## Item 1: Procedural Business

<table>
<thead>
<tr>
<th>ITEM</th>
<th>ACTION</th>
<th>PRESENTER</th>
<th>MIN</th>
<th>TIME</th>
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<tbody>
<tr>
<td>1.1</td>
<td>Karakia</td>
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<td></td>
<td>9.30am</td>
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<tr>
<td>1.2</td>
<td>Apologies</td>
<td>Record</td>
<td>F Wilde</td>
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<td>1.3</td>
<td>Continuous Disclosure – Conflict of Interest</td>
<td>Accept</td>
<td>F Wilde</td>
<td>2</td>
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<tr>
<td>1.4</td>
<td>Confirmation of Draft Minutes 30 May 2018</td>
<td>Approve</td>
<td>F Wilde</td>
<td>5</td>
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<tr>
<td>1.5</td>
<td>Matters Arising</td>
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<td>1.6</td>
<td>Action List</td>
<td>Note</td>
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<td>1.7</td>
<td>HSC Work Programme</td>
<td>Note</td>
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## Item 2: Presentation

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<thead>
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<tbody>
<tr>
<td>2.1</td>
<td>Investment Planning Approach</td>
<td>R Haggerty</td>
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## Item 3: Decision

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<thead>
<tr>
<th>ITEM</th>
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<tbody>
<tr>
<td>3.1</td>
<td>2018/19 CCDHB Draft Annual Plan excluding Financials</td>
<td>R Haggerty / P Guthrie</td>
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<tr>
<td>3.2</td>
<td>System Level Measures Improvement Plan</td>
<td>R Haggerty / A Balram</td>
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## Item 4: Discussion

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<thead>
<tr>
<th>ITEM</th>
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<tbody>
<tr>
<td>4.1</td>
<td>Even Better Health Care Programme Progress Report</td>
<td>R Haggerty / J Langton</td>
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<tr>
<td>4.2</td>
<td>HHS Bi-Monthly Report</td>
<td>C Lowry</td>
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## Item 5: Information

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<tbody>
<tr>
<td>5.1</td>
<td>Investment Planning to Support Living Well, Dying Well</td>
<td>S Williams</td>
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<tr>
<td>5.2</td>
<td>Investment Planning to Support Healthy Ageing</td>
<td>S Williams</td>
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<tr>
<td>5.3</td>
<td>Older Persons Performance Dashboard</td>
<td>S Williams</td>
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**DATE OF NEXT MEETING** 25 JULY – BOARD ROOM, 11TH FLOOR GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL
# HEALTH SYSTEM COMMITTEE

## COMMUNITY & PUBLIC HEALTH AND HOSPITAL ADVISORY COMMITTEE

## Conflicts & Declarations of Interest Register

**UPDATED AS AT JUNE 2018**

<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
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</thead>
</table>
| Dame Fran Wilde       | • Ambassador Cancer Society Hope Fellowship  
                       • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims  
                       • Chair, Remuneration Authority  
                       • Chair Wellington Lifelines Group  
                       • Chair National Military Heritage Trust  
                       • Deputy Chair, Capital & Coast District Health Board  
                       • Deputy Chair NZ Transport Agency  
                       • Director Museum of NZ Te Papa Tongarewa  
                       • Director Frequency Projects Ltd  
                       • Member Whitireia-Weltec Council |
| Mr Andrew Blair       | • Chair, Hutt Valley District Health Board (from 5 December 2016)  
                       • Advisor to the Board, Forte Health Limited, Christchurch  
                       • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector  
                       • Former Member of the Hawkes Bay District Health Board (2013-2016)  
                       • Former Chair, Cancer Control (2014-2015)  
                       • Former CEO Acuracy Health Group Limited |
| Ms Sue Kedgley        | • Member, Capital & Coast District Health Board  
                       • Member, CCDHB CPHAC/DSAC committee  
                       • Member, Greater Wellington Regional Council  
                       • Member, Consumer New Zealand Board  
                       • Deputy Chair, Consumer New Zealand  
                       • Environment spokesperson and Chair of Environment committee, Wellington Regional Council  
                       • Step son works in middle management of Fletcher Steel |
| Dr Roger Blakeley     | • Member of Capital and Coast District Health Board  
                       • Deputy Chair, Wellington Regional Strategy Committee  
                       • Councillor, Greater Wellington Regional Council  
                       • Director, Port Investments Ltd  
                       • Director, Greater Wellington Rail Ltd  
                       • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council  
                       • Member, Harkness Fellowships Trust Board  
                       • Independent Consultant  
                       • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland |
<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
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</table>
| **Ms ‘Ana Coffey**  
*Member* | • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington  
• Invited to join the Board of the Wesley Community Action Group  
• Member of the Regional Steering Group, Warm Healthy Homes |
| **Ms Eileen Brown**  
*Member* | • Member of Capital & Coast District Health Board  
• Councillor, Porirua City Council  
• Director, Dunstan Lake District Limited  
• Trustee, Whitireia Foundation  
• Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board  
• Father is Acting Director in the Office for Disability Issues, Ministry of Social Development |
| **Ms Sue Driver**  
*Member* | • Community representative, Australian and NZ College of Anaesthetists  
• Board Member of Kaibosh  
• Daughter, Policy Advisor, College of Physicians  
• Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital)  
• Advisor to various NGOs |
| **Mr Fa’amatuainu Tino Pereira**  
*Member* | • Managing Director Niu Vision Group Ltd (NVG)  
• Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG)  
• Chair Pacific Business Trust  
• Chair Pacific Advisory Group (PAG) MSD  
• Chair Central Pacific Group (CPC)  
• Chair, Pasefika Healthy Home Trust  
• Establishment Chair Council of Pacific Collectives  
• Chair, Pacific Panel for Vulnerable Children  
• Member, 3DHB CPHAC/DSAC |
| **Dr Tristram Ingham**  
*Member* | • Senior Research Fellow, University of Otago Wellington  
• Member, Capital & Coast DHB Māori Partnership Board  
• Member, Scientific Advisory Board – Asthma Foundation of NZ  
• Chair, Te Ao Mārama Māori Disability Advisory Group  
• Councillor at Large – National Council of the Muscular Dystrophy Association  
• Member, Executive Committee Wellington Branch MDA NZ, Inc.  
• Trustee, Neuromuscular Research Foundation Trust  
• Member, Wellington City Council Accessibility Advisory Group  
• Member, 3DHB Sub-Regional Disability Advisory Group  
• Professional Member – Royal Society of New Zealand  
• Member, Institute of Directors |
<table>
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<tr>
<th>Name</th>
<th>Interest</th>
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</table>
|      | • Member, Health Research Council College of Experts  
|      | • Member, European Respiratory Society  
|      | • Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association)  
|      | • Director, Miramar Enterprises Limited (Property Investment Company)  
|      | • Wife, Research Fellow, University of Otago Wellington |
PROCEEDINGS

1 PROCEDURAL BUSINESS
1.1 PROCEDURAL
The Karakia was led by Eileen. Committee Chair, Dame Fran Wilde, welcomed the public, members and the DHB staff.

1.2 APOLOGIES
Apologies were received from Andrew Blair, Fa’amatuainu Tino Pereira, Ashley Bloomfield, Ms Eileen Brown.

1.3 INTERESTS
1.3.1 REGISTER OF INTERESTS
Action:
1. Committee Secretary to update the Conflicts Register.

1.4 CONFIRMATION OF PREVIOUS MINUTES
The minutes of the CCDHB Health System Committee held on 2 May 2018, taken with public present, were confirmed as a true and correct record.

Moved: Roger Blakeley Seconded: Eileen Brown Carried

1.5 MATTERS ARISING

1.6 ACTION LIST
Eileen noted in item 3.1 the word equity is missing. Other reporting timeframes on the other open action items were noted.

Tristram arrived at 9.36am

1.7 TERMS OF REFERENCE
The Committee noted that it is challenging at times to meet the quorum but it shouldn’t impede the discussion.

1.8 The Committee endorsed the importance of the attendance of the Executive Leadership Team, including GM, Corporate Services and the CFO join future HSC meetings given that the discussions do centre on the investment in the health system.

1.9 The Committee endorsed the opportunity to invite a representative from Otago University to assist in the areas of population health and regional health and also other areas of research in an effort to strengthen relationships and increase collaboration.

The Committee approved the Terms of Reference.

Moved: Roger Blakely Seconded: ‘Ana Coffey Carried

1.10 2018 WORK PROGRAMME
The Committee approved the 2018 Work Programme.

2 FOR INFORMATION

2.1 2018/19 CCDHB PLANNING PROCESS UPDATE
The paper was taken as read.

The Committee:

a) Noted the Minister of Health’s Letter of Expectations, outlining Government’s priorities and areas of focus;

b) Noted the Government’s Budget was announced on the 17th May and the Chief Financial Officer (CFO) will present a paper outlining the CCDHB 2018/19 budget to 27 June FRAC meeting;

c) Noted the initial draft MOH Annual Plan using the 2017/18 template was approved by the Board in March. This pro-active approach enabled CCDHB to deliver a Statement of Performance Expectations (SPE) and Service Change Schedule to the Ministry of time and at short notice, which has been noted by Ministry officials;

d) Noted the MOH Annual Plan and Planning Guidance has now been issued. Management is updating the March draft Annual Plan for presentation to the HSC and Board for approval on the 27th June and 11th July respectively;

e) Noted the dates for the SPE is prior to the Annual Plan for statutory compliance reasons. The final SPE must be submitted to the Ministry by the 29th June; the final draft SLM must be submitted to the Ministry by the 2nd July; and the draft Annual Plan must be submitted to the Ministry by the 16th of July. No Statement of Intent (SOI) will be required in 2018/19. This will be refreshed in 2019/20.
Action:
1. SIP to bring an organisational approach on equity to the Committee. This approach is being developed by the Māori Health team.
2. SIP to present to the Committee at a future HSC meeting the development of suicide prevention approach and the DHB role as a health system.
3. SIP to share the School Based Health System strategy with the Committee at a future HSC meeting.

3 FOR DECISION

3.1 INVESTMENT IN AND PERFORMANCE OF CCDHB NGO PROVIDERS FOR CHILD SERVICES

The paper was taken as read.

The Committee notings were summarised. The Committee:

a) Noted the Ministry of Health contracts Plunket at a national level for the balance of the well child checks. The Ministry of Health is collating well child check information at a national level which will be available to DHBs in 2018/19 for the first time;
b) Noted the 2017/18 CCDHB investments in local providers for Before School Check services; green prescriptions; Porirua Ear Van Service; Kenepuru Accident and Medical centre for services providing free under 13s care in after hour clinics; Project Energise; vision and hearing screening for school aged children and secondary school based health services (SBHS);
c) Noted the initial dashboards for children 0 to 4 years and school aged children presented at this meeting;
d) Noted that persistent inequalities occur for Māori and Pacific children and require significant focus;
e) Noted the opportunities to improve services for young children through working with local WCTO providers and Plunket to improve our understanding to improve our data and our understanding of how children are using the services to improve coverage for our high need populations;
f) Noted the opportunities to improve services for youth through the actions of the youth SLA-improving sex and gender diverse young person’s access to care and health outcomes; establishing an Alcohol and Other Drug / Co existing Problems (AODCEP) service to better support young people experiencing AODCEP; developing and implementing a plan for integrated youth services in Porirua (2018/19);
g) Endorsed the SIP team working with the DHB Pacific and Māori teams PHOs, child service providers and other providers to develop an approach to achieving equity which will be linked to the improvement in equity in the use of primary care services (agenda item 3.1 2 May 2018 meeting).

Action:
1. SIP to report on the integration progress of the different programmes at a future HSC meeting.
2. SIP to present the investment planning approach at the next meeting in June:
   a. Whole system approach
   b. Life course investment
   c. How we use investment planning to redirect our current investment
   d. How do we get public health to be a part of DHBs
   e. Development of new performance framework based on our new investment models
3. SIP to continue to provide examples in the system for future papers. Board members need to be better informed in terms of context rather than just facts.
4. Reconsider the use of BMI as an indicator (item 6.5) as the Māori and Pacific population doesn’t fit in with the standard body type.
5. Housing issues to be discussed at a future HSC meeting and SIP will bring back information to the Board regarding what actions they will be taking.

*The Committee took a break at 11am and resumes at 11.10am.*

### 4 FOR DISCUSSION

#### 4.1 MHAIDS BI-MONTHLY PERFORMANCE REPORT

The paper was taken as read. Eileen endorsed the organisation of the Mental Health Inquiry and acknowledged recommendation point e.

The Committee:

a) Noted a final report has been presented by the MHAIDS Advisory group to the 3CEs and is documented in this report;

b) Noted that Phase 1 of the Client pathway/Digital Client Records is now complete;

c) Noted that the National Mental Health Inquiry has begun with various meetings with the Panel taking place during May 2018;

d) Noted that ICAFS launched two new teams on 30th April, as per the review;

e) Noted that there are acute on going demands and pressure for the Intensive Recovery Sector.

Moved: Eileen Brown  Seconded: Sue Driver  Carried

#### 4.2 REGIONAL PUBLIC HEALTH BI-MONTHLY REPORT

The paper was taken as read.

The Committee:

a) Noted RPH provided both a written and oral submission on the Sale and Supply of Alcohol (Renewal of Licenses) Amendment Bill (No 2);

b) Noted RPH completed submissions on Councils’ Long Term Plans;

c) Noted RPH activity with Councils in the Central Region on “Healthier Food and Drink Environments.” RPH is working alongside Councils to improve health food and drink environments;

d) Noted RPH is collaborating with the Institute of Environmental Science and Research (ESR) with research on the impact of repeat vaccination on response to influenza virus infection;

e) Noted RPH is organising the 2018 Australasia Tuberculosis Conference for 30 - 31 August 2018;

f) Noted RPH is supportive of and participated in the annual Creekfest 2018 festival;

g) Noted RPH provided the evaluation of the Porirua Whānau Centre Ko wai au Programme 2016;
h) **Noted** the RPH Public Health Nurse activity in primary and intermediate schools January – March 2018;

i) **Noted** the Public Health Nurse activity based at Porirua Work and Income;

j) **Noted** the Human Papilloma Virus (HPV) vaccination (Gardasil) progress for 2018;

k) **Noted** RPH has commences planning for a Centreport Pandemic Preparedness Exercise in May 2018

**Action:**
1. Peter Gush to join the meeting when the next Regional Public Health Bi-Monthly Report is presented.
2. It is important for RPH integration to occur across the DHB services and strategies.

The meeting closed at 12.05pm.

5 **DATE OF NEXT MEETING**

27 June 2018, 9.30am, Moa Room, Ratonga Rua o Porirua, 20 Upper Main Drive, Kenepuru.
# SCHEDULE OF ACTION POINTS – HEALTH SYSTEM COMMITTEE (HSC)

<table>
<thead>
<tr>
<th>AP No:</th>
<th>Topic:</th>
<th>Action:</th>
<th>Responsible:</th>
<th>How Dealt With:</th>
<th>Delivery Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSC Public Meeting 30 May 2018</td>
<td>General</td>
<td>1. To approach University partner for a participant on HSC to bring links to research work.</td>
<td>Director, SIP</td>
<td>Discussed with full Board. Being actioned by R Haggerty</td>
<td>Open</td>
</tr>
<tr>
<td></td>
<td>2.1 2018/19 CCDHB Planning Process Update</td>
<td>2. SIP to bring an organisational approach on equity to the Committee. 3. SIP to present to the Committee at a future HSC meeting the development of suicide prevention approach and the DHB role as a health system. 4. SIP to share the School Based Health System strategy with the Committee at a future HSC meeting.</td>
<td>Director, SIP</td>
<td>These items are now scheduled in the work programme</td>
<td>Closed</td>
</tr>
<tr>
<td></td>
<td>3.1 Investment in and Performance of CCDHB NGO Providers for Child Services</td>
<td>1. SIP to report on the integration progress of the different programmes at a future HSC meeting. 2. SIP to present the investment planning approach at the next meeting in June. 3. SIP to continue to provide examples in the system for future papers. Board members need to be better informed in terms of context rather than just facts. 4. Reconsider the use of BMI as an indicator as the Maori and Pacific population doesn’t fit in with the standard body type. 5. Housing issues to be discussed at a future HSC meeting and SIP will bring back information to the Board regarding what actions they will be taking.</td>
<td>Director, SIP</td>
<td>These items are now scheduled in the work programme</td>
<td>Open</td>
</tr>
</tbody>
</table>
### Regional Public Health Bi-Monthly Report

1. Peter Gush to join the meeting when the next Regional Public Health Bi-Monthly Report is presented.
2. It is important for RPH integration to occur across the DHB services and strategies.

### HSC Public Meeting 2 May 2018

#### 3.1 Investment in & performance of CCDHB Primary Health Organisations (PHOs)

1. SIP to create space on the dashboard that focuses on child population to mitigate risk of losing the fidelity of this population in amalgamated data.

#### 3.2 Investment & Performance – Aged Residential Care, Community Dental Agreement, Community Pharmacy Service Agreement

1. Equity expectation on combined dental agreement is an issue to be added to the work plan to identify how long it takes to work out.

### Closed since last meeting – 30 May 2018

#### 3.1 Investment in & performance of CCDHB Primary Health Organisations (PHOs)

- SIP to amend the recommendation (g) to include Tristram’s advice of adding additional data points across all populations and remove the word “particularly”.
- SIP to add an additional recommendation (i) “SIP to advise the Board to explore further mechanism for accountability.”

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<tr>
<td>HSC Public Meeting 30 May 2018</td>
<td>3.1</td>
<td>Investment in &amp; performance of CCDHB Primary Health Organisations (PHOs)</td>
<td>SIP</td>
<td>Amended</td>
<td>May</td>
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- Included in Actions
- Included in Work Programme
<p>|   | An action from Sue requesting that at some point, for the Board to look at the whole public healthcare funding. |   |   |   |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>CCDHB</th>
<th>CCDHB</th>
<th>Ratonga Rua o Porirua</th>
<th>CCDHB</th>
<th>CCDHB</th>
<th>Kenepuru Community Hospital</th>
<th>Kāpiti District Council</th>
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**Health System Investment and Prioritisation**

- Investment & Prioritisation - TBC

**System Performance Reporting**

- Integrated Performance Monitoring
- Healthy Aging System Performance
- Community Health Networks Performance
- Integrated Performance Monitoring
- TBC
- TBC

**Provider Performance**

- HHS Bi-monthly performance report
- MHAIDS Bi-Monthly performance report Regional Public Health Bi-Monthly Report
- EBHC Bi-monthly performance report
- MHAIDS Bi-Monthly performance report Regional Public Health Bi-Monthly Report
- EBHC Bi-monthly performance report
- MHAIDS Bi-Monthly performance report Regional Public Health Bi-Monthly Report
- EBHC Bi-monthly performance report
- MHAIDS Bi-Monthly performance report Regional Public Health Bi-Monthly Report
- EBHC Bi-monthly performance report
- HHS Bi-monthly performance report

**Community Providers**

- Performance report - (ARC, PHO, Dental, Pharmacy)
- Performance report - (NGOs, Integrated Care)
- Performance report - (Older Persons)
- Performance report - (PHO, Integrated Care)
- Performance report - (ARC, PHO, Dental, Pharmacy)
- Performance report - (NGOs, Integrated Care)
- Performance report - (ARC, PHO, Dental, Pharmacy)

**System and Service Planning**

- Draft Regional Services Plan
- Draft Annual Plan
- Planning Projects
- School Based Health Services
- Planning Projects
- Equity Approach
- Housing Approach
- Planning Projects
- Suicide Prevention
- Planning Projects and Integration of Child Health Services
- Planning Projects and Service Plans - Topics
- Planning Projects and Service Plans - Topics

**Prioritisation and Investment Update for implementing the Health System Plan**

- Investment Planning Approach
- Across all providers including HHS/MHAIDS
- Investment Plan
- Porirua Integration Approach
- Whole of System Investment Update
- Investment Plan - TBC
- Investment Plan - TBC
- Investment Plan - TBC
**HEALTH SYSTEM COMMITTEE DECISION**

**Date:** 27 June 2018

<table>
<thead>
<tr>
<th>Author</th>
<th>Peter Guthrie, Manager Planning and Performance</th>
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<tbody>
<tr>
<td>Endorsed by</td>
<td>Rachel Haggerty, Director - Strategy, Innovation &amp; Performance</td>
</tr>
<tr>
<td>Subject</td>
<td>2018/19 CCDHB Draft Annual Plan excluding financials</td>
</tr>
</tbody>
</table>

**RECOMMENDATION**

It is recommended that the Health System Committee (HSC):

a) **Note** the Minister’s Letter of Expectations and the MoH Annual Planning Guidance were issued in May and that this draft plan reflect the guidance requirements.

b) **Note** the initial draft Annual Plan, using the 2017/18 template, was approved by the Board in March.

c) **Note** that the Board approved the Statement of Performance Expectations at the Board meeting of 13 June 2018

d) **Note** that the draft System Level Measures Improvement Plan (SLM) was developed in partnership with PHO, HHS and SIP through the Integrated Care Collaborative (ICC) Alliance Leadership Team (ALT) processes and is with the Health System Committee for endorsement.

e) **Note** that the draft Annual Plan has been reviewed and endorsed by the Executive Leadership Team and will also be reviewed by the Māori Partnership Board, the Sub-Regional Pacific Strategic Health Group, the Sub-Regional Disability Advisory Group and Clinical Council prior to the final presentation to the Board in July 2018;

f) **Note** that the timeline for submission of the final Annual Plan, including financials, has not yet been confirmed by the Ministry of Health;

g) **Review and provide comment** the draft Capital & Coast DHB Annual Plan 2018/19, excluding financial, for endorsement to the Board on 16 July 2018;

**APPENDICES**

1. **CCDHB 2018/19 ANNUAL PLAN: SECOND DRAFT**

**1. PURPOSE**

The purpose of this paper is to update the HSC on the status of Capital & Coast District Health Board’s (CCDHB) Annual Plan 2018/19. This paper outlines the content of the second draft of the CCDHBs Annual Plan 2018/19 to be submitted to the Ministry of Health (MoH) by the 29th of June 2018. The timeline for submission of the final Annual Plan has not yet been confirmed by the Ministry.

**2. BACKGROUND**

CCDHB started the annual planning process prior to the Minister’s Letter of Expectations and Ministry’s Guidance Package being released. A first draft was prepared by updating the 2017/18 Annual Plan and was presented to the Board in March.
The pro-active approach enabled CCDHB to respond quickly to the Ministry’s requests for submission of the draft Statement of Performance Expectations and draft Service Change Schedule. Both sections were submitted on time on the 30th of April and 11th of May respectively with positive comment from the MoH.

An update on the Annual Planning Process was provided to the HSC at their May meeting, outlining the Minister’s Letter of Expectations and the MoH Annual Planning Guidance.

The attached second draft Annual Plan 2018/19 has been prepared as per the MoH Annual Planning Guidance and the Template provided. The Ministry expects the Annual Plan to be brief, high-level outcome focus with explicit measurable actions and to have a strong equity focus. We have revised our draft annual plan with these requirements in mind, particularly equity, with all measures now split out by population to allow CCDHB to explicitly monitor performance across all areas.

3. ANNUAL PLAN GUIDANCE 2018/19

As outlined in the May HSC paper, the areas of substantive change include:

- A greater focus on equity and population performance as part of the overview of strategic priorities section;
- The Ministry expects DHBs to have a strong focus on health equity in their Annual Plans;
- A greater emphasis in key areas include: a wider focus on addictions, the mental health service improvement initiatives including reduction in seclusion, maternal mental health services, school based health services, public health service delivery, climate change, and waste disposal;
- The workforce and IT parts of the Stewardship section have been extended;

The Ministry has scheduled in a meeting with senior CCDHB officials to discuss performance expectations in early July. The health targets and cross government targets will be incorporated as they become available.

4. TIMELINES

The timing of the release of the Minister’s Letter of Expectations and the MoH Annual Planning Guidance has resulted in an updated timeline for the Annual Planning Process. Key submission dates, as required by the Ministry, include:

- Final Statement of Performance Expectations (SPE) to MoH by the 29th of June
- Final draft SLM to MoH by the 2nd of July
- Draft Annual Plan, excluding financial, to MoH by the 16th of July

Feedback on the Annual Plan will be provided by the MoH at the beginning of September, as part of the development of the final Annual Plan. Timeline for submission of the final draft Annual Plan has not yet been confirmed by the Ministry.

5. NEXT STEPS

The HSC is asked to review and provide comments on the second draft of the CCDHB Annual Plan 2018/19 and SLM 2018/19. The draft annual plan will also be reviewed by the Māori Partnership Board, the Sub-Regional Pacific Strategic Health Group, the Sub-Regional Disability Advisory Group and Clinical Council.

Feedback from the HSC and the advisory groups will be incorporated into a revised draft document. The revised draft plan will then be presented to the Board for approval at their July meeting for submission to the Ministry of Health on the 16th of July 2018.
Annual Plan dated xx June 2018
(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)
Minister’s 2018/19 Letter of Expectations to Capital & Coast DHB

Hon Dr David Clark
MP for Dunedin North
Minister of Health

Mr Andrew Blair
Chair
Capital & Coast District Health Board
Private Bag 7902
WELLINGTON 6242

Dear Mr Blair

Letter of expectations for District Health Boards and Subsidiary Entities for 2018/19

This letter sets out the Government’s expectations for District Health Boards (DHBs) and their subsidiary entities for 2018/19.

The Government wishes to signal an increased priority for primary care, mental health, public delivery of health services, and a strong focus on improving equity in health outcomes.

This Government listened to New Zealanders, and campaigned on these concerns. We will deliver on our democratic mandate to ensure New Zealand has a strong and effective public health service that we can all be proud of. To achieve this we want the public health service to be accessible and affordable for all New Zealanders, and to ensure that appropriate services are provided in the right locations at the right times.

Our Approach

Our Government wants to improve population health. Population health approaches and services are essential components of strategies to address determinants of health and achieve better health equity and wellbeing. I expect DHBs to work closely with and support their local public health units and health promotion providers. New Zealanders have made it clear that they are concerned about the increasing unaffordability of primary health services, regional inequity of access to secondary health services, and inadequate mental health service provision nationwide.

Our Government takes a longer term view. To this end, we will review the primary care funding formula and DHB targets, as well as wider sector settings. The Ministerial Advisory Group will also advise me on further opportunities to improve equitable health outcomes for all New Zealanders including how the system needs to change to enable these improvements. It is expected that you will be fully supportive of this work, and where appropriate will provide direct contribution.

