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Next Meeting Date 20 March 2018
Deadline for Agenda Items 2 March 2018

MidCentral District Health Board

A g e n d a

Meeting of the

Healthy Communities Advisory Committee

and

Quality & Excellence Advisory Committee

to discuss matters of shared interest

Part 1

Date: 13 February 2018

Time: 10.45 am

Place: Board Room
Board Office
Heretaunga Street
Palmerston North

MidCentral District Health Board

Healthy Communities Advisory Committee Meeting
Quality & Excellence Advisory Committee

Tuesday, 13 February 2017

Matters of Shared Interest - Part 1

Order

1. ADMINISTRATION MATTERS 10.45am

1.1. Apologies

1.2. Late Items

1.3. Conflict and/or Register of Interests Update

2. STRATEGIC & ANNUAL PLANNING 10.50am

2.1. 2018/19 Regional Service Plan – priorities and approach

Pages:	3-7
Documentation:	report from the Manager, DHB Planning and Accountability dated 25 January 2018
Recommendation:	that the regional service planning priorities for 2018/19 and progress to date be **noted**.

2.2. 2018/19 MidCentral DHB Operational Business Plan – Implementation Update

Pages:	8-26
Documentation:	report from the Manager, DHB Planning and Accountability dated 31 January 2018
Recommendation:	that the progress report against the DHB's Operational Business Plan for the period ending December 2017 be **noted**.

For:

	Decision
	Endorsement
x	Noting

To	Healthy Communities Advisory Committee Quality & Excellence Advisory Committee
Author	Vivienne Ayres Manager, DHB Planning and Accountability
Endorsed by	Craig Johnston General Manager, Strategy Planning and Performance
Date	25 January 2018
Subject	**2018/19 REGIONAL SERVICE PLANNING – APPROACH AND PRIORITIES**

RECOMMENDATION

It is recommended that:

the regional service planning priorities for 2018/19 and progress to date be **noted**.

Strategic Alignment

This report concerns the 2018/19 annual planning round, with particular attention to the partnerships with other District Health Boards in the Central Region and to addressing regional strategic and operational planning priorities.

Glossary

CE(s)	Chief Executive(s)
COO(s)	Chief Operating Officer(s)
DHB(s)	District Health Board(s)
GM(s)	General Managers
MoH	Ministry of Health
P&F	Planning and Funding
RSP	Regional Service Plan
TAS	Central Region Technical Advisory Service

1. PURPOSE

This report updates the Committee on the approach and development of Central Region's Regional Services Plan for the 2018/19 year. This report is for information – no decision is required.

2. BACKGROUND

Since inception of the New Zealand Public Health and Disability (Planning) Regulations 2011, District Health Boards within a defined geographical area (one of four regions) have been required to prepare a Regional Service Plan under section 38(1)(b) of the New Zealand Public Health and Disability Act 2000. The content and form of the Regional Service Plan (RSP) is specified in the Planning Regulations and must include a strategic element and an implementation element. As with the Annual Plan, a DHB that is involved in preparing a RSP must consult with the public in relation to the plan if the Minister considers that:

(a) the plan proposes changes to services, including to service eligibility, access, or the way services are provided; and
(b) the proposed changes will have a significant impact on recipients of services, their caregivers, or providers.

Before the Minister of Health and the DHBs agree on the regional service plan, the Board of each DHB that is to participate in the plan must agree to it, with their Chair and CE signing the plan on its behalf. The implementation element of a regional service plan must be reviewed annually and RSPs must be updated annually.

The RSP is developed annually to both ensure national priorities set by the Government are implemented by the each region, and to highlight and address agreed regional priorities that relate to the services to be provided by the contributing DHBs.

The Central Technical Advisory Service (TAS) coordinates the completion of the RSP on behalf of the six DHBs of Central Region. This year, the Central Region's DHBs via the Chief Executives, Chief Operating Officers (COOs) and General Managers (GMs) Planning and Funding (P&F) have indicated an intention to move beyond the Ministry priorities to develop a stronger regional strategy to address service priorities and planning. This will be represented in the RSP for 2018/19 and will form the basis of planning for future years.

The Ministry of Health issues planning guidelines that include government and national planning priorities that are to be factored into the implementation element of the RSP. The RSP is subject to a review process by the Ministry of Health and is submitted for approval by the Minister.

3. REGIONAL SERVICES PLANNING APPROACH AND PRIORITIES

Executive leadership for the development of the RSP rests with the DHB COOS and GMs. Overall leadership of the regional strategy is with the DHB CEs. The development of the regional strategy continues.

Our vision for the central region is “Central Region DHBs leading together to achieve New Zealand’s healthiest communities”. Three key outcome areas have been identified. These are:

- digitally enabled health system
- clinically and financially sustainable health system
- developing the workforce

A review of existing regional networks and regional programmes has commenced to inform and agree on arrangements for the 2018/19 year. A regional strategy and RSP meeting is being planned and facilitated by TAS in February. Representatives from regional DHB executive groups (nursing, medical, allied health, Maori and Pacific, information technology, finance, human resources), DHB planners and chairs of the regional networks have been invited to attend.

While to date the RSP has recognised the diverse nature of the region’s population requirements with a coordinated approach to meet the needs of individual communities, a stronger population and patient centric approach for future RSPs is proposed. This approach will recognise the diversity of patient needs and that services should be tailored further to ensure that health outcomes are improved and equity of access across services in the region exists.

Updated data received from Statistics New Zealand has been used to draft an updated population profile to inform planning and to include in the 2018/19 RSP document.

Regional planning guidance material and the government planning priorities expected to be included in the implementation planning component of the RSP has not yet been received. Indications to date suggest that the requirements for the 2018/19 RSP will be very similar to 2017/18, with the key enablers continuing to be workforce, information technology and capital. It has been suggested that the focus for the 2019/20 RSP will be very different however; we are awaiting more information on this. Linkages and ‘line of sight’ between the DHB’s Annual Plan and the RSP will be made evident as the implementation planning process proceeds for each of the priority programmes.

