



District Annual Plan
2008-2011

17 December 2008

Statement from Chair and CEO

The 2008/09 Annual Plan sets out the programme of work for the Capital & Coast District Health Board for the 2008/09 financial year. The programme places emphasis on:

- Maintaining the good primary and community health initiatives that have been put in place in previous years;
- Maintaining the current level of output and overall span of clinical procedures;
- Starting what will be a three year programme of work to fully take advantage of occupying the New Regional Hospital; and finally
- Investing in and commissioning new business process systems – both clinical and financial – and also in fit for purpose and up to date equipment.

Maintaining the primary and community health initiatives together with the clinical outputs will come at a cost. Revenue budgeted for C&C DHB for the 2008/2009 financial year is approximately 3.7% higher than that for the 2007/2008 year. Staff costs have continued to rise markedly, due to shortages of medical staff and Australasia-wide competition for those staff. The cost of C&C DHB's increasing debt and capital charges will also increase as the costs of the New Regional Hospital impact. If the predicted drop in the value of the New Zealand dollar materialises then most of the equipment and many of the medical supplies will also become proportionately more expensive. Investments in new and improved business process systems – both clinical and financial – cannot and should not be realistically delayed any longer. In the medium term the investments in new and improved business process systems should result in financial savings. However, the net effect for next year will be that rising costs will overwhelm the revenue stream. On that basis a financial deficit will be generated on the operations of the Board, and deficit support will be required from government as has been the case in previous years.

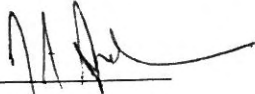
Although unwanted and undesirable, the increasing deficit situation is a similar situation to other DHB's who have undertaken major capital developments. It is C&C DHB's intention to learn from other DHB's who have undergone this type of process and systematically isolate, investigate and address each of the root causes that underlie the deficit. C&C DHB will also work very closely with the Ministry of Health through this process.

Occupancy of the New Regional Hospital

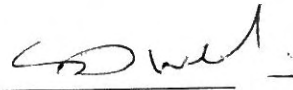
During the planning year, the new regional hospital at Newtown will have begun to be systematically occupied. Moving into the new regional hospital presents a major opportunity to begin what is planned to be a three year programme of changing the way the clinical services are able to be delivered. New models of nursing care will be put into place together with a number of modern nursing and clinical support systems. The model of care and the new support systems are designed to more effectively care for patients.

Preserving Options for the Future

Having completed the new regional hospital, C&C DHB has had to look ahead and decide how to best use the existing good facilities at Newtown and Kenepuru and elsewhere to meet foreseeable needs over the next five, and hopefully ten, years. It must do this on behalf of not only its own local population, but also the wider southern North Island and northern South Island populations. Decisions about which of the many other good C&C DHB facilities will be used will determine how the staff and equipment will be deployed overall. Regardless of the need to confront its immediate and considerable pressures and challenges, C&C DHB would be failing in its duty if it did not look ahead and make sensible provisions for the future.



Sir John Anderson
Chair

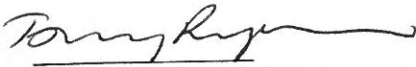


Ken Whelan
Chief Executive

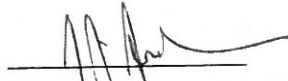
District Annual Plan Approval

Signatories

The Capital & Coast District Health Board's Annual Plan is approved on:



Hon Tony Ryall
Minister of Health



Sir John Anderson
Chair
Capital & Coast DHB

Date: 23.12.08

Date: 11.2.09



Office of Hon Tony Ryall

Minister of Health
Minister of State Services

Sir John Anderson
Chair
Capital and Coast District Health Board
Private Bag 7902
Newtown
WELLINGTON 6242

Dear Sir Anderson

Capital and Coast District Health Board: 2008/09 District Annual Plan

I am pleased to advise you that I have signed Capital and Coast District Health Board's (Capital and Coast DHB) 2008/09 District Annual Plan (DAP) for one year and that the Board has my full support for implementing this one-year plan.

The size of the DHB deficit, while agreed in the current year and the Board's reluctance to take responsibility for new regional hospital costs, evidenced in the bottom line in the DHB's letter to me of 2 December 2008 is a great concern to the Government. It is imperative that you work actively to eliminate this deficit in the shortest possible time. I also expect to see a positive financial direction and clear pathway to financial sustainability reflected in the 2009/10 DAP.

I strongly encourage your Board to ensure that the collaborative approaches outlined in your DAP are implemented. I expect to see examples of this collaboration to include best practice sharing between DHBs, clinical networks, intersectoral cooperation and constructive engagement with non-Government organisations in the sector. In particular I expect to see a high degree of collaboration with other Central Region DHBs.

I remind you that my approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry where any proposals may require my approval.

My approval of your DAP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the National Capital Committee. Approval of such projects is dependant on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I wish you and your management team every success with the implementation of your 2008/09 DAP, and thank you for your contribution and efforts to improve the health of New Zealanders.

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

Yours sincerely

A handwritten signature in black ink, appearing to read 'Tony Ryall', with a horizontal line extending to the right.

Hon Tony Ryall
MINISTER OF HEALTH

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1 Our priorities for 2008-09

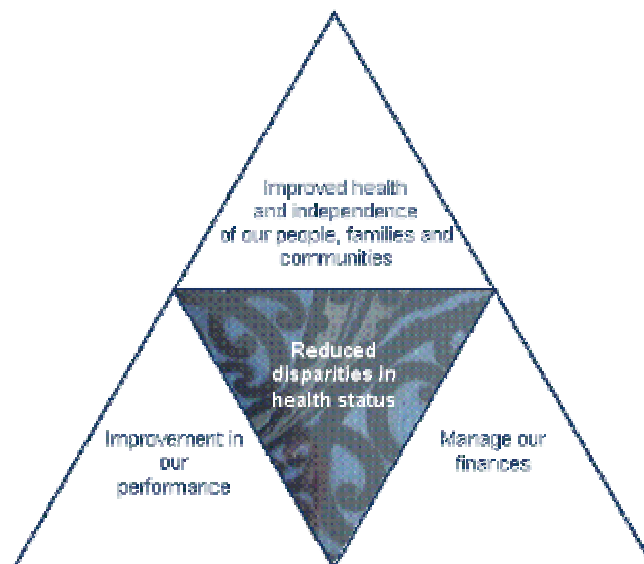
Capital & Coast DHB's District Annual Plan (DAP) is devoted to providing high level information on our work programme for the next year and includes sections on our contribution to the national health targets and Minister's priorities, performance measures and key risks to the delivery of this plan. Our District Strategic Plan (DSP) provides the strategic direction and framework for our 2008-2011 DAP in which we summarise our intentions for the next three years.

1.1 Strategic Direction

Our Vision

Better health and independence for people, families and communities.

Our Health Goals



Our Mission

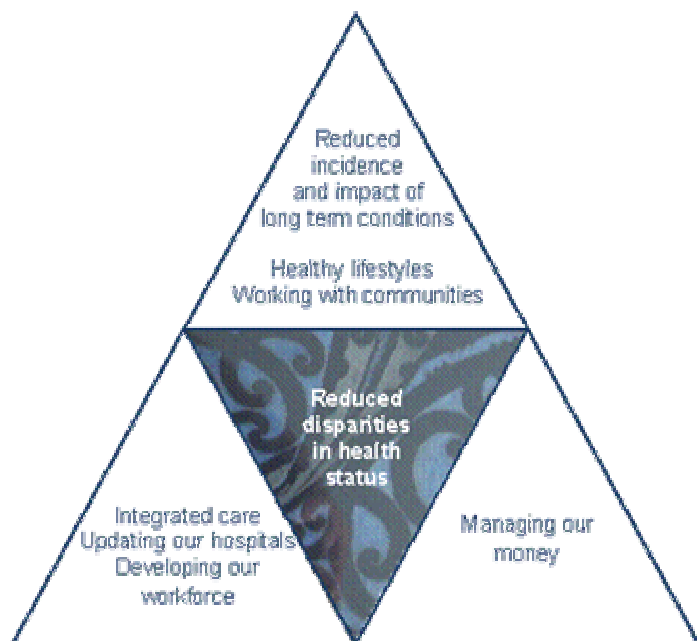
Together, improve the health and independence of the people of our district.

Our Organisational Values

focusing on people and patients;
innovation;
living the Treaty;
professionalism;
action;
excellence.

This strategic framework maps to our DSP as illustrated in the diagram below. It demonstrates emphasis on reducing disparities for Māori, Pacific and those on low incomes and reducing the incidence and impact of long term conditions (chronic conditions). In addition, it strengthens our emphasis on improving our performance and managing our finances - key priorities for us in the next three years.

We will continue to work on the national health targets, the Minister's priorities and priorities identified in the New Zealand Health Strategy and the New Zealand Disability Strategy. Changes need to be driven by our values as well as building trust in our relationships between management and clinicians.



1.2 Minister of Health's Priorities 2008-09

1. Value for money – better value for money provides more health care for more New Zealanders
2. Getting ahead of chronic conditions – maintain the pace of programme implementation
3. Reducing disparities, especially for Māori and Pasifika populations
4. Child and youth health – implement current programmes and build on the well child review
5. Primary health – improve the interface, through planning and working together with PHOs
6. Infrastructure – especially workforce development and coordinated information systems
7. Health of older people – continue to give priority to new service models.

1.3 Summary of Objectives

Goal 1 Reduced disparity in health status

Māori health – Implementation of Te Plan II

Pacific health – Action Plan implementation

Primary health development – focus on:

- avoidable hospital admissions
- joint primary secondary governance
- child health - immunisation and before school check roll out
- youth health engagement with youth and youth friendly services

Progressing the New Zealand Disability Strategy - Developing a Promoting Participation Action Plan for 2008-2012

Goal 2 Improved health and independence of our people, families and communities

Population approach to health service delivery

- Implement our local Population Health Strategy
- Implement “Keeping Well 2008-2012” - Regional Public Health Plan
- Implement Tobacco Control Plan
- Support and promote healthy lifestyles – implement HEHA Ministry Approved Plan (MAP)

Working with communities – engage intersectorally e.g. healthy housing

Management of long term conditions

- Diabetes
- Cardiovascular disease/Stroke
- Respiratory

Health of Older People – implement the Integrated Home and Community Care programme

Mental health – progress The Journey Forward

Cancer Control and Palliative Care - implement strategy and plan

Goal 3 Improvement in our performance

Improving HHS business process efficiency

Valuing our people

Safe, high quality services

Goal 4 Manage our finances

Financial strategy

- Invest in systems, processes and our workforce
- Influence national pricing programme
- Work with owner to develop a strategy to improve our balance sheet

Funding allocation for 2008/09

Financial environment and information

1.4 Major changes for 2008/09

This Annual Plan presents the areas where we propose to make changes during the 2008/09 year. Because of funding constraints, most of the changes in this DAP reflect activity that will be undertaken within current budgets, are full implementation of initiatives commenced in the 2007/08 year or have tagged funding from the Ministry of Health.

The migration to the new regional hospital (NRH) and associated clinical change programme to improve our service delivery in hospital and community based services is our major focus for our activity in 2008/09.

Over the past few years there has been active review of contracts and reconfiguration every year of different contracts to align with changing priorities and environment. For the Hospital and Health Service (HHS) this occurs through the Price Volume Schedule (PVS).

Our priorities for changes are aligned to the national health targets and are often clusters of activity that work together as many are interdependent, e.g. nursing development, primary care development, immunisation and reducing inequalities.

Overall Financial Situation for 2008/2009

Revenue

The total revenue for C&C DHB is budgeted to be \$746 million, some 4.9% higher than for 2007/2008. The source of the revenue is shown in Table 1.

Table 1 C&C DHB revenue 2007/08 and 2008/09

Revenue Source	2007/2008 (millions)	2008/2009 (millions)	Increase (Decrease)	% Increase (Decrease)
Population based funding ¹	\$517	\$533	\$16	3.1%

¹ C&C DHB has been notified that it will receive 5.89% of national total health funding, although the population that C&C DHB directly services comprises 6.6% of the total population.

This is because the population that C&C DHB directly services comprises:

An unusually high proportion of working age people and also an unusually low proportion of old people; and additionally

Tertiary hospital expenses payment	\$11	\$10	-\$1	-9.1%
Payments from other DHBs for clinical services provided to their patients	\$133	\$137	\$4	3.0%
Other revenues such as ACC payments	\$60	\$64	\$4	6.7
Totals	\$720	\$746	\$26	3.7%

The modest increase in population based funding (PBF) for 2008/2009 is due to re-calculation using 2006 census figures. When coupled with the reduction in the tertiary hospital expenses payment this increase greatly constrains C&C DHB from mounting new initiatives even if expenses were to be the same as last year.

Expenses

The total expenses for C & C DHB are budgeted to be some \$815 million, 7.2% higher than for 2007/2008. The major expenses are shown in Table 2a.

Table 2a. C&C DHB Expenses 2007/08 and 2008/09

Expense Class	2007/2008 (millions)	2008/2009 (millions)	Increase (Decrease) (millions)	% Increase (Decrease)
Staff costs	\$287	\$305	\$18	6.3%
Clinical supplies	\$79	\$81	\$2	2.5%
Non-clinical supplies & services	\$58	\$59	\$1	1.7%
Payments to other providers for clinical services provided to C&C DHB patients	\$22	\$12	(\$10)	(46.9%)
Payments to primary and community health services providers	\$274	\$292	\$18	6.6%
Change Management / NRH Transition	\$3	\$12	\$9	380.8%

An unusually high proportion of people of high socio-economic status as well as an unusually low proportion of people of low socio-economic status.

It is a matter of record that if C&C DHB were to have a population with an average distribution of age classes and an average distribution of socio-economic classes then it would receive \$67 million more in population based funding. (See Appendix 1 for Health Needs Assessment)

Depreciation	\$19	\$29	\$10	52.6%
Financing costs	\$17	\$25	\$8	47.1%
Totals	\$760	\$815	\$55	7.2%

Staff costs, and costs of non-clinical supplies and services, which together make up nearly half of total costs, are budgeted to rise markedly. The rise in staff costs is mainly due to wage and salary increases and to a lesser extent the cost of fully staffing the hospital facilities. The impact of full staffing is reflected in the lower budget to pay other providers for clinical services provided to C&C DHB patients. Although it is shown as 7.2%² in Table 2a, the increased cost of payments to primary and community health providers is 6.6%. Finally there are significant increases in financing costs and in depreciation due to the impact of accounting for the investment in the NRH.

The total additional costs for the new regional hospital for 2008/09 is \$50 million including depreciation, interest and capital charge of \$35 million, \$7.5 million for clinical change programme and transition planning and a further capital cost of \$7.5 million for information systems enablement to the new facility. Although the transition and enablement costs reduce in the out years, these are offset by additional depreciation charges resulting in total additional costs of \$46 million and \$48 million for 2009/10 and 2010/11 respectively (Table 2b).

Table 2b. New Regional Hospital Costs

New Regional Hospital	2008/09	2009/10	2010/11
Depreciation	14	21	24
Interest*	14	14	14
Capital Charge	7	7	7
Change Management	7	3	3
IT Systems Enablement (Capex)**	8	1	0
Total New Costs	\$50	\$46	\$48

* includes capitalised interest of \$6.1M.

** will need approval by the Minister, not yet obtained.

Addressing our Deficit

Due to the mismatch between revenue and costs a \$53 million deficit is budgeted to be generated this year. Excluding the NRH additional costs the operating deficit is \$33 million before profit on sale of properties and reducing to \$22.3 million in 2009/10 and to \$10.1 million in 2010/11.

C&C DHB acknowledges that deficits are both undesirable and unsustainable and over the planning period will be requesting deficit support from the Ministry of Health. Over the 2008/09 year it is intended that the root causes of the deficit will be carefully analysed so that correct remedies are applied. Issues such as the adequacy of payments from other DHBs for the

² This reflects the impact of phasing 2007/08 new initiatives and movement of cancer treatment drug payments out of the provider arm into the funder (impact \$10m). Had this new expenditure been provided for all of the 2007/2008 year then the 2007/2008 expenditure would have been \$282 million i.e. the 2008/2009 year only represents a 3.5% increase.

specialised services that C&C DHB provides, whether the cost of all of the C&C DHB tertiary services can be afforded and whether the C&C DHB is undercapitalised, need to be analysed.

Efficiencies will be looked for. The first efficiency steps will include better business processes – upgraded financial reporting at all levels, procurement and inventory control, clinical information systems, clarification of roles and responsibilities.

C&C DHB will work with the Ministry of Health while doing these root cause analyses, and will draw on the experience of other DHBs.

Move into the New Regional Hospital

The migration to the NRH and associated clinical change programme to improve our service delivery in hospital and community based services is our major focus for our activity in 2008/09. Over 2500 staff will relocate. This will include a change in their physical environment, the way patients are managed in inpatient areas, the way services are provided to the wards, the nursing model of care, rosters and teams, and the management structure staff work in.

In the administration areas we will reduce the turnaround time for all clinical typing. We will also implement standardised processes across clerical functions managed by over 350 clerical staff. We will manage the effective transition of over 166,000 outpatient appointments, 37,000 inpatient episodes and 47,000 acute admissions per year so that the hospital continues to operate to best practice standards 24/7.

Improving patient care is a journey extending beyond the migration to the NRH. It is a 3 year strategy based on laying strong patient care foundations that allow us to build sustained change. We do not have the capacity or capability to address every issue in year one. We therefore need to match the speed of change to the capacity of the organisation and the very real risks involved. We need to take people with us while ensuring progress is maintained.

Our focus in 2008/09 is to move into the NRH with standardised processes for: patients to access and receive treatment, services that support staff to deliver care and plan a service improvement strategy

In 2009/10 our focus will be on Integration: improving patient pathways within the new facility, developing tools to monitor and reveal performance and undertaking service improvement reviews.

In the final year of our 3 year programme, 2010/11, our focus will be on optimising the opportunities of the NRH, implementing service reviews, driving a benefits realisation strategy within core delivery areas and addressing long term sustainability issues.

Other benefits we are expecting over time include: reduced medical average length of stay, an increased day patient percentage over 3 years, rationalisation of Kenepuru activities, full electronic health record implemented in phases, and improved business processes to streamline administration and improve information systems.

Achieving the transition to the NRH and laying the foundations for change will require new investment in 2008/9. This will be focused on the implementation of new systems, processes and management structures for safe operation in the NRH, and staff trained and supported to move safely.

We are scheduling a period of one week lost productivity on elective surgery during the transition and will seek to outsource the surgery to maintain our annual production plan.

Information Systems

Our Information Systems Strategic Plan highlights a number of objectives that require ICT support. The plan supports the Board's priority focus on the NRH in the period to June 2009. In doing so, it also enables greater integration between health providers working towards improving health outcomes by:

- enabling a core electronic health record for each patient to be available electronically where and when required, within appropriate privacy and security;
- providing a more robust and secure infrastructure that supports health

- professionals;
- ensuring appropriate ability to recover systems in the event of a disaster (eg. computer room fire) integrated with plans for the continuation of business activity during the disaster event; and
- providing timely access to accurate information to support clinical and management activity.

C&C DHB's strategic goals are:

- the electronic health record that will provide a single user interface through which DHB stakeholders can securely access integrated clinical information;
- stable modern ICT infrastructure supported by appropriate disaster recovery and testing capability;
- effective ICT implementation will allow the NRH to fully realise its clinical and management potential;
- reliable, timely provision of information to support clinical and management decision making; and
- clinician access across the central region to core clinical information through a regional electronic health record.

The main goals over the next 12 months are to:

- equip the NRH with ICT to ensure it functions as designed;
- implement electronic clinical systems to support the new models of care in the NRH;
- provide managers and clinicians with information to support good decision making;
- ensure our critical systems are resilient to planned or unexpected disruptions; and
- update ageing ICT infrastructure and ensure that we have sufficient storage capacity for data.

The plan for 2008/09 includes \$7.5 million for the NRH ICT and systems enablement, \$9.4 million for disaster recovery systems and infrastructure replacement and \$3.9 million for enhancement of clinical and management systems. Some projects still require approval of the Minister.

Valuing our people

The workforce issues facing C&C DHB take on additional complexity over the next 12-18 months as we move towards the NRH. Our human resources systems and organisational development systems and processes are required to support this critical task whilst also supporting other population health strategies. At the same time systems, processes and leadership behaviour need to focus on improving individual performance and organisational sustainability. The work proposed in 2008/09 lays an integrated foundation for Workforce and supports sustainable performance for the long-term.

We are promoting the principle of workforce capability and capacity, especially in relation to Māori, Pacific peoples and refugee and migrant people. Currently these people are underrepresented in the health workforce, yet the patient populations of the same ethnicities are overrepresented in patient utilisation of our services.

Improving quality

To build public confidence a key focus of our work in 2008/09 will be implementing our Clinical Governance and Quality Structure with an emphasis on consumer involvement, clinical performance (audit and clinical effectiveness), clinical risk management and professional development.

C&C DHB will work at both the national collective level and at the DHB level to deliver the Quality Improvement Committee (QIC) programme over the next 3-4 years. We acknowledge that 2008/09 is the establishment phase for the programme and expect to be actively gearing up our DHB over 2008/09 to be ready to start implementing outputs by the end of 2008/09. We

expect our commitment to resources to increase over the 2009 and 2010 calendar years as the programme enters its implementation phase.

Maintaining a focus on primary and community care

Our plan maintains a focus on population-centred approaches to health service delivery, integration and chronic disease management and an emphasis on reducing disparities through support and development for our Māori and Pacific service providers.

We continue our commitment to improving health outcomes by ongoing review of our progress against targets and service delivery. A major change in the next year is our work to provide support to reduce avoidable admissions, joint primary secondary clinical governance and implementation of our long term conditions plan.

Implementation of our plan to coordinate action on Healthy Eating, Healthy Action (HEHA) includes physical activity promotion, breastfeeding support funds, and healthy food environments in schools and early childhood education centres.

Implementation of the Integrated Home and Community Care Project will assist us in managing the growth of the over- 65-years population.

Other areas where changes will occur include:

- Revision of our strategy for Child Health
- Oral health business case
- Increased radiation therapy capacity
- Implementing 'Keeping Well 2008-2012' our Regional Strategic Plan for Public Health
- Development of our local Population Health Plan
- Tobacco Control
- Cancer Control Strategy and Palliative Care Plan.

1.5 Risks and Challenges

1.5.1 Risk management

The Board of the C&C DHB is committed to ensuring that the DHB has a Risk Management framework in place which effectively identifies and manages strategic and operational risks, including effective mitigation to the New Regional Hospital. To this end it has established a Risk, Quality Assurance and Audit Committee to obtain assurance on the Board's behalf that effective systems, controls and processes are in place. The role of the recently formed Risk and Quality Assurance (RQA) Committee according to its Terms of Reference is to review the adequacy of the organisation's Risk Management.

The RAQ Committee will therefore be interested in:

- Identification of Strategic Risks:
- Risks which through the assessment process are assessed to fall within the "intolerable" (or high) band;
- Mitigation strategies (including policies, systems, processes) which are used to mitigate the risks; and
- Monitoring the risk assessment following the implementation of effective controls.

Risk Areas

There are several areas of risk that have been identified in the Terms of Reference that the Committee would cover:

- ICT systems risk;
- Clinical Risks and Quality Control;
- Project Risk;
- Operating Risk (including insurance cover);
- Other Risks (including safety policies),

Priority will be given by the committee to review of clinical risks and risks associated with migration to the NRH.

Risk Framework and Policy

The Risk Management Framework and policy, which were introduced in C&C DHB in 2006, have been recently reviewed. This framework will continue to be applied in C&C DHB to provide information to the Committee and the Board to facilitate monitoring and decision-making. The recently established role of Director of Internal Audit and Risk will ensure that the robustness of the Risk Management Framework is enhanced to support the work of the Risk and Quality Assurance Committee.

Internal Audit

A permanent Internal Audit function has recently been established at C&C DHB. This role reports to the Audit Committee as well as the Risk and Quality Assurance Committee and will provide additional assurance to the Risk Management framework by ensuring that risk mitigation controls are in place and effective, as well as providing assurance on financial systems and processes.

1.5.2 Risks achieving Goal 1 Reduced disparities in health status

Growth in demand-driven expenditure (e.g. pharmaceuticals) and other payments (e.g. CarePlus) associated with increased Primary Health Organisation (PHO) enrolment and increased primary care access may impact on our ability to reduce disparities.

Our ability to influence fees at general practice/primary health care and after-hours services is constrained by nationally agreed policies and processes and may lead to increased disparities as it differentially affects low income populations and increases demand on Emergency Department (ED), Accident & Medical (A&M) and hospital services.