We intend to better resource primary care in order to deliver better health outcomes, and to reduce the growing pressure on emergency services. In Budget 2018, we will lay out our plan to reduce the cost of access to primary care for New Zealanders.
In our first 100 days we have introduced legislation to increase access to medicinal cannabis, and launched the Government Inquiry into Mental Health and Addiction. We expect your staff and members of your community to participate in the Inquiry and I expect you will encourage your people to do this.

Funding

There is no doubt that there has been a low priority on funding health in recent years. In contrast to other countries, core Crown health expenditure in New Zealand dropped as a proportion of the overall economy between 2008 and 2017. It is a credit to those who serve across the health sector that health outcomes have held up as well as they have despite nine years of under investment. Please pass on my sincere thanks to your staff for their commitment and service to the public, particularly during difficult times.

The Government is committed to delivering a well-funded public health service. That is why we will invest $8 billion to meet cost pressures and deliver new initiatives over the next four years. While this is more generous than before, much of the new funding will be absorbed in the service improvements already signalled by the Government. The public will rightly want to see the health system delivering more for them in return for the increased investment.

Capital Planning

I expect that your DHB will continue to focus on long term capital planning. This work should include service planning and understanding the state of your assets. I anticipate the need to prioritise the available capital funding, and your work in this area will assist in this process. I also require you to continue to work regionally when developing business cases for investment.

Accountability for Improved Performance

We will hold DHB Chairs directly accountable for their DHB’s performance. We expect Boards to be highly engaged and to hold Chief Executives and management tightly accountable for improved performance within each DHB, particularly in relation to equity of access to health services and equity of health outcomes.

Under the previous government, relationships across the health sector became strained. My expectation is that the Ministry Advisory Group will work with the Ministry of Health to strengthen these relationships.

I trust that you will work with your regional DHBs to support regional delivery of services where appropriate. There should be strong shared responsibility and accountability across regions to ensure that regional services are delivered well and support equity of access for the population.

I expect that you will incorporate and share best practice innovation with the wider sector. Clinical leaders play a key role in this work. Strong and proactive relationships with the Ministry, other DHBs, primary health organisations (PHO), non-governmental organisations, and other stakeholders across the sector will be required. I am looking for increased collaboration across all parts of our health
service to deliver more affordable primary care, improved elective surgery volumes, improvements in equity of access to services, and a higher quality of care.

I will be meeting and speaking with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to work together to deliver in the Government’s priority areas, and to keep within budget.

**Workforce**

To deliver affordable, accessible and quality care, workforce changes will be needed. This includes greater utilisation of different workforces in primary care settings. With a growing and aging population, there will be more work for all, and an increased emphasis on the use of generalist workforces for less specialised tasks will be required. Health care professionals from allied health, nursing, medicine and related fields will need to operate at the top of their scope of practice. I expect DHBs to be bold in their vision for change while also remaining responsive to the concerns raised by the workforce.

I understand DHB Chief Executives have collectively signed up to having Care Capacity Demand Management fully in place in all DHBs by July 2021 with oversight of progress and feedback on milestones monitored by the Safe Staffing and Health Workplaces Governance Group. I encourage you to proceed with timely implementation and expect that acute mental health inpatient services are a first priority. I also encourage you to address wider workforce development to better respond to mental health issues, in line with the *Mental Health and Addiction Workforce Action Plan*.

Additionally, to ensure greater community-based care and assist in workforce development, I expect all DHBs to adhere to the Medical Council’s requirement for Community Based Attachments for interns.

We are also interested in expanding the role of health-based professionals in school settings. This includes considering the role of health-based professionals in primary and early education in the future, and extending School Based Health Services so all secondary schools have a comprehensive youth health service.

**Expansion of PHARMAC model to manage hospital medicines**

PHARMAC’s role in managing hospital medicines has steadily increased. Most recently, since 2013 PHARMAC has made decisions on the adoption of new technology in hospital medicines. In my letter of 27 April 2018, I confirmed that from 2018/19 the full budget management responsibility for all remaining hospital medicines will move from DHBs to PHARMAC, in order to support our wider health priorities.

**National Patient Flow**

As you will be aware, National Patient Flow is a new developmental national collection that the Ministry and DHBs have been implementing over the past three years. The collection will provide information at key points of the patient journey through secondary and tertiary care, helping DHBs to quantify unmet referred
demand for services, and to better understand and improve their patient management processes.

I anticipate that this will become a core national collection in the future, and I expect DHBs to continue working in partnership with the Ministry with a focus on improving data submission and data quality for the National Patient Flow collection during 2018/19.

Planning for 2018/19 and the future

We are focused on ensuring better health outcomes for the public, and have clear expectations for all DHBs. This includes the following.

- Increasing the rate of organ donations. DHBs are expected to manage the associated costs within their baselines.
- Improving the health and wellbeing of infants, children and youth. I expect that your 2018/19 annual plan shows how you will achieve this, particularly for Māori, Pacific people, and people living in high areas of deprivation.
- Improving equity and reducing the burden caused by long term conditions, in particular diabetes. I expect DHBs in their contracts with PHOs to explicitly require improvements in performance and reporting. I expect DHBs to incentivise PHOs to demonstrate improvement in primary care settings and increase PHO accountability for effectively managing long term conditions with particular regard to diabetes.
- The Government also wants to support our health system to implement a strong response to climate change, this will include working with other DHBs, other agencies and across Government. Plans to address climate change and health, need to incorporate both mitigation and adaptation strategies, underpinned by cost benefit analysis of co-benefits and financial savings.

Your DHB’s annual plan for 2018/19 will need to reflect my expectations. In addition, I am not requiring your DHB to refresh your Statement of Intent in 2018/19. However, I will expect all DHBs to demonstrate a renewed focus on their strategic direction by refreshing their Statements of Intent in 2019/20.

Finally, I would like to thank you and your DHB again for your ongoing work to improve the health of New Zealanders. The public deserves the highest standards of leadership and performance, and by working together we can ensure that improvements are made for our population.

Yours sincerely

Hon Dr David Clark
Minister of Health
Minister’s 2018/19 Letter of Approval to Capital & Coast DHB

(Placeholder for Annual Plan approval letter - pending approval of Annual Plan)
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SECTION 1: Overview of Strategic Priorities

1.1 Strategic Intentions & Priorities
This Annual Plan articulates Capital and Coast District Health Board’s (CCDHBs) commitment to meeting the Minister of Health’s expectations to implement the New Zealand Health Strategy and continue the commitment to deliver CCDHBs vision of:

“Best possible quality of life throughout life for all, through keeping people well including focussed action to eliminate inequitable differences of the health of our population.”


1.1.1 Achieving health equity in CCDHB
The New Zealand Public Health and Disability Act 2000 provides explicit reference to the Treaty of Waitangi and commits all DHBs to the specific objective of reducing health disparities by improving the health outcomes for Māori and other New Zealanders.

Across the New Zealand health sector there is general agreement to the use of the World Health Organization definition of equity, that is:

“Equity is the absence of avoidable, unfair, or remedial differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.”

For CCDHB, equity is about looking at how well different population groups are doing compared with each other, identifying where the differences are unjust and working to close the gap. We know that we don’t do as well for Māori and Pacific peoples in our district as we aim to, and we can see this in the health statistics we have that show inequity between Māori and the non-Māori, non-Pacific population and inequity between Pacific and the non-Pacific, non-Māori population. CCDHB is also committed to improving health outcomes and achieving equity for people with a mental illness and/or addiction or have a disability.

Our strategic priorities for addressing equity this year include development of Taurite Ora, the CCDHB Māori Health Strategy 2018-2030 and the CCDHB Equity Strategy 2019-30, as well as further delivery of Toe Timata Le Upega, the Pacific Action Plan 2017-2020 and the Sub-Regional Disability Strategy 2017-2022.

The CCDHB Equity Strategy will put in place the building blocks for CCDHB to work strategically to further advance as a pro-equity organisation.
1.2 Strategic Vision
The Capital and Coast Health System Plan 2030 (HSP2030) outlines CCDHBs strategy to improve the performance of the region’s healthcare system. To achieve our obligations to the Minister, the region and our communities, we will use our resources wisely and strategically to:

For the 2018/19 year, CCDHB will especially focus on:
- Equitable outcomes for vulnerable populations, particularly Māori and Pasifika
- Mental Health and Addictions services
- Primary Care services
- Child Wellbeing
- The strength of our publically funded health system

We will achieve our obligations and deliver these outcomes as well as delivering services within available resources. We will also operate with a long-term view supported by the ten-year long-term investment plan. To do this we have a programme of work that builds on existing successes and finds new ways to:

These approaches will strengthen CCDHBs ability to be people powered, provide services closer to home, operate as one team, use smart systems and ensure value and high performance.

Improving the health and wellbeing of communities requires a more broadly approach than the traditional boundaries of health and social services. Partnership with communities (including Councils, Government Agencies, NGOs from other sectors and community organisations), to strengthen their contribution to their own health and wellbeing, is required to better respond to the social determinants of health.

CCDHB is well placed to successfully deliver against the New Zealand Health Strategy objectives, as we implement our longer term view of how services will be delivered for our population (HSP2030).
1.3 Population Performance

As part of the HSP, CCDHB adopted the life course approach to achieve better outcomes for its population. The HSP describes three macro models of care for major service user groups of the healthcare system. These groups represent the major flows through the health system:

- Pregnancy, children, youth and families;
- Complex care requiring system coordination and:
- Core healthcare service users

The table below outlines the specific actions CCDHB will do in 2018/19 for the five life course groups, as identified by the Ministry of Health:

<table>
<thead>
<tr>
<th>Life course group</th>
<th>One significant action that is to be delivered in 2018/19</th>
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<tbody>
<tr>
<td>Pregnancy</td>
<td>Primary Birthing Project - Finalise the feasibility study that will investigate the development of a primary birthing unit within CCDHB.</td>
</tr>
<tr>
<td>Early years and childhood</td>
<td>Integration Services - Investigate the provision of an integrated approach to antenatal services and childhood obesity services</td>
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<tr>
<td>Adolescence and young adulthood</td>
<td>Youth Services in Porirua - Increase provision, coordination and integration of services for young people in Porirua.</td>
</tr>
<tr>
<td>Adulthood</td>
<td>Living Well with Long-Term Conditions Strategy – Development of a long-term conditions needs assessment to inform the long-term conditions investment plan (2019/20). This investment plan will support people to live well with long-term conditions, enabling them to be pro-active in their healthcare and delaying the progressing of disease.</td>
</tr>
<tr>
<td>Older people</td>
<td>Healthy Aging Strategy – Development of a healthy aging strategy to: (i) enhance the support available in primary care and community teams; (ii) reduce isolation through the implementation of community circles in Kapiti; (iii) give people the opportunity to say what matters to them in planning for end of life by supporting people to write their Advance Care Plans.</td>
</tr>
</tbody>
</table>
Message from the Chair

I am delighted to present Capital & Coast District Health Board’s 2018/19 Annual Plan, which sets out our performance intentions for the coming year.

We have planned for action towards achieving equity of access to health services and equitable health outcomes for our communities, particularly for Māori, Pacific peoples and communities experiencing high deprivation. This renewed equity focus is essential for CCDHB to deliver improved health outcomes, meet its statutory responsibilities and reach its medium term goals for a clinically and financially sustainable local health system. The plan sets out how we will give effect to local, regional and national priorities and deliver value and high performance from our DHB. Where possible we will simplify services, giving us greater capacity to intensify care for those who need it most.

At CCDHB, we are deliberate in our investment choices to deliver better care and outcomes for our communities. We work collaboratively with our strategic partners including our Māori Partnership Board, community and primary care partners to inform these choices. A critical element in our investment decision-making is strong clinical leadership from across our health system. The maturing role of our Clinical Council is particularly important for ensuring we get this leadership at the right points and I am pleased to see its ongoing development as a leadership forum.

Knowing that the services we deliver are achieving the outcomes we want, in a sustainable way, is a top priority for me. Oversight of high quality performance monitoring is an integral role for the Board. As a Board, we have set a strong expectation that CCDHB measures and reports on the right things – including equity - clearly and consistently. We also expect the DHB to respond appropriately to performance issues in a timely way. The DHB is building its capability to use data and evidence in smarter ways to support this focus. I anticipate further improvements over the coming year in our ability to use information and insights to respond to challenges we face.

We are actively engaged in meeting the expectations of the Minister of Health, which align well with our own long term vision for our health system. We continue to emphasise action to improve the wellbeing of our tamariki and rangatahi, enhance the capacity of primary care, improve mental health outcomes, support older people to live well and maintain strong publicly delivered health services. I look forward to delivering the ambitious goals we have set ourselves in this coming financial year.

Andrew Blair
Board Chair
Capital & Coast District Health Board
Message from the Chief Executive
(Placeholder for Message from the Chief Executive – being drafted)

Julie Patterson
Interim Chief Executive
Signature Page

Agreement for the Capital & Coast DHB 2018/19 Annual Plan between

Hon. Dr. David Clark
Minister of Health
Date:

Hon. Grant Robertson
Minister of Health
Date:

Andrew Blair
Chair
Date:

Dame Fran Wilde
Deputy Chair
Date:

Julie Patterson
Interim Chief Executive
Date:
SECTION 2: Delivering on Priorities

This section outlines CCDHB’s commitment to deliver on the Minister’s Letter of Expectations and key activities and milestone to deliver on the Planning Priorities. More information on the Ministry’s performance measures is provided in SECTION 5: Performance Measures.

2.1 Health Equity

CCDHB will show commitment and leadership to deliver on equity as a strategic priority including:

- Embedding equity as a value across the organisation by developing an equity goal (one that is clear about what equity looks like for the organisation), and embedding an expectation of equity at all levels of the organisation.
- Being results focused including understanding what drives current inequities and identifying intervention points to reverse these drivers; and ensuring key planning decisions and services are focused on meeting the health need of the people carrying the weight of current inequities and not currently served well by the organisation.
- Demonstrating equity and improved health outcomes particularly for Māori and Pacific by requiring high quality ethnicity data across the organisation, and regular and transparent monitoring data (including public reporting).
- Building a fit for purpose workforce by ensuring robust HR policies and guidelines to recruit for equity skills and expertise, matched with performance indicators, core competencies and training / development across the organisation.

Regionally, the three DHBs (Wairarapa, Hutt Valley and Capital and Coast) are working to establish local and shared strategic views of equity and ensure that a medium-to-long term strategy to address equity is explicit across all DHB strategies, clinical services planning, service commissioning and investment decisions.

CCDHB will also deliver on our equity priorities by focusing on improving Māori and Pacific health outcomes through the specific actions and milestones for 2018/19 outlined in the section below.
2.3 Government Planning Priorities

Equity actions include the code “EOA” for “Equitable Outcome Action” immediately following any action.

<table>
<thead>
<tr>
<th>Government Planning Priority</th>
<th>Focus Expected for the DHB</th>
<th>Link to NZ Health Strategy</th>
<th>CCDHB Key Response Actions to Deliver Improved Performance</th>
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<tr>
<td>Mental Health</td>
<td>Population Mental Health</td>
<td>One Team</td>
<td>Activity</td>
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| Mental Health and Addictions Improvement Activities | Outline actions to improve population mental health and addictions, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness and addiction, further integrating mental and addiction and physical health care, and coordinating mental health care with wider social services. Please refer to section 2.3.1 Mental Health Focus Areas for a list of areas that your chosen actions should focus on improving. | 1. Investment approach/ MHA Strategy/ commissioning: Develop a whole of system approach for mental health and addictions that facilitates: wellbeing models across the life course; integrated health service and social service responses that meet the needs of people and their whanau; care that strengthens peoples wellbeing and resilience, in addition to responding to their clinical needs, and intervening earlier. (EOA) | Q2: 2030 MHA strategy completed  
Q3: Implementation plan for 2018/19 |
|                             |                             |                            | 2. Integration: Integrated care work programme across primary and secondary care top ensure continuity of care; population data and analysis, life course model of care and community mental health (based on geographic hubs). (EOA) | Q1: Integration approach completed  
Q2: Performance framework completed  
Q4: Model of care for integrated MHA care complete |
|                             |                             |                            | 3. Suicide prevention and postvention: Develop a health system response to prevent suicide. Work across NGO, primary and secondary care providers. Target for the most at risk of suicide and Māori. (EOA) | Q1: Scope completed  
Q2: Implementation of agreed framework |
|                             |                             |                            | 4. Establish a prototype community wellbeing hub (Porirua) | Q1: Project established  
Q2: Integrated Care Collaborative Established  
Q3: Implementation of Action Plan |
<p>|                             |                             |                            | 5. Establish a new Mental Health Network reporting to the Alliance Leadership Team to identify and drive service integration activity and new initiatives. | Q2: Reporting established |
|                             |                             |                            | 6. Establish a sub-regional secondary-care service for young people with alcohol and other | Q3: Sub-regional secondary-care service established |</p>
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<tr>
<th>Government Planning Priority</th>
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<td>drug problems and co-existing problems. This service will include specialist support to primary and NGO providers.</td>
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<td>7. Collaborate with local council to implement training for community groups and key stakeholders around suicide prevention and supporting first symptoms of mental health. This training will help better equip a diverse range of people within community settings to engage with people experiencing mental health issues.</td>
<td>Q1; Training for community groups implemented</td>
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<td>8. Co-design and establish a dedicated Housing Co-ordination service to assist people with mental health or addiction needs overcome housing issues and sustain secure housing.</td>
<td>Q1; Housing Co-ordination service established</td>
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<td>9. Implement a Vocational Support Service to assist people with mental health or addiction needs to find and retain employment.</td>
<td>Q1; Vocational Support Service implemented</td>
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<td>1. Mental Health Inquiry Panel Meetings: meetings across the three DHBs with the panel to ensure opportunity for consumers, the community and NGO sector, the workforce and the MHAIDS provider to make representation to the panel.</td>
<td>Q1; Responses to the Mental Health Inquiry submitted</td>
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<td>2. Regional Collaboration: Collaborate with our regional DHB partners (Hutt Valley and Wairarapa) to support the Inquiry</td>
<td>Q1; Completed</td>
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<td>3. Arrange for the Inquiry team to meet with relevant clinical and management DHB staff, mental health and addiction service providers, and community groups across the three DHBs.</td>
<td>Q1; Completed</td>
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<td>4. Promote Inquiry public meetings through our DHB provider networks and our website.</td>
<td>Q1; Completed</td>
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<td>1. Seclusion: Develop a seclusion dashboard and continue to monitor and reduce the use of seclusion through the Restraint and Seclusion Elimination Monitoring and Advisory Group</td>
<td>Q1; Seclusion dashboard developed Q1-Q4; Seclusion Monitored through the Restraint and Seclusion Elimination Monitoring and Advisory Group</td>
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<td>One Team</td>
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<td>Government Planning Priority</td>
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<td><strong>Activity</strong></td>
<td><strong>Milestones</strong></td>
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<td>2. Redesign <strong>Te Whare Ahuru Acute Inpatient Unit</strong> to deliver best practice and culturally safe models of care in a modern environment that is safe, restful and supports recovery and greater wellbeing</td>
<td>Q4; Te Whare Ahuru Acute Inpatient Unit redesigned</td>
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<td>3. Establish a <strong>Youth Mental Health Respite Service</strong> with a focus on meeting the needs of young Māori Tangata whai ora and Pacific people. (EOA)</td>
<td>Q4; Youth Mental Health Respite Service established</td>
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<td>4. Implement a new <strong>Regional Alcohol and Other Drugs Acute Residential Treatment Service</strong>, including: (i) the development of a regional pathway of care to move service users and their family/whānau seamlessly through the alcohol and other drug continuum (including intensive residential and respite services); (ii) service that is responsive to Māori, Pacific, and at-risk populations (EOA).</td>
<td>Q4; Regional Alcohol and Other Drugs Acute Residential Treatment Service implemented</td>
</tr>
<tr>
<td>Addictions</td>
<td>For those DHBs that are not currently meeting the PP8 addiction related waiting times targets (for total population or all population groups), please identify actions to improve performance.</td>
<td></td>
<td>1. Continue to reduce <strong>wait times</strong> through improvements to the Infant, Child, Adolescent and Family Service (ICAFS) and Child Adolescent Mental Health Service (CAMHS), including: (i) embedding the Choice and Partnership Approach (CAPA) throughout the service with CAPA training and resources to all staff; (ii) standardising evidence-informed approaches to common presenting problems; (iii) strengthening links with Iwi and Māori service providers; and (iv) ongoing management of referrals from Te Haika (secondary adult service) to ICAFS/CAMHS.</td>
<td>Q1-Q4</td>
</tr>
</tbody>
</table>

**Value and High Performance**
<table>
<thead>
<tr>
<th>Government Planning Priority</th>
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<td></td>
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<td>2. Explore and scope other potential service improvements to the ICAFS/CAMHS, including: (i) technology to enhance efficiency and effectiveness; (ii) new systems for sharing information and collecting and reporting data; (iii) survey tools to collect real-time feedback from service users; (iv) mechanisms for consumer participation in service changes; (v) enabling electronic appointment booking across the service; and (vi) outreach services.</td>
<td>Q4: Scope of potential service improvements to the ICAFS/CAMHS completed</td>
</tr>
</tbody>
</table>
|                             |                            |                           | 3. Alcohol and Other Addictions Strategy: Develop a model of care to support freedom from addiction. (EOA) | Q2: Model of care developed  
Q4: Business case completed |
| Primary Health Care         | Access                     | TBC                       | PHO Enrolment: work with PHOs to identify opportunities to increase the rate of Māori enrolment. (EOA) | Q2: 87% of Māori are enrolled in a PHO  
Q4: 90% of Māori are enrolled in a PHO |
|                             |                            |                           | PHO Enrolment: collaborate with PHOs and key stakeholders to increase PHO enrolment of Pacific children aged 0-4 years. (EOA) | Q4: 90% of Pacific children aged 0-4 are enrolled in a PHO |
|                             | Integration                |                           | Strengthen Alliance: ICC ALT Programme Board to work with Māori Health Director, Pacific Health Directors across the DHB and PHOs to embed processes to ensure equity remains a focus for the ICC ALT. (EOA) | Q4: ICC Outcome Framework Updated as required to strengthen focus on equity based targets.  
Q4: All ICC ALT projects have equity based impact measures |
|                             |                            |                           | Broadening Membership of the Alliance | Q2: Incorporation of ambulance service providers into ICC Steering Group focused on acute demand and consumers into Steering Groups without representatives |
|                             |                            |                           | Service Development: Progress roll-out of the Health Care Home (HCH) model of care across primary care, targeting practices with high volumes of Māori and Pacific patients. Continue to integrate the District Nurses and Community Allied Health Teams. (EOA) | Q4: The HCH model rolled-out across at least 10 more practices.  
Q4: Ensure ≥70% of enrolled Māori and Pacific populations are enrolled in the HCH model of care |
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<tr>
<td>1. Ambulatory Sensitive Hospitalisations (ASH): Achieve within DHB equity for all population groups over 5 years (by 2021/22). For 2018/19, 17% reduction in ASH rate for Pacific and 9% reduction for Māori. (EOA)</td>
<td>Service Development: Increase the utilisation of ICT enablers including the patient portal, shared electronic health record access, concerto access and shared care plan.</td>
<td>Q2; Ethnicity based patient portal uptake data collection processes with relevant vendors implemented Q4; &gt;25% of CCDHB enrolled population activated on the patient portal</td>
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<td>2. Amenable Mortality: A 4% reduction for Māori and 6% reduction for Pacific. (EOA)</td>
<td>Workforce Utilisation: HCH “workforce team” development planning to consider the population mix, particularly Māori and Pacific populations and actively expand the team more than the traditional GP-Practice Nurse model. (EOA)</td>
<td>Q2; Workforce survey completed across the HCH with ethnicity and discipline breakdown to inform “workforce team” development planning Q3: Each HCH develops a workforce plan. The plans will incorporate their specific population needs and considers a diversified team Q4: Time to Next Available Appointment is measured in the HCH and is able to demonstrate an improvement.</td>
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<td>3. Acute Bed Days (ABD): A 16% reduction in ABD rate for Pacific (i.e. approximately 1,264 fewer ABD) and 11% reduction for Māori (i.e. approximately 1,167 fewer ABD). (EOA)</td>
<td>National Enrolment Service (NES), new-born enrolment improvement: TBC</td>
<td>Q2; Ethnicity based patient portal uptake data collection processes with relevant vendors implemented Q4; &gt;25% of CCDHB enrolled population activated on the patient portal</td>
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<td>4. Babies Living in Smoke-Free Homes: work with local PHOs to identify babies in households with smokers and improve the proportion of these household members offered brief advice and uptake of cessation support. (EOA)</td>
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<td>Q2; Workforce survey completed across the HCH with ethnicity and discipline breakdown to inform “workforce team” development planning Q3: Each HCH develops a workforce plan. The plans will incorporate their specific population needs and considers a diversified team Q4: Time to Next Available Appointment is measured in the HCH and is able to demonstrate an improvement.</td>
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<td>5. Patient Experience of Care: For 2018/19 maintain or improve the overall response rate, and improve the Māori and Pacific response rates by 6% and 7%, respectively, to that of the “other” population. (EOA)</td>
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<td>Q2; Workforce survey completed across the HCH with ethnicity and discipline breakdown to inform “workforce team” development planning Q3: Each HCH develops a workforce plan. The plans will incorporate their specific population needs and considers a diversified team Q4: Time to Next Available Appointment is measured in the HCH and is able to demonstrate an improvement.</td>
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**System Level Measures**

Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.
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<td>CVD and diabetes risk assessment</td>
<td>Commit to achieve and maintain 90% CVD and Diabetes Risk Assessment rate for the eligible population. Work closely with the alliance partners to achieve 90%. Describe specific actions the alliance will take to reach this target. These actions could be part of the actions committed to in the System Level Measures Improvement Plan, in which case this should be cross-referenced, if that is appropriate. If specific risk assessment activity is not part of the SLM Improvement Plan, actions to improve the level of risk assessments provided must be included in this section along with two quarterly milestones. In addition each DHB should identify three priority areas they will be undertaking for quality improvement in diabetes care and services with key actions and milestones. These areas may be informed by their self-assessment against the Quality Standards for Diabetes Care 2014.</td>
<td>6. Youth Access to and Utilisation of Youth-Appropriate Health Services: In 2018/19 CCDHB will focus on the Alcohol and Other Drugs domain of the Youth SLM and aim to improve the identification of youth at risk of harm from alcohol across primary care and the hospital. This work is linked to the Porirua Youth Integration Programme (outlined below). (EOA)</td>
<td>Q1-Q4: Monitor and report against progress made each quarter to MoH Porirua Youth Integration Programme milestones outlined below</td>
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<td>1. Heart and Diabetes Checks: Increase coverage of More Heart and Diabetes Checks for Māori and Pacific men aged 35-44 years (SLM). (EOA)</td>
<td>Q2 &amp; Q4: 5% increase in the coverage of More Heart and Diabetes checks for Māori and Pacific men aged 35-44 years by the end of Q4 (to achieve 90% rate for total eligible population)</td>
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<td>2. Quality Improvement in Diabetes Care and Services: Improve the outcomes for people diagnosed with type 2 diabetes at a young age (with a focus on Māori and Pacific aged 15-39 years) by tailoring interventions for young people and their families. Report on the success of targeted initiatives. (EOA)</td>
<td>Q2 &amp; Q4: Report on the success of targeted initiatives to tailor intensive diabetes care to individuals and families. Reduce number of Māori and Pacific with an HBA1C greater than 64mmol/mol by 4% by the end of quarter 4</td>
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<td>3. Quality Improvement in Diabetes Care and Services: Analysis of Burden of Disease: Assess the burden of disease of people with diabetes experience in CCDHB (including a focus on impact of age at diagnosis, ethnicity and social environment, complications and outcomes).</td>
<td>Q4: Report on the burden of disease including focus on the impact of age and ethnicity.</td>
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<td>4. Quality Improvement in Diabetes Care and Services: Renal Screening - Improve the coverage of renal screening. Including analysis of equity of coverage as renal disease has larger burden for Māori and Pacific populations.(EOA)</td>
<td>Q2: Report the coverage of renal screening in primary care practices, set a target for improvement in Q4. Q4: Report against target set Q2 and provide exception report if not met.</td>
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<td><strong>Pharmacy Action Plan</strong></td>
<td>Continue to engage with the agreed national process to develop and implement a new contract to deliver integrated pharmacist services in the community.</td>
<td>One Team</td>
<td>1. <strong>Pharmacy Contracting</strong>: Implement decisions made in relation to the pharmacy contracting arrangements.</td>
<td>Q1: Decisions from the pharmacy contracting arrangements implemented</td>
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<td>Continue to support the vision of the Pharmacy Action Plan by working with pharmacists, consumers and the wider health sector (e.g., primary health care) to develop integrated local services that make the best use of the pharmacist workforce.</td>
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<td>2. <strong>Identify Health Needs</strong>: which are amenable to Community Pharmacy interventions</td>
<td>Q2: Decision made regarding interventions</td>
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<td>3. <strong>Contract for Local Services</strong>: Use “Intensify” criteria to fund local community pharmacy services to improve health of population. Equity for Māori and Pacific will be considered when contracting these services. (EOA)</td>
<td>Q3: Schedule 3 contracts with appropriate pharmacies initiated</td>
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<td>4. <strong>Procurement for CPAMS</strong>: Develop and use new criteria focusing on equity to select 6 pharmacies to provide this service (funding will be within baseline pharmacy budget). Equity for Māori and Pacific will be a consideration when contracting these services. (EOA)</td>
<td>Q3: CPAMs contracts awarded implemented 19/20 year</td>
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<td><strong>Child Health</strong></td>
<td>Please identify the most important focus areas to improve child wellbeing and that realises a measurable improvement in equity for your DHB. Identify key actions that demonstrate how the DHB is building its understanding of population needs, including those of high-needs populations, and making connections with and between local service providers of maternal health, child health and youth focused services.</td>
<td>Value and High Performance</td>
<td>1. <strong>Shaken Baby Prevention Programme</strong>: Implement recommendations from 2017/18 evaluation of the Shaken Baby Prevention Programme. (EOA)</td>
<td>Q1-Q4: Improvement activities planned and implemented. Q2-Q4: A data audit undertaken to ensure accurate ethnicity data collection and identify areas of high utilisation by Māori and Pacific</td>
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<td><strong>Child Wellbeing</strong></td>
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<td>2. <strong>Violence Intervention Programme (VIP)</strong>: Continue the rollout of the VIP training to DHB health professionals. (EOA)</td>
<td>Q4: 60% of clinical staff received VIP Training across hospital health services.</td>
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<td>3. <strong>Child Protection Services</strong>: (i) Continue to work with local agencies to promote better alignment and integration of child protection services; and (ii) Coordination of partner and child abuse and neglect programmes to support increased identification of vulnerable children. (EOA)</td>
<td>Q4: Participate in the Interagency Governance Group addressing family harm</td>
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<td>Maternal Mental Health Services</td>
<td>Commit to have completed a stocktake by the end of quarter two, of community-based maternal mental health services currently funded by your DHB, both antenatal and postpartum. Please include funding provided to PHOs specifically to address primary mental health needs for pregnant women and women and men following the birth of their baby. Commit to identify, and report in quarter four on the number of women accessing primary maternal mental health services both through PHD contracts that the DHB holds and, through any other DHB funded primary mental health service.</td>
<td></td>
<td>1. Maternal Mental Health Screening: Develop a model for mental health screening as part of a pepi pod support package. This work will focus on Māori and Pasifika families’ (EOA) Q2: Options investigated Q3: Preferred option developed Q4: Model implemented as part of the SUDI work programme.</td>
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<td>2. Māori and Pacific workforce: To ensure accurate ethnicity data collection to inform areas of high utilisation by Māori and Pacific, as consideration for an increase in Māori and Pacific representation in the relevant workforce. Q3: Undertake analysis of services and identify areas for development Q4: Plan for implementation of actions in 2018/19 to address results of review</td>
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<td>3. Community-Based Maternal Mental Health: (i) 'Complete a stocktake of community-based maternal mental health services (both antenatal and post-partum)'; (ii) Improve quality of information available to new families about options for mental health support. Q2: Stocktake completed of community-based maternal mental health services (both antenatal and post-partum); Q3: Engage with Māori and Pacific communities to assess options for the provision of information Q4: A plan developed and implemented to deliver new and updated information to families</td>
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<td>4. Intimate Partner Violence (IPV): Increase Routine Enquiry relating to IPV for eligible patients presenting to Postnatal and Maternity Inpatient Services (Woman’s Health; WH), Paediatric Inpatient Services (Youth Health; YH), and Emergency Department (ED)</td>
<td>Q3: 80% of eligible patients presenting to WH will be subject to routine enquiry ('screening') for IPV Q3: 50% of eligible patients presenting to CH will be subject to routine enquiry ('screening') for IPV Q4: 30% of eligible patients presenting to ED will be subject to routine enquiry ('screening') for IPV</td>
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<td>5. Child Abuse &amp; Neglect (CAN): Increase the use of the Injury Flow Chart relating to CAN for eligible patients (children &lt; 2 years) presenting to ED. Q4: 75% of eligible patients (children &lt; 2 years) presenting to ED will have an Injury Flow Chart completed.</td>
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<td>6. Sex &amp; Gender Diverse Youth: (i) Continue work to develop model for primary-based trans-affirmative care for youth Q2: Review and assess existing support services Q3: Recommendations developed based on findings of 2017/18 model of care work</td>
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<tr>
<td>Supporting Health in Schools</td>
<td>Identify actions currently under way to support health in schools by the end of quarter two (in addition to School-Based Health Services – see guidance below).</td>
<td><strong>1. Oral Health:</strong> Develop action plan to address Māori and Pacific inequities in utilisation of DHB-funded adolescent dental services. (EOA)</td>
<td>Q4; Action plan developed</td>
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<td><strong>2. Youth Diabetes:</strong> Scoping and development of strategy to use digital technologies to address diabetes management with a focus on Māori and Pacific youth (ages 15 – 19). (Refer to ‘CVD and diabetes risk assessment’) (EOA)</td>
<td>Q3; Strategy developed</td>
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<td><strong>3. Comprehensive School Based Health Services:</strong> exploration of models to increase mental health support in school settings.</td>
<td>Q2; Project plan developed</td>
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<td><strong>4. Youth Services in Porirua:</strong> Increase provision, coordination and integration of services for young people in Porirua. (EOA)</td>
<td>Q4; Project plan developed</td>
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<tr>
<td>School-Based Health Services (SBHS)</td>
<td>Commit to have completed a stocktake of health services in public secondary schools in the DHB catchment (MoH to provide list of schools) by the end of quarter 2. Commit to have developed an implementation plan including timeframes for how SBHS would be expanded to all public secondary schools in the DHB catchment (MoH to provide template) by the end of Q4. Note that the implementation plan should include an equity focus.</td>
<td><strong>1. School Based Health Services:</strong> Develop a service delivery model for school based health services to increase acceptability and uptake by Māori youth (EOA)</td>
<td>Māori: Q4; Model developed</td>
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<td><strong>2. Health Services in Public Secondary Schools:</strong> Complete a stocktake of health services in public secondary schools within the CCDHB Catchment</td>
<td>Q2; Stocktake completed</td>
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<td><strong>3. School Based Health Services Expansion:</strong> Develop an implementation plan, with equity focus, to expand SBHS to all public secondary schools in the CCDHB catchment. (EOA)</td>
<td>Q4; CCDHB Youth ICC Steering Group to approve implementation plan</td>
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| Immunisation                | Work as one team across all immunisation providers within your region, and in collaboration with other child services, to improve immunisation rates and equity for the key milestone ages in early childhood. This includes delivery of the primary series of vaccines under one year of age, and completion of immunisations due at two and five years of age, with a particular focus on increasing immunisation rates for Māori infants. | One Team | 1. Immunisation Rates Māori and Pacific (EOA)  
Māori: scope, implement and formalise a plan of activities to reduce the decline / non-completion rate for Māori children  
Pacific: scope, implement and formalise a plan of activities that will improve 5 year immunisation rates. |
|                            |                             | Q1; Conduct investigation   | Q1-Q4; Advocate for improvements to NIR IT systems |
|                            |                             | Q2; Plan developed and implemented | |
|                            |                             | Q1 - Q4; Maintain Health Target | |
|                            | Please provide three specific actions that will increase Māori infant immunisation coverage levels and sustain high levels during 2018/19. These actions must be accompanied by a date for implementation of the action, an expected outcome, and a date by which the outcome will be achieved. | Value and High Performance | 2. National Immunisation Register: Advocate for improvements to the NIR IT systems to support providers in achieving the Health Target (EOA) |
|                            |                             | Q1-Q4; Advocate for improvements to NIR IT systems | |
| System Settings            | Strengthen Public Delivery of Health Services | Value and High Performance | 1. Māori Infant Immunisation Coverage Levels:  
The specific actions will be incorporated within the Māori focussed Equity action where in Quarter 1-2 an investigation will be conducted into immunisation performance; A plan will be developed, implemented and monitored |
|                            | Identify any activity planned for delivery in 2018/19 to strengthen access to public health services. | Q1; Conduct investigation   | Q1; Conduct investigation |
|                            |                             | Q2; Plan developed and implemented | Q2; Plan developed and implemented |
|                            |                             | Q1 - Q4; Maintain Health Target | Q1 - Q4; Maintain Health Target |

2. Cervical Screening: Work with PHOs on a data matching and quality improvement initiative to improve coverage of cervical screening for Māori and Pacific women. (EOA)  
Q4; Reach target coverage for Māori and Pacific (80%)
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<td><strong>Cancer Services</strong></td>
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<td><strong>Value and High Performance</strong></td>
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<td>1. Equitable access to diagnosis and treatment:</td>
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<td>Enable equity of access to timely diagnosis and</td>
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<td>treatment services for all patients on the Faster</td>
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<td>Cancer Treatment (FCT) pathway (eg system/service</td>
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<td>improvements to minimise breaches of the 62 day FCT</td>
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<td>for patient or clinical consideration reasons)</td>
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<td>Identify potential improvements to drive equity</td>
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<td>(i.e. improving supportive care services for</td>
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<td>Māori) (EOA)</td>
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<td>Q1; Performance monitoring and reporting from FCT</td>
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<td>steering group</td>
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<td>Q2; Opportunities for improvements identified</td>
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<td>Q1/2; Regionally agreed cancer CT/MRI protocols and</td>
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<td>diagnostic pathways implemented</td>
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<td>Q3/4; Improvements to Cancer MDM business processes,</td>
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<td>data reporting and clinical resourcing implemented</td>
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<td>Q3/4; Regional coordination and support of actions</td>
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<td>to improve cancer systems and services to ensure</td>
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<td>health gain for Māori and equitable and timely</td>
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<td>access to cancer services</td>
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<td>Q3/4; Partner with the Cancer Society and CCN to</td>
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<td>deliver survivorship programmes for Māori</td>
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<td>Q4; Prostate decision support tool implemented by</td>
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<td>primary care providers</td>
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<td>Q4; Clinical pathways reviewed to ensure links to</td>
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<td>the tool are included and content is aligned</td>
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<td>Q4; Urologists and oncologists informed about the</td>
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<td>content and use of the decision support tool</td>
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<td>Q1/2; Socialise the national survivorship consensus</td>
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<td>statement and identify opportunities to review</td>
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<td>existing services/programmes or develop new ones</td>
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<td>Q1-Q4; A cancer analytics framework for the region</td>
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<td>Q1-Q4; A prioritised tumour stream approach for the</td>
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<td>region developed and implemented</td>
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<td>Q1/2; Project initiated - commence implementation</td>
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<td>of an Integrated Oncology Management System (IOMS)</td>
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<td>Q3/4; MOSAIQ implemented</td>
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<td>Implement improvements in</td>
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<td>accordance with national</td>
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<td>Q1-Q4; A cancer analytics framework for the region</td>
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<td>Q1-Q4; A prioritised tumour stream approach for the</td>
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<td>region developed and implemented</td>
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<td>Q1/2; Project initiated - commence implementation</td>
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<td>of an Integrated Oncology Management System (IOMS)</td>
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<td>Q3/4; MOSAIQ implemented</td>
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<td>Government Planning Priority</td>
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| **Healthy Ageing**          | Deliver on actions identified in the Healthy Ageing Strategy 2016, involving older people in service design, co-development and review, and other decision-making processes, including:  - working with ACC, HQSC and the Ministry of Health to promote and increase enrolment in your integrated falls and fracture prevention services as reflected in the associated “Live Stronger for Longer” Outcome Framework and Healthy Ageing Strategy  - contributing to DHB and Ministry led development of Future Models of Care for home and community support services. In addition, please outline current activity to identify drivers of acute care. | Close to Home | 6. **Cancer Services Review**: Implement recommendations from cancer model of care reviews and establish work programme to support increased access to care, while reducing health disparities, integrating health care across our health system, and living within our means. This review will incorporate an external clinical perspective and patient perspective.  
   Q1; Progress service reviews (complete data review, engage consumer and external review)  
   Q2/3; Delivery of chemotherapy at Hutt Valley DHB and Kapiti reviewed  
   Q2/3; Improvements to acute flow reviewed by utilising the Acute Assessment Unit for week day acute admissions and progress changes arising from service review. |
| **Close to Home**            | 1. **Support Access’s “Family Choice” employment option**: This enables whānau, where appropriate and preferred, to be employed by Access Community Health to provide care. |  | Q4; Increase the number of Māori supported by 10%; increase the number of Pacific supported by 10% |
| 2. **Ageing Safely and Independently**:  
   (i) Develop an Investment Plan for Healthy Aging;  
   (ii) implement community circles in Kapiti; and  
   (iii) Identify Frail and Prefrail individuals in the CCDHB population and match primary and secondary care data at a NHI level. |  | Q3; Investment plan approved for 19/20 investments  
   Q4; Community circles implemented in Kapiti  
   Q2-4; Ongoing data collection and matching with individuals added to cohort as they meet the identification criteria. |
| 3. **Community Integrated Falls and Fracture Prevention Programme**: Implementation and monitoring of the 3DHB Community Falls Management Programme. |  | Q1; Services implemented and reporting in place  
   Q4; Analysis of service utilisation and performance for the first year completed including equity considerations. |
| 4. **Working with the Ministry and Sector to Develop Future Models of Care**: Commission Design Process. HVDHB to lead, CCDHB to support. |  | Q2; Commission Design Process  
   Q3-4; Ensure that review outcomes are implemented in accordance with MoH future model of care. |
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<tr>
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<tr>
<td>Demand for people 75 plus presenting at ED (or at lower ages for disadvantaged populations).</td>
<td>5. Advance Care Planning (ACP): improve ACP awareness and use by: Engaging older people with ACP and support them &amp; their whānau to discuss ACP; educating consumers and health professionals about ACP; engaging Māori by collaborating with Māori Women’s Welfare League and taking ACP to marae/s; and supporting people to document their ACP with their GP teams by building capacity &amp; systems/processes. (EOA)</td>
<td>Q3; 15 Age Concern Community champions trained Q2-4; 4 conversation coaching groups delivered Q2-4; Social isolation programme delivered to older people Q1-4; ACP education sessions to consumers and health professionals Q1; local ACP workshop facilitators trained Q2-4; ACP one day workshops delivered locally by local trainers</td>
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<td>Disability Support Services</td>
<td>Commit to develop e-learning (or other) training for front line staff and clinicians by the end of quarter 2 2018/19 that provides advice and information on what might be important to consider when interacting with a person with a disability. (Some DHBs have developed tools which could be shared, contact DSS). Commit to report on what % of staff have completed the training by the end of quarter 4, 2018/19.</td>
<td>1. E-Learning Tool: The E-Learning Tool is in place to improve decision making within clinical situations. For 2018/19 the current 3DHB e-learning tool will be reviewed, including usage, Māori &amp; Pacific focus and outcomes.</td>
<td>Q2; Finalise the review Q4; Adapt current tool for implementation in Q1 2019/20</td>
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<tr>
<td>One Team</td>
<td>2. Disability Educator Role: re-establish CCDHB’s disability educator role within Capability and Development, to work with local and wider disability and other teams.</td>
<td>Q1; Disability educator appointed Q2-Q4; Alignment of disability educators’ work programmes and priority areas across the 3DHBs</td>
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<td>3. Disability Alerts - Quality: CCDHB aims to reduce unsafe longer admissions for disabled people by improving information given to clinicians by patients. People who have disabilities and/or chronic health conditions are invited and supported to complete Disability Support Solutions Forms to engage clinical staff in proactive well-informed care. For 2018/19, CCDHB will establish a view of the current quality of the Disability Alerts. Develop education in line with the e-Learning review (1) and the educators’ work programme and priorities (2)</td>
<td>Q1-Q2; Establish the quality Q3: Plan for education</td>
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<td>4. Disability Alerts – Equity: Work with CCDHB’s Māori and Pacific Directorates to support the uptake of Disability Alerts for Māori and Pacific populations. (EOA)</td>
<td>Q1-Q2; Establish view of Disability for Māori and Pacific populations Q3-Q4; Develop a plan to support increased uptake by Māori and Pacific.</td>
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<td>Improving Quality</td>
<td>Identify actions to improve equity in outcomes and patient experience by demonstrating planned actions to: - work to improve equity in outcomes as measured by the Atlas of Healthcare Variation (DHB to choose one domain from: gout, asthma, or diabetes) - improve patient experience as measured by your DHB’s lowest-scoring question in the Health Quality &amp; Safety Commission’s national inpatient experience surveys.</td>
<td>1. Consumer Engagement: (i) continue to participate in the National Patient Experience survey (EOA); (ii) focussed improvement work in the four patient experience survey domains. This will be achieved through staff communication training from the cognitive institute, implementation of co-design principles focussed on an agreed improvement project for each of the four domains (in partnership with the HQSC)</td>
<td>Q4; Hospital (Inpatient) Experience Survey response rate will meet or be above the national average response rate for each of the four quarters. Hospital (Inpatient Experience Survey) met the 2018/19 targets for all four domains of the inpatient experience survey.</td>
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<td>2. Improve Patient Outcomes: Continue to apply CCDHB patient outcomes programmes including: (a) reducing opioid medication errors; (b) reducing hospital acquired pressure injuries; (c) improving early detection of the deteriorating patient; (d) supporting the national HQSC programmes; to identify areas for improvement; and (e) improve the process for those who are reaching the end of their lives. (EOA)</td>
<td>Q4; Achieve targets for Māori, Pacific and total as set in Statement of Performance expectations related to: (a) opioid medication errors; (b) hospital acquired pressure injuries; and (c) early detection of the deteriorating patient. Q1-Q4; Support national HQSC programmes.</td>
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<td>3. In-Patient Falls Management: (a) progress the HHSG initiatives linked to the Falls Prevention and Management Model in partnership with ACC (refer Health Ageing). (Target group are inpatient’s with fragility fracture and patients presenting to ED but not admitted); and (b) focussed improvement work to reduce inpatient falls rate in five identified high falls rate inpatient areas. EOA</td>
<td>Q1-Q4; Appropriate discharge summary information and allied health referrals completed for target group. Achieve targets for Māori, Pacific and total as set in SPE related to reduction in falls rate in five key inpatient areas.</td>
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<td>Government Planning Priority</td>
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| Climate Change              | Commit to individually and collectively make efforts to reduce carbon emissions and, where appropriate, promote the adoption of CEMARS (or other carbon neutral scheme). Commit to undertake a stocktake to be reported in Q2 to identify activity/actions being delivered, including procurement, that are expected to positively mitigate or adapt to the effects of climate change. | Value and High Performance | **Activity**  
4. Leadership & Capability: (a) continue the capability and leadership programmes focussed on improvement science to support a culture of continuous improvement; (b) implementation of the speaking up for safety and reliability science improvement series as part of the Cognitive Institute Partnership Program; (c) continue with the service reviews focussed on wider service integration and whole of system change as outlined in the EBHC plan; and (d) implementation of QLIK sense (a data visualisation system) aimed at fostering the use of data and other forms of information into actioned insights that enable the DHB to achieve its strategic goals.  
**Milestones**  
Q1 - Q4; Continue with the CCDHB Improvement Movement and front-line leadership programme with measurable outcomes (percentage of staff trained).  
Q1 – 4; Demonstrate improved patient and staff safety outcomes as a result of the speaking up for safety and reliability science improvement series (programme evaluation measures)  
Q1-Q4; Demonstrate wider service integration and whole of system change through the service review process with measurable outcomes  
Q1 –Q4; QLIK sense fully implemented  
**Measures** |
| Waste Disposal              | Provide actions to raise awareness and actively promote the use of your DHB’s pharmaceutical waste collection and disposal arrangements. Commit to undertake a stocktake to be reported in quarter 2 of 2018/19 | Value and High Performance | 1. Public Awareness: (i) Community nurses and CCDHB website communicate the pharmaceutical waste collection; (ii) Collection of sharps from community pharmacies is advertised via posters in community pharmacies and some public buildings (libraries, community halls) in the Wellington City area.  
Q1: CCDHB website set up to communicate information about waste.  
Q2: Posters send to pharmacies and other points to display  
**Measures** |
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<th>Government Planning Priority</th>
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<td>to identify activity/actions to support the environmental disposal of hospital and community (eg, pharmacy) waste products (including cytotoxic waste).</td>
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<td>2. Stocktake: CCDHD is committed to provide a stocktake that provides strategical, tactical and operational activities that support the environmental disposal of hospital and community waste products including cytotoxic waste.</td>
<td>Q1-Q4: Quarterly reporting on community pharmacy waste collection (weight, number of cartons and pharmacies collected from). Q1: Stocktake completed Q2: Report on the Stocktake</td>
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<td>Fiscal Responsibility</td>
<td>Commit to deliver best value for money by managing your finances in line with the Minister’s expectations. Local improvement activities to respond to Government intentions (DHBs required to include actions in this sections will be advised)</td>
<td>Value and High Performance</td>
<td>CCDHB Even Better Health Care Plan: Continue implementing the CCDHB Even Better Health Care Plan 2017-2021 (previously Sustainability Plan) within the context of the HSP by strengthening our operating environment and redesigning service delivery models across four programme areas: Hospital and Health services, Integrated Care, MHAIDS and Infrastructure</td>
<td>Q1-Q4: Prioritised projects within each programme implemented, tracking progress to ensure key project deliverables are met. Q4: Programme deliverables completed for year three of the Even Better Health Care Plan 2017 - 2021</td>
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<td>Budget 18 Initiatives</td>
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<td>Health Targets</td>
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<td>Cross-Government Targets</td>
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### Delivery of Regional Service Plan

**Focus Expected for the DHB**
Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan. In particular, for Elective Services, identify local actions to support planned Elective activity in the regional service plan across, Workforce, Clinical Leadership, Quality and Pathways. There is a strong focus on regional collaboration in 2018/19 for Orthopaedics, Ophthalmology, Vascular and Breast Reconstruction.

**CCDHB Key Response Actions to Deliver Improved Performance**

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<th>Activity</th>
<th>Milestones</th>
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| CCDHB will support the region to deliver the RSP. The RSP focuses on four key regional priority areas:  
- **Cancer** - Activities TBC in the RSP  
- **Cardiac** – Develop standardised AF and HF programmes to reduce barriers of access for Māori and assess feasibility of standard monitoring system to capture Atrial Fibrillation and Heart Failure  
- **Mental Health and Addiction** - Activities TBC in the RSP  
- **Regional Care Arrangements** - Regional Service stocktake to identify issues with current model |  
- **Cancer** – Milestones TBC in the RSP  
- **Cardiac** – Q1-Q2; AF an HF stocktake completed, Q4; standardised programme is established that improves access for Māori  
- **Mental Health and Addiction** – Milestones TBC in the RSP  
- **Regional Care Arrangements** – Q1-Q2; Regional service stocktake completed | NA |
Financial Performance Summary
(Placeholder for Financial Performance Summary pending release of Funding Envelope)
SECTION 3: Service Configuration

Service Coverage
All DHBs are required to deliver a minimum of services, as defined in The Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually. Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups.

CCDHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.

CCDHB is not seeking any formal exemptions to the Service Coverage Schedule in 2018/19.

Active Service Changes
The table below describes all service changes that have been approved for implementation at CCDHB in 2018/19. Sub-regional service changes that do not affect the CCDHB domiciled population are excluded.

