Regional Public Health

2016-2017 Business Plan

Regional Public Health
Better Health For The Greater Wellington Region

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Introduction

This annual business plan is for the year 1 July 2016 to 30 June 2017. It has been approved by the Ministry of Health and endorsed by Wairarapa, Hutt Valley and Capital & Coast District Health Boards (DHBs).

Regional Public Health (RPH) is one of twelve public health units in New Zealand and provides services as per the Ministry of Health's (MoH) service specifications for public health services and contractual agreements with the MoH, Wairarapa, Hutt Valley and Capital & Coast DHBs, and other funders. RPH ensures statutory responsibilities are met as specified by the MoH. This plan aligns to the three DHBs' annual plans, DHBs' Māori health plans and Ministry of Health's annual planning guidelines for public health units.

Table 1. DHB local priorities

Wairarapa DHB	• Living Within Our Means • Health Equity • Child and Youth Health • Long Term Conditions • System Integration • Quality • Workforce • Care Closer to Home
Hutt Valley DHB	Our overarching priority is to continue to focus on the 'triple aim plus one': • For our Patients - Improved quality, safety and experience of care and a better patient journey • For our Populations - Improved health and equity for all populations • For the Public - Best value for health system resources and living within our means • A thriving organisation, including our organisational culture, clinical leadership, engagement and workforce development.
Capital & Coast DHB	• Improve child health and child health services • Better Elder Care • Integrated Care • Empowered Self-Care • Enhanced Clinical Leadership • Continuous Outcome Evaluation and Monitoring

NB: Relevant national level DHB targets and priorities have been included within each action plan, at the end of the summary statement.

RPH's vision is to achieve 'better health for the greater Wellington region' by focusing on communities and the environment, rather than at the individual level. A multidisciplinary workforce undertakes all five of the core public health functions for New Zealand:

- Health assessment and surveillance
- Public health capacity development
- Health promotion
- Health protection and
- Preventive interventions.

These functions are integrated into a population-based approach, meaning staff work within a variety of settings where people live, work, learn and play.

RPH aims to work in collaboration with Māori, Pacific peoples, communities and providers across the health sector (primary health care in particular). Collaboration at local, sub-regional, central region and national levels is emphasised. An example is on-going active involvement in the National and Central Region Public Health Clinical Networks. To focus action on more equitable health and wellbeing outcomes, RPH links with a wide range of government, non-government and community organisations, addressing barriers and enablers such as access to health care services, housing, income, employment and education.

In November 2013, RPH established the RPH Planning Framework to replace the Keeping Well population health strategy for the greater Wellington region (see figure 1). This framework is informed by the New Zealand Public Health Clinical Network's report 'Core Public Health Functions for New Zealand' and the Ministry of Health's tier one public health service specification.

The Ministry of Health began an assessment of public health services in 2013, including a review of the service specifications for public health services. A revised tier one service specification was released in February 2014. The review of tiers two and three remain in draft.

This RPH annual business plan is also available at www.rph.org.nz. A summary progress report will be submitted to the MoH after six months, and a full annual report after one year.

Figure 1. RPH Planning Framework

Regional Public Health Planning Framework

Vision: Equitable, sustainable and healthy futures for all

Bold Goal: Halving the rate of avoidable hospital admissions for Māori, Pacific and children by 2021

Inputs	Key principles	Core public health functions	Public health service outcomes
Health status of the population	Focusing on the health of communities rather than individuals	Health assessment and surveillance	A healthier and more productive population
Government	Influencing health determinants	Public health capacity development	Reducing health disparities, including a focus on Pacific peoples and vulnerable groups
Ministry of Health	Prioritising improvements in Māori health	Health promotion	Improving Maori health
District Health Boards	Reducing health disparities, including a focus on Pacific peoples and vulnerable groups	Health protection	Increased safeguards for the public's health
Funding and Planning Unit	Basing practice on best available evidence	Preventive interventions	A reduced burden of acute and chronic disease
	Building effective partnerships across the health sector and other sectors		
	Remaining responsive to new and emerging health threats		

Bold Goal and priorities

Since 2012, RPH has had a deliberate focus on aligning all activities to achieve a 'Bold Goal' of 'halving the rate of avoidable hospital admissions for Māori, Pacific and children by 2021'.

The Bold Goal is an aspirational outcome statement developed by staff to challenge and motivate them, and bring a collective purpose to their work.

For 2016-2017, the annual priorities are:

- Working with Māori.
- Focus on children.
- Engagement with primary care.

The Bold Goal and annual priorities are used to prioritise services to make the best use of available resources.

This annual business plan takes into account the Government's expectations as well as national, central region, sub-regional and district priorities. This includes alignment to the MoH's Statement of Intent (2014 to 2018). RPH contributes to many of the Government's and DHBs' health targets and priorities. For example, activities to increase access to healthy food choices can over time, contribute to preventing diabetes and other long term conditions. See Table 1 – page 3.

Long Term Conditions

RPH is developing a plan for the prevention of Long Term Conditions (LTCs) based on the Ottawa Charter and the socioeconomic determinants of health, including the high level actions. The high level actions are:

- **Advocate:** for political, economic, social, cultural, environmental, behavioral and biological factors to favour health and not be harmful to it;
- **Enable:** people to achieve their fullest health potential by taking control of the things that determine health – a supportive environment, access to information, life skills and opportunities to make healthy choices;
- **Mediate:** between organisations, groups and individuals with differing interests in society for coordinated action in the pursuit of health.

Health Promotion Action occurs at five levels to address any issue:

- Building Healthy Public Policy;
- Creating Supportive Environments;
- Strengthening Community Action;
- Developing Personal Skills; and
- Reorienting the Health (and Social) Sectors.

In addition, and alongside action on the Ottawa Charter is action on the wider determinants of health as set out by Dahlgren and Whitehead in 1991.

- Age, sex and hereditary factors: relatively unchangeable
- Individual lifestyle factors: smoking, alcohol intake, physical activity
- Social and community influences: social networks, feeling valued, empowerment, ability to participate in decisions that affect our health
- Living and working conditions: safe housing, decent employment conditions
- General socioeconomic and environmental conditions: position in society including income, education and employment which affects our ability to participate.

The environment people live in determines their behaviours. But behaviour change also requires a trigger for behaviour change. Both need to be considered in the prevention of LTCs.

RPH is actively engaged in work on the risk factors for long term conditions: tobacco use; alcohol related harm; poor nutrition and physical inactivity. On the basis of the plan being developed, it will be possible to see how this work can be better integrated. This will also include working with our stakeholders to increase the impact of strategic alliances.

RPH is engaged with the Healthy Families Lower Hutt work and will continue to do this. RPH is also adopting a Community Action Neighbourhood approach initially in three communities. People in communities tend not to see themselves as separate conditions (heart disease, cancer etc) but as a whole person. The result of our Community Action approach will inform wider RPH work on what matters to people in communities.

There is a national focus on obesity both as a condition and a risk factor for other conditions. Focusing on children and youth for obesity prevention will also be a part of our consideration of preventing LTCs.

Healthy Families Lower Hutt

RPH is proactively working with Healthy Families Lower Hutt. We support the Healthy Families Lower Hutt workforce and their Prevention Partnership networks in the planning, implementation and evaluation of strategic health promotion action. This includes: meeting bi-monthly with Healthy Families Lower Hutt and Te Awakairangi Health Network (PHO) to share work plans and plan joint activity; supporting Health Families Lower Hutt in initiatives in workplace settings (RPH has a representative on Healthy Families Lower Hutt Workplace Special Interest Group); working jointly with Healthy Families Lower Hutt to encourage Hutt City Council to increase Smokefree outdoor spaces, provide community water fountains, provide physical activity opportunities and healthy food and beverages; working with Healthy Families Lower Hutt in education settings, particularly on *water only* in schools; pro-actively sharing learnings from current and previous local health promotion activities, including via data analysis support, where appropriate, - in particular sharing the data on Lower Hutt educations settings held by RPH and Healthy Families Lower Hutt, and assisting Healthy Families Lower Hutt with their evaluation.

Māori health

RPH recognises and respects the Treaty of Waitangi, and the principles of partnership, participation and protection, acknowledging the special relationship between the Crown and tangata whenua. The national Māori Health Strategy: He Korowai Oranga (2014) provides the strategic direction that guides health sector contributions to pae ora – healthy futures.

The vision for RPH in contributing to improving Māori health outcomes and reducing inequalities is "Māori are healthy and enjoying equal quality lifestyles, from infants to elderly" (RPH Māori Strategic Plan 2014 – 2017). There are four pathways identified in the RPH Māori Strategic Plan, to support and challenge staff to "think Māori first":

- Te Ara Tuatahi - Pathway One - Relationships.

- Te Ara Tuarua - Pathway Two - Workforce development.
- Te Ara Tuatoru - Pathway Three - Accountability.
- Te Ara Tuawha - Pathway Four - Communications.

To move forward along each pathway, actions and measures are woven into all the annual operational actions plans that are summarised to produce the annual business plan. Additionally, the Māori Health Action Plan provides a mechanism to implement organisation-wide actions. The RPH Activities E-tool provides a view of activities that have been identified as specifically prioritising improvement in Māori health outcomes (refer to the section 'RPH Activities E-tool' for more information).

RPH contributes directly and indirectly to many of the specified national, central region, sub-regional and local Māori health targets and priorities. For example, RPH activities to reduce the supply of tobacco products can, over time, contribute to the reduction in smoking prevalence which in turn can contribute to reductions in cancers, respiratory disease and heart disease.

Regional Public Health

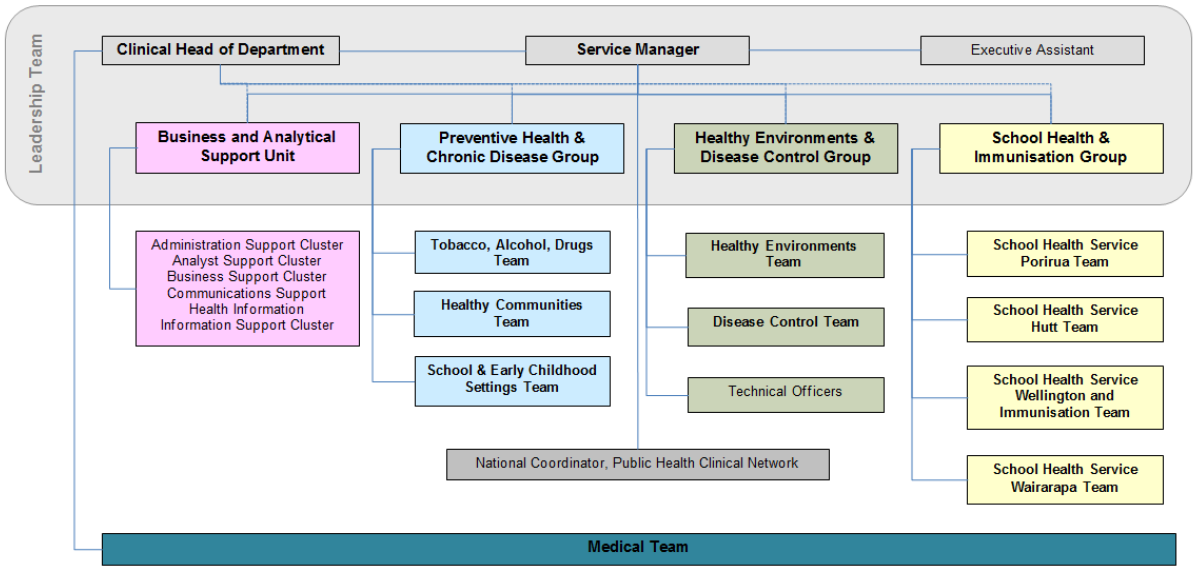
RPH values are integrity, excellence, equity, compassion, and being culturally responsive.

Staff work in teams within groups, based on areas of focus (see figure 2):

- Healthy Environments and Disease Control Group
- Preventive Health and Chronic Disease Group
- School Health and Immunisation Group
- Business and Analytical Support Unit

There is a wide range of roles: health protection officers, medical officers of health, medical officers, public health advisors, public health analysts, public health nurses, public health physicians, visions and hearing technicians, management, administration, communications, and information systems.

