northern Region Health Plan encompasses:

- The priority service development actions from 2012 until 2017 as identified in the Ministry of health's Mental Health and Addiction Service Development 'Rising to the Challenge' plan
- The five key objectives, as identified in the 2014-15 Ministry toolkit for Regional Service Plans
- The eight actions that DHBs are required to progress as part of the District Annual Planning process
- A number of objectives that the Northern region has carried forward from 2013-14

Our regional plan also recognises the health disparities for people with experience of mental illness or addictions, and the inequalities in outcomes for Maori and Pacific. Within the ongoing regional work programme we will continue to address these issues through:

- Supporting the achievement of smokefree objectives within the region
- Supporting local, regional and national responses to KPI programme information, utilising stratified ethnicity data to monitor and respond to variations through quality improvement initiatives
- Ensuring workforce initiatives identify opportunities to develop the Maori and Pacific mental health and addictions workforce
- Providing, and supporting the use of, PRIMHD data to NGOs to improve data integrity, and support decision making and service development

We recognise the need for greater integration between primary, secondary and community services. The Northern region will ensure locally responsive services complement regionally delivered services.

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Our objectives for 2014/15 are to:

- Improve availability of and access to the range of eating disorder services (EDS)
- Improve adult forensic service capacity and responsiveness through the national forensic network
- Improve capacity and responsiveness of youth forensic services
- Improve perinatal and infant mental health service options as part of a service continuum
- Increase capacity and improve responsiveness of mental health and addiction services for people with high and/or complex needs,
- Increase access by young people to specialist Alcohol and Other Drug (AOD) services
- Determine appropriate forensic and general mental health and addiction services capability and capacity to meet the growing prison muster
- Improve secondary service support to primary care settings

How we will achieve these outcomes

The Northern Region Mental Health and Addictions Team will continue to build capacity and improve the responsiveness of services to individuals, their family/whanau and the community by working collaboratively with:

- The Youth network to support implementation of the Prime Minister's Youth Mental Health Initiative, and to progress the development of a Youth Forensic reporting framework (including exploration of access by young Māori and Pacific in the Youth Justice system)
- The specialist addiction sector to continue to build access rates for young people to these services
- The Health of Older People network to improve mental health services delivered in aged care residential settings.
- key stakeholders to implement the agreed adjustments to the Eating Disorders model of care
- The Ministry and Waitemata DHB to establish secure inpatient capacity for people with high and/or complex needs
- The DHBs to establish a regionally collaborative mechanism to coordinated access to services for people with high and/or complex needs
- Serco and the Department of Corrections to determine appropriate responses to meet the needs of prisoners both locally and regionally, including monitoring that the rate of prisoner admissions to forensic inpatient services that meet the agreed acute & sub-acute targets is maintained or increased
- Maternity and Midwifery services to establish and embed new Acute Perinatal and Infant mental health service options.

In addition we will progress work to identify the workforce requirements to deliver the adjusted and/or enhanced models of care in:

- Youth Forensics, including application of the additional Youth Forensic FTE available in 2014-15
- Eating Disorders
- Acute Perinatal & Infant Mental Health.

Stroke

Stroke is a significant cause of death and disability

The impact of stroke on individuals and their whanau / 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 TIA's often provide good warning that a stroke is imminent. Good care of an acute stroke patient will improve the chances of survival and recovery.

Key challenges:

- Stroke is the third largest killer in New Zealand (about 2500 people every year). Around 10 percent of stroke deaths occur in people under 65
- 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.
- Stroke is largely preventable, yet about 9000 New Zealanders every year have a stroke
- On average, Maaori and Pacific people suffer strokes 10 years younger, and have worse outcomes, compared to New Zealand Europeans.

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 2014/15 we want to achieve further gains in preventing stroke and improve the quality of care we provide for people who have had strokes. Specifically we want to achieve:

- 8% of acute ischaemic stroke patients are thrombolysed
- 80% of patients who have had an acute stroke are treated in a stroke unit
- Proportion of people with acute stroke who are transferred to inpatient rehabilitation services
- Proportion of people with acute stroke who are transferred within 10 days of acute stroke admission; target 60%

How will we achieve these outcomes

Over recent years the Northern Region has invested in improving the management of stroke services. The Northern Region Stroke Interest Group, which is a multidisciplinary clinical group, 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 Maori and other ethnic groups, and instigate actions to address inequities.

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

Youth Health

The Northern Region is committed to lifting the health of the young people within the region. Inequities can be clearly seen across a range of measures relating to youth with Maori young people and Pacific young people experience poorer health than other young people.

Key areas youth health will focus on are:

- School based health services
- Access to primary care
- Sexual health
- Mental health.

What we want to achieve

This year we aim to:

- Agree improved standards of care for school based services.
- Progress towards development/ agreement of standards for delivery of care for youth in other primary care settings.
- Progress towards development/ agreement of standards for delivery of developmentally appropriate care for young people in secondary care, including the interface with primary care.
- Implement the Prime Ministers initiative for youth mental health.

How we will achieve these outcomes

To progress our aims we will:

- Develop clinical outcome measures for reporting
- Explore and develop standards of care for school based services
- Review and further develop standards of care for services and clinicians working in other primary care settings
- Review and further develop standards of care for delivery of developmentally appropriate care for young people in secondary care settings
- Support improved access to mental health services – both in secondary and primary care.

Goal Three: The Informed Patient

Engage patients and their families in decisions about care

The objective of this goal is to achieve greater patient participation and improved health care through patients being better informed across the full health spectrum; from prevention and early diagnosis to better treatment of disease. The outcomes we want to achieve from this work include:

- A greater sense of individual ownership and responsibility toward health
- Reduction of unplanned care and avoidance of acute presentations at hospital emergency departments
- Increased patient compliance with treatments and care plans
- Involvement of patients and their whanau in decisions about care options
- Increased health literacy, awareness and knowledge among our population to ensure early decisions to seek diagnosis and care.

Tools to improve patient information or patient communication should be developed or reviewed with consumer input and to best practice health literacy guidelines

We are targeting Advance Care Planning as a specific regional action against Goal Three. The themes of enhancing self-directed care, individual ownership and responsibility are also developed within our other work areas; particularly those relating to:

- Goal Two - Life and Years
- Enablers - IS/IT.

Engaging patients and their whanau in decision about care

Advance Care Planning ACP

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

Key Challenges

The key challenges with regard to advance care planning are:

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

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

What we want to achieve

Our aim is to improve communication between patients/whanau and clinicians around their end of life care and treatment. Patients and their whanau require more, and clearer, information to enable them to make informed choices.

This year our key performance measures are:

- A 20% increase in patients having ACP conversations (measured against the respective DHBs total number of conversations in 2013/14)
- Health workforce training in the Northern Region including:
  - Deliver 13 ACP Level 2 training workshops
  - Train 123 L2 ACP Practitioners (95% attendance at 13 courses)
- Conversations that Count consumer awareness campaign
- "Conversations That Count" train-the-trainer programme consolidated, and 12 consumers trained to deliver this programme.

How we will achieve these outcomes

We will continue to build on the progress made since 2011/12 and will:

- Train and raise awareness in ACP for the health workforce including primary care
- Strengthen consumer and wider community engagement through:
  - Awareness of ACP and its benefits in the wider community
  - Resources development to meet the specific needs of Maori, Pacific and Asian consumers
- Develop the programme infrastructure model to support ongoing

continuous quality improvement initiatives such as evaluation tools, production of communications material and measurement processes

- Strengthen planning and delivery of services through supporting:
  - Local DHB ACP deployment teams
  - Development of DHB policies and procedures.

National Health Targets

We are committed to achieving the National Health Targets

We have made significant progress towards achieving the National Health Targets since they were introduced. The regional priorities we have developed for 2014/15 are aligned and complementary to our focus on health targets. The National Health Targets for 2014/15 are shown in the table below:

Table 3 : National Health Targets

Shorter stays in emergency departments	95% of patients will be admitted, discharged, or transferred from an Emergency Department within six hours.
Improved access to elective surgery	The volume of national elective surgery will be increased by at least 4,000 discharges per year; of which 2,118 discharges will relate to the Northern Region.
Shorter waits for cancer treatment	All patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy.
Increased immunisation	95% of eight month olds will have their primary course of immunisation on time by July 2015.
Better help for smokers to quit	95% of patients who smoke and are seen by a health practitioner in public hospitals and 90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.
More heart and diabetes checks	90% of the eligible population will have had their cardiovascular risk assessed in the last five years.

Top 10 Patient-Focused Regional Commitments for 2014/15

During 2014/15 we are committed to achieving the key targets set out below:

Table 4 : Top-10 Patient Focussed Regional Commitments for 2014/15

All Interventions 1. Achieve and maintain the Minister's health targets
First, Do No Harm 2. Reduction in falls causing major harm in the acute sector to a rate of less than 0.07 per 1,000 bed days
Life and Years 3. 86% of Well Child Tamariki Ora core checks in first year all completed by December 2014 (rising to 95% by June 2016) 4. % of ARRC residents with completed InterRAI assessment and associated care plan 5. 80% of patients who have a stroke are treated on a stroke unit 6. 80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes, 7. Improvement in the % of patients referred urgently with a high suspicion of cancer receiving their first cancer treatment (or other management) within 62 days from date of referral (achievement of the 85% Health Target by July 2016) 8. 1.25% of young people aged between 12 and19 years old are accessing specialist Alcohol and Other Drug (AOD) services (quarter 4) 9. 37,000 patients undergo retinal screening
The Informed Patient 10. A 20% increase on the 2013/14 end of year ACP conversations documented by each of the four DHBs
We will investigate the opportunity to analyse these measures by ethnicity and, where feasible and value adding, data collection mechanisms will be put in place to progress the inequalities / disparities workstream.

5. Service Planning

Implementing a whole of system approach with a staged change process

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

- Agreement on the principles and rules by which we work as one region
- Testing of new ideas
- Embedding of new ways of working, one step at a time.

Building on previous work, we will continue to adopt a regional focus on the following services:

- Laboratory
- Radiology
- Pharmacy
- Elective Services
- Other service planning.

Our overall aim in focussing on these services is to support clinical collaboration and advancements, cost-efficiency, improved access and timeliness of care and alignment across clinical services models of care.

Progress expected by service is detailed below. The implementation plans for each of the services is provided in Appendix A3.

Laboratory Services

Best utilisation of a skilled workforce and laboratory assets region wide is key to the delivery of sustainable laboratory services.

The Northern Region DHBs are working collaboratively to ensure a robust laboratory service is in place for all patients in the Northern Region. This requires strong clinical leadership and strong working relationships between all providers of laboratory services in the Northern Region.

Key challenges include:

- Growing volumes and workload being driven by population growth, an ageing population and changes in clinical practice
- A fragmented laboratory system with multiple laboratories in greater Auckland and in Northland
- Workforce shortages in some areas coupled with pressure for sub specialisation
- Pressures on anatomical pathology services to implement the recommendations arising from the Breast Biopsy Review, synoptic reporting, and implementation of new oncology models of care, faster cancer treatment and tumour stream implementation plans
- Increasing costs of providing services
- Maintaining clinical and patient confidence in laboratory services.

What we want to achieve

We want to ensure that the Northern Region's population has access to a high quality clinically and financially viable laboratory service, with regionally consistent work practices. Priority is being placed on:

- Ensuring the smooth transition of community referred anatomical pathology laboratory services
- Ensuring effective governance arrangements are in place
- Developing a robust long term direction to assist with key decision making regarding investment in laboratory facilities, effective workforce utilisation, effective management of services and future contracting arrangements
- Building resilience and future proofing the laboratory system to cater for changes in clinical practice and demand
- Working towards more standardised access levels and processes regionally.

How we will achieve this outcome

Over the next three years we will continue to build on the progress made recently to deliver:

- Smooth transition of community referred laboratory services
  - Clinically lead transition team established
  - Robust transition plan developed and supported by all parties to the agreement
  - Service levels defined and agreed between LabPlus and metro DHBs
  - Staged transition plan implemented with minimal adverse impacts for patients, referrers and staff
- Strengthened governance of laboratory services
  - Effective contract management with providers working to agreed KPIs
  - Strong clinical oversight of all regional laboratory work
  - Enhanced collaboration between the community and DHB Pathology workforce
- Development of a long term model of delivery for laboratory services that supports
  - Clinically and financially viable community and hospital laboratory services
  - Effective utilisation of all assets
  - Retention of specialist laboratory expertise
  - Cost effective service delivery
- Building resilience and future proofing for change
  - PC3 lab developed to support Auckland DHB's role as a national provider of TB service
  - Timely delivery of laboratory services linked with regional pilots (e.g. bowel screening, rheumatic fever)
- Enhanced consistency and alignment of work practices regionally
  - Timely delivery of accurate results to all referrers
  - All laboratory service providers meeting agreed KPIs
  - Test ordering appropriate with demand management being targeted in prioritised areas. Progressively aligning information systems to better support service delivery.

Radiology

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

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

Key challenges for radiology services include:

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

What we want to achieve

The Radiology targets for 2014/15 are:

- 75% of reports validated within 24 hours
- 5% DNA rate for outpatient and community referrals
- 90% wait time less than 6-weeks for CT
- 80% wait time less than 6 weeks for MR and ultrasound

How we will achieve these outcomes

This year the Regional Clinical Radiology Network will closely align its work program to the National Radiology Advisory Group, along with a focus on:

- Addressing the Sonography workforce shortage through:
    - Implementing the 12-week intensive training pilot
    - Advocating for set eligibility criteria for overseas candidates
    - Continuing the cross-sector collaboration
- Implementing the paediatric radiology service plan and developing new plans for other sub-speciality services
- Developing regional pricing model for inter-DHB Radiology work
- Develop and embed a regional radiology IS governance model to support current and future IS solutions and projects

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Pharmacy

Access to affordable and appropriate medications and medication management support

People need access to the right medications at the right time. However, population growth, our aging population and the increasing numbers of new medicines, together with the complexity of regimens, is putting increasing pressure on:

- Our budgets
- Prescribers' ability to ensure that all patients are receiving the right mix of medications
- Pharmacists ability to deliver the right level of medication management support according to patient need.

Community pharmacists, as the primary source for medications for most people, are a valuable resource within our communities. We must support ways to better harness their unique skill set. The new model of community pharmacy service delivery means that DHBs costs are managed within a fixed funding envelope and community pharmacists are to provide a level of service that meets an individual patient need.

Key challenges

Challenges include:

- The Community Pharmacy Services Agreement (CPSA) 2012 is the national agreement between community pharmacies in New Zealand and their local DHBs. Pharmacists are contracted to deliver a range of patient centric services according to patient need. However, as we enter the third year of a 3–year transition we still have little data available on the type and level of community pharmacy services that are being delivered and the outcomes of these
- Medication safety errors require systematic approaches to be adopted across the sector if we are to further reduce the risk and harm attributable to them.

What we want to achieve

The Region continues to support the new national community service model as a means to contain cost growth and to build a sustainable pharmacy model for the long term. Continuing to support integration of community pharmacy into primary/secondary care as a way of working is necessary and will support the developing localities-based approach.

Over the next one to two years we expect to see measurable improvements in key performance areas including:

- The implementation of the next stages of the national community pharmacy contract with a focus on improved patient care within predetermined financial constraints
- Better integration of community pharmacy and the primary care sector resulting in services that dovetail with localities initiatives
- Progressive roll out of medications safety initiatives and e-medication management applications across hospital and community settings.

How we will achieve these outcomes

We will work regionally to :

- Ensure the implementation of the next stages of the national pharmacy agreement within all pharmacies and that we leverage the full potential of this contract to:
  - Explore the range of potential initiatives to deliver better access to mental health, aged residential care, and primary care clients
  - Continue to develop substantial links between primary, secondary care services and community pharmacies consistent with a localities-based approach and patient needs
- Improve medication management by:
  - Participating in the pilot/roll-out of IT-enabled initiatives in the region including eShared Care, e-prescribing, eNZ Prescription Service and mechanisms of sharing relevant information between community pharmacy and other care team members.
  - Supporting initiatives to reduce harm from medication errors.

Elective Services

Ensuring timely access to elective surgery

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

The key challenges in our region include:

- Meeting the reduced wait time targets for First Specialist Appointment and treatment (ESPI 2 and ESPI 5) such that all patients wait 4 months or less for first specialist assessment and treatment from the end of December 2014.
- Disparity in intervention rates for elective surgery across our region
- 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 will impinge on our ability to deliver elective volumes.

What we want to achieve

The region is committed to meeting the shorter wait time target of

- 100% of patients receive First Specialist Appointment within four months by the end of 2014
- 100% of patients receive treatment within four months once the decision to treat has been made by the end of 2014,
- Maintain a maximum waiting time of four months from January 2015 for First Specialist Appointments and treatments.
- The region will deliver at least 54,118 elective surgery discharges.

We are also committed to regional capacity planning as well as continuous improvement and service delivery planning.

How will we achieve these outcomes

This year we will focus on:

- Implementation of initiatives to improve efficiency and productivity and completing activities under the regional Elective Services Productivity and Workforce Programme contract:
    - Implementation and continuous improvement of the regional reporting framework for elective services capacity planning
    - Implementation of the upper gastrointestinal pathway for NDHB domicile patients requiring care in Auckland Metro DHBs
    - Implementation of the eReferrals inter and intra DHB pilot in chest pain and angiography services
- Improving alignment and usage of clinical prioritisation tools across the region.

Other Service Planning

Service Planning and Development

Developing services to meet a dynamic and changing context

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

Services of regional importance identified for ongoing regional attention during 2014/15, include:

- Acute spinal cord impairment to implement a single location of service for these patients at Counties Manukau DHB
- Maxillo facial surgery to support a small and fragmented workforce
- Rehabilitation services to ensure that plans are based on consistent assumptions regarding patient flows and models of care and to identify whether there are any additional specialist rehabilitation services that would be best delivered in a centralised location
- Sexual Health Review with work initially focusing on Waitemata and Auckland DHBs with subsequent extension to Counties Manukau Health

In addition Auckland DHB will be reviewing the specification and costing of tertiary services. Findings may impact on the configuration and scope of some services.

Collaborative service development models

In a new initiative being led by the DHB Chairs, our region will promote rational regional service distribution that:

- Strengthens the region overall
- Creates the opportunity for certain services to be delivered locally
- Does not destabilise any particular DHB.

To this end the plan is to set in place a moratorium on service repatriation and, in

the place of service repatriation, to have 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. Immediate areas of focus are the services of:

- Ophthalmology service provision in the Waitemata District
- Chemotherapy local outpatient treatment service provision in the Counties Manukau District
- Urology local elective service provision in the Counties Manukau District

To support these services, we will adopt a process which has worked well in the past. This includes appointing a lead clinician or manager to work with key stakeholders across the region to articulate the issues and develop solutions which address the key issues. Senior executive and clinical leaders will also be closely involved with this process.

For the services which are reliant (at least in-part) on national effort, the region will continue to input into national work; national leadership and impetus will also be required to progress these services.

6. Enablers

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

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

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

Workforce

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

The total combined clinical, technical, clerical and other workforce in our region is over 26,569 employees[8] representing 36% of the total workforce across all DHBs.

Indicative workforce projections suggest that by 2021 the demand for labour will grow by 52%, but supply of labour will grow by just 29%[9]. 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 and to have a workforce that reflects our population.

While most clinical professions have access to a pool of new graduates, recruiting to some specialty areas and finding experienced staff remains an issue across the region. This situation impacts the ability of some services to deliver care and places strain on the current workforce.

In addition to medical, nursing & midwifery and allied health, scientific & technical staff, we are also dependent on a large number of support staff to ensure that we deliver high quality, safe services in the most appropriate setting for our population. To meet the demands, we need the right staff, in the right place, at the right time.