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<th>Change</th>
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<th>Benefits of Change</th>
<th>Change for local, regional or national reasons</th>
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<tr>
<td><strong>Contract Changes for Non-Devolved Services</strong></td>
<td>A number of contracts, currently funded through direct contracts with MoH / other agencies or CFA obligations, may be terminated early if funding is not approved for 2018/19.</td>
<td>- Decisions not under CCDHB control unless DHB decides to prioritise funding to the services</td>
<td>National</td>
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<tr>
<td>Community Pharmacist Services</td>
<td>Implement the national pharmacy contracting arrangement. Review local service delivery through Community Pharmacies and the Pharmacy Facilitation Service.</td>
<td>- More integration across the primary care team - Improved access to pharmacist services by consumers - Consumer empowerment - Safe supply of medicines to the consumer - Improved support for vulnerable populations - More use of pharmacists as a first point of contact in primary care.</td>
<td>National</td>
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<tr>
<td>Bowel Cancer Screening Programme</td>
<td>Tranche 2 implementation of bowel cancer screening service in line with national programme.</td>
<td>- Improved detection and management of people with bowel cancer</td>
<td>National</td>
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<tr>
<td>Cancer Services</td>
<td>The three cancer services (Haematology, Medical Oncology) all have experienced increasing demand which has led to capacity and resource constraints. A programme of change will be developed for these services which will: - Identify opportunities for performance improvement.</td>
<td>- To manage demand and ensure the provision of affordable, high quality and safe services into the future.</td>
<td>Regional</td>
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<tr>
<td>Change</td>
<td>Description of Change</td>
<td>Benefits of Change</td>
<td>Change for local, regional or national reasons</td>
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<td>Oral Maxillofacial</td>
<td>Develop a single acute service model for Lower North Island as part of the Central Region Service.</td>
<td>- Improve service sustainability</td>
<td>Regional</td>
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<tr>
<td>Central regional cardiology STEMI Model</td>
<td>Establish Local/Central coordination for a regional pathway</td>
<td>- Improved access to PCI</td>
<td>Regional</td>
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<tr>
<td>Radiology Demand (not led internally by Radiology Services)</td>
<td>During 2018/19 there will be service changes to the referral criteria to Radiology services as led by the hospital Demand Management group (in response to the 2017/18 Sapere service review of 3DHB Radiology Services).</td>
<td>- Improve service sustainability - Improve efficiency - Improve waiting times</td>
<td>Regional (3DHB service capacity and scheduling)</td>
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<tr>
<td>MHAIDS Integration</td>
<td>Work is being carried on the structure and nature of services currently provided which may result in service changes. These changes will reflect the outcome of the Mental Health inquiry</td>
<td>- Equitable outcomes - More integrated services</td>
<td>3DHB Sub-regional</td>
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<tr>
<td>Sub-Regional Breast Disease Services Review</td>
<td>To develop an integrated, coherent model of service delivery and care for the management of breast cancer patients for the Wellington 3DHB sub-region</td>
<td>- Improve outcomes for patients across the sub-region - Provide a patient centric, coherent, consistent plan to improve outcomes and equity of care for all patients - create a sustainable service including staffing needs</td>
<td>3DHB Sub-regional</td>
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<tr>
<td>National Transport Agreement</td>
<td>Change to taxi transport for patients undergoing renal dialysis. Provider change and also patients supported may change depending on patient’s clinical need.</td>
<td>- Appropriate usage of NTA using the national criteria</td>
<td>Hutt Valley DHB and CCDHB</td>
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<tr>
<td>Home and Community Support Services</td>
<td>The DHB is reviewing its commissioning of Home and Community Support Services for people over 65 years of age, which may result in the procurement of these services in 2018/19. This may result in new providers entering the market for these services, and will result in the transition of some clients from Access to another provider.</td>
<td>- Improved health outcomes - Address health inequities - Improved responsiveness to older persons - Supports Ageing in place</td>
<td>Hutt Valley DHB and CCDHB</td>
</tr>
<tr>
<td>Sub-Regional Clinical Services Planning</td>
<td>As part of Hutt DHB’s clinical services plan development, further work is now required to understand the sub-regional opportunities in the configuration of specialist hospital services in particular. A programme of work will be kicked off to review potential configurations of some specialist services across the 2 DHBs.</td>
<td>- Value for money - Improved clinical capacity and sustainability - Improved health outcomes</td>
<td>Hutt Valley DHB and CCDHB</td>
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<tr>
<td>Change</td>
<td>Description of Change</td>
<td>Benefits of Change</td>
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| **Integrated Youth Services for Porirua** | Co-design approach to integration of services for youth in Porirua locality involving colocation of some services. Agreed model to be developed following intensive community and provider engagement. | - Improved access  
- Improved patient experience  
- Reduced duplication and increased efficiency of service delivery  
- Improved patient outcomes | Local |
| **Comprehensive School Based Health Services** | Develop multidisciplinary team model for school health clinics including mental health support. Co-design approach with schools to create community-specific services. | - Improved access  
- Earlier, effective intervention for young people experiencing mental distress | Local |
| **Whole of Life Needs Assessment and Service Coordination** | Scope a whole of life approach to needs assessment and service coordination inclusive of DHB mental health and Ministry of Health funded NASC services. | - More responsive services  
- Improved patient access  
- Improved patient outcomes  
- Improved patient satisfaction  
- More efficient services | Local |
| **Refugee services** | Commissioning of services ensuring the funding that we have is fairly distributed and targeted at people’s needs - impacts will be in 19/20 | - Equitable outcomes  
- Increase efficiency of service  
- Improve resource utilisation | Local |
| **Palliative Care** | Commissioning of services to improve patient journey, provide better outcomes for people and their families and optimal use of investments - changes in 19/20 | - Improved outcomes for patients  
- Improved patient experience | Local |
| **Healthy Aging** | Commissioning of services to improve patient journey and ensuring optimal use of investment - changes in 19/20 | - Improved outcomes for patients  
- Improved patient experience | Local |
| **Maternity Services** | Review DHB-run primary birthing centre services, to align with the Locality Network service model as set out in CCDHB’s Health System Plan. | - Increase efficiency of service  
- Improve resource utilisation | Local |
SECTION 4: Stewardship

This section provides an outline of the arrangements and systems that CCDHB has in place to manage our core functions and to deliver planned services.

4.1 Managing our Business

Organisational performance management

CCDHB’s performance is assessed on financial, quality, service delivery and system-level measures. Internally, performance is presented to the Clinical Council, ELT, the Healthy System Committee (HSC), and the Board. CCDHB reports to the Ministry on a quarterly, six-monthly or annual basis.

Funding and financial management

CCDHB’s key financial indicators are spend against budget and budget against deficit. These are assessed against and reported through CCDHB’s performance management process to the ELT and the Finance and Risk Assessment Committee (FRAC). Further information about CCDHB’s planned financial position for 2018/19 and out years is contained in section 2.4 Financial Performance Summary.

Investment and asset management

CCDHB is committed to three year sustainability pathway (CCDHB Even Better Health Care) that emphasises cross-organisation and system governance of financial and service delivery performance. It is supported by an Investment Approach that considers all investments across the health system, and determines their impact on the optimisation of the system. Part of the work programme is the development of whole of system investment plans, capital investment, infrastructure development and service investment strategies as reflected in the Long Term Investment Plan currently being updated.

Shared service arrangements and ownership interests

CCDHB has a part ownership interest in Central Region Technical Advisory Service (CRTAS), the Regional Health Information Partnership (RHIP), Allied Linen Services Ltd (ALSL) and New Zealand Health Partnerships (NZHP). The DHB does not intend to acquire interests in companies, trusts or partnerships.

Risk management

The CCDHB Risk Management Framework provides principles and process to ensure CCDHB is operating in accordance with the 2008 Health and Disability Service Standards, the AS/NZS ISO 31000:2009 standard for Risk Management, and the Health and Safety at Work Act 2015 and associated regulations.

Health and Safety (H&S) is a particular focus across the DHB. Accountability for H&S is the responsibility of every manager and employee. Systems for reporting, investigating and managing H&S incidents and risk are deployed across the organisation.

The Finance, Risk & Audit Committee (FRAC) of the CCDHB Board has oversight of internal controls (including risk management) and is focussed on financial and contractual matters of significance.

The DHB has established external and internal Audit functions which provide independent professional assessments of key risks, the accuracy and integrity of CCDHB financial reports, and the adequacy of internal controls. We are progressing improvement plans for the Treasury Investor Confidence Rating.

Quality assurance and improvement

Evidence indicates that patient experience, partnerships with consumers and family-centred care are linked to improved health, clinical, financial, service, and patient satisfaction outcomes.
Quality of care is underpinned by the “Triple Aim”, an international healthcare improvement policy that outlines a plan for better healthcare systems. CCDHBs clinical governance structures provide leadership for continuous improvement, patient safety and process design to enable us to achieve these priorities.

CCDHB has a three year programme with the Cognitive Institute to improve safety for staff and patients, continue to build staff capability and capacity in improvement methodology.

4.2 Building Capability

Capital and infrastructure development

CCDHB has a significant investment in capital assets particularly property, ICT and clinical equipment. Our plans for capital investment are outlined in our Asset Management Plan. Key activities include:

- The development of a Master Site Plan for all CCDHB facilities.
- CCDHB has a number of older properties which are not suitable for use. Options for these properties are being considered. CCDHB has significant property assets with poor utilisation due to historical design. Options are being investigated to improve utilisation and reduce occupancy.
- The Wellington Regional Hospital domestic hot and cold water systems are exhibiting signs of failure. Plans are being developed to resolve this issue.

Information technology and communications systems

Information technology and communications systems (ICT) are integral to shorter, safer patient journeys, supporting new models of care and sustainable health services. The role of ICT is to support:

- Individuals and their whānau/families to have access to information and tools to maintain their health and wellbeing and know that information is safely shared across their health team.
- Healthcare Professionals to have anywhere, anytime access to information and tools, so as to release more time for, and to provide the best care possible for their patients.
- Managers and Administrators to have the tools and information to efficiently and effectively allocate resources, manage operations and plan for the future.

Workforce

The Minister of Health has identified a strong public health system as a key priority for 2018/19, with a focus on addressing inequalities, the provision of primary care and mental health services and building an engaged workforce.

It is essential that the CCDHB People Strategy interacts with the NZ Health Strategy, in particular actions to build “one” team and the HSP to enable organisational success and health system sustainability.

Our People Strategy has the following principles and strategic intent:

<table>
<thead>
<tr>
<th>Principle</th>
<th>Strategic Intent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong foundations</td>
<td>Invest in the fundamental building blocks that ensure our people have the skills and tools to excel and to lift health outcomes for our whole population, with a focus on Māori and Pacific peoples.</td>
</tr>
<tr>
<td>Trust and partnership</td>
<td>Support open respectful communication, shared decision making, easy processes, transparency and individual accountability.</td>
</tr>
<tr>
<td>Promoting wellbeing</td>
<td>Work together for the health and wellbeing of our people and the community we serve.</td>
</tr>
</tbody>
</table>
Learning from excellence  Foster innovation to ensure we do more of what we do well. Recognise the efforts and contribution of individuals, teams, leaders and managers.

Nationally the People Force 2025 developed by the Workforce Strategy group continues to be relevant and guides investment in workforce development. We expect the evolution of this approach and its application to CCDHB, will create a clear link to the contribution that CCDHB will make to delivering on the Government’s Expectations for Employment Relations in the State Sector.

We will work with the Director Planning, Improvement and Regional Workforce to develop and deliver a workforce plan as part of the 2018/19 Regional Service Plan. The workforce plan will outline regional actions, key milestones and will reflect our approach to meeting Health Workforce New Zealand expectations.

Internally we will implement actions from our engagement survey and further our people strategy.

Key initiatives include:

- **Values** - the people strategy has highlighted what is important to our staff. The next step is to refresh the organisational values and to identify and embed expectations and behaviours consistent with these values.

- **Supporting Safety Culture** - Our first focus is Speaking Up For Safety. Our primary focus over the coming months is the launch and roll out of Speaking Up For Safety. During that period, we will be developing the broader concept of Safety Champions and choosing from the range of targeted interventions Cognitive Institute provides to improve clinician communication, coaching and feedback. We will also be exploring how the Promoting Professional Accountability framework can best be utilised in our setting.

- **Communication** - Optimising organisational communication is a key focus area identified through the staff engagement survey. Key activities will focus on integrating communications for the people strategy, HSP, EBHC and values work to ensure staff are actively engaged, informed and involved.

- **Leadership** - Strengthening leadership by creating a clear message about what we value in leaders, supporting our leaders to develop their confidence, skills and expertise. Providing growth through on-the-job opportunities, formal programmes, mentorship and coaching. Fostering a working knowledge of the wider context of health systems. Growing our own next generation of leaders through talent management processes.

- We will continue to build our understanding of our workforce. We will be developing our ability to integrate workforce intelligence and utilise forecasting tools.

We strive to be a good employer and are aware of our legal and ethical obligations. We are aware that good employment practices are critical to attracting and retaining top health professionals who embody our values and culture in their practice and contribution to organisational life.

We recognise the aims, aspirations, cultural differences and employment requirements of Maori people, Pacific Island people and people from other ethnic or minority groups. We provide opportunities for individual employee development and career advancement.

Postgraduate Year 1 and 2: Continue to build capability through our commitment to workforce initiatives and high quality training for PGY 1s and 2s

**Co-operative developments**

CCDHB is developing its approach to health and social service integration using a localities approach to working with communities, NGOs, PHOs, charitable organisations and health and social service agencies. This approach is commencing in Porirua and in the support of young people with mental health needs.

In the delivery of hospital and health services CCDHB is developing a work plan with its nationwide tertiary care partners and in the region as a complex care provider. This includes developing a clinical services planning approach in partnership with Hutt Valley DHB for services that may be shared.
In the delivery of Mental Health, Addiction and Intellectual Disability services CCDHB is a nationwide provider of complex services, a regional provider and the sub-regional provider. CCDHB has strong relationships with its two PHOs and the NGO sector. The partners work together for system improvement through the local Alliance Leadership Team, the Integrated Care Collaborative (ICC).

4.3 Workforce

4.3.1 Healthy Ageing Workforce

During 2018/19 the DHB will work closely with regional DHB shared services continuing its work to identify the workforce requirements around the service delivery needs for services to older people and their family / whānau / informal carers.

This work builds on current data collection processes and continues within the context of existing sub-regional service developments and national workforce programmes, including the ongoing implementation of pay equity, guaranteed hours, in-between travel and regularisation. The work will enable development of a workforce plan that ensures those working with older people have the training and support they require to deliver high-quality, person-centred care.

The workforce plan will:

- focus on the primary, secondary and tertiary service requirements and endeavour to bring together the respective workforces needed to deliver these services effectively at the DHB, sub-regional and regional levels
- strategies to support specialist workforces to deliver education and training sessions for non-specialist workforces
- identify and prioritise vulnerable workforces
- prioritise allied health, kaiāwhina and carer and support worker workforces
- refer to and incorporate guidance and actions outlined in the Healthy Ageing Strategy

4.3.2 Health Literacy

CCDHB has a significant programme of work underway to shift our organisation’s culture, in how our people work together, with our communities and with patients and whanau. Improving health literacy and achieving greater empowerment for patients is dependent upon and will be informed by this work over the coming year to strengthen and enable our people.

CCDHB will build our understanding and approach for supporting health literacy through our Optimal Ward project. With a strong co-design process at its heart, we will gather input and guidance from patient and whanau groups, and specifically Maori and Pacifica. Through optimising the environment, processes, tools, and staff capability, we will identify and prioritise key opportunities to impact health literacy outcomes – for patients and whanau to be engaged in their healthcare and feel supported and able to manage their healthcare needs. Learnings from this project will feed into our people capability planning for professional development priorities.

The Optimal Ward project draws on the expertise of our Maori and Pacifica Health units and will build internal capability to continue this transformation with CCDHB services.

During the coming year we will continue to grow our new orientation programme, Te Rā Whakatau, with the ingoing input of our Maori Health Development Group and Pacific Health Units. They will continue to provide support and guidance for the design or review of policies, staff resources, and patient and whanau information materials. Our Capability Development team will work to support the design and delivery of clinical and non-clinical development, to weave key themes and priorities into staff training and professional development courses as they are developed.
## 4.4 IT

<table>
<thead>
<tr>
<th>Work Programme</th>
<th>Activity for 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Maternity System</td>
<td>Complete the planning for adoption of the National Maternity System with a view of implementation in 2019/20.</td>
</tr>
<tr>
<td>Digital Health Services</td>
<td>(i) Complete transition to the Indici Shared Care Record; (ii) Progressively expand the use cloud based tools to support team based communications, Multi Disciplinary Team meetings and telehealth/virtual care; (iii) Transition to smart GP eReferrals platform; (iv) Implement enablers for a Community Health Service including single referral point and staff scheduling tools; (v) Implement 1-Click Access for GPs to their patient’s hospital record; and (vi) Implement a Shared Care Planning tool using Indici.</td>
</tr>
<tr>
<td>Patient Observations</td>
<td>(i) Business Case and pilot for a Patient Observations Platform; and (ii) Plan for the rollout of Patient Observations.</td>
</tr>
<tr>
<td>Medication Management</td>
<td>(i) Implement hospital access to NZePS (dispensing) and Medi-Map (rest homes) to support medicines look up / reconciliation; (ii) Develop an eMedication Management Roadmap; and (iii) Business case and RFP for a Hospital ePrescribing Solution.</td>
</tr>
<tr>
<td>MHAIDS</td>
<td>Completion of Phase 2 of the Client Referrals Pathways project to complete the fully integrated client management system between secondary and primary providers of mental health services, including electronic prescribing.</td>
</tr>
<tr>
<td>IT Planning</td>
<td>(i) Develop a reference architecture; (ii) Implement Asset Management and Application Catalogue systems for ICT systems &amp; applications, linked to the reference architecture; and (iii) Updated Long Term Investment Plan for DHB critical assets (Category 1 &amp; 2) with upgrade dates and plans.</td>
</tr>
<tr>
<td>National/Regional Alignment</td>
<td>(i) Regional Clinical Portal : Complete Data Replication from Local to Regional Portal; (ii) Regional Radiology System : Complete Migration; (iii) National Screening Solution: Initiate scoping and planning; (iv) National EHR : Contribute to the development of a the Single Electronic Health Record; and (v) National Maternity Clinical Information System.</td>
</tr>
<tr>
<td>Medical Oncology System</td>
<td>Implement the Mosaiq Medical Oncology Case Management and Prescribing System which is also used in MidCentral DHB to provide a platform for sharing of patient information and protocols across the 2 regional cancer centres.</td>
</tr>
<tr>
<td>Digital Capability</td>
<td>(i) Pilot of Electronic desk-based and Mobile Laboratory Ordering; (ii) Further development of Ward and Service Electronic Whiteboards; (iii) Implement of a Capacity Planning tool to forecast and manage demand for services; (iv) Mobile Application Development Programme to develop high value mobile clinical apps; (v) Implement a Scanning capability for medical records; (vi) Implement Office 365 suite of tools; and (vii) eMedication Management.</td>
</tr>
</tbody>
</table>
SECTION 5: Performance Measures

5.1 2018/19 Performance Measures

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- achieving Government’s priority goals/objectives and targets or ‘Policy priorities’
- meeting service coverage requirements and supporting sector inter-connectedness or ‘System Integration’
- providing quality services efficiently or ‘Ownership’
- purchasing the right mix and level of services within acceptable financial performance or ‘Outputs’.

<table>
<thead>
<tr>
<th>Performance measure</th>
<th>Performance expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HS5: Supporting delivery of the New Zealand Health Strategy</td>
<td>Quarterly highlight report against the Strategy themes.</td>
</tr>
</tbody>
</table>
| PP6: Improving the health status of people with severe mental illness through improved access | Age 0-19: 3.93%  
Age 20-64: 3.74%  
Age 65+: 1.26% |
| PP7: Improving mental health services using wellness and transition (discharge) planning | 95% of clients discharged will have a quality transition or wellness plan.  
≥95% of audited files meet accepted good practice.  
Report on activities in the Annual Plan. |
| PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds | ≥80% of people seen within 3 weeks.  
≥95% of people seen within 8 weeks.  
Report on activities in the Annual Plan. |
| PP10: Oral Health- Mean DMFT score at Year 8 | Year 1: ≤0.51  
Year 2: ≤0.51 |
| PP11: Children caries-free at five years of age | Year 1: ≥72%  
Year 2: ≥72% |
| PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years) | Year 1: ≥85%  
Year 2: ≥85% |
| PP13: Improving the number of children enrolled in DHB funded dental services | Year 1: ≥95%  
Year 2: ≥95% |
| Focus Area 1: Long term conditions | Implement actions from Living Well with Diabetes. |
| Focus Area 2: Diabetes services | Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator). |
| Focus Area 3: Cardiovascular health | ≥90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.  
Percentage of ‘eligible Māori men in the PHO aged 35-44 years’ who have had their cardiovascular risk assessed in the past 5 years. ≥90% |
| Focus Area 4: Acute heart service | ≥70% of high-risk patients receive an angiogram within 3 days of admission.  
≥95% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days and ≥99% within 3 months. |
### Focus Area 4: Acute heart service (continued from previous page)

- ≥95% of patients undergoing cardiac surgery at the regional cardiac centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge.
- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF

### Composite Post ACS Secondary Prevention Medication Indicator

- ≥10% of patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.
- ≥80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.
- ≥60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team i.e. RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge.

### PP21: Immunisation coverage

- ≥95% of two year olds fully immunised
- ≥95% of four year olds fully immunised
- ≥75% of girls fully immunised – HPV vaccine
- ≥75% of 65+ year olds immunised – flu vaccine

### PP22: Delivery of actions to improve system integration including SLMs

- Report on activities in the Annual Plan.

### PP23: Implementing the Healthy Ageing Strategy

- Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4 – 6 for assessment urgency

### PP25: Youth mental health initiatives

- Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.
- Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).
- Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB’s youth population.

### PP26: The Mental Health & Addiction Service Development Plan

- Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, Improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions.

### PP27: Supporting child well-being

- Report on activities in the Annual Plan.

### PP28: Reducing Rheumatic fever

- Reducing the Incidence of First Episode Rheumatic Fever

- ≤1.0

### PP29: Improving waiting times for diagnostic services

- 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).
- 95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).
- 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.
- 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.
- 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.

### PP30: Faster cancer treatment

- ≥85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.

- Report on activities in the Annual Plan.
### PP31: Better help for smokers to quit in public hospitals

≥95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.

### PP32: Improving the quality of ethnicity data collection in PHO and NHI registers

Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).

### PP33: Improving Māori enrolment in PHOs

Meet and/or maintain the national average enrolment rate of 90%.

### PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders

Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.

### PP37: Improving breastfeeding rates

60% of infants are exclusively or fully breastfed at three months.

### PP39: Supporting Health in Schools

Report on activities in the Annual Plan.

### PP40: Responding to climate change

Report on activities in the Annual Plan

### PP41: Waste disposal

Report on activities in the Annual Plan

### PP43: Population mental health

Report on activities in the Annual Plan

### SI1: Ambulatory sensitive hospitalisations

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>See System Level Measure Improvement Plan</td>
</tr>
<tr>
<td>45-64</td>
<td>See System Level Measure Improvement Plan</td>
</tr>
</tbody>
</table>

### SI2: Delivery of Regional Plans

Provision of a progress report on behalf of the region agreed by all DHBs within that region.

### SI3: Ensuring delivery of Service Coverage

Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).

### SI4: Standardised Intervention Rates (SIRs)

- **Major joint replacement procedures** - a target intervention rate of 21 per 10,000 of population.
- **Cataract procedures** - a target intervention rate of 27 per 10,000 of population.
- **Cardiac surgery** - a target intervention rate of 6.5 per 10,000 of population.
- **Percutaneous revascularization** - a target rate of at least 12.5 per 10,000 of population.
- **Coronary angiography services** - a target rate of at least 34.7 per 10,000 of population.

### SI5: Delivery of Whānau Ora

Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.

### SI7: SLM total acute hospital bed days per capita

As specified in the jointly agreed (by district alliances) SLM Improvement Plan.

### SI8: SLM patient experience of care

As specified in the jointly agreed (by district alliances) SLM Improvement Plan.

### SI9: SLM amenable mortality

As specified in the jointly agreed (by district alliances) SLM Improvement Plan.

### SI10: Improving cervical screening coverage

80% coverage for all ethnic groups and overall.

### SI11: Improving breast screening rates

70% coverage for all ethnic groups and overall.

### SI12: SLM youth access to and utilisation of youth appropriate health services

See System Level Measure Improvement Plan

### SI13: SLM number of babies who live in a smoke-free household at six weeks post-natal

See System Level Measure Improvement Plan

### SI14: Disability support services

Report on activities in the Annual Plan

### SI15: Addressing local population challenges by life course

Report on activities in the Annual Plan

### SI16: Strengthening Public Delivery of Health Services

Report on activities in the Annual Plan

### SI17: Improving quality

Report on activities in the Annual Plan

### SI18: Improving newborn enrolment in General Practice

55% of newborns enrolled in General Practice by 6 weeks of age

85% of newborns enrolled in General Practice by 3 months of age

Report on activities in the Annual Plan

### OS3: Inpatient length of stay

Elective LOS suggested target is 1.45 days, which represents the 75th centile of national performance.
<table>
<thead>
<tr>
<th>Focus Area 1: Improving the quality of data within the NHI</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New NHI registration in error (causing duplication)</td>
<td>Group A &gt;2% and &lt;= 4%</td>
</tr>
<tr>
<td>Recording of non-specific ethnicity in new NHI registrations</td>
<td>&gt;0.5% and &lt;= 2%</td>
</tr>
<tr>
<td>Update of specific ethnicity value in existing NHI record with non-specific value</td>
<td>&gt;0.5% and &lt;= 2%</td>
</tr>
<tr>
<td>Validated addresses excluding overseas, unknown and dot (.) in line 1</td>
<td>&gt;76% and &lt;= 85%</td>
</tr>
<tr>
<td>Invalid NHI data updates</td>
<td>TBA</td>
</tr>
</tbody>
</table>

Focus Area 2: Improving the quality of data submitted to National Collections

<table>
<thead>
<tr>
<th>nbRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)</th>
<th>&gt;= 97% and &lt;99.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Collections File load Success</td>
<td>&gt;= 98% and &lt;99.5%</td>
</tr>
<tr>
<td>Assessment of data reported to NMDS</td>
<td>&gt;= 75%</td>
</tr>
<tr>
<td>Timeliness of NNPAC data</td>
<td>&gt;= 95% and &lt;98%</td>
</tr>
</tbody>
</table>

Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)

| Provide reports as specified about data quality audits. |

Output 1: Mental health output Delivery Against Plan

| Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan. |

Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.
APPENDIX A: Statement of Performance Expectations including Financial Performance

The following sections provide baselines, forecasts and targets for each Output Area.

