Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Capital & Coast District Health Board

Annual Plan 2018/2019

Annual Plan dated 12 February 2019
(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

Associate Minister of Finance

Received On

10 MAY 2018

Chief Executives Office

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 those 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.

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

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

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

27 FEB 2019

Mr Andrew Blair
Chair
Capital & Coast District Health Board
andrew@blairconsulting.co.nz

Dear Andrew

Capital & Coast District Health Board 2018/19 Annual Plan

This letter is to advise you I have approved and signed Capital & Coast District Health Board's (DHB) 2018/19 Annual Plan for one year together with the Minister of Finance.

I have been clear that my expectation for the total DHB sector financial position was that it was an improvement on 2017/18. I am concerned that this expectation is unlikely to be met. I have previously emphasised to you that it is important DHBs are doing all they can individually and collectively – both regionally and nationally to live within the funding provided.

I note your DHB has planned a deficit for 2018/19 and a return to breakeven in the out years. I understand that you have advised the Ministry of Health that you should be able to hold your deficit to a lower level than currently budgeted in 2018/19. This will require a concerted effort and I trust that you will continue to work with the Ministry to evaluate and improve your financial performance.

Your Production Plan is still to be confirmed, and you will work with the Ministry to resolve this.

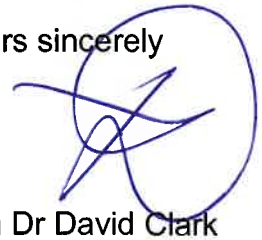
I am aware you are planning a number of service reviews in the 2018/19 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders. I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2018/19 Annual Plan. I look forward to seeing your achievements.

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely



Hon Dr David Clark
Minister of Health

cc: Ms Julie Patterson, Acting Chief Executive, Capital & Coast District Health Board, julie.patterson@ccdhb.org.nz

Table of Contents

SECTION 1: Overview of Strategic Priorities

1.1 Strategic Intentions & Priorities

This Annual Plan articulates Capital and Coast District Health Board's (CCDHB) 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."

In setting the strategic priorities necessary to achieving this vision, CCDHB is guided by core legislative and governmental strategic directions including, the New Zealand Public Health and Disability Act 2000, the Treaty of Waitangi, the New Zealand Health Strategy and its accompanying strategies: He Korowai Oranga – the Māori Health Strategy, 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018, Healthy Ageing, Living with Diabetes, Rising to the Challenge – Mental Health and Addiction Service Development Plan, Enabling Good Lives Disability Strategy and the Primary Health Care Strategy. CCDHB is also guided by the Government's commitment to the United Nations Convention on the Rights of Persons with Disabilities.

CCDHB is committed to focus in key areas:

- Improving Performance: CCDHB continues on a pathway to improve system performance and outcomes for our communities. We are taking a "simplify/intensify" approach to service provision; services for those with resources are simpler, while services for those with less resources are intensified.
- Equity: CCDHB is investing to sustainably implement equity, with a focus on those where inequitable outcomes have the greatest negative impact such as Māori, Pacific people and those in lower socio economic status. Specific equity initiatives are outlined in the planning priority section.
- Primary Care: The roll out of Healthcare Home is a key priority for CCDHB. The emphasis in year three of this programme is on equity and ensuring models of service delivery are effective for our Maori and Pacific communities as well as those with disability and enduring mental illness. This includes access to after-hours primary care especially on the Kāpiti Coast.
- Hospital Specialist Services: CCDHB is committed to improving regional care arrangements as the tertiary specialist provider in the Central Region. This will ensure
- Financial Sustainability: CCDHB remains on a target pathway to achieve breakeven. In this Annual Plan we will achieve the agreed target for 2018/19. Actions within this Annual Plan contribute to manage demand and support a health system that is more sustainable in 2019/20.
- Capital Issues: The build of a new Children's Hospital is underway with the support of Treasury and MoH. Capital investment is under review as part of the Long Term Investment Planning process and we will ensure MoH are appraised of any significant requirements as they arise.
- Regional Collaboration: CCDHB has close sub-regional relationships with Hutt Valley and Wairarapa DHBs. For 2018/19, CCDHB will strengthen the shared planning processes across Hutt Valley and CCDHB as we move to a shared Chief Executive.
- Mental Health and Addictions: CCDHB is facing a growing need for mental health and additional services. CCDHB has a comprehensive programme of work to prepare for implementation of the Mental Health Inquiry recommendations.

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 or remedial differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms."*

For CCDHB, equity is about looking at how well different population groups are doing compared with each other, identifying where the differences are 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 Peoples 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 2019-2030, 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 puts in place the building blocks for CCDHB to advance as a pro-equity organisation.

1.2 Strategic Vision

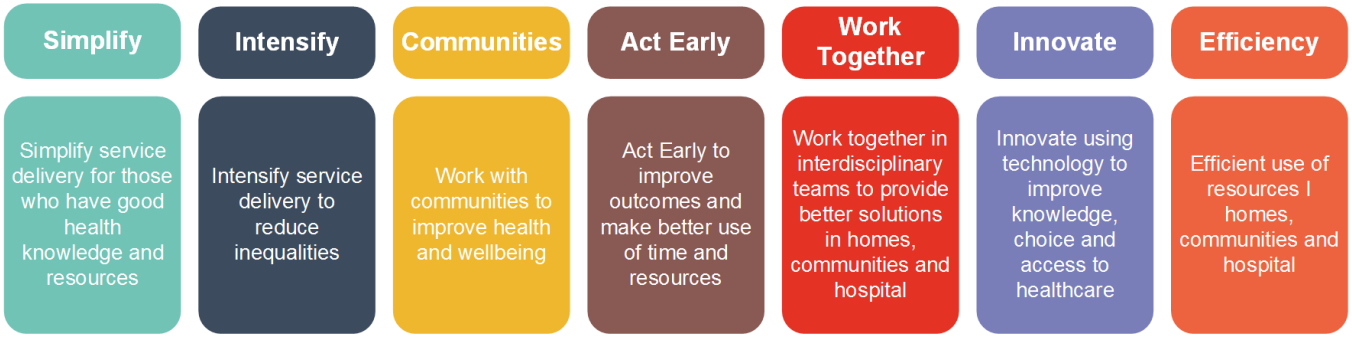
The Capital and Coast Health System Plan 2030 (HSP2030) outlines CCDHBs strategy to improve the performance of the region's healthcare system. To achieve our obligations to the Minister, the region and our communities, we will use our resources wisely and strategically to:

For the 2018/19 year, CCDHB will especially focus on:

- Equitable outcomes, particularly Māori and Pacific Peoples
- 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 CCDHB's 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 broad 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 HSP2030, CCDHB adopted a life course approach to achieve better outcomes for its population. The HSP2030 describes three 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
- Mental illness and addiction
- Core healthcare service users being acute and planned personal health

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

Life course group	One significant action that is to be delivered in 2018/19
Pregnancy	Primary Birthing Project – Complete the feasibility study for a primary birthing unit within Wellington/CCDHB.
Early years and childhood	Integration Services - Develop an integrated approach to antenatal services, breastfeeding and childhood obesity services with a focus in Porirua.