4. 2018/19 REGIONAL SERVICE PLANNING – PRIORITIES

The COOs and GMs P&F have agreed four main strategic priority programmes for the region:

- Cancer
- Cardiac
- Mental Health and Addictions
- Clinical Care Arrangements

Each of the four priority programmes for 2018/19 has an agreed regional clinical and executive representative group leading the strategy development and implementation planning for their programme. The respective programme plans are currently being drafted.

Planning to date has focused on these priority programmes, as summarised below.

Regional Cancer Strategy:
Following development of background material and initial planning meetings to identify key outcomes and actions, further engagement and a series of workshops will be conducted in February 2018. The aim of the workshops is to strengthen clinical governance and create mechanisms for planning how cancer services are delivered across the region to improve quality and outcomes for the region. Ernst Young has been engaged to support the process.

Regional Cardiac Strategy:
Development of background material and initial planning meetings held. Detailed planning for echocardiography work completed and implementation planning is underway. Initial discussions regarding total service development for Percutaneous Coronary Intervention (PCI) completed; further planning meetings scheduled.

Mental Health and Addictions Strategy:
Development of background material and initial planning meetings held. Preliminary areas of focus identified by the leadership team are workforce, IT, models of care, and equity. Specific service priority areas will be identified at a facilitated workshop scheduled for end of January.

Regional Clinical Care:
This considers issues such as the inter district flow of patients between DHBs. A baseline case analysis has been completed for inpatient casemix events. Specialty areas for further work have been identified. These are cardiac services, neurosurgery, paediatric surgery and vascular service. Baseline work for analysis of non casemix activity is underway, focused on cancer and neurosurgical specialties.

5. NEXT STEPS

- TAS will continue to facilitate meetings throughout February for each network with a key focus on the four main clinical service priority programmes. They will begin to consolidate the key issues to be addressed and what the programme outcomes and prioritised objectives for the next year are intended for their implementation plan.
- In February there will be a larger planning meeting with all the network leads and professional groups, DHB Planners, COOs and GMs P&F to further develop the regional strategy
- Ministry of Health planning guidance material (including timeframes) regarding government and national planning priorities for the 2018/19 RSP is expected sometime in February (considerably later than usual). This will be communicated to all networks and groups for consideration and inclusion in the RSP once it comes to hand.
- The first draft RSP will be submitted to the regional CEs at the beginning of March 2018. It is currently anticipated that the first draft RSP will be required by the Ministry of Health for their first review at the end of March 2018.

- Board members will receive a copy of the draft RSP at the earliest opportunity for their consideration and feedback.

6. RECOMMENDATION

It is recommended that:

the regional service planning priorities for 2018/19 and progress to date be noted

Vivienne Ayres
Manager
DHB Planning and Accountability

	**For:** [ ] Decision [ ] Endorsement [X] Noting
To	Healthy Communities Advisory Committee Quality and Excellence Advisory Committee
Author	Vivienne Ayres Manager, DHB Planning and Accountability
Endorsed by	Craig Johnston General Manager -Strategy, Planning and Performance
Date	31 January 2018
Subject	**2017/18 MidCentral DHB Operational Business Plan - Implementation Update**

RECOMMENDATION

It is recommended that:

- the progress report against the DHB's Operational Business Plan for period ending December 2017 be **noted**

Strategic Alignment

Operational performance is aligned to the DHB's Strategy, advancing each of the four strategic imperatives through planned activities detailed in the DHB's Operational Plan. This report supports stewardship and accountability of the organisation to progress the delivery of quality health services to the district's population.

Glossary

CCN-LTC	Community Clinical Nurse – Long Term Conditions
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CPHO	Central Primary Health Organisation
DHB	District Health Board
ED	Emergency Department
FCT	Faster Cancer Treatment
FTE	Full time equivalent

GPT	General Practitioner Team
HCSS	Home and Community Support Services
IFHC	Integrated Family Health Centre
ICT	Information and Communications Technology
LMC	Lead Maternity Carer
LRT	Local Response Team
MoH	Ministry of Health
MDHB	MidCentral District Health Board
MHAS	Mental Health & Addiction Service
MSD	Ministry of Social Development
NGO(s)	Non Government Organisation(s)
OST	Opioid Substitution Therapy
PHO	Primary Health Organisation
RCTS	Regional Cancer Treatment Service
RN	Registered Nurse
SACAT	Substance Addiction (Compulsory Assessment and Treatment) Act, 2017
SBHS	School based health service
TOAM	Te Ohu Auahi Mutunga (smoking cessation service)

1. PURPOSE

This report provides the Committee with an update on progress against the planned initiatives outlined in the DHB's Operational Business Plan. It is for information and discussion – no decision is required.

2. SUMMARY

The format of this report is aligned to the proposed Integrated Service Model to be delivered by 'clusters'. This report focuses on the initiatives outlined in the DHB's annual Operational Business Plan derived from the cluster group Operational Plans for the 2017/18 year, excluding those aligned to the hospital (acute and elective services), which are reported to the Quality and Excellence Advisory Committee.

Progress against the initiatives aligned to the Government's planning priorities identified in the 2017/18 Annual Plan are separately reported each quarter to the Board Committees together with the results of the non-financial monitoring framework and performance measures (including health targets), as reported to the Ministry of Health.

The following table summarises the key programmes that feature in the DHB's Operational Business Plan for the 2017/18 year.