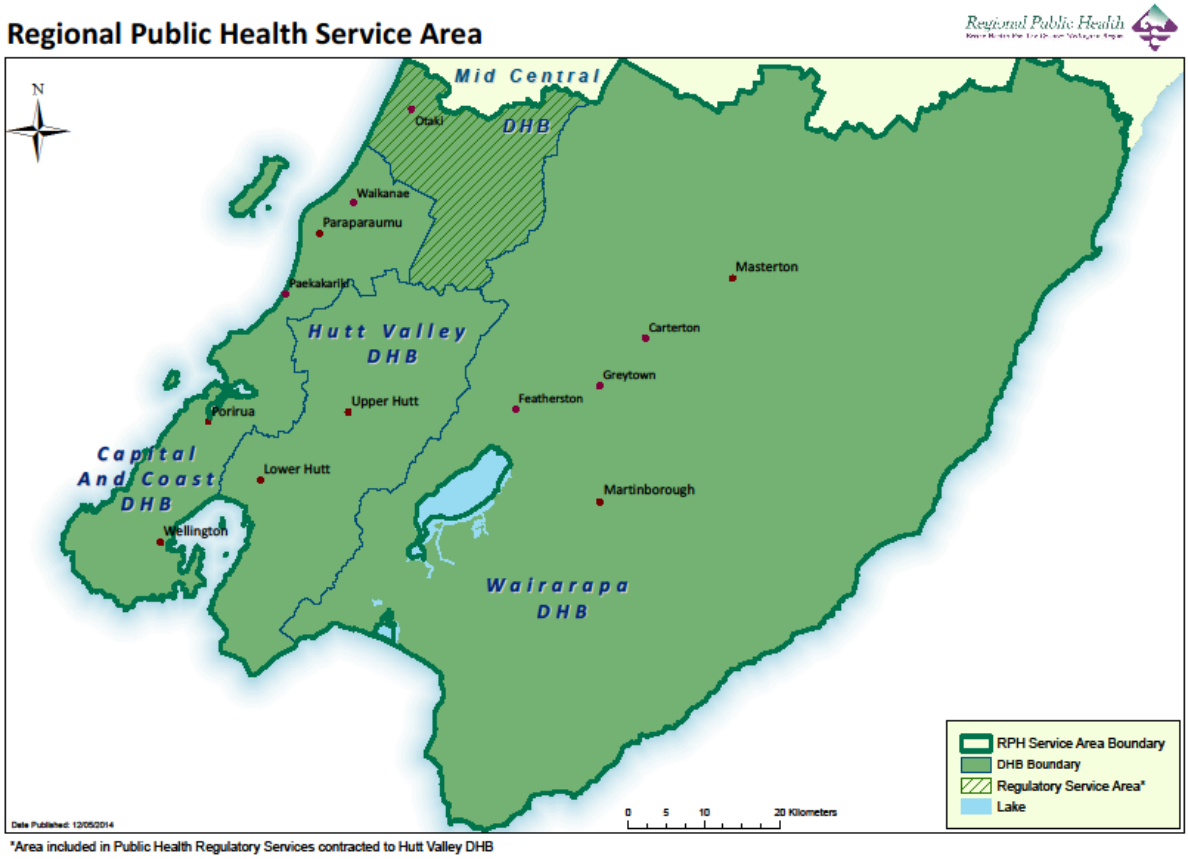
Figure 2. RPH Organisational Chart


Leadership Team
Clinical Head of Department
Service Manager
Executive Assistant
Business and Analytical Support Unit
Preventive Health & Chronic Disease Group
Healthy Environments & Disease Control Group
School Health & Immunisation Group
Administration Support Cluster
Analyst Support Cluster
Business Support Cluster
Communications Support
Health Information
Information Support Cluster
Tobacco, Alcohol, Drugs Team
Healthy Communities Team
School & Early Childhood Settings Team
Healthy Environments Team
Disease Control Team
Technical Officers
National Coordinator, Public Health Clinical Network
School Health Service Porirua Team
School Health Service Hutt Team
School Health Service Wellington and Immunisation Team
School Health Service Wairarapa Team
Medical Team

The geographical area RPH covers includes (see figure 3):

- Hutt Valley DHB (Hutt City Council, Upper Hutt City Council)
- Capital & Coast DHB (Wellington City Council, Porirua City Council, Kapiti Coast District Council – note health promotion services for the Otaki Ward are provided by the MidCentral DHB Public Health Service)
- Wairarapa DHB (Masterton District Council, Carterton District Council, South Wairarapa District Council).

Figure 3. RPH Service Area

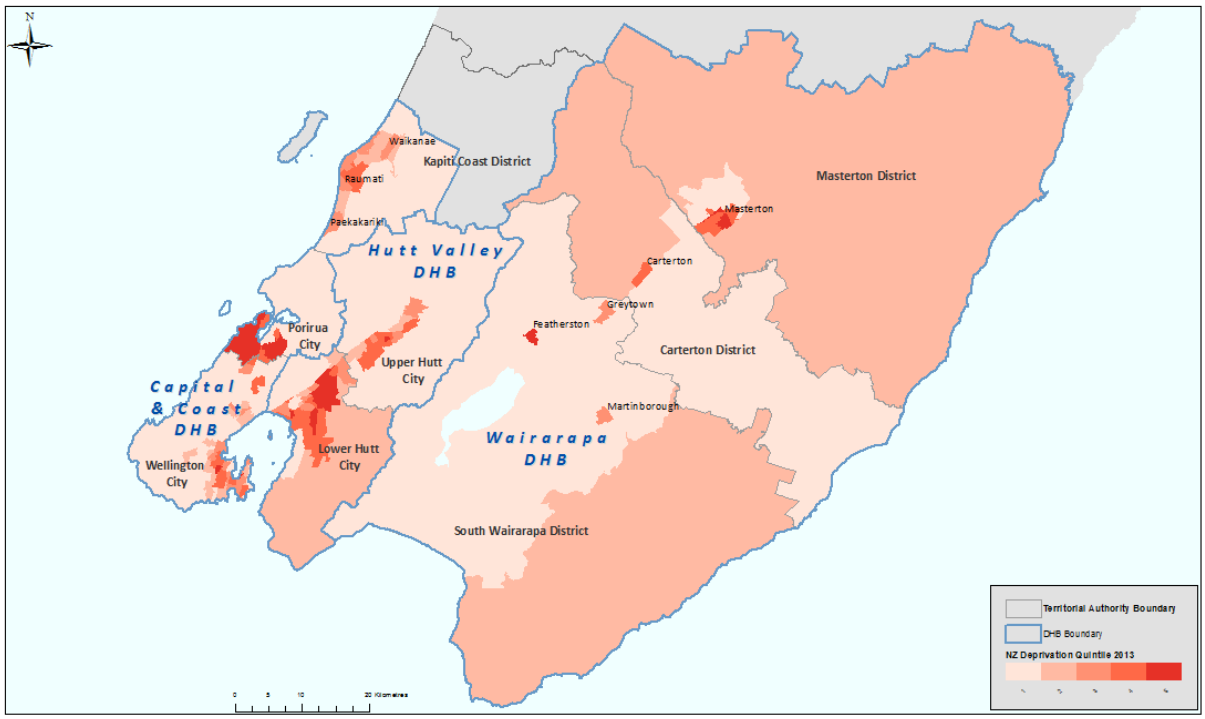


Population profile[1]

Geography and population

The DHBs in the greater Wellington area, Wairarapa, Hutt Valley and Capital & Coast (i.e. Wellington sub-region), represent three of the twenty DHBs in New Zealand. They comprise urban, rural and coastal settings. Capital & Coast CDHB is the largest DHB of the sub-region, followed by Hutt Valley and Wairarapa. The population for the three DHBs was 463,230 at the last census (2013), which represented ten percent of New Zealand's total population of approximately 4.2 million. The map in figure 4 shows the deprivation distribution by quintile across the greater Wellington area.

Figure 4. Map of 3DHB sub-region by deprivation quintile



Census Area Unit mapping is based on Statistics New Zealand's data which are licensed by Statistics New Zealand for re-use under the Creative Commons Attribution -Non commercia 3.0 New Zealand license.
Deprivation data was sourced from Department of Public Health, University of Otago.

The Wairarapa is a diverse rural area, separated from the rest of the Wellington region by the Rimutaka ranges. The Wairarapa DHB (41,109 people, 9% of the sub-region) includes three territorial authorities (TAs), Masterton, Carterton and South Wairarapa, covering a total land area of 5,936 square kilometres. Masterton, with a population of around 23,000, is Wairarapa's one large urban town.

The land area of Hutt Valley DHB is 916 square kilometres. The area is predominantly flat in the Hutt River valley, bordered by mountainous ranges in the east (Rimutakas) and north (Akatarawas and

[1] 2015 Health Needs Assessment For Wairarapa, Hutt Valley and Capital & Coast District Health Boards, 2015.

Tararuas) and a coastal southern edge. Lower Hutt City and Upper Hutt City are the Hutt Valley's two TAs, with a combined population of 138,417 people (30% of the sub-region).

The Capital & Coast district has a land area of 739 square kilometres. It is made up of three TAs: Wellington City, Porirua City and Kapiti Coast District, with a combined population of 283,704 people (61% of the sub-region). The Kapiti Coast District includes some territory which is part of the Midcentral DHB (Otaki and near surrounds). The Capital & Coast area has relatively high density residential living (by New Zealand standards), with on-going expansion of urban areas.

Population growth

The Wellington sub-region population is growing and ageing. In 2013, the census 'usually resident population'[2] for the Wellington sub-region was estimated to be 463,230, a five percent increase from the last census in 2006 (441,387). The largest percentage change was seen in Wairarapa DHB (6.5%) and CCDHB (6.4%). Population growth is expected to continue and by 2033 the sub-region is expected to be home to over half a million people. In all three DHBs, numbers of older people (65+) are projected to increase while the population under 25 years stays about the same or declines.

Socioeconomic deprivation

Over the last few decades there have been major changes in the way New Zealand society is organised and in the ways in which we view our communities. The New Zealand Index of Deprivation 2013 (NZDep2013) is a summary measure derived from the 2013 Census of Population and Dwellings.

The index, constructed from nine Census 2013 variables, provides a summary deprivation score from 1 to 10 for small areas. A score of 1 is allocated to the least deprived ten percent of areas, and 10 is allocated to the most deprived ten percent of areas across New Zealand. NZDep2013 is sometimes presented as quintiles, with 1 being the least deprived and 5 the most deprived.

The NZDep2013 index of deprivation reflects eight dimensions of material and social deprivation. These dimensions reflect lack of income, employment, communication, transport, support, qualifications, owned home and living space.

In the Wairarapa DHB the most deprived areas are found in central Masterton and Featherston, but overall the population is spread over all deprivation indices.

The Hutt Valley DHB population is distributed reasonably evenly across the deprivation index. The most deprived areas are in Lower Hutt City, around the areas of Taita, Naenae and Wainuiomata.

[2] The census 'usually resident population' count of an area in New Zealand is a count of all people who usually live in that area and were present in New Zealand on census night. Excluded are: visitors from overseas, visitors from elsewhere in New Zealand, and residents temporarily overseas on census night.

The territorial authorities of Capital & Coast DHB have contrasting socioeconomic profiles. Porirua City is a city of two halves; about 35% of the population live in highly deprived areas (deciles 9 and 10) and about 40% live in the areas of least deprivation (deciles 1 and 2). The most deprived areas are concentrated in eastern Porirua and areas to the west of State Highway 1. In contrast, Wellington City population predominantly lives in the least deprived areas. There are small pockets of deprived areas in the corridor from Te Aro to Berhampore, and around Miramar and Strathmore in the south. In Kapiti district the majority of people live in the mid-range of the deprivation index.

Figure 5. Wairarapa population distribution across deprivation deciles, 2013

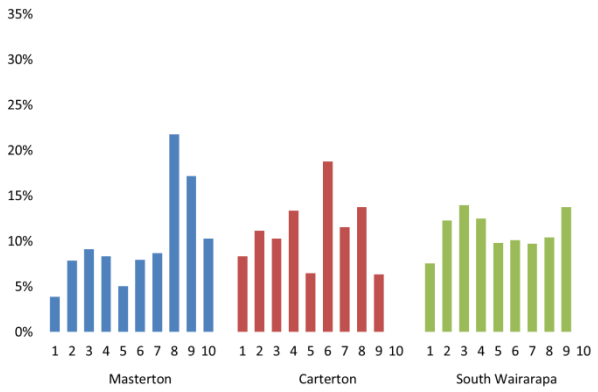


Figure 6. Hutt Valley population distribution across deprivation deciles, 2013

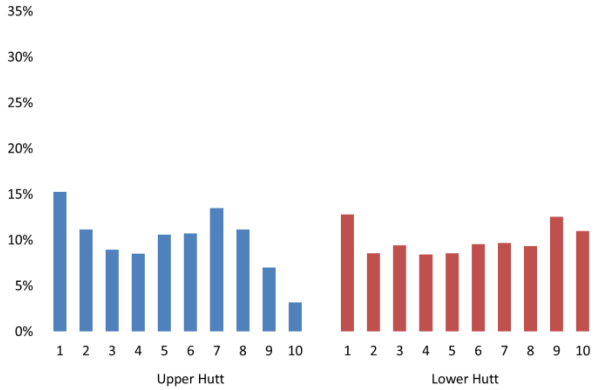
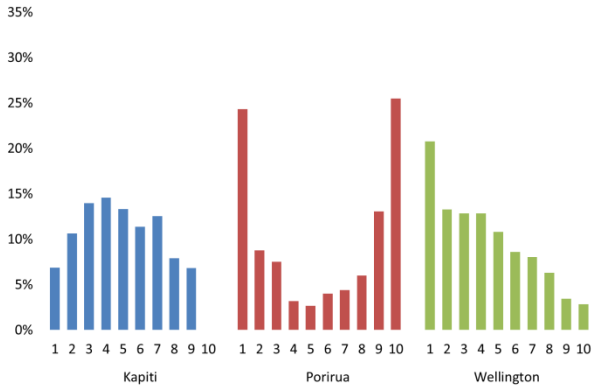
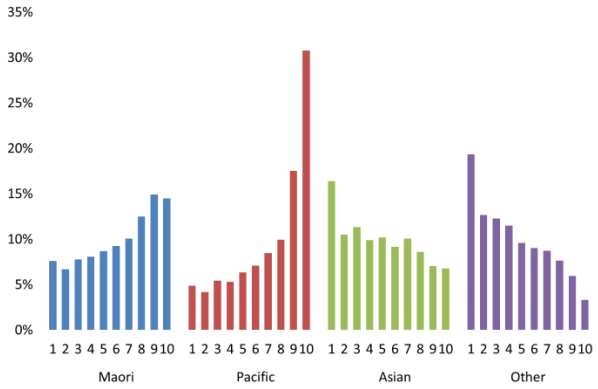


Figure 7. Capital & Coast population distribution across deprivation deciles, 2013



Within the sub-region, 48% of Pacific people were living in the most deprived neighbourhoods. Nearly a third were living in a decile 10 area. Māori were also over-represented in the most deprived areas, with 29% living in decile 9 or 10. In comparison, 16% of Asian and 19% of Other[3] lived in a decile 1 neighbourhood.