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

Seven objectives support the direction for implementation in 2014/15

The region has identified seven workforce objectives which are aligned with both national HWNZ strategies and local DHB activity. These are:

1. **Enable workforce flexibility and affordability 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 and to manage peaks and troughs in demand.
2. **Build and align the capability of the workforce to deliver new models**

[8] DHB Shared Services. (2013). DHB Employed Workforce Quarterly Report 1 July to 30 September 2013.

[9] NZIER. (2005). Counties Manukau DHB: Health service needs and labour force projections. Statistical report to CMDHB.

of care: We need to have a workforce that is prepared and capable of delivering new models of care, particularly to support the focus of integrated care and a greater level of complex care provided in the community. There are opportunities to better utilise the non-regulated workforce, and engage with primary care and residential care to participate in training and post-graduate placements. We also need to be at the forefront of evaluating and implementing new roles in key areas.

3. **Grow the capacity and capability of our Maori and Pacific workforce**: A regional strategy will be developed to increase the capacity and capability of the Maori and Pacific workforce. We will promote and support the Nga Manukura o Apoppo Maori nurse and midwifery workforce development programme and the Leadership Academy, and development programmes for Maori and Pacific staff. We will continue to implement regional Kia Ora Hauora activity across the region.
4. **Build a workforce that engages effectively with the community it serves**: We will continue to invest in building the cultural competency of staff to achieve a workforce that can engage effectively with the community we serve.
5. **Promote advanced practice roles and working at top of scope**: We will continue to invest in piloting and implementing new models of care delivery utilising advanced practice roles in areas such as Aged Care, Mental Health, Diabetes, Primary and Community Care. To do this we will work in partnership with professional leaders, primary care and unions to progressively extend scope of practice for key roles.
6. **Adopt a regional HR approach to developing a healthy and engaged workforce**: We will take a regional approach on specific workforce initiatives to strengthen our efficiency and effectiveness. In particular we will review and jointly develop HR policies & procedures/processes across the region, standardise our approach to student clinical placements and contracts.
7. **Optimise the capacity and capability of the RMO workforce.**

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 expectations of the training hub in respect to delivery of this plan and the objectives set by HWNZ for training hubs are set out in the section below.

The workforce and training hub has an important role

Northern Region Workforce and 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 the monthly national teleconference and quarterly meetings organised by HWNZ.

Information Systems

Supporting Continuity of Patient Care

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

The Northern Regional Information Strategy (RIS 2010-20), and the Northern Region Information Systems Implementation Plan set the direction on information management, systems and services in the Northern Region. They align with national and regional information strategies and are a key enabler for us to achieve our clinical and business objectives.

Strengthening Core IS Operations & Infrastructure

Historic underinvestment in IT infrastructure has resulted in an inherent service continuity risk for IS services and a bow wave of infrastructure upgrade and system resilience requirements in the Northern Region. The Northern Region DHBs began to address this in 2013/14 and this will continue in 2014/15, with investment in the following areas:

- Microsoft license compliance
- Clinical and business systems upgrades to ensure systems remain on supportable versions and can realise the potential available with later versions
- Clarification of DHB service requirements and realignment of IS services to better support the Northern Region within available funding
- Improved resilience and security of IS systems to improve system availability, access and data integrity
- Mobility adoption.

The Northern Region has committed $24.37M to fund the ICT programme of work in 2014/15. Prioritisation of the above areas is a fundamental pre-requisite for maintenance of current IS services and investment in our future systems.

Continued Implementation of the Strategic Plan

The region is progressively adopting a strategic approach to regional capital investment planning for information services. Multi-year capital investment plans have been developed for the ICT programme of work, and for the following non-ICT priority programmes /projects. Further details of these and other activities are provided in Appendix A4:

- CareConnect ($5.56M regional investment for FY2014/15)
  - eReferrals and eDischarges
  - Patient Portal
  - Shared Care
  - Clinical Pathways
- eMedicines ($5.81M regional investment for FY2014/15)
  - Hospital ePharmacy
  - NZ ePrescription Service
  - eMedicines Reconciliation (eMR)
  - ePrescribing and Administration (ePA)
  - NZ Universal List of Medicines (NZULM)

- NZ Formulary (NZF)

- Regional Patient Administration System ($0.9M regional investment for FY2014/15)
- eOrders for Laboratory & Radiology ($2.01M regional investment for FY2014/15)
- National Patient Flow

Regional IS Governance

Fundamental to the achievement of our objectives is the performance of our shared services support agency, healthAlliance NZ Ltd. The Northern Region CIO Group comprising representatives from each DHB and healthAlliance has been established to:

- Define the business requirements of the Northern Region DHBs in IS shared services
- Monitor the performance of IS shared services in line with regional priorities and requirements
- Prioritise the regional ICT programme of work, ensuring that resilience and security risks are appropriately addressed
- Provide strategic IS direction for the region
- Prioritise national, regional and local capital IS projects
- Monitor the performance of key projects
- Reduce duplication through greater regional collaboration.

An appropriate IT governance framework is also required to support the successful delivery of our key projects. The CIO Group have developed an IT governance framework to ensure that these projects have appropriate sponsorship, coordination, stakeholder engagement, monitoring and assurance.

Some of these projects are aligned such that they form a specific programme of work, while others are significant due to their complexity, amount of investment required, risk profile or the need for a regional approach. These types of projects will have a sponsor (responsible for ensuring the overall objectives of the project are met on behalf of the region as a whole), a lead CIO and a regional governance group comprising various members to provide technical, financial and other advice/assurance as appropriate. These programmes/projects will provide regular reports to the Regional CEO/CMO Group.

Commitment to National Alignment

The Regional CIO Group is committed to working closely with the National Health IT Board and Health Benefits Limited to ensure that regional capital investment plans are aligned with national priorities and programmes of work.

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

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

- Improve operational ICT management.

healthAlliance will demonstrate support for this direction by:

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

Continuously improving operational IS Service Management and the effectiveness of shared services.

Procurement and Supply Chain

Achieving savings, increased efficiency and cost effectiveness

The region has agreed a procurement and supply chain savings target for the next five years, contributing to the $700 million target of Health Benefits Limited. Over the past year much of the foundation work has been put in place to change historical practices and introduce more streamlined and standardised processes. The region is making good progress around supply chain initiatives through its business support agency healthAlliance.

Overarching priorities within supply chain are to:

- Shift the procurement paradigm
- Deliver the procurement programme to unlock the agreed savings to the Northern Region
- Continue to align Northern Region supply chain processes to the Finance, Procurement and Supply Chain (FPSC) national model to improve the reliability, efficiency and cost effectiveness of these services to support our clinical community and patient care
- Progress the business case for the establishment of inventory ownership and creation of an Auckland distribution centre.

The region is prioritising the supply chain programmes of work so that these are aligned with regional priorities and objectives and those of HBL. The extent of national supply chain initiatives being delivered through HBL is yet to be fully determined, and requires a degree of agility in the region's plans to ensure ongoing alignment. Under FPSC, healthAlliance will not be an agent for HBL rather healthAlliance will be an agent for each DHB in respect of the existing procurement contracts from 1 July 2014. hA (FPSC) are currently developing standard operating procedures to implement such agency agreements with each DHB.

Excellence in supply chain service to support the clinical community and patient care

End-to-end supply chain services are fundamental to the Northern Region's ability to deliver on the whole of system approach to health service delivery that is embedded throughout the Northern Region Health Plan. A key clinical driver is to improve the continuity of care for patients in our region across primary, secondary and tertiary settings and reduce risks associated with supply that may affect patients' care. This relies on an efficient and reliable supply chain service to support all clinicians involved in a patient's care.

healthAlliance continues to implement a centralised model of delivery, underpinned by common processes in all DHBs. Through healthAlliance we will:

- Continue to develop efficient, effective solutions to reduce cost, reduce waste, and release time to care for clinical staff where possible
- Maintain close links with its customers, take a 'whole of system' approach with DHBs, and deliver high service satisfaction levels
- Streamline the 'to hospital' supply chains and progressively remove the duplication of infrastructure, inventory and transport charges that exist currently. This includes progressing the case for establishment of a warehouse third party provider for the Northern Region, potentially with healthAlliance ownership of inventory.

A single region catalogue and ERP

The region has moved from four product catalogues with no standard classification or nomenclature to a single instance of Oracle. This has enabled the region to enhance and standardise processes and supply chain delivery across

the region.

Key areas to focus on this year include:

- Achieving volume transaction processing efficiencies and provide visibility across the entire region of inventory. This will enable better working capital effectiveness and reducing risk of waste. We intend that the Northern Region will be ready to enter the national supply chain programme by the end of 2014
- Developing enhanced business intelligence to provide clinicians with detailed product usage information and enable benchmarking. This will be achieved through optimising the supply chain off campus, increasing the efficiency of inventory management, and commencing the integration of the FMIS into patient and other applications. This will reduce the need for clinicians to spend time managing inventory
- Improving the DHBs visibility of their expenditure by providing information on catalogue purchasing activity.

healthAlliance will work across the region and with suppliers to continue to streamline the supply chain processes and reduce costs. In addition, healthAlliance will support HBL in reviewing the opportunities for a national supply and distribution model.

2014/15 Supply Chain Priorities

We are well placed to proceed with the identified initiatives

The Northern Region continues to be well placed to proceed with supply chain improvement initiatives. This work will be led by healthAlliance in partnership with DHBs and the clinical community.

Key initiatives that will be undertaken in 2014/15 include:

- First iteration of the Northern Regional Procurement & Supply Chain Business Plan which sets the direction and roadmap for activity over the next three years. This will remain aligned with and support HBL initiatives and targets
- Refresh Supply Chain improvement plans for each DHB in line with three year road maps formed in 2012/13
- Progress the business case for the establishment of an Auckland distribution centre managed by healthAlliance.
- Extend Oracle inventory management through CM Health and WDHB to more closely resemble the ADHB model of service
- Establish detailed service level schedules with the DHBs.

Facilities / Capital

A large value of assets, most of it hospital based

The Northern Region DHBs, have approximately $2.2 billion worth of assets on their books, with a replacement cost valuation of $3.3 billion.

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

About 15% of our asset base is in clinical and other equipment; with large amounts invested in certain higher cost assets supporting services such as radiology and oncology. healthAlliance owns the Northern Region information system assets.

A need to invest, but limited funds

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

- **Growth** - Over the next 20 years the Northern Region population will grow by nearly 500,000. This will exceed the current population of any other DHB and will account for two out of every three additional people in New Zealand. It also has the fastest rate of growth in the 65+ population who place heavy demands on health services
- **Pressure on main acute sites** - All acute facilities in the region are operating at occupancy rates well above the 85% 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 25%[10] of our buildings are ranked 'poor', 'very poor' or as 'moderate' (largely with less than five years of life left). There are also buildings with seismic issues that will need to be addressed.
- **IT and IS investment** - Our Region recognises that IT and IS are key enablers of change and wants to invest capital in clinical systems that support changes to models of care. Equally there is a pressing need to renew existing systems to keep abreast of developments in software and technology
- **Replacement burden** - The region has a large 'fleet' of clinical equipment that requires regular replacement to support delivery of services Regionally around $40million is spent annually on 'renewals'.
- **Affordability** - The financial pressures on all DHBs in the region are substantial which impacts the region's ability to fund and finance capital investments.

Clarity regarding the Minister's expectations

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

A process to ensure Capital investment is aligned to regional needs

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

- Longer term capital intentions are signaled via the annual planning process. These ensure long term visibility of potential expenditure enabling good communication between stakeholders, strong alignment of

[10] % of insured asset $ value rated 'Average', 'Poor' or 'Very Poor' (score 3, 4 or 5)

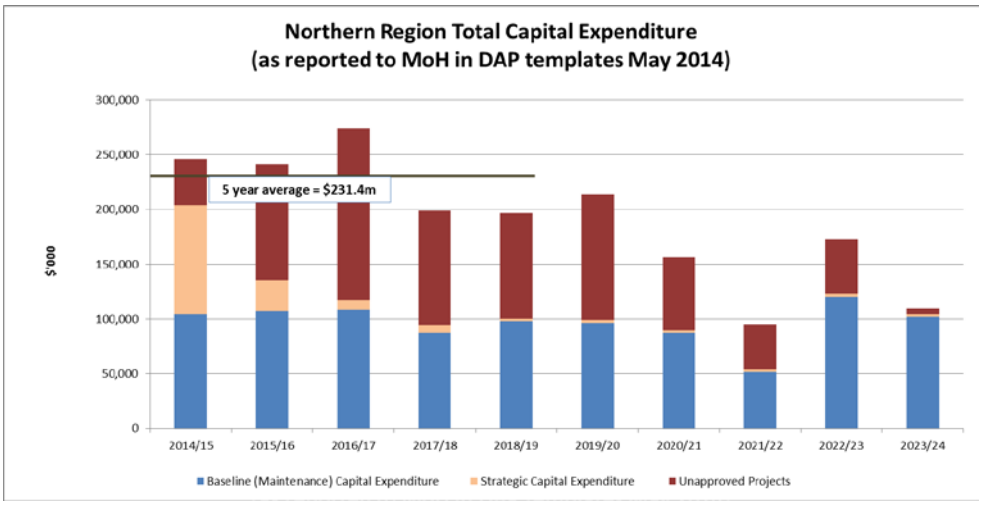
potential spend with strategic direction and prioritisation of capital projects from a regional perspective

- 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.

Capital Investment plans that sum to approximately $231m per annum

As a region, the planned overall capex expenditure profile equates to an average of $231 million per annum over the five years 2014/15 to 2018/19.

Figure 10 : Northern Region Planned Capital Expenditure



Source : DHB Draft capital intentions at 5 June 2014

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

The Northern Region DHBs intent with regard to the arrangements for funding of the capital investment proposals detailed in their plans is that:

- NDHB, WDHB and CMDHB will be seeking some crown funding for some strategic priority projects
- ADHB currently intends to fund capital investment from DHB funds over the next 4 years.

An ongoing planning process with key projects planned across our Region

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

- Northland DHB's key projects include
  - Whangarei Maternity Unit (underway)
  - Whangarei Cancer Centre (underway)
  - Whangarei Office Building (underway)
  - Bay of Islands IFHC (planning)
  - Dargaville IFHC (planning)

  Subject to the current refresh of the Whangarei Hospital Site Master Plan future stages include -
  - Whangarei ED/AAU
  - Whangarei Theatres
  - Whangarei Wards
  - Whangarei Ambulatory Care Centre

  Note that the Whangarei Kitchen Project has been put on hold pending the outcome of the National Foodservice procurement.
- Waitemata DHB's main capital projects include:
  - Taharoto replacement (nearing completion)
  - Mason Clinic; as a fast track development due to urgent clinical requirements (underway)
  - Additional Medical Beds
  - North Shore Hospital Tower Refurbishment
  - North Shore Hospital Mini Tower
  - Waitakere Site development; including ED refurbishment (already underway) and Maternity
  - North Shore Hospital Car Park
  - Purchase of Community & Commercial Building; WDHB is also considering the purchase of a building currently leased by the DHB.
  - Ambulatory and Cancer Centre
- Auckland DHB's key projects during the planning horizon include:
  - Starship Hospital and operating theatres upgrade; although this is expected to occur as a series of maintain and renewal projects until there is clarity regarding the national strategy for children's services.
  - Auckland City Hospital – Cancer Service Facility
  - Auckland City Hospital Adult Emergency Department redevelopment
  - PC3 Laboratory development to support ADHB's role as national provider of TB services
  - LabPlus Expansion L4 shell, Anatomical Pathology fit-out
  - Hybrid Operating Room
  - Child and Family Unit - new build 35 bed unit (further planning required)
  - ACH Fraser McDonald Unit redevelopment
  - ACH and Greenlane additional car parking capacity
  - Greenlane Clinical Centre developments including renal precinct, colonoscopy endoscopy and capacity for bed growth

- Counties Manukau DHB has a number of itemised capital projects:
  - The most significant include:
    - Adult Mental Health facilities
    - Rehabilitation facilities
    - Project Swift; A whole of system business improvement enabling investment
  - Other key points of note include:
    - The Women's Health development is still proposed but has been delayed by 3 years with a potential start date in 2018/19.
    - CMDHB was planning a significant capital investment on the Manukau Health Park but has recently made a decision to refocus the business case and to take greater account of:
      - The changed funding outlook
      - Localities business cases
      - Other projects underway

      As a result, the investment business case process is focused on aligning future strategic investment objectives with other Counties Manukau Health programmes and projects in order to recommend an integrated investment direction for the next ten years. "Investment" in this context does not just mean capital; some initiatives require significant operational investment (including borrowing costs for any new facilities).

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

Capital Investment Committee timeline

The following table outlines the anticipated business case submissions that will be provided from the Northern Region to the Capital Investment Committee during 2014/15.

Table 5 : Proposed Business Case Submissions to NHB CIC July 2014- June 2015

DHB – Project	Strategic Assessment	Indicative Business Case	Detailed Business Case
NDHB – ED/AAU	Dec -14	June -15	Dec-15
WDHB – North Shore Hospital minitower	Feb -15	Oct -15	Mar -16
WDHB – North Shore Hospital Carpark	Single Stage Business Case expected to CIC : Mar 2016		
WDHB – Purchase of Community & Commercial Building - still to be defined			
ADHB – PAS Replacement (+ EMR)		Likely June -15	To be confirmed
CMDHB – Acute Mental Health	Complete	Complete	To be developed
CMDHB – Specialist Rehab	Complete	May -14	To be confirmed
CMDHB – Diagnostics	Single Stage Business Case Expected to CIC: Aug/Sept 2014		

Specific areas for further regional capital planning work

Regional work over the coming year will be focused on:

- Ensuring appropriate regional oversight, review and endorsement of DHB capital development plans and business cases by the Regional Capital Group
- Meeting the capital planning requirements of the Ministry of Health and The Treasury and to work with both these entities on the Health Capital Review 2014/15
- Enhancing the existing regional processes to prioritise capital intentions over ten years; including increased consistency of capital planning practice across our region
- Achieving a view on the most appropriate capital plans for certain specific areas, namely:
  - Information Systems; further clarifying and confirming a capital budget for hA and impact on DHB financial plans
  - Radiology
  - The Counties Manukau Strategic Investment Project, while being progressed by the DHB, will also be a focus for collaborative regional capital planning with regard to specific development areas, including:
    - Inpatient rehabilitation services
    - Mental health facilities
  - Other service development areas with potential for greater regional co-ordination
  - Regional implications of HBL business cases for food services, linen and laundry services and National Infrastructure Platform.

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

Regional Governance of Capital Planning

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

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

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

The Regional Capital Group ensures that appropriate challenge of capital projects takes place across the region; at all levels in the planning process.

Commitment to ensure effective utilisation of our assets

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

7. The Way Forward

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

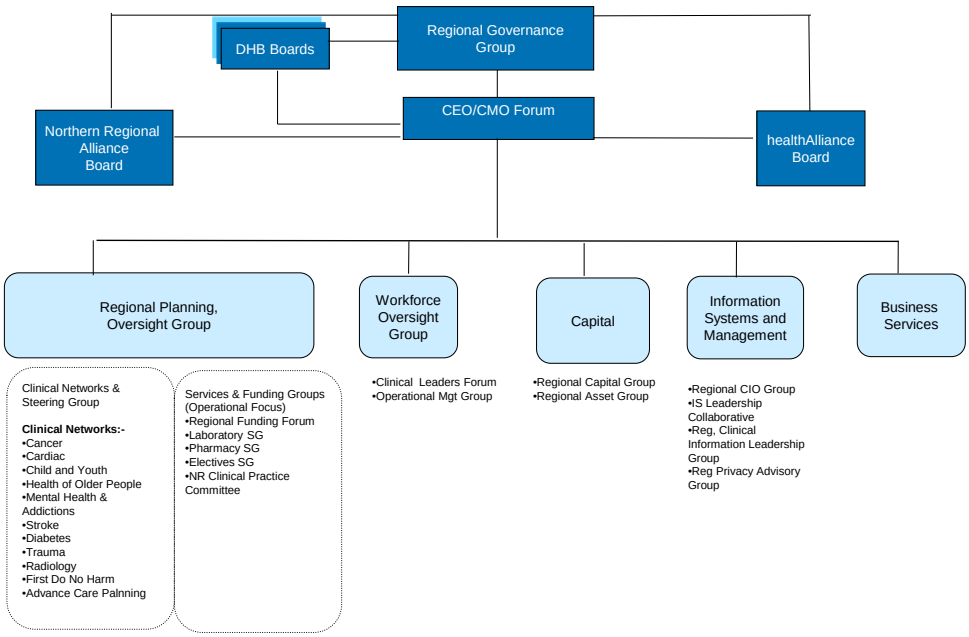
Accountability for delivering our plan will depend on strong governance

Regional governance arrangements in the Northern Region have recently been amended with implementation commencing in March 2014.