Adolescence and young adulthood	Youth Services in Porirua – Invest in the provision, coordination and integration of services for young people in Porirua.
Adulthood	Develop a health system response to develop and implement a pro-active whole of system suicide prevention responses in health service providers. The response will develop solutions across NGO, primary and secondary care providers.
Older people	Healthy Aging – Development of a healthy aging investment plan to: (i) enhance the support available in primary care and community teams for older people (ii) reduce social isolation through community circles in Kāpiti (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.

1.4 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 the care we provide to our population who have greater resources, and intensify the care we provide in our communities who are disadvantaged.

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. We will also continue to support our DHB partners in the central region as a tertiary provider.

A critical element in our investment decision-making is strong clinical leadership from across our health system. The maturing role of our Clinical Council and our focus on clinical governance is particularly important for ensuring we get this leadership at the right points and I am pleased to see our ongoing leadership development.

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 and quality - clearly and consistently.

We also expect the DHB to respond appropriately to safety, quality and 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 the challenges we face.

We know our workforce matters. Our people and their capability is critical to our success. We continue to strengthen our commitment to the safety and development of our workforce.

We are actively engaged in meeting the expectations of the Minister of Health, which our own long term vision for our health system is well aligned with. 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

1.5 Message from the Chief Executive

I am pleased to present Capital & Coast District Health Board's Annual Plan for the 2018/19 financial year. This plan establishes clear priorities for CCDHB to allocate our resources and focus our efforts on elevating performance to meet the needs of key groups within our population.

It reflects a strong relationship between the wider factors influencing health and the leadership role we must take to build partnerships with other agencies, services and communities to build resilience and improve health and social wellbeing. Our localities activity will increase throughout the coming year and lay the foundations for ongoing sustainable partnerships with our communities. The development of our regional care arrangements across the Central region will continue to be strong as we serve our central region DHBs.

The life course focus we are taking to ensure services are equipped to meet peoples' needs throughout every stage of life is critical for optimising health outcomes for our communities. A strong feature of our prioritised activity is improving our responsiveness to maternity care, children and youth – getting the best start is a great investment for achieving improved outcomes throughout life for our communities. It has an important role to play in creating a future where we have equitable health outcomes for all.

Our key actions across the life course include:

- Equitable outcomes, particularly Māori and Pacific Peoples
- Mental Health and Addictions services
- Primary Care services
- Child Wellbeing
- The strength of our publically funded health system

Our plan reflects both the local CCDHB and broader interdependent planning and delivery of health services across the Wellington sub-region and the wider Central Region. CCDHB will continue to partner with Hutt Valley DHB and Wairarapa DHB where it best serves our communities and makes the best use of resources. CCDHB will also continue to partner with our Central Region DHBs and this plan should be read in conjunction with the Regional Service Plan for 2018/19.

We have started to develop and apply new ways of working and have established some sound building blocks including the development of a long-term health services strategic plan (HSP2030), integrated support services key projects and the Even Better Health Care Plan.

We continue to strengthen our commitment to the safety and development of our workforce including implementing Care Capacity Demand Management (CCDM). Continuing to build our clinical governance will further strengthen our focus on the quality and safety of the services we deliver.

These new ways of leveraging the existing strengths in our organisation including our strong relationships within and across our communities, a committed and involved clinical workforce, and our equity focus will be key to deliver on the ambitious targets we have set ourselves for 2018/19.

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: 24/2/19

Hon. Grant Robertson
Minister of Finance
Date: 24/2/19

Andrew Blair
Chair
Date: 14.02.19

Dame Fran Wilde
Deputy Chair
Date: 13.2.19

Julie Patterson
Interim Chief Executive
Date: 13/2/19

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 Peoples by requiring high quality ethnicity data across the organisation and regular, transparent, data monitoring (including public reporting)
- Building a fit for purpose workforce by ensuring robust people and capability policies and guidelines to recruit for equity skills and expertise, matched with performance indicators, core competencies and training / development across the organisation.

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

2.1.1 Addressing inequities

Improving equity performance is a priority. In this plan we start to address some of the drivers of inequities to improve outcomes particularly for Māori and Pacific Peoples and other populations experiencing inequities. The following choices are making a contribution to improving equity:

- Living wage investment and pay equity settlements make a contribution to equity as there is a relationship between income and health outcome.
- Increasing Māori enrolment in primary care.
- Increased BEE Healthy dental enrolments and treatments focus on our Porirua children.
- Youth focused services will be extended into the Porirua community.
- Youth community alcohol and drug services will be commission to support vulnerable youth.
- Transgender psychological services will support a very vulnerable youth population.
- NZ Sign Language resources and support to ensure health services are accessible to our deaf populations.
- Supporting access to urgent care in Kāpiti to prevent avoidable travel to Kenepuru and Wellington Regional Hospital.