Interpreting Our Baseline and Target Performance

Types of measures
Identifying appropriate measures for each output class requires us to do more than measure the volumes of patients and consumers through our system. The number of services delivered or the number of people who receive a service is often less important than whether the right person or enough of the right people received the right service, and whether the service was delivered at the right time. Therefore, in addition to volume, we have added a mix of output measures to help us to evaluate different aspects of our performance. The outputs are categorised by type of measure, which shows whether the output is targeting coverage, quality, quantity (volume), or timeliness. In addition, some of our performance measures look at the health of the people who live in our district (DHB of domicile view), while other performance measures relate to the performance of the services we provide, regardless of where people live (DHB of service view). When possible and relevant, we have also broken our performance down by ethnicity.

Standardisation
Different populations have different characteristics, and these different population characteristics can lead to different rates between populations. One such characteristic is the age structure of a population. By standardising for age, we can see what the rates would have been if the two populations had the same proportion of people in each age group, and therefore draw comparisons. In the following outputs, if measures have been standardised (often by the Ministry of Health to allow comparison between DHBs), we have noted why and how.

Targets and estimates
Some of our performance measures are demand-based and are included to show a picture of the services that the DHB funds and provides. For these measures, there are no assumptions about whether an increase or decrease is desirable. For performance measures that are demand-based, we have provided an estimate of our 2017/18 performance (indicated with ‘Est.’), based on historical and population trends. Baselines marked with (*) are from January to December 2016 and (**) are from January to December 2016.
Output Class – Prevention

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising of services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction. Preventative services support health-promoting individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. Preventative services include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and population health protection services such as immunisation and screening services. On a continuum of care, many of these services are population-wide preventative services.

### Output Area: Public Health Protection and Regulatory Services

**Output Area Description:** Health protection activity is enacted through a range of platforms, as described by the Ottawa Charter: public policy, reorienting the health system, environments, community action, and supporting individual personal skills. This is done to address the prerequisites of health, such as income, housing, food security, employment, and quality working conditions. While health has a significant role here, it requires a whole-of-sector approach; and our DHB and our Public Health Unit, Regional Public Health; work with other sectors (housing, justice, and education) to enable this.

**What we want to achieve:** Protected healthy environments where environmental and disease hazards are minimised.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19 – 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of disease notifications investigated</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>1,126</td>
<td>1,126</td>
<td>1,126</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>88</td>
<td>88</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>49</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>The number of environmental health investigations</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>668</td>
<td>688</td>
<td>688</td>
</tr>
<tr>
<td>The number of premises visited for alcohol controlled purchase operations</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>12</td>
<td>22</td>
<td>12</td>
</tr>
<tr>
<td>The number of premises visited for tobacco controlled purchase operations</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>27</td>
<td>27</td>
<td>27</td>
</tr>
</tbody>
</table>

### Output Area: Health Promotion and Preventative Intervention Services

**Output Area Description:** Health promotion service: inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choices.

**What we want to achieve:** People are healthier and better supported to manage their own health. Children have a healthy start in life. Lifestyle factors that affect health are well-managed. Equitable health outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19 – 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>17</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The percentage of infants fully or exclusively breastfed at 3 months</td>
<td>Prevention / Coverage</td>
<td>Total</td>
<td>62%</td>
<td>65%</td>
<td>≥60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>43%</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>49%</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>Number of new referrals to Public Health Nurses in primary/intermediate schools*</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>1,126</td>
<td>1,126</td>
<td>1,126</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>475</td>
<td>475</td>
<td>475</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>411</td>
<td>411</td>
<td>411</td>
</tr>
<tr>
<td>The number of adult referrals to the Green Prescription programme (CCDHB component)</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>1,922*</td>
<td>2,777*</td>
<td>≥600</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori &amp; Pacific</td>
<td>N/A</td>
<td>924*</td>
<td>≥360</td>
</tr>
<tr>
<td>The number of adult referrals to the Green Prescription Plus programme (CCDHB component)</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>250*</td>
<td>1,020*</td>
<td>≥600</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori &amp; Pacific</td>
<td>N/A</td>
<td>298*</td>
<td>≥360</td>
</tr>
<tr>
<td>Measure</td>
<td>Class / Type</td>
<td>Group</td>
<td>Baseline 2016/17</td>
<td>Forecast 2017/18</td>
<td>Target/Est. 18/19 – 19/20</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-----------</td>
<td>------------------</td>
<td>--------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>The number of children (5 -18 yrs.) referred to the Active Families</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>120</td>
<td>163</td>
<td>≥120</td>
</tr>
<tr>
<td>programme (CCDHB component)</td>
<td></td>
<td>Māori &amp; Pacific</td>
<td>N/A</td>
<td>153</td>
<td>≥72</td>
</tr>
<tr>
<td>The number of pregnant women referred to the Maternal Green</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>N/A</td>
<td>79</td>
<td>≥66</td>
</tr>
<tr>
<td>Prescription programme (CCDHB component)</td>
<td></td>
<td>Māori &amp; Pacific</td>
<td>N/A</td>
<td>38%</td>
<td>≥70%</td>
</tr>
<tr>
<td>The number children (3 - 5 yrs.) referred to the Pre-School</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>148</td>
<td>103</td>
<td>≥111</td>
</tr>
<tr>
<td>Active Families programme (CCDHB component)</td>
<td></td>
<td>Māori &amp; Pacific</td>
<td>N/A</td>
<td>59%</td>
<td>70%</td>
</tr>
<tr>
<td>The number of primary schools enrolled in the Project Energize</td>
<td>Prevention / Quantity</td>
<td>Total</td>
<td>25</td>
<td>25</td>
<td>≥25</td>
</tr>
<tr>
<td>Programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*3DHB Performance for 2016/17.

*3DHB Performance for 2017.

**Output Area: Immunisation Services**

**Output Area Description:** Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The work spans primary and community care and allied health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk.

**What we want to achieve:** Fewer people experience vaccine preventable diseases. A high coverage rate. Equitable health outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19-19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of two year olds fully immunised</td>
<td>Prevention / Coverage</td>
<td>Total</td>
<td>94%</td>
<td>93.2%</td>
<td>≥95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>95%</td>
<td>92.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>98%</td>
<td>97.8%</td>
<td></td>
</tr>
<tr>
<td>The percentage of eight month olds fully vaccinated</td>
<td>Prevention / Coverage</td>
<td>Total</td>
<td>93%</td>
<td>94.4%</td>
<td>≥95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>86%</td>
<td>94.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>91%</td>
<td>93.5%</td>
<td></td>
</tr>
<tr>
<td>The percentage of Year 7 children provided Boostrix vaccination in</td>
<td>Prevention / Coverage</td>
<td>Total</td>
<td>72%</td>
<td>72%</td>
<td>≥70%</td>
</tr>
<tr>
<td>schools in the DHB</td>
<td></td>
<td>Māori</td>
<td>81%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>88%</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>The percentage of Year 8 girls vaccinated against HPV (final dose) in</td>
<td>Prevention / Coverage</td>
<td>Total</td>
<td>64%</td>
<td>64%</td>
<td>≥75%</td>
</tr>
<tr>
<td>schools in the DHB</td>
<td></td>
<td>Māori</td>
<td>62%</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>79%</td>
<td>79%</td>
<td></td>
</tr>
</tbody>
</table>

**Output Area: Smoking Cessation Services**

**Output Area Description:** Smoking cessation services: are provided by clinical staff to smokers to help smokers quit. Clinicians follow the ABC process: Ask all patients whether they smoke and document their response; if the patient smokes, provide Brief advice to quit smoking; and if patient agrees, provide Cessation support (e.g. a prescription for nicotine gum or a referral to a provider like Quitline).

**What we want to achieve:** Fewer people take up smoking tobacco and quit attempts are made by more current smokers. Equitable health outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19 – 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of PHO enrolled patients who smoke have been offered</td>
<td>Prevention / Coverage</td>
<td>Total</td>
<td>89%</td>
<td>91%</td>
<td>≥90%</td>
</tr>
<tr>
<td>help to quit smoking by a health care practitioner in the last 15</td>
<td></td>
<td>Māori</td>
<td>88%</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>months</td>
<td></td>
<td>Pacific</td>
<td>87%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>The percentage of hospitalised smokers receiving advice and help to</td>
<td>Prevention / Coverage</td>
<td>Total</td>
<td>91%</td>
<td>88%</td>
<td>≥95%</td>
</tr>
<tr>
<td>quit</td>
<td></td>
<td>Māori</td>
<td>91%</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>90%</td>
<td>86%</td>
<td></td>
</tr>
</tbody>
</table>
### Measure

**The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit smoking**

<table>
<thead>
<tr>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19 – 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention / Coverage</td>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>≥90%</td>
</tr>
<tr>
<td></td>
<td>Māori</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

### Output Area: Screening Services

**Output Area Description:** These services help to identify people at risk of ill-health and to pick up conditions earlier. **What we want to achieve:** More eligible people participate in screening programmes. Children entering school are ready to learn. Equitable health outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class/Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19-19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of eligible children receiving a B4 School Check</td>
<td>Prevention / Coverage</td>
<td>Total</td>
<td>90%</td>
<td>86%</td>
<td>≥90%</td>
</tr>
<tr>
<td>The percentage of eligible women (25-69 years old) having cervical screening in the last 3 years</td>
<td>Early Detection &amp; Management / Coverage</td>
<td>Total</td>
<td>77%</td>
<td>77%</td>
<td>≥80%</td>
</tr>
<tr>
<td>The percentage of eligible women (50-69 years old) having breast screening in the last 2 years</td>
<td>Early Detection &amp; Management / Coverage</td>
<td>Total</td>
<td>73%</td>
<td>73%</td>
<td>≥70%</td>
</tr>
</tbody>
</table>
Output Class – Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Māori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care, these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Output Area: Primary Care Services

Output Area Description: Primary care services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals; aimed at improving, maintaining, or restoring health. These services keep people well by: intervening early to detect, manage, and treat health conditions (e.g. health checks); providing education and advice so people can manage their own health; and, reaching those at risk of developing long-term or acute conditions.

What we want to achieve: Accessible, affordable and connected primary care services. Long-term conditions are well-managed. Increased availability of urgent and acute primary health care services. Fewer people are admitted to hospital for avoidable conditions. Equitable health outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19-19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of the DHB-domiciled population that is enrolled in a PHO</td>
<td>Early Detection &amp; Management / Coverage</td>
<td>Total</td>
<td>94%</td>
<td>94%</td>
<td>≥94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>85%</td>
<td>84%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>&gt;100%</td>
<td>&gt;100%</td>
<td>100%</td>
</tr>
<tr>
<td>The percentage of the eligible population assessed for CVD risk in the last five years</td>
<td>Early Detection &amp; Management / Coverage</td>
<td>Total</td>
<td>89%</td>
<td>89%</td>
<td>≥90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>86%</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>87%</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>The number of people enrolled in the CCDHB Health Care Home model of care</td>
<td>Early Detection &amp; Management / Quality</td>
<td>Total</td>
<td>59,000</td>
<td>148,327</td>
<td>200,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori New</td>
<td>18,554</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific New</td>
<td>13,662</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The number of cases discussed between Health Care Homes and the integrated hospital services in multidisciplinary team meetings</td>
<td>Early Detection &amp; Management / Quality</td>
<td>0</td>
<td>450</td>
<td>550</td>
<td></td>
</tr>
</tbody>
</table>

Output Area: Oral Health Services

Output Area Description: Dental services are provided to children (pre-schooler, primary school & intermediate school children) and adolescents (year 8 up to their 18th birthday) by registered oral health professionals to assist people in maintaining healthy teeth and gums.

What we want to achieve: Sustained level of utilisation of dental services by children and adolescents. Better teeth and gum health in children with reduced numbers of caries, decayed, missing and filled teeth. Equitable health outcomes. A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is also indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016</th>
<th>Forecast 2017</th>
<th>Target/Est. 18/19-19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of children under 5 years enrolled in DHB-funded dental services*</td>
<td>Early Detection &amp; Management / Coverage</td>
<td>Total</td>
<td>97%</td>
<td>94%</td>
<td>≥95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>70%</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>86%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>The percentage of adolescents accessing DHB-funded dental services**</td>
<td>Early Detection &amp; Management / Coverage</td>
<td>Total</td>
<td>77%</td>
<td>77%</td>
<td>≥85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori New</td>
<td>55%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific New</td>
<td>78%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Output Area: Pharmacy

**Output Area Description:** The provision and dispensing of medicines and are demand-driven. Community pharmacies provide medicine management services to people living in the community. Medication management is particularly important for people on multiple medications to reduce potential negative interactive effects.

**What we want to achieve:** People are on the right medications to manage their conditions.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19-19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of initial prescription items dispensed</td>
<td>Early Detection &amp; Management / Quantity</td>
<td>Total</td>
<td>2,325,515</td>
<td>2,602,774</td>
<td>Est. 2,655,870</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>220,632</td>
<td>226,893</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>177,322</td>
<td>179,134</td>
<td></td>
</tr>
<tr>
<td>The percentage of the DHB-domiciled population that were dispensed at least one prescription item</td>
<td>Early Detection &amp; Management / Coverage</td>
<td>Total</td>
<td>80%</td>
<td>78%</td>
<td>Est. 78%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>66%</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>82%</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>The number of people registered with a Long Term Conditions programme in a pharmacy</td>
<td>Early Detection &amp; Management / Coverage</td>
<td>Total</td>
<td>5,920</td>
<td>6,371</td>
<td>Est. 6,370</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy</td>
<td>Early Detection &amp; Management / Quantity</td>
<td>Total</td>
<td>171</td>
<td>172</td>
<td>Est. 172</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>
Output Class – Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a ‘hospital’. These services are generally complex and provided by health care professionals that work closely together. On a continuum of care, these services are at the complex end of treatment services and focussed on individuals. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.

### Output Area: Medical and Surgical Services

**Output Area Description:** Unplanned hospital services (Acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need of care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned Services (Elective surgery) are services for people who do not need immediate hospital treatment and are ‘booked’ services. This also includes non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups, or preadmission assessments).

**What we want to achieve:** Reduced acute/unplanned hospital admissions. People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19 – 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of patients admitted, discharged or transferred from Emergency Department within six hours</td>
<td>Intensive Assessment &amp; Treatment / Timeliness</td>
<td>Total</td>
<td>90%</td>
<td>92%</td>
<td>≥95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>90%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>89%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>The number of surgical elective discharges</td>
<td>Intensive Assessment &amp; Treatment / Quantity</td>
<td>Total</td>
<td>10,785</td>
<td>11,166</td>
<td>10,849</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>The standardised inpatient average length of stay (ALOS) in days, Acute</td>
<td>Intensive Assessment &amp; Treatment / Timeliness</td>
<td>2.31</td>
<td>2.30</td>
<td>2.31</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>New</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>The standardised inpatient average length of stay (ALOS) in days, Elective</td>
<td>Intensive Assessment &amp; Treatment / Timeliness</td>
<td>1.57</td>
<td>1.55</td>
<td>1.57</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>New</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>Number in-hospital cardiopulmonary arrests in adult inpatient wards (total and by ethnicity) Deteriorating Patient</td>
<td>Intensive Assessment &amp; Treatment / Quality</td>
<td>Total</td>
<td>New</td>
<td>New</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td>5</td>
</tr>
<tr>
<td>The rate of identified opioid medication errors causing harm, per 1,000 bed days.</td>
<td>Intensive Assessment &amp; Treatment / Quality</td>
<td>Total</td>
<td>New</td>
<td>New</td>
<td>≤5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td>≤1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td>≤1</td>
</tr>
<tr>
<td>The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days</td>
<td>Intensive Assessment &amp; Treatment / Quality</td>
<td>Total</td>
<td>0.8</td>
<td>0.4</td>
<td>≤0.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td>≤0.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td>≤0.1</td>
</tr>
<tr>
<td>The total rate of inpatient falls causing harm per 1000 bed days from five identified inpatient areas ((MAPU, ORA, 5 South, 5 North, 6 East).</td>
<td>Intensive Assessment &amp; Treatment / Quality</td>
<td>Total</td>
<td>New</td>
<td>New</td>
<td>≤0.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td>≤0.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td>≤0.1</td>
</tr>
</tbody>
</table>
### Output Area: Cancer Services

**Output Area Description:** Cancer services include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre.

**What we want to achieve:** People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19-19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred</td>
<td>Intensive Assessment &amp; Treatment / Timeliness</td>
<td>Total</td>
<td>81%</td>
<td>91%</td>
<td>≥90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>

### Output Area: Mental Health and Addictions Services

**Output Area Description:** Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population.

**What we want to achieve:** People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19-19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of people accessing secondary mental health services</td>
<td>Intensive Assessment &amp; Treatment / Quantity</td>
<td>Total</td>
<td>10,080</td>
<td>10,683</td>
<td>≥10,683</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>2,046</td>
<td>2,287</td>
<td>≥2,287</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>718</td>
<td>729</td>
<td>≥729</td>
</tr>
<tr>
<td>The percentage of patients 0-19 referred to non-urgent child &amp; adolescent mental health services that were seen within eight weeks</td>
<td>Intensive Assessment &amp; Treatment / Timeliness</td>
<td>Total</td>
<td>87%</td>
<td>90%</td>
<td>≥95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>The percentage of patients 0-19 referred to non-urgent child &amp; adolescent addictions services that were seen within eight weeks</td>
<td>Intensive Assessment &amp; Treatment / Timeliness</td>
<td>Total</td>
<td>77%</td>
<td>88%</td>
<td>≥95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>The percentage of people admitted to an acute mental health inpatient service that were seen by mental health community team in the 7 days prior to the day of admission</td>
<td>Intensive Assessment &amp; Treatment / Quality</td>
<td>Total</td>
<td>57%</td>
<td>57%</td>
<td>≥75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>The percentage of people discharged from an acute mental health inpatient service that were seen by mental health community team in the 7 days following the day of discharge</td>
<td>Intensive Assessment &amp; Treatment / Quality</td>
<td>Total</td>
<td>63%</td>
<td>64%</td>
<td>≥90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
</tbody>
</table>
Output Class – Rehabilitation and Support

Rehabilitation and support services are delivered following a ‘needs assessment’ process and co-ordination input by NASC Services for a range of services including palliative care, home-based support and residential care services. On a continuum of care, these services will provide support for individuals.

**Output Area: Disability Services**

**Output Area Description:** Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the DSS, which work with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports.

**What we want to achieve:** Responsive health services for people with disabilities. Enhanced quality of life for people with disabilities.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19-19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of sub-regional and CCDHB Disability Forums</td>
<td>Rehabilitation and Support / Quantity</td>
<td>CCDHB:2 3DHB:2</td>
<td>1</td>
<td>≥1</td>
<td></td>
</tr>
<tr>
<td>The number of sub-regional Disability Newsletters</td>
<td>Rehabilitation and Support / Quantity</td>
<td></td>
<td>12</td>
<td>≥3</td>
<td></td>
</tr>
<tr>
<td>The total number of hospital staff that have completed the Disability Responsiveness eLearning Module</td>
<td>Rehabilitation and Support / Quality</td>
<td></td>
<td>718</td>
<td>949</td>
<td>TBA</td>
</tr>
<tr>
<td>The total number of people with a Disability Alert who are Māori or Pacific</td>
<td>Rehabilitation and Support / Quality</td>
<td>Total</td>
<td>7,165</td>
<td>7,667</td>
<td>≥9,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>10.4%</td>
<td>≥11.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>5.9%</td>
<td>≥7.0%</td>
</tr>
</tbody>
</table>

**Output Area: Health of Older People Services**

**Output Area Description:** These are services provided to enable people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups.

**What we want to achieve:** Improve the health, well-being, and independence of our older people. Reduced acute/unplanned hospital admissions. Older people with complex health needs are supported to live in the community. Services provided are safe and effective.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Class / Type</th>
<th>Group</th>
<th>Baseline 2016/17</th>
<th>Forecast 2017/18</th>
<th>Target/Est. 18/19–19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical (interRAI) assessment and a completed care plan</td>
<td>Rehabilitation and Support / Coverage</td>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home</td>
<td>Rehabilitation and Support / Coverage</td>
<td>Total</td>
<td>63%</td>
<td>62%</td>
<td>≥63%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>The percentage of the population 65+ who are in Aged Residential Care (at all levels; subsidised &amp; non-subsidised)</td>
<td>Rehabilitation and Support / Coverage</td>
<td>Total</td>
<td>4.9%</td>
<td>4.9%</td>
<td>4.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific</td>
<td>New</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>The percentage of residential care providers meeting three or more year certification standards</td>
<td>Rehabilitation and Support / Quality</td>
<td>Total</td>
<td>100%</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td>The percentage of residential care providers meeting four year certification standards</td>
<td>Rehabilitation and Support / Quality</td>
<td>Total</td>
<td>N/A</td>
<td>45%</td>
<td>≥48%</td>
</tr>
</tbody>
</table>
Financial Performance

(Placeholder for Financial Performance Tables – pending release of the Funding Envelope)
APPENDIX B: System Level Measures Improvement Plan

(Placeholder for System Level Measures Improvement Plan – pending approval)
HEALTH SYSTEM COMMITTEE
DECISION
Date: 15 June 2018

Author               Astuti Balram, Manager, Integrated Care
Endorsed by          Rachel Haggerty, Director, Strategy Innovation and Performance
Subject              SYSTEM LEVEL MEASURE (SLM) PLAN 2018/19

RECOMMENDATION
It is **recommended** that the Health System Committee (HSC):

a) **Note** the SLM Plan is a DHB Annual Plan requirement and advice from the MOH was released on 14th May;

b) **Note** the draft SLM Plan has been developed in partnership with PHO, HHS and SIP through the Integrated Care Collaborative (ICC) Alliance Leadership Team (ALT) processes. The draft included has incorporated the first round of feedback from these partners;

c) **Note** improvement in equity is required across most of the SLM measures;

d) **Note** the SLM Plan captures collective planning and developments underway. It is expected that collectively CCDHB stakeholders will continue to identify opportunities and implement changes to contribute to the SLM measures and therefore population outcomes throughout the year;

e) **Note** this draft will be presented to the ICC ALT at its meeting on June 21st for discussion and feedback;

f) **Note** the CCDHB SLM Plan is required to be submitted to the Ministry of Health (MOH) for consideration on 2nd July 2018 with the aim to have the CCDHB SLM Plan approved by the 30th May 2018; and

g) **Note** the SLMs are being considered in the wider CCDHB Integrated Performance Framework development.

APPENDICES

1. SYSTEM LEVEL MEASURE PLAN
Capital & Coast DHB
System Level Measures
Improvement Plan 2018/19

Written by: Astuti Balram. Manager – Integrated Care
on behalf of the CCDHB Integrated Care Collaborative (ICC) Alliance
CCDHB SLM Improvement Plan 18/19 WORKING DRAFT 1
## Signatories

<table>
<thead>
<tr>
<th>Organization</th>
<th>Signatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital &amp; Coast DHB</td>
<td>Julie Patterson, Chief Executive (Interim)</td>
</tr>
<tr>
<td>Integrated Care Collaborative</td>
<td>Dr Bryan Betty, Chair</td>
</tr>
<tr>
<td>Compass Health</td>
<td>Martin Hefford, Chief Executive</td>
</tr>
<tr>
<td>Cosine Primary Care Network Trust</td>
<td>Dr Peter Moodie, Director</td>
</tr>
<tr>
<td>Ora Toa PHO</td>
<td>Teiringa Davies, Manager</td>
</tr>
</tbody>
</table>
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Introduction

Background
The Capital and Coast Health System Plan 2030 outlines our strategy, or roadmap, to improve the performance of the region’s healthcare system.

CCDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities of our region. This requires CCDHB to collaborate with relevant organisations to plan and coordinate at local, regional, and national levels to ensure the effective and efficient delivery of health services.

CCDHB aims to improve health outcomes, prevent avoidable demand for healthcare, and improve the use of healthcare services.

The ICC programme of work is a key mechanism through which the CCDHB HSP will be realised. The ICC programme of work has included the implementation of the Health Care Home model, the integration of Community District Nurses with practices, the expansion of primary care packages of care, implementation of Health Pathways, focused drives to increase patient portal utilisation, diabetes consultants collaborative case conferencing and implementation of the falls model of care. The benefits of these developments are monitored through a number of process, quality and impact measures that include some of the national SLMs.

The SLMs are another lever which will support improvements aligned with the CCDHB HSP. The System Level Measures Framework at a national level aims to improve health outcomes and provides a framework for continuous quality improvement and system integration.

The six System Level Measures (SLMs) being implemented for 2018/19 are:
- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates under 75 years.
- Proportion of babies who live in a smoke-free household at six weeks post natal
- Youth access to and utilisation of youth-appropriate health services

The following three SLMs and two primary care Health Targets will be incentivised through the Primary Health Organisation (PHO) Services Agreement:
- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Better help for smokers to quit
- Increased immunisation for eight month olds
Collaborative Development Team

The CCDHB SLM development has been led through the CCDHB Alliance Leadership Team (ALT) – the Integrated Care Collaborative (ICC) in partnership with the following:

- PHO CE and/or Clinical Quality Leads
- Hospital Services Quality Team
- Māori Health Director and Māori Health Development Group, CCDHB
- Pacific Health Director and Pacific Directorate Team, CCDHB
- Strategy, Innovation & Performance Directorate
- ICC Steering Groups eg. Youth
- GM, Mental Health & Addictions, Strategy, Innovation & Performance Directorate

Principles for Improvement

The ICC ALT and the SLM Development Group agreed that the milestones for the SLMs should take into consideration the strategic priorities across the sector and focus on equity.

In selecting the contributory measures (CM) the following principles were applied:

- Linked to current strategic priorities
- Relevant to family & whanau; clinicians; managers
- Focus that improves equity
- Relevant to vulnerable populations including but not limited to older people and children
- Impact on a reasonable sized population
- Evidence based interventions
- Balancing a mix of outcomes and outputs
- Performance can be influenced through stakeholders and partners engaged with the DHB
- Return on input investment

Improvement Methodology

The CCDHB SLM Plan has been developed with the improvement methodology: Plan-Do-Study-Act. This planning stage has included the analysis of each SLM to understand progress and further opportunities for improvement. In particular, analysis of performance with an equity lens has been completed to ensure that the focus on improving outcomes for Māori and Pacific populations remains a focus. We have worked to identify and define our goals for the SLMs, as well as the key drivers for improvement as identified by the selected CMs.
SLM Plan 2018/19 Governance

The ICC ALT maintains oversight of the system, which is represented through their programme monitoring dashboards. SLMs are included in the ICC ALT overarching dashboard, and the ICC ALT utilises more detailed SLM specific dashboards to track the specific quality improvement initiatives and related CMs. Linkages in oversight are also maintained with groups that are key to the delivery of the activities that will enable improvement in performance, particularly the PHO Clinical Quality Board and support groups within the CCDHB system.