There is a trade off between ensuring sufficient primary health care capacity for high need populations already enrolled in PHOs and investing to make sure everyone can enrol. Increasing capacity for people on low incomes in existing providers with low fees may be at the expense of other people who can't enrol and access subsidised primary care. This may lead to higher avoidable admissions and reduce resources to invest in primary care capacity.

1.5.3 Risks achieving Goal 2 Improved health and independence for our population

Growth in the number of people aged over 65 in the district and supporting changes to the carers policy in the aged care sector may impact on our ability to improve this population's health and independence.

Integrated services between primary and secondary care are required in order to meet the national targets for avoidable hospital admissions. Notable populations include Māori in the 45–64 age group (who are more likely to be admitted with an avoidable condition or preventable injury than non- Māori), and children under 14 years. Our rates are slightly above the national rate for Pacific children and significantly above the average rate for all children in the district.

Our ability to improve our contribution to the national adolescent oral health target is constrained. The Oral Health Business Case approval and funding is critical to improvements in meeting this target.

Delivery of the Elective Services Health Target will be challenging with the disruption of migration to the NRHand may require outsourcing of services.

We are reliant on commissioning of the new Linear Accelerator to achieve the national target for Cancer treatment.

1.5.4 Risks achieving Goal 3 Improvement in our Performance

To successfully move into the NRH and to address deficit concerns our improvement initiatives need to be progressed in the 2008/09 year. The changes envisaged are both significant and complex. Integrating change initiatives and ensuring that the organisation has the capacity to effectively implement and sustain these initiatives will remain an issue throughout 2008/09. Phasing initiatives to match organisation capacity is critical.

To be successful the change programme requires a fundamental shift to focus on patient pathways as opposed to service specific concerns. This requires significant change and change leadership at all levels in the organisation.

Specific risks include:

- Shortages of key staff (especially nursing, midwifery and junior doctors);
- Staff morale / satisfaction;
- Surgical service underperformance and theatre inefficiency;
- Bed blocking – insufficient resourced inpatient beds;
- Poor inpatient flow capacity / excess length of stay;
- Inefficient/unreliable patient administration processes;
- Information systems not delivering regional service;
- Lack of Public confidence;
- Adverse patient care events;

- Insufficient readiness for the NRH;
- Inefficient procurement and supply systems;
- Financial costs arising from the new regional hospital; and
- Inability to provide the current range of tertiary services with current volumes and pricing.

1.5.5 Risks achieving Goal 4 Managing our Finances

The 2008/09 funding package from the MoH has delivered an unexpected \$10 million shortfall made up of FRS3 \$3 million above our PBF share, a \$1.4 million change in tertiary adjustor with no increase in case weighted funding, a \$2.77 million reduction in demographic funding despite our population growing at nearly the national average (3.1% versus national average of 3.2% over the next 3 years) and a \$2.4million gap in funding for pharmaceutical cancer treatments.

C&C DHB has committed to improving our financial position but deficits continue to be forecast for the next current DAP Planning years. There are considerable risks in meeting forecasts arising from factors linked to Ministry of Health funding policy and the financial costs arising from the NRH.

C&C DHB provides a range of specialist services for other DHBs in the region and acts as a provider of last resort for the region. Viability is compromised as other DHBs establish similar services, impacting on the critical mass needed to support specialties. Our collaborative work on a regional clinical services plan is aimed at ameliorating this situation.

Specific risks include:

- adverse patient care events impact on our ability to live within our means;
- pressure for Pharmaceutical Cancer Treatments and Pharmaceuticals in Primary care;
- devolution of the Interim Funding Pool for disability and disabled persons services (DSS) for under 65 year olds by the Ministry of Health (tentatively scheduled for February 2009) may impact adversely on C&C DHB;
- risks around new electives funding with inevitable down-time associated with the move to the New Regional Hospital affecting productivity and delivery to target;
- collective employment (MECA) settlements for employees have the potential to outstrip the funding increases available through the Forward Funding Track especially with flow on to community providers;
- initiatives to avoid hospitalisations in the primary sector that is experiencing pressure on the community radiology budget; and
- ensuring we have made adequate provision for all the enablement costs of moving into the New Regional Hospital in the budget.

1.6 Agreed contribution to the National Health Targets for 2008/09

Health Target	Indicator	8. Percentage of patients treated who were prioritised using nationally recognised tools	Local Target	95%	>90%
Improving immunisation coverage	Progress toward 95% of 5 year olds are fully immunised ²		Local Target	Pacific	Total
			73%	79%	85%
Improving oral health	Progress is made towards 85% adolescent oral health utilisation		Māori	Pacific	Other
			43%	43%	43%
		ESPI	C&C DHB Target	Threshold	
		1. Communication of referral acceptance, & triage status within 10 working days to patient and primary care referrer	95%	>90%	
		2. Patients waiting longer than six months for their first specialist assessment (FSA)	1.6%	<2%	
		3. Patients waiting without a commitment to treatment whose priorities are higher than actual treatment threshold (ATT)	4.0%	<5%	
		4. Clarity of treatment status. Certainty of plan of care. No patients on residual waiting lists	N/A	N/A	
		5. Patients given a commitment to treatment but not treated within the last six months	<4.0%	<4.9%	
		6. Patients in active review who have not received a clinical assessment within last six months	<12%	<15%	
		7. Patients who have not been managed according to their assigned status and who should have received treatment	<4.0%	<5%	
		8. Percentage of patients treated who were prioritised using nationally recognised tools	95%	>90%	

Improving elective services cont.	Each District Health Board will agree an increase in the number of elective service discharges, and will provide the level of service agreed		Base	Add.	Total		
		Est. E Discharges	6624	662	7286		
Reducing cancer waiting times	All patients wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D)						
Reducing ambulatory sensitive admissions	There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0-74, under 5 years and 45-64 years across all population groups						
	ASH Health Target	0-74	45-64	0-4			
	Maori	Base 07/08 85% Target <95%	Base 07/08 86% Target <95%	Base 07/08 77.5% Target <95%			
	Pacific	Base 07/08 78% Target <95%	Base 07/08 74% Target <95%	Base 07/08 76% Target <95%			
	Other	Base 07/08 86% Target <95%	Base 07/08 86% Target <95%	Base 07/08 91% Target <95%			
Improving diabetes services and cardiovascular disease (CVD)	<p>There will be an increase in the percentage of people in all population groups:</p> <ul style="list-style-type: none"> estimated to have diabetes accessing free annual checks on the diabetes register who have good diabetes management risk assessment measures 		Total	Māori	Pacific	Other	Asian
		Annual Check	45%	42%	47%	44%	
		Management	76%	65%	60%	80%	
		<p>CVD Risk Assessment – targets not required to be set in 2008/09 until methodology developed</p> <p>Māori , Pacific & Indian men >35 yrs</p> <p>Māori , Pacific & Indian women >45 yrs</p> <p>NZ European & other men >45 years</p> <p>NZ European & other women >55 years</p>					
	There will be improved equity for all population groups in relation to diabetes and CVD management						

Improving mental health services	At least 90% of long-term clients have up to date relapse prevention plans (National Mental Health Sector Standards (NMHSS) criteria 16.4)	Total	Māori	Pacific	Other
		95%	95%	95%	95%
Improve Healthy Eating Healthy Action	District Health Board activity supports achievement of health sector targets Proportion (%) of infants exclusively and fully breastfed; 74% at six weeks; 57% at three months; 27% at six months				
	Proportion (%) of adults (15 + years) consuming at least three servings of vegetables per day and proportion (%) of adults (15+ years) consuming at least two servings of fruit per day: 70% for vegetable consumption; 62% for fruit consumption				
Reduce the harm caused by tobacco	District Health Board activity supports achievement of health sector targets: Increase the proportion of “never smokers” among Year 10 students by at least 3% (absolute increase) over 2007/08 (baseline 57.9%) An increase for both Maori Year 10 ‘never smokers’ and Pacific Year 10 ‘never smokers’ that is greater than that for European Year 10 ‘never smokers’. To reduce the prevalence of exposure of non-smokers to second hand smoke (SHS) inside the home to less than 5% (baseline 2006 12.5%, 2007 7.5%) and A reduction in the prevalence of exposure of non-smokers to SHS inside the home for Maori (baseline 2007 16.1%) and for Pacific (baseline 2007 16.4%) that is greater than that for European (baseline 2007 6.5%)				
Reduce percentage of the health budget spent on the Ministry of Health	The percentage of the health budget spent on the Ministry of Health is reduced to 1.65% of the total vote health budget over the three years to 2009/10				

2 Goal 1 Reduced disparity in health status

Building capacity in primary health care remains the cornerstone of our programme to reduce disparities for Māori, Pacific and low income people in C&C DHB. To address disparities in our population we will progress implementation of year 1 of the Te Plan II and the Pacific Action Plan and develop a Promoting Participation Action Plan for 2008-2012.

In 2008/09 consolidation and realistic expectations are strong themes in primary care. Useful knowledge and information will be shared and joint primary/secondary clinical governance supported to improve planning and services across the interface of hospital services with primary care and other community-based services to reduce avoidable hospital admissions.

Our focus for children will be on meeting our immunisation targets through immunisation outreach services and the roll out of the before school checks. For youth, our focus will be on improving engagement to ensure youth friendly services are available in our DHB.

2.1 Māori health – Implementation of Te Plan 11

Māori make up 10.5% of the district's population (compared to 14% of the New Zealand population). 35% of our Māori population live in the most deprived areas (NZDep 9 and 10) with 82.5% under the age of 45.

Iwi Representation

A Memorandum of Understanding was agreed in 2003, between the C&C DHB and the Māori Partnership Board (MPB). MPB is represented by the three main Iwi (Mana Whenua) groups within the C&C DHB region. These are Te Ati Awa Ki Whakarongotai (Kapiti); Te Ati Awa (Wellington) and Ngati Toa Rangatira (Porirua). Two representatives from Taurahere, other Iwi living in the district, complete the Māori governance group - a total of 8 members. Mana Whenua make up 14% of the Māori population and Taurahere 86% within the C&C DHB region. MPB provides the Māori / Māori community perspective, monitors Māori health indicators and advises the C&C DHB Board.

C&C DHB and MPB Partnership

A strong working and partnership ethos has developed since 2000 and jointly they have;

- agreed MPB representation on all C&C DHB statutory committees and advisory groups;
- established a joint C&C DHB/MPB work programme, which includes; regular meetings, joint workshops on priority issues, hui with Māori communities, providers and PHOs;
- developed and endorsed the “Māori Health Policy”;
- identified Māori health measures for MPB/C&C DHB monitoring;
- agreed the implementation of a joint Māori Communications Plan 2007; and
- agreed the implementation of the Māori Action Plan -Te Plan II 2007-12.

The board and management are well supported from the local Iwi and this is evident with local kaumatua/kuia leading important events and or standing with the Board, CEO and staff when/if appropriate.

Strategic Overview

Our vision for Māori health is “Whanau Ora - a healthier next generation”. This will be achieved through using strengths based approaches, recognising the diversity of Māori society and working beyond “a one size fits all” view, understanding the challenge of working with traditional values in modern times and making the best from collective resources and collaborative action.

The key priorities for the next five years are; building the workforce; reducing the burden of long term illness; quality services and quality providers; and, sharing information and measuring progress. Refer to C&C DHB Māori Health Action Plan - Te Plan II 2007–12 for

proposed actions.

Objectives and Actions	July 2009 Targets and Milestones
Promote & Communicate Māori Health information Implement all the key recommendations in the C&C DHB: Māori Communication Plan and Marketing Strategy	<i>Improved access to Māori Health information and positive Māori imagery</i>
Support early intervention and improve access to effective treatments Implement the recommendations from the Cancer Action Research	<i>Increased service coverage Improve access to services and effective treatments Increased access to secondary/tertiary interventions</i>
Trial a new Assertive Treatment programme for Māori who are at risk, by combining: <ul style="list-style-type: none">• Clinical treatment(s)• Socio-behavioural change models• Evaluation	<i>Increased attendance at Annual Checks Increased number of patients with an HbA1c < 8 Improved Cardiac risk detection Improved access to the best pharmacological treatments Increased access to healthy eating and activity interventions</i>
Consolidate current and trial new Healthy Eating, Healthy Action (HEHA) initiative(s) that are Youth/Community developed/led	<i>Improved access and participation in services /initiatives</i>
Reduce the impacts of long term illness for patients and their whanau Establish services aimed at younger aged Māori living with long term illness	<i>Age appropriate service established Increase in access to Health of Older People/Disability Support Services (DSS) Services delivered to Māori with long term illness that are age appropriate</i>
Expand community cardiac service(s) in Porirua (see Cardio vascular section)	<i>Increased service coverage</i>
Improve Service Capability Review and report on youth services delivering Māori specific initiatives, identify gaps/concerns and plan improvements.	<i>Improved physical activity and reduction in youth obesity Increased Primary Care utilisation rate</i>
Review uptake of Māori and Pacific to Palliative Care services – Implement the recommendations of the review.	<i>Increased access by Māori to palliative care services</i>

Objectives and Actions

July 2009

Targets and Milestones

Implement the recommendations from the evaluation of Cardiac navigation in the hospital.

Improve access to services and effective treatments

Review and report on Māori DSS services in the HHS

Increased access to secondary/tertiary interventions

Increased service / patient satisfaction

Optimise across sector action for Māori health gain

Work with other agencies and groups to identify and agree projects that will promote better and warmer housing.

At least one intersectoral project, with demonstrated impact on Māori health and/or social outcomes i.e. avoidable admissions

Improve Provider Capability

Expand Community/Consumer led mental health services in Porirua & Wellington (refer also to Mental Health section)

Investments, developments and achievements are clearly identified and measured

Review provider capability (including Mental Health), plan developments and implement recommendations.

Capability plan developed for all Māori providers

Mainstream Effectiveness

Support services to set Māori health targets/priorities for implementation

Services, organisations and or Māori Health Plans identify targets for Māori health gain (HKO-03)

Guide and advise on a means by which the HHS can address disparity of access

Increase the number of Māori in the Health and Disability workforce

Implement regional social marketing project to encourage Māori into careers in health.

Identify the intersectoral projects implemented at local level

Identify the impact of projects on the number of Māori accessing health as a career option (HKO-02)

Retain Māori in the health sector in district

Implement leadership and management training for Māori

Increase the number of Māori undertaking training and/or qualifications achieved (baseline to be provided)

Implement the professional development plan for Māori nurses

Increase the number of Māori on a planned pathway

Increase the number of Māori on clinical placements

2.2 Pacific Health – Pacific Action Plan

C&C DHB is committed to continue to work and develop its partnership with Pacific communities and health professionals to provide services that meet the needs of people at the right time and in the right place, at community, primary, secondary and tertiary health levels.

Developing the primary provider sector for Pacific, building community cooperation, increasing the number of Pacific enrolled in PHOs and promoting healthy lifestyles have all been major outcomes of the Pacific Health Action Plan and for Pacific people in the region. It targets some specific strategies to achieve the goals outlined above including:

- Developing workforce
- Supporting and promoting healthy lifestyle
- Working with communities
- Focusing on people through integrated care.

Objectives and Actions	July 2009 Targets and Milestones
<p>Pacific engagement</p> <p>Develop initiatives to increase Pacific youth participation and “voice” in DHB decisions</p> <p>Establish a Pacific Advisory Committee which will provide direct links with the Pacific Community.</p>	<p><i>Pacific Advisory Committee established</i></p>
<p>Primary Care</p> <p>Strengthen and develop Pacific primary care service in Wellington South by establishing a 2nd GP position.</p>	<p><i>Increased Pacific children and youth will be enrolled with a PHO.</i></p>
<p>Primary Care Chronic Disease</p> <p>Continued development and implementation of health promotion initiatives (‘Eat Rite’ ‘Eat Lite’ ‘Left Rite’) with a focus on cancer, obesity, diabetes, cardiovascular and stroke.</p>	<p><i>Improved outcomes for Pacific in relation to diabetes and cardiovascular disease</i></p> <p><i>Health targets for diabetes and cardiovascular disease are met for Pacific people</i></p>
<p>Mental Health</p> <p>Work with Mental Health to explore the integration of mainstream and Pacific providers to enable better access and treatment to mental health care.</p>	<p><i>Access rate for Pacific people to mental health services increased (POP-06)</i></p>
<p>Pacific Workforce development</p> <p>Develop and implement new initiatives with providers that will strengthen workforce capacity and capability.</p> <p>Promote C&C DHB as an employer of choice among Pacific students and graduands.</p> <p>Identify pathways for existing staff to transition into specified health roles.</p>	<p><i>Increased Pacific clinical workforce – baseline 5.4% at December 2007</i></p>

Objectives and Actions

July 2009

Targets and Milestones

Pacific – HEHA

Expand the Pacific breastfeeding promotion initiative

Fund Pacific community HEHA projects

Fund/undertake Pacific HEHA workforce development

Promote nutrition in Early Childhood Centres services and schools with a high Pacific roll

*Reduction in risk factors for obesity
Minimum of 3 Projects in the
community funded*

Tobacco control

Develop and implement a Pacific Youth Smoking Cessation programme.

Reduced smoking prevalence by xx %

Quality – also refer to aged care

Completion of Regional Disability Audit (current initiative with Age Care Team)

Work with providers to develop a reporting and monitoring framework.

*Project completed and report prepared
including recommendations and action
plan*

2.3 Primary care development

There is good international evidence showing that primary health care has an independent effect on improving health status and reducing health inequalities. The intervention logic for maintaining and, over time increasing investment in primary health care, particularly in the areas of highest health need, is that improved access to primary health care improves health outcomes, reduces avoidable hospital demand and a more primary health care oriented health system is more cost efficient.

Primary health care encompasses both community-based health services and the broad range of intersectoral action and community partnerships developed to address the social and environmental determinants of health.

C&C DHB has a track record of high quality primary health care, good performance across a range of population level indicators and a consistent focus on improving access, quality of primary care and reducing inequalities. The DHB will continue to respect and support the primary health care providers and systems that achieve this.

C&C DHB will continue to support active community participation in PHOs, community-led initiatives, diverse approaches to meet the needs of different populations and collaborative planning with PHOs and other key stakeholders. This includes those involving the youth community and Youth Health Advisory Group, joint planning and review with the MPB, joint planning with Pacific communities (ethnic specific), work to address concerns of different communities (particularly Porirua East, Kapiti, Wellington South), older people, people living with long term conditions, refugee communities and other vulnerable populations/communities with high needs.

In 2008/09 consolidation and realistic expectations are strong themes in primary care. Useful knowledge and information will be shared and joint primary/secondary clinical governance supported to improve planning and services across the interface of hospital services with primary care and other community-based services.

Compliance with regulatory protections that assure safe care is required in contracts, audited in provider audits and reinforced in quality review programmes such as Cornerstone (Royal New Zealand College of General Practitioners) Te Wana, professional accreditation and peer review processes.

Information about Māori satisfaction will be gathered through service reviews, consumer satisfaction surveys (HHS) and informal feedback, hui and community networks.

Objectives and Actions

July 2009

Targets and Milestones

Primary sector engagement

Support PHO, primary care providers, non-governmental organisations (NGO) and community input into Health Needs Assessment

Utilise the primary/secondary clinical governance group, general practitioner (GP) liaisons, primary care nursing network, Local Diabetes Team, PHO Advisory Group, palliative care forum and other joint forums.

Acknowledge and celebrate the anniversary of Alma Ata Declaration and progress in primary health care in New Zealand and C&C DHB.

PHOs formally involved in DAP planning and receive four progress reports against relevant targets.

Primary/secondary clinical governance group will meet at least four times.

At least four examples of improved service delivery across the community/hospital interface.

One celebration of primary health care progress to mark the 30th birthday of the Alma Ata Declaration of Primary Health Care

Primary Care Access and Effectiveness

Continue to monitor trends in primary care access (utilisation) as a whole and with respect to gender, age groups, ethnicity and, where feasible, NZDep.

Review the impact on access of investment in additional services to improve primary care capacity in Kapiti and Porirua for young people.

Improve primary care capacity in Kapiti.

Support primary/secondary care joint clinical governance.

Work with the HHS, NGOs, community-based and ambulatory services on at least one project agreed with primary care to improve efficient use of hospital resources, reduce avoidable admissions and improve patient/whanau experience

Contribute further to the DHB After Hours Strategy

A 1% gain in PHO enrolment over Dec 2007 baseline

A 2.5% increase in Māori enrolment in PHOs over December 2007 baseline

Increased PHO enrolment of people aged 12-25 years over December 2007 baseline

Increased PHO enrolment in Kapiti over December 2007 Baseline

At least two active and agreed projects to improve services across the primary/secondary interface

Primary Mental Health

Continue primary mental health service developments for mild to moderate mental health conditions across all PHOs. Work with Ministry of Social Development (MSD) to ensure opportunities for increased mental health service access are developed collaboratively and effectively.

Review two current programmes offering primary health care to people living with serious mental illness/high and complex needs.

Support establishment of general practice services to Te Korowai Whariki

Support implementation of drug and alcohol assessment initiative at District Court.

Support mental health promotion through PHO health promotion plans and youth initiatives, including collaborative projects to reduce the impact of alcohol use.

Increased participation (over December 2007 baseline) through the 6 primary mental health 'pilots' servicing 7 PHOs.

At least one initiative with MSD to offer expanded access to primary mental health services.

Sustainable and equitable funding approach to primary health care for people with serious mental illness and high/complex needs.

1 drug and alcohol initiative at District Court.

At least one mental health promotion initiative with a youth focus.

Develop primary care workforce and capacity refer to the Valuing our People section

Increased Māori and increased Pacific workforce in primary care

At least 4 cadetships in primary care

Primary care nursing workforce

Developing and improving primary health care nursing capacity to optimise service delivery in the primary sector and integrated care sector.

At least two examples of quality initiatives/frameworks for primary health care nurses.

Develop clinical skills in chronic diseases management especially in geographical areas of high needs.

Develop nursing leadership capability with the primary care sector.

Evidence of at least two nurse-led services and advanced nursing roles including Nurse Practitioner increase.

Continue to implement direct entry for nurse graduates into primary health care.

Nurse Entry to Practice Programme Expanded

Support uptake of nursing post graduate education, research and scholarship within primary health care nursing.

At least one example of increased primary health care nurse capacity (over Dec 2007 baseline) in geographic area of high need (Porirua /Wellington South).

Develop nurse led services, expanded roles for nurses, and using nursing resources in innovative ways, improving practice to align nursing to community needs.

4 general forums (topic specific) and at least one Māori nurses forum

Develop advanced nurse practice roles and support at least four nurses in nurse practitioner development

Graduate nurses -Implement the Nurse Entry to Practice primary expansion programme (via District Health Boards New Zealand (DHBNZ)

Post graduate - maximum uptake of Nurses applying for funding through CTA reduce barriers to post graduate education.

One pilot in the aged care sector

Pharmacy changes

Emphasis on new contracting for value added services which improve the population's access and use of pharmaceuticals.

New contracts signed

Monitor the use of pharmaceuticals, determine trends and work with the sector to improve demand management.

Examples of collaborative work with pharmacists in PHOs

At least one initiative undertaken with the sector to improve use of pharmaceuticals

Achieve PHO performance on the key performance indicator relating to pharmaceutical use

2.3.1 Child Health

Improved child health services will contribute to reduced inequalities, in particular because Māori and Pacific children make up an increasing proportion of our children. Effective early intervention in childhood will reduce the incidence of chronic disease later in life.

A 3 year child health strategy will be completed and implemented in 2008. The strategy will assist the DHB in meeting its targets in respect to:

- immunisation for two year olds target
- improved oral health

- improving nutrition, increasing physical activity and reducing obesity
- reducing ambulatory sensitive hospitalisations
- improving Well Child and tamariki ora coverage and implementing B4 school checks.

If C&C DHB's Oral Health business case is not approved we will be unable to implement the early childhood and 2.5 - 12 years oral health plan, and potentially improve the oral health outcomes for these age groups (5 years and Year 8 key performance indicators).

Objectives and Actions

July 2009

Targets and Milestones

Immunisation

Support good data quality on the National Immunisation Register (NIR) and work actively with Lead Maternity Carers (LMC), maternity and child health hospital services, GPs and all primary care providers to meet coverage targets for child hood immunisations.

Progress towards the target of 95% 2 years olds fully immunised

Meet agreed milestone targets

Improvements in BCG information/access (where indicated) over Dec 2007 baselines

Provide concise relevant information in formats (e.g. workshops, information packs) to optimise ability of LMCs, Well Child providers, community-based health workers.

Work with LMCs and other providers to improve documentation/service delivery for BCG and neonatal Hep B. Work regionally and across HHS/PHOs/community to ensure collaborative planning, early distribution of resources/effective publicity to support influenza immunisation (see avoidable hospitalisations)

Support providers to implement new immunisation schedule and distribute relevant public information about new schedule and pneumococcal vaccine.