Figure 8. Sub-regional population distribution across deprivation deciles by ethnicity, 2013



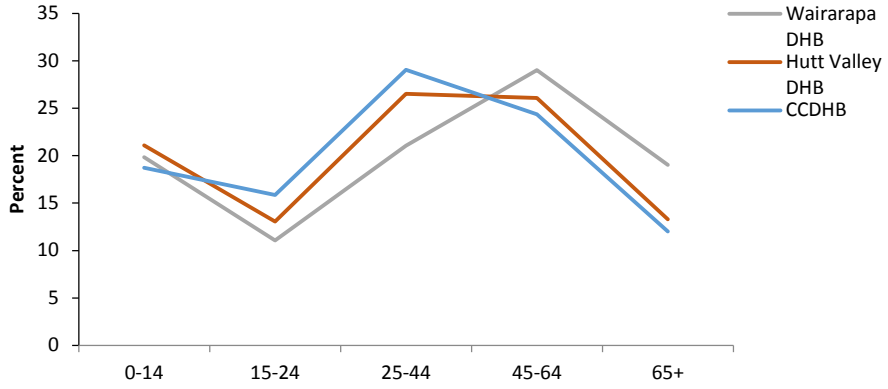
Age profile

The age profile differs markedly across the sub-region. Wairarapa DHB is noted for a proportionately larger older population compared to Capital & Coast DHB and Hutt Valley DHB. Hutt Valley DHB has a similar age distribution to Capital & Coast DHB, but has slightly larger population under 15 years than the other two DHBs. The age distribution of CCDHB is characterised by a large proportion of adults of working age.

The age profile of the TAs in the Wairarapa, and Kapiti District areas are similar with lower proportions of youth and an aging population. Lower Hutt City and Upper Hutt City are similar in their age group distribution, with higher proportions of children and middle aged people. Wellington City TA is noted for the highest population of young working age, whereas Porirua City has the highest proportion of children aged under 15 years.

[3] Other ethnicity includes Other, European, MELLA – Middle Eastern, Latin American or African ethnicities, and ethnicities which have not been included elsewhere

Figure 9. Sub-regional age group distribution, 2013



Ethnic profile

Māori and Pacific peoples make up 12% and 10% respectively of the sub-region's population and both are young populations. The ethnic groups are distributed differently across the sub-region; the TAs with the largest numbers of both Māori and Pacific peoples are Wellington City, Lower Hutt City, and Porirua City (36% of Pacific peoples in the sub-region live in Porirua City).

Overall, the 'Other' ethnic group makes up around 70% of the sub-region's population, and is the dominant ethnic group in all three DHBs. Across the sub-region, the people in this ethnic group tend to be in the older working age group. Asians make up 10% of the population, with the greatest proportions being in the 25-35 year age group.

Figure 10. Ethnic composition by territorial authority, 2013

The ethnic composition of the sub region is likely to change in the next 20 years. Growth is expected in the Māori population, most noticeably in Capital & Coast DHB where it is expected to be about

20% larger than in 2013. The Asian population by 2033 is expected to have grown by at least 50% from 2013, in all three DHBs. Pacific peoples and Other populations are expected to grow much more slowly and even decline in some younger age groups.

Finance

For 2016-2017 RPH financial information is presented in an issues-core public health functions matrix to align with the core functions approach and the current Ministry of Health purchasing units for public health (communicable disease, etc.).

With the signing of a contract last year, Ministry of Health total core contract funding remains the same for the next financial year (except for additional volume pressures adjustment funding). There have been some contracts from the Ministry of Health that have come to an end including *Rheumatic Fever Prevention: Healthy Homes System* (31-Dec-16) as well as a range of DHB contracts that have come to an end including; *Rheumatic Fever Nurse, Hutt Tobacco Control Clinical Champion* among others.

The bulk of RPH activity is funded by the Ministry of Health through the core contract supplemented by five non-core Ministry of Health contracts for specific work. Other activity is mainly funded by Wairarapa, Hutt Valley and Capital & Coast DHBs.

The following table summarises revenue and forecast expenditure by core contract funding lines (public health issues) and links this to the relevant Ministry of Health core public health function. Revenue has been matched against costs mapped to each action plan activity and then mapped to a core function area. It includes a summary of DHB and other funding, forecast expenditure, as well as a summary of current FTE for each core public health function.

Regional Public Health has experienced a drop in revenue for most DHB contracts along with the cessation of several contract lines. This coupled with the continually increasing cost pressures has resulted in Regional Public Health facing significant challenges in 2016-17. Although this business plan is fully costed, RPH will look to deliver a cost neutral budget and a break-even result for the 2016-17 year.

RPH 2016-17 Business Plan revenue and costs by contract and core function

Funding lines		Finance			Core public health function					FTE
Funder	MoH Issue	Total Funding	Total Costs	Shortfall / Surplus	Health Assessment & Surveillance	Public Health Capacity Development	Health Promotion	Health Protection	Preventive Interventions	FTE by funding line
MoH - Core	Physical Environment	$1,576,486	$1,588,169	-$11,683			$369,594	$1,218,575		13.69
MoH - Core	Communicable Disease	$1,785,754	$1,873,391	-$87,637		$187,339	$18,734	$1,667,318		15.84
MoH - Core	Social Environment	$874,895	$999,224	-$124,329	$29,257	$381,974	$587,993			8.58
MoH - Core	Alcohol & Other Drugs	$633,730	$802,485	-$168,755	$40,124		$200,621	$561,739		6.70
MoH - Core	Tobacco Control	$483,237	$530,128	-$46,891			$318,077	$212,051		4.96
MoH - Core	Nutrition & Physical Activity	$706,528	$913,855	-$207,327			$913,855			8.17
MoH - Core	Sexual Health	$134,083	$113,496	$20,587			$113,496			1.07
MoH - Core	Mental Health Promotion	$79,851	$74,903	$4,948			$74,903			0.66
MoH - Core	Generic / Public Health Infrastructure	$746,860	$839,104	-$92,244	$113,142	$725,962				7.80
MoH - Core	Volumes Pressures (Psychoactive Drugs Enforcement Act)	$60,000	$60,000	$0				$60,000		0.00
MoH - Core	Volumes Pressures	$99,467		$99,467						
Sub Total - MOH Core contract Schedule A		**$7,180,891**	**$7,794,754**	**-$613,863**	**$182,523**	**$1,295,275**	**$2,597,273**	**$3,719,683**	**$0**	**67.46**
MoH - Core	Schedules B & C Refugee and Asylum Seeker Health & INH - Wellington Region - Refugee Health	$245,344	$272,884		$27,288	$54,577	$191,019	$191,019		2.26
MoH - Core	Central Region Public Health Advice	$114,470	$78,548		$78,548					0.58
Sub Total - MOH Core contract Schedule B, C and D		**$359,814**	**$351,432**	**$8,382**	**$0**	**$105,836**	**$54,577**	**$191,019**	**$0**	**2.84**
Total MOH Core Contract		**$7,540,705**	**$8,146,186**	**-$605,481**	**$182,523**	**$1,401,111**	**$2,651,850**	**$3,910,702**	**$0**	
FTE by core public health function – Core contract					**1.54**	**12.45**	**23.56**	**32.75**	**-**	**70.30**
Sub Total - MOH Non Core Contracts		**$742,187**	**$863,463**	**-$121,276**	**$0**	**$101,815**	**$618,739**	**$142,909**	**$0**	
Sub Total – All MoH Contracts		**$8,282,892**	**$9,009,649**	**-$726,757**	**$182,523**	**$1,502,926**	**$3,270,589**	**$4,053,610**	**$0**	
Sub Total – District Health Boards		**$4,285,804**	**$4,905,337**	**-$619,532**	**$19,537**	**$250,048**	**$786,943**	**$0**	**$3,848,808**	
Total - All Contracts		**$12,715,241**	**$14,061,530**	**-$1,346,289**	**$202,060**	**$1,809,176**	**$4,057,532**	**$4,143,953**	**$3,848,808**	
FTE by core public health function - Total					**1.76**	**16.19**	**37.34**	**34.14**	**40.42**	**129.86**

RPH Activities E-tool

An interactive on-line version of the activities and measures in this business plan is also available. This allows public access so that readers can group, sort, order and filter the activities by a range of criteria, including:

- Core public health function
- MoH core contract issues
- Contract lines
- Activities expected to lead to Māori health gain
- Activities expected to lead to Pacific peoples health gain
- Activities expected to lead to children's health gain
- Activities by geographical area of focus e.g. DHB, sub-region, region, national.

We expect to have this operational by October 2016 and available on our website at www.rph.org.nz.

How to read the Action Plan section of the business plan

The work that RPH delivers is collated into annual operational 'action plans'. These incorporate work from one or more contracts. Each action plan contains a number of 'activities'. Within each activity there is a number of 'tasks' which break the work down further into manageable pieces. These tasks are not included in the business plan as they are for operational planning and monitoring.

Core public health functions have been incorporated at activity level. This groups all our work into the five core public health functions as per the tier one and tier two public health service specifications.

Each action plan begins with a high-level summary statement. This also includes the relevant DHB priorities that the activities within the action plan will contribute to.

The activity tables include three performance accountability measures, based on Results Based Accountability™ (RBA) and the MoH guidelines for PHU planning. These measures cover the three dimensions of performance accountability:

- How many did we do? (quantity of effort): # (number)
- How well did we do it? (quality of effort): % (percentage)
- Is anyone better off? (quantity and quality of effect): # and %.

From the MoH guidelines: " 'Is anyone better off' equates to 'client outcomes'. 'Client' in Public Health means 'the people, organisations, settings, partners who engage with or receive benefit/services from working with a public health service provider'."

Four categories are required to identify the direct/indirect 'client' outcome or 'effect' of the activities provided – i.e. 'is anyone better off':

- SK: change in skills/ knowledge
- AO: change in attitude/opinion
- BC: behavioural change
- CC: circumstance change

Also required is:

- S: subjective data
- O: objective data

It should be noted that performance measures for activities that are funded from contracts other than the core MoH contract, are based on the contractual reporting requirements for the specific contract – not RBA.

Table 2. Core public health functions mapped to MoH core contract activities

Core function	Action Plan	Activities
Health Assessment and Surveillance	4.1	3,4
	7.6	2
Public Health Capacity Development	1.4	1,4
	1.5	2,5
	5.1	5,8
	7.4	1,2,3
	7.6	1,3
	7.8	1,2,3
	7.9	1,2,3,4,5
Health Promotion	1.3	1,2,3
	1.4	2,3,5
	1.5	1,4
	2.1	2,3,4
	3.1	1,2,3,4,5,6,7,8,9
	4.1	5,6
	5.5	1,2,3
	6.2	1,2
	6.3	1,2,3
Health Protection	1.5	3
	2.1	1
	4.1	1,2
	5.1	1,2,3,4,6,7,9
	6.1	1,2,4,5,6,7,8,9,10,11,12,13
	6.3	4
	6.6	1,2,3,4
Preventive Interventions	-	-

Table 3. MoH core contract issues mapped to MoH core contract activities

MoH Issue	Action Plan	Activities
Alcohol and other drugs	4.1	1,2,3,4,5,6
Communicable disease	5.1	1,2,3,4,5,6,7,8
Mental health	1.3	2,3
Nutrition and physical activity	3.1	1,2,3,4,5,6,7,8,9
Physical environments	6.1	1,2,4,5,6,7,8,9,10,11,12,13
	6.2	1,2
	6.3	1,2,3,4
	6.6	1,2,3,4
Generic/Public health infrastructure	5.1	9
	7.4	1,2,3
	7.6	1,2,3
	7.8	1,2,3
Sexual and reproductive health	5.5	1,2,3
Social environments	1.3	1
	1.4	1,2,3,4,5
Tobacco control	2.1	1,2,3,4
Schedules B and C: Refugee and other asylum seekers	1.5	1,2,3,4,5
Schedule D: Central region public health advice	7.9	1,2,3,4,5

Table 4. MoH non-core contracts mapped to action plans and activities

Contract	Action Plan	Activities
Community Action on Youth and Drugs (CAYAD)	4.2	1,2,3,4
Drinking Water Assistance Programme Facilitation	6.1	3
Health Promoting Schools	6.4	1
Public Health Clinical Network Secretariat	8.1	1

Table 5. DHB contracts mapped to action plans

Funding DHB	Service	Action Plan
CCDHB	Porirua Mobile Ear Nursing Service	1.7
CCDHB	Primary Healthcare Nursing Innovation – Public Health Nurse in WINZ, Porirua	1.8
HVDHB	DHB NIR Administration Services	5.2
HVDHB	Outreach Immunisation Coordination	5.2
HVDHB	Public Health Nurse - Healthy Housing	6.2
HVDHB	Hutt Valley DHB Tobacco Control	2.1
WaiDHB	Wairarapa DHB Tobacco Control	2.1
HV & CCDHBs	BCG Nurse Services	5.6
Wai, HV & CCDHBs	Healthy Housing Programme	6.2
Wai, HV & CCDHBs	HPV and Boostrix Immunisation Programme	5.3
Wai, HV & CCDHBs	Vision and Hearing Technicians	1.7
Wai, HV & CCDHBs	School Based Public Health Nursing	1.6

Table 6. Other contracts mapped to action plans

Other Contracts	Action Plan
Central Region Registrar Supervision	8.1
MidCentral Medical Officer of Health	8.1

Table 7. Action plans across all contracts

Across all contracts	Action Plan
Business support	7.1
Māori action plan	7.2
Pacific Peoples action plan	7.3

Action Plans

1.3 - Building healthy social environments

The components of this action plan are a Community Action Neighbourhood Approach to service delivery and leading suicide post-vention work.