Strategic Priorities – 2017/18 Work programme

WHY? (Desired Outcomes)	WHAT? (Priority programmes)
Early detection and intervention ▪ Reduced amenable mortality ▪ Increased screening coverage ▪ Increased enrolments ▪ Reduced overdue examinations ▪ Reduced time to treatment ▪ Improved equity of outcomes	Primary mental health Oral health Cervical, Breast (Bowel screening) Sexual and reproductive health Pregnancy and parenting Health check programmes Faster cancer treatment Vulnerable children and youth Māori, Pacific, Refugees Kaianga Whanau Ora
Closer to home – long term conditions ▪ Reduced ambulatory sensitive hospitalisations (priority conditions) ▪ Increased home-based dialysis ▪ Improved collaborative care planning and case management ▪ Improved equity of outcomes	Renal services plan Diabetes programme Cardiology services plan District Nursing integration Community based options Supportive care framework Mental health – shared care
Service improvement programmes – Mental Health / Women's Health ▪ Better experience of care ▪ Improved patient safety, responsiveness and effectiveness of clinical care ▪ Reduced variation in practice	Ward 21, Community mental health Māori mental health Models of service delivery Primary Birthing Unit Consumer engagement Intersectoral collaboration/partners
Better use of resources ▪ Optimised theatre capacity ▪ Improved patient flow	Psychogeriatric service, STAR1 Acute and urgent care strategy Emergency Department facility

▪ Reduced acute bed days ▪ Contained cost growth ▪ Reduced waste	improvements Hospital Operations Centre and escalation protocols Electives schedule / production plan Referral and treatment pathways Interface geriatrics service Workforce configuration Investment strategy and capital plan Hospital campus strategy

As at the end of December 2017, the majority of the initiatives under each of the non-hospital based programmes covered in this report are at various stages of implementation, some have been completed as planned and others are at the initiation phase.

The following projects / initiatives have been delayed:

- The increase in resources to better address the needs of children with learning and behaviour difficulties and complex care needs. As there is further work happening by the Ministry of Health in this area, and together with our financial constraints, it would seem prudent to defer this project. This is discussed in a separate paper on the HCAC agenda.
- Implementation of the fluoride application programme for 'at risk' children will now not commence until the 2018/19 year. This is due to a delay to implementing the prerequisite risk assessment programme in the new child oral health clinical information database. Having established the completeness and integrity of data in the first instance, development of the risk assessment programme will now commence in February 2018, which will then enable the targeted fluoride application programme to proceed.
- Implementing the Ministry of Health's Commissioning Framework for Mental Health is behind schedule. The framework is being developed as a guide to planning and funding decisions for 2018. We are awaiting a further update from the Ministry of Health.

Reducing ambulatory sensitive hospitalisations for specified cardiovascular diseases, diabetes and respiratory conditions in the adult age group remains a challenge, although there were fewer admissions resulting from asthma and myocardial infarctions in this cohort over the 12 months ending September 2017. General Practice Teams contracted to provide the LTC Programme this year are supported to manage their population utilising a Quality Improvement Plan (QIP) process.

3. RECOMMENDATION

It is recommended that:

the progress report against the DHB's Operational Business Plan for period ending December 2017 be noted

4 OPERATIONAL BUSINESS PLAN PROGRESS UPDATES

4.1 Primary Health Care Operational Plan

Overall Summary of Progress to 31 December 2017

The 2017/18 Operational Plan for Primary Health Care year to date focuses on enabling better access to patient information, better support for people with long term health conditions and integrating nursing services. The majority of activities are tracking to plan although there has been a delay to the implementing the broader integrated nursing services model.

Objective: Increase uptake and utilisation of patient e-portal

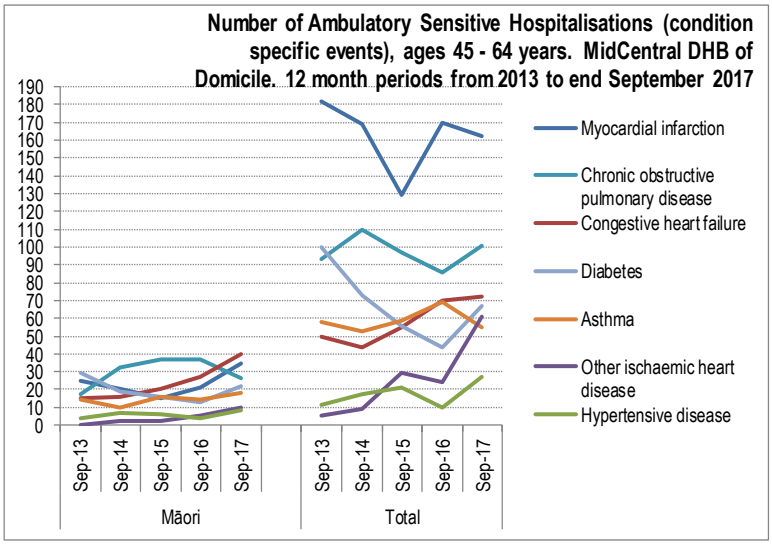
Activity	Progress Update to 31 December 2017 (2017/18 Quarter 2)		
	Status	Progress	Comment
Support GPTs to increase options to undertake e-consultations by 30 June 2018	G	I	Portal registrations have been steadily increasing

2017/18	Total Enrolled	Total Registered	Percent
Q1	158,334	10,630	6.7%
Q2	158,334	13088	8.0%

Three practice portal workshops were held across the district to encourage general practice uptake. Sixteen of the 32 (50%) general practices are signed up to the patient portal and are at various stages of registering patients.

Objective: Improve management of long term conditions

Results to date



Projected DHB populations:

Ethnicity	2013	2014	2015	2016	2017
Other	37270	37330	37500	37590	37480
Maori	5640	5830	5990	6190	6370
Total	42910	43160	43490	43780	43850

Data for hospitalisations for specific ambulatory sensitive conditions over 12 months ending September 2017 shows an increase for the total cohort across these conditions (545 compared to 473 over 12 months ending September 2016), although there were fewer admissions for myocardial infarction and asthma and the number of admissions for congestive heart failure were similar to the previous year.

Notable increase in admissions of Maori with congestive heart failure and diabetes, although fewer with COPD compared to previous 12 month period.

The rates (standardised and non standardised) per 100,000 MidCentral DHB population were all higher than the national rates for each of these conditions, with the exception of COPD.