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

2.2 Government Planning Priorities

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

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
Mental Health	**Population Mental Health** **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 co-ordinating mental health care with wider social services.	**One Team**	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)	Q4: 2030 MHA strategy completed Q4: Implementation plan for 2019/20	PP43
				2. **Integration**: Integrated care work programme across primary and secondary care to 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: 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 Q3: Implementation of agreed framework	
				4. 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.	Q2: Training for community groups implemented	
				5: Implementation of **Supporting Parents Healthy Children**	Supporting Parents Healthy Children implementation across MHAIDS is underway	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
					Q1-Q4: Training of adult community mental clinicians in Let's Talk and Single Session Family Consultation models Q2 to Q3: Develop, test and implement SharePoint page so MHAIDS clinicians can easily access information / learning and resources for parents.	
Mental Health	**Mental Health and Addictions Improvement Activities**	Outline how the DHB will ensure your staff and members of your community will be encouraged to participate in the Government Inquiry into Mental Health and Addiction.		1. **Mental Health Inquiry Panel Meetings**: Host meetings across the three DHBs with the panel to provide opportunities for consumers, the community and NGO sector, the workforce and the MHAIDS provider to make representation to the panel.	Q1: Responses to the Mental Health Inquiry submitted	
				2. **Regional Collaboration**: Collaborate with our regional DHB partners (Hutt Valley and Wairarapa) to support the Inquiry	Q1: Completed	
				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.	Q1: Completed	
				4. Promote Inquiry **public meetings** through our DHB provider networks and our website.	Q1: Completed	
		Outline your commitment to the HQSC mental health and addictions improvement activities with a focus on minimising restrictive care (including the aspirational goal of eliminating seclusion by 2020) and improving transitions.	One Team	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	Q1: Seclusion dashboard developed Q1-Q4: Seclusion Monitored through the Restraint and Seclusion Elimination Monitoring and Advisory Group	PP7 PP36
				2. Redesign **Te Whare Ahuru Acute Inpatient Unit** to deliver best practice and culturally safe models of care in a modern environment that is safe, restful and supports recovery and greater wellbeing	Q4: Te Whare Ahuru Acute Inpatient Unit redesigned	
				3. Establish a **Youth Mental Health Respite Service** with a focus on meeting the needs of young Māori Tāngata Whai Ora and Pacific Peoples. (EOA)	Q4: Youth Mental Health Respite Service established	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
				4. Implement a new **Regional Alcohol and Other Drugs Acute Residential Treatment Service**, 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 Peoples, and at-risk populations (EOA).	Q4: Regional Alcohol and Other Drugs Acute Residential Treatment Service implemented	
				5. **Transition Planning**: "Connecting care" initiative to transition clients from crisis response teams to community mental health teams for face to face contact within 14 days "Back to primary and integrated care delivery" to improve identification and breaking down barriers to discharge	Q4: Connective care initiative implemented Q4: Back to primary and integrated care delivery initiative implemented	
Mental Health	**Addictions**	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.	Value and High Performance	1. Continue to **reduce wait times** 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.	Q1-Q4: Meet the PP8 addiction related waiting time targets for youth (See Statement of Performance Expectations).	PP8

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
				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.	Q4: Scope of potential service improvements to the ICAFS/CAMHS completed	
				3. **Alcohol and Other Addictions Strategy**: Develop a model of care and strategy to support freedom from addiction. (EOA)	Q2: Model of care developed Q4: Implementation plan developed	
Primary Heath Care	**Access**	As per Budget 2018 announcements, commit to the implementation of new primary care initiatives to reduce the cost of access to primary care services. This includes extending zero fees for under-13s to zero fees for under-14s and reducing fees for community service card holders. Describe actions that will ensure at least 95% of eligible children aged under 14 have zero fee access to afterhours care within 60 minutes travel time. This includes general practice services and prescriptions.	**Closer to Home**	1. **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	PP33
				2. **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	
				3. **Zero Fees Access to GPs for Under 14s**: work with our PHOs and Pharmacies to implement >95% coverage for Under 14s by 30th June 2019 (depending on funding). Ensure information about providers is available through our website	Q4: >95% coverage zero fees access to GPs for Under 14s Q4: information about providers available through our website	
				4. **Reducing Fees for Community Service Card Holders:** work with our PHOs to implement >90% coverage for Community Service Card holders by 30th June 2019 (depending on funding).	Q4: >90% coverage reduced fees for Community Service Card holders	
Primary Heath Care	**Integration**	DHBs are expected to continue to work with their district alliances on integration including (but not limited to):	**Closer to Home**	1. **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	PP22

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
		- strengthening their alliance - broadening the membership of their alliance - developing services, based on robust analytics, that reconfigure current services. In addition: -please identify actions you are undertaking in the 2018/19 year to assist in the utilisation of other workforces in primary health care settings. -identify actions to demonstrate how you will work proactively with your PHOs and other providers to improve new-born enrolment with general practice in 2018/19.		2. **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	
				3. **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	
				4. **Service Development**: Increase the utilisation of ICT enablers including the patient portal, shared electronic health record access, concerto access and shared care plan.	Q2: Ethnicity based patient portal uptake data collection processes with relevant vendors implemented Q4: >25% of CCDHB enrolled population activated on the patient portal	
				5. **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)	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	
				6. **National Enrolment Service (NES):** Work with the Ministry of Health to gain access the NES	Q4: CCDHB can access the NES.	
Primary Heath Care	**System Level Measures**	Please reference the jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix.	**Value & High Performance**	**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)	Q1-Q4: Monitor and report against progress made each quarter to MoH	PP22 SI1 SI7 SI8 SI9
				2. Amenable Mortality: A 4% reduction for Māori and 6% reduction for Pacific. (EOA)	Q1-Q4: Monitor and report against progress made each quarter to MoH	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
				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)	Q1-Q4: Monitor and report against progress made each quarter to MoH	SI12 SI13
				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)	Q1-Q4: Monitor and report against progress made each quarter to MoH	
				5. Patient Experience of Care: For 2018/19 maintain or improve the overall response rate, and improve the Māori and Pacific Peoples response rates by 6% and 7%, respectively, to that of the "other" population. (EOA)	Q1-Q4: Monitor and report against progress made each quarter to MoH	
				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 in Active Service Changes). (EOA)	Q1-Q4: Monitor and report against progress made each quarter to MoH	
Primary Heath Care	**CVD and diabetes risk assessment**	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	**One Team**	**1. Heart and Diabetes Checks**: Increase coverage of More Heart and Diabetes Checks for Māori and Pacific men aged 35-44 years (SLM). (EOA)	Q2 & 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)	
				2. Quality Improvement in Diabetes Care and Services (as identified in the self-assessment of diabetes services)**:** Improve the outcomes for people diagnosed with type 2 diabetes at a young age (with a focus on Māori and Pacific Peoples aged 15-39 years) by tailoring interventions for young people and their families. Report on the success of targeted initiatives. (EOA)	Q2 & Q4: Report on the success of targeted initiatives to tailor intensive diabetes care to individuals and families. Reduce number of Māori and Pacific Peoples with an HBA1C greater than 64mmol/mol by 4% by the end of quarter 4	PP20