The Preventive Health and Chronic Diseases Group (PHCD) in RPH, in collaboration with others, has developed a Community Action Neighbourhood Approach in three areas: Titahi Bay, Wainuiomata and Wairarapa. The framework for this approach involves the accommodation of community empowerment in core public health programmes to reduce harm from tobacco, alcohol and obesity. The relationships PHCD builds in these three communities will influence what RPH does to address issues raised by the community.

Leading suicide post-vention work includes providing input into the Child and Youth Mortality Review Committee for the Ministry of Health.

Community Action Neighbourhood Approach activities contribute to the following DHB priorities: Social Sector Trials (CCDHB only); Child and Youth Health; Long Term Conditions; Obesity; and Tobacco.

Suicide post-vention activities contribute to the following DHB priorities: Mental Health.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
1.3.1	Health Promotion	Social environments	Lead and coordinate work across RPH to strengthen community led action and enhance community empowerment.	Work with three geographical communities in the Wellington region to strengthen community led action and enhance the accommodation of community empowerment within RPH's programmes in the local designated areas.	Planning framework used clearly illustrates the accommodation of community empowerment into RPH core business activity at the local level in designated areas.	#/% collaborative initiatives begun in each community (BC,O).
1.3.2	Health Promotion	Mental health	Lead coordinated multi-disciplinary response to all suicides in the sub-region to prevent further deaths by suicide.	# RPH responses to completed suicides in the region.	% completed suicides responded to according to protocol.	Not applicable to this activity.
1.3.3	Health Promotion	Mental health	Influence the policy recommendations that the Child and Youth Mortality Review Committee provide for the Ministry of Health.	# deaths RPH responds to that are also reviewed by the Child and Youth Mortality Review Group.	Not applicable to this activity.	#/% reports on regional and national recommendations accepted by Clinical Head of Department (BC,O).

1.4 - Community liaison: Porirua and Hutt Valley

This action plan aims to make RPH more effective in high needs communities (Maori, Pacific and low income families) in Porirua and the Hutt Valley. This will be achieved by:
- Improving links among RPH staff working in those communities.
- Improving relationships between RPH staff and those communities.
- Providing public health advice to community groups and community projects.
- Continuing to develop community action processes.

The community liaison work in Porirua will link closely with the development and implementation of a Community Action and Neighbourhood Approach (CANA) in Titahi Bay and Porirua.

The community liaison work in Hutt Valley will link closely with the development and implementation of Healthy Families NZ Lower Hutt.

Activities contribute to the following DHB priorities: Long Term Conditions (CCDHB, HVDHB only); and Healthy Families NZ Lower Hutt (HVDHB only).

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
1.4.1	Public Health Capacity Development	Social environments	Establish, develop and maintain internal RPH relationships that will support external relationship building as a means to improving the delivery of service to Maori, Pacific and low socioeconomic families.	# RPH team meetings attended by the community liaisons to engage teams in community activities (minimum 4).	% RPH teams who engage in community activities in Porirua or Hutt Valley following community liaison staff input.	#/% community activities implemented following team meetings (BC,S).
1.4.2	Health Promotion	Social environments	Support community action in Porirua and the Hutt Valley.	# (internal) cluster groups formed (2). # meetings held by each cluster group (2x4).	Not applicable to this activity.	#/% of identified community groups implementing community action as a result of RPH support (BC, S).

1.4.3	Health Promotion	Social environments	Connect RPH teams with stakeholders that require RPH services.	# teams supporting community groups or stakeholders (minimum 3).	% supported stakeholder groups who request evaluation expertise.	#/% stakeholders and community groups report being well supported by RPH teams (AO,O). #/% of identified stakeholders implementing community action as a result of RPH support (BC, S).
1.4.4	Public Health Capacity Development	Social environments	Develop and maintain partnerships and communication with external stakeholders and communities.	# network groups in each geographical area provided with public health advice (minimum 2).	Not applicable to this activity.	#/% network groups report they have incorporated public health advice into their initiatives as a result of RPH support (BC,S).
1.4.5	Health Promotion	Social environments	Coordinate and support RPH involvement with community events/programmes led by stakeholders.	# community events in each geographical area supported by RPH.	% community events RPH supports where we are invited to be on the organising committee.	#/% organisations/stakeholders/community groups that report being better informed on public health issues through RPH being involved with organising committee groups (SK,S).

1.5 - Promote the health of refugees (includes Schedules B & C)

This action plan delivers refugee health services to quota refugees, refugee family support category (RFSC) and asylum seekers settling in the greater Wellington region.

The plan involves clinical services which facilitate refugees transitioning into the New Zealand health system, training and education that builds health sector capacity (i.e. GP services) and health promotion activities for both refugee communities and volunteer support organisations who work with refugee communities (i.e. Red Cross Refugee Services).

Activities contribute to the following DHB priorities: System Integration/Configuration.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
1.5.1	Health Promotion	Refugees/Other Asylum seekers	Active involvement in the planning of regional and national health services for refugees, in collaboration with partner agencies.	# intersectorial meetings attended by RPH staff.	% actions assigned to RPH within regional and national refugee plans completed.	Not applicable to this activity.
1.5.2	Public Health Capacity Development	Refugees/Other Asylum seekers	Build capacity across health and social services to respond to identified refugee health needs.	# training opportunities facilitated by RPH. # of meetings facilitated by RPH.	Not applicable to this activity.	#/% training participants who report an increase in skills and knowledge (SK,S).
1.5.3	Health Protection	Refugees/Other Asylum seekers	Assess and plan health care services for refugee populations (quota, asylum and family support category refugees).	# refugee families and/or individuals supported by RPH.	% quota refugees who receive at least one home transition visit from RPH. Internal audit to assess visits completed within 6-10 weeks.	#/% refugee clients are connected and engaged with health services within the region and health needs addressed (BC,O).
1.5.4	Health Promotion	Refugees/Other Asylum seekers	Promote the health of refugee populations, including teaching sessions, documents requiring translation and refugee community workshops in collaboration with other providers.	# documents (health resources) identified for translation into other languages.	% identified documents translated and peer reviewed by refugee communities.	#/% translated documents used by health professionals in the care of their refugee clients (CC,O).

1.5.5	Public Health Capacity Development	Refugees/Other Asylum seekers	Enhancing RPHs capacity and capability to improve and deliver refugee population health services across the region (staff professional development).	# public health nurses within the Disease Control team identified for staff development.	% staff who have completed identified training.	Not applicable to this activity.

1.6 - Work with schools to identify and address health needs

This action plan summarises the work carried out by public health nurses in primary and intermediate schools. In Wairarapa this includes early childhood centres and te kohanga reo.

Public health nurses work to identify and manage health concerns that arise from the underlying wider social determinants of health. A broad range of services are provided to all primary schools, with a focus on improving the health and wellbeing of children and their whanau. The provision of a targeted model of service delivery means the high deprivation areas and lower decile schools receive a more intensive service from public health nurses. Public health nurses receive referrals from parents, schools and other community providers for children with unmet health needs. Public health nurses work collaboratively with a wide range of services, agencies and organisations.

Activities contribute to the following DHB priorities: Social Sector Trials (CCDHB only) Maternal and Child Health; Supporting Vulnerable Children; Rheumatic Fever; Long Term Conditions; Obesity; and System Integration/Configuration.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
1.6.1	Preventive Interventions	Not MoH core contract	Personal health referrals received and health concerns addressed.	# personal health referrals that support education learning and developmental and behaviour concerns. # personal health referrals are documented and reported monthly. # referrals out to specialised services including community, NGOs and hospital. # nursing interventions and treatments as per tier 1 and 2 service specifications.	Timely intervention occurs and continuity of care is provided. Feedback annually from selected schools on the quality of the service received.	#/% students have their health needs met with timely intervention, and continuity of care and appropriate referrals (BC,S).
1.6.2	Health Promotion	Not MoH core contract	Rheumatic fever awareness raising activity in the Hutt Valley and Porirua involving working with primary and secondary services to support education and information.	# education sessions provided to primary and secondary services. # school PHN rheumatic fever sessions to classes or newsletters.	% Hutt and Porirua public health nurses skilled to deliver rheumatic fever messages (target: 100%).	Not applicable to this activity.

1.6.3	Preventive Interventions	Not MoH core contract	New entrant assessments offered to children in decile 1-3 schools who do not complete a B4SC, and to other identified vulnerable children in decile 4-10 schools.	# new entrant assessments completed will be recorded in monthly reports. # referrals from the assessment.	% children in decile 1-3 schools who have not received a B4SC, offered a new entrant assessment (target: 90%).	Not applicable to this activity.
1.6.4	Health Promotion	Not MoH core contract	Health education, health promotion and population health focused activities support and address public health priorities.	# quarterly communication of health messages to schools with a population health focus. # selected hauora (health) events in the community, attended. # internal and external stakeholder meetings with a population health focus, attended. # RPH Governance meetings attended.	Feedback from schools, families and stakeholders reflect equitable healthcare for students. % decile 1-3 schools that received health support and education from a PHN (target: 100%).	Not appplicable to this activity.

1.6.5	Preventive Interventions	Not MoH core contract	Integration and collaboration with Maori, Pacific and through liaison with Maori and Pacific community providers and iwi. Develop refugee support by building connections with Government and community agencies. Use of interpreters and health literacy awareness to support timely, effective healthcare delivery. Child, Youth and Family (CYF) panels have public health nurse input. Close collaboration with education specialist support services. Collaborative relationships with Police to support children living within vulnerable communities.	# personal health referrals that support education learning and developmental and behaviour concerns. # engagements recorded in monthly reports. # regular meetings with Disease Control team clinical nurse specialist regarding status of refugee health. All regional CYF panels have PHN contribution - # recorded in monthly reports. # Healthscape entries for Police, NGO's, and social service providers e.g. Strengthening Families and Red Cross Refugee Services.	Referrals support education learning and developmental and behaviour concerns. Annual audits to demonstrate health literacy actions to support care planning. % referrals resolved by the PHN, or referrals to specialist and culturally appropriate agencies.	Not applicable to this activity.
1.6.6	Preventive Interventions	Not MoH core contract	Early identification and treatment of children with poor skin integrity and skin infections in decile 1-6 schools and other children referred from higher decile schools.	# referrals treated per skin standing orders. # skin infections referred to other services. # referrals receiving preventive care.	% skin standing orders audited.	#/% CCDHB and HVDHB PHNs who have completed the Massey University on-line skin education modules (SK,O). #/% of PHNs signed off to work under standing orders (SK,O). #/% children better off after treatment under standing orders (BC,S).
1.6.7	Preventive Interventions	Not MoH core contract	Child advocacy and protection. PHN's respond and support child where child protection identified as issue.	# child protection referrals responded to.	% referrals with correct DHB procedures followed.	Not applicable to this activity.

1.7 - Improving vision and hearing

This action plan works towards improving the hearing and vision of children in the greater Wellington region, and will improve health outcomes for children and youth through the following streams of activity:
- The provision of a mobile ear van for children and youth.
- Routine vision and hearing screening at B4SC, following enrolment at school, and screening on request.
- Both services have a focus on reaching Maori tamariki with priority screening in quintile 5 B4SC areas, and priority planning screening in decile 1-4 schools.
- Providing ear health education and training to public health nurses to enable a high level of competence.
- Appropriate referral system to the ear van clinic, primary or secondary care when needed.

RPH will target providing services to Maori and Pacific children and youth as these groups have higher hearing failure rates (source: B4SC MoH Monthly Report and Quality Letter).

Activities contribute to the following DHB priorities: Systems Integration/Configuration, Child and Youth health.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
1.7.1	Health Assessment and Surveillance	Not MoH core contract	Investigate the value of the use of standing orders for medication to be supplied at the first visit to the ear van.	# standing orders.	% children with ear infections that would benefit from standing orders.	#/% children who receive medication at the ear van to treat ear infections (BC,O).
1.7.2	Preventive Interventions	Not MoH core contract	Provide free mobile ear van service, located in identified high needs communities in Porirua.	# ear nurse clinics per week.	% booked clinic appointments attended.	#/% children with improvement to their ear health or appropriate referral made (CC,O).
1.7.3	Health Promotion	Not MoH core contract	Establish strong links with kohanga reo and aoga amata Pacific language nests in Porirua.	# kohanga reo and Pacific language nests (aoga amata) early childhood centres visited.	% children seen by the ear nurse that also receive ear health education.	#/% centres who promote the ear van service with a whanau ora approach evidenced by family appointments (BC,O).
1.7.4	Health Promotion	Not MoH core contract	Ear nurses to establish closer working relationships with B4SC and Well Child Tamariki Ora services in Porirua.	# drop-in clinics held at Cannons Creek Plunket rooms, and Waitangirua Health Centre concurrently with B4SC clinics. # meetings with B4SC and Well Child Tamariki ora services.	% children who received access to the Ear Van service on the B4SC clinic days.	#/% children with improvement to their ear health or appropriate referral made (CC,O).