Improve support and information offered to parents and community groups on immunisation.

Māori

Increased outreach service

Link immunisation information and service access to other service developments that are Māori -led and/or working with Māori communities –e.g. Wellington South nursing project, Porirua Work and Income nurse, housing and health, health literacy and youth/whanau ora initiatives.

Improved immunisation coverage for Māori children at 2 years

Meet agreed targets.

Immunisation for Māori is prioritised for improvement in PHO Performance Programme plans, PHO Māori Health Plans.

Pacific**Increased outreach service**

Link immunisation information and service access to other service developments that are Pacific-led and/or working with Pacific communities –e.g. Wellington South nursing project, Porirua Work and income nurse, housing and health, church-based initiatives.

Implementation of service improvements to increase Pacific immunisation access/coverage through PHOs

Improved immunisation rates at 2 years for Pacific children

Immunisation is prioritised for improvement in PHO Performance Programme Plans, PHO Pacific Health Plans and through Pacific Health Service in HHS.

Wellington South Child and Family Nursing initiative.

Evaluate and then extend to appropriate communities in Wellington South

Evaluation of nursing initiative completed.

B4 School Check Programme

Implement this MoH initiative, with an emphasis on Māori, Pacific and low income families, and fully utilising outreach services.

Deliver programme as per Ministry of Health Crown Funding Agreement variation

Family violence

Engagement and active C&C DHB involvement with intersectoral leadership forum and participation in Te Rito meetings.

Consolidate relationships with the NGO sector, and primary health care organisations

Promote training opportunities for health sector to support recognition of family violence and knowledge of appropriate intervention and relevant services

Participate in two leadership forums and at least 4 Te Rito meetings

Results of a scoping project on a public health approach to family violence implemented

Participate in project work coming out of the Wellington Leaders Forum on family violence

Oral health (also see youth health)

Contingent on approval of the Business Case and receipt of funding from the Ministry, commence implementation of the service for mothers and their children age 0–2.5 years. Work with the Ministry and current C&C DHB Well-child and Tamariki Ora to enhance the oral health component of the Well-child service.

Progress on improvements in child oral health dependent on approval of funding from MoH

Improve percentage of children cares free at age 5 years (POP-05)

Improve mean DMFT score at year 8 (POP-04)

Receive approval from the Ministry of Health (Ministry) on the joint C&C DHB and Hutt Valley DHB (HVDHB) Oral Health Business Case (application for funding to improve oral health services for children and adolescents age 0–18 years).

Increase health promotion with a focus on dental access and utilisation among Pacific people.

Contingent on approval of the Business Case and receipt of funding from the Ministry, begin implementation of the service changes for children age 2.5–12 years:

Contingent on approval of the Business Case and receipt of funding from the Ministry, commence the building of the first oral health community clinic in Cannons Creek

Develop service specification for a community health promoter / Well-child liaison.

Pursue short and medium term initiatives to improve workforce availability. Such as offering dental therapy scholarships to increase dental therapy trainee numbers.

Māori: Develop and implement an approach to support coverage and increase utilisation of dental services.

Pacific: Work with Regional Public Health and HVDHB to develop a plan for Pacific Oral Health in district.

2.3.2 Youth health

C&C DHB's Youth Health Advisory Group (YHAG) has been functioning for three years and provides advice to C&C DHB on youth health issues specific to the C&C DHB region. The YHAG strives to create a safe and supportive forum for young people to provide feedback on existing youth health initiatives and bring issues to the group, from their own experience and perspective, on behalf of the organisations or stakeholder groups that they are connected with and to maintain information exchange.

In 2007/08 the Youth Health Advisory Group contributed to the development of C&C DHB's Youth Health Action Plan 2008-11.

C&C DHB is well below the national target for adolescent oral health although information from various reports (e.g. New Zealand Health Survey) suggests our child and adolescent oral health outcomes are not significantly different to national health outcomes. We are investigating whether many of our adolescents are accessing private dental services. Of particular concern is access for Māori, Pacific and Low income adolescents. There are issues around both demand and supply. We have low levels of dentists willing to provide services under the agreement. We have limited funds available to invest in increased services either with alternative delivery methods or the current agreements even if we were to attract more dental service providers.

Objectives and Actions	July 2009 Targets and Milestones
<p>Maintain YHAG and other mechanisms for youth voice to the DHB, including through the external website as well as support/participation in other youth and related activities</p> <p>Provide youth input into key C&C DHB developments such as the NRH, The Journey Forward and opportunities to review progress against the C&C DHB Youth Health Action Plan.</p> <p>Provide induction for new YHAG members and opportunities for relevant training/development for all YHAG members</p>	<p>At least four meetings of the YHAG.</p> <p>At least two youth-focussed health promotion initiatives.</p>
<p>Strengthen youth-friendly health services and service access for young people. Work with youth health services, student health services, Regional Public Health, schools, primary care services, general practices, Māori and Pacific providers to increase PHO enrolment of youth and improve access to appropriate health information and health care.</p> <p>Continue to promote free sexual health services for people under 25 years, using a variety of formats and media. Provide youth-specific pregnancy, breastfeeding and parenting support for young people.</p> <p>Work with secondary schools and alternative education and training providers to engage young people in HEHA.</p> <p>Continue to develop primary mental health services for young people, building on primary mental health 'pilots', work with MSD and PHOs, Child and Adolescent Mental Health Services and NGOs.</p> <p>Implement actions from the Long Term Conditions Action Plans to improve transition from paediatric care to adult services for youth with long term conditions.</p>	<p><i>Increase in PHO enrolment of 15-24 year olds over 2007/08 baseline</i></p> <p><i>Increase Public Health Nurse resource in schools over 2007/08 baseline</i></p> <p><i>Review of primary sexual health service utilisation and further distribution of promotional resources.</i></p> <p><i>At least one new pregnancy and parenting initiative for youth</i></p>

Continue work with Porirua City Council and Interagency Strategic Coordination Group to improve youth health and social outcomes, increasing youth activities provided in Porirua East, Elsdon and Titahi Bay.

Continue to work with Police, Wellington City Council, MSD and other agencies to support community-based programmes in Wellington South.

Workforce development

Continue Mahi ki te Ora Industry Partnership with MSD, promoting health as a career, through cadetships in primary and community care.

At least 4 cadetships in primary/community settings.

Oral health

Improve adolescent oral health by understanding position relating to 85% adolescent oral health utilisation target

Seek PHI information from the recent national health survey about adolescents attending dental services

Māori and Pacific: Develop and implement an approach to support coverage and increase adolescent utilisation of dental services and target high deprivation and high risk hard-to-reach youth not currently receiving oral health messages and/or treatment.

Fully implement Ora Toa Dental Services for youth in Porirua district.

Increase access to oral health services for Māori and Pacific aged 13-18.

Work with Ora Toa in the development of its new oral health service and encourage a greater service mix between adolescents and adults

Discuss the combined Dental Agreement with private dentists in Wellington given the new fees and commitment nationally to continued work on the contract

Explore provider arm capacity to service increased adolescents and ensure any adolescents treated are captured in adolescent oral health data.

Māori Youth

Improved access and participation in services /initiatives

Consolidate current and trial new HEHA initiative(s) that are Youth/Community developed/led

Pacific Youth

Reduced smoking prevalence by xx %

Develop and implement a Pacific Youth Smoking Cessation programme.

2.4 Promoting participation - Implementing NZ Disability Strategy

C&C DHB's Promoting Participation framework has been in place for the past three years, and has been very effective in guiding our implementation of the New Zealand Disability Strategy. It aims to remove barriers to participation and build the capacity of health services to be more responsive to disabled people's needs, and contribute to the independence, health and wellbeing of everyone.

The completion of the New Regional Hospital will mark a major milestone towards improved accessibility of hospital services for disabled people. Further strategies need to be developed to improve access to primary health and disability support services. Ongoing strategic collaborative work will continue to improve access to the wider community, transport systems, and social infrastructure.

Objectives and Actions	July 2009
Targets and Milestones	
Review "Promoting Participation" document.	<i>Action plans developed and supported</i>
Develop promoting participation action plan for 2008- 12	<i>Board approve action plan</i>
Implement findings from evaluation project	<i>Evaluation framework included in Action Plans</i>
Undertake further surveys and access assessments of community health and disability support services.	<i>At least two examples of improved access/responsiveness in primary care for people with disability.</i>
Work with PHOs to develop action plans	
Clinical and front line staff are responsive to and competent in dealing with needs of people with disabilities.	<i>Generic Orientation Programme introducing the New Zealand Disability Strategy developed</i>
Responsiveness Training workshops including, Generic Disability, Blindness, Deaf and Deaf Culture	
Useful and accessible information.	<i>Information databases and links to databases to make information available in a variety of formats developed.</i>
Promotion of the use of Assistive Hearing devices in health and disability support services.	<i>A programme of assisted hearing device promotion will be in place in ED and Radiology</i>
Continue to build on relationships with: Pasifika Disability Network; CCS Tumu Whakarae; People First; DHB National Disability Network; TLA consumer group.	<i>Assurance of strong linkages with other significant stakeholders in the sector, allowing for collaborative and supportive approaches to implement the NZ Disability Strategy</i>
Other strategies for reducing disparities for those with disabilities are discussed elsewhere within the DAP under the headings:	
<ul style="list-style-type: none"> • Quality • New Regional Hospital 	

3 Goal 2 Improving the health and independence for our people, families and communities

Our second high level goal is to reduce the number of people who develop ongoing illness or disease, and to reduce the impact of such disease on people's lives. Two key developments in our 2007/08 DAP were the development of a Population Health Strategy and the development of a Long Term Condition Management Framework and Action Plan.

In 2008/09 C&C DHB will complete the development of our Population Health Strategy and begin implementation. It is an overarching framework designed to integrate the range of health promotion and illness-prevention activity that is delivered across our district and will contribute to the DHB goals of reducing disparities in health status and reducing the impact of long term conditions. Implementation of the strategy potentially contributes to the national health targets including: reducing harm caused by tobacco, improving nutrition, increasing physical activity and reducing obesity, improving diabetes and cardiovascular disease, and reducing avoidable hospital admissions. At a regional level the Wellington Region Strategic Plan for Public Health "Keeping Well 2008-2012" will be implemented pending sign-off from the Board.

To reduce the incidence and impact of Long Term Conditions in 2008/09 we will be focusing our efforts on implementing our Long Term Condition Management Framework with a specific focus on improving our performance on the national health targets for diabetes, cardiovascular disease and Ambulatory Sensitive (avoidable) Hospitalisations (ASH).

In 2004, after extensive community consultation and Board approval, C&C DHB began implementation of the 'Integration of Home, Community, Primary and Specialist Services Programme'. In 2008/09, the focus will be on the HHS/primary care and community interface and how system improvements can be made that improve the patient/whanau experience of service, patient safety and reduce readmissions. These initiatives will build on collaborative work, investments, interventions and evaluation in 2006/07 and 2007/08.

Progressing The Journey Forward (C&C DHB 5 year Mental Health Plan) change programme, developing our Cancer Control Strategy and Palliative Care Plan are priorities in 2008/09. We will also continue to leverage health outcomes through intersectoral activity and securing "other sector" funding to help develop holistic service mechanisms and influence social determinants of health.

3.1 Population health

3.1.1 C&C DHB Population health strategy

C&C DHB will complete the development of our Population Health Strategy in 2008. The Population Health Strategy contributes to the DHB goals of reducing disparities in health status and reducing the impact of long term conditions.

It is an overarching framework designed to integrate the range of health promotion and illness-prevention activity that is delivered across our district. It will:

- inform and guide our investment approach to population health over the next five years
- progressively achieve health gains in a number of priority areas across our communities
- utilise relationships with our intersectoral partners to improve social and economic determinants of health across our district, and
- provide benchmarks and goals that will allow us to more robustly demonstrate intervention logic around our investment decisions, and to evaluate the health outcomes achieved by our investments.

Implementation of the strategy potentially contributes to many of the Ministry's targets, in particular the targets of reducing harm caused by tobacco, improving nutrition, increasing physical activity and reducing obesity, improving diabetes and cardiovascular disease, and

reducing avoidable hospital admissions.

3.1.2 Wellington Region Strategic Plan

The Wellington Region Strategic Plan for Public Health “Keeping Well 2008-2012” and associated action plan is a strategy for public health for the Wellington, Hutt and Wairarapa region. C&C DHB is working with the Ministry of Health, Wairarapa DHB and Hutt Valley DHB to implement this regional population health strategy pending sign-off from the Board.

The purpose of the strategy is to guide collaborative DHB, Ministry of Health leadership for public health issues in order to improve the health of the whole population and improve outcomes for high needs groups, including Māori and Pacific and high needs geographic areas. Priority areas are:

- Equal opportunity to good health
- Smoke-free living
- Healthy eating healthy action
- Mental well-being
- Lives free from harm due to alcohol and drugs
- Control of infectious diseases
- Living conditions that nurture human health
- Families enjoying violence-free lives.

Implementation of our Population Health Strategy will be closely linked to C&C DHB’s involvement in Keeping Well. In addition, there will be ongoing work with Regional Public Health in relation to an integrated service project instigated by Regional Public Health to improve health and reduce inequalities for the people of Porirua.

C&C DHB have established a number of mechanisms to enhance collaboration and planning with Regional Public Health which will continue into 2008/09. These include a jointly-funded public health physician at C&C DHB and Regional Public Health to assist with collaboration and liaison, and regular bi-monthly meetings between senior staff in the DHB and Regional Public Health.

3.1.3 Public Health provided by Regional Public Health

As the largest provider of public health services in the Wellington region and therefore for C&C DHB, Regional Public Health has a key role in delivering public health services and activities that contribute to C&C DHB priorities/outcomes.

Regional Public Health will deliver integrated health promotion, health protection and school health services to promote population health and reduce inequalities. The implementation of the Keeping Well 2008–2012 strategy (currently in draft form only), will underpin new ways of working including more community focused work in partnership with other agencies. Regional Public Health’s work will continue to take into account the wider determinants of health and health inequalities.

Objectives and Actions

July 2009

Targets and Milestones

Implementing “Keeping Well”

This will contribute to reducing disparities, HEHA, mental well-being, family violence, infectious disease, alcohol and drug interventions

Regional Public Health will prioritise work to focus on 8 priority areas of strategy

Healthy Porirua Project - Development of an integrated service wide project in an area of high need.

We will monitor Regional Public Health's stated performance milestones and report to CPHAC.

We will monitor Regional Public Health's contribution to reducing inequalities and working from community empowerment model

Intersectoral

Participation in:

- Wellington Regional Social Development Forum (includes Strengthening Families Governance Group)
- Centre for Excellence (Porirua)
- Porirua Strategic Coordination Group

Contribution to reducing inequalities

Healthy public policy

Work to ensure that the projects and plans that sit under Regional Land Transport Strategy (RLTS) maintain the public health goals of the Strategy.

Submissions on sub-projects and plans

Use of health impact assessment

Public health nurses in schools

New entrant assessments, involve a comprehensive health assessment with parents/family and child together, offered to all schools and children of 5 years.

A family violence screening component to the new entrant assessments will be scoped and developed.

Primary schools - Continue to work with a focus on determinants of health and reducing disparities.

Secondary schools - Provision of more intensive youth health service as part of Ministry of Health Youth Health

Oral health promotion - encourage and promote enrolment in dental services

Oral health promotion/education in the context of personal health services delivery

Achieve targets and milestones set in contract with Regional Public Health

Increased Public Health Nurse capacity in at least two secondary schools.

Increased enrolment in school dental service

Improved oral health performance

Public health nurses in the community

Free walk-in ear check clinics in Porirua for children aged 0-18 years

Ear and vision testing screening programme for pre-school, new entrants, and year 7

South Wellington initiative – joint Plunket/C&C DHB/RPH initiative

Continue the joint C&C DHB/ RPH public health nurse initiative in Work and Income office in Porirua to improve access to income, housing, employment in vulnerable populations and connect people to health services

Increase volume of children screened in Porirua and Wellington South.

Improve hearing target

Evaluation of early implementation complete. Expanded service in Wellington South.

Reduced disparities in access to income support, employment and health services (3 year timeframe)

Mission-On/HEHA

Continue collaborative programme to deliver Fruit in schools in the 11 schools in C&C DHB:

- Porirua Canteen project
- Healthy Schools team members to continue to be part of the C&C DHB HEHA education sub group.
- Public Health dietician from the Healthy Schools team to be available to assist the schools that have received the Nutrition Fund to achieve their goals.

Expansion of Fruit in Schools programme to 3 schools in C&C DHB,

Family violence work

Participate in local Te Rito Group and other forums

Link with C&C DHB Family Violence coordinator

Results of a scoping project on a public health approach to family violence implemented

Project work coming out of the Wellington Regional Leaders Forum on family violence implemented

Evidence based practice

Support increasing use of evidence based practice in designing interventions

Improved use of public health surveillance data for health gain

Emergency management

Develop an interagency border health plan, aligned public health responsibilities under the international health regulations 2005, for the international airport and port to ensure RPH is able to respond to pandemic influenza or other significant international public health threat.

Plan completed.

3.1.4 Tobacco Control

Work in this area contributes to the DHB goal of reducing the incidence of chronic disease and to reducing inequalities as tobacco use makes a major contribution to inequalities in health

outcomes. In addition, tobacco control contributes to many of the Ministry's targets, in particular the target of reducing harm caused by tobacco, but also improving cardiovascular disease, reducing avoidable hospital admissions and improving oral health.

Objectives and Actions

July 2009

Targets and Milestones

Implement Tobacco Control Plan

Develop and implement a Pacific Youth Smoking Cessation programme.

Increase smoking cessation attempts as referred by DHB services by 10%

Review the impact of smoking cessation services in the district, identify the need for consolidation and/or expansion of these services.

Refocus HHS based Smoking Cessation Coordination toward Pregnant and Maternity and patients

Improved quit rates amongst pregnant women and breast feeding mothers by 5%.

3.1.5 Healthy Eating Healthy Action (HEHA)

Objectives and Actions

July 2009

Targets and Milestones

HEHA implementation (supported by Ministry of Health dedicated funding)

Complete a 5 year Strategic Plan for HEHA

Implement the 2008/9 HEHA Ministry Approved Plan (MAP) working collaboratively with key stakeholders

Implement the 2008/9 HEHA Plan communications strategy

Support the national media campaigns (e.g. breastfeeding and Feeding our Futures) via community newspapers and Māori and Pacific radio.

Regular meetings with the nutrition and physical activity workforce to allow for sharing of ideas, peer support and workforce development

Support implementation of Wellington Urban Physical Activity Strategy and Kapiti Physical Activity Strategy

Fund Māori community HEHA projects with a focus on whanau ora and breastfeeding

Fund Pacific community HEHA projects with a focus in church based settings and parents and young families

Fund activities that will promote Māori and Pacific workforce development in nutrition and physical activity.

Implement collaborative HEHA projects in Wellington, Porirua and Kapiti working with PHOs, Territorial Local Authorities (TLAs), NGOs and the Regional Sport Trust

Promote increased fruit and vegetable consumption and healthier food options across all age groups

Prioritise HEHA activities for Māori and Pacific and their families/whanau as priority groups

5 Year strategic plan for HEHA completed.

Increase the proportion of adults (15+ yrs) eating 3 or more servings of vegetables per day to 70% or greater.

(subject to nationally agreed methodology for baseline and progress measurement)

Increase the proportion of adults eating 2 or more servings of fruit per day to 62% or greater

(subject to nationally agreed methodology for baseline and progress measurement)

At least two Māori community HEHA projects funded

At least two Pacific HEHA projects funded

Improved breastfeeding

Establish a Māori breastfeeding service.

Strengthen breastfeeding services in the community for Pacific

Work collaboratively with breastfeeding stakeholders to better coordinate community lactation support services

Interim measure: Increase in the proportion of Māori and Pacific women exclusively breastfeeding at discharge over the December 07 baseline

Fund a part-time DHB lactation coordination role

Fund community lactation consultancy services

Undertake activities that support the national breastfeeding campaign

Undertake training and activities that support maintenance of Baby Friendly Hospital Initiative (BFHI) accreditation

Fund a peers support breastfeeding training programme

Develop processes consistent with national data standards to collect breastfeeding information from LMCs, Well Child and tamariki ora providers

Promote nutrition in schools and early childhood centre service environment

Adoption of Food and Nutrition Guidelines by schools and early childhood centres

Support introduction of Food and Nutrition Guidelines and the Food and Beverage Classification System into schools and early childhood centres through school/ Early Childhood Education (ECE) visits, meetings with school clusters, provision of relevant resources.

Identify opportunities to promote HEHA through existing providers working with families e.g. PHOs, Well Child and tamariki ora providers

Fund nutrition projects in schools and ECE Services

Promote increased fruit and vegetable consumption and healthier food options in children and youth

Māori

Fund Māori community HEHA projects with a focus on whanau ora and breastfeeding

Increased breastfeeding rates for Māori (see targets)

Establish a Māori breastfeeding service.

At least one workforce development initiative for Māori health/school/ECC workforce

Fund/undertake Māori HEHA workforce development

Promote nutrition in Early Childhood Centres services and schools with a high Māori roll

Pacific

Strengthen breastfeeding services in the community for Pacific

Increased breastfeeding rates for Pacific (see targets)

Fund Pacific community HEHA projects with a focus in church based settings and parents and young families

At least one workforce development initiative for Pacific/school/ECC workforce

Fund/undertake Pacific HEHA workforce development

Promote nutrition in ECE Centres services and schools with a high Pacific roll

3.2 Working with Communities

3.2.1 Engaging intersectorally

Leveraging health outcomes through intersectoral activity makes sense in terms of securing “other sector” funding, developing holistic service mechanisms and influencing social determinants of health. To this end, we developed a specific intersectoral strategy in 2006 which has assisted us to develop a number of successful initiatives.

PATHS

The Wellington PATHS service is a partnership between C&C DHB, Work and Income and the Inner City Project. The service provides intensive multi-disciplinary case management to Work and Income sickness beneficiary clients who want to return to work, but are inhibited by long waiting lists for health interventions.

To date, the service has worked with over 200 clients and assisted over a quarter of these into full or part time employment, further training or education. Employment and training outcomes reflect only part of the success however. Many of the clients’ journeys to wellness and self-sufficiency tend to require considerable medium to long term management, and PATHS is proving to be a very effective service to reach clients who might otherwise remain welfare beneficiaries with exacerbating chronic illness for many years.

Primary and Community Cadetship Initiative

Through partnership funding of \$480,000 from Work and Income, the DHB has assisted 28 youth and sole parents into cadetship employment opportunities across the District’s primary health and community care sectors. All of the cadets presented with low or no qualifications and were unemployed. Through sector employers’ commitment and a mix of targeted training, these individuals are now on paths to sustainable careers in health administration and health promotion. Not only has this project actively assisted some of the district’s most disadvantaged individuals into employment, but it has allowed primary and community care providers to build capacity through financial assistance.

On the back of the success of this initiative, Work and Income and the DHB are currently planning another intake for 2008/09.

Healthy Housing

In collaboration with the local councils and other agencies, the DHB has continued to support an intersectoral funding approach to Healthy Housing projects across the district.

This year we have committed around \$160,000 to a multi-agency funding pool of around \$600,000 for the district. This will ensure around 350 low income households across the district will benefit from improved insulation, ventilation and heating. In turn, as the evidence shows, this upstream investment will result in improved health outcomes amongst low-socio economic communities and be of considerable benefit in respect to our admission avoidance strategies.

Objectives and Actions

July 2009

Targets and Milestones

Influencing national policy

Collaborating nationally with other DHBs to increase intersectoral engagement with government departments such as MSD, Work and Income New Zealand, MoE, Housing New Zealand

Community Engagement

A planned and accessible approach to Community Engagement

The completion of a community engagement plan for Planning and Funding Directorate including a calendar of local forums

More comprehensive engagement with community about service planning, resulting in less consultation burn out and community apathy.