The Regional Governance Manual sets out the DHBs' new 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 new governance model is outlined below.

Figure 11 : Regional Governance Model



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

Two key governance groups oversee all clinical and business services activities. These are:

- **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.

A new Regional Planning and Service Delivery Group has been established to:

- Provide visible and credible leadership to the region for health service planning including Northern Region Health Plan development, oversight and embedding activity in business as usual operation
- Develop regional strategy and oversee the 3 year regional planning cycle
- Provide Clinical network and regional service delivery oversight
- Strengthen whole of systems clinical engagement in health service planning and delivery oversight
- Oversee population health analysis and the development of an appropriate regional performance reporting framework and processes to support the implementation of this framework
- Oversee the development of future models of care and configuration of services, ensuring the clinical and financial sustainability of services and the region's workforce
- Sponsor key regional health service projects including laboratory services, radiology services, service reviews, vulnerable services etc
- Monitor and receive updates on key regional strategic initiatives
- Act as point of escalation for health services issues that require urgent progress or resolution.

The healthAlliance Board will oversee business services activity

healthAlliance is the regional business services agency for the four DHBs. The key service activities are finance (transactional processing), procurement, supply chain, information services, and Regional Internal Audit Services. The activities of this organisation are governed by the healthAlliance Board which comprises five directors including one representative from each DHB and one representative from Health Benefits Limited. This reinforces the commitment between HBL and hA to ensure there is strong alignment between their priorities and work programmes.

healthAlliance leads the delivery of the business services, including Information Systems and Procurement and Supply Chain as outline in this Plan.

Chief Executive Officer and clinical leadership is embedded in all regional activity

Our CEOs and clinical leaders are at the forefront of leading and being involved in regional activity.

Our CEOs have each taken a lead role on different aspects of the Northern Region Health Plan. Clinical governance of the overall Northern Region Health Plan is provided by the Chief Medical Officers who provide networks with support and leadership, and are the key link between networks and other senior management.

Clinical leaders are appointed to lead the networks and are the key people on point for their services. The leaders work in partnership with the multidisciplinary members of the network to identify and progress the specific initiatives. Clinical membership on networks typically comprises doctors, nurses and allied health from across the primary and secondary sector, and the non-governmental sector.

Much of the successes over the past three years can be attributed to our senior executive commitment and our clinical leaders. Over 2014/15 they will continue to be instrumental in creating a trusting and collegial regional culture and promoting leading practice and innovation in clinical care.

Whole of System Implementation

A whole of system plan with accountability for delivery shared between all signatories

There is a reasonably complex array of organisations involved in the implementation of the initiatives highlighted in this plan. In some instances one organisation will lead an initiative, and others will contribute and participate to supporting the lead. In a number of instances all organisations will have shared accountability for delivery and performance.

The following articulates, at a high level, the alignment of the role and 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 Whanau 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 for the population
  - Engagement with primary, community and secondary care providers.

- **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 proposed 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.

  Ten priority areas are identified to support these areas of PHO focus, which largely align to the Northern Region Health Plan. During 2014/15 work will be undertaken to progress initiatives in these areas, in line with the Northern Region Health Plan work where relevant, to provide a much stronger and more concerted effort to address the priorities.

  The Northland PHOs have signaled their intent to consider the Auckland PHO focus areas as they develop their own planning intentions.

- **Other Social Sector Agencies**

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

- **Aged Residential Care**

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

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

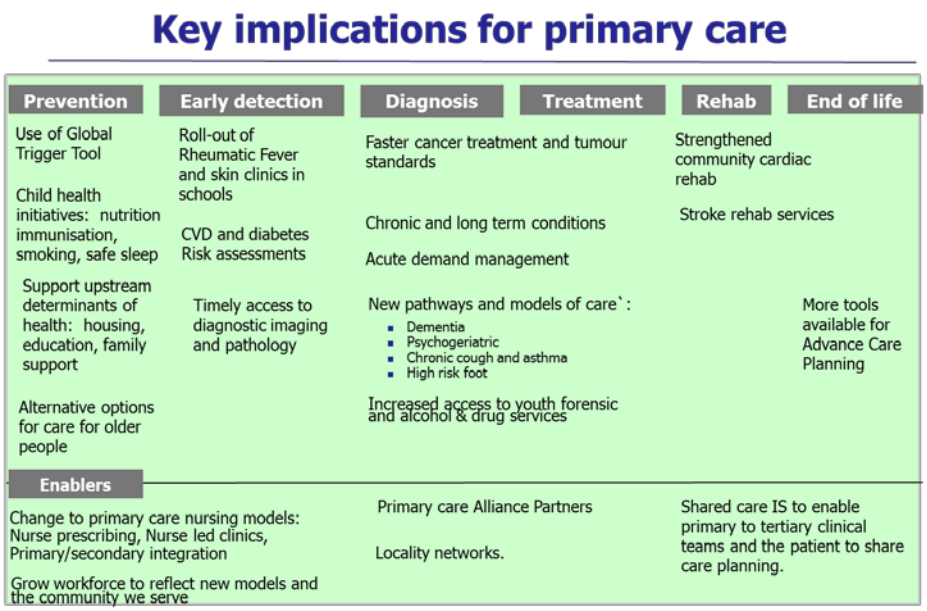
  This sector is also important in many aspects of this plan, particularly around health of older people, cancer, and child health. In each of these workstreams, linkages are made or strengthened to share information and align activities. These relationships are important to ensure consistent messages are being provided, regardless of where our population seeks help.

- **National Organisations**

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

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

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



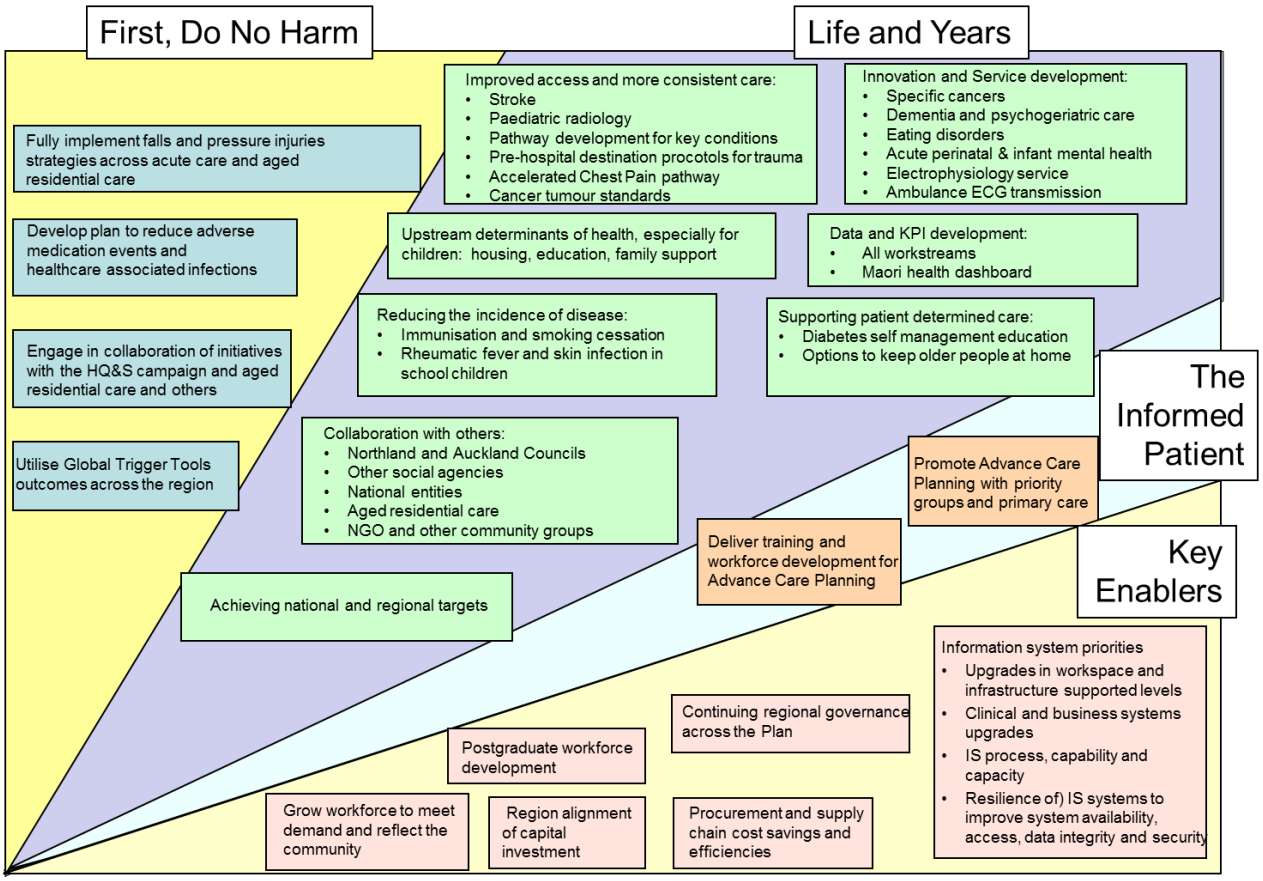
Implementation Plan

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

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

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

Figure 13 : Implementation Plan Roadmap



Clinical networks are firmly established and driving change

The region has established clinical networks and steering groups to drive change through our priority areas. During this year, and beyond, the clinical networks will progressively drive initiatives which directly impact patient outcomes. Engagement with patients will be enhanced and in many instances network participation will include consumer representatives as well as interagency and cross sector inputs.

The process for implementation comprises generic steps crossing all areas of interest, as well as actions that are specific to a particular initiative. An iterative process evolves around:

- Progressing the planning and implementation of early initiatives
- Assessing the impacts of these implementations on patient outcomes (and other measures).

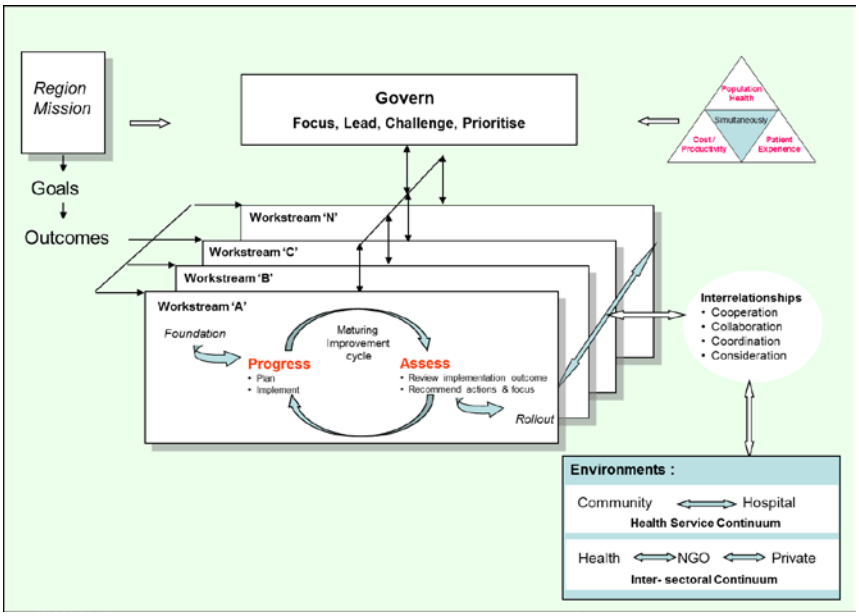
Once we have a solution that has been challenged and agreed as worthwhile, we will put it in place across the whole of our region.

The delivery process is based on strong governance to keep individual work streams focussed and aligned to the regional goals. Our process recognises the interrelationships that exist between the different:

- Work streams within the programme of work outlined within this plan
- Environments, where this plan needs to influence change.

Our implementation process approach is summarised in the following diagram.

Figure 14 : Implementation Process



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. The region has no option but to embark on this change agenda if it is to bring about the step change required. Our plan is not without risk, however only some of this risk can be managed regionally.

Table 6 : Implementation Risks

Risk	Description
Impact on primary health care	There is significant cumulative change on primary care arising from the directions articulated in this plan. The scope of work is being expanded so more patients are more proactively managed in the community, and new models of care are being developed. Primary care comprises a large group of doctors, nurses and allied health and other people. Therefore there are a number of challenges associated with communicating the key directions, managing the changes, and evaluating the impacts of the changes. Time and effort will be needed to support primary care providers to implement the changes.
Implementation costs	All DHBs in the region are actively working to reduce their deficits. This plan requires ongoing funding. Some funding may be managed by internally shifting resource, and some will require funding in 2014/15 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.

Risk	Description
Affordability	The operating cost of current models of care and the capital investment required to maintain these models is of particular concern to the Region. Facilities in the region are working to capacity. Substantial investment is required in staff, facilities and key equipment if waiting times and service levels are to be met and demographic growth accommodated. It will take 5 - 10 years before changes outlined in this plan can be expected to have a significant impact on slowing growth in demand for hospital based services.
Information systems	Information systems are critical to support many of the proposed changes in models of care. It will however take several years to deliver on the prioritised initiatives. This may be slowed further by access to capital funding and affordability of proposed investments.
Workforce	Time is needed to grow the workforce to work in new fields, and expanded roles. Until the workforce role changes occur it will be hard to build momentum around some initiatives where current staff is already stretched to deliver in their current roles.
Interdependencies with other work	Concurrent work is being undertaken at local, regional and national levels. There is strong alignment but the cumulative change agenda is significant and will require careful management at a regional level.

These risks will need to be monitored on a regular basis and mitigation strategies developed, as required.

Commitment to Achieving Better Outcomes for Our Population

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

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

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

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

Glossary of Terms

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

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

RF	Rheumatic Fever
RIS	(Northern) Regional Information Strategy
RMO	Resident Medical Officer
ROOG	Regional Oncology Operations Group
RVU	Relative Value Unit (Radiology)
SMO	Senior Medical Officer
STEMI	ST Elevation Myocardial Infarction
SUDI	Sudden Unexplained Death of an Infant
TIA	Transient ischemic Attack
TOP	Terminations of Pregnancy
WDHB	Waitemata District Health Board

Appendix A.1:

Northern Region Health Plan - Development Phase Contributors

	REGIONAL GOVERNANCE GROUP							
			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
	NDHB	Meng Cheong				X		
		Brett Halvorson				X		
	WDHB	Robert Paine				X		
		Avinesh Anand				X		
		Jo Brown				X		
	ADHB	Rosalie Percival				X		
		Auxilia Nyangoni				X		
	CMDHB	Ron Pearson				X		
		Pauline Hanna				X		
	hA	Mike Schubert				X		
		Ross Chirnside				X		
	NRA	Sarah Prentice				X		
		Tony Phemister				X		

Regional Funding Forum	REGIONAL FUNDING FORUM							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	NDHB	Kim Tito				X		
	WDHB/ ADHB	Debbie Holdsworth				X		
		Simon Bowen				X		
	CMDHB	Lisa Gestro				X		
		Benedict Hefford				X		
	NRA	Sarah Prentice				X		

	CLINICAL LEADERS							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	NDHB	Mike Roberts	X					
		Margareth Broodkoorn		X				
	WDHB	Andrew Brant	X					
		Jocelyn Peach		X				
		Phil Barnes			X			
	ADHB	Margaret Wilsher	X					
		Margaret Dotchin		X				
		Sue Waters			X			
	CMDHB	Gloria Johnson	X					
		Denise Kivell		X				
		Martin Chadwick			X			

	Northern Chief Information Officer Group							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	NDHB	Darren Manley						
	WDHB	Andrew Brant						
		Stuart Bloomfield						
	ADHB	Ailsa Claire						
		Linda Wakeling						
		Janes Edgar						
	Counties Manukau Health	Sarah Thirlwall						
	Health Alliance	Claire Govier						

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

CL – Clinical Lead

Life and Years	**CANCER**							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
	Northern Region Cancer Governance Board	Andrew Brant (Chair) (CL)	X					
		Ailsa Claire				X		
		Wilbur Farmilo	X					
		Rowena Lewis				X		
		Richard Sullivan	X					
		Cath Cronin				X		
		Fionnagh Dougan				X		
		Deirdre Maxwell				X		
		Margaret Dotchin		X				
		Kim Tito				X		
		Marty Rogers				X		
		Benedict Hefford				X		
	Network Tumour Streams	Richard Sullivan (ADHB) (CL)	X					
		Deirdre Maxwell				X		
		Chris Lewis	X					
		Rowan Collinson	X					
		Garth Poole	X					
		Richard Doocey	X					
	Regional Oncology Operations Group	Richard Sullivan (Chair)	X					
	Faster Cancer Treatment Technical Group	Ian Butler (Chair)				X		
	Cancer Control Steering Group Chairs	Nick Chamberlain (NDHB)	X					
		Peter Sandiford (WDHB)	X					
		Richard Sullivan (ADHB)	X					
		Wilbur Farmilo	X					

CL – Clinical Lead

	CARDIOVASCULAR DISEASE							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Tony Scott (WDHB) (CL)	X					
		Helen McKenzie				X		
		Tony Phemister				X		
	NDHB	Ada Schuler		X				
		Andrew Potts				X		
		Karen O'Keeffe		X				
		Peter Wood				X		
		Stephen Jennison	X					
	WDHB	Barbara O'Shaughnessy				X		
		Sue Crengle	X					
		Hamish Hart	X					
		Kim Bannister					X	
		Jo Brown				X		
	ADHB	Jim Kriechbaum					X	
		Jim Stewart	X					
		Mark Webster	X					
		Wendy Hoskin				X		
		Peter Ruygrok	X					
	CMDHB	Brad Healey				X		
		Helen Liley					X	
		Leanne Elder				X		
		Andrew Kerr	X					
		Patrick Kay	X					
		Wing Cheuk Chan	X					
	Diabetes	Jo Rankine				X		

CL – Clinical Lead

	CHILD HEALTH							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Siobhan Isles				X		
		Pam Henry (GAIHN)				X		
		Tony Phemister				X		
	NDHB	Roger Tuck	X					
		Jacqui Westren				X		
		Clair Mills	X					
	WDHB	Stacey Strang				X		
		Timothy Jelleyman (CL)	X					
		Andrew Brant	X					
		Marianne Cameron		X				
	ADHB	Richard Aickin	X					
		Alison Leversha	X					
	ADHB / WDHB	Ruth Bijl				X		
	CMDHB	Phillipa Anderson	X					
		Summer Hawke				X		
		Carmel Ellis				X		
	NHC	David Jansen					X	
	GAIHN	Neil Hefford					X	
		Jennifer Ngenga	X					
	Alliance Health Plus	Alan Moffit	X					
		TePora Peseta		X				
	Procare	Nicola Young		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	
	WDHB	Marty Rogers				X		
		Fiona Ironside				X		
		Jean-Marie Bush				X		
		Leani Sandford				X		
	ADHB/WDHB	Ruth Bijl				X		
		Alison Leversha	X					
		Rachael Harry	X					
		Sione Feki				X		
	CMDHB	Bridget Farrant	X					
		Carmel Ellis				X		
		Simon Denny	X					
		Paul Vroegop	X					
	NRA	Helen McKenzie				X		
	Health West	Maria Keikus					X	