1.7.5	Health Assessment and Surveillance	Not MoH core contract	Investigate the viability of a 3 year old tymping programme in kohanga reo in the Hutt Valley.	# engagements with key stakeholders in monthly reports.	100% stakeholders are receptive to the establishment of a 3 year old tymping programme in the Hutt Valley.	#/% specialist and GP services report the value of a 3 year tymping programme in the Hut Valley (AO,S). #/% kohanga reo are receptive to implementation of a 3 year old tymping programme (AO,S).
1.7.6	Preventive Interventions	Not MoH core contract	Deliver National Vision Hearing Screening Programme.	# children from B4SC, new entrant and Year 7 screened as part of the national vision hearing screening programme. # HealthScape entries.	100% of children who have a B4SC will be screened by the VHT. Plunket report regular VHT attendance to planning meetings and B4SC clinics. Monthly reports show B4SC are completed and closed. Plunket, parents and schools report positive engagements with RPH VHT staff.	#/% B4SC, new entrant and Year 7 referrals are actioned by specialist or GP services (BC,O). #/% RPH VHT staff value close working partnership with Plunket (AO,S). #/% parents and schools are aware of VHT programme through feedback to stakeholders (SK,S).
1.7.7	Health Promotion	Not MoH core contract	Closer links with integrated care partners i.e. public health nurses, Plunket, PHOs, Tamariki Ora, Porirua Children's Ear Van, early childhood centres (ECC) and schools.	# B4SC area meetings with coordinators. # VHT/ear nurse clinics in Porirua. # combined VHT and school PHN meetings. # ECC and school VHT visits.	Feedback is received from B4SC, ear nurses, school PHNs, ECCs and schools. Minutes show VHT attendance at meetings.	#/% partners report increase knowledge of the role of the RPH VHTs through referral numbers and types (SK,S).
1.7.8	Public Health Capacity Development	Not MoH core contract	All RPH VHTs will complete a biennial competency assessment by the end of 2016.	# VHTs have undertaken a peer review of their practice using the competency assessment tool.	% VHTs have completed an assessment of their practice.	#/% VHTs have increased knowledge and skills through identification of professional development needs (SK,S).

1.8 - Support for Work and Income clients to improve their health outcomes

Public health nursing to improve the health outcomes of the Porirua Work and Income client population.

This area of work connects Work and Income clients to services, and connects Porirua health and social services to relevant information regarding Work and Income. The nurse also connects health and social services together with the aim of providing a smooth service for the client.

Activities contribute to the following DHB priorities: Porirua Social Sector Trails (CCDHB only) and Systems Integration/Configuration (CCDHB only).

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
1.8.1	Health Promotion	Not MoH core contract	Develop links with Porirua marae and Maori health providers. Support the annual Work and Income Health Expo. Assist clients to make lifestyle changes and better manage long term conditions, disability and palliative care.	# referrals to other services, GP health specialties and NGOs. # marae with on-going links to Work and Income PHN. # Maori health providers with on-going links to Work and Income PHN. # presenters at the annual Work and Income health expo. # Work and Income clients attending the annual health expo.	60% local marae with on-going links to Work and Income PHN. % Maori health providers with on-going links to Work and Income PHN.	80% clients, who have previously not accessed healthcare, have been linked and supported back to primary care (BC,O).
1.8.2	Health Promotion	Not MoH core contract	Maintain a monthly calendar of health events for the Work and Income Porirua Links office. Annual review of health calendar.	# providers invited to Porirua Links office to contribute to a health event on the calendar.	% providers satisfied with health calendar opportunities at Work and Income.	90% clients that engage with providers at health event are more informed (SK,S).
1.8.3	Health Promotion	Not MoH core contract	Develop and maintain links with Work and Income staff, management and clients. Work with Work and Income staff to reduce the number of job seekers by providing health input for clients. Attend weekly site meetings.	# referrals from Work and Income case managers.	Narrative reporting from feedback from Work and Income manager, case managers and clients. 70% site meetings attended.	80% referrals to health worker from case managers have needs addressed and appropriate referrals made. Narrative report on client outcomes (case study) (BC,O).

2.1 - Smokefree Nation 2025

This action plan focuses on a range of activities and work areas as follows:
- Increasing compliance and awareness of the Smokefree Environments Act 1990.
- Increasing public support for the overall goal of a Smokefree Aotearoa by 2025.
- Increasing successful smoking cessation.
- Strengthening strategic alliances and interagency networks.
- Supporting the 'Better Health for Smokers to Quit' target within primary and secondary care settings.
- Reducing health inequities for Maori, Pacific peoples, and those in lower socioeconomic groups who have much higher rates of smoking and higher rates of ill-health and death from both smoking and passive smoking. Tobacco use is recognised as a major contributor to health inequities. The health burden attributable to tobacco smoking prevalence is higher amongst those within the low socioeconomic position where Maori are over-represented.

Tobacco control activities contribute to the following DHB priorities: Long Term Conditions; and Tobacco.

Smoking cessation activities contribute to the following DHB priorities: Systems Integration/Confiuration (HVDHB, Wairarapa DHB only); Long Term Conditions; and Tobacco.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
2.1.1	Health Protection	Tobacco control	Increased compliance and awareness of the Smokefree Environments Act 1990 (please note we must continue to allocate at least 40 percent of tobacco control budget towards regulatory budget).	1. # retailer education visits completed (Note: one visit equals one visit to one retailer). 2. # controlled purchase operations (CPOs) completed (Note: one CPO equals one total operation that targets a number of premises).	1. % tobacco retailers included in CPO. 2. % Smokefree Nation 2025 FTE tobacco taken for a tobacco retailer education visit (= staff FTEs for education visits/tobacco retailer visits).	#/% tobacco retailers that are compliant at time of CPO (BC,O).
2.1.2	Health Promotion	Tobacco control	Increase public support for Smokefree Aotearoa 2025.	1. # organisations supported to develop or review Smokefree-Auahi Kore policies.	Not applicable to this activity.	1. #/% smokefree te kohanga reo in RPH area (BC,O). 2. #/% smokefree workplaces (BC,O).

2.1.3	Health Promotion	Tobacco control	Increase successful smoking cessation (region-wide smoking cessation service). This service focuses high risk communities including Wainuiomata and Titahi Bay.	1. # smokefree providers accessing the bulk supply of Nicotine Replacement Therapy (NRT) through RPH. 2. # smokefree providers accessing new NRTs (nicotine mouth sprays/inhalers).	% clients received face to face cessation services (# clients received face to face services X100/# referrals).	Brief narrative report on outcomes.
2.1.4	Health Promotion	Tobacco control	Strengthen strategic alliances and interagency networks.	1. # key stakeholders in alliances linked to the Tobacco Action Plan. 2. # smokefree project/programmes introduced together with other stakeholders.	% projects/programmes mainly targeted at Maori and Pacific communities.	#/% homes and/or cars in Wainuiomata that have become Smokefree following the Wainuiomata Intermediate programme, via school survey (BC,O).
2.1.5	Health Promotion	Not MoH core contract	Meet the 'Better Help for Smokers to Quit' target within secondary care. Provide technical advice and support on smoking cessation to primary and secondary healthcare services at Hutt Valley and Wairarapa DHBs.	# quarterly reports that indicate the 95% target for 'Better Help for Smokers to Quit' was achieved in secondary care (Hutt Valley and Wairarapa).	% Maori and Pacific patients given ABCs through the 'Better Help for Smokers to Quit' programme.	#/% participants in ABC training report an increased level of knowledge (SK,S).

3.1 - Nutrition and physical activity

To achieve sustained reductions in the increase of preventable long term conditions and to create lasting improvements in the health and wellbeing of people and communities, RPH needs to not only promote healthier lifestyles but also improve the environments where people live, learn, work and play. Poor nutrition and physical inactivity are two significant risk factors in the development of long term conditions. Pathways to achieve prevention include through the building of healthy public policy, creating supportive environments and strengthening community action by focusing on the communities of highest need.

This action plan aligns with the Healthy Families New Zealand approach which suggests that concentrated community-led health promotion, tailored to specific community need can be successful in addressing the underlying causes of chronic diseases.

Activities contribute to the following DHB priorities: Healthy Families NZ Lower Hutt (HVDHB only); Long Term Conditions; and Obesity.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
3.1.1	Health Promotion	Nutrition and physical activity	Engage with stakeholders in a range of settings to support the development of healthy food and beverage guidelines and policies.	# DHB boards that move from using healthy food and beverage guidelines to establishing a finalised policy.	% DHBs that successfully implement a menu meeting the healthy food and beverage guideline standards.	#/% impacts of food policy implementation reported by food service operators in an evaluation report, that are positive (BC,SK,S).
3.1.2	Health Promotion	Nutrition and physical activity	Strengthen community action to improve the availability of healthy food through fruit and vegetable cooperatives.	# and location of new fruit and vegetable hubs established.	% growth of hubs over 2016-2017.	#/% increase in households accessing fresh fruit and vegetables through the fruit and vegetable co-ops over 2016-2017 (BC,O). #/% increase in orders of fresh fruit and vegetables through the fruit and vegetable co-ops over 2016-2017 (BC,O).
3.1.3	Health Promotion	Nutrition and physical activity	Strengthen and maintain strategic alliances and interagency networks actively working on nutrition and physical activity in the community (e.g. with Healthy Families NZ Lower Hutt, local councils, obesity networks, active transport).	# collaborative meetings attended. # quarterly food and nutrition newsletters produced.	% readers surveyed indicate satisfaction with the newsletter.	Not applicable to this activity.

3.1.4	Health Promotion	Nutrition and physical activity	Scope and complete an environmental scan of opportunities for organised physical activity in Porirua and Lower Hutt.	# physical activity opportunities identified in Porirua and Lower Hutt.	% positive working relationships established with physical activity providers (evidenced by regular contact and collaboration).	Not applicable to this activity.
3.1.5	Health Promotion	Nutrition and physical activity	Scope and complete a review of evidence based public health physical activity initiatives.	# recommendations for potential implementation.	% peer review completed for the physical activity initiatives review paper.	#/% recommendations approved for implementation (AO,S).
3.1.6	Health Promotion	Nutrition and physical activity	Connect decile 1-4 schools with physical activity providers in Porirua and Lower Hutt.	# decile 1-4 schools linked to physical activity providers.	% Porirua and Lower Hutt schools linked to physical activity providers.	#/% decile 1-4 school key contacts report working with physical activity providers (BC,S).
3.1.7	Health Promotion	Nutrition and physical activity	Work with Hutt City Council to implement and further develop the pilot for up-cycled sports equipment (Action Replay) in the Hutt Valley.	# and location of physical hub/s established to store equipment donated to Action Replay.	Not applicable to this activity.	#/% schools who report using donated equipment regularly (BC,S).
3.1.8	Health Promotion	Nutrition and physical activity	Lead facilitation of the implementation of the Wairarapa Breastfeeding Priority Plan 2016-2019.	# mothers engaged with the Wairarapa Breastfeeding Network.	% mothers reporting they're satisfied (Likert Scale) with engagement with Breastfeeding Wairarapa Network.	Not applicable to this activity.
3.1.9	Health Promotion	Nutrition and physical activity	Engage with Wairarapa local organisations to strengthen community action, with Wairarapa school communities as the key focus.	# schools supported with school-led initiatives (5).	% schools satisfied with RPH engagement (Likert Scale).	#/% schools reporting implementation of positive changes influenced by RPH engagement (BC,S).

4.1 - Alcohol and other drugs

Public health actions in this action plan are aimed at reducing the levels of harm from alcohol and other drug use in the greater Wellington region. Activity is divided into three main areas:
- Supply control.
- Demand reduction.
- Problem limitation.

The approaches taken to this work are a combination of regulatory and health promoting approaches. To deliver on activity in the plan RPH works with police, councils and community agencies using a regulatory and health promotion approach to understand and address the issues driving the harmful consumption of alcohol and drug use. Communities will be empowered to address their concerns.

Activities contribute to the following DHB priorities: Healthy Families Lower Hutt (HVDHB only); Child and Youth Health; Long Term Conditions; and Mental Health and Addictions.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
4.1.1	Health Protection	Alcohol and other drugs	Inquire, report on and prepare briefs of evidence/submissions for all alcohol licensing matters.	# applications received for all licence types (on, off, club, special). # applications inquired into. # applications that had matters in opposition or recommendations made.	% applications that followed our standard operating procedure.	#/% reported applications that had successful outcomes i.e. were declined, had conditions applied or negotiated settlement (CC,O).
4.1.2	Health Protection	Alcohol and other drugs	Collaborate in police led controlled purchase operations (CPOs) to reduce the sale of alcohol to minors.	# CPO events conducted (i.e. 1 event equals 1 evening). # premises visited specifying # of - on, off, club visited.	% CPOs focused on communities with high Maori populations or areas of high deprivation.	#/% premises that are compliant at the time of the CPO (BC,O).
4.1.3	Health Assessment and Surveillance	Alcohol and other drugs	Undertake regional and local analysis of alcohol related health data (Wellington ED, hospital health data) along with other relevant information e.g. demographics and use the analysis/reports to influence other parties at a local and regional level.	# agencies/services the analysis of ED and other relevant data is presented to.	% reports with robust (peer reviewed) use of data.	#/% DLC hearing decision reports referencing RPH input e.g. data (AO,O).

4.1.4	Health Assessment and Surveillance	Alcohol and other drugs	Conduct financial year analysis of alcohol licence applications, CPOs, and compliance visits from RPH database HealthScape. Complete a report to inform strategic and workload planning across the reporting agencies.	# reports completed and circulated.	% reports completed to internal specifications, including peer review.	#/% parties who report they found the analysis of value i.e. useful for planning work load and strategy internally and with partner agencies (AO,S).
4.1.5	Health Promotion	Alcohol and other drugs	Strengthen strategic alliances and interagency networks to reduce alcohol and other drug related harm e.g. facilitate and support activities in our neighbourhood approach communities of Wainuiomata and Titahi Bay, Healthy Families NZ Lower Hutt, Safer City Wellington.	# networks engaged with. # collaborative activities/projects.	% networks whose activities support communities with high Maori, Pacific peoples or young persons. % projects that support communities with high populations of Maori, Pacific peoples and young persons.	#/% networks that exhibit a strong commitment to addressing alcohol and other drug related harm or risk factors associated with that harm (BC,S).
4.1.6	Health Promotion	Alcohol and other drugs	Support territorial authorities (TAs) and other agencies to develop policies that support reducing alcohol and other drug related harm.	# policy submissions. # policies developed.	% RPH submissions or policy reviews that are peer reviewed.	#/% organisations that have implemented a policy that reflects a public health perspective. Complementary narrative on any barriers to success (BC,S).