At least six monthly community engagement forums

Effective information access and feedback channels

Updated information about planned services and engagement opportunities on the internet

Enhanced feedback loop through phone line

Inclusion

Support and Maintenance of the Youth Health Advisory Group

Effective advocacy of youth health issues and implementation of youth health action plan

Provision of Partner Support to the Wellington Regional New Comers Settlement Strategy

Improved access to health services by disadvantaged migrant and refugee communities

Continued leveraging of relationships with key agencies to better support those with low incomes

Improved full and correct benefit entitlement rates in the region

Enhanced opportunities for employment those unemployed

Improved access and participation of those with Disabilities

Refer Promoting participation

3.3 Reduce the Incidence and Impact of Long Term Conditions

To reduce the incidence and impact of Long Term Conditions in 2008/09 we will be focusing our efforts on:

- Implementing our Long Term Condition Management Framework
- Diabetes
- Cardiovascular disease
- Respiratory disease
- Ambulatory sensitive (avoidable) hospitalisations (ASH)
- Health of Older People
- Mental health
- Cancer control and palliative care
- Regional Cancer Network
- Regional Clinical Services Plan

3.3.1 Long Term Condition Management Framework and Action Plan

The purpose of the C&C DHB Long Term Conditions Management Framework is to identify and establish overarching service strategies to achieve our goals over the next 3 years. The action plans support our high level outcomes to: “Reduce Disparities in Health Status’ and ‘Reduce the Incidence and Impact of Chronic Disease’. This framework is designed for inform direction and the work of C&C DHB and its partners in health to prevent and better manage chronic conditions.

This framework has informed the development of our plans for diabetes, cardiovascular and respiratory disease in this Annual Plan.

3.3.2 Diabetes

Developments in diabetes services are linked to the DHB-wide development of a Long Term Condition Management Framework and Action Plan. Key areas of focus for 2008/09 will be quality improvement, improving access for Māori and appropriate service options linking to New Zealand Disability Strategy.

Māori have high rates of type II diabetes. Prevention is linked to poverty reduction, improved nutrition including access to appropriate/traditional foods/food sources, higher levels of physical activity.

Pacific populations have high rates of diabetes. Interventions to reduce childhood obesity and improve family income, access to healthy nutrition choices including traditionally eaten foods and physical activity will address the main risk factors.

Early recognition of diabetes supports the opportunity for better self management and reduced complications.

Much of the morbidity and premature mortality from diabetes is linked to cardiovascular and renal complications of diabetes. Service coordination to optimise management of co-morbidity will improve the patient experience, provide safer and more efficient service, reduce avoidable admissions and improve health outcomes.

Tailored approaches are needed to meet the information needs, lifestyle, family and cultural context of different population groups with high morbidity from diabetes.

Service developments that support better transition for young people from child health services to adult services/self management and attention to the particular issues of adolescents with diabetes will reduce ED presentations, admissions, medium term health service use and improve outcomes in adulthood.

C&C DHB has formalised mechanisms for participation in the planning, delivery, and assessment of services through consumer groups, Local Diabetes Team (LDT), Primary Health Organisation Advisory Group (PHOAG), HHS service leaders, Diabetes Youth Wellington, paediatric diabetes group, peer support groups (Māori) and the Pacific Diabetes Society and fono. This network has been used to gain consensus about the service model, priorities and to review progress.

C&C DHB also participates in national and local quality and safety improvement initiatives. Currently C&C DHB is transitioning all providers to the new Canary database. This will improve access to PHOs and providers to their own population level data and support quality and audit.

Objectives and Actions

July 2009

Targets and Milestones

Establishment of formal linkages between PHOs/ Māori providers/Pacific providers and across primary/secondary care

Achieve National Health Targets for Diabetes Annual Checks

Māori (42%) Pacific (47%) and Others (44%)

Promotion of free annual checks (diabetes - Get Checked Aotearoa) in the community and linkage with the cardiovascular risk assessment programme.

Implement recommendations from local diabetes team (LDT) to support access for Māori with diabetes to free Annual Checks

Improve service coordination, self management support and health outcomes for people living with diabetes.

At least 4 LDT meetings a year and one multidisciplinary forum

Continue to plan and review through the LDT, paediatric diabetes group, Primary/secondary clinical governance group, PHOs, HEHA groups and multidisciplinary meetings.

Monitor access of high risk groups and related long term conditions to health services. Trial additional service coordination across HHS diabetes/cardiology/renal and other services for patients with complex needs.

Improved equity for all population groups in relation to diabetes management detection

Health Target for diabetes management met for Māori (65%), Pacific (60%) and others (80%)

One initiative to improve diabetes coordination

Source and distribute resources in appropriate languages and formats to support appropriate information and services for Māori, Pacific, Asian, Other ethnic groups, youth, older people.

Examples of resources developed and/or distributed

Māori

Build on 2007/08 additional investment (Māori specialist nurse, Māori provider development and PHO Māori health plans).

Example of, Increased Māori capability within HHS and/or primary care services.

Develop additional capacity to support prevention of diabetes (see Māori Health, HEHA)

Initiative to support self/whanau management of diabetes and related conditions.

Pacific

Build on 07/08 additional investment, developments in Pacific workforce, the Pacific diabetes fono, Pacific Diabetes Society and mainstream responsiveness to Pacific people with diabetes.

Improved diabetes management for Pacific people in Get Checked programme

Prevention of diabetes (see Pacific health, HEHA).

3.3.3 Cardiovascular Disease / Stroke

Early cardiovascular risk assessment and appropriate advice, medication and other risk reduction strategies reduce cardiovascular disease or delay the onset.

Māori and Pacific populations have a high burden of cardiovascular disease and well documented premature mortality from cardiovascular disease. History demonstrates that 'mainstream' screening programmes do not reach high levels of uptake for Māori and Pacific populations without Māori -specific and Pacific-specific programme support and priority given 'up front' to these high need populations. Promotion of cardiovascular risk assessment will initially aim to attract Māori and Pacific people, but will also be offered to other eligible people as the opportunity arises.

PHOs will take the lead in implementing our cardiovascular risk assessment and risk reduction programme, using their networks with relevant communities. The implementation will require ongoing attention to effective risk reduction strategies for different populations. The DHB will utilise the cross-over of HEHA and tobacco control planning to assist in meeting this anticipated need.

A planning group involving HHS and primary care clinicians has informed developments. The primary/secondary clinical governance group will continue to support implementation and manage the inevitable increase in identified cardiovascular disease.

The DHB and PHOs have used learning and innovation from other national programmes and from Porirua's experience to inform planning of the cardiovascular risk assessment programme. The DHB has provided funding to reduce cost barriers for those most at risk to reduce barriers to care.

Objectives and Actions

July 2009

Targets and Milestones

Support PHOs with resources to prioritise eligible Māori and Pacific populations for cardiovascular risk assessment

Establish baseline for recording uptake of cardiovascular risk assessment in primary care and develop PHO and District targets.

Support appropriate interventions to reduce risk.

Links to -tobacco plan, HEHA, Māori health, Pacific health, primary care nursing, HHS plan.

Māori

Offer cardiovascular risk assessment in primary care to eligible Māori men and women

Establish a baseline for cardiovascular risk assessment in the Māori population

Use appropriate promotional resources to support uptake/access.

Monitor cardiovascular risk profile at population level

Develop mechanisms to review effectiveness of risk reduction strategies.

Pacific

Offer cardiovascular risk assessment in primary care to eligible Pacific men and women using appropriate promotional resources to support uptake/access.

Establish a baseline for cardiovascular risk assessment in the Pacific population

Monitor cardiovascular risk profile at population level and develop mechanisms to review effectiveness of risk reduction strategies.

3.3.4 Respiratory

Objectives and Actions	July 2009 Targets and Milestones
Expand healthy housing projects in Wellington, Porirua and Kapiti and strengthen links with HHS, Wellington South project (nursing), Work and Income public health nurse services, whanau care services, Pacific health service and PHOs.	<i>Number of houses assessed/insulated in Wellington, Porirua and Kapiti through joint healthy housing initiatives</i>
Complete Stocktake of current information and support services for asthma and Chronic Obstructive Respiratory Disease	<i>Stocktake completed</i>
Support spirometry use across all general practices/ primary care clinical services	<i>Number of practices offering spirometry</i>
Source and distribute resources in appropriate languages and formats to support self management of respiratory conditions.	Examples of different language/format resources distributed

3.3.5 Ambulatory Sensitive (avoidable) Hospitalisations (ASH)

The measurement of ASH assesses the effectiveness of the primary health care system, other ambulatory services and public health services (e.g. the public health aspects that contribute to oral health, respiratory illness etc, associated with ASH).

C&C DHB already has a very low level of ASH relative to other DHBs, reflecting the strength of primary health care and ambulatory care systems and collaborative inter-agency work on social determinants of illness.

Reducing ASH further can be achieved through better service coordination when admissions first occur and through better linkages and support with disability and other supports/resources to avoid readmissions.

In C&C DHB, oral health is a major contributor to ASH in children. Improving oral health promotion and service access will substantially reduce ASH, particularly in Pacific children.

The interventions of the skin infection project undertaken by C&C DHB with Regional Public Health have shown some effect in reducing admissions. This work needs to be strengthened and links to a planned project to improve options for treatment of cellulitis in the community.

In 2008/09, the focus will be on the HHS/primary care and community interface and how system improvements can be made that improve the patient/whanau experience of service, patient safety and reduce readmissions. These initiatives will build on collaborative work, investments, interventions and evaluation in 2006/07 and 2007/08.

The Regional Clinical Services Plan (RCSP) and national initiatives to improve patient safety will be discussed and interventions planned in the primary/secondary clinical governance group, at the PHOAG and in other relevant forums.

The DHB and PHOs will work together to develop better information about co-morbidity for the Health Needs Assessment. Primary/secondary clinical governance group will review systems and service design issues.

Improve service delivery in agreed key areas through feasible joint initiatives with PHOs, hospital, primary care services, Māori providers, Pacific providers, NGOs, consumer groups and public health providers, specifically:

- Trial acute medical clinics in selected specialties; and
- A GP help line in selected specialties.

Health Target for admissions to hospital that are avoidable or preventable by primary health care achieved.

Reduce inequalities in this sector

Reduced ambulatory admissions from Kapiti.

Improve HHS patient information systems, specifically:

- GP access to C&C DHB's patient electronic health records (EHR)
- Changes to HHS business processes, specifically:
- Improve access to diagnostic radiology for patients from ED to potentially avoid admissions; and
- Explore access to acute minor surgery on operating lists (e.g. for abscess drainage)

Extend the range of clinically appropriate services in the community by interested primary care providers, specifically:

- Community-based treatment (including IV treatment) of cellulitis;
- Additional support to rest homes and continuing care hospitals to support patients' Advanced Healthcare Directives
- Trial a sub-acute service option with nursing component and medical oversight in Kapiti.
- Work with emergency services in Kapiti, Ministry of Health, ACC, Kapiti PHO/general practices, Care Coordination Centre and aged care residential providers to increase capacity for local assessment /treatment where appropriate.

Invest with other partners in interventions such as healthy housing, smokefree promotion

Reduced respiratory related admissions in children.

Support developments in oral health promotion and access to appropriate oral health services.

Reduction avoidable dental admissions in children

Work actively with the Immunisation Management Advisory Committee (IMAC), Regional Public Health, NGOs and PHOs to support influenza immunisation in under 65 year olds with chronic illness.

PHO influenza immunisation targets reached (PHO performance programme)

Implement recommendations of diabetes review and monitor effectiveness of expanded heart failure service.

Reduced avoidable admissions for adults with diabetes, cardiological and renal co-morbidity and with heart failure.

Objectives and Actions

July 2009

Targets and Milestones

Explore further options for improving the transition for young people with disability and/or long term conditions from paediatric to adult services.

At least one example of a transition initiative for youth with long term conditions or disability

Continue to support work to improve service coordination and access for children and young people with diabetes, history of rheumatic fever and with ADHD.

Māori specific initiatives:

- Healthy housing
- Palliative care

Health Target for admissions to hospital that are avoidable or preventable by primary health care achieved for Māori

Strengthen service delivery and effectiveness for Māori with diabetes, building on review in 2007 and investment in Māori specialist nurse (HHS) and improved support for whanau/self management.

Pacific Specific initiatives

Support Pacific primary health service expansion in Porirua

Build on Pacific diabetes project, expanding capacity.

Health Target for admissions to hospital that are avoidable or preventable by primary health care achieved for Pacific

3.4 Health of Older People

Our population is aging and our focus is on assisting older people to remain active and engaged in their community. To achieve this many people require care and support that is integrated and co-ordinated between various health care providers and social agencies.

In 2004, after extensive community consultation and Board approval, the Health of Older People team began implementation of the 'Integrated Home and Community Care Programme'.

The new service approach involves significant ongoing change management and long term development. It requires the design of new service and funding approaches, and the development of new service cultures, processes, training and performance management throughout community services.

Objectives and Actions

July 2009

Targets and Milestones

Implement the Integrated Home and Community Care Programme

Action Board decisions on the outcomes of the development of the provision of specialist community health and therapy services project

Improve integration of community health service with primary care and community care and restorative home care packages over 2007 baseline.

Further develop Care Coordination Centre role in supporting health targets, eg; preventing ASH and managing chronic conditions

Increase engagement and collaboration of Care Coordination Centre with Primary Care and general practice.

Embed and increase the restorative "Package Approach" to home and community services.

Transition of existing home-based support clients into restorative packages completed.

Design and develop specific packages that link with health targets, for example supported discharge and packages designed to avoid hospital admissions.

Clinical capacity within packages of care is increased over 2007 baseline

Collaborate with joint DHBs (10) benchmarking project for restorative home & community care

Decreased ASH for 0-74 years over Dec 2007 baseline.

Specific packages trialled and evaluated

Benchmarking of 10 DHBs delivering restorative approach to community care completed and report completed

Prevent ASH from aged residential care

Implementation of advanced directives established in Aged Residential Care facilities

Approach to preventing avoidable hospital admissions from aged residential care developed and planned, including implementing advanced directives.

Restorative respite approaches developed and implementation planned.

Explore alternative approaches to aged residential care.

InterRai Single Assessment Process

A single assessment process established across 2-3 services.

Expand the range of services accessed through the InterRai assessment tools.

Joint trial of InterRai with Accident Compensation Corporation (ACC) completed.

Progress the Supporting Carers Project

Further develop the proactive, preventative and directed approach to support for informal carers⁴ through the Care Coordination Centre assessment and goal facilitation and coordination of carers needs

Improve inclusion of support for carers in packages of care over 2007 baseline

Carers' needs and goals addressed in care plans

Evaluation of the impact of new approach on carers included in the evaluation of the Integrated Home and Community Care programme.

Appropriate integrated services for Dual Diagnosis clients

Develop appropriate integrated services for people aged 65 or over with mental illness (i.e. spanning both Mental Health and Health of Older People Services in conjunction with Journey Forward programme).

Mental Health 'graduates' review completed and approach planned.

Reviews completed with recommendations

Review dual diagnosis services Barac – Residential Care & Wesley Care – Community care

Workforce Development – see valuing our people section

3.5 Mental health

C&C DHB wants to improve the health status of people with serious mental illness and decrease unnecessary admissions to acute services. We will assist those with, or at risk of, mental illness to identify problems early by ensuring people have access to collaborative and effective treatment and support plans through the services we provide and fund.

By increasing capacity in mental health services for children and young people we can reduce long term and chronic mental health conditions when these people become adults.

Increased access will allow problems to be dealt with early and more easily, reducing the impact of psychological and social harm.

To achieve this we will:

- Continue to implement The Journey Forward (C&C DHB's 5 year Mental Health and Addictions Service Development Plan 2005 – 2010) utilising structured input in developing, planning and implementing service and system changes through a wide range of stakeholders, across provider arm, NGOs and primary care.
- Maintain involvement in national plans and initiatives such as Te Kokiri (the National Mental Health and Addiction Action Plan 2006 – 2015) and PRIMHD (The national Project for the Integration of Mental Health Data)
- Reduce unnecessary service duplication and reprioritise key services in line with national and local strategies
- Improve data and information collection and use

During 2007/08 our mental health services were split into two groups with one group focusing on local services (Local Mental Health Group) and the other on regional services, Te Korowai Whariki. The two groups were formed to reflect the different populations being served, drivers and stakeholders.

3.5.1 Local Mental Health Services

The Journey Forward will continue to be the key mechanism to engage DHB provided services, NGO services and primary care in a common goal to develop the best mix of services for the greatest consumer benefit. The Journey Forward Leadership Group will map and monitor progress across the range of Local Mental Health improvement projects and new initiatives (as listed below in the objectives and actions) and ensure that they all align with the overall goal of improved responsiveness, flexibility, quality and efficient integration of services.

An alternative to inpatient psychiatric treatment has been developed and will commence during the 2008/09 year. The Short Term Assessment and Recovery Service STARS will provide clinical treatment and peer support by way of a locally developed model of care. This initiative is the product of collaboration with a community provider and the service will accommodate up to 10 service users. A community provider is contracted to provide the facility and staff. The C&C DHB provider arm will provide consultant psychiatry to the programme. The service is a joint venture and it has a partnership group and a service development advisory group to guide its progress. An evaluation process is in place to measure the outcomes of the service.

Prevention and Promotion	<i>See Intersectoral and Primary Care sections</i>
<p>Building mental health services (development of acute services)</p> <p>Develop service specifications and negotiate contract for the first Short Term Assessment and Recovery Service (STARS).</p> <p>Progress design of hospital based acute assessment unit. Continue improvements to the environment of existing ward 27 in the meantime</p>	<p><i>STARS implemented and early evaluation completed.</i></p> <p><i>Design based on 2007 national design forum reviewed and capital funding options developed which will determine the timing for the final business case</i></p>
<p>Increase investment in acute packages of care.</p> <p>Additional 2 full-time equivalent (FTE) DHB-based Child and Youth clinicians. One FTE focused on reducing Child and Youth waiting lists. 1 FTE in a change leadership role to implement 7 Helpful Habits (UK developed model to assist child and youth services currently in development) of effective Child Adolescent Mental Health Service (CAMHS)</p> <p>Implement regional foster family initiative (Wairarapa DHB lead)</p> <p>Continue target and audit results for quality of relapse prevention plans</p> <p>Develop appropriate integrated services for people aged 65 or over with mental illness and physical health problems (in conjunction with Health of Older People Team).</p>	<p><i>Increase on baseline</i></p> <p><i>Evidenced improvement of access to child and youth services.</i></p> <p><i>Regional initiative (s) developed and established</i></p> <p><i>95% of people in contact with mental health services for two or more years have relapse prevention plans</i></p> <p><i>Mental Health 'graduates' review completed and approach planned.</i></p>
Responsiveness	
<p>Implement projects to improve service access and responsiveness</p> <p>Implement expansion of Mental Health Line to 0800 open access with appropriate technology and response for triage, prioritisation and to collect population needs data</p>	<p><i>Systems to monitor, evaluate and coordinate optimal patient pathways through acute services established</i></p> <p><i>Service configuration for people with high and complex needs reviewed.</i></p> <p><i>Access targets for teams and link to resources established</i></p> <p><i>Expanded service implemented subject to affordability</i></p>
Integration	
<p>Establishment of collaborative governance group to manage and integrate the interface between primary care services and C&C MHS, and improve access to services</p>	<p><i>Enhanced integrated working across the sector, increase information sharing and encouragement for local innovations which improve consumer access</i></p>

Objectives and Actions

July 2009

Targets and Milestones

Scope physical health project and review current investment/capacity to support primary health care for people with high and complex needs

Evaluation criteria and collect baseline in relation to expected outcomes developed

Develop a link worker position to facilitate improved access – specific focus on Pacific people to be explored

Link worker approach and job description approved

Workforce and culture for recovery

Integrated training plan for Local Mental Health across provider arm, NGO's and primary care in place

1 FTE to establish core resource for regional mental health workforce development.

Adopt integrated training plan and related software installation

Resource for regional mental health workforce planning and development established

Improve service responsiveness to Māori tangata whaiora and whanau and encourage more Māori into the mental health workforce

300 clinicians participate in Whakapai/He Whakarito education

Addiction

Contribute to the development of an intersectoral “wet hostel” for homeless heavy drinkers. A joint initiative with Wellington City Council to provide housing, health ad social supports to homeless people.

Intersectoral wet hostel for homeless heavy drinkers established

Improve the availability of and access to quality addictions services, and strengthen the alignment between addiction services and services for people with mental illness across C&C DHB and Hutt Valley DHB

Addiction Service developed and plan for the District developed

Alcohol and other drugs (AoD) District Court initiative

Māori

Develop a proposal for Māori to remain within their community with mental health services providing ongoing whanau based input using a community-based framework

Scoping phase for the development of a business case for Māori community-based model of care complete

Investigate access rates and length of stay for Māori whaiora/consumers in Te Whare o Matairangi

Quantitative and qualitative analysis using a Kaupapa Māori methodology complete

Evaluate Māori mental health models of care and assess effectiveness in both kaupapa Māori mental health and mainstream settings

Research into effectiveness of models complete

Pacific

Integrate the Pacific Island Reference Group (C&C DHB) into the Journey Forward as an advisory body for Pasifika tangata whaiora/consumers

Relationship with Pacific Island Reference Group established

Investigate access rates and length of stay by Pasifika consumers tangata whaiora to assess needs

Quantitative and qualitative analysis complete

Health Pasifika services delivered in safe physical environment

Health Pasifika relocated to new premises(subject to CAPEX approval)

Funding mechanisms for recovery

Reconfigure Mental Health Service team budgets to reflect access targets

Achieve mental health efficiency gains, tracked and monitored through regular financial reporting

National health target achieved

Transparency and trust

Enhance data systems to enable the extracts required to inform service and financial decisions. Develop sound quality and compliance systems and reporting.

PRIMHD initiative (integrating MHINC, MHSMART data across DHB's and NGO's) implemented

Continue work with service providers, including NGO's to get consistent, relevant and usable data on service outputs and outcomes

System wide dashboard of key indicators developed and circulated to key stakeholders

Human factors training – Te Korowai Whariki and the Local Mental Health Services, will develop and implement a comprehensive training that focuses on patient safety (the Human Error and Patient Safety (HEAPS) programme).

June 2009

Eromed will provide an initial training course for senior mental health staff and invigilate subsequent training

90% of mental health services personnel will have completed training by June 2010.

Initial training will be followed by a “train the trainers’ course that will build capability for ongoing courses to be provided by C&C DHB mental health staff.

Working together

Build on current eating disorder service to develop a “centre of excellence” for central region DHB's and regional community capacity.

Implement findings of eating disorder review undertaken by the Ministry of Health

3.5.2 Regional mental health services (Te Korowai Whariki)

Objectives and Actions

July 2009

Targets and Milestones

Building mental health services

Second forensic residential service established

Establish regional 4-bed forensic residential places with a high level of support for people leaving forensic inpatient services (C&C DHB lead).

Responsiveness

Continuous improvement of Consumer Council (Advisory and support group for regional forensic services made up of former service users of mental health services) terms of reference and evaluation

Ongoing relationship management with IHC

Operate Regional Intellectual Disability Care Agency (RIDCA) under the banner of Te Korowai Whariki (Regional Forensic Mental Health Service operated by C&C DHB) and ongoing review and liaison with MoH on the functioning of the Pilot

Workforce and culture for recovery

Integrated regional training plan and related software installation

Confirm partners in regional staff exchange programmes and complete agreements

Primary mental health

Implement a 'resource coordinator' position

Establishment of General Practice Services with the Te Korowai Whariki site and service to be commissioned

Enhanced integrated working across the sector, increase in information sharing and encouragement for local innovations which improve consumer access

Negotiations and finalisation of contract funding for the Forensic Plan

Enhance data systems to enable the extracts required.

Develop sound quality and timely systems and reporting. Review and evaluate core training. Continue work to get consistent, relevant and usable data on training and outcomes

Extracts required to meet reporting requirements are attained, regular submission for monitoring achieved

3.6 Cancer and palliative care

C&C DHB wish to reduce the rates of cancer in our district and prevent cancer at every point of intervention, address lifestyle related problems for Māori, Pacific, children and young people. We wish to ensure tangible gains for Māori, reduce inequalities between groups by ensuring equity of access to services and a focus on tobacco control.

We wish to use a population approach to improve health over the long term and work closely with the Central Cancer Network to ensure our programme of work gains from collaboration. The Central Cancer Network programme of work is based around:

- Collaboration and leadership
- Prevention and promotion
- Screening and early detection
- Diagnosis and treatment
- Palliative care
- Support and rehabilitation

C&C DHB wish to provide good and equivalent access to palliative care for all patients who are suffering and dying within C&C DHB. We will work to increase access to palliative care so that services are based on assessed need, and not simply diagnosis or time left to live. In this way our focus will also encompass meeting the needs of patients who have diagnoses other than cancer, and whose deaths may perhaps be months or sometimes years away. We will work collaboratively with all providers of palliative care in our District through the District Palliative Care Forum, as well as work to integrate a palliative care culture and approach within our DHB where appropriate. We will continue to develop services where people with palliative care needs will be able to access good symptom management and appropriate psychological, social and spiritual support wherever they may be. We will also develop systems and pathways to ensure that people in the last few days of life will receive good care in the bed they die in, be that in their own home, our hospitals, or a residential care facility.