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
		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.		**3. Quality Improvement in Diabetes Care and Services** (as identified in the self-assessment of diabetes 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).	Q4: Report on the burden of disease including focus on the impact of age and ethnicity.	
				4. Quality Improvement in Diabetes Care and Services (as identified in the self-assessment of diabetes 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)	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.	
Primary Heath Care	**Pharmacy Action Plan**	Continue to engage with the agreed national process to develop and implement a new contract to deliver integrated pharmacist services in the community. 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.	One Team	**1. Pharmacy Contracting**: Implement decisions made in relation to the pharmacy contracting arrangements.	Q1: Decisions from the pharmacy contracting arrangements implemented	
				2. Identify Health Needs: which are amenable to Community Pharmacy interventions	Q2: Decision made regarding interventions	
				3. Contract for Local Services: Use "Intensify" criteria to fund local community pharmacy services to improve health of population. Equity for Māori and Pacific Peoples will be considered when contracting these services. (EOA)	Q3: Schedule 3 contracts with appropriate pharmacies initiated	
				4. Procurement for CPAMS: 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 Peoples will be a consideration when contracting these services. (EOA)	Q3: CPAMs contracts awarded implemented 19/20 year	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
Primary Heath Care	**Support to quit smoking**	Please identify activities that continue to support delivery of smoking ABC in primary care	One Team	**1. Smoking Cessation Services:** Increase referrals to smoking cessation services from Primary care for Māori, Pacific and other	Q1-4: Increase cessation support indicator ***by 3% by quarter 4***	
				2. Hospital focus: Maintain a programme of continuous quality improvement initiatives to support achievement of the hospital target, including equity for Māori and Pacific.	Q1-Q4; Achieve Better help for Smokers to Quit in Public Hospitals target.	
				3. Hapū Ora: Increase referrals to the Hapū Ora service for young Māori parents with children (0 to 4 years) to provide opportunities for babies to grow up in Smokefree homes.	Q1: Set baseline for referral target; Q2 & Q4: increase referrals by 10%.	
				4. Pharmacy integration: Assess the impact of pharmacies prescribing NRT and referring to Smoking Cessation Services including analysis of equity of access. This activity will depend on the uptake of the new community pharmacy contract	Q2 & Q4: Number of individuals referred to Smoking Cessation Services; Q4: Number of individuals successfully quit as a result of referral.	
Child Health	**Child Wellbeing**	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	Value and High Performance	**1. Shaken Baby Prevention Programme:** Implement recommendations from 2017/18 evaluation of the Shaken Baby Prevention Programme. (EOA)	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 Peoples	PP27
				2. Violence Intervention Programme (VIP): Continue the rollout of the VIP training to DHB health professionals. (EOA)	Q4: 60% of clinical staff received VIP Training across hospital health services.	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
		populations, and making connections with and between local service providers of maternal health, child health and youth focused services.		3. **Child Protection Services**: (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)	Q4: Participate in the Interagency Governance Group addressing family harm	
				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)	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	
				5. Child Abuse & Neglect (CAN): Increase the use of the Injury Flow Chart relating to CAN for eligible patients (children < 2 years) presenting to ED.	Q4: 75% of eligible patients (children < 2 years) presenting to ED will have an Injury Flow Chart completed.	
Child Health	**Maternal Mental Health Services**	Commit to have completed a stock-take 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.	Closer to Home	**1. Maternal Mental Health Screening:** Develop a model for mental health screening and support including a focus on Māori and Pasifika families' (EOA)	Q2: Options investigated Q3: Preferred option developed Q4: Model implemented as part of the SUDI work programme.	PP44
				2. Māori and Pacific Peoples workforce: To ensure accurate ethnicity data collection to inform areas of high utilisation by Māori and Pacific Peoples, as consideration for an increase in Māori and Pacific Peoples 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	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
		Commit to identify, and report in quarter four on the number of women accessing primary maternal mental health services both through PHO contracts that the DHB holds and, through any other DHB funded primary mental health service.		**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 Q4: Report on the number of women accessing primary maternal mental health services	
Child Health	**Supporting Health in Schools**	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).	Closer to Home	**1. Oral Health**: Develop action plan to address Māori and Pacific Peoples inequities in utilisation of DHB-funded adolescent dental services. (EOA)	Q3: Action plan developed	
				2. Youth Diabetes: 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)	Q3: Strategy developed Q4: Implementation Plan developed	
				3. School-Based Health: Identify actions currently under way to support health in schools.	Q1: Develop list in collaboration with providers Q2: Provide report to Ministry	
				4. Youth Services in Porirua: Increase provision, coordination and integration of services for young people in Porirua. (EOA)	Q1: Project plan developed Q2: Commence Co-design Q3: Implement the service	
Child Health	**School-Based Health Services (SBHS)**	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	Closer to Home	**1. Health Services in Public Secondary Schools:** Complete a stocktake of health services in public secondary schools within the CCDHB Catchment	Q2: Stocktake completed	PP25
				2. School Based Health Services: Develop a service delivery model for school based health services to increase acceptability and uptake by Māori youth. (EOA)	Q3: Model developed	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
		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.		**3. School Based Health Services Expansion:** Develop an implementation plan, with equity focus, to expand SBHS to all public secondary schools in the CCDHB catchment. (EOA)	Q4: CCDHB Youth ICC Steering Group to approve implementation plan	
Child Health	**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 for Māori:** Scope, formalise and implement a plan of activities to reduce the decline/non-completion rate for Māori children. (EOA)	Q1: Conduct investigation Q2: Plan developed and implemented Q1 - Q4: Achieve Target	PP21
				2. Immunisation Rates for Pacific Peoples: Scope, formalise and implement a plan of activities that will improve 5-year immunisation rates.	Q1: Conduct investigation Q2: Plan developed and implemented Q1 - Q4: Achieve 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	**1. Māori Infant Immunisation Coverage Levels:** Implement actions from Immunisation Rates for Māori to reduce the decline/non-completion rate for Māori children. (EOA)	Q1: Conduct investigation Q2: Plan developed and implemented Q1 - Q4: Achieve Target	
				2. PHO Enrolment: Work with PHOs to identify opportunities to increase the rate of Māori enrolment. This will be done by data matching the NIR against enrolment codes to identify children who aren't currently involved in practice and follow up. (EOA)	Q2: 87% of Māori are enrolled in a PHO Q4: 90% of Māori are enrolled in a PHO	
				3. Influenza immunisation: Implement additional immunisation outreach over the winter period in Porirua for all high risk Māori & Pacific children. (EOA)	Q3: Influenza immunisation coverage ≥2017	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
Child Health	**Responding to childhood obesity**	Please identify activities that continue to respond to children identified as obese at their B4 school check.	Value and High Performance	Improve coordination and collaboration between projects focussed on Reducing Childhood Obesity to develop specific activities to achieve equitable outcomes for Māori and Pacific children and children with disabilities.(EOA)	Q2; Finalise referral pathways between the relevant agencies. Q3-4; Agencies to establish quarterly oversight group to monitor the implementation of the referral pathways against outcomes.	PP38
System Settings	**Strengthen Public Delivery of Health Services**	Identify any activity planned for delivery in 2018/19 to strengthen access to public health services.	Value and High Performance	**Cervical Screening:** Work with partners across the health system 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 women (80%)	SI10 SI16
System Settings	**Shorter Stays in Emergency Department**	Please identify activities that continue to improve patient flows through hospital.	Value and high performance	**Improve flow in ED:** Continue improvement project in ED including: 1. increase use of green zone 2. Further development of ED Observation Unit model of care 3. Increase flow in department by better use of discharge zone **4.** Maximise efficiency in peak time between 11am and 11pm **5.** Refinements to MoC including Zone model and triage and front of house	Q2 increase use of green zone by 5% Q2; resourcing evening and night shifts reviewed Q1; Discharge area usage increased by 5% Q4; Triage model Reviewed	