4.2 - CAYAD (Community Action on Youth and Drugs)

NB: The following activities and performance measures are subject to change, pending notification from the MoH of changes to planning and reporting requirements for 2016-2017.

Enhance, promote and strengthen the supports provided to rangitahi in the Hutt Valley to improve outcomes for drugs and alcohol. This will be achieved through the following three core project areas:
- Enhance sector quality and sustainability.
- Promote protective factors to reduce alcohol and drug harm.
- Challenge local and other drug culture.

These projects support the four national CAYAD objectives:
- Effective policies and practices to reduce harm.
- Increased informed community discussion and debate about issues related to illicit drugs.
- Increased local capacity to support young people in education, employment and recreation.
- Reduced supply and demand of drugs to young people.

Activities contribute to the following DHB priorities: Youth Health, and Mental Health and Addictions (HVDHB only).

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
4.2.1	Health Promotion	Not MoH core contract	Support organisations to develop healthy and sustainable policy and practices to enhance environments to reduce AOD related harm.	# organisations/community groups supported.	% organisations/community groups you engaged with who have started the policy development/review process.	#/% organisations/community groups with new or improved AOD policies in place as a result of the provider's activity (BC,O).
4.2.2	Health Promotion	Not MoH core contract	Engage with and support organisations/community groups to plan and deliver community action initiatives to reduce alcohol and other drug related harm affecting young people.	# organisations/community groups supported.	% organisations/community groups report they are satisfied or very satisfied with provider's support (i.e. rating of 4 or 5 for Likert scale of 1 to 5).	#/% outcomes in community action initiatives achieved (CC,O).

4.2.3	Health Promotion	Not MoH core contract	Design, deliver and support awareness-raising activities that provide opportunity for informed discussion and debate, increase knowledge and/or create behaviour change around the use of alcohol and other drugs.	# participants.	% awareness-raising messages are aligned with Government, Ministry of Health and other evidenced based policies/strategies.	#/% participants report an increased knowledge of topic and/or increased understanding of key strategies to reducing AOD related harm (SK,S).
4.2.4	Health Promotion	Not MoH core contract	Support organisations/community groups to increase input into local, regional and national decision-making, including engaging in policy/law/by-law development processes and the alcohol licensing process.	# organisations/community groups supported to develop a submission.	% organisations/community groups that have involved youth in the submission development process.	#/% organisations/community groups report they have put in a written/oral submission including licensing objections, as a result of provider's support (BC,S).

5.1 - Communicable diseases

The aim of this action plan is to prevent illness and effectively respond to notifiable diseases and outbreaks of public health concern. Through effective public health disease surveillance, investigation and control, the impacts of communicable, waterborne and foodborne diseases can be minimised, therefore reducing the incidence of cases from further spread. Robust collection of ethnicity data and review of surveillance data by ethnicity will help direct response activities to the most vulnerable communities where the burden of disease is higher. These include Maori, Pacific and children.

Activities contribute to the following DHB priorities: Systems Integration/Configuration.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
5.1.1	Health Protection	Communicable disease	Respond promptly to cases and outbreaks of communicable, waterborne and foodborne diseases.	# disease notifications and outbreaks reported by disease.	#/% significant disease investigations initiated within 24 hours of notification.	#/% case and outbreak investigations successfully completed. Reduction in the incidence of secondary cases and further spread of diseases (CC,O).
5.1.2	Health Protection	Communicable disease	Facilitate successful completion of drug regimens for tuberculosis (TB), latent tuberculosis infected (LTBI) and leprosy clients.	# notified TB, LTBI and leprosy cases.	#/% clients that report via a client satisfaction survey their clinical support was of a high standard and they were well supported to complete their treatment.	#/% clients who completed their treatment in the reporting year (BC,O).
5.1.3	Health Protection	Communicable disease	Work collaboratively with primary care to improve secondary prophylaxis treatment for rheumatic fever clients. Respond to and manage notifications of rheumatic fever from DHBs and primary care.	# active rheumatic fever clients on the rheumatic fever register supported by RPH.	% bicillin non-compliant rheumatic fever clients followed up by RPH to encourage and facilitate bicillin compliance and regular health reviews by their specialist.	#/% rheumatic clients compliant with bicillin timeliness and compliance (BC,O).

5.1.4	Health Protection	Communicable disease	Work collaboratively with health professionals to achieve a reduction in the incidence of acute and/or recurrent rheumatic fever in the greater Wellington region, particularly in Maori and Pacific communities.	# health professional groups supported by RPH to notify acute and/or recurrent rheumatic fever cases within seven working days.	#/% health professional groups who report they are satisfied or very satisfied with RPH training and/or support provided (rating of 4 or 5 for Likert scale of 1 to 5).	#/% health professionals that report they have implemented processes to ensure timely notification of acute rheumatic fever as a result of RPH engagement (BC,S).
5.1.5	Public Health Capacity Development	Communicable disease	Maintain capacity to respond to any emergency event which may impact public health (such as natural disasters, chemical spills, communicable disease outbreaks, extreme weather events, ill travellers, shipwrecks and oil spills, incursion of exotic mosquitoes, water supply failures). Refer to Action Plan 6.6, Activity 2.	# emergency events RPH has responded to.	% emergency management reports submitted to relevant agencies within 24 hours of event occurrence.	#/% HPOs who have the skills and knowledge to report to participating agencies within appropriate timeframes (target 90% via an internal survey) (SK,O).
5.1.6	Health Protection	Communicable disease	Work towards improving infection control practices in the appearance (tattoo, skin piercing, and beauty therapy) industry.	# nail bars identified that participated in the survey.	% participating nail bars that found the interaction with public health useful (target 70%).	#/% nail bars surveyed post implementation of report recommendations, who have adopted key infection control strategies at their facility and implemented changes in their practice (BC,O).
5.1.7	Health Protection	Communicable disease	Reduce the burden of disease outbreaks in te kohanga reo.	# te kohanga reo invited to a disease outbreak workshop.	% invited te kohanga reo who participated in a disease outbreak workshop.	#/% te kohanga reo who have adopted key outbreak strategies at their centre and implemented changes in practice, as reported by a six monthly post workshop survey (BC,O). #/% te kohanga reo who report they have an increased knowledge about how to identify and control a disease outbreak at their centre (SK,S).

5.1.8	Public Health Capacity Development	Communicable disease	Build capacity and capability in the health sector to improve the follow up of serious notifiable diseases.	# health initiatives/education sessions facilitated and/or provided by RPH.	#/% workshop attendees that rate the workshops as 'good' or 'very good' on the five point Likert scale.	#/% workshop attendees that report an increase in their clinical/knowledge skills at completion of the workshop (SK,S).
5.1.9	Health Protection	MoH core contract generic	Maintain a working relationship with managers of needle exchange services within our health district to facilitate an annual review of their service, ensuring the service is operating in accordance with their authorisation documentation.	# visits/reviews of needle exchange facilities.	100% needle exchange facilities receive an annual review of their facility.	#/% needle exchange facilities that have their annual authorisation approved by the medical officer of health (CC,O).

5.2 - Promote and facilitate immunisation

This action plan outlines the safe delivery of all immunisation programmes in the greater Wellington region and focuses on education, training, delivery, data collection and promotion of immunisation in the community. Health professionals and community agencies are supported to provide positive immunisation messages. Successful implementation of all of these components will ensure the Ministry of Health targets for childhood vaccination is achieved.

Activities contribute to the following DHB priorities: Immunisation; Systems Integration/Configuration.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
5.2.1	Preventive Interventions	Not MoH core contract	Promote national immunisation targets through collaboration with key stakeholders.	Record quarterly meetings with stakeholders. Monitor monthly reports on immunisation targets.	Not applicable to this activity.	Not applicable to this activity.
5.2.2	Preventive Interventions	Not MoH core contract	Maintain infrastructure for immunisation delivery including Local Immunisation Programme (LIP).	Record and report on the number of education sessions (at least 4 annually).	90% providers will be recorded on a list of authorised vaccinators and ensure that those who have not attended an update be required to do so.	Not applicable to this activity.
5.2.3	Preventive Interventions	Not MoH core contract	Maintain cold chain accreditation checks for all HVDHB and those within the Hutt Valley that provide immunisation.	Monthly, quarterly and annual reporting to identified stakeholders.	Low or no reports of cold chain failures.	Not applicable to this activity.

5.3 - Deliver Year 7 and 8 Boostrix and Gardasil vaccination programmes

School based immunisation programmes have been shown to be an effective means of delivering immunisation to the school population. Vulnerable communities in particular, benefit from a service that provides students with vaccinations at school therefore reducing potential issues for families who face barriers to access.

The Year 7 Boostrix programme delivered to all boys and girls affords protection from three diseases - diphtheria, tetanus and pertussis (whooping cough). Pertussis is still a frequently notified disease, and continues to be prevalent in some communities.

The Year 8 Girls Gardasil programme provides immunisation against the four common human papillomavirus viruses (6, 8, 11 and 18) that can lead to cervical cancer, genital warts and other cancers later in life.

The Ministry of Health is proposing a reduction to two doses of HPV immunisation, as global evidence has shown that there is ample cover from this immunisation following the second dose.

Activities contribute to the following DHB priorities: Immunisation; Systems Integration/Configuration.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
5.3.1	Preventive Interventions	Not MoH core contract	Ensure that data entered is correct and transferred to appropriate databases: SBVS, Wairarapa Excel spreadsheets and NIR. Work collaboratively with key stakeholders in order to get the best outcome for these immunisations.	100% education sessions, immunisation clinics and catch-up clinics will be recorded and reported as per contract.	100% eligible children will be recorded correctly on the databases. All targets are met and/or exceeded.	Not applicable to this activity.
5.3.2	Preventive Interventions	Not MoH core contract	Promotion of the Year 7 Boostrix and Year 8 Gardasil vaccinations through schools and community settings.	# education sessions to all schools in the programme. # quarterly newsletters to schools from the School Health and Immunisation Group. # attendance at stakeholder meetings.	% schools enrolled in the school based programe.	#/% eligible population who receive appropriate immunisation via school based programme (BC,O).

5.3.3	Preventive Interventions	Not MoH core contract	Deliver Year 7 Boostrix and Year 8 Gardasil vaccinations in schools.	# immunisations given are recorded and reported on. # those who have declined or have not completed all doses will be referred to their GP.	% schools enrolled in the school based programe.	#/% eligible population who receive appropriate immunisation via school based programme (BC,O).
5.3.4	Preventive Interventions	Not MoH core contract	Cold chain monitoring of all vaccines to be done on a daily basis as per RPH immunisation policy and procedures manual. Cold chain maintenance will be recorded on chilly bins that are used for transporting vaccines to venues.	Daily recordings of vaccination fridge temperatures. Daily recording from data logger on chilly bin.	100% daily temperatures of the immunisation fridge will be monitored. 100% chilly bins used to transport vaccines will have data loggers. 100% data logger reports will be stored electronically.	Not applicable to this activity.

5.5 - Sexual health promotion

The intent of this action plan is to provide sexual health advice, primarily to young Maori and Pacific peoples and those that work with this group to improve awareness, prevention and management of sexually transmitted infections.

Activities contribute to the following DHB priorities: Youth Health; Maori Health; and Pacific Peoples Health.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
5.5.1	Health Promotion	Sexual and reproductive health	Provide sexual health information sessions to students from schools and alternative education providers with high Maori and Pacific enrolments.	# sexual health information sessions provided to students from an alternative education provider with high Maori and/or Pacific enrolments.	% students providing positive feedback on sexual health information sessions.	#/% students make better decisions regarding their own sexuality, sex and/or relationships (BC,O).
5.5.2	Health Promotion	Sexual and reproductive health	Provide sexual health promotion at community events with high Maori and Pacific participation.	# community events in the greater Wellington region where sexual health is promoted. # of information packs diotributed.	Not applicable to this activity.	Not applicable to this activity.
5.5.3	Health Promotion	Sexual and reproductive health	Provide sexual health information sessions for lead community members who work closely with community to increase knowledge and capacity of communities.	# sexual health information sessions delivered to lead community members including primary health care workers by June 2017 (4).	Not applicable to this activity.	#/% participants from sexual health information sessions report that the information helps them in their work with the wider community (AO,S).

5.6 - Deliver neonatal BCG vaccination

Tuberculosis infection continues to occur in New Zealand. At risk groups in New Zealand are offered a BCG immunisation in a timely manner. The neonatal BCG nurse provides education to caregivers before and after delivery of the immunisation.

Activities contribute to the following DHB priorities: Immunisation.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
5.6.1	Preventive Interventions	Not MoH core contract	Promotion of BCG service to maternal and child health providers.	# quarterly meetings with Lead Maternity Carers (LMC). # six monthly meetings with primary health and community health providers. # quarterly meetings with DHB immunisation stakeholders.	% LMCs aware of the referral process.	#/% identified eligible population who received appropiate vaccination (target: 90%) (BC,O).
5.6.2	Preventive Interventions	Not MoH core contract	Deliver the BCG programme to eligible children 0-5 years.	# eligible referrals.	% eligible clients who attend booked clinics.	#/% identified eligible poulation who received appropriate vaccination (target: 90%) (BC,O).