Objectives and Actions

July 2009

Targets and Milestones

Collaboration/leadership

Actively engage with the Central Cancer Network (CCN) and Local Cancer Network (LCN)'s framework and workplan, including:

- Stakeholder Engagement
 - Understanding the cancer burden within the district
 - Recognition of a continuum approach for cancer
 - System issues which impact on inequalities are identified and addressed
-

Narrative report on DHB participation on CCN governance and workstreams completed

Prevention and promotion

- Tobacco control (refer to healthy communities section)
- Healthy Eating, Healthy Action (HEHA)
- Ultraviolet exposure reduction programmes
- Monitor the development of DHB wide health promotion plans

Reduced smoking, reduced obesity and improved nutrition for our district's population.

An increase in the level of physical activity for our district's population.

Screening and early detection

- National Screening Unit and CCN work with providers to reduce inequalities

An increase in cervical screening and breast screening rates (PHO monitoring)

Improved coverage rates for Māori and Pacific Island

Diagnosis and treatment

- Complete purchase and commissioning of third Linac by October 2008
- Support the recommendations of the Cancer Patient Navigator service report: "Design and establish a service to support Māori patients with Cancer"
- Finalise District 5 year Cancer Care Strategic Plan in collaboration with a Regional Cancer Advisory Group
- Review Radiation Oncology patient journey from referral to treatment
- Improve waiting list reporting for chemotherapy
- Focus on vulnerable populations (Māori, Pacific and those geographically isolated) by improving support for access to surgical and non-surgical cancer services
- Planning for the implementation of Patient Management Frameworks for common cancers
- Implementation of a Multidisciplinary meetings framework
- Lung Cancer services – CCN developing a 3 year plan for services
- Implementation of clinical guidelines for melanoma and early stage breast cancer (NZ Guidelines Group)
- Radiation Therapist New Graduate Programme
- Maintain coordination of paediatric oncology to enable the delivery of a tertiary service

All patients in category A, B, and C wait less than 6 weeks between FSA and start of radiation oncology treatment - Health target achieved

Establish a Regional Cancer Advisory Group

Implementation of Multi-disciplinary meetings framework

Streamlined patient journey from referral to treatment

Monitor the Ministry of Health's investigation into the implementation of patient management frameworks for common cancers as a benchmark for service development and delivery

Implementation of lung cancer service delivery protocol recommendations.

Evaluation of MoH's (Cancer Control funded) radiation therapist new graduate programme completed by August 2008 for January 2009 programme consideration

Successfully recruit two paediatric oncologists in October 2008

Palliative Care

Finalise District 5 year Palliative Care Strategic Plan in collaboration with Palliative Care Forum. In particular, this will take a quality improvement approach to:

- Drive seamless, coordinated and evidence based Service development
- Ensure consumer involvement
- Workforce and capacity development

Palliative Care Forum agrees Palliative Care Plan

Assess the feasibility of regional collaboration on the palliative care focus areas for 2008/09 and begin implement of the pathway forward

All Care Managers trained in recognising and meeting palliative need through assessment, care planning, liaison and referring to other services when necessary

- A population approach to ensure:
- Equity of access
- Culturally appropriate services

The plan will focus on:

Integrated and Collaborative Service Model of Care Approach

Develop and implement Specialist Palliative Care Services in accordance with new Specialist Palliative Care Service specifications (Hospital and community)

Extended role of specialist palliative care in delivering liaison and education (Hospital and community)

Develop approaches to ensure home nursing services for people with palliative needs at the very end of life will be available to people with diagnoses other than cancer

Work with providers (CCC, HHS, Mary Potter hospice, primary care providers/PHOs) to ensure flexible packages of quality care for people with diagnoses of terminal illness, and high levels of palliative, nursing and support needs are developed to enable people, including children, to live and die in the setting of their choice

End of life strategy, hospital and community, with emphasis on systems approach – eg Liverpool Care and Dying Pathway

Barriers to accessing care and undertaking analysis of patient referral, care, interventions and treatments identified and improvements considered and planned.

Staged implementation of Integrated and Collaborative Service Model of Care planned.

Networks are engaged in the development of cancer supportive care guidelines process and inform key stakeholders

24/7 specialist telephone advise for generalists – model agreed with view to implementation

All Care Coordinators at Mary Potter Hospice function as Care Managers as defined in the Home, Community, Primary and Specialist services model

Packages of care include nursing, allied health and support services above 2007 baseline

Discharge pathways to facilitate dying in the community Improved above 2007 baseline as appropriate

Complete review of uptake of Māori and Pacific to Palliative Care services

Implementation plan for end of life strategy in place

Support and rehabilitation

- Focus on vulnerable populations (Māori, Pacific and those geographically isolated) by improving support for access to cancer services
- Implementation of Supportive Care Guidelines
- Implementation of patient management frameworks
- Care co-ordination framework

Regional CCN works with stakeholders to develop a regional care co-ordination framework

Provide support to MoH Expert Advisory Group to develop draft Cancer supportive care guidelines.

Networks are engaged in the development of cancer supportive care guidelines process and inform key stakeholders

Research and Surveillance

Register of research undertaken

Clinical information is integrated across primary and secondary sectors to allow for improved health outcomes and improved resource usage

Monitoring key indicators

Research opportunities identified

Key cancer performance indicators are monitored and are regularly reported to LCNs and the CCN

4 Goal 3 Improvement in our performance

The C&C DHB provider arm has experienced enormous stresses over the past year, and faces significant challenges in the period ahead. We have workforce shortages that are creating serious clinical challenges and production bottlenecks. We have experienced adverse publicity which has undermined our public reputation and made recruitment more difficult. Our core clinical and corporate information systems require major investments of management time and financial resources to bring them up to industry standard, before they will consistently support core clinical and business processes.

Despite these limitations patient care is generally of a very good standard according to available robust measures. But systems and processes do not reliably support clinical care meaning that in isolated cases care fails to meet accepted standards and patient suffer adverse events.

We have been unable to provide services within the national pricing and population based funding parameters leading to significant underlying operating deficits over the past five years. These deficits will be exacerbated by the costs of migrating into the New Regional Hospital, and post migration capital costs – debt servicing, equity repayment and depreciation. Our workforce and facility bottlenecks, as well as increasing acute demand have meant that we are not able to take advantage of the new elective funding except by outsourcing services to private providers.

Our goal overall is simple:

- to improve hospital systems and processes so that they support clinicians,
- to resolve workforce issues by valuing our people, and
- to put in place clinical governance arrangements that deliver safe, high quality services to patients.

The task of turning the organisation around will take the full three years of this District Annual Plan. A great deal can be achieved in year one, using the New Regional Hospital as a launching pad for system improvement. However, the New Regional Hospital will also incur substantial disruption and migration costs and in year one will reduce the amount of leadership time available to achieve change outside the New Regional Hospital core requirements.

We are committed to participating in the national Value for Money programme, including the benchmarking programme. Value for Money includes the capture of all sources of additional revenue, delaying or avoiding cost increases as well as economy, efficiency and effectiveness.

The DHB makes Value for Money decisions regularly and many Value for Money decisions are embedded in this Plan, for example, regional and national initiatives, in addition to the initiatives included in this Improving Performance section.

4.1 Improving hospital systems and processes

The focus in this section is on improving systems and business processes in order to deliver contracted services more efficiently.

The outputs to be delivered by our provider arm include:

- 14,860 elective procedure cwds
- 33,951 acute procedure cwds
- 48,000 ED attendances

In general, the outputs to be produced in 2008/09 are similar to those contracted in 2007/08.

Objectives and Actions

July 2009 Targets and Milestones

(note these targets to be divided into July 09 and outyears)

Improve Clinical Administrative Systems and Processes

Centralise administrative services. Review and improve processes, design new administration services in New Regional Hospital & implement.

Reduce typing turn around time and increase ACC and non-eligible patient revenue.

Decreased DNA rate

Capture DNA rates by ethnicity

Centralised amalgamation /management of 50,000 departmental patient records.

Migrate from technical upgrade for the current electronic health record system to Orion.

Commence a technical scanning pilot for outpatients records.

Improved acute patient journey

Development of a Medical Acute Planning Unit/ Acute Planning Unit and improved inpatient flow management.

Stop medical acute admissions to Kenepuru.

Improve discharge processes and define geriatric service at Kenepuru.

Introduce admission avoidance programme.

Emergency medicine length of stay improved

Systems put in place to reduce medical ALOS in future years.

Objectives and Actions

July 2009 Targets and Milestones

(note these targets to be divided into July 09 and outyears)

Improve elective patient flow and theatre productivity to support compliance with the Ministry of Health Elective Services requirements

Theatre cancellation rate decreased to equal to or <x% (target over 3 years =5%)

Improve flow through peri-operative services and theatre to achieve reduced patient cancellations, meet elective targets and increase revenue.

Theatre utilisation rate increased to benchmark target of 85% over 3 yrs.

Develop General Practitioner Liaison roles to support improved communication and identification of issues relating to access and waiting times.

ESPIs achieved

HHS output contracts achieved. (local and IDF)

Replace/upgrade Orsus and Filemaker – to meet elective service requirements.

Elective Services Patient Flow Indicators Compliance maintained at a specialty level

Fully implement the Fit for Surgery model across all specialties

Responsibility for elective services performance is part of normal business practice

Review and document processes to ensure a standardised approach across all services

Beds and theatre capacity is utilised at Kenepuru to support patient flow and achievement of volumes

Ensure priority for First Specialist Assessment and surgical treatment is assigned and supports the delivery of services according to priority.

*Daycase % versus target achieved
Day of Surgery Admission (DOSA) versus target achieved.*

Monitor waiting list volumes and available capacity to ensure services are able to be provided within the guidelines

Monthly audit and validation of all waiting lists

Quarterly audit of compliance with guidelines and scoring tools

Implement telecoms programme

Reduced spending on pagers, reduced costs

Replace ageing base telephony equipment

Introduce vocera and voice over internet capability if cost effective to do so.

Upgrade winscribe, introduce voice to text functionality and digital dictation on mobile devices.

Improve non-clinical support systems and processes

Contract implemented to achieve service specification

Review of functionality of meals, orderlies, cleaning and other Non-clinical support services.

Reduce domestic tasks performed by nurses and nursing auxiliaries

Define and agree service specification.

Decide whether to re-invest in Capital & Coast DHB laundry

Objectives and Actions**July 2009 Targets and Milestones**

(note these targets to be divided into July 09 and outyears)

Improve Materials Management capability

Efficient delivery systems

Control consignment stock,

Plan endorsed by managers, Industrial agreement in place, Manager appointed

Imprest extended to further 20% of consumables

Reduce local stock holdings

FMIS stage 2 in place and working

Data in FMIS 1 cleansed and useful.

Stage 1 implemented of electronic management scheduling in place

Price of supplies against the 2007-8 spend reduced

Increase the level of contract purchasing

Reduce manual reporting of expenditure analysis

Service Reviews

Develop plan to review efficiency and viability of each service/specialty and determine required changes to achieve financially and clinically sustainable services.

Pilot 2 service reviews in quarters 1&2 following scoping and Service Review project plan in 07/08. Continue Service reviews as per project plan in quarters 3&4 once successful migration to New Regional Hospital.

Key stakeholders (CHFA and MOH) assured that we are addressing issues to improve efficiencies and address our HHS deficit.

Improve HR, rostering and payroll processes

Accurately deploy nursing staff

Use predictive planning tool that can assist in accurate staff deployment.

OneStaff rostering system implemented and payroll, annual leave and absence data interfaced to payroll.

HR on line – electronic time sheets

Improve performance framework

Implement new service structure and alignment

Introduce new reporting monitoring framework

Improve devolution of service and clinical decision making

Devolve accounting function

Eleven divisions reorganised into six directorates (July)

New roles implemented

Monthly performance review framework and monitoring (August)

Change delegation and decision making processes for directorates

4.2 Valuing our people

The workforce issues facing C&C DHB take on additional complexity over the next 12–18 months as we move towards the New Regional Hospital. Our human resources systems and organisational development systems and processes are required to support this critical task whilst also supporting other population health strategies. At the same time systems, processes and leadership behaviour need to focus on improving individual performance and organisational sustainability. We are moving to a devolved accountability structure and our workforce development programme is designed to support this approach.

The work proposed in 2008/09 lays an integrated foundation for Workforce and supports sustainable performance for the long term.

The risks areas this plan addresses are:

- Shortages of key staff (especially nursing, midwifery and junior doctors)
- Staff morale / satisfaction.
- Change leadership.

The key areas of focus are:

- Development of the allied health workforce.
- Remuneration strategy.
- Human resource information system.
- Refocusing professional development on a whole of district approach.

Objectives and Actions

July 2009

Targets and Milestones

Celebrate our successes

Develop proactive communication capability and promote clinical innovations.

Engage community and stakeholders through the strategic and operational planning processes.

Rebuild DHB reputation.

Development of an email contact database- August 2008

Social Marketing to support health gain using internet.- August 2008

New Regional Hospital Communications strategy implemented - October 2008

Annual Quality publication

Branding and Active Communication of Clinical Governance and Safety activity - October 2008

Implementation of internal action plan from Staff Survey – completed October 2008.

Re-survey for impact of changes Oct/Nov 08.

Further action planning and implementation – ongoing.

Organisation systems to support recruitment and retention improved

Role description system implemented

Talent management system implemented

Recruitment system designed and implemented

Establishment of remuneration principles and processes, including robust benchmarking.

All roles reviewed and updated and links established to performance management – June 2010.

First 'graduates' from talent management programme June 2009.

Key priority roles identified, supply and demand issues understood and plans in place to address – December 2008.

Remuneration strategy signed off May 2009 and implemented from October 2009 Individual Employment Agreement (IEA) review.

Introduction of HR administration with operational directorates

Workforce and sector capability developed

Organisational capability developed by focusing on role clarity, leadership and performance. Role clarity process completed for leadership and priority HHS roles. Role relationships defined across the DHB.

Leadership expectations clearly and consistently defined at all levels of the organisation.

Suite of leadership programmes updated and implemented.

Leadership survey linked to performance review.

Development of integrated service level workforce development plans modelling for sustainability.

Role description system approved July 2008. Capability for key positions determined by June 2009 and all positions by June 2010.

Performance management reviewed, system designed and implemented October 2008, reviewed and improved June 2009

Leadership programmes aligned to improvement concepts, new models of care and Lominger Competencies – March 2009.

Executive leadership programme developed and implemented to support leadership of the ongoing change programme – December 2008 then ongoing.

Leadership survey based on Lominger competencies incorporated to annual review process – October 2008

1st directorate and provider arm annual workforce plans - March 2009.

Objectives and Actions

July 2009

Targets and Milestones

Implement changes to charge nurse manager and other 4th tier roles to reflect new service and facility configurations.

Implementation of new management structure and facility – service relationships. Clarify clinical leader roles and responsibilities.

Development and implementation of new models of care in New Regional Hospital, including development of role of Health Care Assistants (HCAs)

Career pathway for health care assistants (HCAs) and other unregulated healthcare workers defined

All unregulated healthcare workers are trained in patient care delivery to minimum Level 3 Accredited NZQA training programme.

Pacific Workforce development

Develop and implement new initiatives with providers that will strengthen workforce capacity and capability.

Increased Pacific clinical workforce – baseline 5.4% at December 2007

Promote C&C DHB as an employer of choice among Pacific students and graduands.

Identify pathways for existing staff to transition into specified health roles.

Māori Workforce development

Develop primary care workforce and capacity

Increased Māori workforce in primary care

Support workforce initiatives to build Māori provider and workforce capacity and capability.

Implement the Māori Health Workforce Plan and the Māori Provider Development Framework.

Implement social marketing project

Implement effective recruitment approaches to attract Māori into the sector.

Mainstream service/s responsiveness to Māori improved

Identify changes in the internal HHS environment that would support the DHB's ability to attract and retain Māori staff.

Central Region Leadership and Management programme implemented

Support Māori career progression and on-going developments.

Continue to focus on raising awareness of health as a career option to Māori by strengthening our relationships with Universities, Polytechnics and community organisations.

Improving health workforce information, effectiveness and efficiency

Building our knowledge of the workforce and establishing an ongoing information and workforce planning infrastructure.

Develop and implement value propositions for priority groups e.g. research links to Wellington School of Medicine for SMOs.

Analyse and evaluate appropriate benchmarks with services across all occupational and professional categories to configure FTEs in line with service models.

Consistent rostering practices implemented through OneStaff implementation and capacity planning info available.

Implement processes and systems to capture and report position and people data to enable reliable human resource reporting.

Each directorate will develop an integrated service level workforce development plan modelling for sustainability – March 2009.

Alignment to national workforce priorities.

Appropriate staffing levels and skills mix.

Paper timesheets eliminated.

Payroll capacity re-aligned to HRIS maintenance and HR information responses.

Implement an HR Information Centre to provide first level HR support to managers and staff.

Identifying and implementing benefits from the Multi Employer Partnership Agreements (MECAs)

Reduced unplanned absence.

Permanent pool to support flexible staffing.

Implement education strategy

Implement education strategy including additional CTA funding and Professional Development Unit relationships with education providers.

Regional and national clinical services planning and collaborative clinical networks.

Implement Director Allied Health to:

lead development of allied health workforce

ensure sustainability programme

develop a professional education framework within organisation

Partnerships with education providers to develop workforce

Programmes in place for continuing development

Skill and competency pathway for nurses developed

Engage with other DHBs to improve long term sustainability of service delivery across the region and nationally.

Develop an academic and research focused hospital strategy

Develop an effective working relationship with Wellington School of Medicine

Promote research and academic links.

Nursing and midwifery core competencies including cultural awareness/safety.

MOU and contract with Victoria University.

Nursing and Midwifery research framework/roles.

Objectives and Actions

July 2009

Targets and Milestones

MSD Cadetship programme

New Mahi ki te Ora Cadetship Programme successfully implemented, promoting health as a career, through cadetships in primary and community care

30 Cadets in place for 2008/2009 – at least 4 cadetships in primary and community settings

4.3 Safe high quality services

Our overriding purpose is to provide safe good quality services that restore health and improve quality of life. Our approach to achieving this to:

- Strengthen Clinical Governance and Quality
- Information Systems Developments – Implement EHR2
- Safe Migration to the New Regional Hospital

4.3.1 Strengthen clinical governance and quality

To build public confidence a key focus of our work in 2008/09 will be implementing our Clinical Governance and Quality Structure with an emphasis on consumer involvement, clinical performance (audit and clinical effectiveness), clinical risk management and professional development.

DHBs are working in a collaborative approach toward the following prioritised issues:

- Optimising the patients journey (refer to HHS business process improvement)
- Management of healthcare incidents
- Leading consumer involvement
- Support patient safety by reducing medication errors
- Infection prevention and control
- National mortality review systems

C&C DHB will work at both the national collective level and at the DHB level to deliver the Quality Improvement Committee (QIC) programme over the next 3-4 years. Each project will be run by a lead DHB with help from other DHBs. Both resources from the lead DHB and DHBNZ will be used to run the programme and to help other DHBs implement the outcomes from the projects.

This DHB is committed to actively working with the national collective to support the lead DHBs and to ensuring that we as a DHB are prepared in terms of planning and resourcing to implement the results of these projects as they become available.

We acknowledge that 2008/09 is the establishment phase for the programme. The Lead DHBs will begin to deliver the first outputs by the end of 2008/09. We expect to be actively gearing up our DHB over 2008/09 to be ready to start implementing outputs by the end of 2008/09. We expect our commitment to resources to increase over the 2009 and 2010 calendar years as the programme enters its implementation phase.

We note that many of the projects have a significant IT component that is yet to be funded. We will continue working with the Ministry at the national collective level to ensure investment decisions are made in a timely manner.

Objectives and Actions

July 2009

Targets and Milestones

Implement the Quality Patient Journey

Improve quality and efficiency through clinical systems and process redesign

(See improve hospital systems and processes section above)

Integration of organisation development functions with patient safety and risk

Implement patient safety officer role

Create directorate of organisation development and patient safety

Appoint Director and Clinical Director of Organisation Development and Patient Safety

Objectives and Actions

July 2009

Targets and Milestones

Develop and implement a performance reporting system (incident management review)

New clinical governance framework (see quality plan for details) implemented

Develop (as per the Communio report) a performance reporting systems to strengthen clinical governance

Patient satisfaction improved

Monitor and analyse trends re nursing and midwifery sensitive indications

Increased % of complaints responded to within timeframe

Introduce an open disclosure policy

Ability to monitor nursing and midwifery sensitive indicators (For example, Pressure areas (adults), Restraint, Seclusion, Septum Ulceration, Drops, Baby Friendly Hospital Initiative, Falls, Medication Errors, Safe Staffing, Acuity/Staffing levels)

Decrease unplanned readmission rate

Consumer involvement with clinical service improvement

Consumer representation on project groups for service redevelopment and change

Safe medication management

Healthcare associated Staphylococcus bloodstream infections decreased

Compliance audit of recently released antibiotic guidelines

Improve patient medication safety as part of safe use of medicines programme

Roll out of PYXIS - dependent on the feasibility study.

Infection prevention and control

Decrease healthcare associated Staphylococcus bloodstream infections

Adhere to Quality Improvement Group Infection Control business case:

Phase 1: Working toward adaptation and adoption of the WHO guidelines on Hand hygiene (in conjunction with MoH and all DHBs).

Develop a monthly report that looks at occupancy and Hand Hygiene product usage per ward/area.

National mortality review systems

Mortality database created

Use existing systems to capture and report on deaths within the DHB, and review deaths to ensure proper coronial reporting.

Implement process for capturing coronial findings and delivering learnings through the DHB

New reporting templates developed to feed existing mortality meeting information back through the DHB

Measure disparities in access to hospital services and reduce over time

Develop baseline disparities

4.3.2 Information Management

Our Information Systems Strategic Plan (ISSP) supports the focus on the new regional hospital and enables greater integration between health providers working towards improving health outcomes. Given the extent of change, our ISSP is primarily focussed on the people, processes, information, applications and infrastructure required for these changes. It is therefore more internally focussed over the next year to ensure that C&C DHB can have the necessary information systems in place to drive leadership and innovation across the district and central region.

Objectives and Actions	July 2009 Targets and Milestones
<p>Electronic Health Record Clinical information from major systems is integrated at a patient level and accessible through the EHR (electronic health record).</p>	<i>EHR implemented</i>
<p>Upgrade Clinical Information Systems Implement lifecycle management for all core clinical applications</p>	<p><i>Priority core clinical applications reviewed and upgraded</i> <i>Upgrade the Patient Management System (IBA)</i></p>
<p>Providing Information to support clinical and management decision making Implementing an enterprise data warehouse and web based reporting tool</p>	<p><i>Enterprise reporting strategy implemented</i> <i>Data warehouse installed</i> <i>Web based reports available</i> <i>KPIs reporting supported with automated production of reports to business and clinical leaders</i></p>
<p>IT System Resilience: disaster recovery Implement comprehensive disaster recovery capability to support a clinical and business environment increasingly reliant on computer based information</p>	<p><i>Off-site disaster recovery capacity implemented (ie at Kenepuru Community Hospital)</i></p>
<p>Decision Support Create centralised organisational unit to provide leadership for information management Consolidation of organisation analytical resources Integration between clinical information system, coding and medical records</p>	<i>Decision support service established</i>
<p>Information Technology Management Renegotiate service level agreement with outsourced IT provider: Develop multiple service schedules each with specific deliverables, reporting metrics and funding</p>	<p><i>Service level agreement finalised</i> <i>Monthly reporting received</i></p>

Objectives and Actions

July 2009

Targets and Milestones

Information Project Governance

Implement robust project and programme governance to ensure successful scoping, budgeting and implementation of ICT projects

ICT Steering Group established with documented processes

Successful project implementations

New Regional Hospital (NRH)

The NRH is supported by integrated information and technology.

Successful implementation of core ICT infrastructure

Successful migration to NRH

Regional collaboration

Increase regional collaboration on IT strategy

4.3.3 Safe migration to the New Regional Hospital

Objectives and Actions	July 2009 Targets and Milestones
Replace deteriorated facilities Complete the new facility at Newtown	<i>Handover of levels 2 and 3 of NRH for equipment and training</i> <i>Early access to tower pre handover for equipment installation.</i> <i>Handover of tower for final installations and training</i> <i>Radiology department early migration and operating in new building</i>
Commission new facility at Newtown Ensure Service staff-trainers are familiar with the building and its services and equipment	<i>Major equipment installed pre handover</i> <i>Volunteer programme in place for familiarisation tours.</i> <i>Training programmes developed and delivered.</i>
Ensure that the New Regional Hospital operational commissioning is well planned and implemented, and that required changes to business processes and systems to support migration are in place.	<i>Manuals prepared for wards and departments</i> <i>Support service available at move date and 6 weeks beyond.</i>
Migrate services to new facility with minimum disruption and maximum patient safety in the physical move.	<i>Detailed plan for each Service/Department</i> <i>Checklists all complete</i> <i>Maximum customer focus for non clinical support services</i>
Residual building works – Complete the briefed scope of work	<i>40% refurbish existing buildings for offices and support</i> <i>Contract documentation prepared to:</i> <i>Demolish Community Health Building</i> <i>Mothball Riddiford building</i> <i>In 2009/10:</i> <i>Complete refurbishment</i> <i>Demolish/dispose of deteriorated buildings</i>

5 Goal 4 Managing our finances

5.1 Financial Strategy

The main driver for next years budget is all about a realistic budget, savings targets that cannot be delivered next year have been removed from the budget.