CL – Clinical Lead

	DIABETES							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Jo Rankine				X		
		Tony Phemister				X		
	NDHB	Nicole McGrath	X					
		Andrea Taylor		X				
		Rose Lightfoot				X		
		Shane Cross						
	WDHB	Michele Garrett			X			
		Andrew Brant	X					
		Jean McQueen		X				
		Rick Cutfield	X					
		Kim Bannister					X	
	ADHB	Jim Kriechbaum					X	
		Paul Drury	X					
	CMDHB	Brandon Orr-Walker	X					
		Helen Liley					X	
	CVD	Tony Scott	X					
		Helen McKenzie				X		

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

CL – Clinical Lead

	Major Trauma							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Region	Ailsa Claire (ADHB)				X		
		Michael Roberts (NDHB)	X					
		Alex Ng (ADHB) CL	X					
		Siobhan Isles PM				X		
	St John Ambulance	Tony Smith	X					
		Derek Liefting			X			
	NDHB	Andrew McClelland	X					
		Scott Cameron	X					
		Mark Sanders	X					
	WDHB	David Lang	X					
		Alison Bowden				X		
	ADHB	James Hamill	X					
		Li Tsee	X					
		Rhondda Paice	X		X			
		Rangi Dempsey				X		
	CMDHB	Murray Cox	X					
		Sylvia Boys	X					
		Kevin Henshall		X				

CL – Clinical Lead, PM = Programme Manager

	Maori Pacific and Inequalities							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	NDHB	Kim Tito				X		
		Ellie Berghan						
	WDHB	Marty Rogers	X			X		
		Sue Crengle						
	ADHB	Marty Rogers	X			X		
		Sue Crengle						
	CMDHB	Tuhakia Keepa				X		

	MENTAL HEALTH & ADDICTIONS							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Life and Years	Regional	Gloria Johnson (CMDHB)	X					
		Lyndsay Fortune				X		
		Iain Nicholson				X		
	NDHB	Maurein Betts				X		
		Patricia Palmer				X		
	WDHB	Murray Patton	X					
		Helen Wood				X		
		Jean-Marie Bush				X		
		Jeremy Skipworth	X					
		Ian McKenzie				X		
	ADHB	Fionnagh Dougan				X		
		Clive Benesemann	X					
		Sarah Wallbank				X		
		Mike Butcher			X			
		Andrew Malone			X			
	CMDHB	Tess Ahem				X		
		Sonya Russell				X		
		Peter Watson	X					

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

CL – Clinical Lead

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

	LABORATORIES – JOINT ADVISORY GROUP							
			DHBS				Primary	
	Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other	
Services	NDHB	David Hammer						
		Vivien Goldsmith						
	WDHB	Mehran Zareian						
		Ross Henderson						
	ADHB	Frank Tracey						
		Margaret Wilsher	X					
		Ross Hewett						
		Steve Absalom						
	CMDHB	Brad Healey						
		Pauline McGrath						
		Ross Boswell						
	DML	Ross Anderson						
	Labtests	Richard Lloydd						
	NRA	Sarah Prentice				X		

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

CL – Clinical Lead

	PHARMACY							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Services	Region	Jillian Sutherland (NDHB)					X	
	NDHB	Paul Barnes				X		
	WDHB/ADHB	Jon Kristiansen			X	X		
		Tim Wood				X		
	CMDHB	Trevor Lloyd			X	X		

	ELECTIVES							
			DHBS				Primary	
		Team Member	Medical	Nursing	Allied Health & Technical	Other	Clinical	Other
Services	Region	Rachel Rush				X		
		Tony Phemister						
	NDHB	Andrew Potts				X		
		Rob Coup	X					
		Jo West				X		
	WDHB	John Cullen				X		
		Cath Cronin				X		
	ADHB	Fionnagh Dougan				X		
		Justin Kennedy-Good				X		
	CMDHB	Jillian Cossey				X		
		Sue Shipperlee				X		
		Wilbur Farmilo	X					

CL – Clinical Lead

Appendix A.2:

Our Priority Goals – Implementation Plan Matrices

First, Do No Harm

Context
We are continuing to harm patients within the health system. A New Zealand study showed that 12.9% of people admitted to hospital suffered an unintended adverse event caused in the management of their condition(s) rather than underlying disease, less than 15% of these adverse events were associated with permanent disability or death and 33% were significantly avoidable[1]. Preventable serious adverse events translated to around 276,000 bed days. At an average cost of NZ$13,000 per adverse event, the cost of avoidable adverse events is estimated to be around NZ$573 million per annum. Whilst these results are not atypical of any Organisation for Economic Co-operation and Development (OECD) country, no significant systematic change has been made to reduce these harmful events within the New Zealand health sector. The development of the Northern Region's *First, Do No Harm* patient safety campaign, launched at the beginning of 2012, is an acknowledgement that the time has come to have a focussed effort on improving the quality and safety of our health system and to raise the profile of patient safety. *First, Do No Harm* is a clinically-led campaign involving the four Northern Region district health boards (DHBs) (Auckland, Counties Manukau, Waitemata and Northland DHBs). The campaign is one of three strategic priorities of the Northern Region Health Plan. The four DHBs share information about patient safety initiatives and use quality improvement strategies consistently across the region. The campaign strategies include raising awareness of patient safety; helping build quality improvement capacity and capability; using a formal improvement methodology to guide quality improvement activities; and developing strong partnerships and alignment with other regional and national programmes and priorities. In May 2013, the Health Quality & Safety Commission (the Commission) launched the national patient safety campaign, *Open for better care*. The focus of this campaign includes areas that the Northern Region had identified as priorities. Going forward, *First, Do No Harm* will continue to be the focal point for assisting the Northern Region achieving the national and regional patient safety goals. As such, the *First, Do No Harm* implementation plan is aligned with the national priorities to facilitate effective implementation of the national campaign objectives and ensures that the national quality and safety markers are an integral part of the plan.

Objectives	Linkages
The *First, Do No Harm* campaign is a vehicle to spread effective process changes that have been shown to reduce harm associated with the provision of healthcare. Main drivers in this priority area include: o Having an engaging communication strategy o Strong partnership with consumers and clinical staff 'safer care together' o An effective measurement dashboard to track progress o Fostering regional learning 'all teach, all learn' o Building the momentum of a safety culture	o Health Quality & Safety Commission o Health of Older People (HOP) Clinical Network o District Health Boards o Residential aged care sector o Primary care networks o Consumer networks

[1] Davis P, Lay-Yee R, Briant R, Ali, W, Scott, A, Schug, S. Adverse events in New Zealand public hospitals I: occurrence and impact. Journal of the New Zealand Medical Association, 13 December 2002, Vol 115, No 1167.

Key achievements

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

Key achievements over the 2013/14 year include:

- Adoption of a regionally consistent Transfer of Clinical Information 'yellow envelope' process
- Regional 'How to' guides for falls and pressure injuries completed
- Regular *First, Do No Harm* e-newsletters and updates to website highlighting patient safety information, learning and activities happening across the Northern Region
- Provision of learning sessions, workshops, training and coaching.
- Launch of a second phase of the regional Falls and Pressure Injuries Collaborative
- Capability improvement with middle managers in a DHB
- Supported clinical staff in use of data for improvement work.
- One district health board showing a 'shift' in the reduction of major harm from falls
- Progressing towards obtaining monthly falls and pressure injuries data from residential aged care sector
- Global Trigger Tool (GTT) workshop, in partnership with national GTT Clinical Lead
- Strong linkages with other work programmes (i.e. Health Quality and Safety Commission, Health of Older People Clinical Network) to ensure alignment with national and regional patient safety programmes and priorities

2014/15 Implementation Plan

Item	*First, Do No Harm* - Process / Action	2014/15 Quarter completed by	2015/16	2016/17
	1. *First, Do No Harm* Measures			
	Reduction in falls causing major harm in the acute sector to a rate of less than 0.07 per 1000 patient days	Q1-Q4 ongoing	√	
	20% reduction in falls causing major harm in those age-related residential care (ARRC) facilities that have implemented a programme	Q1-Q4 ongoing	√	
	75% of ARRC facilities have implemented a falls and pressure injuries reduction programme[2]	Q1-Q4 ongoing	√	
	90% percent of older patients assessed for the risk of falling (**QSM** [3])	Q1-Q4 ongoing	√	
	Percentage of older patients assessed as at risk of falling who received an individualised care plan that addressed these risks **(QSM)**	Q1-Q4 ongoing	√	

[2] Implementation of a falls and pressure injuries reduction programme defined as having the following in place (1) a relevant assessment tool; (2) intervention guides; (3) participation in training; and (4) data capture and reporting of falls and pressure injuries.

[3] QSM = quality and safety marker is a set of indicators concentrating on the four areas of harm covered by the Health Quality & Safety Commission (HQSC) national patient safety campaign *Open for better care* (i.e. falls, healthcare associated infections, perioperative harm and medication safety). Data is reported quarterly by HQSC.

Item	*First, Do No Harm* - Process / Action	2014/15 Quarter completed by	2015/16	2016/17
	In-hospital falls resulting in a fractured neck of femur **(QSM)**	Q1-Q4 ongoing	√	
	Reduction in hospital acquired pressure injuries Grades 3 and 4 to 'never events' in the acute sector	Q1-Q4 ongoing	√	
	20% reduction in pressure injuries in those ARRC facilities that have implemented a programme	Q1-Q4	√	
	Monitor target of <1 CLAB per 1000 line days	Q1-Q4 ongoing	√	
	Percentage of central line insertions in ICUs where the insertion bundle was used correctly **(QSM)**	Q1-Q4 ongoing		
	>95% compliance with correct dose of recommended antimicrobial prophylaxis (cefazolin ≥ 2g) **(QSM)**	Q1-Q4 ongoing	√	
	100% compliance with appropriate timing for antimicrobial prophylaxis in surgery (0-60 minutes before surgical incision) **(QSM)**	Q1-Q4 ongoing	√	
	100% compliance with appropriate skin antisepsis in surgery (alcohol/chlorhexidine or alcohol/povidone iodine) **(QSM)**	Q1-Q4 ongoing	√	
	Rate of surgical site infection per 100 procedures for total hip joint replacement and total knee joint replacement **(QSM)**	Q1-Q4 ongoing	√	
	Percentage of reviewed operations where all three parts of the surgical safety checklist were used **(QSM)**	Q1-Q4 ongoing	√	
	Perioperative DVT/PE and sepsis **(QSM)** (wording to be confirmed)	Q1-Q4 ongoing	√	
	Medication safety quality and safety marker process and outcome measures to be confirmed **(QSM)**	Q1-Q4 ongoing	√	
	2. Foundation Activity			
	Appoint 0.5 FTE Programme Support/Administration	*Q1*		
	Appoint regional 2.5 FTE (total) Implementation Managers to work across patient safety work streams	*Q2*		
	3. Process Activity			
	3a. Work streams			
	Reduce harm from falls			
	Engage acute and residential aged care sector teams in regional falls activities in partnership with Health of Older People (HOP) Clinical Network	Q1-Q4	√	
	Provide learning opportunities for DHBs and residential aged care facility teams working on improvement activities	Q1-Q4	√	
	Support HOP Clinical Network to investigate regional solution for residential aged care falls data capture and reporting	Q1-Q4	√	
	Develop and implement exit strategy to incorporate reducing harm from falls initiatives into business as usual	-	√	
	Link with national patient safety campaign quality and safety marker for falls	Q1-Q4 ongoing	√	
	Reduce harm from pressure injuries			
	Engage acute and residential aged care sector teams in regional pressure injury activities in partnership with HOP Clinical Network	Q1-Q4	√	
	Provide learning opportunities for DHBs and residential aged care facility teams working on improvement activities	Q1-Q4	√	
	Support HOP Clinical Network to investigate regional solution for residential aged care pressure injuries data capture and reporting	Q1-Q4	√	
	Develop and implement exit strategy to incorporate reducing pressure injuries initiatives into business as usual	-	√	
	Reduce harm from healthcare-associated			

Item	*First, Do No Harm* - Process / Action	2014/15 Quarter completed by	2015/16	2016/17
	infection (HAI)			
	Maintain and monitor monthly reporting of central line associated bacteraemia (CLAB) rates for Northern Region	Q1-Q4 ongoing	√	√
	Support national surgical site infection (SSI) programme initiatives at regional level	Q1-Q4 ongoing	√	√
	Monitor regional performance on surgical site infection quality and safety marker and address any variation across the region	Q1-Q4 ongoing	√	√
	Improve medication safety			
	Support national medication safety programme initiatives at regional level	Q1-Q4 ongoing	√	√
	Monitor regional performance on medication safety quality and safety marker and address any variation across the region	Q1-Q4 ongoing	√	√
	Investigate ethnic specific reporting of quality and safety marker for medication safety	Q2		
	Reduce peri-operative harm			
	Support national peri-operative harm prevention programme initiatives at regional level	Q1-Q4 ongoing	√	
	Monitor regional performance on peri-operative harm quality and safety marker and address any variation across the region	Q1-Q4 ongoing	√	
	Utilise Global Trigger Tool			
	Share findings from Global Trigger Tool (GTT) across the region to ensure GTT outcomes are used more effectively to identify patient safety issues and develop appropriate targeted programmes to address them	Q1-Q4 ongoing	√	√
	Link with the Commission's GTT programme and Clinical Lead to ensure alignment with the local, regional and national agenda	Q1-Q4 ongoing	√	
	Quality accounts			
	Investigate development of regionally consistent template for quality accounts	Q2		
	3b. Workforce			
	Develop a quality improvement culture			
	Provide learning events and coaching to improve capacity and capability for improvement activities	Q1-Q4 ongoing	√	√
	Identify and recruit clinical leaders and managers in DHBs/residential aged care to participate in patient safety activities	Q1-Q4 ongoing	√	√
	Support consumer participation in regional patient safety activities and planning	Q1-Q4 ongoing	√	√

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. Maori children and Pacific children experience poorer health than non-Maori, non-Pacific children. Children living in poorer neighbourhoods also have poorer health. The determinants of child health outcomes extend beyond the traditional boundaries of the heath sector. The health outcomes of our children are affected in a very real way by issues such as the quality of housing, maternal mental health, parental smoking, nutrition income, employment status of caregivers, and urban design which challenge us to think more broadly about solutions. Problems such as overcrowded and unhealthy housing contribute to unacceptable rates of diseases such as respiratory infection, skin sepsis and rheumatic fever.

Objectives	Linkages
Five main objectives are to: • Optimise health outcomes for infants and children, including improved equity • Use a regional voice to advocate for improvements in the upstream determinants of child health • Co-ordinate resources with other sectors more effectively • Achieve greater consistency and quality of care for children through workforce development and systems improvement • Foster a regional approach to child health monitoring and research, influencing future planning and strategic development	• Children's Action Plan • Better Public Services • Local authorities, social development, housing, transport • Rheumatic Fever programme • Regional groups for maternity, youth, primary care, etc • Education and schools • Tamariki Ora Well Child providers • District Annual Plans • Child Health Implementation Plan • First 2000 Days

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

Key achievements over the past two years

The formal Northern Region Child Health Network was established in July 2012, building on a collaborative network in the metro area and various joint initiatives across the region. Key achievements include:

– Over 40,000 children receive better access to primary care through the school based program to identify and treat Group A Streptococcus (to prevent Rheumatic fever) and skin infections
– Consistent guidelines to manage children who present in primary care for skin infections and lower respiratory tract infections have been developed and implementation is ongoing
– A regional 'Sudden Unexpected Death of an Infant' (SUDI) strategy and policy
– Four short videos to promote safe sleep for Maori babies
– Comprehensive research on unintentional injuries in young children including Northern Region epidemiology.

014/15 Implementation Plan

Item	Child Health : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	1. Patient Outcome Measures			
	86% of Well Child Tamariki Ora core checks in first year all completed by December 2014 (rising to 95% by June 2016)	Q2-Q4		
	86% Oral health enrolment by December 2014	Q2-Q4		
	95% Immunisation completed at 8 months age by December 2014	Q2		
	88% Primary care enrolment at 12 weeks by December 2014	Q2		
	2. Process activity			
	2a. Models of care and service			
	Communications and engagement			
1	Review, update and implement communications strategy for target groups and child health workforce	Q1-Q4 ongoing	√	√
2	Develop key messages on how to keep our children healthy and to improve engagement with services	Q1	√	√
3	Engage with key stakeholders across the sector to support the progress of the network's priorities including MoH and other regional groups	Q1-Q4 ongoing	√	√
	Upstream determinants – health agencies			
4	Continue to strengthen the integration of care across a range of child health services including primary care, LMCs, maternity services, Well Child Tamariki Ora, and hospital services	Q1-Q4 ongoing	√	√
5	Support and develop initiatives to promote good health, by increasing smoke-free environments, vaccination, and breastfeeding rates, and improved childhood nutrition	Q1-Q4 ongoing	√	√
6	Develop an agreed regional process to inform primary care when an infant or child has died	Q 1- 3	√	
	Upstream determinants – cross sector			
7	Work with other sectors to achieve the priorities of the network. This will include local authorities, social services, education and housing (e.g. Auckland Wide Housing Initiative)	Q1-Q4 ongoing	√	√
8	Stocktake models of care and systems of support for children and their whanau who experience multiple adversity, and assess their effectiveness. This links to the development of the Children's Action Plan	Q3		
	Rheumatic Fever			
9	Continue to support implementation of Rheumatic fever prevention programs including: • School based program • Primary care and rapid access	Q1-Q4 ongoing	√	√
10	Regional Rheumatic Register Rebuild		√	√

Item	Child Health : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
11	Support regional and national consistency in monitoring and evaluation	Q1-Q4 ongoing	√	√
	SUDI			
12	Implement SUDI Action Plan and Policy across DHB and non-DHB maternity and child health services	Q1-Q4 ongoing	√	√
13	Explore options within the Well Child Tamariki Ora framework to provide more advice and support for babies at risk of SUDI, and other health issues	Q1-4	√	√
	Unintentional Injuries			
13	Develop recommendations for regional implementation informed by research	Q2-4	√	√
14	Join up planning regionally with Safe Kids, local government and Well Child Tamariki Ora Providers	Q1-4	√	√
	Skin infections, cellulitis and abscesses			
15	Monitor the implementation and effectiveness of the skin infection pathways	Q3 ongoing	√	√
	Respiratory Tract Conditions (to include chronic cough, asthma, bronchiectasis)			
16a	Work with partners to develop pathway	Q1-2		
16b	Monitor the implementation and effectiveness of the Respiratory Tract Conditions pathways	Q3-4 ongoing	√	√
	2b. Workforce			
17	Develop targeted initiatives to increase the capability of the health workforce to improve health literacy amongst high needs groups	Q4	√	√
	2c. Information Technology and Systems			
18	Develop a performance monitoring management framework	Q2-4	√	√

Inequalities / Disparities

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

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

2014-15 Implementation Plan

Item	Inequalities Disparities : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	1. Patient Outcome Measures			
	95% of smokers who are hospitalised patients who are seen by a health practitioner are offered brief advice and support to quit	Q1 – Q4 ongoing	√	√
	90% of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking.	Q1 – Q4 Ongoing	√	√
	Track the access rates for Māori and Pacific Youth to Youth Forensic services.	Q2 -Q4 ongoing	√	√
	Increase to 1.25% of those aged between 12 &19 years old accessing specialist AOD services	Q2 -Q4 ongoing	√	√
	86% of pre-school children enrolled in DHB-funded oral health services	Q2 -Q4 ongoing	√	√
	% of eligible adolescents aged 13-17 years accessing and utilising publicly-funded dental services	Q2 - Q4 ongoing	√	√