6.1 - Minimise environmental hazards promote safe drinking water sustainable resource management

This action plan involves the delivery of regulatory work relating to the physical environment. Specifically it includes promoting the availability of safe drinking water to all communities, reducing adverse health effects from the use or mis-use of hazardous substances and ensuring safe recreational water. It also focusses on reducing health inequalities by influencing strategic public health policies and through Resource Management Act processes.

All activities are carried out in accordance with the Environmental Health Protection Manual, Radiation Incident Responders Handbook, National Health Emergency Plan, Microbial Water Quality Guidelines, International Accreditation New Zealand requirements relating to drinking water, and any other relevant plans, guidelines, manuals (additional), policy and advice provided by the Ministry of Health.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
6.1.1	Health Protection	Physical environments	Influence national, regional and local policies, plans and documents that have significant implications for sustainable resource management and public health.	# submissions on national, regional or local policies and plans.	% submissions that are peer reviewed by topic expert.	#/% national, regional or local bodies that report that they have utilised public health advice (BC,S).
6.1.2	Health Protection	Physical environments	Undertake drinking water functions as required by Part 2A of the Health Act and maintain work standards and systems to ensure compliance with inspection body requirements (IANZ), including: maintaining the National Drinking Water Register, providing advice to water suppliers in interpretation of legislation and the NZ Drinking-water Standards, undertaking the annual drinking water quality survey, maintaining IANZ accreditation and undertaking all four drinking water scope item work as programmed.	# annual reviews undertaken for all registered drinking water supplies supporting a population of 100 or more people, excluding self supplies.	% drinking water annual survey information that is accurate and provided on time.	#/% registered drinking water supplies supporting a population of 100 or more people that comply with the New Zealand Drinking Water Standards, excluding self supplies (BC,O).

6.1.3	Health Protection	Not MoH core contract	Deliver the Drinking Water Assistance Programme and work with vulnerable communities to raise the standard of small drinking water supplies.	# small water supplies provided with advice.	% DWAP six monthly workplans accepted by the Ministry of Health.	#/% small water supplies that have accepted advice provided (BC,S).
6.1.4	Health Protection	Physical environments	Provide advice on the benefits of drinking water fluoridation to District Health Boards and support the District Health Boards when working with the community.	# times RPH has provided fluoride related advice.	% fluoride information provided that is peer reviewed.	#/% District Health Boards that utilise advice provided (BC,O).
6.1.5	Health Protection	Physical environments	Undertake public health functions relating to vertebrate toxic agents (VTAs) in accordance with Section 95A of the Hazardous Substances and New Organisms Act 1996 and Ministry of Health guidelines.	# VTA permissions assessed.	% reports completed on time, including the Hazardous Substances Activities and Intentions Report, incidents reports and copies of vertebrate toxic agents permissions to the Environmental Protection Agency.	#/% Vertebrate Toxic Agent (VTA) operations compliant with permit approval conditions (BC, O). Numerator: # VTA operations compliant; Denominator: total # VTA permissions.
6.1.6	Health Protection	Physical environments	Monitor, assess and respond to significant recreational water quality issues in the greater Wellington region, including recreational bathing water quality alerts, working with swimming pool operators to ensure good filtration and faecal incidence management, work on the Porirua Harbour and Catchment Strategy implementation, and maintaining relationships with councils involved with fresh water and marine recreational water environments.	# commercial swimming pools provided with advice regarding pool water quality and operation, particularly in relation to cryptosporidium.	% commercial swimming pools receptive to audit process.	#/% commercial swimming pools which have adequate operating procedures to minimise the spread of communicable diseases (BC,S).
6.1.7	Health Protection	Physical environments	Attend and participate in the Local HAZMAT Committee (HSTLC) meetings.	# local HAZMAT meetings attended.	% agency members that attend each HAZMAT meeting.	Not applicable to this activity.

6.1.8	Health Protection	Physical environments	Maintain a database of premises storing polychlorinated biphenyls (PCBs) and audit compliance of premises with conditions of exemption until the programme finishes on 31 December 2016.	# PCB audits carried out.	% PCB audits that have followed agreed guidelines.	#/% PCB storage operators that comply with the regulations (BC,O).
6.1.9	Health Protection	Physical environments	Use Hazardous Substances Disease and Injury Reporting Tool (HSDIRT) to record chemical injury cases and utilise reports provided by the Centre for Public Health Research.	# chemical injury notifications received.	% chemical injury notifications entered appropriately into HSDIRT.	#/% hospital emergency departments and GPs using HSDIRT (BC,O).
6.1.10	Health Protection	Physical environments	Carry out surveillance under the Hazardous Substances New Organisms Act 1996, investigate breaches of, and carry out enforcement action where necessary.	# issues/complaints followed up and/or referred to Worksafe NZ or other relevant agencies.	% complainants that receive feedback.	#/% retail outlets that are compliant at the time of an investigation (CC,O).
6.1.11	Health Protection	Physical environments	Identify and visit all commercial solaria/sunbed operators every six months, provide information on best practice to reduce the public health risks.	# solaria/sunbed operators contacted for a visit every six months.	% solaria/sunbed operators that provided information willingly.	#/% commercial solaria/sunbed operators that have improved their operation since the previous visit (CC,BC).
6.1.12	Health Protection	Physical environments	Take a multi-agency approach to applying public health legislation to identify, assess and manage risks arising from the physical environment e.g. air quality, environmental noise, disinterment, infirm and neglect, lead paint and asbestos, contaminated sites, spray drift and ionising and non-ionising radiation.	# disinterment, repatriation and other burial and cremation matters processed.	% applications for disinterment and repatriation processed within 15 working days and in accordance with relevant standard operating procedures.	Not applicable to this activity.
6.1.13	Health Protection	Physical environments	Maintain a 24/7 on-call response.	# HPOs and MOoHs that carry out on-call duties.	% HPOs and MOoHs that have maintained the required competency.	Not applicable to this activity.

6.2 - Promote safe and healthy urban environments

RPH will influence key decisions made in health, housing and urban planning processes that have the greatest potential to improve Maori, Pacific, and child health. RPH will do this by:
- Delivering healthy housing programmes focused on improving the living environments of those at risk of housing related illnesses, including rheumatic fever.
- Working with communities, local and central government to influence good urban design and planning that will positively impact on the health of the community.

Healthy housing activities contribute to the following DHB priorities: Long Term Conditions; and Rheumatic Fever.

Activities working with communities, local and central government to influence good urban design and planning, contribute to the following DHB priorities: Long Term Conditions.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
6.2.1	Health Promotion	Physical environments	Assess relevant planning or community initiatives for likely public health impact and influence planners and developers to improve health outcomes through sustainable and community centered design.	Provide evidence based public health advice to at least five urban design or transport planning processes and/or policy making processes.	% identified urban design or transport planning processes and/or policy making processes responded to.	#/% territorial authorities that report that they have utilised public health advice (BC,S).
6.2.2	Health Promotion	Physical environments	From a Health in all Policies approach develop and promote public health intelligence that supports healthy urban environments in areas of high socioeconomic deprivation through information papers, research and workshops.	# public health intelligence initiatives completed.	Not applicable to this activity.	#/% territorial authorities, private planners and/or community groups that RPH has engaged with, that have obviously used public health input. (BC,S)
6.2.3	Health Promotion	Not MoH core contract	Deliver a sustainable, region-wide healthy housing programme to improve the health outcomes of Maori, Pacific and children in areas of high socioeconomic deprivation.	# Maori, Pacific and low income families who receive a healthy housing assessment.	% families who receive a healthy housing assessment receive a standardised follow-up within 12 weeks of the referral being received.	#/% families provided with healthy housing interventions (BC,O).

6.2.4	Public Health Capacity Development	Not MoH core contract	Deliver healthy housing training to primary and secondary health care staff working with clients and whanau in high deprivation areas, with a focus on Maori, Pacific and child health providers.	# primary and secondary care staff who received heahlthy housing traininig.	% trainining participants who are from a Maori, Pacific, or child health provider.	#/% health providers who received healthy housing training reported an improved knowledge around addressing common housing issues with clients and whanau (SK,S).

6.3 - Early childhood

The intent of this action plan is to improve public health outcomes for children attending early childhood services, especially te kohanga reo and pacific services. RPH public health advisors work with staff to raise awareness of regulatory requirements, gastro-enteric illness and to encourage the uptake of healthy food.

The work in early childhood centre settings will also support the development and implementation of Healthy Families NZ Lower Hutt as it unfolds.

Activities contribute to the following DHB priorities: Healthy Families NZ Lower Hutt (HVDHB only); Child Health; and Obesity.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
6.3.1	Health Promotion	Physical environments	Increase wellness in early childhood centres.	# hits on the website when outbreaks of illness arise (400-800).	% feedback received from early childhood services provided with advice and support for an outbreak indicates satisfaction with RPHs input.	#/% outbreaks in early childhood services that are notified when there is less than 30% of the roll impacted (BC,O).
6.3.2	Health Promotion	Physical environments	Support te kohanga reo kaimahi to build healthier environments for nga mokopuna.	# te kohanga reo RPH engages with (8).	% te kohanga reo who participate in workshops report satisfaction with the knowledge and advice they receive.	#/% increase in te kohanga reo mokopuna enrolled in oral health services (BC,O).
6.3.3	Health Promotion	Physical environments	Increased health promotion focus on Wairarapa early childhood sector, high need centres in particular, and their respective communities.	# high-medium need centres RPH is actively working with (15).	% early childhood centres indicate satisfaction (Likert Scale) with RPH service provision.	#/% early childhood centres changed some practice/behaviour as a result of RPH engagement (BC,O).
6.3.4	Health Protection	Physical environments	Conduct regulatory work in all early childhood centres as required by Ministry of Education.	# pre-licensing inspection recommendations supported by the Ministry of Education.	% licensing inspections carried out in accordance with Education (Early Childhood Centre) Regulation 2008.	Not applicable to this activity.

6.4 - Health Promoting Schools

This action plan is designed to work within school based settings to improve child health outcomes in communities of high need - Maori, Pacific and low income.

Activities contribute to the following DHB priorities: Healthy Families NZ Lower Hutt (HVDHB only); Child Health; and Obesity.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
6.4.1	Health Promotion	Not MoH core contract	Work with schools decile 1-4, year 1-6 of high Maori and Pacific enrolments.	# workshops provided for schools decile 1-4, year 1-6 (2).	% schools decile 1-4, year 1-6 that participate in a workshop.	#/% school communities developing ways in which to effectively engage with their wider community (BC,S).

6.6 - Border health and response to emergency events

This action plan aims to improve the health outcomes for the population of the sub-region including vulnerable communities through reducing risks associated with the introduction to New Zealand of vectors and diseases of public health significance. Through collaborative emergency planning and response, the impact of emergency events on vulnerable communities (particularly Maori) will be minimised.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
6.6.1	Health Protection	Physical environments	Ensure designated points of entry maintain core capacities as required by the International Health Regulations 2005, undertake regular mosquito surveillance and response protocols, ship sanitation inspections and pratique requests.	# designated points of entry as required by International Health Regulations 2005.	% designated points of entry that complete their annual verification audits.	#/% designated points of entry that have met the requirements of the annual verification assessment (BC,O).
6.6.2	Health Protection	Physical environments	Maintain capacity to respond to any emergency which may impact on public health (such as natural disasters, chemical spills, communicable disease outbreaks, extreme weather events, ill travellers, shipwrecks and oil spills, incursion of exotic mosquitoes, water supply failure).	# emergency events RPH has responded to.	% emergency management reports submitted to relevant agencies and a copy to the Ministry portfolio manager within 24 hours.	#/% HPOs who have the skills and knowledge to report to participating agencies within appropriate timeframes (target 90% via an internal survey) (SK,O).
6.6.3	Health Protection	Physical environments	RPH will proactively work with our three DHB & Regional Emergency Planners. This work includes participating in national, regional and local meetings, exercises and training opportunities and also the review of RPH plans to enable an effective response to a range of public health emergencies.	# Emergency Services Co-ordinated Committee meetings attended by key RPH staff.	% RPH staff who attend intersectorial emergency management meetings who currently hold a CIMS Level 2 or 4 qualification.	#/% on-call HPO response staff who report that they have an increased knowledge concerning risks and activities in the region (SK,S).

6.6.4	Health Protection	Physical environments	Work collaboratively with local marae to strengthen and enhance resilience following an emergency event and support those marae who will operate as a welfare centre.	# marae collaborated with and supported by RPH.	% marae who report they have an increased knowledge about how to manage/co-ordinate their community in an emergency.	#/% marae who have adopted emergency strategies at their facility as reported by a six month post collaboration survey (BC,O).

7.1 - Business support

This action plan outlines the business support services that will be provided by RPH. It includes four clusters of work: administration support; information support; working with primary healthcare; and business support. The administration support cluster provides administrative and desktop publishing service to the organisation. The information support cluster develops and maintains information systems, provides specialist informatics and data management and manipulation services for RPH. The primary care work involves a public health physician who works with primary health care to identify and build links and synergies to support them to contribute towards improving population health through preventing disease and promoting healthy behaviours. The business support cluster leads the strategic and operational business and financial planning and reporting services for RPH as well as providing support in project management.