Our strategy moving forward will be to:

- invest in systems and processes and our workforce (see Goal 3) to improve service efficiency and effectiveness and to remove production bottlenecks related to shortages of key staff. This will result in additional provider arm revenue from insourcing elective surgery, and better counting of services currently provided.
- take advantage of efficiencies derived from the new building and new processes to reduce administrative and management costs.
- influence the National Pricing Programme to achieve fair prepayment for service provided.
- work with the owner and other DHBs to establish which tertiary services can be provided in Wellington at what cost and to gain fair compensation for services desired.
- work with the owner to develop and implement a strategy for improving our balance sheet.

5.2 Funding allocation for 2008/09

Our population generally has good health except for pockets of disparity in Porirua and South Wellington. A Public Health Intelligence publication released in December 2005 shows that C&C DHB ranks second behind Waitemata DHB in terms of DHB life expectancies at birth, health inequality indexes, and rankings. The Population Based Funding we receive reflects this. We receive 5.89% of national total health funding, yet we have 6.6% of the total population. Funding at the national average amount per person for our population would provide an extra \$67m in the 2008/09 financial year.

Our funding package provided C&C DHB with a 3.7% increase for 2008/09. This is significantly lower than in 2007/08 when we received a 7.3% increase.

The 2008/09 funding package from the MoH has delivered an unexpected \$10 million shortfall made up of asset revaluation \$3 million above our population based funding share, a \$1.4 million decrease in tertiary adjustor with no increase in case weighted funding above future funding track (FFT), a \$2.77 million reduction in demographic funding despite our population growing at nearly the national average (3.1% versus national average of 3.2% over the next 3 years) and a \$2.4million gap in funding for pharmaceutical cancer treatments.

The National Pricing Programme sets prices for hospital services. The 2008/09 round has failed to deliver any additional funding to C&C DHB to offset the growth in costs of the current hospital services. As it is based on historical costs it also fails to offset the expected additional costs for the NRH when it becomes operational in 2008/09. The programme uses average costs which will be insufficient to offset the new cost structure of the NRH.

Factors which also contribute to the shortfall include:

- the low population base for secondary services due to the concentration of other secondary hospitals in the area, this leads to economies of scale issues which are not felt by other tertiary hospitals who tend to have a higher secondary service population.
- the current inability of the National Pricing Programme to address the costs of teaching hospitals for tertiary facilities
- the volume of tertiary services within the region which are not situated at Wellington (cancer services and Plastics and Burns services are delivered by two other DHBs in the central region). More tertiary level services are delivered outside of the central region than in other regions. The other three regions tend to have one tertiary referral

centre within their region. This appears to affect the amount of the tertiary adjuster which is attributed to the central region and may impact on the costs structures of hospitals within the central region.

- the Governments directive to provide 24/7 services at Kenepuru Hospital
- the underinvestment in information systems over the last five years.

5.2.1 Manage Contracts and Volumes for the Hospital

Objectives and Actions	July 2009 Targets and Milestones
<p>Meet budget targets for the treatment of patients</p> <p>Further develop management systems to monitor volume management to contract and within budget allocation</p> <p>Meet financial and service volume obligations in the Annual Plan (Appendix 1)</p> <p>Manage the impact of changes from regional service planning including any associated cost reductions</p> <p>Maintain accurate coding to support revenue recognition and contract management</p> <p>Report risks monthly and mitigation activities to achieving budget</p> <p>Report variance to plan, explaining issues and take corrective action</p>	<p><i>Regular Monthly meetings held with Provider Arm Group Managers / Clinical Directors.</i></p> <p><i>Maintain open effective and responsive links for information and communication with managers</i></p> <p><i>Ensure clarity of accountabilities in customer/supplier relationship</i></p> <p><i>Ensure regular review and discussion of performance and agree actions where necessary</i></p> <p><i>Implement clear escalation and risk management processes, including early warning signals to identify risks</i></p>
<p>Manage to contracted volumes</p> <p>Complete regional and national processes to manage Inter District Flows:</p> <ul style="list-style-type: none"> • Monitor adherence to agreed business rules • Monitor agreed volumes and access levels with other DHBs or Ministry of Health depending on Crown funding path adopted under Population Based Funding 	<p><i>Elective services reports delivered to other regional DHBs monthly</i></p> <p><i>Adherence to business rules for all service changes</i></p> <p><i>IDF revenue identified and collected</i></p> <p><i>IDF expenditure correctly identified</i></p>

5.2.2 Sustainable health services

Objectives and Actions	July 2009 Targets and Milestones
<p>Influencing national policy</p> <p>Resolving national and regional issues that adversely affect C&C DHB's ability to manage funding by working with Ministry officials and other DHB CEOs</p> <p>Participate in DHBNZ work programmes around pricing, workforce etc</p> <p>Collaborate nationally with other DHBs to increase intersectoral engagement with Government departments such as MSD, WINZ, MoE, HNZ</p>	<p><i>Increased funding received</i></p> <p><i>Data requests submitted on a timely basis for all national pricing programmes</i></p> <p><i>Staff contribute to national workstreams</i></p>

5.2.3 Regional Collaboration

Collaboration with other DHBs is essential to assist achieving effective, efficient and high quality services. Central Region DHBs (Capital & Coast, Hutt Valley, Wairarapa, Whanganui, MidCentral, Hawke's Bay) work closely together on a number of endeavours and continue to invest in their shared service agency, Central Region Technical Advisory Service Limited (TAS) to support much of this work. TAS is jointly owned by the six District Health Boards in the Central region and each District Health Board participates in its governance through the board structure.

A service level agreement is negotiated each year and outlines the work that typically includes the following components; health information and analysis, service planning (mental health and personal health), audit services and administrative and coordination support for regional groups. Investment into regional work increased over 2007/08 following the decisions to progress Cardiology Project implementation and develop a Clinical Services Plan for the Central Region (RCSP).

Central Region DHBs will progress a range of collaborative initiatives in 2008/09 including:

- implementing the work programmes for the service development initiatives already underway: Plastics, Burns and Maxillofacial Surgery, Cardiology Services and Renal Services
- complete establishment of CCN work streams in the following areas; prevention, early detection and screening, diagnosis and treatment, support and rehabilitation, palliative care and research and surveillance and tumour specific steering groups. Implementation of the CCN Work Plan including development of Local Cancer Networks against CCN guidelines, development of a shared operations framework and a regional strategic plan
- progression of the recommendations of the 2004 ENT (Otorhinolaryngology, Head and Neck Services) review
- implementation of a communications plan focusing on wide engagement and consultation on the draft RCSP
- developing an implementation plan for key priorities identified in the RCSP
- progression of the shared learning Acute Demand Project aimed at identifying successful strategies and tools to assist DHBs to manage acute demand
- implementation of the Mental Health Service Plan
- finalisation of the Regional Information Systems Strategic Plan based on the priorities identified in the RCSP
- data warehousing and improvements in information management and reporting capabilities
- regional repository of medical images (regional PACs)
- audit and assurance (ongoing programme)
- sharing information relating to the implementation of the Quality Improvement Committee (QIC) Programme at DHB level with possible cooperation of a range of regional and sub regional initiatives e.g. medicines reconciliation
- progressing a regional approach towards the implementation of the NZNO MECA Partnership Agreement
- progressing a regional approach and response to clinical and workforce initiatives and issues
- developing a regional leadership development programme.

5.3 Financial environment and information

5.3.1 Financial assumptions

The assumptions are the best estimates of future factors which affect the predicted financial results. As such there is necessarily a degree of uncertainty about the accuracy of the predicted result, which is unable to be quantified.

Factors which may cause a material difference between these prospective financial statements and the actual financial results would be a change in the type and volume of services provided, significant movement in staff levels and remuneration, plus unexpected changes in the cost of goods and services required to provide the planned services.

Funding Assumptions	<p>The majority of funding is provided by the Ministry of Health under a population based formula. As such there is a low risk of significant variance from the forecast amount.</p> <p>Overall volumes for the Hospital and Health Services (HHS) include previously unfunded volumes and targeted funding initiatives.</p> <p>The overall price increase for the HHS is in line with FFT and includes change to WIES NZ8.</p> <p>National prices are to be paid for IDFs and local volumes where applicable in line with FFT.</p> <p>A price uplift of 3.298% has been applied to mental health services.</p> <p>Any increase in expenditure on PHOs driven by further primary care strategy policy implementation by the MoH will be met by the Ministry through wash-ups.</p> <p>The payment of the Ministry of Health revenue is in the month in which the services are provided except those provided by HHS when payment is received in the month following.</p>						
Associate Company	<p>A nil result is expected from HIQ Limited.</p>						
Depreciation	<p>Rates based on economic life in accordance with the DHB policy.</p>						
Capital Charge	<p>8% as per current policy of the Ministry of Health.</p>						
New Debt	<p>New debt will be financed by the Crown Health Financing Agency except for a one off government approved private sector issue of \$28 million as part of the New Regional Hospital funding. Capex items not funded from operating cash flow are financed via debt, equity or lease.</p>						
Interest Rate	<p>Forecast rates used in the plans are as follows:</p> <table><tr><td>2007/08</td><td>6.6%</td></tr><tr><td>2008/09</td><td>6.6%</td></tr><tr><td>2009/10</td><td>6.6%</td></tr></table> <p>These rates are for new debt; existing term debt is running at 6.6%.</p>	2007/08	6.6%	2008/09	6.6%	2009/10	6.6%
2007/08	6.6%						
2008/09	6.6%						
2009/10	6.6%						

Foreign Exchange	<p>NZD/USD 0.70</p> <p>NZD/AUD 0.85</p> <p>NZD/EU 0.50</p> <p>Prices should be adjusted where there are known FX clauses providing price variability around the assumptions to be provided. Large assets purchases >\$100k will need individual exchange rate assumptions. Budgeted rates reflect that current exchange rates are over valued.</p>
Supplies	<p>All known price increases and inflation pressures are incorporated into this DAP. Initiatives such as standardisation policy are included to hold costs within FFT.</p>
Personnel	<p>Central budget allowance has been included for Individual Employment Agreement (IEA) and Collective Agreements negotiated. Budgets include clinical career pathways and grade step increases.</p> <p>A central budget allowance is based on HR industrial relation projections for the sector and DHB specific industry contracts, to provide a general provision to cover all labour cost increase.</p>
Capital Expenditure (CAPEX)	<p>CAPEX is limited to items: of a legal and safety nature; required for safe service delivery; support DAP or DSP priorities; are minor CAPEX, and items with a payback under 1 year.</p> <p>The DHB is also considering a number of CAPEX items of new investment that will only proceed if the item is fully funded and has a breakeven operating outcome.</p>
New Regional Hospital (CAPEX)	<p>The Minister has approved the financing of \$346 Million which is fully funded and managed as a separate capital project.</p>
Deficit support	<p>Deficit support is available to cover the full operating deficits in all years net of any gain on asset sales.</p>
Approval of DAP	<p>The Board understands that the approval of the District Annual Plan 2008/09 does not amount to approval if individual business cases signalled within the DAP</p>
DRG ICD version	<p>08/09 policy: ICD 10 v3, AR-DRG v5.0 NZWIES08</p>
Holidays Act	<p>The impact of moving from the statutory 3 to 4 weeks annual leave has been accrued during 2006/07 and is included within operating costs.</p>
Alterations	<p>Any alteration to this plan will require Funding Management Committee (FMC) (for funding), Capex Review Group (CRG) (for CAPEX), CEO (for FTE) or Board approval.</p>
Sustainable budget	<p>The budget includes cost savings within identified costed initiatives at cost centres level.</p>

5.3.2 Asset revaluations

Background

Current policy is for buildings, plant & equipment to be revalued every 5 years. A revaluation was completed at 30 June 2006.

Assumption

C&C DHB have not included an asset revaluation within the current plan.

5.3.3 Non Case Weight (CWD) wash-ups

Background

Currently there is not a provision for addressing over or under delivery of non-CWD volumes against funded levels when delivering to other DHBs. C&C DHB has previously identified a potential of significant unfunded volumes.

A process is in place to perform the adjustment for CWD volumes and C&C DHB recognises the same or similar process should be in place for non-CWD volumes. While C&C DHB has planned for the wash-up process to be in place from 2009/10, work will be undertaken to implement a wash-up process for 2008/09.

Assumption

C&C DHB has not assumed any additional revenue but that a wash-up process will be in place for 2009/10.

5.3.4 Regional Capital Tertiary Premium

Background

The New Regional Hospital Development (NRH) will significantly upgrade the facilities of C&C DHB. This redevelopment will add significant additional fixed assets (\$346 million project cost) to the balance sheet. These costs are currently included within population-based funding (PBFF) calculated on an average cost of capital basis. The cost to fund the new facility will be significantly greater than the average cost and therefore C&C DHB will incur cost greater than revenue received.

It is recognised that C&C DHB is the Central Region Tertiary provider and as such has planned and is upgrading facilities (NRH) to ensure that these services can continue to be provided. However, the improved facilities and improved service delivery will add significant cost to C&C DHB, which should be recognised by the region.

Assumption

C&C DHB has not assumed it will receive revenue funding by way of a regional capital tertiary premium. However, from 2008/09 C&C DHB recognises the cost of the improved regional tertiary facilities and will review this issue within the Central Region DHB's.

5.3.5 Personnel costs

Background

C&C DHB has recognised that to achieve improved efficiencies and reduced cost of service delivery, all costs must be reviewed and savings achieved where appropriate.

Bench-marking, service delivery redesign and reconfigurations, changes to models of care, appropriate use of outsourced staff and other initiatives to ensure the efficient use of human resources while maintaining safe and quality service delivery, are among cost-reducing techniques being implemented.

Personnel are a significant portion of the cost to the DHB and therefore make up the major portion of current and future service delivery.

Assumption

C&C DHB has assumed the maintenance of personnel costs at the level required to meet market rates during each year plus increases of FTE based on approved business cases or where change is supported by benchmark modelling.

5.3.6 Asset Management Plan

We have been actively working on refining our asset management strategy as part of a collaborative approach by the health sector which the Ministry of Health, DHBNZ and the DHB Chief Financial Officers (CFO) Forum are leading.

The board has completed the updated asset management plan (AMP) in line with the Ministry's requirements.

An internal steering group has been over-viewing the project including: strategic resource implications, software upgrades, user needs and in particular the encouragement of internal collaboration as a precursor to inter-DHB collaboration as part of a new sector-wide capital investment framework.

The work completed during 2006/07 includes developing AMP at clinical group level and to date has shown that the DHB is well positioned to build on its current asset management infrastructure, to meet the planned release date of October 2008.

5.3.7 Property Disposal Plan

Porirua Surplus land

The current steps being undertaken by the Board:

- Identify Previous Owners and if necessary, offer the land back to them (or their immediate descendants) as required by sections 40-42 of the Public Works Act 1981. The investigative work is complete and the reports have been submitted to LINZ for ratification.
- Seek Resource Consent from the Porirua City Council to Subdivide the Land. The application for local authority approval to carry out a subdivision under the Resource Management Act 1991 has been submitted to the Porirua City Council.
- Completion of the Process during 2008/09. There are 3 sequential steps required to complete the process:
- Obtain new titles to all parcels of land created through the subdivision - new titles have to be obtained before the surplus land can be entered into the Māori Protection Mechanism.
- Māori Protection Mechanism - Once new titles have been obtained all surplus crown land must be entered into the Māori Protection Mechanism. The crown may at this stage decide to land-bank all of the surplus land or any portion and the following step will therefore not be necessary.
- Marketing the Surplus Land (if not land-banked) - if the Crown has decided not to land-bank the surplus land and has confirmed its approval for the Board to dispose of it on the open market, the Board will select and engage one or more real estate agents to assist with the marketing and sale process.

5.3.8 Capital Expenditure

This year's business planning round for CAPEX followed previous patterns, where demand significantly outstripped available funding. A total of \$61.9m of requests were received for CAPEX for the 2008/09 year (compared to \$69.8m requests in the previous year). Requests for the next 5 years totalled \$133.4m compared with \$116.6m projected (for 5 years) last year. Hence, this year's requests for CAPEX funds put additional pressure on limited internal funding available.

This year's CAPEX allocation followed the same process as in the previous year. Each request was supported by a short justification. The plan was reviewed and reduced down to its present value after a detailed process of consultation by the Executive Team and Senior Management Team representing all the service areas. Only items of a legal & safety nature, or essential to support the District Annual Plans (DAP)/District Strategic Plan (DSP) or yielding a very fast payback have been included to be funded from the free/internal cash flow.

Key Issues

The CAPEX for 2008/09 requires \$23.1 million (excluding NRH & HIQ). This is to be fully financed through cash flow.

The aim when setting the plan was to provide expenditure that closely matched with the organisation's depreciation while identifying additions which need new capital. The plan has limited the CAPEX to the barest minimum, by postponing some projects to 2009/10 and out years. No provision has been allowed for contingencies or unforeseen breakdown of clinical and other equipment. This poses a degree of risk to the uninterrupted provision of services (and hence to the overall profitability). The DHB hopes to actively manage this risk by critically evaluating each project within the plan prior to final approval and implementation, thus, maintaining a tight rein over funds actually deployed for CAPEX.

The other risk to the plan is the escalation of costs, leading to potentially adverse financial performance to plan, thus eroding the capability to fund the CAPEX cash flow. The DHB will nevertheless actively manage any cost increases to ensure planned results are met, and will rely on the receipt of deficit support.

New Regional Hospital

The accumulated expenditure for the New Regional Hospital (NRH) project up to the end of 2007/08 is forecast to be around \$280 million including capitalised interest (COI) of \$25 million.

The expenditure forecast for 2008/09 is \$56.6 million including COI and \$50.6 million excluding COI. The expenditure for the completion in 2009/10 is \$9.4 million.

Direct funding for this project by the Crown does not include capitalised interest and is consequently financed from operating cash flow and is hence itemised separately.

The NRH project has caused the significant level of expenditure under land & buildings in the forecast statement of cash flows included in this document.

5.3.9 Analysis of 2008/09 CAPEX Plan:

The entire cash flow budget by type is summarised below and includes the rollover from the 2008/09 year.

	2008/09	2009/10	2010/11	Total
Category	\$'000	\$'000	\$'000	\$'000
Clinical Equipment	15,958	8,338	14,089	38,385
IT Equipment	22,888*	28,282	11,195	62,365
Building / Civil Works	3,396	3,037	4,441	10,874
Other Equipment	3,744	3,057	1,449	8,250
Total Net Capex excluding NRH	45,986	42,714	31,174	119,874

* Yet to be approved by the Minister

5.3.10 Debt & Equity

Equity drawing

Equity is drawn in the plan as follows:

Equity Type	2008/09	2009/10	2010/11	Total
Equity for Capex	23m	-	-	23m
Equity for NRH Project	25m	-	-	25m
Equity Deficit Support	53m	68m	58m	179m
Total	101m	68m	58m	227m

Equity is drawn for Capex items which are over and above base depreciation. Equity is drawn for the NRH so that the project is financed with the maximum amount of debt v equity. The P&L deficit in all years is financed by equity.

Core Debt

The net interest cost on the Core CHFA debt of \$115 million is currently at 6.6%, and the plan assumes roll-over of maturing debt is financed at 6.6%.

Working capital

The Board has a working capital facility with the ASB bank and this is limited to one month's provider's revenue, being \$40 million, to manage fluctuating cash flow needs for the DHB and the NRH project.

NRH Project funding

A \$196 million facility with the CHFA is in place to finance the NRH project and is fully drawn.

An on-demand equity receivable of \$22 million from the MoH is also available to finance the NRH and will be fully drawn by October 2008.

This receivable is drawn at the conclusion of the project in line with agreement of the MoH, and has a shielding effect on the capital charge payable, with the charge not payable until drawn.

5.3.11 Gearing and Financial Covenants

No Gearing covenants are in place.

The ASB bank has a covenant required for C&C DHB to stay within operating cash flow as defined by NZGAAP.

5.3.12 Accounting policies

The accounting policies adopted are consistent with those used in the prior year and as represented in the SOI.

5.4 Forecast statements of financial performance

Capital & Coast DHB Statement of Financial Performance Budget for the Three Years Ending 30 June 2011		Actual 2006/07 (000s)	Actual 2007/08 (000s)	Plan 2008/09 (000s)	Plan 2009/10 (000s)	Plan 2010/11 (000s)
REVENUE						
Government and Crown Agency Sourced		639,770	696,243	726,016	754,439	785,038
Patient / Consumer Sourced		3,376	3,540	3,559	3,677	3,798
Other Income		24,025	20,101	16,750	21,321	26,727
TOTAL REVENUE		667,172	719,884	746,325	779,437	815,563
OPERATING COSTS (Excluding NRH)						
<i>Personnel Costs</i>						
Medical Staff		74,807	84,845	92,048	95,857	99,836
Nursing Staff		106,005	117,512	120,098	125,216	129,774
Allied Health Staff		35,817	35,043	42,697	44,776	46,292
Support Staff		6,027	6,891	7,303	7,546	7,791
Management / Administration Staff		36,691	42,343	44,879	42,110	41,306
Total Personnel Costs		259,347	286,634	307,025	315,505	324,999
<i>Clinical Costs</i>						
Outsourced Services		16,749	22,302	11,747	8,353	7,731
Clinical Supplies		71,060	78,845	81,150	82,342	86,909
Total Clinical Costs		87,809	101,147	92,897	90,695	94,640
<i>Other Operating Costs</i>						
Hotel Services, Laundry & Cleaning		9,205	11,445	11,368	12,159	12,563
Facilities		10,737	13,647	13,441	14,000	14,500
Transport		2,594	3,508	3,167	3,309	3,413
IT Systems & Telecommunications		13,862	18,229	20,034	20,706	21,446
Interest & Financing Charges		13,825	17,093	10,239	9,215	9,215
Depreciation		17,269	16,223	14,303	18,816	16,521
Professional Fees & Expenses		2,974	3,461	967	2,507	2,507
Other Operating Expenses		10,571	7,518	7,614	12,428	11,153
Democracy		370	661	594	594	594
Provider Payments		246,846	274,490	292,287	301,846	314,159
Internal Allocations		-	-	10	(0)	(0)
Total Other Operating Costs		328,252	366,274	374,025	395,579	406,072
NRH Transition Contingency				5,000	-	-
TOTAL COSTS		675,409	754,055	778,947	801,779	825,710
OPERATING SURPLUS / (DEFICIT) (Excluding NRH)		(8,238)	(34,171)	(32,621)	(22,342)	(10,147)
Asset Disposals		18	(824)	16,250	-	-
NET SURPLUS / (DEFICIT) (Excluding NRH)		(8,219)	(34,995)	(16,371)	(22,342)	(10,147)
NRH Costs						
Interest & Financing Charges				14,368	21,442	21,442
Depreciation		2,500	2,808	14,472	21,301	24,587
Change Management		2,300	2,873	7,500	2,800	2,800
Total Other Operating Costs		4,800	5,681	36,341	45,543	48,829
OPERATING SURPLUS / (DEFICIT) NRH		(4,800)	(5,681)	(36,341)	(45,543)	(48,829)
NET SURPLUS / (DEFICIT) Including NRH Costs		(13,019)	(40,676)	(52,711)	(67,885)	(58,976)