Government Planning Priority	Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			Optimise the performance of the inpatient wards to enhance patient flow, models of care, environment and tools: **1.** Test rounding, discharge and inter-district flow processes **2.** Develop and agree the performance measures for an optimal ward	**Q1** Model of care changes for rounding and discharge processes trialled **Q3** Model of care changes implemented **Q4** Model of care changes rolled out to other wards **Q1** Agreement with region to extend solution that provides visibility of regional cardiology patients to include cardiothoracic patients **Q2** Solution developed for cardiothoracic patients **Q3** Extend functionality of solution to include admission information from referring DHB **Q2** Dashboard developed in QLIK **Q3/Q4** Dashboard rolled out to other wards	
			Establish a set of principles in relation to "**what good looks like for our patients, staff and communities**" to: 1. better understanding the needs of our patients and communities 2. Achieve greater staff collaboration and engagement 3. reduce the non-value add activities **4.** improve processes	**Q1** Baseline staff survey completed **Q2** Baseline inpatient survey completed **Q2** Establish frameworks and processes for supporting areas that can be rolled out to other wards **Q2** Resurvey staff to measure degree of change **Q3** Rollout staff and inpatient survey to other wards **Q4** Resurvey staff and inpatients to measure degree of change	
			Undertake **HQSC co-design** training with Māori and Pacific Peoples consumers: 1. Engage with Māori and Pacific Peoples communities to understand inpatient experience and what support is required pre/post discharge to reduce readmissions **2.** Test and implement co-design initiatives	Q2 Agree co-design initiatives Q4 Co-design initiatives implemented Q3/Q4 Measure impact co-design initiatives	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
System Settings	**Access to Elective Services**	Please provide three specific actions that will support your delivery of the agreed number of Elective discharges, in a way that meets timeliness and prioritisation requirements and improves equity of access to services. At least one action to improve equity of access to Elective Services should be included. 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	**1. Elective Discharges Target:** Achieve Elective Discharges Target by: • Continuing with patient focused scheduling to ensure DNA rate is minimised • Continuing with production planning to ensure surgical lists are backfilled or taken up by other specialities • Outsourcing patients to private facilities when capacity does not meet demand in some specialities	Q1-Q4: On track to achieve Target Q4: Target achieved (11,205)	Number of Elective Discharges SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Elective Services Patient Flow Indicators
				2. Prioritisation: Consistently achieve >90% of services prioritising referrals within required time frames	Q1-4: Work with services that do not consistently achieve prioritisation within the required timeframes to identify and remove barriers for performance Q1-2: Explore possibility of implementing electronic prioritisation	
				3. Pre-assessment Processes: Improve access to pre-assessment to ensure that patients are optimally prepared for surgery and that delays in accessing pre-assessment does not impact theatre scheduling (list utilisation), including for Maori, Pacific and distant communities (e.g. Kāpiti).	Q4 (17-18) Pre-assessment improvement project initiated Q1-Q4: Implement recommendations from project and roll out across more specialties	
				4. Operating Theatre Session Utilisation: Improve the management of SMO leave to reduce the impact of leave on theatre session utilisation.	Q1: Strategies, to ensure that surgical lists are able to be backfilled during surgeon leave, (identified in Q4 17-18) to be implemented across 4 services Q2-4: Strategies rolled out across other specialties Q3-4: Improved HR processes are in place to assist in the management of SMO leave	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
System Settings	**Cancer Services**	Implement improvements in accordance with national strategies and demonstrate initiatives that support the areas outlined below. All initiatives will demonstrate clear strategies for addressing Māori health gain, equitable and timely access to services and the use of data to inform quality improvement across those initiatives. DHBs will describe actions to: -ensure equity of access to timely diagnosis and treatment for all patients -implement the prostate cancer decision support tool to improve the referral pathway across primary and secondary services -provide support to people following their cancer treatment (survivorship).	Value and High Performance	**1. Equitable access to diagnosis and treatment:** Enable equity of access to timely diagnosis and treatment services for all patients on the Faster Cancer Treatment (FCT) pathway (e.g. system/service improvements to minimise breaches of the 62 day FCT for patient or clinical consideration reasons) Identify potential improvements to drive equity (i.e. improving supportive care services for Māori) (EOA)	Q1: Performance monitoring and reporting from FCT steering group Q2: Opportunities for improvements identified to drive equity Q1/2: Regionally agreed cancer CT/MRI protocols and diagnostic pathways implemented Q3/4: Improvements to Cancer MDM business processes, data reporting and clinical resourcing implemented Q3/4: Regional coordination and support of actions to improve cancer systems and services to ensure health gain for Māori and equitable and timely access to cancer services Q3/4: Partner with the Cancer Society and CCN to deliver survivorship programmes for Māori	PP30
				2. Prostate Cancer: Implement the prostate cancer decision support tool to improve the referral pathway across primary and secondary services.	Q4: Prostate decision support tool implemented by primary care providers Q4: Clinical pathways reviewed to ensure links to the tool are included and content is aligned Q4: Urologists and oncologists informed about the content and use of the decision support tool	
				3. Survivorship: Provide support to people following their cancer treatment.	Q1/2: Socialise the national survivorship consensus statement and identify opportunities to review existing services/programmes or develop new ones	
				4. Pathways: Regional coordination and support of actions to improve cancer systems and services to ensure health gain for Māori and equitable and timely access to cancer services. (EOA)	Q1-Q4: A cancer analytics framework for the region developed and implemented Q1-Q4: A prioritised tumour stream approach for the region developed and implemented	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
				5. IT activity: Implement the MOSAIQ oncology management system at CCDHB, to provide improved patient safety with the utilisation of standardised prescribing protocols, quality checklists, etc. for medical and haematology oncology services.	Q1/2: Project initiated - commence implementation of an Integrated Oncology Management System (IOMS) Q3/4: MOSAIQ implemented	
				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 Kāpiti 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	
System Settings	**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 demand for people 75 plus	Closer to Home	**1. Support Access's 'Family Choice" employment option:** Enable 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 Peoples supported by 10%	PP23
				2. Ageing Safely and Independently: (i) Develop an Investment Plan for Healthy Aging. A co-development approach to design with older persons will be used; (ii) Investment in an extended community based team focussed on early intervention and management of the pre-frail older person group. (iii) Implement community circles in Kāpiti; (iv) Identify Frail and Prefrail individuals in the CCDHB population and match primary and secondary care data at a NHI level. (v) Use the Health of Older People Dashboard to identify drivers of acute demand for people 75+	Q3: Investment plan approved for 19/20 investments Q4: Community –based teams in place Q4: Community circles implemented in Kāpiti Q2-4: Ongoing data collection and matching with individuals added to cohort as they meet the identification criteria. Q1: The falls programme service implemented Q3: Polypharmacy approaches to medicine reviews implemented Q4: Increased access to geriatrician advice Q1-4 Monitor acute demand through the Health of Older People Dashboard including (1) non-admitted ED presentations (aged 75 and over; rate per 1000); and (2) acute medical admissions (aged 75 and over admitted acutely to med specialties, rate per 1000)	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
		presenting at ED (or at lower ages for disadvantaged populations).		**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 for Home Care Support Services: Commission Design Process. HVDHB lead, CCDHB to support.	Q2: Commission Design Process Q3-4: Ensure that review outcomes are implemented in accordance with MoH future model of care.	
				5. Advance Care Planning (ACP): improve ACP awareness and use by: Engaging older people with ACP and support them & their whānau to discuss ACP; educating consumers and health professionals about ACP; engaging with Māori by collaborating with Māori providers, Māori Women's Welfare League and taking ACP to Marae; and supporting people to document their ACP with their GP teams by building capacity & systems/processes. (EOA)	Q1: Local ACP workshop facilitators trained Q1-4: ACP education sessions to consumers and health professionals Q3: 15 Age Concern Community champions trained Q2-4: 4 conversation coaching groups delivered Q2-4: Social isolation programme delivered Q2-4: ACP one day workshops delivered locally by local trainers	
System Settings	**Disability Support Services**	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.	One Team	**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 & Pacific Peoples focus and outcomes.	Q2: Finalise the review Q4: Adapt current tool for implementation in Q1 2019/20 Q4: Report the percentage of staff who have completed the e-Learning training	SI14
				2. Disability Education Plan: strengthen to educator roles and develop and implement a plan to improve disability capability across the workforce.	Q1: CCDHB Disability educator appointed Q2-Q4: Alignment of disability educators' work programmes and priority areas across the 3DHBs	
				3. Disability Alerts - Quality: Improve the quality of information available to clinicians on patients' support needs through the Disability Support Solutions Forms.	Q1-Q2: Establish the quality of the Disability Alerts. Q3: Plan for education related to Disability Alerts in line with the e-Learning review (1) and the educators' work programme and priorities (2)	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
				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)	Q1-Q2: Establish view of Disability for Māori and Pacific populations Q3-Q4: Develop a plan to support increased uptake by Māori and Pacific Peoples.	
System Settings	**Improving Quality**	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 & Safety Commission's national inpatient experience surveys.	Value and High Performance	**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).	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	SI17
				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 Health Quality and Safety Commission (HQSC) programmes, to identify areas for improvement. This includes the development and implementation of the 'Co-design Partners in Care Programme'; and (e) improve the process for those who are reaching the end of their lives. (EOA) (f) improve outcomes for people diagnosed with type 2 diabetes at a young age, with a focus on Māori and Pacific peoples (see planning priority 'CVD and diabetes risk assessment')	Q4: Achieve targets for Māori, Pacific Peoples 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. (d) Q1-Q4: Support national HQSC programmes.	