Example of SLM performance linkages through the system:

The DHB is also progressing its maturity as a data driven organisation through its development of system dynamic modelling processes, recruitment of additional analytical expertise, investment in a data visualisation, upskilling in data and information literacy and in the development of a system wide integrated performance framework. These tools will in future years support the ongoing maturity of the improvement processes for overall CCDHB system and SLM performance. e.g. ABD – ED analysis and system dynamic modelling to understand Acute demand flow; whose presenting to hospital; what access to them do we have in hospital and how do we support them out.
Acute Bed Days

Better health and independence for people, families and communities is the CCDHB vision. We want our population to be well in the community and supported to receive appropriate care when they are not well.

Acute Bed Day (ABD) 2018/19 milestone: 2.2% reduction in acute bed days for Pacific (approximately 72 fewer acute stays at the current acute ALOS) and 1.8% reduction in acute bed days for Māori (approximately 73 acute stays at the current acute ALOS). This equates to a reduction in acute bed days of 1 per day or 144 fewer acute events in total.

The long-term aim is to ensure that the ABD rates for Māori and Pacific populations reduce to at least the rates of the other population groups.

The CCDHB HSP identifies that a comprehensive health service requires effective coordination and organisation across the different settings of care – a person’s home, community based health care and the hospital. As the DHB system evolves improvements in acute bed days should be realised, particularly for vulnerable populations.

Opportunity

Health Care Homes (HCH) are focused on providing proactive, preventative and acute care to people well in the community and prevent the requirement for them to attend the hospital

- Continue the roll-out of the HCH model with the requirement of “same day acute appointments”
- Implement real-time reporting that enables practices to better support people after presenting to the hospital
- Drive the targeting of POAC e.g. for cellulitis treatment to HCH with high presentation hospital rates

Fractures contribute higher volumes and bed days for vulnerable populations. There are proactive activities to reduce the incidence and follow-up activities that can reduce recurrence

- Pro-active identification and support for people who are at risk of falls by primary care
- Implementation of community based and in-home strength and balance services
- Support for people post-fracture through primary care based fracture liaison processes

Improvements to reduce the time people spend in ED and on the wards have been explored and are being focused on improving ED processes

- Develop the model of care in ED to support streaming of patients and maximise ED green zone utilization
- Advance strategies to improve response times to ED resulting in early assessment
- Implement process that support early discharge

Cross sector winter planning has identified the need for a collaborative approach to preparing for and managing through the upcoming influenza season (following the Northern hemisphere experience)

- Raising awareness about influenza risk mitigation and management strategies
- Maximising vaccination rates for at risk populations and the CCDHB workforce
- Creating readiness for increased acute demand capacity requirements to support the hospital and general practice teams requirements during the winter months.

Actions

Contributory measure

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Actions</th>
<th>Contributory measure</th>
</tr>
</thead>
</table>
| Health Care Homes (HCH) are focused on providing proactive, preventative and acute care to people well in the community and prevent the requirement for them to attend the hospital | • Continue the roll-out of the HCH model with the requirement of “same day acute appointments”
• Implement real-time reporting that enables practices to better support people after presenting to the hospital
• Drive the targeting of POAC e.g. for cellulitis treatment to HCH with high presentation hospital rates | Acute/arranged hospital admissions of PHO enrolled population 15-74yrs
| Fractures contribute higher volumes and bed days for vulnerable populations. There are proactive activities to reduce the incidence and follow-up activities that can reduce recurrence | • Pro-active identification and support for people who are at risk of falls by primary care
• Implementation of community based and in-home strength and balance services
• Support for people post-fracture through primary care based fracture liaison processes | Rate of hospital admissions due to a fall injury (Fracture, fractured neck of femur and other ), people >65yrs +
| Improvements to reduce the time people spend in ED and on the wards have been explored and are being focused on improving ED processes | • Develop the model of care in ED to support streaming of patients and maximise ED green zone utilization
• Advance strategies to improve response times to ED resulting in early assessment
• Implement process that support early discharge | Inpatient Average Length Of Stay (ALOS) for acute admissions
| Cross sector winter planning has identified the need for a collaborative approach to preparing for and managing through the upcoming influenza season (following the Northern hemisphere experience) | • Raising awareness about influenza risk mitigation and management strategies
• Maximising vaccination rates for at risk populations and the CCDHB workforce
• Creating readiness for increased acute demand capacity requirements to support the hospital and general practice teams requirements during the winter months. | Influenza vaccinations for > 65yo
Amenable Mortality

The CCDHB HSP outlines that supporting population interventions to create healthier communities and preventing the onset of long term conditions is a priority in reducing amenable mortality.

Amenable Mortality (AM) 2018/19 milestone: At the end of 2019, maintain AM rates for all ethnicities lower than the 2015 baseline. The time to influence the change in the AM rate and current delay in the reported data are barriers to establishing time relevant milestones for this SLM. In 2014 and 2015, AM rates improved for Māori and Pacific. However, rates have fluctuated due to the relatively small population size.

The long-term aim is to ensure that the AM rates for Māori and Pacific populations reduce to at least the rates of the other population groups.

To achieve the improvements in the AM rates in the future will require multifactorial improvements focused on proactive and preventative care, effective management of conditions and overall support for well being. These approaches require a life-course approach and tailoring to the needs of particular population groups.

### Opportunity

- Smoking is a key risk factor for a number of the most common drivers long term conditions as a cause of amenable mortality and supporting people to quit will create significant health gains.
- Effective management for people with diabetes in primary care with support from specialist services is vital in assisting them to keep well.
- Proactive screening to ascertain cardiovascular risk for the overall population and in particular Māori and Pacific males will enable the early intervention and management strategies to reduce the burden of disease.
- Supporting wellbeing for vulnerable populations, particularly our youth is vital in changing the suicide statistic. A range of protective factors can enhance a person’s wellbeing and resilience, and reduce their risks.

### Actions

- Improve the NRT and behavioural support for people through a data feedback loop to practices identifying people who have received brief advice and want to quit without further support
- Health Care Homes focused to maintain smoking health target performance
- ICC Diabetes Clinical Network provide regular best practice messaging with an equity focus to practices via PHOs
- Focused support by the Nurses Practice Partnership team to increase insulin initiation skills and initiation for people with elevated HbA1c
- PHO Clinical Quality teams dissemination of key messages from the updated CVDRA guidelines
- PHO implement new data reports for practices to drive proactive screening in the younger age groups, particularly Māori and Pacific men.
- SIP directorate in partnership with stakeholders complete youth population health analysis to enable the mapping of suicide prevention and post-prevention service developments

### Contributory measure

- Smoking quit rate (not in library)
- People with HbA1c>64mmol/mol and not on insulin (not in library)
- PHO enrolled people within the eligible population who have had a CVD risk recorded within the last ten years
- Number of youth suicides per annum

---

### Top 3

- **Coronary Disease (28%)**
- **Suicide (11%)**
- **Cerebrovascular Disease (23%)**
- **Breast Cancer (10%)**

### Top 3 Amenable conditions, Māori*

- **Coronary Disease (28%)**
- **Diabetes (23%)**
- **Smoking (23%)**
Babies Living in Smokefree Homes
Supporting our whānau and their children, giving them the best start in life, is a HSP priority and linked to the national SUDI prevention programme.

Babies in a Smokefree Home 2018/19 milestone: CCDHB and the local PHOs will work to identify babies in households with smokers. By the end of 2018/19 at least 50% of all Māori and Pacific babies have been screened in primary care for the presence of a smoker in the household.

As the HSP 2018/19 is implemented it is expected that all services that support women and children to live well will be connected within a defined locality and linked with their primary health care team.

The National SUDI prevention programme, that CCDHB will focus on smoking cessation during the antenatal and postnatal periods and bed-sharing. Primary care and the hospital are key vehicles for the implementation of the programme to support vulnerable babies in this early stages and as they grow.

**Opportunity**
There remains a gap in understanding and identifying whānau who would benefit from having smoking cessation support.

**Actions**
- PHOs facilitate data matching in practices to identify babies who live in a household where there are others identified as smokers.
- WCTO providers drive improved processes to ensure that they regularly ask about smoking status

**Contributory measure**
Rate of babies in a household with smokers (not in library)

**Opportunity**
Babies should be enrolled with their general practice soon after birth so they can receive essential health care including immunisations on time and current rates highlight gaps in enrolment.

**Actions**
- Introduction of an enrollment quality indicator to practices for Māori, Pacific and other children to support them to focus on early enrollment

**Contributory measure**
NES enrolment rates

**Opportunity**
Access to smoking cessation support during antenatal and postnatal periods will contribute to reduce the risk of SUDI for the CCDHB babies.

**Actions**
- Implement the SUDI prevention programme smoking cessation activities including establishing referral pathways with LMCS and supporting stop-smoking incentive service models
- Increase access to smoking cessation support to wider whānau members, in addition to the parents

**Contributory measure**
Smoking cessation support volumes (not in library)
Patient Experience of Care

Partnership and involvement of people in their care and being empowered to self manage is vital for the health of our people and efficiencies in our health system.

Patient Experience of Care – Primary Care 2018/19 milestone: Maintain or improve the overall response rate, and improve the results for each of the survey domains to the national average for total, Māori and Pacific.

The uptake of the PES across primary care have increased and the hospital PES continues to be a driver for ongoing improvements. CCDHB’s response rate to the Adult Inpatient Experience Survey has historically been higher than the national average. In 2018, the response rate is recovering from an anomaly in response rates from November 2017.

In addition to the PES, CCDHB is enhancing its approach to involving people in the supporting of service developments and learning from communities about better ways to engage and enable care. CCDHB is exploring tools such as the Marama Real Time Feedback Tool in Mental Health services.

CCDHB’s scores for the primary health survey are at or above the national average for the 4 domains: Communication, Coordination, Partnership, Physical & Emotional needs. CCDHB is above the national average for 3 domains for Māori, and 2 domains for Pacific For the hospital survey CCDHB’s scores are at or above the national average for the 4 domains: Communication, Coordination, Partnership, Physical & Emotional needs. Scores by ethnicity are not publicly available.

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Actions</th>
<th>Contributory measure</th>
</tr>
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</table>
| Hospital PES scores identified improvements focused on improving coordination from hospital to home as part of the wider Improvement Movement training. | • Introduce pharmacist input on discharge for higher risk patient population  
• Revise referral pathway to physiotherapy to improve FSA booking time  
• Improve referral management for district nursing services | Patient experience – Hospital coordination (not in library) |
| Health Care Homes provide a platform for collaborative team work, both within the practice and with hospital services to provide better care for people with higher health needs. | • Implement multi-disciplinary team meetings in primary care involving District Nurses and Allied Health for people identified through risk stratification  
• HCHs establish patient engagement strategy/programme with support of a patient engagement framework toolkit  
• Implement the Shared Care Planning tool prioritized across the Health Care Homes | Patient experience – Primary care coordination & partnership scores (not in library) |
Ambulatory Sensitive Hospitalisations 0-4 Years

One of CCDHB’s strategic goals is to improve child health and child health services in the CCDHB. Our system will empower all families to maximise their children’s health and potential.

Ambulatory Sensitive Hospitalisation (ASH) 0-4yo 2018/19 milestone: 6% reduction in ASH events for Pacific and 6% reduction for Māori.

The aim is to over five years ensure that the ASH rates for these populations reduce to at least the rates of the other population groups. To achieve this a larger improvement is required for Pacific children.

CCDHB’s ASH rate for 0-4yo is 38% higher than the national average. Of the seven DHB’s monitored for Pacific ASH rates, CCDHB has the highest rate nationally. For Māori children, CCDHB has the 3rd highest ASH rate nationally.

To achieve the improvements in the ASH 0-4yo rates will require multifactorial improvements and as identified in the CCDHB HSP it is crucial to give every child the best start in life to support good health and reduce inequities across the life course.

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Actions</th>
<th>Contributory Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood scheduled and influenza immunisation will support children to keep themselves and others well in the CDHB community. Immunisation rates for Māori and Pacific children have not achieved the 95% target and the potential influenza epidemic is a new driver for the influenza vaccine.</td>
<td>Work with MoH team to address immunization data capture issues</td>
<td>Childhood scheduled Immunisation rates by 2 years Influenza immunisation volumes for tamariki 0-4 years old. (not in library)</td>
</tr>
<tr>
<td>Respiratory conditions (asthma, pneumonia, respiratory tract infections and ENT infections) contribute the majority of the ASH events for Māori, Pacific and all other children in CCDHB. The CCDHB Pacific Alliance has identified this as a priority area looking to take a multifactorial approach including access to health, support for families, targeted clinical follow up and socio-economic factors.</td>
<td>Asthma Nurse Educators will initiate support for children in preschools</td>
<td>Hospital admission rates for children aged 4yrs with a primary diagnosis of asthma (not in library)</td>
</tr>
<tr>
<td>Dental conditions continue to contribute to 222 children presenting to the hospital. In addition to increased support for good dental care within the community enrollments for the dental service are vital.</td>
<td>Complete an updated data match process with the dental service and PHO registers to identify children who should be enrolled.</td>
<td>Carries Free at 5yrs Arrears rates (not in library) Treatment rates</td>
</tr>
</tbody>
</table>
Youth access to & utilisation of youth appropriate services

Supporting our youth to build healthy and safe lives is a focus in the CCDHB HSP. Young people are not high users of the health system but the choices they make now impact on their future health demand.

In 2018/19 CCDHB will focus on the Alcohol and Other Drugs domain of the Youth SLM and aim to improve the identification and treatment of youth at risk of harm from alcohol across primary care and the hospital. The Youth Alcohol and Other Drugs 2018/19 milestone: 50% of youth presenting to primary care have been screened for alcohol consumption and their status recorded.

The long-term aim is that young people experience less alcohol & drug related harm and receive appropriate support.

Primary care practices and YOSS are key contact points for youth and their whānau. As a result they provide an avenue to identify young people who would benefit from additional support.

Improving the capability and capacity of the workforce to work with young people who are experiencing Alcohol & Other Drug and Coexisting problems.

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Actions</th>
<th>Contributory measure</th>
</tr>
</thead>
</table>
| Primary care practices and YOSS are key contact points for youth and their whānau. As a result they provide an avenue to identify young people who would benefit from additional support. | • PHOs and practices initiate alcohol screening and recording processes for youth aged 13-24yo  
• PHO Clinical Quality teams dissemination of tools and advice to support youth with alcohol and drug support | Alcohol screening rate in primary care – youth (not in library) |
| Improving the capability and capacity of the workforce to work with young people who are experiencing Alcohol & Other Drug and Coexisting problems. | • Implement the Alcohol & Other Drug Coexisting Problem (AOD CEP) model of care in partnership with Youth One Stop Shops and secondary level care  
• Youth ICC Steering Group investigate options for increasing mental health support in school based health services. | Treatment of AODCEP issues in primary care setting. |
RECOMMENDATION

It is recommended that the Health System Committee (HSC):

a) Note HHS has undertaken detailed analysis for the Optimal Ward project during this period, developed a Staff pulse survey and a draft performance Dashboard;

b) Note the initiation of the System Acute Flow Demand Modelling project to inform opportunities to invest in action that avoids acute Emergency Department presentation

c) Note MHAIDS has focused on its 24hr Operations Centre Security Systems Business case, detailed scoping for the Rehabilitation Model of Care and Digital Client Pathways Project and refining the MHAIDS project outcomes to inform benefits metrics and dashboard development.

d) Note the MHAIDS project outcomes approach

e) Note the Integrated Care programme – e-referrals project has started a procurement process to secure an electronic referral platform for GP to specialist referrals

f) Note the ongoing development of the Allied health models of care project

g) Note that benefits will be presented to the Board at the July meeting

APPENDICES

1. SUMMARY LIST OF PROJECTS

2. OPTIMAL WARD DRAFT PERFORMANCE DASHBOARD

3. OPTIMAL WARD STAFF PULSE SURVEY

4. MHAIDS PROJECT OUTCOMES

1. PURPOSE

This paper updates the Health System Committee on progress with the Even Better Healthcare (EBHC) programmes of work since these were presented to the committee at its 2 May meeting. It highlights the key achievements and areas of interest over the past two months.

2. BACKGROUND

As previously advised, CCDHB is implementing a three to four year plan to enhance its long term clinical and financial sustainability known as Even Better Healthcare (EBHC). The summary list of projects currently within
EBHC is attached as Appendix 1. EBHC is focused on improving operational performance and developing new service delivery models that will help us deliver on the Health System Plan (HSP) - Vision 2030. There is a strong focus on people and systems, emphasising better outcomes for patients and improving the working environment for staff.

3. PROGRESS TO DATE

The EBHC priority for enhancing our use of data and analytics has geared up during the latest period, with the first new analyst resource coming on-board and action underway to build our modelling capability. This is focusing the projects on establishing the base metrics for measuring benefits, with benefits realisation remaining a top priority for ELT.

3.1 EBHC Programme highlights

- The Clinical Letters to GPs successfully went live on Tuesday 29 May with no known issues. There were 3000 letters sent electronically in the first week.
- A cross functional team visited Waitemata DHB’s cardiology department to view their operating model, which provided valuable insight into the opportunities that exist with the Optimal Ward. These findings are helping identify priorities for implementing, especially within the technology and accountability space.
- The Optimal Ward ‘Pulse’ survey will go out the week commencing 18 June and be conducted quarterly to measure the impact of the initiatives being undertaken in the Heart & Lung unit.
- The procurement approach for e-Referrals has been agreed for a common 3DHB eReferral platform enabling automated referrals from GPs to specialists.
- Detailed scopes for the MHAIDS ‘Digital Client Pathway Enhancements’ & ‘Rehab Models of Care’ projects are being developed to enable planning

3.2 Speaking up for Safety Culture

By the end of May, more than 300 people had been trained in 'Speaking Up For Safety'. A communications approach for maintaining focus on Speaking Up For Safety has been developed. Seven work streams have been set up to take the project forward from this point. Initiating 'Promoting Professional Accountability' has been deferred until Feb 2019 due to Cognitive Institute's availability. In the meantime, activity will focus on building internal systems and capability to respond optimally to issues raised when people Speak Up.

4. HHS PROGRAMME

The Optimal ward project continues to progress well and more detailed scoping of other priorities within this programme are also underway. In particular, refining the direction for enhancing the benefits of our Integrated Operations Centre (IOC) and establishing a system dynamic modelling project to generate actions that will deliver the largest gains for improving patient flow within our health system.

4.1 Optimal Ward

The optimal ward puts patients and their whānau at the centre of everything we do creating a ward environment that is fit for purpose for staff to provide quality and timely care. The approach to identify actions is twofold:

1. Staff interviews (both clinical and non-clinical) were held to identify daily tasks and time spent completing value add, governance, or non-value add (waiting, chasing, not having access to tools, equipment etc.) activities
2. A series of workshops around what a ‘good day’ looks like for our staff, patients and Māori and Pacific communities are underway or being planned

The staff interviews established the following themes and challenges:
Teamwork and communication challenges on a daily basis
Chasing and waiting (staff, files, beds, patients, equipment)
Issues with availability of decision makers
People working at the bottom of their scope or completing low value add activities
Manual or inconsistent processes
Duplicate data entry or ‘copy paste’ of information
Not having the tools and equipment to do their job
Technology gaps which result in more paper and reliance on physical files
Not having access to real time information
Working within a constrained physical space

Initiatives to respond to these challenges have been developed across people, process, tools/technology and environment categories and are currently being prioritised for implementing with staff. Alongside prioritising these actions, the project is developing a ward dashboard to measure performance from a staff experience, patient journey, ward management and financial/efficiency perspective (See Appendix 2). The metrics are being tested with clinical leadership and management to inform target setting. The dashboard will underpin benefits realisation monitoring.

A staff survey (see Appendix 3) is being undertaken to baseline staff views about the support mechanisms that contribute to the successful operation of the service - teamwork, culture, processes, tools/technology and the environment. It also considers whether staff are well equipped to deliver the very best experience to patients, their whānau and wider communities. The survey will be completed quarterly as a measure of both staff engagement and whether the optimal ward initiative is successfully embedding change.

4.2 System Acute Flow Demand Modelling

The System Acute Flow Demand Modelling initiative is part of a broader data and evidence driven approach to developing and delivering high quality effective care within available resources across the local health system.

The analysis combines known health service use, population demographic information, and health need data to describe a “current state” of the local health system. Then using expert stakeholder advice it identifies patient groups at different points in their acute care journey who with additional support or alternate models of care may be prevented from having an acute Emergency Department presentation or Hospital stay.

The project is delivering three phased pieces of analysis.

- Patient flow into the HHS Emergency Department
- Patient use of acute inpatient beds, including assessment of CCDHB local population and sub-regional and regional patient use of services.
- Acute surgical patient demand and the overall capacity of surgical services to meet need.

There are 5 patient groupings where scenarios are being modelled:

- Patients with uncomplicated acute conditions that need a course of clinically supervised treatment in the community to avoid an ED presentation or acute admission
- Older frail people who with the right acute response in the community could avoid an ED presentation or have an acute admission.
- Older people with poorly controlled chronic conditions who have an acute exacerbation of their health conditions
- Patients who require acute hospital assessment, stabilisation and treatment and who have short hospital stays and use CCDHB Acute Assessment and Planning Unit services (APUs).
- Patients currently receiving tertiary levels of hospital care that could be safely cared for by their local hospital and closer to home.
- How improvements in hospital/ward productivity might improve hospital stay and health outcomes of people in inpatient acute beds?
The initial modelling results were presented to stakeholders on 7 June and resulted in refinements to the scenario including the removal of one topic – which only needs analysis not modelling.

5. INTEGRATED CARE PROGRAMME

The focus has been on establishing momentum with e-referrals and Allied health in the past two months.

5.1 E-Referrals and Community Health Network Enablers

The procurement process is underway within the Integrated Care eReferrals project to identify a preferred provider of an automated eReferrals system across the three sub regional DHBs.

CDHB is seeking to optimise the value of its largely manual referral processes through which General Practices currently access specialist advice and services. While some parts of the referral process are automated, it does not apply to all services nor does the current solution possess the functionality to deliver a level of consistency and integration to maximise the value of electronic referrals.

Each year, CCDHB processes more than 100,000 referrals from GPs, DHB Specialists and other community providers. Reducing wasteful effort, re-work and triage demands could release significant effort across the referral pathway each year. Referral sources are broadly split 50% GP, 30% DHB Specialists and 20% others currently.

While this first step is focused on e-referrals into the hospital, over the longer term, full digitisation of the referral pathway with e-referrals fully integrated into the hospital’s Patient Administration System (PAS) will enable the release of even more administrative value for the system.

The anticipated benefits from e-Referrals include:

- Reduced volume of referrals declined, mis-directed or needing follow up to get missing information, therefore minimising lost effort and re-work across the referral pathway
- Freeing up specialists’ time through reduced triage time and where possible, transitioning to a triage by exception model
- Improving overall processing time of through reducing delays (e.g. by referrals sent to the wrong place)
- Improving information management and security
- Better connectivity between referrals and HealthPathways - the system will enable referrals to be accessed through HealthPathways.

5.2 Allied Health models of care and workforce

This work focusses on Allied Health Therapies, including, but not limited to, services delivered by dietitians, occupational therapists, physiotherapists, podiatrists, psychologists, social workers and speech and language therapists. These professions work across CCDHB in all settings – in homes, in the community, in outpatients and in hospitals, with almost all patient groups who touch health services.

The breadth and depth of Allied Health skills means there is considerable potential to improve health outcomes and experiences for people across the system with a greater emphasis on prevention and wellbeing through better use of those skills. Allied Health is by nature difficult to define and draw boundaries around. During the project’s discovery phase, the scope includes:

- Allied Health (therapies) services provided by the HHS, excluding MHAIDs and the Child Development Service. The main group of staff (165 FTE) are located in ORA (Older Adults, Rehabilitation and Allied Health).
- Vote Health funded Allied Health provided in primary and community settings, for example in PHOs, Hospice and Home and Community Support Services.

The boundaries are pragmatic. In reality, the project is generating learnings and themes that will be valuable for Allied Health in any setting.
Needs analysis is helping us understand who the people are that use Allied Health services. To date we have learnt that within ORA services:

- Allied Health sees over 20,000 people per year.
- Use of Allied Health increases with age (16% of CCDHB people over 65 saw at least one Allied Health clinician in 2017, 36% of people over 85 years accessed Allied Health).
- Allied Health services see less Māori (8%) compared to Māori within the CCDHB population (11%).

Scotland is a leader in reshaping the role and contribution of Allied Health to the health system. Scotland are using the ADL (Activities of Daily Living) Lifecurve to understand the needs of their population, and to lead the discussion with Allied Health workers about changing the way they work. The Lifecurve describes how the process of ageing can be modified to enable people to live longer with a higher quality of life as shown in the diagram below.

The Allied Health project is considering how the Lifecurve can be applied within our context to generate insights and understanding as the model of care is developed at CCDHB.

6. MHAIDS PROGRAMME

The MHAIDS Programme has focused on supporting the development of the Security Systems Business Case, detailed scoping of the Digital Client Pathways and rehab models of care projects and benefits alignment with organisational priorities. Appendix 4 shows the outcomes sought by the MHAIDS projects and their alignment with Health System Plan 2030 principles and outcomes. Benefits metrics are being developed to monitor progress towards these outcomes and to establish a performance dashboard.

6.1 24 hour Operations Centre within the 3DHB MHAIDS service (MHOC project)

The Security Systems Business Case has been the priority for the MHOC. This continues to be refined to ensure the appropriate strategic links are made to optimise the benefit of the investment. The scope is also being further defined and detailed through engagement with the TrendCare Project and the HHS IOC Improvement Project to leverage potential learnings across both pieces of work and minimise duplication. An implementation plan has been drafted for consideration by the project board.