Capital & Coast Provider Statement of Financial Performance Budget for the Three Years Ending 30 June 2011		Actual 2006/07 (000s)	Forecast 2007/08 (000s)	Plan 2008/09 (000s)	Plan 2009/10 (000s)	Plan 2010/11 (000s)
REVENUE						
Government and Crown Agency Sourced		28,682	32,281	40,077	41,934	43,553
Patient / Consumer Sourced		3,376	3,540	3,559	3,677	3,798
Other Income		19,324	10,756	13,123	17,530	22,919
Funder Arm Sourced		362,345	388,147	392,966	408,785	425,253
TOTAL REVENUE		413,728	434,724	449,725	471,925	495,522
OPERATING COSTS						
<i>Personnel Costs</i>						
Medical Staff		74,807	84,845	92,048	95,857	99,836
Nursing Staff		106,006	117,506	120,098	125,216	129,774
Allied Health Staff		35,817	35,043	42,697	44,776	46,292
Support Staff		6,027	6,891	7,303	7,546	7,791
Management / Administration Staff		34,457	39,496	42,156	39,407	38,667
Total Personnel Costs		257,114	283,781	304,301	312,802	322,360
<i>Clinical Costs</i>						
Outsourced Services		16,004	21,396	10,957	7,562	6,941
Clinical Supplies		71,059	78,043	81,150	82,342	86,909
Total Clinical Costs		87,063	99,439	92,107	89,904	93,849
<i>Other Operating Costs</i>						
Hotel Services, Laundry & Cleaning Facilities		9,184	11,423	11,359	12,150	12,554
Transport		10,724	13,536	13,285	13,843	14,344
IT Systems & Telecommunications		2,482	3,413	3,074	3,217	3,320
Interest & Financing Charges		13,824	18,190	20,028	20,698	21,438
Depreciation		13,825	17,093	10,239	9,215	9,215
Professional Fees & Expenses		17,269	17,018	14,298	18,813	16,519
Other Operating Expenses		2,661	2,436	430	1,970	1,970
Democracy		10,425	7,393	7,489	12,302	11,028
Internal Allocations		387	455	444	444	444
		(2,425)	(2,606)	(2,503)	(2,513)	(2,513)
Total Other Operating Costs		78,356	88,349	78,143	90,139	88,318
NRH Transition Contingency				5,000	-	-
TOTAL COSTS		422,533	471,570	479,551	492,845	504,527
OPERATING SURPLUS / (DEFICIT)		(8,806)	(36,846)	(29,826)	(20,920)	(9,005)
Asset Disposals		18	(824)	16,250	-	-
NET SURPLUS / (DEFICIT)		(8,788)	(37,670)	(13,576)	(20,920)	(9,005)
NRH Costs						
Interest & Financing Charges				14,368	21,442	21,442
Depreciation		2,500	2,808	14,472	21,301	24,587
Change Management		2,300	2,873	7,500	2,800	2,800
Total Other Operating Costs		4,800	5,681	36,341	45,543	48,829
OPERATING SURPLUS / (DEFICIT) NRH		(4,800)	(5,681)	(36,341)	(45,543)	(48,829)
NET SURPLUS / (DEFICIT) Including NRH Costs		(13,588)	(43,351)	(49,917)	(66,463)	(57,834)

Capital & Coast Governance & Funding Administration					
Statement of Financial Performance					
Budget for the Three Years Ending 30 June 2011					
	Actual 2006/07 (000s)	Forecast 2007/08 (000s)	Plan 2008/09 (000s)	Plan 2009/10 (000s)	Plan 2010/11 (000s)
REVENUE					
Funder Arm Sourced	5,501	6,647	5,888	5,888	5,888
TOTAL REVENUE	5,501	6,647	5,888	5,888	5,888
OPERATING COSTS					
<i>Personnel Costs</i>					
Medical Staff	-	-	-	-	-
Nursing Staff	(1)	7	-	-	-
Allied Health Staff	-	-	-	-	-
Support Staff	-	-	-	-	-
Management / Administration Staff	2,234	2,846	2,723	2,703	2,639
Total Personnel Costs	2,234	2,853	2,723	2,703	2,639
<i>Clinical Costs</i>					
Outsourced Services	745	906	790	790	790
Clinical Supplies	1	3	-	-	-
Total Clinical Costs	746	908	790	790	790
<i>Other Operating Costs</i>					
Hotel Services, Laundry & Cleaning	20	22	9	9	9
Facilities	14	113	157	157	157
Transport	111	95	93	93	93
IT Systems & Telecommunications	38	40	10	10	10
Interest & Financing Charges	-	-	-	-	-
Depreciation	-	6	5	3	2
Professional Fees & Expenses	312	924	537	537	537
Other Operating Expenses	147	129	121	123	124
Democracy	(17)	206	150	150	150
Internal Allocations	2,425	2,606	2,513	2,513	2,513
Total Other Operating Costs	3,050	4,140	3,594	3,594	3,594
TOTAL COSTS	6,030	7,901	7,108	7,088	7,024
NET SURPLUS / (DEFICIT)	(529)	(1,255)	(1,220)	(1,199)	(1,136)

Capital & Coast Funds					
Statement of Financial Performance					
Budget for the Three Years Ending 30 June 2011					
	Actual 2006/07 (000s)	Forecast 2007/08 (000s)	Plan 2008/09 (000s)	Plan 2009/10 (000s)	Plan 2010/11 (000s)
REVENUE					
Government and Crown Agency Sourced	609,565	667,021	683,773	710,652	739,650
TOTAL REVENUE	609,565	667,021	683,773	710,652	739,650
OPERATING COSTS					
<i>Other Operating Costs</i>					
Provider Payments	605,524	659,050	682,122	707,500	736,281
Internal Allocations	2,944	3,947	3,227	3,375	3,375
Total Other Operating Costs	608,468	662,997	685,349	710,875	739,656
TOTAL COSTS	608,468	662,997	685,349	710,875	739,656
NET SURPLUS / (DEFICIT)	1,097	4,024	(1,575)	(223)	(6)

5.4.1 Forecast Statements of Financial Position

Capital & Coast DHB					
Statement of Financial Position					
Budget for the Three Years Ending 30 June 2011					
		Actual	Forecast	Plan	Plan
		2006/07	2007/08	2008/09	2009/10
		(000s)	(000s)	(000s)	(000s)
					Plan
					2010/11
					(000s)
Non Current Assets					
	Land	30,850	30,850	25,300	25,300
	Buildings	138,067	137,089	377,366	383,962
	Clinical Equipment	43,134	43,740	79,681	71,090
	Information Technology	586	1,041	589	151
	Work in Progress (Incl NRH)	153,693	235,880	7,499	(4,079)
	Other Fixed Assets	1,853	2,187	5,405	7,655
	Investment in Associates	6,862	20,669	20,669	20,669
	Total Non Current Assets	375,044	471,457	516,509	504,748
					483,471
Current Assets					
	Cash	13	14	13	13
	Trust/Investments	5,183	5,599	5,800	13,008
	Prepayments	254	633	400	450
	Accounts Receivable	21,328	19,452	11,000	11,000
	Inventories	5,632	5,864	6,000	6,000
	Equity Receivable	86,000	22,482	-	-
	Other Current Assets	21,888	37,791	50,000	50,000
	Total Current Assets	140,297	91,834	73,213	80,471
					103,899
Current Liabilities					
	Bank	1,553	18,859	17,515	-
	Payables & Accruals	85,723	103,885	96,494	92,497
	GST & Tax Provisions	7,523	5,554	5,352	5,862
	Current Private Sector Debt	74	-	-	-
	Current Crown Debt - CHFA	62,000	28,000	-	-
	Capital Charge Payable	2,069	893	500	500
	Total Current Liabilities	158,942	157,191	119,861	98,859
					180,509
Net Current Assets		(18,645)	(65,357)	(46,648)	(18,388)
					(76,610)
NET FUNDS EMPLOYED		356,399	406,101	469,861	486,360
					406,861
Term Liabilities					
	Non Current Private Sector Debt	-	-	12,000	28,000
	Non Current Crown Debt - CHFA	217,400	283,000	311,000	311,000
	Restricted & Trust Funds Liability	170	175	165	165
	Non Current Provisions & Payables Personnel	4,402	5,422	4,750	5,250
	Total Term Liabilities	221,972	288,597	327,915	344,415
					264,916
Net Assets		134,426	117,503	141,946	141,945
					141,945
General Funds					
	Crown Equity	208,133	231,407	310,753	378,638
	Revaluation Reserve	33,010	33,010	30,819	30,819
Retained Earnings					
	Retained Earnings - Funds	4,726	8,750	7,175	6,952
	Retained Earnings - GFA	(2,349)	(3,598)	(4,818)	(6,017)
	Retained Earnings - Provider	(109,094)	(152,066)	(201,983)	(268,446)
	Total Retained earnings	(106,716)	(146,914)	(199,626)	(267,511)
					(326,488)
Total General Funds		134,426	117,503	141,946	141,946
					141,945
NET FUNDS EMPLOYED		356,399	406,101	469,861	486,361
					406,861

5.4.2 Forecast Statement of Cash Flows

Capital & Coast DHB					
Statement of Cashflows					
Budget for the Three Years Ending 30 June 2011					
	Actual	Forecast	Plan	Plan	Plan
	2006/07	2007/08	2008/09	2009/10	2010/11
	(000s)	(000s)	(000s)	(000s)	(000s)
Operating Activities					
Government & Crown Agency Revenue Received	638,269	745,763	732,927	754,439	785,038
Interest Received	1,085	1,089	834	862	890
All Other Revenue Received	21,161	21,465	19,475	24,136	29,635
Total Receipts	660,515	768,316	753,236	779,437	815,563
Payments for Personnel	(250,339)	(279,854)	(316,565)	(317,505)	(326,999)
Payments for Supplies	(142,983)	(152,387)	(163,631)	(143,741)	(143,399)
Interest Paid	(6,330)	(8,536)	(15,791)	(21,405)	(21,405)
Capital Charge	(3,541)	(7,441)	(9,210)	(9,209)	(9,209)
GST (net)	(705)	(2,098)	(18,000)	(18,000)	(18,000)
Other Payments	(250,666)	(274,490)	(292,287)	(301,846)	(314,159)
Total Payments	(654,564)	(724,805)	(815,485)	(811,707)	(833,172)
Net Cashflow from Operating	5,951	43,511	(62,249)	(32,270)	(17,608)
Investing Activities					
Sale of Fixed Assets	10	-	24,972	-	(0)
Decrease in Investments & Trust Funds, Int Rec'd	1,085	1,089	834	862	890
Total Receipts	1,095	1,089	25,806	862	889
Land, Buildings & Plant	(80,275)	(95,374)	(24,692)	(3,037)	(4,441)
Clinical Equipment	(12,075)	(6,449)	(23,265)	(21,760)	(14,089)
Other Equipment	(3,974)	(191)	(18,811)	(3,057)	(1,449)
Informations Technology	(1,079)	(14,346)	(5,792)	-	-
Total Capital Expenditure	(97,403)	(116,361)	(72,558)	(27,854)	(19,979)
Net Cashflow from Investing	(96,308)	(115,272)	(46,752)	(26,992)	(19,090)
Financing Activities					
Equity Injections	(3,484)	(3,670)	45,633	0	(0)
Deficit Support		26,600	52,711	67,885	58,976
Current Private Sector Debt	(53,074)	(74)	12,000	16,000	-
Current CHFA	162,400	31,600	-	-	-
Equity Receivable	-	-	-	-	-
Non Current Private Sector					
Total Repaid / (Borrowed) Debt	105,843	54,456	110,343	83,883	58,976
Net Cashflow from Financing Activities	105,843	54,456	110,343	83,885	58,976
Net Cashflow	15,485	(17,305)	1,343	24,623	22,277
Plus: Opening Cash	(17,025)	(1,540)	(18,845)	(17,502)	7,121
Closing Cash	(1,540)	(18,845)	(17,503)	7,121	29,399
Closing Cash comprises:					
Balance Sheet Cash	13	14	13	7,121	29,399
Balance Sheet Operating Overdraft	(1,553)	(18,859)	(17,515)	-	-
Total Cashflow Cash (Closing)	(1,540)	(18,845)	(17,502)	7,121	29,399

5.4.3 Statements of Movements of Equity

Capital & Coast DHB					
Statement of Movement in Equity					
Budget for the Three Years Ending 30 June 2011					
	Actual 2006/07 (000s)	Forecast 2007/08 (000s)	Plan 2008/09 (000s)	Plan 2009/10 (000s)	Plan 2010/11 (000s)
Total Equity at beginning of period	151,114	134,426	117,503	141,946	141,946
Net Results for the period - GFA	(529)	(1,249)	(1,220)	(1,199)	(1,136)
Net Results for the period - Provider	(13,587)	(42,815)	(49,917)	(56,463)	(37,834)
Net Results for the period - Funds	1,097	4,024	(1,575)	(223)	(6)
Equity injections	(3,484)	23,117	79,346	57,885	38,976
Revaluation of Fixed Assets	(185)	0	(2,191)	-	-
Total Equity at end of the period	134,426	117,503	141,946	141,946	141,946

5.4.4 Statement of Revenue and Expenses by Output Class

Capital & Coast DHB					
Statement of Objectives and service performance					
Budget for the Year Ending 30 June 2009					
Statement of revenue and expenses by output class					
	Funding (000s)	Goverance & funding (000s)	DHB Hospital Provider (000s)	Elimination (000s)	Total DHB (000s)
REVENUE					
Crown	683,773	5,888	433,043	(393,210)	729,494
Other			16,682		16,682
Total Revenue	683,773	5,888	449,725	(393,210)	746,177
EXPENDITURE					
Personnel		2,723	304,301		307,025
Depreciation		5	28,770		28,776
Capital charge			9,210		9,210
Other	685,349	4,380	157,360	(393,210)	453,879
Total Expenditure	685,349	7,108	499,642	(393,210)	798,889
Net Surplus/(Deficit)	(1,575)	(1,220)	(49,917)	-	(52,712)
Reconciliation to retained earnings					
Opening retained earnings	8,750	(3,598)	(152,066)	0	(146,914)
Less deficit for the year	(1,575)	(1,220)	(49,917)	-	(52,712)
Closing retained earnings	10,326	(4,818)	(201,983)	-	(199,626)

6 Measuring our success

6.1 Key performance indicators

Indicators of DHB performance	Reporting Expectations/Targets																													
<p>HKO-01</p> <p>Local iwi/ Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain</p> <p>Dimension: Consultation and Collaboration</p> <p>Required Q2 & Q4</p>	<ol style="list-style-type: none"> 1. 100 % of PHOs with MHPs have been agreed by the DHB. 2. 100% of board members that have undertaken TOW training. 3. Visible engagement with local iwi/ Māori. 4. Planned frequent engagement is undertaken. 5. DHBs name the PHOs that implement their MHPs. 6. % of board members have undertaken TOW training. 7. Q2: Progress on the implementation of the MHP. Q4: At least 2 key milestones have been achieved for 08/09. 																													
<p>HKO-02</p> <p>Development of Māori health workforce and Māori health providers.</p> <p>Dimension: Ownership</p> <p>Required Q2 & Q4</p>	<table border="1"> <thead> <tr> <th>Baseline 31 Dec 2007</th> <th>FTE Māori #</th> <th>FTE non-Māori #</th> <th>FTE Total#</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Management</td> <td>4</td> <td>39.85</td> <td>43.85</td> <td>9.12</td> </tr> <tr> <td>Administration</td> <td>62.07</td> <td>603.73</td> <td>665.8</td> <td>9.32</td> </tr> <tr> <td>Clinical</td> <td>105.4</td> <td>2,379.0</td> <td>2484.4</td> <td>4.24</td> </tr> <tr> <td>Other</td> <td>11.04</td> <td>138.79</td> <td>149.83</td> <td>7.37</td> </tr> </tbody> </table>	Baseline 31 Dec 2007	FTE Māori #	FTE non-Māori #	FTE Total#	%	Management	4	39.85	43.85	9.12	Administration	62.07	603.73	665.8	9.32	Clinical	105.4	2,379.0	2484.4	4.24	Other	11.04	138.79	149.83	7.37				
Baseline 31 Dec 2007	FTE Māori #	FTE non-Māori #	FTE Total#	%																										
Management	4	39.85	43.85	9.12																										
Administration	62.07	603.73	665.8	9.32																										
Clinical	105.4	2,379.0	2484.4	4.24																										
Other	11.04	138.79	149.83	7.37																										
<p>Provide a copy of the DHB (regional) Māori health workforce plan and timetable to complete plan.</p> <p>Report on achievements based on deliverables in the DHB (regional) Plan</p>																														
<p>HKO-03</p> <p>Improving mainstream effectiveness.</p> <p>Dimension: Services</p> <p>Required Q2 & Q4</p>	<ol style="list-style-type: none"> 1. A report on more than one review of "pathways of care" in the past 12 months. 2. Report on an example of actions taken to share lessons identified in the reviews 																													

<p>HKO-04</p> <p>DHBs will set targets to increase funding for Māori Health and disability initiatives.</p> <p>Dimension: Ownership</p> <p>Required Q4</p>	<p>To report expenditure on:</p> <p>Māori Health Providers</p> <p>Specific Māori Services</p> <p>Iwi/ Māori led PHOs</p> <p>A comparison between expenditure for above measures</p>																									
<p>PAC-01</p> <p>Pacific people are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain.</p> <p>Dimension: Ownership</p> <p>Required Q2 & Q4</p>	<p>1. % of the DHB strategies and plans on which Pacific communities or representatives consulted.</p> <p>2.% of DHB working groups and steering groups that have included representation from Pacific communities.</p> <p>3.</p> <table border="1" data-bbox="491 846 1348 1261"> <thead> <tr> <th>Baseline as at 31 Dec 2007</th> <th>FTEs Pacific #</th> <th>FTE non-Pacific #</th> <th>FTEs Total #</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Management</td> <td>4.0</td> <td>40.9</td> <td>44.9</td> <td>8.9</td> </tr> <tr> <td>Administration</td> <td>38.2</td> <td>631.8</td> <td>669.9</td> <td>5.7</td> </tr> <tr> <td>Clinical</td> <td>135.1</td> <td>2,367.4</td> <td>2,502.5</td> <td>5.4</td> </tr> <tr> <td>Other</td> <td>24.0</td> <td>103.1</td> <td>127.1</td> <td>18.9</td> </tr> </tbody> </table>	Baseline as at 31 Dec 2007	FTEs Pacific #	FTE non-Pacific #	FTEs Total #	%	Management	4.0	40.9	44.9	8.9	Administration	38.2	631.8	669.9	5.7	Clinical	135.1	2,367.4	2,502.5	5.4	Other	24.0	103.1	127.1	18.9
Baseline as at 31 Dec 2007	FTEs Pacific #	FTE non-Pacific #	FTEs Total #	%																						
Management	4.0	40.9	44.9	8.9																						
Administration	38.2	631.8	669.9	5.7																						
Clinical	135.1	2,367.4	2,502.5	5.4																						
Other	24.0	103.1	127.1	18.9																						
<p>POP-01</p> <p>Risk reduction-Smoking</p> <p>Dimension: Improving health outcomes</p> <p>Required Q3</p>	<p>The percentage of enrolled persons >14 years (by ethnicity) with smoking status on their record. An achieved rating is obtained by being able to measure this indicator.</p>																									
<p>POP-02</p> <p>Cardiac rehabilitation programme</p> <p>Dimension: Improving health outcomes</p> <p>Required Q3</p>	<p>Percentage of people (by ethnicity) who have suffered Acute Coronary Syndrome who were discharged from hospital, that attend a cardiac rehab programme.</p> <p>2006/07 Actual 58%</p> <p>2007/08 no target set</p> <p>Ministry of Health target 95%</p>																									

<p>POP-03</p> <p>Organised stroke service</p> <p>Dimension: Improving health outcomes</p> <p>Required Q3</p>	<p>The number of people who have suffered a stroke event, who have been admitted to organised stroke services and remain there for their entire hospital stay</p> <p>1. % where patient admitted to stroke service 100%</p> <p>2. % where patient in Stroke service for full length of stay 50%</p> <p>3. % where patient is discharged alive from stroke service 90.4%</p>												
<p>POP-04</p> <p>Mean DMFT score at year eight.</p> <p>Dimension: Improving health outcomes</p> <p>Required Q3</p>	<p>Data by ethnic group, fluoridation status, mean components of DMF.</p> <table border="1" data-bbox="475 589 1342 846"> <thead> <tr> <th></th> <th>Baseline Dec 2007</th> <th>Target 08/09</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>1.07</td> <td>1.0</td> </tr> <tr> <td>Pacific</td> <td>1.19</td> <td>0.9</td> </tr> <tr> <td>Other</td> <td>0.6</td> <td>0.68</td> </tr> </tbody> </table>		Baseline Dec 2007	Target 08/09	Māori	1.07	1.0	Pacific	1.19	0.9	Other	0.6	0.68
	Baseline Dec 2007	Target 08/09											
Māori	1.07	1.0											
Pacific	1.19	0.9											
Other	0.6	0.68											
<p>POP-05</p> <p>Percent of children caries free at age five years.</p> <p>Dimension: Improving health outcomes</p> <p>Required Q3</p>	<p>Data by ethnic group, fluoridation status.</p> <table border="1" data-bbox="475 940 1321 1198"> <thead> <tr> <th></th> <th>Baseline Dec 2007</th> <th>Target 08/09</th> </tr> </thead> <tbody> <tr> <td>Māori</td> <td>39.6</td> <td>50.0</td> </tr> <tr> <td>Pacific</td> <td>29.2</td> <td>42.0</td> </tr> <tr> <td>Other</td> <td>67.0</td> <td>75.0</td> </tr> </tbody> </table>		Baseline Dec 2007	Target 08/09	Māori	39.6	50.0	Pacific	29.2	42.0	Other	67.0	75.0
	Baseline Dec 2007	Target 08/09											
Māori	39.6	50.0											
Pacific	29.2	42.0											
Other	67.0	75.0											

POP-06 Improving the health status of people with severe mental illness. The % of people domiciled in the DHB region, seen per year, rolling every 3 months, being reported for: Dimension: Services Required all Qs			Actual 2006/07	Forecast 2007/08	Target 08/09
	Ages 0-19	Māori	1.9	2.0	2.4
		Pacific	0.9	0.9	1.5
		Other	2.0	2.2	2.4
		Total	1.9	2.0	2.3
	Ages 20-64	Māori	3.5	3.9	3.9
		Pacific	1.6	1.7	2.1
		Other	2.0	2.2	2.3
		Total	2.1	2.3	2.5
	Ages 65+	Māori	1.4	1.6	2.0
		Pacific	0.9	1.0	1.4
		Other	0.9	1.1	1.3
		Total	1.0	1.1	1.4
	All ages	Māori	2.8	3.0	3.2
		Pacific	1.3	1.4	1.9
		Other	1.8	2.0	2.2
		Total	1.9	2.1	2.3
<p>Note: The change in Access Target percentages between 2007/08 and 2008/09 results from the change in methodology used to derive the numbers and percentages. We have reforecast the Access targets using the 2006 Census Population data (previous percentages were based on the 2001 Census population data).</p> <p>This means there will be an additional 2,210 clients utilising Mental Health services - total of 8,810 by 2011/12 or 3% of the 2006 Census population target. Adults 20-64 will increase to 2.5% in 2008/09 and to 3.1% by 2011/12.</p> <p>This reforecast indicates a more realistic realignment both in ethnicity and age groups for the overall target of 3% by 2011/12.</p>					
Exception reporting	Provide evidence and an analysis of : Clients domiciled in DHB, seen by another DHBs services; DHB mental health team performance Referral sources: are referrals unevenly distributed by sector in DHB.				