Item	Inequalities Disparities : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	2. Process activity			
	2a. Models of care and service			
	Disparities and inequalities			
	Develop capacity and capability of the northern region clinical networks to engage and build responsiveness to Māori and Pacific health priorities	Q4		
	Māori Health Dashboard			
	Implement the regional Māori health dashboard	Q2		
	Report the Māori health dashboard quarterly to regional CEO/CMO Forum and Clinical Networks	Q2 – 4 ongoing	√	√
	Review of dashboard implementation and indicator suitability on an annual basis	Q4		
	Asian and MELAA Health			
	Work with DHBs to continue implementing Cultural and Linguistically Diverse (CALD) training to DHB and Primary health care staff	Q1-Q4	√	√
	2b. Workforce			
	Grow the capacity and capability of our Maori and Pacific Workforce			
	Implement national initiatives arising from Kia Ora Hauora – Recruit a minimum of 100 Maori students to a health study pathway in this region – Support at least 20 Maori into first year tertiary study.	Q4	√	√
	Implement regional and local initiatives to grow our own through, Ko Awatea, Pacific Mentoring, Health Science Academies including: – A minimum of a 100 Maori and Pacific students enrolled in high school based health career programmes – Maori and Pacific people offered scholarships for tertiary health study – A minimum of 100 Maori and Pacific students offered gateway, work experience placements, or work exposure to a health setting in the region	Q4	√	√
	Increase the graduate placement numbers for Maori and Pacific graduates regionally in each of nursing, midwifery, medicine and allied and technical staff.	Q2-Q4	√	√
	Develop a dedicated regional recruitment and retention strategy (end to end support) for Maori and Pacific staff including: – Jointly review recruitment policies in regard to affirmative action for recruitment of Maori and Pacific people into the workforce – Promote and support the Nga Manukura A Apoppo Maori Nurse and midwifery workforce development programme.	Q2 Q2		
	Build a workforce that engages effectively with the community it serves			
	Continue building on the cultural competency training to staff members: – 400 per DHB for CMDHB / ADHB / WDHB staff enrolled for Culturally and Linguistically Diverse (CALD) training	Q1-Q4	√	√

Item	Inequalities Disparities : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	courses annually – Provide access to CALD training courses for Northland DHB.			
	Tikanga and Pacific cultural training is included as part of mandatory training schedule for all staff: – Establish regional plan – Implement plan (years 2 & 3)	Q4	√	√

Health of Older People

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

Objectives	Linkages
The key drivers for HOP are to: • Plan for projected growth in the population of older people including management of acute demand • Provide informed choice for older people in their care, minimise dependence and protect the vulnerable aged population • Improve service coordination and deliver whole of system care through enhancing cooperation with primary, community and ARRC sectors	• District Health Boards (DHB) • Age-Related Residential Care sector (ARRC) • First Do No Harm Network (FDNH) • Greater Auckland Integrated Health Network (GAIHN) • National Dementia Cooperative • Health, Quality & Safety Commission • Ministry of Health

Key achievements over the past three years

The first (foundation) year of the HOP RSP, ended on a note with a cohesive network group in place, the building of commitment and focus on health priority areas for people 65+ years with progress towards these, and a sound plan with patient outcome measures agreed for 2012/13.

The second (establishment) year of the HOP RSP has meant more focus and measurement around key areas such as dementia, acute hospitalisation and falls/pressure injuries. Much of this work has been successfully achieved in partnership with other networks like First Do No Harm, GAIHN and Advance Care Planning.

The third (consolidation) year of the HOP RSP has been a further concentration of effort on fewer, major areas.

√ Achieved
- Strong linkages with other work programmes (i.e. National Dementia Cooperative, FDNH, HQSC & GAIHN) to ensure alignment with national and regional programmes.
- Retention of a majority of founding members on the network.
- Recruitment of Consumer & Maaori representation on network.
- Supporting FDNH, DHBs and many ARRC providers to be involved in a cross-sector collaboration for falls and pressure injuries.
- Consideration of a regional IS solution for ARRC reporting of falls and pressure injury data.
- Facilitating Fracture Liaison Service coordination for the region.
- Publication of a Northern Region Dementia Services Guidelines Document.
- Regional collaboration around Dementia Care Pathway development.
- Active participation across national dementia initiatives.
- A review of Psycho-Geriatric Beds across the Northern Region
- Adoption of a regionally consistent Transfer of Clinical Information process ("Yellow Envelope").
- Building regional consistency for GP e-Referrals into HOP services.

– Enhanced understanding of interRAI capability and challenges, establishing a regional data repository and developing reporting parameters.

2014/15 Implementation Plan

Item	Health of Older People: Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	1. Patient Outcome Measures			
	% of primary care clinicians utilising an electronic dementia care pathway	Q4	√	√
	20% reduction in falls causing major harm in those age-related residential care (ARRC) facilities that have implemented a programme.	Q1-Q4	√	
	20% reduction in pressure injuries in those ARRC facilities that have implemented a programme	Q1-Q4	√	
	Proportion of ARRC facilities that have implemented a falls & pressure injury reduction programme will increase from 30-75%	Q1-Q4		
	% of ARRC residents with completed InterRAI LTCF assessment.	Q4	√	
	65% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 12 months	Q4	√	√
	2. Process Activity			
	2a. Models of care and service			
	Cognitive Impairment			
	Regional Dementia Working Group provides oversight & expert advice for regional initiatives.	Q1-Q4 Ongoing	√	√
	Support development of DHB models of care for dementia across the region	Q1-Q4 Ongoing	√	√
	Implement regional recommendations arising from Psycho-Geriatric Review	Q1-Q3		
	Undertake stocktake dementia services	Q3		
	Administer regional Dementia funding for primary care education & training	Q1-Q4 Ongoing	√	
	Continue to participate in national dementia initiatives and achieving alignment with regional activities	Q1-Q4 Ongoing	√	√
	Evaluate literature for ethnicity and inequalities >65 and assess impacts for northern region		√	√
	Quality & Safety			
	Engage additional acute and ARRC sector teams in regional Falls and Pressure Injuries Collaborative in partnership with First Do No Harm (FDNH) Network	Q1-Q4 Ongoing	√	
	Support ARRC in the measurement and reporting of improvement in harm from falls & pressure injuries enabled by Quality Of Care For Older People	Q4	√	√
	Provide coordination for Fracture Liaison Services across the region	Q1-Q4 Ongoing	√	
	Support development of Community Acquired Pneumonia Pathway for ARRC	Q1-Q4		
	Evaluate potential for falls Prevention & minor injury initiatives in community	Q3-4		
	Evaluate management of noroviruses & other infections in ARRC & the opportunities for improvement		√	
	Age Related Residential Care Sector (ARRC)			
	In partnership, develop a quality agenda with ARRC sector	Q3-4		

Item	Health of Older People: Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	Review national contract in respect to regional imperatives	Q1		
	Develop regional EOI/RFP template for new ARRC beds	Q1		
	Analyse rates of admission to ARRC	Q2		
	Publicise PG bed access criteria across region	Q1		
	Develop specifications for specialised facility design	Q4		
	Standardise process for palliative care funding in ARRC	Q2		
	Home Based Support Services			
	Establish regional KPIs in line with national initiatives eg triage times for NASC	Q1-Q4 Ongoing		
	Medication Management			
	Partner with FDNH/HSQC on Medication Safety initiative/s	Q1-Q4		
	interRAI			
	Establish regional governance group	Q1		
	Support pilot / demonstration sites for interRAI	Q1-Q4		
	Establish data & reporting specifications	Q1-Q4		
	Develop KPI & baseline for HBSS referral triage times	Q3		
	2b. Workforce			
	Facilitate training & education to primary care clinicians on specific dementia initiatives	Q1-Q4 Ongoing	√	
	Recommend MHSOA workforce to support PG care	Q4		
	2c. Information Systems			
	Enable the Cognitive Impairment Electronic Pathway Tool	Q1-Q4		
	Enable the Community Acquired Pneumonia Electronic Pathway Tool	Q1-Q4		
	Implement the Quality Care For Older People database	Q1-Q4		
	Support the roll-out of the triage process associated with e-Referrals	Q3-4		
	2d. Capital and other expenditure			
	Inform & participate in regional rehabilitation/community planning	Q1-Q4 Ongoing	√	√

Cancer Services

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

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

Key achievements since July 2013

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

- √ 100% of patients requiring radiation therapy will receive this within four weeks.
- √ 100% of patients requiring chemotherapy will receive this within four weeks.
- √ Faster cancer treatment indicators, regional achievements
    - 64.8% of patients referred urgently with high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days from date of referral (as at Q2 2013/4).
    - 43.8% of patients referred urgently with high suspicion of cancer who have their first specialist assessment within 14 days.
    - 81.4% of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 31 days of decision to treat.
- √ Establishment of a new Northern Region Cancer Governance Board, and the drafting of a new strategic framework for cancer in the region.
- √ Continued successful implementation of the Bowel Screening Programme at Waitemata DHB.
- √ Production of a new clinically validated health literacy tool for lung cancer, through the Lung Cancer Tumour Stream.
- √ Colonoscopy data validation and waiting list improvements underway consistent with Ministry process.
- √ Revision of the metro-Auckland direct access colonoscopy outpatient e-referral form for GPs, consistent with national referral criteria, by the Bowel Cancer Tumour Stream.
- √ Review of the national lung, head and neck, and sarcoma standards within the Northern region.
- √ Implementation of the Northern Region Faster Cancer Treatment Implementation Plan, and secured funding to continue into 2014/15.
- √ Publication of four provisional national tumour stream standards, hosted nationally from the Northern region.
- √ Development of the national SMO Role Delineation Project consistent with the Medical Oncology Models of Care work, hosted from the Northern region.
- √ Continued implementation of new Care Coordinator positions within DHBs.

2014/15 Implementation Plan

Item	Cancer Services: Process/Action	**2014/15** Quarter completed by	2015/16	2016/17
	1. Patient Outcome Measures			
	62 day indicator – Improvement in percentage of patients referred urgently with a high suspicion of cancer receiving their first cancer treatment (or other management) within 62 days from date of referral. Achievement of the 85% health target by July 2016	Ongoing	√	√
	31 day indicator – percentage of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 31 days of decision to treat (Policy priority)	Ongoing	√	√
	100% of patients requiring radiation therapy will receive this within four weeks (Policy priority).	Ongoing	√	√
	100% of patients requiring medical oncology treatment will receive this within four weeks (Policy priority).	Ongoing	√	√
	75% of patients accepted for an urgent diagnostic colonoscopy receive their procedure within 2 weeks (14 days).	Ongoing	√	√
	60% of patients accepted for a diagnostic colonoscopy receive their procedure within 6 weeks (42 days).	Ongoing	√	√
	60% of people waiting for a surveillance colonoscopy receive their procedure within twelve weeks (84 days) of the planned date.	Ongoing	√	√
	2.Process activity			
	2a. Models of care and service			
	Regional Health Targets			
1	Regional service to work collaboratively through ROOG process to continue achievement against health targets.	Ongoing	√	√
2	All DHBs to progress and resolve capacity and resourcing issues around faster cancer treatment, including transitioning indicator collection towards business as usual.	Q1 ongoing	√	√
3	All DHBs to progress and resolve capacity and resourcing issues around achievement of colonoscopy indicators.	Ongoing	√	√
	Faster Cancer Treatment			
3	Continue to develop FCT measurement capacity and improvements in cancer pathways for all cancers, across all DHBs by tumour stream, consistent with Regional Implementation Plan priorities. Regional process to support DHBs to improve data quality based on expectations outlined in 2013/14 'Support for improving the FCT indicator reporting' agreement. Note improvements possible through negotiated and prioritised implementation of Regional Medical Oncology Models of Care Plan and National Radiation Oncology Plan.	Ongoing	√	√
4	Engage with DHBs through the tumour stream approach to agree service improvements in lung, bowel and colonoscopy access and timeliness to treatment, reflecting progress against targets.	Ongoing	√	√
5	Continue national tumour stream(s) standards of service provision by working regionally to prioritise phased implementation across nominated tumour streams, to include an audit of a further three tumour standards.	Q4		

Item	Cancer Services: Process/Action	**2014/15** Quarter completed by	2015/16	2016/17
6	Progress scoping and implementation work concerning regional Cancer clinical data repository requirements, consistent with the Northern Region IS Strategy and the national process (refer 19 below).	Q4		
7	Continue the four year trial of a bowel screening programme implemented at Waitemata DHB.	Ongoing	√	√
	Delivering Whole of System Care			
8	Work with the Ministry of Health to agree, and in time implement the priority areas identified in the National Medical Oncology Models of Care Implementation Plan 2012/13, within available resources. 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 4 additional tumour streams and work regionally to improve the effectiveness of MDMs. Report % of patients presented to MDM by tumour streams with electronic templates, consistent with national recommendations concerning which patients are to be presented, when determined through national process.	Q4		
10	Implement the priorities identified in the Prostate Cancer Quality Improvement Plan through the establishment of a Regional Prostate Cancer Steering Group to identify and oversee implementation of regional priorities.	Ongoing	√	√
11	Provide regional support for the implementation of the extended Auckland District Health Board Bone Marrow Transplant service, opening in July 2014.	Ongoing	√	√
12	Provide regional support for the ongoing activities of the Waitemata DHB Bowel Screening Pilot.	Ongoing	√	√
13	Continue to work with the Ministry of Health to support the implementation of the Endoscopy Quality Improvement Programme.	Ongoing	√	√
14	Present an annual equity assessment, with a focus on Maori, to include FCT indicators for lung cancer, % presentation at MDM for lung cancer by ethnicity, and colonoscopy indicators.	Q4		
	2b. Workforce			
16	Increase the provision of oncology service through the establishment and implementation of Tele-health services within and between DHBs.	Ongoing	√	√
17	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	√	√
18	Establish a Registered Nurse Expanded Practice Training and Credentialing Programme, in support of increased colonoscopy provision in the region's DHBs.	Q4		
	2c. Information Systems			
19	Work with the Ministry and National Health IT Board to progress the Regional Non-Surgical Cancer Patient Management System, as a precursor to a regional clinical data repository.	Ongoing	√	√

Cardiovascular Disease

Context
Improving access to cardiac services will help our population to live longer, healthier, and more independent lives. The Northern Region's Cardiac Clinical Network has identified the following issues with CVD management in the Northern Region; • There is variation in both access and timeliness of access to core cardiology assessment, investigation and management across the primary-secondary continuum. • There are variations in CVD outcomes by socio-economic status and ethnicity with the effect that these groups do not meet accepted intervention rates and health outcomes. • The reporting infrastructure to measure activity and support improvement initiatives is incomplete across the region for both primary and secondary care.

Objectives	Linkages
We want to achieve: • Adequate, timely and equitable levels of access to key cardiac assessment and management across primary and secondary care. • Appropriate CVD risk management across the population. • Regionally consistent monitoring and auditing of investigations, management and outcomes across the four DHBs including primary care. • Models of care that better meet demand and regionally agreed standards of care by: o Reducing waiting times for First Specialist Appointments. o Ensuring appropriateness and timeliness of follow up visits. o Providing better support for discharged patients. o Reducing age standardised CVD admission rates.	• Diabetes Network • District Health Boards (DHBs) • National Cardiac Network • DHB Shared Services • GAIHN • Auckland Metro & Northland PHOs • Regional Clinical Practice Committee • National Health Committee

Key achievements since July 2013

Last year the Northern Region's Cardiac Clinical Network met the following objectives for the 2013/14 Regional Service Plan.

√ Strengthened the Northern Region's Cardiac Clinical Network by;
- Appointing a Public Health physician to the network who is able to advise on Maori access and equity issues.
- More closely integrating with primary care by appointing a GP liaison for WDHB to the network. (Currently there are primary care representatives for the other three DHBs on the network)
- Increasing the involvement of Advanced Cardiac Nurse Specialists in network projects.
- Supporting the implementation and effective use of ANZACS-QI in both ADHB and WDHB.

√ Refined the reporting of Regional KPIs. Cardiac KPI reports including details by ethnicity and inclusion of ANZACS QI reporting. Reporting continues with regard to:
- Summary report for all KPIs
- Cardiac Surgery
- Primary Care Adherence
- Cardiology First Specialist Appointment Waiting times including chest pain FSAs and follow ups
- Inpatient Coronary Angiography for ACS
- Outpatient Angiography
- Door to Balloon for Primary PCI
- Trans-thoracic Echocardiography
- National Medicine Adherence Report
- Electrophysiology
- Medicine adherence for PHO & practise-level report
- PHO medicine adherence comparison for DHBs

√ Developed:
- After hours Primary PCI- 'ECG transmission by ambulance process' has been implemented across the Northern Region along with continued utilisation of established standardised transfer processes. Transmission is occurring at CMDHB, WDHB and NDHB in all areas where there are ambulances equipped with transmissible defibrillators.
- Ongoing maintenance of Cardiac Surgery Targets have been achieved and to ensure the appropriate capacity is available to meet targets priority has been placed on operating CVICU (ACH) at higher capacity with the appointment of an additional cardiac surgeon and contracting to outsource cardiac procedures work programmes.
- CVD Risk Management has been improved by further progressing CVD risk assessments within the hospital and the community. PHOs have engaged with DHBs to work together toward the national target.
- Clinical Guidelines for treating out of hours STEMI are being maintained and updated as appropriate.
- A forum for advanced cardiac nurse specialists for the purpose of sharing information has been undertaken with this strengthening links and providing a basis for a regional approach to all facets of cardiac nursing across the region.
- The CVD Risk Registry continues to be progressed with development of the reporting requirements underway.
- An agreed Regional Electrophysiology Services (EP) model of care has been developed and regional reporting for EP services is now underway

2014/15 Implementation Plan

Item	Cardiovascular : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	1. Patient Outcome Measures			
	80% of all outpatients triaged to chest pain clinics to be seen within 6 weeks for cardiology assessment and stress test.	Q 2	√	√

Item	Cardiovascular : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	90% of out-patient coronary angiogram waiting time to <3 months.	Q1	√	√
	70% of patients presenting with an acute coronary syndrome who are referred for angiography receive it within 3 days of admission (day of admission being day 0)	Q 1	√	√
	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	√	√
	Maintain the nationally agreed cardiac surgical delivery and waiting list management targets.	Q1	√	√
	90% of eligible patients will have had their CVD risk assessed in the last 5 years	Q 4	√	√
	95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection.	Q 3		
	Aim for 95 % of outpatient Echos to have been completed within 5 months of referral	Q 3	Reducing to 4 months	Reducing to 3 months
	2. Process activity			
	2a. Models of care and service			
	Finalise a regional plan for Electrophysiology Services to better meet the patient demand.	Q 2	√	
	Develop a process to maintain ACS guidelines as a living document to allow for continuous improvement	Q 2	√	√
	Further develop the regional Primary PCI service in collaboration with St John Ambulance and ED staff to support more rapid transit of ST elevation MI patients direct to a PCI Centre.	ongoing		
	Current measures will be continued and closely monitored to ensure the appropriate capacity is available to meet cardiac surgery across the region.	ongoing		
	Utilise urgency scores to determine priority for treatment within agreed timeframes	ongoing		
	Support a variety of different approaches to CVD risk assessment in each DHB, in-line with the CVD Risk Recommendations document.	Ongoing	√	√
	Instigate collaborative improvement process for CVD Risk Management in primary care and monitor those processes.	ongoing		
	Support / improve development of three primary care pathways.	ongoing		
	Continue to improve access to Echo to support diagnosis of Heart Failure and other conditions including those requiring cardiac surgery.	ongoing	√	
	Planned implementation of Accelerated Chest Pain pathways (as per Minister's Health Report)	Q 3		

Item	Cardiovascular : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	Actively support existing Smoking Cessation Programmes	ongoing	√	√
	2b. Workforce			
	Host an Allied Health/ regional forum to share existing models of care across primary and secondary levels	Q 3		
	Implement the preferred pathway and tools for chest pain and angiography (in support of the MOH electives, e-referrals project work).	Q 3		
	2c. Information Systems			
	Implement ANZACS QI in NDHB and continue to provide ongoing support for use of KPI reporting and ACS quality improvement throughout the region.	Q 2		
	Support the population of the CVD Risk Registry	Q 3		
	Support better integration of ECG transmission by ambulance	Q 3		
	2d. Capital and other expenditure			
	Additional FTE may be required to support ECHO and EP	As required	√	√
	Ongoing FTE commitment for additional FTE for in-hospital CVD risk assessment in support of target	As required	√	√
	CMDHB business case for 2nd Cardiac Catheter lab	In progress		
	Cost implications for maintenance of equipment and call charges for ECG transmission by ambulance	As required	√	√
	Cost implications of additional SMO FTE for Regional After-Hours Call-back for the Cardiac Catheter Laboratory	As required		
	Additional FTE may be required for ANZACS QI in order to meet national targets for Cardiac Registries.	As required		

Diabetes Implementation Plan 2014/15

Context
Diabetes is a chronic disease that leads to disability through blindness, amputation of limbs, cardiovascular disease and renal failure - and it shortens lifespan. Nearly 82,000 people have diabetes in the region and this is projected to grow to 150,000 by 2026 (an increase of 82%). Certain ethnic groups experience higher rates of the disease, particularly Māori, South Asian and Pacific. To prevent / minimise the co morbidities early detection and treatment that targets retinopathy, the high risk foot, renal failure and cardiovascular disease is critical. The bulk of this activity occurs within primary care settings, rather than in hospitals. The primary care workforce needs assistance to build its capacity and capability to manage increasingly numbers of complex patients in community settings. More effective utilisation of allied health and nursing workforces and alternative care models are needed. Practice variation exists for a variety of reasons and ultimately has an inequitable impact on patients. Through a variety of quality improvement activities the Network will promote, support and monitor adherence to guidelines / care pathways and the utilisation of data to improve practice performance. Because of the lifestyle factors (for example obesity) and co-morbidities associated with the development of Type 2 Diabetes we cannot solely rely on the medical model to provide the necessary prevention and treatment. Increasing the patient's understanding and ownership of their disease is essential as it improves their ability to self-manage and undertake preventative activities. The Network will support this through improving the quality of -and access to - Diabetes Self-Management Education (DSME) and the development of information resources that better support practitioners and patients.