Government Planning Priority	Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			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	Q1-Q4: Appropriate discharge summary information and allied health referrals completed for target group Achieve targets for Māori, Pacific Peoples and total as set in SPE related to reduction in falls rate in five key inpatient areas	
			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 Programme; (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.	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	

Government Planning Priority		Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
				Activity	Milestones	
System Settings	**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	**1. Stocktake:** CCDHB will undertake a stocktake to identify activity/actions being delivered to positively mitigate or adapt to the effects of climate change. CCDBHs Environmental Sustainability Policy target areas are: sustainable energy management, materials and waste flows, sustainable journeys (for staff patients and goods and services), designing for sustainability (Master Site Planning) and carbon management and reduction.	Q1: Stocktake completed Q2: Report on the Stocktake	PP40
System Settings	**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 to identify activity/actions to support the environmental disposal of hospital and community (e.g., pharmacy) waste products (including cytotoxic waste).	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.	Q1: CCDHB website set up to communicate information about waste. Q2: Posters send to pharmacies and other points to display	PP41
				2. Stocktake: CCDHB 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	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	
Fiscal Responsibility		Commit to deliver best value for money by managing your finances in line with the Minister's expectations.	Value and High Performance	**Even Better Health Care Plan:** Continue implementing the CCDHB Even Better Health Care Plan 2017-2021 to strengthen our operating environment: Hospital and Health services, Integrated Care, MHAIDS and Infrastructure	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	Agreed Financial Templates

Government Planning Priority	Focus Expected for the DHB	Link to NZ Health Strategy	CCDHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			Budget performance: Maintain a clear management focus on the financial parameters of the 2018/19 budget.	Q1 – Q4 Achieve quarterly financial targets.	Agreed financial templates
			Long Term Investment Plan: Develop and complete the Long Term Investment Plan supported by a models that assess the impact of the Health System Plan 2030; the impact of changing health demand; and the current state of assets.	Q4 – Draft plan prepared for organisational and Board review.	Investor Confidence Rating Assessment
Delivery of Regional Service Plan	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.	One Team	**CCDHB will support the region to deliver the RSP.**		SI2
			1. Support work in our region's identified **priority area**s (Cancer, Cardiac, Mental Health and Addiction, and Regional Care Arrangements)	Q1-Q4: Quarterly report on milestones (SI2)	
			2. Elective Services: Support work in our region to develop and implement regional models of care for **vascular** services, age-related macular degeneration and glaucoma (**ophthalmology**), and **breast reconstruction.**	Q1-Q4: Quarterly report on milestones (SI2)	
			3. Elective Services: Complete a regional review of current orthopaedic workforce resources.	Q1-Q4: Quarterly report on milestones (SI2)	
			4**. Hepatitis C:** Consolidate the engagement, assessment/testing and treatment pathways and related services across the Central Region.	Q1-Q4: Quarterly report on milestones (SI2)	