Activities with primary healthcare contribute to the following DHB priorities: Child Health (HVDHB only); Long Term Conditions (HVDHB only); and Systems Integration/Configuration.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
7.1.1	Public Health Capacity Development	Internal allocation for all contracts	Maintain and develop the information systems that underpin good public health service delivery.	# entries into HealthScape for this period.	% locations geo-coded in HealthScape.	Not applicable for this activity.
7.1.2	Public Health Capacity Development	Internal allocation for all contracts	Coordinate and facilitate the RPH annual planning and reporting processes. (This activity links with 7.4.1).	# contractual annual plans submitted to contract funders for approval.	% contractual reports submitted on or before the due date.	#/% 2016/17 RPH Business Plan activities that specifically prioritise improving Maori heath outcomes, as identified in the online RPH Activities E-tool (CC,S).
7.1.3	Public Health Capacity Development	Internal allocation for all contracts	Provide administrative support, desktop publishing and maintenance of the office work environments for the four bases.	# significant design projects carried out.	% client satisfaction with work done.	Not applicable for this activity.
7.1.4	Public Health Capacity Development	Internal allocation for all contracts	Development of a new staff checklist to be used by line managers, accompanied by processes and resources to assist orientating new staff.	# new staff orientated.	% line managers that used the orientation checklist.	#/% new staff report they are confident about their new role (AO,S).

7.1.5	Public Health Capacity Development	Internal allocation for all contracts	Influence and support DHB and primary care to take public health approaches.	# DHB/PHO/Service Level Alliances meetings attended.	% PHO Advisory Group meetings attended.	Not applicable for this activity.

7.2 - Maori action plan

The intent of this action plan is to implement and embed service wide components of our Maori Strategic Plan. The initial action plan will largely focus on establishing an internal organisational culture change that supports future action planning.

Activities contribute to the following DHB priorities: Maori Health.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
7.2.1	Public Health Capacity Development	Internal allocation for all contracts	Whanaungatanga - Relationships: Working closely with Maori is critical to RPH contributing to improving Maori health and reducing inequities. As an organisation, RPH wants to be dependable and reliable in relationships with Maori. Existing relationships with iwi and Maori health networks are a vital and valuable taonga to be cherished and nurtured.	# occasions that RPH Leadership initiates meetings with each of the three DHB Maori Partnership Boards; at least twice per annum with each Board (total of six meetings per annum).	Not applicable to this activity.	Not applicable to this activity.
7.2.2	Public Health Capacity Development	Internal allocation for all contracts	Workforce development - Being comfortable and confident working with Maori and making practical connections is important to effective public health practice. RPH wants us all to grow and be empowered. Providing a platform of information, guidance, training and opportunities to learn from others will help everyone to work more effectively with Maori and will strengthen relationships.	# employment opportunities promoted directly to iwi and Maori health service provider networks.	% recruitment advertisements actively used to recruit Maori.	#/% increase in the number of quality Maori staff recruited (BC,O).

7.2.3	Public Health Capacity Development	Internal allocation for all contracts	Accountability - RPH wants to deliver great services, all of the time. Part of achieving this includes having effective mechanisms to encourage and strengthen the accountability for Maori health. In particular, seeking feedback from Maori on RPH services and improving RPH practice as a result will enhance relationships and increase understanding of how RPH might make a tangible difference.	# annual RPH hui to critically reflect on and improve performance for the Maori community (1).	Not applicable to this activity.	Brief narrative report.
7.2.4	Public Health Capacity Development	Internal allocation for all contracts	Communication - RPH wants a cohesive service where staff trust one another and work with each other to achieve outcomes for Maori. RPH wants to be transparent, inclusive and accountable to each other and for Maori health. To support this, strong and proactive internal communication and feedback mechanisms are essential.	# dedicated communications are sent to RPH staff (quarterly).	% increase of sharing and showcasing Maori specific stories, research and information from Maori stakeholders and nation-wide sources.	#/% increase in the number of RPH staff exposed to Maori specific stories, research and information (SK,S).
7.2.5	Public Health Capacity Development	Internal allocation for all contracts	RPH - The intention of this action plan is to implement and embed service-wide components of the Maori Strategic Plan. The initial action plan will focus on establishing an internal organisational cultural change that will integrate with future action planning.	# Regional Public Health: Hui-a-RPH (annual).	% feedback from RPH management and staff demonstrates the integration of the Maori Strategic Plan operationally (Likert Scale 1-5).	#/% RPH Maori Strategic Plan tasks operationalised in practice (BC,O).

7.3 - Pacific Peoples action plan

This action plan focuses on strengthening RPH responsiveness to Pacific communities. Its ultimate aim is to improve public health outcomes for Pacific peoples across all RPH project and work areas. A key aspect of this goal is improving the engagement experience of any Pacific person who comes into contact with RPH staff through their line of work. It recognises the importance of improving RPH skills, systems and processes to better support this goal. The action plan therefore focuses on developing organisational capacity and building staff capability. It aims to do this in various ways over time, including continuing to support Pacific cultural competency training for all RPH staff.

Activities contribute to the following DHB priorities: Pacific Health.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
7.3.1	Public Health Capacity Development	Internal allocation for all contracts	Deliver Pacific cultural competencies training for RPH staff.	# cultural competencies workshops held by April 2017.	% RPH staff report positive feedback about delivery and content of workshops.	#/% RPH staff report increased awareness of Pacific cultural values as a result of the workshops (SK,S).
7.3.2	Preventive Interventions	Internal allocation for all contracts	Support increased Pacific referrals to Well Homes project.	# referrals from the Pacific community to Well Homes programme.	% increase of referrals from Pacific communities within agreed timeframe.	#/% Pacific families referred report positive* outcomes for their families from the programme (CC,S). (*Positive outcomes are defined as one or more of the following key outcomes: 1) number of low income Pacific families receiving a healthy housing assessment; 2) number of standardised follow ups made within 12 weeks of referral being received for Pacific families who have received a healthy housing assessment; 3) Pacific families provided with a health housing intervention).
7.3.3	Public Health Capacity Development	Internal allocation for all contracts	Establish a partnership project with Whitireia Polytechnic School of Nursing.	# opportunities to present on public health to Whitireia Pacific student nurses.	% positive feedback from faculty and students on quality of public health presentations.	#/% Pacific student nurses with increased awareness and interest in public health as a future career option (SK,O).

7.4 - Public health infrastructure

Public Health infrastructure support for generic core contract deliverables including service wide workforce development; public health governance (quality); and support and compliance with Ministry of Health core contract planning guidelines.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
7.4.1	Public Health Capacity Development	MoH core contract generic	Coordinate and facilitate the RPH annual planning and reporting systems and processes. (This activity links with 7.1.2).	# contractual annual plans submitted to contract funders for approval.	% contractual reports submitted on or before the due date.	#/% 2016/17 RPH Business Plan activities that specifically prioritise improving Maori heath outcomes, as identified in the online RPH Activities E-tool (CC,S).
7.4.2	Public Health Capacity Development	MoH core contract generic	RPH meets minimum standards for workforce development; including work to increase RPH staff public health qualifications towards the MoH goal of 75% and the offering of scholarships to Maori and Pacific staff.	# staff initiating study in public health during the period.	% staff working towards a recognised public health qualification.	#/% staff with a recognised public health qualification, including breakdown of ethnicities (CC,O).
7.4.3	Public Health Capacity Development	MoH core contract generic	Implement a public health governance/quality improvement programme including a three year cycle of quality assurance using public health standards adapted from the National Public Health Performance Standards of America; implementing quality improvement initiatives and projects; and aligning to DHB quality and risk systems.	# new quality improvement projects identified.	% active quality projects completed.	Not applicable to this activity.

7.6 - Public health analytical services

This action plan outlines the range of analytical services that will be provided by the Business and Analytical Support Unit (BASU) and the Medical team to support RPH and the wider public health sector. The focus of the plan is health assessment, surveillance and public health analytical capacity development core functions.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
7.6.1	Public Health Capacity Development	MoH core contract generic	Use evidence based research and evaluation to develop and improve public health programmes and interventions. Action includes analytical support (survey research, evaluation, logic modelling, GIS services and public health medicine specialist expertise). The scope is projects to improve the health of Maori and other vulnerable populations in the greater Wellington region. We will support projects that RPH either leads or is participating in.	# projects that analytical support was provided for.	#/% projects where analytical support was provided that focus on Maori and other vulnerable populations.	#/% projects where results have been useful for future planning or delivery (AO,S).

7.6.2	Health Assessment and Surveillance	MoH core contract generic	Collect and report information about local population health with a focus on health equity and the health of Maori. Includes: a) Community profiles, support for health needs assessment. Profiles to include Maori statistics and information about factors in the community that typically influence health status. b) Processes or tools to make operational service delivery easier or more efficient (e.g. on line data collection of outbreak surveys, incubation calculation tool). c) Processes or tools to transform data into useable public health intelligence products to meet the needs of relevant end users. d) Analysing information to help RPH teams to have a better understanding of resources used for project delivery.	# community profiles and reports completed.	100% reports include Maori health statistics.	Not applicable in this case.
7.6.3	Public Health Capacity Development	MoH core contract generic	This activity includes the training and development of RPH staff, peer review of analytical work across the service and the mentoring of staff that are applying analytical techniques to their work. This year there will be a focus on data visualisation techniques, improving communication of results to Maori, the use and integration of the analytical package 'R' and possibly cost effectiveness techniques.	# skills development activities provided.	#/% clients who report they are satisfied or very satisfied with BASU led skill development training (i.e. rating of 4 or 5 for Likert scale of 1 to 5).	#/% attending training who report they have increased confidence/skills (SK,S).

7.8 - Communications support and health information dissemination

This action plan outlines the RPH communications support and health information dissemination services. This work includes two areas of work: communications support and health information. The communications support work area is responsible for developing and implementing a consistent, high quality approach to communications across RPH. The work supports RPH staff by overseeing the development of resource material, providing media advice and management of online content, including web and social media. The health information work area is responsible for improving health literacy by maintaining an efficient health education resource distribution service to support health professionals and the delivery of public health services.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
7.8.1	Public Health Capacity Development	MoH core contract generic	Provide media management for RPH staff and medical officers of health.	# times RPH features in print media proactively and reactively each month.	% proactive media pitches captured in printed media.	Not applicable to this activity.
7.8.2	Public Health Capacity Development	MoH core contract generic	Continue to provide support to maintain and update the RPH website and RPH's social media platforms.	# new visitors to the RPH website per month.	% RPH web content (parent pages) up-to-date at 30 June 2017.	Narrative report on the top five pages visited per month, compared with new/ emergent issue (i.e. during a measles outbreak, the 'measles' page of the RPH website ranks at the top of the five most visited pages for the month).
7.8.3	Public Health Capacity Development	MoH core contract generic	Distribute health information resources and update stakeholders on revised, deleted and new resources.	# requests received for health information resources.	% requests for health information resources are responded to within five working days.	Not applicable to this activity.

7.9 - Central region public health advice (Schedule D)

The goal of this action plan is to improve public health through supporting central region public health services and providing regional leadership. This will be achieved through: providing specialist and technical public health advice for central region public health units, facilitating training relevant to the needs of the public health units, facilitating and leading collaboration with the central region public health units through Central Region Public Health Clinical Network (CRPHCN), and providing specialist public health advice and/or representation to the Ministry of Health or other relevant central government agencies

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
7.9.1	Public Health Capacity Development	MoH core contract schedule D	Provide specialist, technical and analytical public health advice for regional public health units and central government agencies.	# instances where specialist, technical and analytical public health advice provided to other public health units and Government agencies.	% public health units that receive specialist, technical and analytical public health advice within agreed timeframes.	#/% public health units who received specialist and technical analytical advice who report that their public health practice was strengthened through the advice (SK,S).
7.9.2	Public Health Capacity Development	MoH core contract schedule D	Lead and participate in the Central Region and National Public Health Clinical Networks including active participation in the health protection and health promotion managers networks.	# central region public health clinical networks actively contributing to.	% central region public health clinical network attended.	Brief narrative report on outcomes of projects (BC).
7.9.3	Public Health Capacity Development	MoH core contract schedule D	Lead in joint central region public health unit's capability planning for emergency response, including providing annual training to other public health units.	# people attending joint public health unit training exercises.	% people attending the joint exercises that reported course satisfaction levels at least four (on a five point scale).	#/% attendees on joint public health unit training exercises from outside of RPH staff who report that they feel more capable in responding to issues following the training (SK,S).
7.9.4	Public Health Capacity Development	MoH core contract schedule D	Participate in central region panel on health protection officer competency assessments.	# primary assessments conducted by RPH staff.	% primary assessments conducted by RPH staff.	#/% health protection officers who submitted work for assessment and were deemed to have maintained competency (SK,O).

7.9.5	Public Health Capacity Development	MoH core contract schedule D	Support Central North Island Drinking Water Assessment Unit administration centre.	# hours of staff time provided to support administrative functions of the Central North Island Drinking Water Assessment Unit.	% Central North Island Drinking Water Assessment Unit offices that have positive working relationship with administration centre, as shown in correspondence.	#/% offices that hold IANZ accreditation for drinking water work (CC,O).

8.1 - Standalone contracts

This action plan brings together a collection of contracts that have their own specific funding lines and are not well aligned to other action plans. It includes contracts that focus on the following areas: support to the national Public Health Clinical Network and supervision for registrars on the New Zealand College of Public Health Medicine vocational training programme in the central region.

#	Core function	Issue	Activity	Performance measures How many = #	How well = %	Is anyone better off = #/%
8.1.1	Public Health Capacity Development	Not MoH core contract	Deliver on the Public Health Clinical Network (PHCN) contract.	Subject to separate contractual reporting requirements.	Subject to separate contractual reporting requirements.	Subject to separate contractual reporting requirements.
8.1.2	Public Health Capacity Development	Not MoH core contract	Provide public health medicine training programme supervision for central region.	Subject to separate contractual reporting requirements.	Subject to separate contractual reporting requirements.	Subject to separate contractual reporting requirements.
8.1.3	Health Protection	Not MoH core contract	Deliver on the MidCentral Medical Officer of Health contract.	Subject to separate contractual reporting requirements.	Subject to separate contractual reporting requirements.	Subject to separate contractual reporting requirements.