<p>POP-07</p> <p>Alcohol and other drug service waiting times.</p> <p>Dimension: Services</p> <p>Required all Q's</p>	<p>Wait times for Inpatient Detoxification, Specialist Prescribing, Structured Counselling. Day Programmes & Residential Rehabilitation by Māori and Other ethnicities</p>		
<p>POP-08</p> <p>Immunisation</p> <p>Dimension: Improving health services</p> <p>Required all Q's</p>	<p>% of children fully immunised by 6 months</p>	<p>Forecast 07/08</p>	<p>Target 08/09</p>
	<p>Māori</p>	<p>55%</p>	<p>57%</p>
	<p>Pacific</p>	<p>57%</p>	<p>60%</p>
	<p>DHB Total</p>	<p>69%</p>	<p>71%</p>
	<p>% of children fully immunised by 12 months</p>		
	<p>Māori</p>	<p>82%</p>	<p>85%</p>
	<p>Pacific</p>	<p>87%</p>	<p>89%</p>
	<p>DHB Total</p>	<p>86%</p>	<p>88%</p>
	<p>% of children fully immunised by 18 months</p>		
	<p>Māori</p>	<p>59%</p>	<p>60%</p>
	<p>Pacific</p>	<p>65%</p>	<p>66%</p>
	<p>DHB Total</p>	<p>70%</p>	<p>72%</p>
	<p>POP-10</p> <p>Radiation oncology and chemotherapy treatment waiting times.</p> <p>Dimension: Improving health outcomes</p> <p>Required monthly & Q4</p>	<p>1. Supply of radiation oncology wait times</p> <p>a. wait from first specialist assessment to assessment</p> <p>b. the time between receipt of referral and start of treatment</p> <p>2. Supply of chemotherapy wait times</p> <p>a. Number waiting for first specialist assessment</p> <p>b. Time between first specialist assessment and treatment</p> <p>3. A report confirming that CCDHB has undertaken a data quality audit from Cancer Centre DHBs.</p>	

<p>POP-11</p> <p>Family violence prevention.</p> <p>Dimension: Improving health outcomes</p> <p>Required Q2 & Q4</p>	<p>Assess the progress made towards taking a systemic approach towards the identification and intervention of child and partner abuse as measured by the AUT hospital responsiveness to family violence, child and partner abuse audit.</p> <p>Target 140/200 or above</p>
<p>QUA-01</p> <p>Quality systems.</p> <p>Required Q3</p>	<p>The DHB provider arm organisational demonstrates an organisation wide commitment to quality improvement and effective clinical audit reporting. Goals:</p> <ol style="list-style-type: none"> 1. More effective service outcomes for Māori 2. Shared vision towards safe and quality care which includes Māori aspirations 3. People are encouraged to participate in the planning, delivery, and assessment of services with active Māori participation, 4. Widespread awareness, understanding and commitment to a quality improvement culture 5. Evolutionary redesign of systems of care to support delivery of quality systems 6. Unexpected adverse outcomes are managed in an open supportive manner, 7. Effective and open communication, coordination and integration of service activities, of service activities that recognise the value of team work 8. Supportive and motivating environment that provides the workforce with appropriate tools 9. Useful knowledge and information including Māori satisfaction information and clinical evidence, is readily available and shared, 10. Regulatory protections that assure safe care are in place to support people and service providers 11. More effective outcomes for Pacific peoples, to address the current situation in New Zealand where Pacific peoples have generally worse health than that of the total population.
<p>QUA-02</p> <p>Results for people with enduring severe mental illness.</p> <p>Dimension: Improving health outcomes</p> <p>Required Q 2</p>	<ol style="list-style-type: none"> 1. The number and percentage of long-term clients in full time work (>30 hours). 2. The number and percentage of long-term clients with no paid work. 3. The number and percentage of long-term clients undertaking some form of education eg University, Polytechnic. <p>Baseline Q2 2007/08</p>

<p>QUA-03</p> <p>Improving the quality of data provided to National Collections Systems (NCS).</p> <p>Dimension: Ownership</p> <p>Required all Q's</p>	<p>1. % of NHI duplications. (1-2%) Baseline Q2 2007/08 = 4.67%</p> <p>2. % of non-specific NHI ethnicity. (3-5%) Baseline Q2 2007/08 = 4.49%</p> <p>3. % of non-specific NMDS ethnicity (1-2%) Baseline Q2 2007/08 = 2.21%</p> <p>4. % of standard vs specific descriptors in the NMDS. (2-3%) – new</p> <p>5. % of events with an error Diagnostic Related Group. (4-7%) – achieved</p> <p>6. % of DHB-sourced records able to be successfully loaded into that National Collection per DHB per quarter (95-98%) Baseline Q2 2007/08 = 0%</p>				
<p>QUA-04</p> <p>Mental health provider audit.</p> <p>(Expectation that 30% of providers are audited)</p> <p>Ownership</p> <p>Required Q 3</p>		<p>No.</p>	<p>Routine Audit</p>	<p>Issues based Audit</p>	<p>%</p>
		<p>1</p>			
		<p>25</p>			
		<p>6</p>			
		<p>3</p>			
		<p>35</p>			
<p>RIS-01</p> <p>Service coverage.</p> <p>Dimension: Services</p> <p>Required all Q's</p>	<p>Ensure that service coverage is delivered for our population. Report progress achieved during the Quarter towards resolution of gaps in service coverage identified in the DAP and any other gaps identified through:</p> <ol style="list-style-type: none"> 1. Analysis of explanatory indicators. 2. Media reporting. 3. Risk reporting 4. Formal audit outcomes. 5. Complaints mechanisms. 6. Sector Intelligence. 				
<p>SER-01</p> <p>Accessible and appropriate services in PHOs.</p> <p>Dimension: Services</p> <p>Required all Q's</p>	<p>C&C DHB target: ≥ 1.00</p> <p>The age standardised rate of GP consultations per high need person compared with the consultations per non high need person.</p> <p>Baseline Q2 2007/08</p> <p>GP consultations 1.02</p> <p>Nurse consultations 1.17</p>				

SER-02 Care plus enrolled population. Dimension: Services Required all Q's		Forecast 07/08	Target 08/09
	Māori	60%	67%
	Pacific	58%	67%
	Other	62%	70%
SER-03 The proportion of laboratory test and pharmaceutical transactions with a valid National Health Index. Dimension: Ownership Required all Q's		Baseline Q2 2007/08	Target
	Pharmaceuticals	95.4	>95%
	Laboratory tests	92.5	>95%
Note: Labs data includes Hutt and C&C DHB			
SER-04 Continuous quality improvement – elective services. Dimension: Services Required Q2 & Q4	1. Standardised Discharge Ratios (SDRs) for 11 elective procedures (excluding hip, Knee and cataracts covered by separate initiatives). 2. Report for any SDR with a rate of less than 0.95, what analysis the DHB has done to review the appropriateness of its rate. Report the reason that the DHB considers the rate to be appropriate for its population, or an action plan as to how it will address its relative under delivery of that procedure.		
SER-07 Low or reduced cost access to first level primary care services Dimension: Services Required all Q's	1. 100% of fee increases that should be referred are referred to the regional fee review committees, and they comply with recommendations. 2. 100% of practices ensure access to fee information.		

6.2 Additional reporting requirements

<p>Report</p> <p>Reducing inequalities achievements (self assessment)</p> <p>Dimension: Improving health outcomes</p> <p>Required Q2 & Q4</p>	<p>Identify one or two examples of initiatives or services that are working well for their populations with regards to reducing inequalities, and tell the Ministry about them. Self evaluation reports should be brief, providing a high level summary of DHB activity (maximum two pages).</p> <p>Use the self evaluation tool located on the National Service Framework Library website to guide and structure their response. Alternatively, the DHB may wish to use other self assessment tools that it considers appropriate.</p>
<p>Report</p> <p>Oral health</p> <p>Dimension: Services</p> <p>Required Q3 (for the period 1 January to 31 December 2008)</p>	<p>1. Number of preschool children enrolled in DHB funded dental services</p> <p>2. Number of preschool and primary school aged children enrolled in DHB funded dental services who did not receive an annual examination</p> <p>The data must be broken down by ethnic group (Māori, Pacific, Other) and school decile of the clinic:</p> <p>3. For 2008/09 DHBs are expected to report on progress achieved in relation to oral health services (reporting template to be developed) specifically focused on:</p> <p>progress in re-orientating child and adolescent oral health services</p> <p>oral health initiatives not related to child and adolescent service improvements</p> <p>oral health workforce development.</p>
<p>Report</p> <p>Delivery of DAP in key priority areas – confirmation and exception report</p> <p>Dimension: Ownership</p> <p>Required Q2 & Q4</p>	<p>Report confirming, by priority/health target area, that all the key services, actions, programmes or initiatives identified in their DAP linked to the progression of health sector targets and ministerial priority areas, are progressing according to plan (quarter two and four and quarter one and three) and have been delivered</p>
<p>Dimension: Ownership</p> <p>Required Q1 & Q3</p>	<p>Report on Other strategic priorities:</p> <p>Regional mental health plans</p> <p>District After Hours Strategic Plan</p> <p>Information Systems Strategic Plan (ISSP)</p>

<p>Report</p> <p>DHB self evaluation – provider arm efficiency</p> <p>Dimension: Ownership</p> <p>Required all Qs</p>	<p>Provide a high level summary report (maximum one page) on the results of a self assessment in one of the areas of focus identified below, including how findings will impact on 2009/10 planning decisions, in terms of targeted and measurable efficiency gains.</p> <ul style="list-style-type: none"> • Access to diagnostics • Day surgery / length of stay • Patient flow and discharge planning • Unnecessary outpatient attendance/follow-up • Acute demand management • Primary secondary interface and referral management • Theatre utilisation • FTE configuration / productivity • Capacity planning (potential / actual) Procurement • Management of Price Volume schedule • Possible tools to support self assessment: • Process / metric benchmarking • Service/system review/evaluation • Audit • Service planning tools (e.g. HEAT) • Shared learning forums • Cost benefit analysis
<p>Report</p> <p>Delivery of Personal Health Services and Mental Health Service volumes</p> <p>Dimension: Ownership</p> <p>Required all Qs</p>	<p>Each DHB must monitor, evaluate and report on the delivery of Personal Health Services and Mental Health Services set out in its DAP Price Volume Schedule (PVS).</p>
<p>Report</p> <p>DHB confirmation and exception reports – risk management</p> <p>Dimension: Ownership</p> <p>Required all Q2 & Q4</p>	<p>DHBs are to report confirming:</p> <ul style="list-style-type: none"> • the DHB uses a formal risk management and reporting system to manage DHB risks and report them to its Board • the system meets current Australia / New Zealand Standard requirements⁵ relating to risk management • how frequently the DHB submits formal risk report updates to its Board (or a Board approved sub-committee).

Appendix 1 Our Local Population

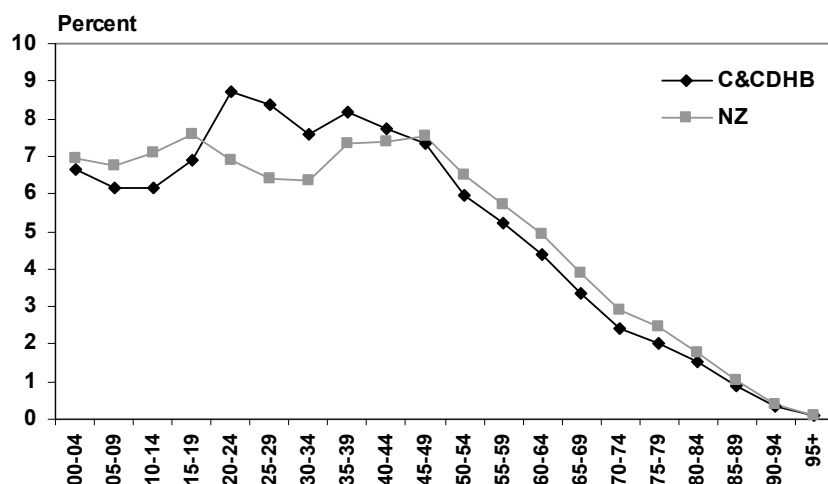
The most recent census was conducted in March 2006, giving C&C DHB an estimated resident population of 283,900 at June 2008. Our population is predicted to increase by 3% over the next three years, which is comparable with national growth.

Ethnicity

Approximately 11% of our population identifies as Māori (compared with 15% in the national population) and 8% as Pacific (6% nationally).

Age

Figure 1: C&C DHB vs NZ age structure, estimated resident population June 2008



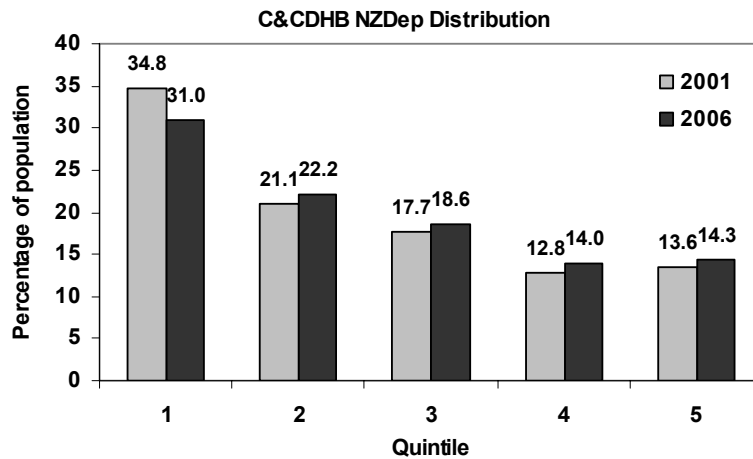
A feature of our population is the large proportion of younger adults (aged 20 to 44). C&C DHB has relatively fewer children and fewer adults aged 50 and over. However, our Māori and Pacific populations have younger age structures with a greater proportion of children and fewer elderly.

As life expectancies increase and birth rates slow, the population is ageing. C&C DHB's population aged 65 and over is predicted to increase by 27% from 2008 to 2016 (8,230 more people).

Socio-economic deprivation

The C&C DHB population is one of the least deprived in the country, with 31% living in quintile 1 (the least deprived areas). The New Zealand Deprivation Index (NZDep) is calculated after each census. The NZDep2006 shows that C&C DHB is slightly more deprived than in 2001, with fewer people living in quintile 1 and an increase in those living in more deprived areas.

Figure 2: Change in NZDep distribution 2001 to 2006, C&C DHB



Geographical areas

The Capital & Coast district is made up of three Territorial Local Authorities (TLAs): Wellington City, Porirua City, and Kapiti Coast south of Otaki. 68% of the population lives in Wellington, 18% in Porirua and 14% in Kapiti. The three TLAs differ significantly in terms of age and ethnic composition, and socio-economic deprivation.

Kapiti has a high proportion of older people and fewer younger adults. The population is dominated by the 'other' (non-Māori non-Pacific) ethnic group. The majority of the Kapiti population lives in quintile 2 to 4 neighbourhoods (77%).

Porirua has a high proportion of children and fewer older people. Approximately 20% of the population is Māori and 25% Pacific. Porirua is a city of contrasts, with highly deprived suburbs (42% of the population live in quintile 5) bordering the least deprived suburbs (30% live in quintile 1).

Wellington has a large population aged between 20 and 44, with fewer children and older people. The population is dominated by the 'other' ethnic group. Overall, Wellington City has an affluent population (34% live in quintile 1) however there are pockets of deprivation in the south-eastern suburbs. These neighbourhoods have low socio-economic status, with high Māori, Pacific and refugee populations.

Health needs and key issues

On average, our people enjoy better health and live longer than people in other districts of New Zealand. This is likely to be largely a result of the overall population being less deprived than the New Zealand population. However, this average picture masks the particular needs of population groups with poor health outcomes.

Our district health needs assessment has identified the following priorities, which support the priorities of various Government strategies:

- Reducing disparities for Māori, Pacific and low income populations.

Nationally the difference in life expectancy for males living in decile 1 compared with males living in decile 10 is approximately 9 and a half years, for females the difference is approximately five and a half years. Māori and Pacific people have poorer health outcomes, and die younger than people of other ethnicities.

Figure 3: NZ life expectancy by NZDep decile, 1998-2000

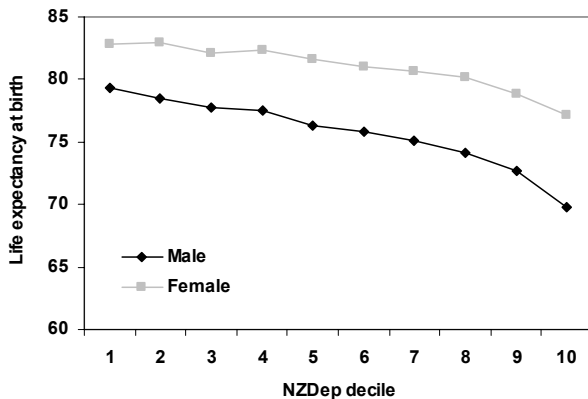
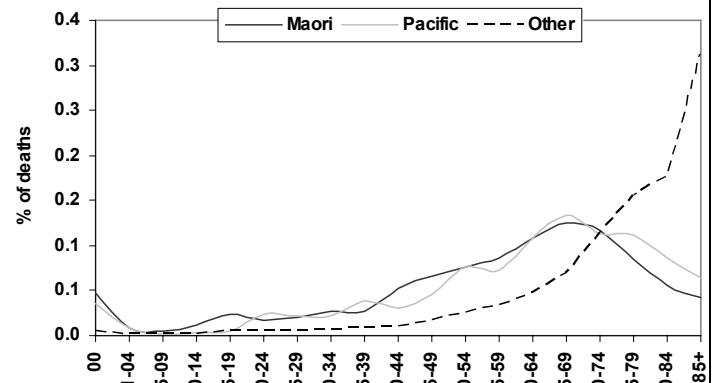


Figure 4: Mortality by ethnicity, C&C DHB 2000-2004



- Addressing health determinants and risk factors as a way to improve population health (including income, employment, housing, smoking, obesity etc).
- Long term conditions including cardiovascular disease, cancer, respiratory conditions and diabetes.

Māori have nearly twice the cardiovascular mortality rate of Other, and Pacific have 1.7 times the rate of Other. Māori have a higher registration rate than Pacific and Other. Māori have a particularly high incidence of lung cancer (nearly three times the rate for Other) and both Māori and Pacific women have a higher incidence of breast cancer.

Figure 5: Cardiovascular disease mortality rates, C&C DHB 2000-2002

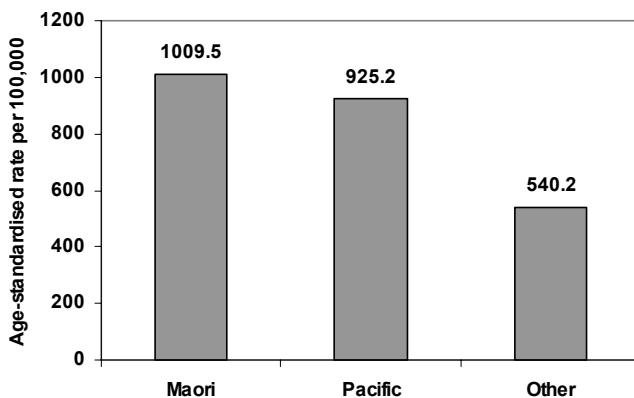
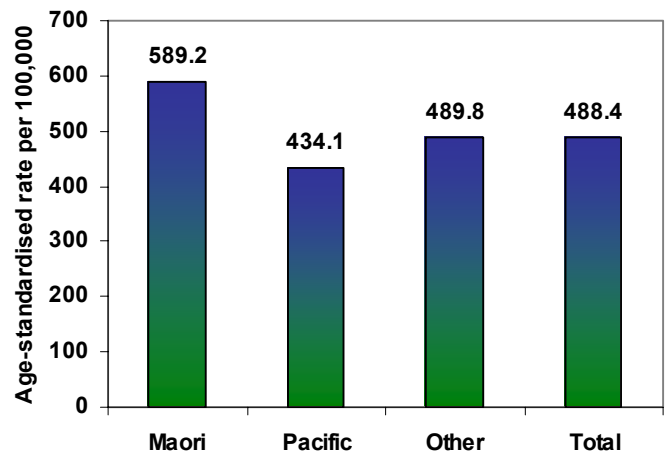


Figure 6: Cancer registration rates, C&C DHB 2000-2003



- Mental health.
- Child and youth health, in particular avoidable hospitalisations, respiratory conditions, oral health, skin infections, sexual health and mental health.

Population preventable hospitalisations are admissions which could be prevented by population level intervention strategies. Ambulatory sensitive hospitalisations are admissions potentially preventable by appropriate primary care (including outpatient services). Conditions include asthma, gastroenteritis, immunisation preventable diseases, rheumatic fever, dental conditions, respiratory infections, ENT infections and cellulitis.

Generally C&C DHB admission rates compare favourably with national rates, however our children have a reasonably high rate of population preventable admissions. Pacific children in particular have poor avoidable hospitalisation rates, when compared with other children in the district and New Zealand.

Figure 7: Population preventable hospitalisations 0-24 yrs

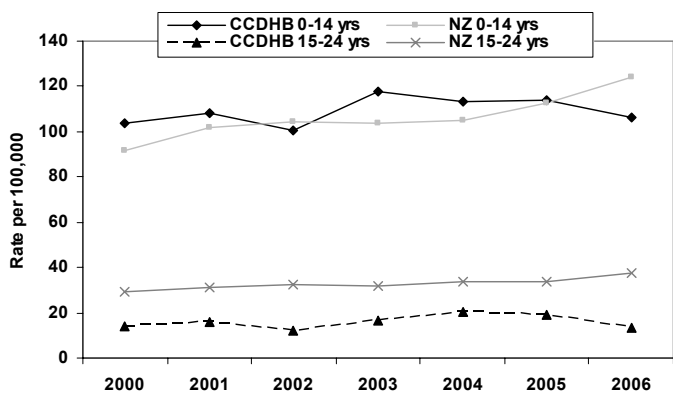
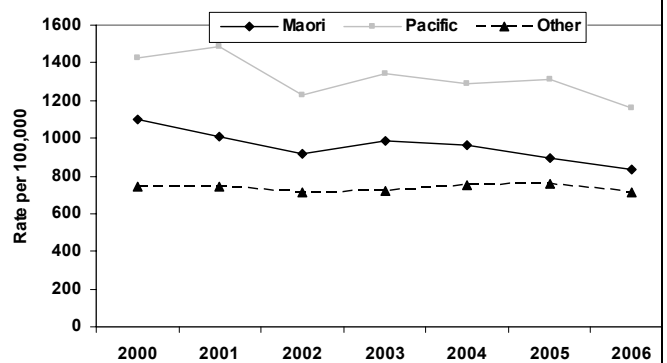


Figure 8: Ambulatory sensitive hospitalisations C&C DHB 0-14 yrs



- **Mental health.**
- **Health of older people.** Older people have the most intensive use of health services and this population is expected to increase significantly in the future. The population aged 65 and over will increase by 27% in the next eight years, and by 2021 will comprise 14% of the district's population.
- **Disability.** Seventeen percent of the New Zealand population is estimated to have a disability. For the population aged 65 and over, 45% are estimated to have a disability.

References

Document	Location
Capital & Coast DHB District Strategic Plan	http://www.ccdhb.org.nz/aboutCCDHB/dsp/dsp.htm
Capital & Coast DHB Health Needs Assessment	http://www.ccdhb.org.nz/aboutCCDHB/reports/HNA_2004.pdf
Te Plan II	http://www.ccdhb.org.nz/Meetings/CPHACpapers/2007_03_15/Maori_HEALTH_STRATEGY_Te_Plan.pdf
Pacific Strategic Action Plan	http://www.ccdhb.org.nz/Meetings/boardpapers/2007_12_05/infoonly/CCDHB_PAP_FINAL_21st_November_07.pdf
Promoting Participation – C&C DHB Framework for implementing the NZ disability strategy 2004-2007	http://www.ccdhb.org.nz/planning/disability/disability.htm
The Journey Forward	http://www.ccdhb.org.nz/aboutCCDHB/reports/webJourneyforwardquestions1.pdf www.ccdhb.org.nz/planning/disability/disability.htm
Long Term Conditions Management Framework	http://www.ccdhb.org.nz/initiatives/LTC/LTC.htm

Glossary

A&D	Alcohol and Drug
A&M	Accident and Medical
ACC	Accident Compensation Corporation
ASH	Ambulatory Sensitive Hospitalisations
CAMHS	Child and Adolescent Mental Health Service
CATT	Crisis Assessment Treatment Team
C&C DHB	Capital & Coast District Health Board
CCMHS	Capital Coast Mental Health Service
CFA	Crown Funding Agreement
CPHAC	Community and Public Health Advisory Board
CQI	Continuous Quality Improvement
CTA	Clinical Training Agency
CWDs	Case weights
CYF	Children, Youth and Family
DHB	District Health Board
DNA	Did not attend
DSS	Disability Support Services
ECE	Early Childhood Centre
ED	Emergency Department
EHR	Electronic Health Record
ESPIs	Elective Services Patient Flow Indicators
FSA	First Specialist Assessment
FST	Financially Sustainable Threshold
FTE	Full Time Equivalent
GP	General practitioner
HEHA	Healthy Eating Healthy Action
HHS	Hospital and Health Services
HIQ	HealthIntelligence
HR	Human Resources
IDF	Inter District Flow
IM	Information Management
IS	Information Systems
ICT	Information Communication Technology
KPI	Key Performance Indicators
LDT	Local Diabetes Team
LMC	Lead Maternity Carer
MHINC	Mental Health Information Network Collection

MOU	Memorandum of Understanding
MPB	Māori Partnership Board
MSD	Ministry of Social Development
NGO	Non-Governmental Organisation
NHI	National Health Index
NIR	National Immunisation Register
NMDS	National Minimum Dataset
NRH	New Regional Hospital
NZDep	New Zealand Deprivation Index
OTS	Opioid Treatment Service
PBFF	Population Based Funding Formula
PHO	Primary Health Organisation
PQAA	Protected Quality Assurance Activity
PRIMHD	Project for the integration of mental health data
PVS	Price Volume Schedule
QIG	Quality Improvement Group
RCSP	Regional Clinical Services Plan
SOI	Statement of Intent
STARS	Short Term Assessment Recovery Service
TAS	Technical Advisory Service
TLA	Territorial Local Authority
YTD	Year to Date