Objectives	Linkages
There are three key drivers to this priority area • Cost – secondary services will not grow at the same rate that the diabetes population is expected to grow. This is further impacted by the global recession. Early detection and treatment in primary care is critical. • There are unacceptable health and life expectancy disparities between ethnic groups in particular Maori, Pacific and South Asian. • There is practice variation impacting on the management of diabetes and the overall standard of care	• Northern Region Cardiac Network • Internal Stakeholders – Planning and Funding, Alliance Leadership, Long Term Conditions Groups, DHB staff • External Stakeholders – Primary care, PHO's, Diabetes NZ, Ministry of Health

Key achievements since July 2011

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

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

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

2014/15 Diabetes Implementation Plan

Item	Diabetes : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	1. Patient Outcome Measures			
A	90% of eligible patients will have had a cardiovascular risk assessment in the last 5 years.	Q1 – Q4	√	√
B	Percentage of Diabetes patients on diabetic medications	Q1 – Q4	√	√
C	Percentage of Diabetes patients on lipid lowering medication	Q1 – Q4	√	√
D	Percentage of Diabetes patients on blood pressure medication	Q1 – Q4	√	√
E	Percentage of Diabetic patients being monitored for HbA1c levels	Q1 – Q4	√	√
F	Percentage of CVD patients with Diabetes on diabetes medications (all 3)	Q1 – Q4	√	√
G	Percentage of Diabetes patients tested with microalbuminuria and on ACE or ARB	Q1 – Q4	√	√
H	37,000 patients undergo retinal screening	Q1 – Q4	√	√
	2. Foundation activity			
1	Recruit Clinical Lead	Q2		
2	Establish integrated allied health groups to provide expert advice and improve the consistency of regional service delivery	Q1		
	3. Process activity			
	3a. Models of care and service			

Item	Diabetes : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
3	Develop advice for General Practice that enhances the management of the pre diabetic patient	Q2		
4	Support the implementation of the Ministry Quality Standards, Gestational Diabetes Guideline and the NZDSS High Risk Foot Pathway and others as published.	Q1 - Q4	√	√
5	Update the NRDN pathways to include screening for depression, alignment with CKD guidelines (when released), link to DSME and other relevant HealthNavigator resources	Q4		√
6	Promote greater utilisation of Nurse Led Clinics in primary care	Q4	√	√
7	Respond to the findings from the 2013/14 retinal screening study	Q4	√	
8	Monitor, support and evaluate quality improvement initiatives in primary care eg Quality Improvement Teams, Integrated Clinics, benchmarking activities, data sharing, national and international best practice models.	Q1 – Q4	√	√
9	Explore options to enhance the reporting function of regional retinal screening volumes reporting to include ethnicity breakdown	Q4		
10	Continue to host the regional diabetes Planning and Funding forum so as to align the approach to diabetes service delivery and quality improvement within primary care	Q1 - Q4	√	√
11	Support the implementation and evaluation of Diabetes Self-Management Education (DSME) standards and curriculum. In particular: • Develop a list of DSME indicators that capture short, medium and long term patient outcomes. Monitor for trends and quality improvement opportunities • Support regional work to improve the quality of the self-management resources eg consistent messages regarding nutrition	Q4	√	
12	Share learnings from DHB innovations eg the CMDHB 20000 Day project (identifying diabetes in-patients)	Q4	√	√
13	Undertake an audit of recent amputations and analyse for quality improvement opportunities to better manage the High Risk Foot	Q3	√	√
	3b. Workforce			
14	Support the development of skills in diabetes within all health professional groups	Q4	√	√
15	Analyse regional Diabetes Workforce data. Develop metrics and utilise for planning.	Q4	√	√
16	Support primary care to initiate insulin. In particular: • Monitor number of practices that commence insulin initiation	Q4	√	√
	3c. Information Systems			
17	Develop podiatry indicators that capture the management of the High Risk Foot	Q4	√	√
18	Enhance the current indicator set. Reporting and analysis of trends, high risk group outcomes	Q1 – Q4	√	√
19	Continue to enhance the alternative indicator set and identify other data sets that can contribute to enhanced monitoring/quality improvement	Q1 – Q4	√	√
20	Continue work on exploring alternative (to TestSafe) routes to obtain /share primary care data for quality improvement purposes.	Q1 – Q4	√	√

Major Trauma

Context
This is a new priority for 2014/15. Each year in this region there are around 500 cases of major trauma and 4,200 of non-major trauma. Our historical model is to provide care at individual hospitals, with referral to tertiary centres when required. While trauma care in the region is very good, we believe we can do better with a more organised and formal trauma system to deliver optimal and equitable care to our patients. A trauma network has recently been established with agreed priorities to improve the quality of care for trauma patients. It is aligned to the national major trauma network, and in line with best practice delivered internationally. The intent is that an effective network can reduce mortality and improve functional outcomes for survivors. We also envisage cost and productivity savings through transferring patients to the right hospital for definitive care and faster inter-hospital transfers.

Objectives	Linkages
The key drivers to this priority area are to establish a formal trauma system through: • Improve outcomes for trauma patients by improving quality of care on scene, in hospitals, and across the system • Improve system efficiencies by delivering the patient to the right hospital for definitive care first time, and **s**tandardising how care is delivered	• National major trauma network • St John Ambulance • ACC

2014/15 Implementation Plan

Item	Process/Action		2014/15 Quarter due for completion	2015/16	2016/17
	1. Radiology Measures				
	KPIs will be developed in line with the work from the national trauma network.				
	2. Foundation Activity				
	Foundation activity in place, no further activity				
	4. Process activity				
	3a. Models of care and service				
	Strengthen clinical governance				
1	Implement regional clinical governance process to audit trauma cases and the trauma system		Q1	√	√
2	Develop and monitor trauma KPIs		Q1		
3	Ongoing research into trauma systems and patient management		Q1-Q4 ongoing	√	√
4	Develop and implement evaluation processes aligned to the network's priorities		Q3		
5	Support the trauma clinical leads and trauma coordinators in each DHB		Q1-Q4 ongoing		
	Pre-hospital destination protocols				
6	Support the implementation of the paediatric destination protocols		Q2		
7	Develop and agree the adult destination protocols		Q3		
	Inter-hospital transfer protocols				
8	Agree and implement new referral processes to tertiary centres e.g. single point of access to receive trauma referral		Q3		
9	Agree thresholds and protocols for inter-hospital transfers		Q3		
	Data analysis				
10	Agree regional minimum dataset for trauma based on the National Trauma Minimum Dataset		Q1		
11	Implement trauma data collection in all four DHBs		Q1	√	√
12	Analyse regional major trauma data to identify issues and inform decisions on system improvements		Q3	√	√
13	Develop process to upload regional data to the National Major Trauma Registry		Q1-Q4 ongoing	√	√
	Regional Consistency				
14	Align to national work to develop consistent standards of care for common trauma procedures		Q4	√	√
15	Undertake a current state stocktake to identify capacity and models of care, and highlight gaps, and work to address these,		Q4		
	Communications				
16	Develop and distribute communications to inform others of the progress of the network		Q1-Q4 ongoing	√	√
	3b. Workforce				
17	Review the opportunities to train and share the trauma workforce more effectively		Q3	√	√
	3c. Information Systems				
18	Monitor and evaluate the interface issues with the St John Ambulance electronic Patient Run Form		Q4		
19	Work with hA IS to develop and implement a regional trauma registry which is based on the minimum dataset and allows access by all four DHBs, regional analysis and upload to the National Registry		Q1		

Mental Health & Addiction

Context	
Rising to the Challenge - the Mental Health & Addiction Service Development Plan articulates the priority service development actions through until 2017. The 2014-15 Ministry toolkit for Regional Service Plans identifies five key objectives and the Northern region will carry forward a number of objectives from 2013-14.	
Objectives	**Linkages**
To improve: • Access to the range of eating disorder services • Adult Forensic service capacity and responsiveness through the national forensic network • Youth Forensic service capacity and responsiveness • Perinatal & Infant mental health service options as part of a service continuum • Mental health & addiction service capacity for people with high and/or complex needs • Access by young people to specialist AoD services	• The Ministry of Health Statement of Intent (2014-15) and the Outcomes framework • The Ministry of Health Output Plan and CI Business Plan (2014-15) • The Ministry of Health *Rising to the Challenge* – Mental Health & Addiction Service Development Plan 2012-2017,and Blueprint 2 • DHB Action Plans 2014-15 • The Northern region Health of Older Persons Cognitive Impairment workstream • The Waitemata DHB Business case for a Forensic decant unit.

Key achievements since July 2011

Increasing sector responsiveness to children and youth at risk

- Increased numbers of young people being seen by Youth Forensics services
- Increasing the percentage of young people being seen by specialist AOD services

Increasing service capability to respond more flexibly to support recovery

- Development of a peer support worker competency framework in collaboration with Midland region and the national workforce centre Te Pou

Developing mental health & addiction capacity in Primary Care settings

- Pilot study on consultation to Primary Care yielded results for methodology and process to support a comprehensive roll-out across Child & Youth, Adult and Older Adult services

Developing capability in services for vulnerable populations

- Completed a review of Services for People with High and/or Complex Needs with recommendations to address system pressure
- Developed and agreed upon a range of new Acute and Intensive Perinatal and Infant Mental Health services to be established.
- Completed the Eating Disorders Model of Care review with recommendations for adjustments in line with emerging clinical evidence

- Development of a single birth plan template ensuring appropriate information, risks, history and the collaborative plan around the woman's birth are available to appropriate services

2014/15 Implementation Plan

Item	Mental Health & Addiction - Process/Action	Completed by	2015/16	2016/17
	1. Patient Outcome Measures			
	Youth Forensics • Tracking the access rates and location of that access for Māori and Pacific Youth to Youth Forensic service • Tracking that the 2012-13 rate of availability of Court Liaison officers to Youth Courts is maintained or increased	Q1 & ongoing Q1 & ongoing	√ √	√ √
	AOD services for Adolescents & Youth • Working to ensure that up to 1.25% of those aged between 12 &19 years old are accessing specialist AOD services	Q4		
	Adult Forensic Psychiatry • Tracking that the percentage of mentally unwell prisoner admissions to Forensic inpatient services that meet the agreed Prison Model of Care acute & sub-acute targets is maintained or increased	Q1 & ongoing	√	√
	2. Foundation Activity / Models of Care / Service Delivery			
1	**Adult Forensics** • Work with Ministry of Health and WDHB to establish an additional 5 secure inpatient beds within the remedial works programme at Mason Clinic	Q1 & ongoing	√	√
2	**EDS Inpatient services** • Implement the agreed EDS model of care adjustments to support o Acute Medical admissions (18 years +); and o Acute Medical admissions (17 years & under)	 Q3 Q3		
3	**Improved capacity for people with high and/or complex needs** • Work with Ministry of Health and WDHB to establish an additional 5 secure inpatient beds within the remedial works programme at Mason Clinic • Implementation of a regionally collaborative mechanism to coordinate access to services for people with high and/or complex needs	 Q1 & ongoing Q2 & ongoing	√ √	√ √
4	**Youth Forensic Services** • Report on the recruitment and application of the 5.54 Youth Forensic FTE as per the regional agreement • Development of a Youth Forensic reporting framework	 Q1 & ongoing Q3	√	√
5	**Perinatal & Infant Maternal Mental HealthAcute service options** • Track and report on access, utilisation and		√	√

Item	Mental Health & Addiction - Process/Action	Completed by	2015/16	2016/17
	recruitment of FTE as the new PIMH Acute Service options are established			
	o 3 Acute Inpatient beds at Starship	Q2 & ongoing		
	o Additional Maternal MH services	Q1 & ongoing	√	√
	o Crisis & Residential services, and	Q2 & ongoing	√	√
	o Northland DHB Acute Support options	Q2 & ongoing	√	√
8	**Older Adult Services** • Working with the Health Of Older Persons Network to implement agreed recommendations from the Review of Psycho-Geriatric Residential beds	Q1 & ongoing	√	√
	3b. Workforce			
9	• Identify workforce requirements to support the implementation of			
	o Emerging framework for a Youth Forensics Model of Care	Q3		
	o Acute Perinatal & Infant MH Service options	Q2		
	o An adjusted Eating Disorders Model of Care	Q3		
13	• Working in partnership with Te Pou and Midland region to establish the framework of service user and peer support work competencies	Q1 & ongoing	√	√
14	• Working in partnership with the GM Māori forum to implement agreed recommendations from the Maori Mental Health & Addiction Workforce stock take	Q1 & ongoing	√	√
	3c. Information Systems			
15	• Support regionally to ensure the efficacy and efficiency of the planned upgrade to HCC	Q1 & ongoing	√	√

Stroke

Context
The impact of strokes and Transient Ischemic Attacks (TIAs) on individuals and their whanau / family is significant. There is a very high risk of death, and for those that survive, the disability caused by the stroke can impact on the ability to work and live independently. The disability often requires support from family and external help to support the person at significant emotional and financial cost. Strokes in the under-65 age group is particularly challenging because of the loss of income and impact on young families. Strokes are largely preventable with improvements to lifestyle such as blood pressure control, stopping smoking, limiting alcohol intake and having a balanced diet with low salt. TIA's also usually provide a good warning sign that a stroke is imminent. Good care of an acute stroke patient 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 to further improve the health and social outcomes for patients who have had a stroke. The key drivers to this priority area: • Strengthen the regional focus on stroke services in key areas • Using the region's intellectual and physical resources to improve stroke care • Avoid duplication	• NZ Stroke Foundation • Rehabilitation/NGO sector • District Health Boards (DHBs)

Achievements since July 2013

The first (foundation) year of the Stroke RSP is progressing well, in large part due to the well-established regional stroke network (in place for close to a decade) and strong national support from the NZ Stroke Foundation.

The second (establishment) year of the Stroke RSP has meant more focus and measurement around key areas such as thrombolysis, dedicated acute stroke care and rehabilitation. Much of this work has been successfully achieved in partnership with the NZ Stroke Foundation.

√ Key Achievements include:

- Progress against thrombolysis, admission to stroke unit, and time to rehabilitation, targets
- Development and implementation of stroke protocols for Hemicraniectomy and Clot Retrieval
- Regional and national alignment of TIA Pathway
- Development of dynamic electronic pathway for TIA
- Reporting and analysis around rehabilitation phase for patients
- Participation in regional rehabilitation asset planning
- Improved data quality with respect to clinical coding of strokes
- Strong linkages and input into national work programmes facilitated by NZ Stroke Foundation.

2014/15 Implementation Plan

Item	Stroke - Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	1. Stroke Measures			
	2013/14 targets			
	8% of acute ischaemic stroke patients are thrombolysed	Q1-Q4 Ongoing	√	√
	80% of patients who have an acute stroke are treated in a stroke unit	Q1-Q4 Ongoing	√	√
	Proportion of people with acute stroke who are transferred to inpatient rehabilitation services	Q2-Q4		
	Proportion of people with acute stroke who are transferred within 10 days of acute stroke admission; target 60%	Q1-Q4 Ongoing	√	√
	2. Process Activity			
	2a. Models of care and service			
1	Strengthen the Northern region stroke network, ensuring adequate DHB/ Sector representation	Q1		
2	Implement a regional "Stroke Dashboard" of indicators	Q1		
3	Report outcomes for Maaori & Pacific Island people with stroke for each KPI	Q2	√	√
4	Establish baseline & target for acute patients transferring to inpatient rehabilitation KPI	Q2		
5	Review ARCOS (Auckland Regional Community Stroke Study) and agree regional actions	Q2	√	√
6	Review National Rehabilitation Study and AROC outputs, and agree regional actions	Q3	√	√
7	Gather information for people discharged directly home with community rehab follow up.	Q3		
8	Define KPI measure & target for patients transferred to community rehabilitation.	Q4	√	√
9	Analyse quarterly, the % of all stroke discharges coded as I64 (unspecified stroke) by each DHB	Q1-Q4		
10	Inform & participate in regional rehabilitation/community planning	Q1-Q4 Ongoing	√	√
	2b. Workforce			
11	Report on training/education events and attendance by multi-disciplinary stroke teams on a quarterly basis	Q1-Q4		
12	Support national workforce initiatives and facilitate these regionally	Q1-Q4	√	√
	2c. Information systems			
13	Enable TIA Electronic Pathway Tool	Q1-Q4		

Informed Patient: Advance Care Planning

Context
We want to achieve greater patient participation and improved health care through patients being better informed across the full health spectrum; from prevention and early diagnosis to better treatment of disease. Advance care planning (ACP) will ensure: • Patients are better informed about future care and treatment choices • Healthcare providers are better informed about patient care preferences; particularly around end of life care.

Objectives	Linkages
The key objectives are to: • Improve patient and whanau access to ACP • Increase health workforce awareness of, and competence in, ACP and communication skills • Enable more efficient and accurate access to health information by health providers and the general public.	• National ACP Cooperative • Regional and national ACP tools tasks teams, project teams – across primary, secondary and tertiary care • Relevant NGO's • Disability representatives.