2.3 Financial Performance Summary

CCDHB Prospective Financial Performance

Capital & Coast DHB Statement of Comprehensive Income & Expenditure Budget for the Four Years Ending 30 June 2022	Actual 2016/17 (000s)	Actual 2017/18 (000s)	Plan 2018/19 (000s)	Plan 2019/20 (000s)	Plan 2020/21 (000s)	Plan 2021/22 (000s)
REVENUE						
Government and Crown Agency Sourced	1,008,507	1,059,652	1,109,589	1,116,999	1,124,999	1,124,999
Patient / Consumer Sourced	4,452	5,245	4,205	4,205	4,205	4,205
Funder Arm Sourced	-	-	-	-	-	-
Other Income	26,282	26,529	25,822	25,598	25,598	25,598
TOTAL REVENUE	**1,039,241**	**1,091,425**	**1,139,617**	**1,146,803**	**1,154,803**	**1,154,803**
OPERATING COSTS						
Personnel Costs						
Medical Staff	148,155	150,607	163,371	163,371	163,371	163,371
Nursing Staff	181,535	193,129	201,960	201,960	201,960	201,960
Allied Health Staff	54,326	55,602	59,489	59,489	59,489	59,489
Support Staff	7,436	7,903	8,055	8,055	8,055	8,055
Management / Administration Staff	59,578	60,531	70,296	70,296	70,296	70,296
Total Personnel Costs	**451,030**	**467,771**	**503,171**	**503,171**	**503,171**	**503,171**
Clinical Costs						
Outsourced Services	23,650	25,808	20,136	19,458	19,458	19,458
Clinical Supplies	118,191	123,130	123,648	124,201	124,201	124,201
Total Clinical Costs	**141,842**	**148,938**	**143,784**	**143,659**	**143,659**	**143,659**
Other Operating Costs						
Hotel Services, Laundry & Cleaning	18,510	19,171	21,917	21,917	21,917	21,917
Facilities	41,042	40,597	41,699	40,145	40,145	40,145
Transport	2,834	2,995	2,936	2,936	2,936	2,936
IT Systems & Telecommunications	13,068	12,435	13,233	14,234	14,234	14,234
Interest & Financing Charges	14,109	24,414	24,735	24,735	24,735	24,735
Professional Fees & Expenses	7,738	7,897	2,174	2,174	2,174	2,174
Other Operating Expenses	7,651	11,308	10,311	10,311	10,311	10,311
Democracy	860	397	517	517	517	517
Provider Payments	356,741	363,160	379,811	379,811	379,811	379,811
Recharges	8,584	10,576	11,193	11,193	11,193	11,193
Total Other Operating Costs	**471,137**	**492,950**	**508,525**	**507,972**	**507,972**	**507,972**
TOTAL COSTS	**1,064,009**	**1,109,660**	**1,155,480**	**1,154,802**	**1,154,802**	**1,154,802**
NET SURPLUS / (DEFICIT)	**(24,768)**	**(18,235)**	**(15,864)**	**(8,000)**	**0**	**0**
*Asset Revaluation (Equity movement - IRFS requirement)	-	113,105	-	-	-	-
TOTAL COMPREHENSIVE INCOME SURPLUS/(DEFICIT)	**(24,768)**	**94,870**	**(15,864)**	**(8,000)**	**0**	**0**

* Please note that for IFRS purposes, any movement in the Revaluation Reserves now needs to be displayed in the Statement of Comprehensive Income (above), as well as in the balance sheet as per normal. This is purely for presentational purposes, and doesn't change the target the DHB is working to. The DHB is still working to the 'Net Surplus / (Deficit) target above, rather than the 'Total Comprehensive Income' amount.

Prospective Financial Position

Capital & Coast DHB **Statement of Financial Position** **Budget for the Four Years Ending 30 June 2022**	**Actual 2016/17 (000s)**	**Actual 2017/18 (000s)**	**Plan 2018/19 (000s)**	**Plan 2019/20 (000s)**	**Plan 2020/21 (000s)**	**Plan 2021/22 (000s)**
Non Current Assets						
Land	25,705	41,165	41,165	41,165	41,165	41,165
Buildings	396,986	474,112	456,010	460,977	463,327	465,676
Clinical Equipment	29,049	26,550	31,634	30,094	30,094	30,094
Information Technology	11,938	11,208	16,380	15,384	15,384	15,384
Work in Progress	23,090	37,710	45,710	42,227	38,744	35,261
Other Fixed Assets	2,600	1,715	2,773	2,773	2,773	2,773
Total Non Current Assets	489,368	592,460	593,672	592,620	591,487	590,353
Current Assets						
Cash	20,403	17,602	14,110	11,760	9,410	7,060
Trust/Investments	8,409	9,693	10,193	9,693	9,693	9,693
Prepayments	5,632	3,075	3,075	3,075	3,075	3,075
Accounts Receivable	40,217	43,580	50,190	50,190	50,190	50,190
Inventories	8,602	8,067	8,067	8,067	8,067	8,067
Other Current Assets	3,745	5,610	-	-	-	-
Total Current Assets	87,009	87,627	85,636	82,786	80,436	78,086
Current Liabilities						
Payables & Accruals	136,335	148,505	151,928	151,939	151,939	151,939
GST & Tax Provisions	8,618	9,351	9,351	9,351	9,351	9,351
Current Private Sector Debt	326	247	247	247	247	247
Total Current Liabilities	145,279	158,104	161,526	161,537	161,537	161,537
Net Current Assets	(58,270)	(70,476)	(75,890)	(78,751)	(81,101)	(83,451)
NET FUNDS EMPLOYED	**431,098**	**521,984**	**517,782**	**513,868**	**510,385**	**506,902**
Term Liabilities						
Non Current Crown Debt - CHFA	302	55	55	55	55	55
Restricted & Trust Funds Liability	8,488	9,746	10,176	9,746	9,746	9,746
Non Current Provisions & Payables Personnel	6,473	6,247	6,247	6,247	6,247	6,247
Total Term Liabilities	15,263	16,048	16,478	16,048	16,048	16,048
Net Assets	**415,835**	**505,936**	**501,304**	**497,821**	**494,338**	**490,854**
General Funds						
Crown Equity	769,751	765,362	776,594	781,110	777,627	774,143
Revaluation Reserve	23,606	136,711	136,711	136,711	136,711	136,711
Trust & special funds no restriction	71	(307)	(307)	(307)	(307)	(307)
Retained Earnings						
Retained Earnings - DHB	(377,593)	(395,830)	(411,694)	(419,694)	(419,694)	(419,693)
Total Retained earnings	(377,593)	(395,830)	(411,694)	(419,694)	(419,694)	(419,693)
Total General Funds	415,835	505,936	501,304	497,821	494,338	490,854
NET FUNDS EMPLOYED	**431,098**	**521,984**	**517,782**	**513,868**	**510,385**	**506,902**