1 https://ailip.lifecurve.uk/Home/Tag-An-Idea
7. INFRASTRUCTURE PROGRAMME

These projects all focus on creating operational efficiencies and reducing waste allowing CCDHB to be more responsive. Progress during the past month includes

7.1 Automation of administration systems

- **Letters to GPs** - the automated GP letters went live on Tuesday 29 May 2018. The system is working as planned with 3000 letters sent in the first week. This initiative has a target to reduce the number of letters sent per month by 5,000 (of an estimated 12,000) where the baseline cost per letter is $5.00.
- **Expenses** - A pilot group of 95 employees are now using the new system and the first payments have gone out with no known problems. A further 90 employees are currently being added to the group and a migration plan is being developed for wider roll out. Training is being delivered to support staff using the application.

7.2 Facilities & Assets

- **Equipment Tracking** - Staff training to support the new tracking system is complete. The pilot was due to begin on 1 June, however this was delayed until 25 June 2018 due to build issues.
- **Occupancy Project** - 'Twenty Two' are working with Surgery Women's and Children's (SWC) staff with a user-centric workplace planning process to develop a workplace concept for Level 11 and ultimately a brief to the architects who will design the layouts. Timeframes are dependent on SWC capacity to be available to 'Twenty Two' for the planning work.

7.3 CCDHB Project Management Framework & Methodology

Our new CCDHB Project management framework and Psoda reporting currently being implemented within EBHC ahead of wider organisational roll out was presented to Treasury at our recent ICR interim assessment meeting. The initial feedback provided at the meeting was positive with officials indicating good progress had been made with establishing practical systems and processes.

8. NEXT STEPS

Detailed scoping of pipeline initiatives is underway within programmes to inform priorities and resourcing needs for out years. This will ensure we are targeting our internal resources optimally to the areas likely to deliver the greatest benefit for the organisation. Further advice is being prepared for the Board about EBHC priorities from 2019.
## APPENDIX 1 EBHC Current Projects

### Even Better Heath Care (EBHC) Projects at a Glance

<table>
<thead>
<tr>
<th>Programme</th>
<th>Project Name</th>
<th>Business Owner</th>
</tr>
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<tbody>
<tr>
<td>EBHC</td>
<td>Qlik Implementation</td>
<td>Rachel Haggerty</td>
</tr>
<tr>
<td>EBHC</td>
<td>Supporting Safety Culture</td>
<td>Andrew Wilson</td>
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<td>ICT</td>
<td>Strategic Technology Investments</td>
<td>Shayne Hunter</td>
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<tr>
<td>Infrastructure</td>
<td>Admin Automation - Clinical Letters to GP's</td>
<td>Chris Bennett</td>
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<td>Infrastructure</td>
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<td>Mike McCarthy</td>
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<td>Integrated Care Portfolio</td>
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<td>Integrated Care Portfolio</td>
<td>E-Referrals</td>
<td>Rachel Haggerty</td>
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<td>Integrated Care Portfolio</td>
<td>Specialist Ambulatory Care</td>
<td>Rachel Haggerty</td>
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<td>Management by Establishment by Team Project</td>
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<td>Digital Client Pathway Enhancements</td>
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<td>MHAIDS</td>
<td>MHAIDs Models of Care Rehab Project</td>
<td>Nigel Fairley</td>
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</tbody>
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DRAFT OPTIMAL WARD DASHBOARD – WARD 6SW

**Patient Journey**

- **Readmissions**
  - 28 Day Readmission rate

- **Acute Inpatient Length of Stay**
  - Average Inpatient Length of Stay (days)

- **Elective Inpatient Length of Stay**
  - Average Inpatient Length of Stay (days)

**Occupancy**

- Average Midnight Occupancy

**Discharge Rates**

- Discharge rate from Transit Lounge

**Patient Experience**

- **Patient Satisfaction**
  - Patient Compliments
  - Patient Complaints

- **Incidents and Events**
  - Severity 1&2 Events
  - Falls

- **Respond to ED**
  - Number of events more than 60 minutes

- **Discharge Rate**
  - Discharge rate before 11am

**Staff Experience**

- **Team Morale**
- **Leadership Pulse**
- **Culture**
- **Staff Assaults and Injury**

- **Unplanned Leave**

**Developmental Indicator**

- Resignations from DHB
  - 18.1% (13/72)

- Resignations from dept and DHB
  - 26.4% (19/72)
OPTIMAL WARD DASHBOARD – WARD 6SW

Ward Management

Vetting for Current staff (28 May 2018)

APC's for Current staff (28 May 2018)

Potential Equity Indicators?

Paid vs. Budgeted FTE

Budgeted vs. Actual Costs

Performance Highlights

Performance Issues

Key

- Achieved
- Partially achieved
- Not achieved

Health System Committee PUBLIC - 4.1 Even Better Health Care Programme Progress Report

PDRP Achievement (28 May 2018)

Overtime

Developmental Indicators

Developmental Indicator

Health System Committee PUBLIC - 4.1 Even Better Health Care Programme Progress Report

APC's for Current staff (28 May 2018)

Overtime

Developmental Indicators

Developmental Indicator

Health System Committee PUBLIC - 4.1 Even Better Health Care Programme Progress Report

APC's for Current staff (28 May 2018)

Overtime

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Developmental Indicator

Health System Committee PUBLIC - 4.1 Even Better Health Care Programme Progress Report

APC's for Current staff (28 May 2018)

Overtime

Developmental Indicators

Developmental Indicator

Health System Committee PUBLIC - 4.1 Even Better Health Care Programme Progress Report

APC's for Current staff (28 May 2018)

Overtime

Developmental Indicators

Developmental Indicator
OPTIMAL WARD PULSE SURVEY – Heart & Lung Unit

I am Nurse, Doctor, Allied Health, Clinical Support Services.

Development

I am given adequate training to do my job
I am satisfied with the opportunities for growth and advancement
I am satisfied with the opportunities that I have to use my skills
I have the skills to recognize and engage with different cultures on the ward
I feel I’m working at the right scope of my job

Comments

Environment (Place)

There is a place where we can have private conversations with patients and whanau
Our environment is welcoming for patients and whanau
Our environment enables me to do my job to the best of my ability
I have the ICT tools to do my job
Our ward has the appropriate equipment to do the job
We always have the right supplies at the right time
I can access the information I need fast (files, patient records etc.)

Comments

Team work

Roles and responsibilities are clearly defined in my profession
We operate well as a multi-disciplined team
We are well organized
I have time to give timely and quality care
I go home on time
I feel empowered to make a difference

Comments
Work Culture

We understand our culture
We have a good culture
We demonstrate our culture in the way we work together
Our leaders demonstrate our culture
I feel able to speak up for safety
There is collaboration between Nursing, Allied Health and Medical/Surgical teams

Comments

Safe working environment

I feel safe at work
I often feel that I am under too much pressure
I feel emotionally drained by my work
I feel physically drained at work
Our patients are always safe
Comments

Constructive relationships

I have good working relationships with my colleagues
I am treated with respect by the staff I work with
I am provided with the support I need from my colleagues to do my job effectively
Communication with my colleagues is open and respectful
Comments

Quality Communication

I feel well informed about what is happening on the ward
I understand how my role contributes to the overall direction of the DHB
I have timely access to decision makers to support my job
I feel comfortable chasing staff I need to make a decision

Comments

Processes

I spend a lot of my time waiting or chasing things
Our processes are efficient
I am able to make suggestions and then something happens
I am encouraged and able to make improvements in my area

Comments

Patients and Whanau

Patients are easy to find
Care for patients is our top priority
Whanau are always welcome on the ward
I welcome patients and whanau in a culturally appropriate way

Comments
Motivation

I look forward to coming to work
I am enthusiastic about my job
Time passes quickly when I’m at work

Comments
HEALTH SYSTEM COMMITTEE

DISCUSSION

Date: 27 June 2018

Author

Chris Lowry, General Manager Hospital & Healthcare Services

Endorsed by

Julie Patterson, Interim Chief Executive

Subject

Hospital & Healthcare Services (HHS) Bi-Monthly Performance Report

RECOMMENDATIONS

It is recommended that the Health System Committee (HSC):

a) Notes that planning has progressed for the winter demand and possible flu outbreak to ensure that we are able to respond to increased demands on services;

b) Notes that the contingency planning for the possible Nurses strike is progressing with the focus on maintaining patient safety;

c) Notes the impact of the increased demand on ICU services on elective surgery for the month;

d) Notes that the ICU extension project is progressing and is due to be completed by 1 August as per the project plan;

e) Notes that performance against the Shorter Stays in ED health target has remained at the improved level of around 92% against a target of 95%;

f) Notes that the Electives Target continues to be achieved year to date;

g) Notes that the DHB remains within the threshold for compliance with the Elective Services and that the performance in this area has been sustained;

h) Notes that performance against the MRI and CT waiting time indicators has remained at a similar level over the past three months and there are plans in place to improve access and performance, in particular:

   a. Outsourcing of both MRI and CT scans;
   b. Additional weekend sessions;
   c. Referral back to DHB of domicile for the scan to be completed;
   d. The establishment of a demand management group led by the Chief Medical Officer;
   e. Review of DHB hours of operation with a view to extending these.

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to inform the Health System Committee of key activities and priorities being progressed through the Hospital and Healthcare Services of CCDHB.
2. DISCUSSION

2.1 Key Strategic Issues / Priorities

2.1.1 Winter Planning

The winter plan has been progressed with recruitment to support the winter ward and additional beds at Kenepuru completed. The new staff have attended the orientation programme with the winter ward opening on 9 June.

Principles that underpin the planning include:
- Patient and staff safety is the priority
- Minimise admissions – decide to admit/not admit
- Share the workload and resources, using the Integrated Operations Centre, TrendCare and other management tools to manage risk across the organisation
- All areas must take responsibility for agreed actions and it is the responsibility of all clinical and operational management staff to ensure their areas are responding as agreed within the plan.

The staff Influenza vaccination programme has progressed well with 67% of staff now having been vaccinated against the target of 80%. The programme continues to be promoted across all staff groups.

We are experiencing similar volumes of both Emergency Department attendances and acute admissions as last year. This is being monitored to identify early changes in trends. A regional Operations group has also been established to monitor patient flow and occupancy levels across the region. The group meets weekly, and more often as necessary with the aim of supporting timely transfer of patients across the region.

2.1.2 Proposed NZNO industrial action July 5 and 12

New Zealand Nurses Organisation (NZNO) members have rejected the revised offer from DHBs and, as previously indicated, will likely undertake industrial action on 5 and 12 July.

Patient safety is, of course, our utmost priority and contingency planning is well underway to ensure we can meet patients’ needs – and those of staff – should the strike actions take place. Key points to know at this stage are:
- special arrangements (life preserving services) will be negotiated with the NZNO where the DHB is unable to provide sufficient appropriately skilled staff to protect life and limb
- communicating and planning with external service partners is critical, and an integral part of the overall planning process
- some services will be closed, and treatments and procedures will be deferred
- non-striking staff may be asked to work elsewhere
- no staff will be required to work outside of their scope of practice.

2.1.3 Ophthalmology Out Patient Services

A project to improve the management of patients requiring follow up has been progressing over this past financial year with the aim of ensuring all patients are followed up within the clinically appropriate time frame. There are four streams of work to support this. The approach has included:

- **Clean up of data**
  Reporting on follow ups has been established. This identified that there were many errors in the follow up data largely due to incorrect inputting of information. A senior administrator has been seconded full time to the department to review the patient bookings and ensure the right information is being loaded into the system. This has corrected a lot of the inaccuracies and has
made a significant difference in the number of patients’ being reported as overdue for their follow up appointments.

- **Catch up of patients waiting**
  Now that the reporting is accurate we are working through the number of additional clinics required to ensure patients are seen within the required timeframe. A model similar to that used in Counties Manukau where mega clinics are run on a weekend, utilising specialist doctors and nurses brought in specifically to do this work is being arranged, as we do not have the capacity within our own workforce.

- **Models of care**
  Funding was received from the Ministry of Health to support the training of a nurse injector for patients requiring the treatment of avastin for Glaucoma. This has been progressed and the training plan to now develop our own nurse injectors has been stepped up with the goal for training to be completed by the end of June. Diabetes, cataract and glaucoma nurse led clinics have also been set up and the number of clinics increased which provides more capacity to meet the demand for these services.

- **Streamlining administration processes**
  This workstream will now be progresses utilising the senior administrator. The aim of this is to improve processes and assist with management of the workload.

### 2.1.4 Intensive Care Services

There has been an increase in the occupancy levels of the unit consistent with the time of the year. May ICU patient numbers increased to an annual high of 10,542 patient hours. This together with an increase in the number of long stay patients, impacted on the number of elective surgical admissions able to be managed within the unit during the month.

The building project continues to be progressed and remains on track to be completed by the beginning of August. The clinical support space, in the former RMO accommodation area, is now completed and in use. The construction work to build the ICU bed spaces is progressing.

A successful recruitment programme for new Registered Nurses has progressed well and is on target for the opening of the new beds. The development of a new model of care to meet the new physical lay out of the unit is being progressed. The purchase of clinical equipment required for the extension to the ICU is being finalised.

### 2.1.5 Clinical Services Planning – Cancer Services

The Even Better Health Care programme of work has been established at CCDHB to implement initiatives that deliver health outcomes in a financial and clinically sustainable way and enable the transformational change toward the 2030 Vision. Included in this programme of work are service planning reviews initiated by the Board in 2017.

The reviews have used a Balanced Score Card framework that considers activity and performance across four key quadrants:

- Population Outcomes
- Patient Journey
- Financial/Efficiency
- Staff Experience.

In December 2017, the clinical service planning review work commenced with the three cancer services (Haematology, Medical Oncology and Radiation Oncology). The three cancer services are large and
complex services. All three services have experienced increasing demand which has led to capacity and resource constraints. Cancer service delivery is a key priority for the Board and the Central Regional DHBs. As part of the review process, Ernst and Young (EY) has been commissioned to provide independent process assurance and analytical support. In the case of the cancer reviews, EY has provided benchmarking analysis which has identified opportunities to review the level of access, improve service provision and outcomes within and across the three cancer services. Initial discussions on the data findings have been undertaken with the Clinical Leaders of Haematology and Medical Oncology, and the Clinical Leadership from Radiation Oncology. As a result, some additional data analysis is being undertaken.

There has been a commitment to a longer-term improvement project to address issues arising from the data analysis and discussions to date. The first stage of this project is to extend and complete the service review by including external peer review and patient input.

The challenges to be addressed by the project include:

- Understanding and developing the options to reduce the workload pressures on staff
- Understanding and developing the options to reduce pressures on ambulatory areas and ward occupancy and the resultant overflow of patients into other wards
- Ensuring future models of care can support the DHB goals of increasing access to care, reducing health disparities, better integrating health care across our health system while living within our means
- Understanding and responding to the concerns from other regional DHBs on the level of servicing of their population
- Being able to clearly justify the levels of servicing of our local population
- Improving the use of data within cancer services

**2.1.6 Neurosurgical Services**

Regional Care Arrangements have been identified as a strategic priority within the regional work programme. This was initiated to provide an agreed framework that documents secondary & tertiary care arrangements between central region DHBs.

Neurosurgery is a surgical discipline that deals with operative management of diseases of the nervous systems, including brain, spinal cord, peripheral and autonomous nerves. Tertiary specialist neurosurgery diagnostic and treatment services are provided by CCDHB for the extended central region: Capital & Coast, Hawke’s Bay, Hutt Valley, MidCentral, Nelson Marlborough, Wairarapa, Whanganui and Taranaki DHBs.

A project has been established within CCDBB to improve delivery of the Regional Elective Neurosurgical service and follows on from the clinical services planning review completed last year. It is an opportunity to re-confirm with stakeholders within the region the tertiary service provision and focus on the patient experience and continuity of safe clinical care. This project intends to streamline the process for all patients who require neurosurgical input.

The project has the following objectives:

- Best for all patients (adults and children) – health care that is sooner, closer to home with appropriate referral to the neurosurgical service which has equitable access
  - CCDHB SMO time is spent delivering the tertiary neurosurgical service and supporting colleagues in regional DHBs to deliver secondary care to their local patients
  - Patient care flows appropriately – regional primary care refer their patient to local secondary care team; secondary care make appropriate referral to the tertiary service; the tertiary service discharge back to secondary or primary care
  - Regional DHBs agree to the new referral process, work to clinical care pathways.
Work has progressed on the development of referral pathways to support the appropriate referrals from secondary care to the tertiary level service. These are to be implemented from 1 July 2018.

Referral pathways from primary care to secondary care are also under development and will continue to be progressed over the next three months.

Future service developments to be explored as the next stage of the project include:

- The DHB of domicile being responsible for their patient’s surveillance care (which may include imaging, community health, allied health, specialist nursing support)
- Specialist Supervised Telephone And Radiology Review (STAR) neurosurgical follow up clinics for clinically suitable patients (i.e. phone call to patients following review of their radiology imaging, reports and test results)
- A review of the outreach outpatient service model that will result from changes to how we deliver services across the region.

### 2.1.7 Mass Casualty Exercise

CCDHB participated in a mass casualty exercise held in Wellington on Thursday 24 May. The scenario was a bus accident involving children on the way to school. Detailed planning which included the development of the scenario, and the involvement of the other emergency services went well. Student actors played the role of the 42 casualties presenting to ED in the scenario.

The exercise was an opportunity for the DHB to test our mass casualty plan and also interact with other agencies including the police, Wellington Free Ambulance services, the Ministry of Health Emergency Response teams and other receiving DHBs. Areas involved within the DHB included the Emergency Department, Operating Theatres, ICU, Wards and the outpatient department along with a varied group of staff including administration and clinical teams.

The exercise confirmed that the response plans are in general very effective and also provided an opportunity to further improve the plans, test some new procedures and train new staff in different roles. The debrief and learnings will be completed by the end of June and amendments to the current plans will then be made.

### 2.2 Health Targets

#### 2.2.1 Shorter stays in ED – improving but target not met

**Current Performance**

Target: 95% of patients will be admitted, discharged, or transferred from the Emergency Department within six hours.

Performance against the SSIED target for the month of May was 91.8%. This was higher when compared to the same month last year which reported a performance of 90.7%.

**Emergency Department Presentations**

The total number of presentations to ED in May 2018 was 5,017. This is a decrease of 208 patients on the number recorded in May 2017 as shown in the table below.
ED Acute Admissions
Acute admissions in May 2018 shows a steady increase each month compared to 2017. There was an increase of 88 acute admissions as compared to May 2017.

Summary of Key features for the last month
- In May we experienced an increase in the number of presentations compared to April, and a slight decrease compared to our average number of presentations year on year.
- Acute admissions in May 2018 was 1940, which is an increase compared to April 2017 of 88.
- The numbers of patients leaving ED before being seen (DNW) this month was 347 compared to 306 in April and 489 in March;
- There was an increase in corridor patients in ED (527 in May vs. 490 in April)
- 95% of all patients were seen and discharged or transferred within 6.98 hours which is an improvement on previous months.

Work continues on improving models of care and processes to support an improvement of patient flow. ED improvement work is focused on increasing flow through the Green zone, increasing use of Ambulatory zone, and the use of the Emergency Department Observation Unit.

General medicine improvement work remains focused on the ambulatory care model, discharges before 11am and changes to the model of care which supports an increased number of post acute teams to better manage the volume of work across the department.

The focus on the ambulatory model is seeing an improvement in the length of stay in the Medical Assessment and Planning unit. The average length of stay (ALOS) in May was 31.5 hours against the KPI of 36 hours. This lower ALOS continue to reflect the implementation of the ambulatory care project focusing on same day discharges instead of overnight admissions.
2.2.2 Cancer Wait Times

Aim: 90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer, and seen within two weeks.

Approximately 25 per cent of newly-diagnosed cancer patients are covered by the 62-day target. A large proportion of newly-diagnosed cancer patients will continue to access treatment through pathways not covered by the target.

CCDHB has achieved 89% for May which is slightly behind the target. There were two capacity breaches for the month and seven breaches for clinical reasons. The capacity breaches were due a long wait time for surgery and the second was long wait time for diagnosis. Work continues across the organisation focusing on the whole pathway to reduce the unnecessary delays.

Monthly result

31 Day Indicator: patients with a confirmed diagnosis of cancer to receive their first cancer treatment within 31 days.

In May 54 patients were included at time of reporting. 52 patients (96%) were within the indicator timeframe.

2.2.3 Elective Health Targets

Performance against the total elective health target is 75 discharges favourable for the month of May, and remains favourable against the year to date target by 283 discharges. Within this overall performance there is an under delivery in elective surgical cases of 326 YTD. This is offset by an over delivery in Elective – Arranged & Nonsurgical cases of 609 cases YTD.

The number of cases outsourced for the month is favourable by 61 and 45 year to date against the plan. 147 patients are planned to be outsourced in June. This result will have us 111 favourable against the plan at year end but this will remain within the outsourced budget target.

2.2.4 Waiting Times

ESPI 2 is the wait list indicator for first specialist assessments (FSA).

ESPI 5 is the wait list indicator for patients waiting for treatment.
For the month of May our internal reporting shows that we remain within the threshold for compliance with 10 patients waiting greater than four months for an FSA and 8 patients waiting greater than four months for treatment.

<table>
<thead>
<tr>
<th></th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESPI 2</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>17</td>
<td>17</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>ESPI 5</td>
<td>6</td>
<td>11</td>
<td>14</td>
<td>12</td>
<td>19</td>
<td>18</td>
<td>8</td>
</tr>
</tbody>
</table>

This is an improvement on the previous month. We are forecasting 11 non-compliant in ESPI 2 and 14 in ESPI 5 for June.

2.2.5 Cardiothoracic Surgery

ICU capacity is having a big impact on cardiac surgery. The numbers of patients being outsourced has increased as planned to ensure the waitlist is managed within the maximum number and that patients are managed within clinically indicated timeframes. We are currently above the maximum waitlist number by seven patients with several patients waiting beyond clinical indicated timeframes for treatment. Ongoing clinical review and management of these patients is being undertaken by the surgeons.

2.2.6 Access to Diagnostics – Radiology

MOH Performance Indicators – CT
Performance against the CT MOH indicator for non-urgent referrals was 57% for the month of May. This remains at a similar level to previous months.

Urgent CT outpatient imaging continues to be completed within two weeks. These are prioritised and scanned within the clinically appropriate timeframe.

The steady increase in the referral rate continues to place demand on the service with an additional 622 referrals received for CT scans this quarter compared to quarter 3, 2016/17 (14% growth). An additional 368 patients were scanned compared with the same period last year. There was an extended downtime period of 11 business days in April which reduced the internal output of CT.

MOH Performance Indicators – MRI
Performance against the MRI MOH indicator for non-urgent referrals remains at a similar level for the last three months and is currently sitting at 24% against a target of 85%.
Urgent out-patient MRI imaging referrals are completed within 2 - 3 weeks. These continue to be prioritised and scanned within the clinically indicated timeframe.

MRI MRT’s are now at full establishment of 5 FTE with the commencement of the new recruit at the end of May.

Additional weekend sessions have commenced in June for both CT and MRI scans. DHB of domicile scanning continues to be progressed with 65 CT & 65 MRI patients/month going to the domicile DHBs. Outsourcing to the private provider is also continuing.

Routine CT and MRI imaging is being prioritised based on the patients with the longest wait and the more complex scans that are unable to be outsourced.

Options for addressing the backlog of patients and the plan for increasing capacity are being further developed. The options being investigated include: increasing staff numbers to extend the hours of operation, increasing the level of outsourcing, and contracting options to operate the MRI and CT scanners outside normal working hours.

The demand management committee chaired by the Chief Medical Officer has developed a presentation on the CT MRI waitlist issue. This will be presented and discussed with individual referring departments with a view to engaging them on options for managing demand. A Surveillance Checklist is also being developed.

It is anticipated that performance against the indicator will remain at a similar level as we focus on reducing the number of patients waiting as the priority will be patients who have waited the longest.

### 2.2.7 Access to Diagnostics - Colonoscopy

#### Urgent Colonoscopy

Internal Diagnostic reports for May indicated that 100% of people accepted for an urgent diagnostic colonoscopy received their procedure within two weeks (14 days) against a Target of 90%. **Target Met**

#### Non-Urgent Colonoscopy

Internal Diagnostic reports for May indicated that 77% of people accepted for a non-urgent colonoscopy received their procedure within six weeks (42 days) against a Target of 70%. **Target Met**.

#### Surveillance Colonoscopy

Internal Diagnostic reports for May indicated that 62% of people waiting for surveillance waited no longer than twelve weeks (84 days) beyond the planned date against a Target of 70%. This is an improvement against the performance of 57% achieved in the previous month. **Target Not Met**.
The services capacity based on historical practice is approximately 230 endoscopy slots per month, subsequently current demand exceeds colonoscopy capacity. We are outsourcing cases to manage the demand and maintain compliance.
1. PURPOSE

This paper outlines the background and work currently underway to develop Investment Plans to support Living Well, Dying Well.

2. BACKGROUND

A Life Course approach has been adopted to support the development of the whole of system investment programme.

RECOMMENDATION

It is recommended that the Health System Committee (HSC):

1. **Note** the investments arising from the investment approach will be monitored under the Healthy Ageing Performance Dashboard including metrics enabling us to assess whether benefits from the investment initiatives are realised.

2. **Note** HSC will receive an update in October 2018 on the Living Well Dying Well work programme.

3. **Endorse** the investment planning approach as a framework for developing an investment framework to support Palliative Care across all CCDHB settings of care.

4. **Endorse** the development of an investment plan to support Palliative Care via engagement with a wide range of stakeholders.

5. **Endorse** the investment planning approach as a mechanism to improve equity for our older Maori and Pacific populations.

APPENDIX

- **PALLIATIVE CARE INVESTMENT PLAN DELIVERABLES**
The development of an investment plan for palliative care is focused on delivering against the Living Well Dying Well and Healthy Ageing Strategy theme of Respectful End of Life across all settings of care.

2.1 Living Well Dying Well Strategy

Living Well Dying Well (2017-2020) was developed collaboratively by the Lower North Island Palliative Care Managed Clinical Network by engaging with many stakeholders, including consumers, across Wellington, Hutt Valley and Wairarapa districts.

Evidence for the effectiveness of palliative care together with the emerging needs of people living with serious chronic illness, have shown a palliative care conversation and options should start earlier than previously thought. Many patients can benefit from receiving life prolonging or disease-modifying treatments while simultaneously having their palliative care needs addressed.

The Living Well, Dying Well strategy has modelled the potential demand on both Primary and Specialist (HSS and Hospice) Palliative care for individuals and their families to support dying in their place of choice using a palliative approach. The graph below shows the CCDHB projected deaths.