(Note: the apparent increase in "other ischaemic disease" over this latest period may reflect a change in clinical documentation and coding practises rather than an increase in incidence)

Status legend:	G	On track to achieve deliverable, measure and/or target, as planned	A	Behind plan – minor risks to achieving deliverable/s. Remedial action plan in place	R	Behind plan – major risks to achieving deliverable/s. Remedial plan, escalation, and exception report	D	Not completed as planned
Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced

Diabetes: 12 months to 31 December, 2017	Total	Maori	Pacific	Other
Number of PHO enrolled population aged 15 – 74 years with diabetes	**6,209**	1,346	316	4,547
Proportion with the most recent HbA1c during the past 12 months of *equal to or less than 64 mmol/mol*	**60.7%**	51.0%	50.6%	64.2%
Proportion with the most recent HbA1c during the past 12 months of *equal to or greater than 101 mmol/mol*	**2.8%**	5.3%	7.6%	1.7%

Activity	Status	Progress	Comment
Utilisation of common data sets and READ codes to target resources to improve outcomes for patients with respiratory, heart disease and diabetes by 31 October 2017	A	I	A group of clinicians and leaders attended a health roundtable event in Auckland looking at cross system data for specified conditions. Work has been commenced on priority areas with an initial hui in December. National dataset(s) for Ambulatory Sensitive Hospitalisations (and other indicators) also continue to be used between DHB and PHO.
Equitable and timely services for people with heart disease through an integrated model of care by 30 June 2018	G	I	A pilot process has been established in two Integrated Family Health Centres to support structured transfer of care of heart failure patients back to their primary care team. Primary Health Care representatives are contributing to the 'Medimorph' project to further identify opportunities to support effective transfer of care.
Establish community-based spirometry service by 30 June 2018	G	I	Since mid-October 110 community spirometry consultations have been undertaken. Clinics have been held at City Doctors, Kauri Health Care, Cook Street Health Centre, Victoria Medical Centre and Milson Medical Chambers. Clinics are currently booked for Group Medical Chambers and Health Hub Project. Most patients treated in these clinics are from the practice where the clinic is held. In the near future it is anticipated that clinics will also be run in smaller general practices. Spirometry is being performed using the Quality Assurance Process designed in phase 1 of the project. Clinical oversight and assistance with quality control and assurance is provided by the experienced Compass Health Respiratory Facilitator who is a Respiratory Physiology Technician with expertise in spirometry. Extending capabilities to deliver spirometry assessment in general practice is occurring with Practice Nurse and CPHO CCN-LTC respiratory champions being developed through an accreditation process.
Promote uptake and utilisation of the TOAM app for quit smoking by 30 June 2018	G	I	Promotion has occurred this quarter to raise community awareness of smokefree support service available in the district (TOAM) through posters and the TOAM app.

Status legend:	G	On track to achieve deliverable, measure and/or target, as planned	A	Behind plan – minor risks to achieving deliverable/s. Remedial action plan in place	R	Behind plan – major risks to achieving deliverable/s. Remedial plan, escalation, and exception report	D	Not completed as planned
Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced

Objective:	Improve integration with the broader health and disability sector		
Activity	**Status**	**Progress**	**Comment**
Broaden integrated nursing model to other community and public health nursing roles by 30 June 2018	A	P	Behind scheduled implementation date (31 December). The Case for Change for the agreed integrated nursing model was endorsed by the Project Board and MDHB Executive Leadership Team in December. Commitment to scale to priority areas of Horowhenua and the suburb of Highbury, Palmerston North received. Detailed planning for phase 3 of the project commencing. A major factor delaying project progress is the lack of access to end-to-end ICT solutions between the MDHB and CPHO and General Practice Teams and access to appropriate mobile devices for District Nurses. The Project Implementation Team is currently awaiting a report, commissioned by the DHB that will detail the current workflows in and out of the District Nursing Service and recommendations for ICT solutions.
Objective	Reduce hospital bed day utilisation and acute readmissions to hospital for people with long term conditions through well-coordinated transfer of care arrangements for the patient and the family/whanau		
Continue to support GPTs to deliver appropriate level of care and support to patients identified with long term conditions	G	I	The Community Clinical Nurses continue to support GPTs with proficient/competent level nurse support for patients with Long Term conditions. CCN-LTCs continue to use the ManageMyHealth (MMH) Comprehensive Health Assessment (CHA) tool for assessments
Embed new IFHC/GPT Long Term Conditions programme: Risk stratification, utilisation of ED and ASH data to target appropriate clients, assessment, care planning / action planning	G	I	Following a co-design process with General Practice teams who undertake funded LTC support, the Enhanced Care Plus programme evolved into the Long Term Condition Programme for 2017/18. The changes made reflected the need for a more flexible, responsive model within the primary care environment; one that allowed GPTs to identify their high needs patients and then determine and provide the required level of support. Practices that have contracted to provide the LTC Programme this year are supported to manage their LTC population utilising a Quality Improvement Plan (QIP) process. The QIP supports the practice to plan improvement activities over a specified period and helps to keep the team focused on the end goals, reducing unwarranted variation in patient centred clinical outcomes. The QIP is also aligned to the district's System Level Measures (SLM) framework and the MoH population health indicators. Reportable data sets are available for routine SLM and population health requirements and are provided monthly. The provision of individualised practice data sets is work in progress currently.

Status legend:	G	On track to achieve deliverable, measure and/or target, as planned	A	Behind plan – minor risks to achieving deliverable/s. Remedial action plan in place	R	Behind plan – major risks to achieving deliverable/s. Remedial plan, escalation, and exception report	D	Not completed as planned
Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced

4.2 Maternal and Child Health Operational Plan

Overall Summary of Progress to 31 December 2017

The 2017/18 Operational Plan for Maternal and Child Health (non hospital based) includes immunisations for pregnant women, supporting pregnant women to quit smoking, commissioning the Primary Birthing Unit, developing the capacity of child development services, transition of care arrangements for children and young people, addressing sudden unexpected death in infancy with Maori whanau, and implementing a fluoride application programme for at risk children. While the majority of activities are tracking to plan, there have been some delays and two projects have been deferred to the 2018/19 year.