Key achievements since July 2013

Key achievements include:

√ Workforce Training:
- The Basic video and four Level 1 eLearning modules launched on the www.advancecareplanning.org.nz website
- Consistent growth in Level 1 training demonstrated by registration for the eLearning and post completion of eLearning module/s certificate requests
- Recruited delegates to attend Level 2 training from across primary, secondary and tertiary care, and have supported development of ACP and communication skill improvement in the regional and national healthcare workforce
- Continuous quality improvement of the Level 2 training course
- Continued to record statistically significant pre and post Level 2 training confidence increases in delegates self reported ability to undertake ACP
- Development of the Level 3 Facilitator skill base at a two day training camp and through ongoing Professional Development Plans
- Commenced the training of a further 10 Level 3 Facilitators (5 are from within the Northern Region)
- Level 3 Facilitators working unsupervised to deliver the Level 2 courses and supporting/mentoring the Level 3s in training
- Two Level 4 Trainer commenced training programme
- Retained 6 Auckland based actors in the program consolidating their skills/expertise
- Recruited and trained 8 Wellington based actors
- Recruited and trained 5 South Island based actors
- Continued to support the development of ACP skills in the Health of Older People work force as a regional priority
- Delivered 12 Northern Region and 9 non Northern Region ACP L2 Practitioner courses nationally – Note: projected to be 24 courses in total by June 2014.

√ Consumer

- Over 4,5000 ACP conversations recorded across the region
- The www.advancecareplanning.org.nz website launched (was previously a landing page)
- Engaged with consumers through the co-design process to developed the ACP website content

√ Cultural engagement
- Maori consumer tools team relaunched in February 2014 after a period where no progress was made (Led by Northland DHB)
- Asian consumer tools team work included ACP team consultation and input to an online resource supporting ACP engagement for the Asian community (Led by Waitemata DHB)
- Initiation of a Pacific Tools task Team (lead by Counties Manukau DHB)

√ Information systems
- IT solution Collaborative Care Management System (CCMS) for the recording, reporting and sharing of ACP conversations and plans is being piloted in ADHB.

2014/15 Implementation Plan – Year 3 of ACP Programme

Item	Informed Patient - Advanced Care Planning: Process/Action	2014/15 Quarter completed by	2015/16	2016/17	Notes
	1. Consumer Awareness and Support Measures				
	1a. Consumer awareness				
	Increase consumer access to ACP conversations				
1.	A 20% increase in the end of year ACP conversations documented by each of the four DHBs	Q4	√	√	
	Increase consumer awareness of ACP and/or CtC				
2.	ACP website 'hit' recorded as a proxy measure of consumer awareness and interest in ACP	Quarterly	√	√	
3.	Record the number of consumer resources (leaflets & ACP Guides) distributed by DHB	Quarterly	√	√	
4.	Record the hits on the Conversations That Count website	Q4	√	√	
5.	Record the 'Likes' on the Conversations That Count FaceBook page	Q4	√	√	
6.	Record the number of sessions each DHB CtC trainer spends promoting ACP to consumers	Quarterly	√	√	
7.	Record the number of consumers who attend CtC sessions	Quarterly	√	√	
	1b. Consumer support measures				
	Ongoing engagement and development of ACP and/or CtC resources in partnership with consumers				
1.	Engage and include the views of the disability community	Ongoing	√	√	
2.	Ensure the different cultural groups are involved/have the opportunity to contribute to ACP resource reviews and or developments	Ongoing	√	√	
3.	Continue the development the national ACP website with consumers	Ongoing	√	√	

Item	Informed Patient - Advanced Care Planning: Process/Action	2014/15 Quarter completed by	2015/16	2016/17	Notes
	• Review of website content and development of additional pages/resources as indicated	Q4	√	√	
	2. Workforce Awareness and Support Measures				
	2a. Workforce awareness measures				
	Increase workforce awareness of ACP				
1.	Annual measurement of ACP and CtC awareness in the 4 DHBs workforce	Ongoing	√	√	
	Active participation in the promotion and development of the Conversations that Count programme				
2.	Support the CTC train-the-trainers • Each DHB to facilitate monthly community CtC sessions	Ongoing	√	√	
3.	Active participation in the national CTC day (April 16th) through • Northern region participation in the CTC steering group	Q4	√	√	
	• Regional workshop in November to plan the approach for each DHB & across the region	Q2	√	√	
	• Post CTC Day regional meeting to review outcomes from the day and start the planning for the following year. Consumers to participate.	Q4	√	√	
	3b. Workforce support measures				
	Standard of care				
1.	Annual audit of the ACP policy and/or processes across each regional DHB	Q4	√	√	
	Support of ACP competency development and roll out				
2.	Each DHB to develop a plan on how they plan to: • Increase the uptake of the Basic Level training	Q1	√	√	
	• Increase the uptake of the Level 1 training	Q1	√	√	
	• Create a reserve list of staff to train as Level 2 Practitioners	Q1	√	√	
3.	Record the number of staff who have completed the ACP Level 1 modules	Quarterly	√	√	Note: ACP Training Co-ordinator will provide these details.
4.	Deliver 13 Level 2 courses across the Northern region. Training space allocation on a population based funding calculation.	Q4	√	√	
5.	Achieve a 95% attendance rate or higher at the Level 2 courses	Q4	√	√	
6.	Each DHB with Level 3 Facilitator/s to develop a plan demonstrating how the L3s will • Support/mentor Level 2 staff	Q1	√	√	
	• Progress ACP roll out in their DHB	Q1	√	√	
7.	Each ACP Level 2 Practitioner to undertake a minimum of 1 ACP conversation a month.	Quarterly	√	√	Where Level 2 staff are no longer working in the region, the relevant DHB to update the ACP Training Co-

Item	Informed Patient - Advanced Care Planning: Process/Action	2014/15 Quarter completed by	2015/16	2016/17	Notes
					ordinator who maintains the database.
	Engage cultural teams				
8.	Continue to work with Maori teams and consumers at local, regional and national level to understand and develop resources which meet the needs of these consumers. **Note:** Northland DHB are leading this work.	Ongoing	√	√	
9.	Continue to work with Asian services to provide resources for • The workforce to engage in ACP with consumers **Note:** WDHB Asian Health services leading this work	Ongoing	√	√	
10.	Develop a Pacific tools team to understand and develop resources which meet the needs of these consumers. **Note:** CMDHB ACP Team are leading this work.	Q2			
	3. Information Systems				
1.	• Each DHB has system/s to accurately record and report on workforce ACP activity	Q4	√	√	

Youth Health

Context
New Zealand has a poor record when it comes to young people's health and wellbeing. Rates of youth suicide, death from motor vehicle injuries, unintended pregnancy and drug and alcohol use are among the highest in the Western world. The distribution of poor health is marked by significant socio-economic and ethnic differences and inequities can be clearly seen across a range of measures. The determinants of youth health outcomes extend beyond the traditional boundaries of the heath sector. The health outcomes of our youth are affected by wider contexts comprising families, schools and communities. Issues such as poverty, disengagement from school and availability of alcohol are examples of risks which impact of the health and wellbeing of young people. The future of Auckland as a vibrant and economically healthy city depends on our young people being prepared to contribute to their families and communities in a rapidly changing and technology sophisticated world. This requires young people to be healthy, emotionally resilient and engaged in education and training with access to high quality health and social services.

Objectives	Linkages
Six main objectives are to: • Optimise health outcomes, including reducing inequities in health outcomes • Use a regional voice to advocate improvements in the upstream determinants of youth health • Target our interventions at those who need them most • Improve the capability and capacity of our workforce so that a young person receives quality care regardless of where they present, • Pool health and other social agency resources more effectively • Achieve greater consistency and quality of care for young people	• Northern Region Mental Health and Addictions network, and its focus on youth forensics • Youth health action plan • Youth development strategy • Auckland Council and its intersectoral groups • Northland Council and its intersectoral groups • Regional groups for maternity, youth, primary care, etc. • Child Health Network

Note: Youth are defined as 12 – 24 years for the purposes of the Youth Health Plan (there is a recognised overlap with the child health age band to reflect the blurred transition from 'Child' issues and 'Youth' Issues affecting younger people)

2014-15 Implementation Plan

Item	Youth Health : Process/Action	2014/15 Quarter completed by	2015/16	2016/17
	1. Patient Outcome Measures			
	Develop clinical outcome measures			
	2. Foundation Activity			
	Develop clinical outcome measures			
	Review youth health standards of care			
	3. Process activity			
	School based health services			
1	Explore and begin developing standards of care for school based services regionally using MOH school based service standards as a guide.			
	Youth appropriate primary care			
2	Review and develop/ refine standards for delivery of care (aspects of service design and clinician skills) for youth in other primary care settings			
	Youth appropriate secondary care			
3	Support/progress youth health services and transitions in secondary care, including the interface with primary care.			
4	**Deliver the Prime Minister's Youth Mental Health Initiative**			
5	Support regional and local development and implementation of the 'Prime Minister's initiative' for youth mental health.			

Appendix A.3:

Services – Implementation Plan Matrices

&

Supporting Material

Laboratory implementation plan

Laboratory Services in the Northern Region are delivered from DHB and private laboratories in the community setting. Key challenges in the environment include:

- Growing volumes and workload being driven by population growth, an aging population and changes in clinical practice
- A fragmented laboratory system with multiple laboratories in greater Auckland and in Northland
- Workforce shortages in some areas coupled with pressure for sub specialisation
- Increasing costs of providing services
- Need to build and maintain clinical and patient confidence in all elements of the laboratory service.

Objectives	**Linkages**
We want to ensure that the Northern Region's population has access to a high quality clinically and financially viable laboratory service, with regionally consistent work practices. Priority is being placed on: • Ensuring effective governance arrangements are in place • Developing a robust long term direction to assist with key decision making regarding investment in laboratory facilities, effective workforce utilisation, effective management of services and future contracting arrangements • Building resilience and future proofing the laboratory system to cater for changes in clinical practice and demand • Working towards more standardised access levels and processes regionally	DHB Laboratories Community Laboratories Referrers Internal & External Stakeholders

Key achievements over the past year

We have further strengthened the governance of community referred laboratory services with the establishment of a Transition Overview Group that is supported by a Clinical Pathology Assurance Group and Anatomical Pathology Advisory Group to provide leadership and assurance around the substantive changes being implemented for community referred laboratory services. The ongoing role of the Joint Advisory Group for laboratory services has been reviewed and the membership of the group strengthened.

Key achievements over the last 12 months include:

- Consistent delivery against KPIs and within contractually agreed targets
- Success transition from DML to Labtests of:
    - Clinical pathology services
    - Collection network
    - Anatomical Pathology Courier services
- Detailed planning for the transition of anatomical pathology services from DML and Labtests to ADHB and the recruitment of the workforce to deliver this service from 1 October 2014
- Approval of business cases for the LabPLUS Fourth Floor development, including a PC3 laboratory and commencement of this redevelopment
- Continued demand management of non schedule tests

- Sponsorship of National Schedule review and leadership/key contributors to working groups which resulted in the publication of a National Laboratory Schedule supported by referrer guidelines for key tests

2014/15 Implementation Plan

Item	Laboratory services : Process/Action	14/15 Quarter due for completion	15/16	16/17
	1. Laboratory services Measures			
	KPI reporting as per community referred laboratory services agreements	Q1-Q4 Ongoing	√	√
	Quarterly dashboard reporting for community referred laboratory services	Q1-Q4 Ongoing	√	√
	2. Process activity			
	2a. Models of care and service			
	Strengthened governance of laboratory services			
1	Effective contract management with providers working to agreed KPIs	Q1-Q4	√	√
2	Strong clinical oversight of all regional laboratory work	Q1-Q4	√	√
3	Enhanced collaboration between the community and DHB Pathology workforce	Q1-Q4	√	√
	Development of a long term model of delivery for laboratory services			
4	Develop a regional framework to inform decision making about where services should be delivered that will ensure: • Community and hospital laboratory services are clinically and financial viable • Effective utilisation of all assets • Retention of specialist laboratory expertise • Cost effective service delivery	Q3 – Q4	√	
	Smooth transition of community referred Anatomical (AP) Pathology services			
5	Clinically lead transition of Anatomical Pathology, supported by all parties to the agreement	Q1-Q3		
6	Service levels for Anatomical Pathology defined and agreed between LabPlus and metro DHBs	Q2		
7	Staged transition plan implemented with minimal adverse impacts for patients, referrers and staff	Q2-Q3		
	Building resilience and future proofing for change			
8	PC3 lab developed to support Auckland DHBs role as a national provider of TB service	Q4		√
9	Timely delivery of laboratory services linked with regional pilots (e.g. bowel screening, rheumatic fever)	Ongoing	√	√
1o	Develop a regional approach to incident management and disaster recovery	Q4		
	Enhanced consistency and alignment of work practices regionally			
11	Timely delivery of accurate results to all referrers	*Ongoing*	√	√

Item	Laboratory services : Process/Action	14/15 Quarter due for completion	15/16	16/17
12	All laboratory service providers meeting agreed KPIs	Ongoing	√	√
13	Demand management strategies in place and duplicate testing reduced	Q2 ongoing		
14	Adoption of common regional protocols/processes for 2-3 priority areas (eg management of unlabelled specimens, reporting of urgent results after hours results)	Q4		
15	Progressively align information systems to better support service delivery	Ongoing		
	2b. Workforce			
16	Develop regional approaches to: • Maximise retention of and grow the laboratory workforce • Support the development of subspecialties as appropriate • Address workforce gaps where they arise	Q1-Q4 Ongoing	√	√
17	Progress Anatomical Pathology Scientific and Technical Workforce Project	Q4		
	2c. Information Systems			
18	Implement eLab Orders	Q4		
19	Specimen tracking business case development and implementation initiated	Q4		
20	Ensure IS systems supporting community laboratory services are transitioned smoothly in line with contract changes	Q2		
	2d. Capital and other expenditure			
21	LabLUS Fourth Floor Shell Completed	Q3		
22	LabPlus PC3 Laboratory Completed	Q4		
23	LabPLUS Fourth Floor Fit Out completed		Q2	

Radiology

Context
Radiology provides screening, diagnostic and treatment imaging support to other clinical services. Imaging is an integral part of healthcare. By providing diagnostic information at critical points in the patient journey, and the option of image-guided minimally invasive interventional procedures, imaging services rationalise the need for intervention and target where it will have the greatest benefit. Interventional radiology procedures allow minimally invasive procedures to be performed and often avoid the need for more invasive surgery Clinical practice is changing for radiology, driven by new models of care which see health care increasingly being delivered in the community, and the introduction of new targets and pathways, particularly for cancer. It is a capital intensive service, particularly in high tech/high cost modalities such as CT and MR. The tight current fiscal environment means we will need to work differently to afford the projected future demand There are also significant workforce shortages in key areas (e.g. Sonographers).

Objectives	Linkages
The key drivers to this priority area: • A sustainable workforce in all Radiology related professional groups • Matching demand to capacity, and maximising productivity of radiology resources • Improving equitable and timely access to high quality imaging • More efficient and accurate access to health information by health providers and the public	• National Radiology Advisory Group • Regional and national PET-CT Variance Committees • Northern Region Cancer Network • Regional Capital Group

Key achievements over the past three years

The Radiology Clinical Network was established at the end of July 2011 with cross DHB and later primary care representation. It is supported by a clinical lead, Chief Medical Officer and programme manager. Since inception, achievements in Radiology in the region include:

- Consistent KPIs implemented, with improvements across most measures
- High level capital and asset plan, and detailed MR capacity analysis
- Established regional consultation and endorsement process for significant Radiology capital expenditure
- Cross-sector work to address Sonography shortage, including public and private providers, training institutions and others
- Regional Paediatric radiology development supported by
    - Paediatric radiology service standards and plan to ensure consistent quality and access across the region
    - Paediatric fellowship
    - On-line paediatric Radiology clinical guidelines and imaging protocols developed and implemented on open source
- PET-CT:
    - New regional referrals process developed
    - Reformed Variance Committee
    - Lead role in establishing multiregional group and revision of national PET-CT approved indications
- Radiology forms with regional access criteria developed and rolled out in Care Connect e-referrals
- Post Implementation Review of the regional RIS/PACS upgrade
- Lead role in development of set of national access criteria for DHB funded community radiology

2014/15 Implementation Plan

Item	Process/Action		2014/15 Quarter due for completion	2015/16	2016/17
	1. Radiology Measures				
	75% validated reports completed within 24 hours		Q1-Q4 Ongoing	√	√
	5% DNA rate for outpatient and community		Q1-Q4 Ongoing	√	√
	90% patients receive CT scan within 6-weeks of referral		Q1-Q4 Ongoing	√	√
	80% patients receive MR scan within 6-weeks of referral		Q1-Q4 Ongoing	√	√
	80% patients receive Ultrasound scan within 6-weeks of referral		Q1-Q4 Ongoing	√	√
	Track $ cost of expired inventory		Q1-Q4 Ongoing	√	√
	2. Foundation Activity				
	Foundation in place, no further activity				
	5. Process activity				
	3a. Models of care and service				
	Regional Radiology service planning and improvement				
1	Implement Paediatric Radiology Service Plan		Q1	√	√
2	Develop more service plans for specific sub-specialities		Q3	√	√
3	Implement agreed Radiology prices for inter DHB studies		Q2	√	√
4	Establish and implement regional quality assurance process across public and private sector		Q1	√	√
	National service improvement				
5	Support the development and implementation of the NHB service improvement toolkit		Q1-Q4 ongoing	√	√
6	Evaluate its implementation and impact		Q4		
	Consistent imaging protocols and wait times		Q3-Q4		
7	Support the Cancer network in development and implementation of standards for Oncology follow-up and surveillance imaging		Q4		
8	Support the development of standard imaging protocols for follow up of incidental findings		Q4		
10	Review regional Community Radiology access criteria in line with National Minimum set.		Q4		
	Strengthen linkages with others				
11	Strengthen linkages with primary care groups including regional primary care advisory group and POAC		Q2		
12	Continue to strengthen linkages between regional PET-CT variance committees		Q1-Q4 Ongoing	√	√
13	Continue to support National Radiology Advisory Group through: • Chair and clinical leadership • Developing national initiatives in key areas		Q1-Q4 Ongoing	√	√
14	Continue to liaise with other groups on radiology issues, e.g. cancer network, development of clinical pathways etc		Q1-Q4 Ongoing	√	√
	3b. Workforce				
15	Support DHBs to increase the number of Sonography trainees		Q1-Q4 ongoing		
16	Continue to lead cross sector work to address the shortage of Sonographers		Q1-Q4 ongoing	√	√

Item	Process/Action		2014/15 Quarter due for completion	2015/16	2016/17
17	Support the new intensive training program for Sonographers		Q1-Q4 ongoing	√	√
18	Continue to engage with HWNZ to support the funding and training of Sonographer trainees		Q1-Q4 ongoing	√	√
19	Engage with the MRTB to facilitate international recruitment for Sonographers, MR technicians and Nuclear Medicine		Q1-Q4 ongoing	√	√
	3c. Information Systems				
20	Explore options for roll out of electronic DHB ordering to WDHB and CMDHB and potentially NDHB		Q3		
21	Roll out MIRC teaching file across the region and to wider clinical groups		Q2		
22	Support the procurement and implementation of metro orthopaedic templating solution		Q3		
23	Champion for increased uptake of E referrals for community radiology requests		Q1-Q4 ongoing		
24	Develop robust and effective regional governance structure for Radiology IS to support current systems and new implementations		Q2		
25	Plan for metro Auckland regional enterprise PACS viewer replacement (including replacement of Web1000 at WDHB and ADHB)		Q3		
26	Advocate the expedient upgrades of Agfa PACS to a common metro Auckland platform and the Agfa RIS to current release		Q1-Q4 Ongoing	√	√
27	Support national Radiology IS initiatives through representation on clinical advisory group of NHITB and in key initiatives		Q4	√	
	3d. Capital and other expenditure				
28	Continue to support business case development, asset planning, and procurement processes		Q1-Q4 Ongoing	√	√
29	Engage with hA to improve procurement processes for radiology equipment		Q1-Q4 Ongoing		

Electives implementation plan

Context
National directions place significant emphasis upon elective services. Over the past three years the wait time targets for elective FSA and treatment has progressively been reduced from 6 months in 11/12, to 5 months in 12/13 and 4 months by the end of December 2014. In addition, DHBs are working to increase the number of elective surgery cases being done. While the Northern Region DHBs have achieved their electives targets in the past, we will be challenged to fulfil our commitment in the future. Constraints on capital funding limit our ability to build additional capacity. To be able to continue to meet our targets our DHBs have actively sought new ways to improve elective productivity within existing resources. We are progressively standardising access and care through the development of pathways so that most people who require elective services receive fast and consistent decisions. We have implemented a range of initiatives to improve productivity and efficiency. We have identified a number of regional initiatives in areas where we can make the most gain by working regionally, with a strong focus on building on the work which has been done locally. We also acknowledge that elective services are managed differently in each DHB and so have focussed on initiatives which have a universal impact across our region.