---

1 Living Well, Dying Well, A Strategy for a Palliative Care Approach 2017
2.2 Equity

Anecdotal evidence suggest Māori do not receive the benefits of a palliative approach early enough, and do not equitably access palliative care services that are available. The reasons for this are complex, and likely to be in part that current palliative care models of care do not specifically address Māori needs and views on death and dying.

3. INVESTMENT PLANNING

The function of an investment plan is to guide the CCDHB in how, when and why it invests in services to ensure equitable, optimal outcomes and best use of resources across the health and social sectors.

3.1 Framework and approach

The investment planning framework is built around two key components of the Health System Plan namely
1. Major Service User Groups and
2. Settings of Care
Stakeholders involved in the development of an investment plan include:

- People and their whanau who use the services;
- Specialist and complex care providers;
- Primary care providers;
- Non-government organisations;
- Community groups; and
- Other funders and government agencies.

Investment planning is part of a cycle of commissioning activity linked to annual planning processes, integrated performance management and continuous quality improvement. Investment Planning creates the platform from which investment and budgeting decisions are made in each financial year.

The investments arising from the investment approach will be monitored under the Healthy Ageing Performance Dashboard. The performance dashboard will include metrics allowing us to assess whether benefits are realised from the investment initiatives.

### 3.2 Developing an investment plan for Palliative Care

The Palliative Care Work Stream reports to the ICC Alliance Group where both primary care and the Hospital and Health services clinicians are represented. We have replicated the ICC approach of Clinical Champions to lead the work by including HHS Palliative Care, Mary Potter Hospice and Primary Care clinicians. Wider stakeholders and service users will be involved to test the concepts during development.

The approach being taken to Palliative Care lends itself very easily to a Partnership Investment Table approach. As we, work through the planning we will consider how this may be configured building on the model in place with the Integrated Care Collaborative.

The Clinical Champions who are guiding this phase of work are as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jonathan Adler</td>
<td>Palliative medicine specialist</td>
<td>Clinical Champion with specialist knowledge of provision of Palliative Care for people with complex needs</td>
</tr>
</tbody>
</table>
Six goals have been identified to support implementation of Living Well Dying Well. These goals will be used to shape the development and subsequent monitoring of the investment plan for palliative care.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Focus for Investment planning for palliative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Management</td>
<td>1. Patients and their whānau have timely identification that end of life is approaching, and early discussions to ensure they make informed choices about what, where and how they receive care and support</td>
</tr>
<tr>
<td>Planning</td>
<td>2. Patients and their whānau receive coordinated assessment, care planning and review throughout their illness</td>
</tr>
<tr>
<td>Integration</td>
<td>3. Patients and their whānau experience equitable and seamless care through coordinated service provision</td>
</tr>
<tr>
<td>Quality</td>
<td>4. Patients and their whanau experience high quality services in different settings</td>
</tr>
<tr>
<td>Last Days of Life</td>
<td>5. Care in the last days of life is comprehensive, with good symptom control, and in the most appropriate setting (user/patient defined), in the company of whanau and or friends</td>
</tr>
<tr>
<td>After Death Support</td>
<td>6. Whanau experience high quality support after death</td>
</tr>
</tbody>
</table>

The first phase of work focuses on:
1. Creating and supporting the Clinical Champion and partnership model to lead the development of the palliative approach across CCDHB.
2. Developing an understanding of how existing palliative care services across CCDHB are used in the last year of life, and where people die. This will be accomplished by developing an NHI linked dataset built from activity delivered across settings of care.
3. Identifying the total investment across all settings of care when palliative care services are delivered, understanding the current outcomes achieved and the flexibility we have in how this pool of money is used across the partnership.
4. Research of models that works well locally, nationally and internationally and an assessment of the ability to replicate benefits in our system.

5. Linking existing work programmes underway across CCDHB (e.g. the development of Healthcare Homes and Community Health networks) and Mary Potter Hospice (in supporting primary care) to enable early adoption of new ways of working as part of investment planning.

6. Working with consumers and stakeholders to develop what is required to support a comprehensive palliative care system including service models, workforce requirements, integration and investments to support equitable outcomes for people with end of life needs.

7. Development of the Investment Plan and establishing the benefit realisation metrics to measure the impact of the investment initiatives.
### Appendix 1

Work Programme for the investment plan to support Palliative Care

<table>
<thead>
<tr>
<th>Stage</th>
<th>Deliverable</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concept</td>
<td>Report complete on current investments analysis</td>
<td>September 2018</td>
</tr>
<tr>
<td>Design</td>
<td>Present concept and design phase findings</td>
<td>November 2018</td>
</tr>
<tr>
<td>Approve</td>
<td>Investment Plan approval</td>
<td>February 2019</td>
</tr>
</tbody>
</table>
| Implement | Implementation planning  
Begins with prioritisation process, and annual planning for 2019/20 and continues in future years | April 2019 – June 2019 and future years |
| Evaluate | Investment management and performance reporting                            | Quarterly from July 2019    |
1. PURPOSE

This paper outlines the background and the current work program underway to develop an Investment Plan to support Healthy Ageing. It includes identification of linkages with other SIP work programmes (Even Better Health Care (EBHC) and the Integrated Care Collaborative (ICC)) and investment management processes to identify opportunities and determine future investment.
2. BACKGROUND

2.1 Health Ageing

The Ministry of Health’s Healthy Ageing Strategy (2016) has a focus on prevention, wellness and support for independence. The Strategy recognises the importance of family/whanau and the community in older people’s lives. This strategy applies a life-course approach to achieving the aim of healthy ageing. It recognises that we age in different ways and have different needs at different times, and that our environment affects our health.

The World Health Organisation defines healthy ageing as ‘the process of developing and maintaining functional ability that enables wellbeing in older age’. Many of the disorders of older age are preventable. A Life Course approach has been adopted to support the development of the whole of system investment programme. This will include strategies for the prevention of disease and promoting capacity enhancing behaviours at younger ages. Our focus will be on initiatives that promote ‘healthy ageing’, focus on building and maintaining peoples physical and mental function and capacity, maintaining independence and preventing and delaying disease and the onset of disability.
As capacity starts to decline, investment needs to be targeted to support older people to remain well and independent and avoid or delay care dependence.

UK research by ADL Research and Newcastle University’s Institute for Ageing shows that early intervention and prevention is most effective with those who are in the early stages of age-related functional decline.

The investment plan for Healthy Ageing will focus on the needs of people who are “pre frail” and living in the community rather than those currently using Aged Residential Care Facilities.

A companion paper is included in the June HSC meeting agenda and presents the investment planning approach for palliative care: ‘Investment Planning to support Living Well, Dying Well’ and focuses on the Healthy Ageing theme of Respectful End of Life across all settings of care.

2.2 Equity

We need to insure that our life course investment plans supports equity in life expectancy through targeted investment for Maori, Pacific.

Success will be an increase in the proportion of Maori and Pacific population-living to 85 years and older in line with that achieved by the our “other” population.
3. INVESTMENT PLANNING

The function of an investment plan is to guide the CCDHB in how, when and why it invests in services for Older People (frail older people are a major service user group in the Health System Plan 2030) to ensure optimal and equitable outcomes and best use of resources across the health and social sectors.

3.1 Framework and approach

The investment planning framework is built around two key components of the Health System Plan namely

1. Major Service User Groups and
2. Settings of Care

Success to the use of this framework is an approach, which acknowledges the complexity of the health system and environment in which the investment plans are developed. The key components include are shown in the diagram.
Stakeholders involved in the development of the investment plan include:

- People and their whanau who use the services
- Specialist and complex care providers
- Primary care providers
- Non-government organisations
- Community groups
- Other funders and government agencies

Investment planning is part of a cycle of commissioning activity linked to annual planning processes, integrated performance management and continuous quality improvement. Investment Planning creates the platform from which investment and budgeting decisions are made in each financial year. See Appendix 1.

The Older Persons Performance Dash Board is presented as separate paper to the HSC for the June meeting. As Investment Planning proceeds the Performance Dashboard will evolve to reflect key themes from the investment plan and their impact over all settings of care for people and the system. The Performance Dashboard will include metrics allowing us to assess whether benefits are realised from the investment initiatives.

### 3.2 Developing the investment plan for Healthy Ageing

To provide leadership and advice in the initial phases of the development of the investment programme we are working with experts in their fields to shape the system approach which we will test and develop with a wider strategic group.

The makeup of this group is as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ken Greer</td>
<td>Primary Care Advisor SIP</td>
<td>Care of the frail and pre frail in primary care including falls management and polypharmacy and management of Long term Conditions</td>
</tr>
<tr>
<td>Emma Hickson</td>
<td>Director of Nursing, Primary Care and Community</td>
<td>Expertise in the role of nursing in supporting older people in the community</td>
</tr>
</tbody>
</table>
Five outcome areas have been identified to support implementation of the Healthy Ageing Strategy (2016). These themes will be used to shape the development and subsequent monitoring of the investment plan for Healthy Ageing.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Focus for Investment planning for older people</th>
</tr>
</thead>
</table>
| **Ageing well**               | 1. Supporting the development and sustainability of age friendly communities that enable older people to age positively  
2. Developing health smart and resilient older people, families and communities to help older people age positively  
3. Achieving equity for populations with poorer health outcomes                                                                                           |
| **Acute and restorative care**| 1. Ensuring appropriate admissions to hospital for older people with acute or urgent clinical / care needs  
2. Co–coordinating care across the health sector  
3. Helping people to regain, maintain or adapt to changed levels of function after an acute event  
4. Looking for ways to weave the family or whānau and wider community support into an older persons recovery and long term functioning |
| **Living well with long term conditions** | 1. Improving our ability to slow or stop the progress of long term conditions towards frailty  
2. Giving individuals the tools and support they need ( including access to technology) to manage their long term conditions to a comfortable level and reduce the impact of those conditions on their lives |
Support for people with high and complex needs

1. Ensuring people are in the right place to receive the care and support that is most appropriate to their needs
2. Individuals maintain choice and control when they need significant support
3. Coordinating, integrating and simplifying health and social services for older people with high and complex needs
4. Providing flexible home and aged residential care services that suit the needs of the increasingly diverse older population
5. Reducing avoidable admissions to emergency departments and acute care amongst the group of potentially high users

Respectful end of life

1. Respecting the goals and preferences of people in their last stages of life
2. Continuing to provide high quality palliative care and preparing the health system for future palliative care needs
3. CCDHB is addressing this theme via the development of a focused investment plan for palliative care

A condensed work plan outlining when key pieces of work will come back to the HSC is in the appendix.

The work focuses on:

1. Developing an understanding of how older people (65 years +) use services across the system by developing an NHI linked data set built from activity delivered across settings of care.
2. Identifying the total investment across all settings of care utilised in delivering services for older people including an understanding of the flexibility we have in how this pool of money is used and where other government agencies invest.
3. Research into what works well nationally and internationally and an assessment of the ability to replicate benefits in our system.
4. Linking existing SIP work programmes and identifying emerging opportunities through current investment management activities (e.g. polypharmacy in older people) to enable early adoption of new ways of working as part of investment planning.
5. Understanding how the current system works from a user’s perspective. The recently published NZ Health Survey, patient experience surveys and engagement with the group shaping the investment plan will inform this view.
6. Development of the investment plan and establishing the benefit realisation metrics to measure the impact of the investment initiatives.

3.3 Emerging opportunities

There are a number of existing and planned programmes of work that will inform the development phase of the investment plan and shape the outcomes required to support healthy ageing in different care settings.

The next sections outline this work.

Changes in Setting of Care

Initial analysis of activity and costs within the HSS has highlighted that both ethnicity and age can be a driver of activity and therefore the required level of investment in complex care provision (see paper Investment Model HHS).
For people aged 65 and over, a number of existing work programmes have the potential to impact on how older people use of general medical services in the short to medium term.
Opportunity Investment plan themes
Increased specialist advice for HCH practices and maturation of Community Health Networks by:

- A focus on management of the pre frail and frail in the community. An investment bid for 2018/19 to increase geriatrician and nurse practitioner resources is currently awaiting prioritisation as part of the annual planning processes.
- Re alignment of the role of Allied Health to provide a rapid response when the potential for a shift in care setting is identified.

- In conjunction with EBHC understand the drivers for ED presentation for people aged 75 and over and the delays in acute flow for this age group once a decision to admit is made. This may require increased access to geriatrician advice and input in care planning at Wellington Hospital to reduce the acute bed days for the over 65 age group.

- Enhancement of access to specialist ambulatory care via the use of telemedicine and work with the Kapiti locality has the potential to reduce travel.

Reduce demand for services
For the people aged 65 plus, a number of existing work programmes across SIP have the potential to impact on how older people use services such as Orthopaedics in the short to medium term. This includes:

Opportunity Investment plan themes
- The 3DHB integrated falls programme with a focus on management of Fragility Fractures and strength and balance programmes in primary care will support a reduction in the need for support for high and complex needs.

- Actions to monitor and address polypharmacy in the older age groups. An investment bid for 2018/19 to increase pharmacist resources is currently awaiting prioritisation as part of the annual planning process. There is existing investment on Pharmacy Facilitation services in primary care, focused on the HCH work which will in integrated into this approach.

Strengthening Support for Carers and Home and Support services
Carers are a critical part of our system to support people to stay at home. The Older Persons dashboard shows an increase in the carers expressing stress. We invest in respite, day activity programs, and other NGOs services such as accredited visiting services. In 2018/19 we will invest sustainably to support the existing day activity programmes and investigate new ways to increase the availability of these services for our Maori and Pacific older people.

The draft 2018/19 annual plan has a number of initiatives focused on strengthening Support for Carers and Home and Support Services including:
Pay equity prices are implemented in contracts which supports the
development of a stable workforce with career progression for
workers.
Understanding how Family Choice is used to support Maori and
Pacific people accessing Home and Community Support services.
Whole of life NASC programme which is looking at ways to smooth
access for people and families with complex needs.
The Ministry of Health has signalled a shift to individualised budgets
for DSS support and this creates an opportunity for CCDHB to consider
an approach locally for our older population.

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Investment plan themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>As the roll out of ACPs matures, the sharing of plans will support people to think about the treatment they do or do not want when the time comes. ACPs support people to communicate and take control of their own health care and health outcomes. During 2018/19 we will work with NGOs on community champion and social isolation initiatives. We will continue to educate and engage with health professionals and people with a focus on Maori and Pacific. ACPs systems and processes in general practice will be enhanced and the new shared care planning platform will make it easier to share ACPs. The Investment plan for Healthy Ageing will give consideration to how these choices can best be shared across the system.</td>
<td>Respectful end of life</td>
</tr>
</tbody>
</table>

The Health System Plan 2030 identified Localities as a key enabler of support for older people to live quality lives, connected to their communities.

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Investment plan themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with the Kapiti Locality has identified that local support for those with disabilities (including those who are aged) need planned investment to facilitate the development of community circles to support independence.</td>
<td>Healthy Ageing</td>
</tr>
</tbody>
</table>
APPENDIX 1 INVESTMENT PLANNING AND MONITORING CYCLE

Year One

- Health Ageing
  - Demographic information of user group and how the utilise setting of care
  - Current Investment plan and value
  - Use of strategies, research, strategic advice and co-production

- All Settings of Care
  - Demographic information of existing users
  - Baseline capacity and activity

- Partnership Table for Investment (integration of planning and action)

- Implementation
  - Performance required from investment
  - Measures – Structural, System & Impact
  - Out Comes Framework

- Local Design & Implementation
  - EBHC supports new way of working to change place and scope of services

- Investment Monitoring
  - Takes data from all settings of care and assesses if anticipated impact is occurring
  - EBHC supports new way of working to change place and scope of services

Year Two

- Investment Monitoring
  - Confirm investment and disinvestment year 1
    - Refresh baseline
    - Agree performance changes for year 2

- Local Evaluation & Consolidation
  - EBHC supports new way of working to change place and scope of services

- Health System Committee PUBLIC - 5.2 Investment Planning to Support Healthy Ageing
## APPENDIX 2

### Work Programme for the investment plan to support Healthy Ageing

<table>
<thead>
<tr>
<th>Stage</th>
<th>Deliverable</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concept</td>
<td>Report complete on current investments analysis</td>
<td>September 2018</td>
</tr>
<tr>
<td>Design</td>
<td>Present concept and design phase findings</td>
<td>November 2018</td>
</tr>
<tr>
<td>Approve</td>
<td>Investment Plan approval</td>
<td>February 2019</td>
</tr>
</tbody>
</table>
| Implement | Implementation planning  
Begins with prioritisation process, and annual planning for 2019/20 and continues in future years | April 2019 – June 2019 and future years   |
| Evaluate| Investment management and performance reporting                             | Quarterly from July 2019                   |
1. PURPOSE

The purpose of this paper is to update the Health System Committee (HSC) on the performance of older person services provided for the CCDHB population.

2. OLDER PERSONS PERFORMANCE DASHBOARD

At the 2 May 2018 HSC meeting, a paper was presented on the performance dashboard for the Older Person Services including aged residential care (ARC), home based support services (HBSS) and Needs Assessment & Coordination (NASC) and other community services. Attached as appendix 1 is the latest version of the performance dashboard for older persons services.

The Investment approach papers for Healthy Ageing and Living Well, Dying Well being presented at the June meeting outline an evolution of the Older Persons Performance Dashboard into the Healthy Ageing Performance Dashboard which will form the basis for measuring and monitoring our investments from the investment approach. Metrics enabling us to assess whether the benefits are realised from the investment initiatives will be included in the dashboard.

RECOMMENDATION

It is recommended that the Health System Committee (HSC):

1. Notes this reporting is part of our process of improving our understanding of how our older persons investment is working for our population including equity (or not) of access to health services, ensuring these services are high quality and safe, and understanding how they improve health outcomes in our community.

2. Endorses the evolution of the Older Persons Performance Dashboard into the Healthy Ageing Performance Dashboard as described in the Investment Planning for Healthy Ageing and Living Well, Dying Well papers. The Dashboard will reflect the themes in the investment plans and the impact across all settings of care forming the basis for measuring and monitoring of changes in investment.
2.1 Interpretation of the Performance Dashboard

Some areas in the Dashboard are still under development - staffing level assessments and consumer satisfaction scores for ARC. Reporting timeframes, which include updates either yearly, six monthly, or quarterly for most indicators has resulted in most indicators remaining the same as the HSC saw in the May Dashboard.

We have refined one indicator reported in May with data from both Hutt Valley DHB and CCDHB. The indicator now shows only the results for CCDHB. This indicator shows the percentage of Clinical Assessment Protocols (CAP) intervention plans for all new CCDHB CAP triggered assessments for December 2017 to February 2018. Over this period, the percentage of plans falls short of the target (63% for falls, 44% for nutrition and 39% for physical activity). The provider undertook CAP training in May, which is expected to result in improvements in performance from June 2018.

The use of InterRAI measures for individual impact is now shown as a trend graph in the dashboard for 4 indicators - loneliness, carer distress, health professional believes person is capable of improvement, and decline in social activity.

Attached, as Appendix 2 is the latest infographic from TAS for the period January 2018 to March 2018 for CCDHB.

<table>
<thead>
<tr>
<th>Indicators Commentary Table</th>
<th>Target</th>
<th>Performance</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Structural Measures: Activity.  
We have good activity data and we are improving our demographic data. | | |
| NASC assessments completed | 95% | 98% | People entering residential care should have an interRAI assessment within 6 months and CCDHB consistently exceeds this measure. |
| Residential care funding by levels of care | Within budget | Is within budget | Entry to ARC is tracking under budget. |
| interRai review | 95% | 85% | Once a person enters residential care it is expected that they have an interRAI review every 6 months. Most facilities are achieving the target. The few who are not are working to increase their percentage achievements. |
| HCSS services in our community by person average in last 6 months | Average for same period in 2016/17 was 2,355 clients. | Average over 9 months to March 2018 was 2,407 clients. | The number of clients and hours of support delivered is stable. |
| And by hour | Average hours in same period in 2016/17 was 34,138. | Average hours in last 9 months to March 2018 was 34,053. | |
| Structural measures: Competence and Compliance  
We monitor competence and compliance through the audit process | | |
| Audits completed and number of years certified | 3 year certification for all providers | 23 ARC audits. 16 have 4 year certification, 15 have 3 year certification, | There is one facility with a 2 year certification. There has been a change in management at this facility. Access home support had a surveillance audit in January 2018. The audit was against |
## Indicators Commentary Table

<table>
<thead>
<tr>
<th>Target</th>
<th>Performance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 has 2 year certification</td>
<td>a sub-set of the Home and Community Support Standard and contracts with the DHBs, ACC and Ministry of Health. The process included a review of policies and procedures, clients and staff files and interviews with clients, staff and management.</td>
<td></td>
</tr>
<tr>
<td>ARC 59</td>
<td>ARC 58</td>
<td>The ARC facility with a 2 year certification has a management plan. All other corrective actions have been actioned with one to be closed when the resident patient satisfaction survey is completed. The Access audit identified four improvements were required.</td>
</tr>
<tr>
<td>Still under exploration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Corrective actions required and time to completion

### System Level Performance: Evidence & Quality Markers
**Understanding our evidence markers enables us to ensure services are meeting system performance requirements and are complemented by quality measures.**

### Status of Access Community Health’s contract KPIs

**For 6 months Sept 2017 – Feb 2018**

- < 2% of rostered cares were not delivered
- Rate of people entering ARC was less than or equal to 54 people per 1,000 aged 75+ years
- 90% of high risk clients received services within 24 hours of referral.

### Responses to Clinical Assessment Protocols (using interRAI)

The intervention plans in place when an assessment shows need

- 90%

### Undelivered Services by Access Community Health

- <2%

### Reporting period 1 January 2017 – 31 March 2018. % includes HVDHB and CCDHB data. For CCDHB of 268,549 cares 168 visits were missed.

### KPI is met

- 0.08% missed visits
- In the 12 months to Feb 2018 42 people per 1,000 aged 75+ entered ARC.

### KPI is met

- 90.43%

### KPI is met

- Falls 63% Nutrition 44% Physical Activity 39%

Access recognise that one to one training is required where nurses are not meeting CAPS expectations. CAPS training occurred in May 2018. This is being monitored weekly as improvement is required.

The previous data on the dashboard included HVDHB and CCDHB numbers. This indicator now shows the CCDHB data only.

Reporting period 1 January 2017 – 31 March 2018. % includes HVDHB and CCDHB data. For CCDHB of 268,549 cares 168 visits were missed.
## Indicators Commentary Table

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Target</th>
<th>Performance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints and resolutions</td>
<td>13 complaints received by the DHB between 27th Feb – 30 May</td>
<td>12 closed</td>
<td>I open complaint is with HDC.</td>
</tr>
<tr>
<td>Consumer satisfaction scores</td>
<td>To be developed for ARC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Impact Measures

These include the impact on the system and the impact for the individual

<table>
<thead>
<tr>
<th>Impact Measure</th>
<th>Target</th>
<th>Performance</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Admission Rate of people over 75yrs</td>
<td>293.9 per 1000 in 15/16 total pop</td>
<td>297.5 per 1000 16/17 total pop</td>
<td>Reported as stable. Admission rates for over 75s indicates they are receiving appropriate and timely care in the community. Overall CCDHB has lower admission rates than the NZ average.</td>
</tr>
<tr>
<td>Acute bed days of people over 75 years</td>
<td>23,736 for 2015/16</td>
<td>26,157 for 2016/17</td>
<td>Reported as stable. Added to the measure above we can infer whether the health system is supporting people in the community.</td>
</tr>
<tr>
<td>Admissions to ED from ARC/HCSS</td>
<td>1,127 admissions in 2015/16</td>
<td>1,193 admission in 2016/17</td>
<td>There is commitment by ARC managers and regional managers to reduce inappropriate admissions. SIP monitors and identifies outliers and addressing specific issues. Specialist consultations and support offered to aged care facilities include Nurse Practitioners, Wound Specialists, and Palliative Care.</td>
</tr>
<tr>
<td>Use of interRAI to measure individual impact:</td>
<td></td>
<td></td>
<td>Informal carers are experiencing more stress. The needs of carers will be considered in the development of an investment plan to support the Healthy Ageing Strategy and Health System Plan 2030.</td>
</tr>
<tr>
<td>1. Feeling lonely</td>
<td>Quarter 2 17%</td>
<td>Quarter 3 18%</td>
<td>The other indicators are relatively stable.</td>
</tr>
<tr>
<td>2. Carers Distressed</td>
<td>23%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>3. Health professional believes person is capable of improvement</td>
<td>5%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>4. Experience decline in social activity</td>
<td>6%</td>
<td>7%</td>
<td></td>
</tr>
</tbody>
</table>

## Conclusion

The Performance Dashboard reporting is part of our process of improving our understanding of how this investment is working for our population including equity (or not) of access to health services, ensuring these services are high quality and safe, and understanding how they improve health outcomes in our community. As described in the Investment Planning for Healthy Ageing and Living Well and Dying Well papers the dashboard will...
evolve into the Healthy Ageing Dashboard to reflect the themes in the investment plans and the impact across all settings of care and will be used to monitor our investments for older persons including palliative care.

The Health System Committee will receive regular dashboard reports that build the confidence of the Board and identify and monitor opportunities to improve the impact of our investment on our community’s health and wellbeing.
Older people assessed by interRAI, Capital and Coast DHB – January to March 2018

One of the ways DHBs help older people get the right support at the right time, is to have a health professional complete an assessment of a person’s health and wellbeing. This assessment is known as an interRAI assessment.

The information in this infographic is from interRAI Home Care assessments for people living at home in the community.

We publish the interRAI Home Care assessment results to encourage health professionals, community groups, and family/whānau to check in with older people and see how they are doing.

Notes:
- 691 interRAI Home Care assessments were completed.
- * Social activity could be going to church, playing bridge or attending seniors clubs.
- **One meal is considered to be a nutritionally balanced plate of food that someone of the same age and culture would choose to eat at a meal time.

Staying socially connected to others is key to healthy ageing.

- 90% have strong and supportive family relationships
- 6% have had less than one meal a day, in the last three days**
- 48% are at risk of experiencing low mood, if no assistance is provided
- 24% have cognitive difficulties with everyday decisions such as when to get up, remembering to take their medicines, what clothes to wear, or using a walking frame when leaving
- 68% have no Enduring Power of Attorney (EPOA).
- 95% have no documented Advance Care Plan (ACP).

31% are content with a decline in their social activities

7% experience their decline in social activity as distressing*