Objectives:	Promote and improve the coverage of influenza and Pertussis vaccination for pregnant women (28 – 40 weeks)		
Activity	**Status**	**Progress**	**Comment**
Improve access to Pertussis and Influenza vaccination for pregnant women (up to 38 weeks gestation) by working alongside Community Pharmacy, GPTs and Māori and iwi providers	A	P	Currently awaiting PHARMAC decision to enable provision of Pertussis and Influenza vaccination for pregnant women within community pharmacies.
Objective:	Reduce modifiable system failures and risk factors contributing to initial and recurrent hospitalisations for acute rheumatic fever Increase spread of advice and support for pregnant women to quit smoking		
Maintain systems to ensure effective follow up of rheumatic fever cases	G	C	Systems in place to ensure effective follow up of rheumatic fever cases occurs.
Maintain support for the Te Ohu Auahi Mutunga (TOAM) smoke free programme using a whānau ora approach	G	I	Matanga are located onsite with direct access to engage directly with and support, women and their whanau to maintain a smokefree environment at home and in their vehicles Matanga midwife promotes early referral to TOAM for hapu women who are smokers Ongoing collaboration between Pepi Haumaru and Mokopuna Ora with Matanga midwife providing a 'wrap-around' approach to promote smokefree whanau
Objective:	Support implementation of the Maternity Review findings and recommendations		
Confirm and agree the operational arrangements for the Primary Birthing Unit, with contract in place, by 31 December 2017	G	C	Annual contract for Te Papaioea Birthing Centre in place with Birthing Centres Limited (BCL) on a capped fee-for-service basis. Contract to be reviewed/renewed 30 June 2018.
Objective	Pregnant women and whanau have access to relevant and meaningful resources and support to quit smoking		
Deliver professional development sessions for hospital midwives to increase the utilisation of smokelysers by women admitted to hospital for labour and delivery to support 'quit smoking' conversation	G	I	Progressing as planned; occurring with TOAM Matanga midwife as well as with PHU Quit Coach for broader application across maternity unit

Status legend:	G	On track to achieve deliverable, measure and/or target, as planned	A	Behind plan – minor risks to achieving deliverable/s. Remedial action plan in place	R	Behind plan – major risks to achieving deliverable/s. Remedial plan, escalation, and exception report	D	Not completed as planned
Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced

Objectives: Improve the capacity of child health services to better meet the needs of children with learning and behaviour difficulties			
Activity	**Status**	**Progress**	**Comment**
Secure appropriate resources (1FTE psychology and 1FTE occupational therapist) to ensure service delivery by 31 December 2017	D	N	Project deferred; further work happening by Ministry of Health in this area and together with our financial constraints, it would seem prudent to defer.
A multidisciplinary approach to management of learning and behaviour referrals is explored, including child health, child development service, CAFs, education sector and Pae Ora Māori health directorate by 31 May 2018	D	N	Progress deferred. As above
Objective Improve transition of care planning between child and adult health services alongside management of adolescents with complex health problems			
Establish a Complex Care Coordinator role by 30 June 2018	D	N	Deferred. As above
Project management resource for transition of care programme is obtained	G	C	Project management resource in place (commenced November). Project planning underway.
Identification of eligible children and young people (potential young people accessing the Home Care Team, Child Development Service, Diabetes and Endocrinology Services	G	P	Initiating stage. In progress.
Establish a case coordination service approach to manage the ongoing transition of young people from child health to adult health services by 30 June 2018	G	P	Underway; development phase.
Objective: Improve the health care experience for children with complex care issues and their families by providing a better coordinated approach to care management			
Profile ASH data, and work with CPHO to provide feedback mechanism to general practice teams.	G	I	Underway and progressing with individual dashboard reporting; linked to incentivised programme for System Level Measures with GPTs
Objectives: Maintain a high proportion of the 0-4 year old children enrolled with the Child and Adolescent Oral Health (CAOH) Service Increase caries free rate of 5 year old children over the next five years with a particular focus on improving oral health equity for Māori and Pacific children			
Activity	**Status**	**Progress**	**Comment**
Continue to provide train the trainer programmes (Lift the Lip campaign) for IFHCs/GPTs to support identification of oral health risk factors through the use of a standardised immunisation checklist	G	C	Standardised checklist redeveloped and implemented in IFHCs/GPTs to accommodate “lift the lip” assessment as part of the child’s health check at the time of immunisations for under 5 year olds. Staff received relevant training with ongoing system in place.

Status legend:	G	On track to achieve deliverable, measure and/or target, as planned	A	Behind plan – minor risks to achieving deliverable/s. Remedial action plan in place	R	Behind plan – major risks to achieving deliverable/s. Remedial plan, escalation, and exception report	D	Not completed as planned
Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced

Implement a pilot fluoride application (six monthly) programme for children identified as 'high risk' as per Ministry of Health recommendations	D	N	Fluoride programme not commenced and deferred date to 2018/19 year;. Flouride application programme dependent on risk assessment and profiling data derived from the clinical oral health information system (Titanium) implemented in the 2017 year. Risk assessment programme using Titanium due to commence from February 2018. Further, dental therapy resource constraints throughout the year (due to vacancies that are difficult to fill) have meant available resources being prioritised to address and rectify the significant number and wait time of children overdue their recall examinations (arrears). There will be three new graduates and an experienced therapist commencing beginning of February 2018. Employment of additional administration resource has also assisted in entry of essential data in Titanium to assist clinical teams and improve data accuracy.
Evaluate the pilot fluoride application programme for children identified as high risk, by June 2018	D	N	To be conducted post implementation in the 2018/19 year. See above.
Objective: Reduce the incidence of sudden unexpected death in infancy (SUDI)			
Provide support for Well Child Providers to improve dissemination of SUDI information to families/whānau at core contact one	G	I	Ongoing activity, with facility to monitor data recorded against core contact visits routinely monitored. Collective support, information and advice continues to be provided through the Pepi Haumaru programme delivered via MidCentral's Maternity Service, community child heath, LMCs and WCTO providers
Contribute to the establishment and implementation of the Central Region's Sudden Unexpected Death in Infancy (SUDI) Prevention programme	G	I	Central Region SUDI Coordinator in place. A Central Region SUDI Prevention Plan has been developed, and has been submitted to the Ministry of Health; currently awaiting feedback.
Objective: Increase newborn enrolment with Central PHO and Well Child Providers			
Strengthen data quality to reflect accurate reporting of newborn enrolment rates for both national and local data	A	I	Discrepancies between local and national datasets continue to be observed. Efforts continue to support on time B-coding of newborn enrolled children within general practices' PMSs. Central PHO practices are implementing the National Enrolment Service (NES) and once fully adopted by all practices with validated data, the NES is expected to reflect accurate reporting of newborn enrolment rates locally.
Objective: Reduce the incidence of unintended teenage pregnancies			
Deliver surgical termination service locally to complement the medical termination service	G	I	Complementary surgical termination service scheduled to commence from 01 March 2018.