Objectives	Linkages
The objectives of the regional work are to: • Implement initiatives which will benefit all DHBs and assist in meeting the ESPI 2 & 5 targets • Support a more collaborative approach between our DHBs • Build on existing work and leverage those we are confident will provide the best results • Improve equitable access to services for our population	Capacity planning National targets Alignment to Elective Services Productivity and Workforce contract between the NHB and NRA The 2014/15 planning guidance for regional plans, and DHB Annual Plans.

2014/15 Implementation Plan

Item	Electives : Process/Action		2014/15 Quarter completed by	2015/16	2016/17
	1. Patient Outcome Measures				
	Meet and maintain ESPI 2 targets - 100% of patients receive FSA within 4 months by the end of 2014		Q2 ongoing		
	Meet and maintain ESPI 5 targets - 100% of patients receive treatment within 4 months by the end of 2014		Q2 ongoing		
	The region will deliver at least 54,118 Elective Services discharges in 2014/15		Q4		
	Improvement in time points for Northland DHB Upper Gastrointestinal patients: referral to specialist appointment, specialist to endoscopy, confirmation of diagnosis, referral between DHBs for NDHB patients with upper gastrointestinal malignancy		Q4 ongoing		
	Tracking of percentage of patients referred through the new electronic referrals system for chest pain and angiography		Q4 ongoing		
	2. Process activity				
	2a. Models of care and service				
	Develop and Implement regional framework for elective services capacity planning				
	Implement priority recommendations		Q1		
	Evaluation of Regional Framework		Q3		
	Continuous improvement of the regional framework including, tools, processes and planning		Q4	X	X
	Common Access Criteria				
	Align with the national work being undertaken in developing and implementing clinical prioritisation tools		Q4		
	2b. Workforce				
	Identify specialties where workforce is likely to be a significant constraint. Use information collected to support local, regional and national work force planning where appropriate.		Q4	X	X
	2c. Information Systems				
	Implementation of the cardiac pathway for chest pain and angiography eReferrals inter and intra DHB pilot		As per ESPWP contract		
	Evaluation report of the chest pain and angiography eReferrals pilot		As per ESPWP contract		
	Explore regional collaboration into contributing to or implementing the National Patient Flow collection. Implement initiatives as appropriate.		Q4	X	X
	2d. Capital and other expenditure				
	Support planning for DHBs capital planning		ongoing		

Pharmacy implementation plan

Context

People need access to the right medicines at the right time and with pharmacy support according to individual need. However, population growth, our aging population and the increasing numbers of new medicines and complexity of regimens is putting increasing pressure on our ability to ensure that patients receive the right level of medication management support and that costs are managed.

The northern region, like many other regions, faces challenges implementing the significant changes to the model of pharmacy care brought about by CPSA. However, some of these challenges are unique to our "urban primary healthcare culture" and also the large numbers of pharmacies in the region.

By 1 July 2014, the CPSA will enter its third year in transition. The national community pharmacy programme (DHBSS-led) to date has by necessity focussed largely on process and payment systems. Little data is available on the clinical services (LTC, PHAM and CPAMS) being delivered by pharmacies and the outcomes of these.

To optimise the value of the CPSA, we need to support some data collection and evaluation of the clinical service delivery at pharmacy to ensure that not only are the contractual obligations of CPSA met but that quality improvement becomes part of pharmacy business culture.

Objectives	Linkages

This year we want to achieve:
• Support further implementation of CPSA, through supporting the change of practice driven by the new funding model. Where possible collect data to inform the type of support required
• Support integration of community pharmacy into primary healthcare teams via:
  o Locality projects including participation in MDT
  o Medicines adherence planning in shared care.
Over the next two or three years we expect to see measurable improvements in key performance areas including:
• Further development of services tailored to patient need within CPSA with a focus on improved patient outcome
• Better integration of community pharmacy and the primary care sector
• Better communication across the medication management continuum ensuring patients are not falling through the gaps at transitions of care
• Progressive roll out of medications safety initiatives and e-medication management applications across the continuum of care
	• Community pharmacists
	• Hospital pharmacists
	• Primary care clinicians
	• Hospital specialist services
	• Primary care locality networks
	• PHOs

Key achievements since July 2013

- Implementation of single metro Auckland Pharmacy Advisory Group.
- Created content and case histories and delivered workshops to train community pharmacists in Medicines Adherence Planning.
- Piloting community pharmacy participation in regional shared care implementation.

2014/15 Implementation Plan

Item	Pharmacy : Process/Action	**14/15** Quarter due for completion	15/16	16/17
	1. Pharmacy Measures			
	Community pharmacy KPI reporting as per DHBSS requirements	Q1-Q4		
	2. Foundation Activity			
1	Resource to support continuing implementation of the CPSA (stage 4 and beyond)			
	6. Process activity			
	Models of care and service			
	Pharmacy service planning and improvement			
2	Support effective implementation of stage 4 of the pharmacy contract (CPSA) including: - Facilitating community pharmacist integration and MDT/patient care team participation o Pilot LTC medicines adherence planning in the CCMS shared care platform o Develop reporting from CCMS to monitor LTC service activity at individual pharmacy level and DHB level o Encourage pharmacy participation in projects at locality level - Monitor progress against national framework and MoH audit requirements. - Prescriber engagement (primary care via PHOs & localities and secondary care via specialist service units and hospital pharmacy)	Q1-Q2 Q3-Q4 Ongoing	√	
3	Collection and disposal of medicines waste including sharps and cytotoxics to meet safety standards: o Finalise implementation of new service	Ongoing	√	
4	Pilot the 'green bag' concept at all transitions of care to facilitate medicines reconciliation and patient medication self-management and medication safety	Q2-Q4	√	
5	Engage clinicians involved in discharge to actively refer patients to Pharmacy Home for LTC Service (LTC), CPAMS and/ or Medicines Utilisation Review Services (MURs) as appropriate to meet the needs of the patient	Q3-Q4	√	
	Regional consistency			
6	Work with Metro-Auckland Pharmacy Advisory Group (MAPAG) to facilitate and support community pharmacist service delivery and participation in locality clinical leadership teams	Ongoing		
	Information Systems			
7	Support community pharmacy participation in regional information sharing initiatives [Shared Care (CCMS),TestSafe, RCD2] ensuring appropriateness for pharmacy needs	Q1-Q4 Ongoing	√	√
8	Participate in national information sharing initiatives (shared care platform/s) to ensure appropriate for pharmacy needs	Q1-Q4 Ongoing	√	√

Appendix A.4:

Enablers– Implementation Plan Matrices

Workforce implementation plan

2014/15 Implementation Plan

Item	Workforce: Process / Action	2014/15 Quarter completed by	2015/16	2016/17
	Enable workforce flexibility and affordability to manage rising demand			
1	Develop a strategy to increase flexibility, and affordability of the workforce that reflects/identifies the correct skill mix focusing on two workforce groups each year.	Q1-Q4	✔	✔
2	Develop a regional approach to improve workforce flexibility to better manage rising demand with a particular focus on strategies to manage demand peaks such as; • Better utilising our workforce regionally • Progressively moving towards 24*7 provision as appropriate	Q2-Q4	✔	✔
	Building and align the capability of the workforce to deliver new models of care.			
3	Promote and increase under graduate training and new graduate employment placements in primary and community care by engaging with PHOs, Residential Care and other community providers for all workforces as appropriate: • Strengthen partnership with aged care facilities • Increase number of new graduate positions in priorities service areas (ring fencing NETP places)	Q3–Q4	✔	✔
4	Identify opportunities to better utilise the non-regulated workforce such as ; • Support the growth of cultural support roles • Identify and support the development of potential leaders • Identify initiatives for implementation/support arising from Kaiawhina Worker Workforce Action Plan	Q3-Q4	✔	✔
5	Train 120 people through the level 2 Advance Care planning programme.	Q2-Q4	✔	✔
6	Regional DHB development and implementation of E Learning best practice sharing of modules between subject matter experts: (target 2 modules annually)	Q2-Q4	✔	✔
	Grow the capacity and capability of our Maori and Pacific Workforce			
7	Implement national initiatives arising from Kia Ora Hauora • Recruit a minimum of 100 Maori students to a health study pathway in this region • Support at least 20 Maori into first year tertiary study.	Q4	✔	✔
8	Implement regional and local initiatives to grow our own through, Ko Awatea, Pacific Mentoring, Health Science Academies including: • A minimum of a 100 Maori and Pacific students enrolled in high school based health career programmes • Maori and Pacific people offered scholarships for tertiary health study • A minimum of 100 Maori and Pacific students offered gateway, work experience placements, or work exposure to a health setting in the region	Q4	✔	✔
9	Increase the graduate placement numbers for Maori and Pacific graduates regionally in each of nursing, midwifery, medicine and allied and technical staff.	Q2-Q4	✔	✔
10	Develop a dedicated regional recruitment and retention strategy (end to end support) for Maori and Pacific staff including: • Jointly review recruitment policies in regard to affirmative action for recruitment of Maori and Pacific people into the workforce • Promote and support the Nga Manukura A Apoppo Maori Nurse and midwifery workforce development programme.	Q2 Q2		
	Build a workforce that engages effectively with the community it serves			
11	Continue building on the cultural competency training to staff members:	Q1-Q4	✔	✔

	• 400 per DHB for CMDHB / ADHB / WDHB staff enrolled for Culturally and Linguistically Diverse (CALD) training courses annually • Provide access to CALD training courses for Northland DHB.			
12	Tikanga and Pacific cultural training is included as part of mandatory training schedule for all staff: • Establish regional plan • Implement plan (years 2 & 3)	Q3	✔	✔
	Promote advanced practice roles / working at top of scope			
13	Work in partnership with professional leaders, primary care, Professional Bodies and unions to progressively extend scope of practice for key roles and roles where there are identified shortages such as: • Support and train increased numbers of Diabetes Nurse prescribers • Develop a regional workforce programme to address bowel screening • Implement Sonographer Trainee pilot • Develop and pilot RN Anaesthetic Assistants Initiative • Progressively implement findings from the CMDHB course pilot on managed care model to support patients with long term conditions.	Q4	✔	✔
14	Support 70 people across the region to participate in Quality Improvement courses offered through Ko Awatea, WDHB and ADHB such as: • Innovation and Improvement Science Programmes • STEPS and FAST Programmes	Q1-Q4	✔	✔
	Adopt a regional HR approach to developing a healthy and engaged workforce.			
15	Review and jointly develop HR policies & procedures/processes across the region for: • 70% of staff immunised for flu • Standardised approach to student clinical placements and contracts.	Q3	✔	✔
16	Recruitment and retention of the workforce in the sector by: • Continuing to develop an effective regional RMO service to support DHBs recruit and retain an RMO workforce aligned with service delivery and training requirements • Supporting all HWNZ funded trainees to develop and implement career plans • Administer voluntary bonding, Advanced Trainee Fellowship Scheme and other HWNZ innovations.	Q1-Q4 Q3 Q1-Q4	✔ ✔ ✔	✔ ✔ ✔
17	Provide analysis and reporting of regional workforce trends. In particular: • Progress work to develop a Medical Pipeline (aligned with national work) • Maintain baseline data on Maori and Pacific health professionals	Q1-Q4 Q1-Q4	✔	✔
18	Meet HWNZ 70/20/10 funding criteria for post entry training in medical disciplines in the region.	Q1-Q4	✔	
	Optimise the capacity and capability of the RMO Workforce			
19	Lead the development of consistent approaches of minimum standards for RMO education and training across the region. • Consolidation of training resources to ensure economies of scale and sharing of good practice by standardising at least four PGY 1 / 2 programmes annually (aligned with national and regional service needs) • Utilise HSPNet to enable centralised tracking and monitoring of RMO training undertaken regionally • Improve flexibility, maximise training and better manage demand peaks of RMO rosters	Q4 Q1–Q4 Q4		
20	Promote and develop a workforce with more generic skills which is flexible to work across hospital and community settings. • DHB placement for GPEP trainees to support integration between primary and secondary care • Develop opportunities for community based experience for PGY 1/PGY 2 in line with MCNZ requirements for general registration	Q2 Q4		

Information Systems Implementation Plan

A = Analyse	C = Complete
I = Implement	R = Rollout

Information Systems Deliverables for 2014/2015	ADHB	CMH	NDHB	WDHB
Northern Region IT Programmes/Projects - Critical				
CareConnect				
• Complete the implementation of eReferrals Phase 2 (eTriage)	R	C	C	C
• Implement eReferrals Phase 3 (Intra & Inter DHBs)	I	I	I	I
• Implement the National Transfer of Care Standards (eDischarge)	I	C	I	I
• Implement a patient portal to provide access to patients to relevant health and clinical information (primary care initiative)	I	I	I	I
• Continue the rollout of the Shared Care Planning Tool to support the management of long-term conditions	R	R	A	R
• Continue to implement Dynamic and Static Clinical Pathways	I	I	A	I
• Improve integration of systems to improve the user experience for primary care users and increase system uptake	I	I		I
eMedicines Management				
• Implement Hospital ePharmacy at NDHB to enable multi-DHB use, and integration with the NZULM & NZF	C	A	R	A
• Continue the rollout of ePrescribing at WDHB, and complete the pilot at ADHB	R	A	A	R
• Implement Medicines Reconciliation at ADHB and continue the rollout at NDHB	I	C	R	C
• Implement the NZ ePrescription Service for hospital pharmacies	I	R	A	I
• Implement NZF and NZULM integration	I	I	I	I
PAS Replacement				
• Select the preferred vendor for the Northern Region PAS	A	A	A	A
eOrders for Laboratory & Radiology				
• Implement eLab Orders	R	R	I	R
• Implement Radiology Order Entry	C	A	A	I
National Patient Flow				
• Report to the National Collection to provide a complete view of the patient's secondary care pathway	R	R	R	R
Microsoft License Compliance				
• Upgrade Servers & SQL Databases to latest version	R	R	R	R
Finance, Procurement, Supply Chain (FPSC)				
• All DHBs will transition to the national system being implemented by HBL as per the HBL project timelines	I	I	I	I
Mobility				
• Develop a mobility strategy to guide investment decisions	C	C	C	C

Information Systems Deliverables for 2014/2015	ADHB	CMH	NDHB	WDHB
• Implement WiFi infrastructure to provide coverage across key clinical and business areas	R	R	R	R
Northern Region IT Programmes/Projects - Important				
Radiology PACS Upgrade and Unification • ADHB, CMH & WDHB will continue work to improve radiology performance, including network changes, system upgrades, server upgrades and configuration changes	R	R		R
Maternity Information System • Implement Maternity System (National Pilot) as the lead DHB in the region for this initiative	A	I	A	A
Telehealth • Continue the implementation of Telehealth solutions to support new ways of working	R	R	R	R
Surgical Site Surveillance • Implement Canterbury DHB solution	R	A	A	R

Facilities / Capital

The major facility projects planned in the Region and their indicative costs over the next 10 years are listed in the following table.

Major Northern Region DHB Capital Projects (Facilities)

HB	Description	National Approval Status	Indicative Commencement Year	Indicative Completion	10 Year Total
NDHB	Whangarei ED/AAU	Unapproved	2017/18	2016/17	$28.3m
	Whangarei Theatres	Unapproved	2018/19	2017/18	$25.7m
	Whangarei Wards	Unapproved	2018/19	2020/21	$72.2m
	Whangarei Ambulatory Care	Unapproved	2021/22	2021/22	$10.9m

DHB	Description	National Approval Status	Indicative Commencement Year	Indicative Completion	10 Year Total
WDHB	Taharoto Mental Health Unit	Approved	2012/13	2014/15	$24.3m
	Mason Clinic Remedial works	Approved	2012/13	2016/17	$9.7m
	Medical Beds Decant BuildingPhase	National Approval not required – Board Unapproved	2015/16	2017/18	$9.9m
	NSH and WTH Clinical Support Services	Unapproved	2015/16	2018/19	$12.2m
	NSH Tower Refurbishment Projects	Unapproved	2014/15	2020/21	$42.6m
	NSH Mini Tower	Unapproved	2014/15	2018/19	$75m
	Ambulatory Cancer Center	National Approval not required – Board Unapproved	2014/15	TBA	$9.9m
	Waitakere ED Refurb	National Approval not required – Board Approved	2013/14	TBA	$9.9m
	WTH Energy & Infrastructure	Unapproved	2015/16	2018/19	$10m
	NSH Energy & Infrastructure	Unapproved	2016/17	2018/19	$11m
	North Shore Hospital Carpark	Unapproved	2015/16	2016/17	$20m
	Awhina	Unapproved	2015/16	2016/17	$21.4m
	Purchase of Community & Commercial Building	Unapproved	2014/15	2014/15	$18.0m

DHB	Description	National Approval Status	Indicative Commencement Year	Indicative Completion	10 Year Total
ADHB	Starship Theatres & Operating Rooms-Building	National Approval not required – Board Approved	2013/14	2014/15	$9.4m
	LabPlus Anatom Path Exp	National Approval not required – Board Approved	2013/14	2014/15	$9.825m
	Greenlane Clinical Centre Bed Growth	Unapproved	2021/22	2023/24	$55m
	Child and Family Unit - new build 35 bed unit	Unapproved	2017/18	2017/18	$17.6m
	Mental Health 30 new acute & extended care beds for growth	Unapproved	2021/22	2022/23	$14.85m
	Replacement Radiotherapy Capacity	Unapproved	2019/20	2019/20	$22.5m
	Auckland City Hospital – Cancer Service Facility	Unapproved	2015/16	2017/18	$30m
	GCC – Renal Precinct	Unapproved	2015/16	2016/17	$15m
	GCC- Colonoscopy / Endoscopy	Unapproved	2017/18	2018/19	$10m
	Greenlane Clinical Centre- new Car Park Building	Unapproved	2023/24	2023/24	$10m
	ACH Fraser McDonald Unit redevelopment	Unapproved	2015/16	2016/17	$10m
	ACH additional car parking capacity	Unapproved	2016/17	2016/17	$10m

DHB	Description	National Approval Status	Indicative Commencement Year	Indicative Completion	10 Year Total
CMDHB	Women's Health	Unapproved	18/19	2020/21	$60.00 m
	Southern Car Park	PPP			$19.00 m
	Acute Mental Health	IBC Complete, Developing full Business Case to CIC Nov 2014	2015/16	2016/17	$50m
	Specialist Rehab	Developing IBC, to CIC Aug/Sept 2014	2015/16	2017/18	$65m
	Diagnostics (Laboratory)	Developing Single Stage Case, to CIC Aug/Sept 2014	2014/15	2023/24	$10.ml
	Project Swift	PPP			TBD ($40m-$100m over 5-10 years)