Status legend:	G	On track to achieve deliverable, measure and/or target, as planned	A	Behind plan – minor risks to achieving deliverable/s. Remedial action plan in place	R	Behind plan – major risks to achieving deliverable/s. Remedial plan, escalation, and exception report	D	Not completed as planned
Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced

4.3 Health of Older People Operational Plan

Overall Summary of Progress to 31 December 2017

The 2017/18 Operational Plan for Health of Older People (non hospital based) incorporates activities across the Aged Residential Care facilities, Home and Community Support Services, last days of life care planning and the national dementia framework. One project pertaining to information technology support requirements was not completed to plan, being superseded by pilot completion first (not material, nor major risk associated with deferment).

Objectives:	Optimise safe medicine management in aged residential care facilities Improve aged residential care knowledge in general palliative care Improve support for older people with timely access to a first interRAI Needs Assessment		
Activity	**Status**	**Progress**	**Comment**
Utilise Medi-Map data to inform the development of Standard Operating Procedures (SOPs) for aged residential care and implement throughout the district	G	C	Standard Operating Procedures developed by utilising Medi-Map data and implemented within aged residential care facilities throughout the district.
Last Days Of Life (LDOL) care plan training available online via Ko Awatea website	G	I	In progress.
Roll out SEQUAL to at least six more aged residential care providers	G	C	SEQUAL has been rolled out successfully to a further six aged residential care providers to date.
Execute training to relevant clinical staff on LDOL care plan across the district	G	I	Training provided to relevant clinical staff continues as planned.
Subject to funding approval, secure appropriate resources (1 FTE Needs Assessor Service Coordinator) to ensure service delivery	G	C	Approval and appointment for Needs Assessor Service Coordinator role completed.
Objective:	Enable the carer workforce in HCSS to support more older people age well and to remain at home		
Activity	**Status**	**Progress**	**Comment**
In home respite care is developed to increase uptake of respite care and provide a range of options	G	C	In home respite care currently being piloted and is monitored on a monthly basis by Steering Group.
Develop information technology support allocations of new packages by 31 December 2017	D	P	Development of IT support allocations for new packages deemed not essential at this stage as in-home respite care is currently being piloted. Development is expected to occur following evaluation of pilot.
Roll out packages of in-home support for respite into new HCSS contracts for the 1 July 2018/19 year	G	P	Work is commencing to roll out packages of in-home support for respite into new HCSS contracts for the 2018/19 year.

Status legend:	G	On track to achieve deliverable, measure and/or target, as planned	A	Behind plan – minor risks to achieving deliverable/s. Remedial action plan in place	R	Behind plan – major risks to achieving deliverable/s. Remedial plan, escalation, and exception report	D	Not completed as planned
Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced

Objective:	Implement an integrated palliative care model that supports staff and consumers		
Activity	**Status**	**Progress**	**Comment**
Develop an integrated palliative care model in partnership with Arohanui Hospice by 31 December 2017	G	I	Currently underway. Workshop held in December 2017. Principles of cluster support developed.
Implement the agreed integrated palliative care model across the district by 31 March 2018	G	P	Initiating phase - on track to deliver on time however awaits further work yet to be completed on an agreed funding model for integrated palliative care services across the district and service locations with several parties involved in delivering a range of services that cover consumers of all ages.

Objective:	Develop service and funding models that support a sustainable, culturally appropriate and person-centred approach to the support of older people		
Activity	**Status**	**Progress**	**Comment**
Collaborate regionally to strengthen the implementation of the New Zealand Dementia Framework through the implementation of the Central Region Action Plan	G	I	The newly formed Local Dementia Action Group (2017) has representation on the regional Dementia Group, which enables MidCentral DHB to collaborate regionally to implement the Central Region Action Plan. MoH now leading the development of the Informal Carer Education Guidelines with regional support through the National Dementia Education Collaborative.

4.4 Mental Health and Addictions Operational Plan

Overall Summary of Progress to 31 December 2017

The 2017/18 Operational Plan (non hospital based) for Mental Health and Addictions for this period includes the development of services in rural localities, the development of Te Ara Rau model (primary mental health) incorporating consult and liaison services, reshaping the older adult mental health services, embedding the performance frameworks with the NGO sector, preparing for introduction of the Substance Addiction (Compulsory Assessment and Treatment) Act, and achieving requirements for Opioid Substitution Therapy. Programmes predominantly tracking to plan, with some completed; and some delays to start dates due to external dependencies or resourcing, but now back on track.

Objectives:	Improve quality of care delivery system, reduce risks and enhance the consumer's experience of care Consider requirements to support the shift to an outcome focused approach		
Activity	**Status**	**Progress**	**Comment**

Status legend:	G	On track to achieve deliverable, measure and/or target, as planned	A	Behind plan – minor risks to achieving deliverable/s. Remedial action plan in place	R	Behind plan – major risks to achieving deliverable/s. Remedial plan, escalation, and exception report	D	Not completed as planned
Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced

Develop a dashboard report across the care continuum in collaboration with primary health care and non-government organisations (NGOs), by 30 June 2018	G	I	The dashboard report provided by secondary specialist clinical services has developed a reporting framework that covers the whole continuum including primary care and NGO providers. Data is being gathered for the report and an initial draft report with populated data is expected to be completed by the end of February.
Determine feasibility of developing a whole of continuum client experience feedback system in partnership with primary health care and NGOs, by 30 June 2018	G	I	The results based accountability reporting framework is being implemented with a major NGO provider. The outcomes approach is dependent on the Ministry of Health guidance on Commissioning Framework for the rest of the NGO providers.
Implement the Ministry of Health Commissioning Framework as per the Ministry guidance, by 30 June 2018	A	N	Potential for delayed completion by June. The commissioning framework is being developed as a guide to planning and funding decisions for 2018. Awaiting further update from the Ministry of Health.
Map and review the primary health care and NGO response to mild-moderate mental health and addictions need and make recommendations for best use of resource by 31 May 2018	G	I	A review of access data between primary health care and secondary specialist services is underway and being analysed by the portfolio manager and the NGO project group. This action is on track
Implement Opioid Substitution Therapy (OST) audit outcomes and establish measures which ensure improved compliance	G	C	Completed. All audit recommendations are implemented. Regular monitoring of progress is internally reported.
Monitor and report on guideline compliance with six monthly reports on adherence to key performance indicators for OST programme	G	I	Monitoring reports are provided six monthly and evidence a reduction in line with goals set to move towards compliance with the OST programme guidelines.
Objectives: NGO collective focusing on improved outcomes for people Support staff to better engage with consumers and family as valued partners in service delivery and service development opportunities across Mental Health Services Contribute to the reduction of suicides and suicidal behaviour through implementation of the Suicide Prevention and Postvention Action Plan Increase support for children of parents with mental illness and/or addiction			
Activity	**Status**	**Progress**	**Comment**
Implement strategic work programme for NGO sector planning and development	G	I	The clinical network group and NGO leadership group together with 'Unison' (a network of providers and stakeholders) are established and provide input to the Operational plan for Mental Health and Addictions across the continuum.
Develop results-based accountability and community development framework	G	I	The results based accountability reporting framework has been implemented with a major NGO provider.

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Develop quantitative and qualitative measures for outcomes improvement and report against as an NGO collective with outcomes validated by service users	G	I	Marama Real time feedback is being incorporated into ongoing business as usual in NGO providers; this feedback is being analysed and incorporated into the Results Based Accountability work with a local NGO. A Collective impact framework is being designed to capture this work.
Develop and implement Consult Liaison Service between primary care and secondary services as the Te Ara Rau Model is developed, by 31 January 2018	G	I	Consult Liaison service to primary mental health has been allocated within the Horowhenua specialist community team. This service will expand to all other Te Ara Rau pilot sites once the primary mental health positions have been established. Changes to the management structure of Te Ara Rau has caused delays in primary health establishing these positions, the expected timeframe for completion now being early February 2018.
Establish Local Response Teams (LRTs) for the Tararua and Horowhenua areas, by June 2018	G	I	Local response team has been established in the Tararua area and work underway to liaise with MSD, Education and other sectors to establish the Horowhenua LRT.
Provide forums and workforce development training to increase capacity and capability of the mental health workforce supporting engagement with consumers and family (four forums by June 2018)	G	I	The plan for the consumer whanau forums is being progressed by the consumer advisor and family whanau advisor with forums being planned for March April of 2018.
Objectives: Improve health outcomes for clients with a long term mental illness Implement district-wide model of care for mental health specialist services for older persons Ensure local and regional capacity to respond to potential requirements from the new Substance Addiction (Compulsory Assessment and Treatment) (SACAT) Act			
Activity	**Status**	**Progress**	**Comment**
Collaborate on the development of an audit framework for the Shared Care Programme confirmed by 31 July 2017	G	C	Completed. A proposal for a shared care audit is with the PHO. The PHO have completed an internal audit trialing the audit framework late in 2017. A response to completing a shared clinical audit between the secondary specialist services and PHO is expected by end of March 2018.
Establish a steering group and working party which will represent all key providers and stakeholders to progress district wide planning for mental health specialist services for older people, by 31 July 2017	G	C	Completed. A steering group was established in July 2017 and has been meeting since. Forums being re-established after the Christmas break with meetings planned in February to progress OAMH planning.
Develop an agreed district-wide service model for specialist services for older persons by 31 October 2017	A	C	Although delayed in terms of milestone date, a model of care has been developed and is used as a working plan to develop the OAMH service in partnership with key stakeholders and partner organisations. The model is reviewed in ongoing steering group forums

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Develop and implement an older persons access pathway by 31 October 2017	A	P	An access pathway has been proposed and agreed, with some remaining work to complete regarding administration resource and coordination of referrals with Older Adult Medical Services.
Implement agreed service model for specialist services for older persons by 31 December 2017	A	I	Model of care is being implemented with some increases in community mental health team resource to manage pressure points in the service. Remaining goals however include appointment to the Older Adult Mental Health Services Clinical Manager role. The role is being re-advertised.
Establish a project team to scope need, and outline a local model of care which clearly delineates all required service components for the SACAT Bill by 31 October 2017	A	C	Completed. A small project team led by the clinical manager Alcohol and Drug (AOD) services has created a model of care in response to the SACAT legislation. A proposal which anticipated a business case for additional resources to manage increase in demand for AOD services generated by SACAT implementation was delayed until a representation of a 'model of care' for the whole AOD continuum. Training of appropriate roles in AOD services is underway.
Complete an impact analysis of potential requirements from the Substance Addiction Bill by working with the Central Region project group by 30 November 2017	G	C	Completed. An analysis of potential requirements was presented to the Executive Leadership Team in November 2017. Work with the Central Region project group is ongoing; MidCentral's Mental Health service is represented by the Clinical Manager AOD services
Agree on any required service changes to better align or develop required services to ensure capacity to meet the identified need arising from the new model of care (under SACAT Act), by 28 February 2018	G	P	Implementation plan developed for workforce training. This is to be completed before February 2018
Establish common care pathways and method for development of individualised plans between 'unison' stakeholders , by 31 December 2017 Establish locality based links with kaupapa Maori services	G	I	The Unison network has adopted Whanau Ora as an approach to care and is engaging with Kaupapa Maori service providers represented in Unison to build better local links. The initial focus on rural areas.

Objectives:	Expand spread of specialist mental health services across communities Improve equity of access and timeliness of service response for all population groups across the district through increased capacity of community based mental health services		
Activity	**Status**	**Progress**	**Comment**
Conduct evaluation of pilots implemented over the year at Horowhenua Community Practice Feilding IFHC and Tararua Health Group, by June 2018	G	I	The integrated rural model continues to be developed. Tararua model of care to be further supported through a move to new facilities with better video conferencing support.

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Implement and utilise video-conferencing option for consultations by 31 December 2017	G	C	Video conferencing option is installed and operational in Pahiatua
Establish network group by 31 May 2018 and develop common plan to improve integrated care	G		The Unison network has adopted Whanau Ora as an approach to care and is engaging with Kaupapa Maori service providers represented in Unison to build better local links. The initial focus on rural areas.
Increase rural community service resource	G	I	Rural community teams in Horowhenua, Feilding, and Tararua have had resource increases, with additional medical resource in Horowhenua as the area of largest need. The programme for expanded resources is on track and due for completion by June 2018.
Develop rural community teams by implementing more integrated models of care e.g. integrating specialist visiting roles within local teams, and allocate dedicated rural time (Tararua by 30 June 2018)	G	I	Integrated models of care are implemented in Horowhenua, including our Kaupapa Maori Mental Health Services, and plans are on track for an integrated model to be rolled out for Tararua June 2018. Feilding has an ongoing plan for a new and more integrated environment (co locating in an integrated family center and relocating in this center with other partners late in 2018
Partner with NGO primary teams to strengthen specialist support of complex presentations in primary care, by 30 June 2018	G	I	Joint forums to consider primary care referrals to secondary specialist services are in place and the MHAS is represented by the Secondary services clinical managers (Palmerston North and Acute Care Team) and leader of the primary mental health PHO based team.

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Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced

4.5 Cancer Services Operational Plan

Overall Summary of Progress to 31 December 2017

The 2017/18 Operational Plan (non hospital based) for Cancer Services includes improvement activities on pathway and service developments for prostate cancer and uro-oncology together with ensuring can access and benefit from implementation of the supportive care framework. A working partnership with the local Maori Cancer Advisory Group (Te Hononga) and the Pae Ora Directorate continues to advise and monitor initiatives and equity priorities to improve services delivered to Maori and Pacific people, The Faster Cancer Treatment programme is reported as part of the national health and quarterly non financial monitoring framework. Programmes are predominantly progressing to plan.

Objective: Strengthen consistency of assessment, referral and treatment of prostate cancer			
Activity	**Status**	**Progress**	**Comment**
Evaluate use of suspected prostate cancer pathway	G	N	The Pathway was completed and published in December 2017 and is to be used across both Whanganui and MDHB. Work, led by a GP and an urologist, has commenced on a generic electronic referral form for General Practice use. It is focused on male lower urinary tract symptoms and haematuria. When this is completed both the Pathway and the referral form will be launched in primary care. Nationally 'Movember' are supporting the implementation of a prostate cancer registry to enable benchmarking against other hospitals, both public and private across NZ and Australia. Evaluation of the pathway will be managed by the CPHO, 6 months post implementation.
Uro-oncology clinical nurse specialist (CNS) drives general practice education in pathway use	A	I	Work continues to establish the uro-oncology CNS role. The role will be undertaken by existing staff but awaits a new model of care to be implemented for continence management in primary care, as currently urology nurse's work across both specialist areas. The continence model requires resourcing, for which a business case has been developed and is progressing through senior leadership.
Objective: Strengthen support for people with cancer and their family/whanau			
Activity	**Status**	**Progress**	**Comment**
Strengthen oncology social work and psychology service through better links with community based whānau ora and other related providers (such as NGOs)	G	C	This has been a key project in the local establishment of the national oncology social work initiative. Well embedded consult, liaison and networking exist within and between groups, including a monthly supportive care network meeting.

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Complete internal assessment of performance against He Anga Whakaahuru: Supportive Care Framework and implement recommendations	G	I	In January 2018 a new role, Clinical Research Coordinator, was appointed to the RCTS. The role is to support cancer services to meet their obligations for on-going evaluation and quality improvement as well as supporting professional development for medical staff. As part of the 2018 work plan the new coordinator will undertake both the supportive care and AYA internal assessments and provide reports through to Cancer Governance by June 18
Complete internal assessment of performance against the Service Provision for Adolescent and Young Adult Cancer Patients in New Zealand and implement recommendations	G	I	

Objective: Decrease disparities in access or outcomes for priority populations			
Activity	**Status**	**Progress**	**Comment**
Evaluate effectiveness of existing financial support services for cancer patients, by 31 March 2018	A	N	This remains an important project for understanding inequity but has yet to be initiated while the right resource is found to undertake the evaluation. A review of which group, from within the wider cancer stakeholder network, that might be able to undertake this work will occur in March 18, thus intended milestone date will not be achieved.
Strengthen partnership between FCT governance, Te Hononga, Local Cancer Network and Pae Ora Directorate	G	C	The FCT governance group has a working partnership with the local Maori Cancer Advisory Group (Te Hononga) and Pae Ora Directorate. All equity priorities in annual plan are monitored monthly.
FCT Governance leads an integrated action plan to address inequities by 31 August 2017	G	C	Equity indicators included in FCT annual work plan, the focus for 2017/18 is on the development of integrated partnerships and establishment of baseline data to inform actions for the next financial year.
FCT Governance monitors ethnicity indicators in routine reporting	G	C	Equity indicators, where available, now included in FCT governance reporting, work continues to improve data reporting across cancer services.
Investigate and eliminate any inequities of prioritisation across pathways, that leads to unwarranted delays	G	I	Three key initiatives for this year, being led by Te Hononga, include hosting a Demystifying Cancer Tour in 2018, a focus on urology services looking specifically at a distress tool for Maori patients with urological cancer and establishing a Facebook page for Māori with cancer and their whānau. These are all on track.
Pilot screening for supportive care needs in a discrete priority population	G	I	Work continues to increase utilisation of the 'distress tool' in secondary services. The tool, which is an evaluative scale of distress, is used extensively in the RCTS specialities to screen for referral to Massey Psychology. The tool however is universal and is now being used more widely to identify patients that would benefit from psycho-social support.

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Develop a tool which PHO and iwi based staff can use to identify particular supportive care needs amongst priority populations	G	P	Te Hononga is also developing a localised version of a cancer Information Booklet for Māori, which has been successfully implemented in Nelson Marlborough DHB. This tool will be used across all providers and will be available later in 2018.

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Progress legend:	P	Initiating	I	Implementing	C	Completed	N	Not commenced