Prospective Cash Flow

Capital & Coast DHB Statement of Cashflows Budget for the Four Years Ending 30 June 2022	Actual 2016/17 (000s)	Actual 2017/18 (000s)	Plan 2018/19 (000s)	Plan 2019/20 (000s)	Plan 2020/21 (000s)	Plan 2021/22 (000s)
Operating Activities						
Government & Crown Agency Revenue Receiv	1,038,337	1,073,627	1,117,851	1,124,842	1,124,842	1,124,842
All Other Revenue Received	21,301	15,512	15,512	15,512	15,512	15,512
Total Receipts	**1,059,638**	**1,089,139**	**1,133,363**	**1,140,354**	**1,140,354**	**1,140,354**
Payments for Personnel	(436,835)	(453,548)	(481,233)	(487,733)	(487,233)	(487,233)
Payments for Supplies	(206,053)	(195,517)	(206,525)	(206,875)	(206,875)	(206,875)
Capital Charge	(5,662)	(24,373)	(24,373)	(24,373)	(24,373)	(24,373)
GST (net)	(3,099)	(1,535)	(1,535)	(1,535)	(1,535)	(1,535)
Other Payments	(379,649)	(385,318)	(399,851)	(399,851)	(399,851)	(399,851)
Total Payments	**(1,031,298)**	**(1,060,291)**	**(1,113,517)**	**(1,120,367)**	**(1,119,867)**	**(1,119,867)**
Net Cashflow from Operating	**28,340**	**28,848**	**19,846**	**19,987**	**20,487**	**20,487**
Investing Activities						
Interest Receipts from 3rd Party	1,436	1,557	1,557	1,557	1,557	1,557
	1,436	**1,557**	**1,557**	**1,557**	**1,557**	**1,557**
Capital Expenditure						
Land, Buildings & Plant	(8,997)	(11,436)	(11,436)	(11,436)	(11,436)	(11,436)
Clinical Equipment	(3,198)	(7,122)	(11,372)	(12,372)	(12,372)	(12,372)
Other Equipment	(941)	(3,191)	(4,191)	(3,191)	(3,191)	(3,191)
Informations Technology	(1,955)	(4,778)	(8,000)	(8,000)	(8,000)	(8,000)
Total Capital Expenditure	**(15,091)**	**(26,528)**	**(35,000)**	**(35,000)**	**(35,000)**	**(35,000)**
Increase in other Investments	(840)	(1,584)	(1,584)	(1,584)	(1,584)	(1,584)
Net Cashflow from Investing	**(14,495)**	**(26,555)**	**(35,027)**	**(35,027)**	**(35,027)**	**(35,027)**
Financing Activities						
Deficit Support	10,000	-	16,000	16,000	16,000	16,000
Interest Paid	(11,324)	-	-	-	-	-
Other Financing Activities	(3,809)	(3,810)	(3,810)	(3,810)	(3,810)	(3,810)
Total Financing Activities	**(5,133)**	**(3,810)**	**12,190**	**12,190**	**12,190**	**12,190**
Net Cashflow	8,713	(1,517)	(2,991)	(2,850)	(2,350)	(2,350)
Plus: Opening Cash	20,100	28,812	27,295	24,304	21,454	19,104
Closing Cash	**28,812**	**27,295**	**24,304**	**21,454**	**19,104**	**16,754**
Closing Cash comprises:						
Balance Sheet Cash	28,812	27,295	24,304	21,454	19,104	16,754
Total Cashflow Cash (Closing)	**28,812**	**27,295**	**24,304**	**21,454**	**19,104**	**16,754**

Prospective Output Class Financials

Capital & Coast DHB Statement of Objectives and service performance Budget for the Year Ending 30 June 2019 Statement of revenue and expenses by output class	Prevention (000s)	Early Detection and Management (000s)	Intensive Assessment and Treatment (000s)	Rehabilitation and Support (000s)	Total DHB (000s)
REVENUE					
Crown	11,735	253,598	715,907	128,349	**1,109,589**
Other	-	-	30,028		**30,028**
Total Revenue	**11,735**	**253,598**	**745,935**	**128,349**	**1,139,617**
EXPENDITURE					
Personnel	186	3,573	497,501	1,911	**503,171**
Depreciation			34,200		**34,200**
Capital charge			24,701		**24,701**
Provider Payments	9,744	201,011	72,279	101,281	**384,315**
Other	1,805	49,013	133,118	25,158	**209,094**
Total Expenditure	**11,735**	**253,598**	**761,799**	**128,349**	**1,155,480**
Net Surplus/(Deficit)	**-**	**-**	**(15,864)**	**-**	**(15,864)**

Capital & Coast DHB Statement of Objectives and service performance Budget for the Year Ending 30 June 2020 Statement of revenue and expenses by output class	Prevention (000s)	Early Detection and Management (000s)	Intensive Assessment and Treatment (000s)	Rehabilitation and Support (000s)	Total DHB (000s)
REVENUE					
Crown	11,895	257,058	725,671	130,101	**1,124,726**
Other	-	-	22,077	-	**22,077**
Total Revenue	**11,895**	**257,058**	**747,748**	**130,101**	**1,146,803**
EXPENDITURE					
Personnel	190	3,645	497,388	1,949	**503,172**
Depreciation			34,200		**34,200**
Capital charge			24,701		**24,701**
Provider Payments	9,905	204,502	84,742	103,046	**402,196**
Other	1,800	48,911	114,717	25,106	**190,534**
Total Expenditure	**11,895**	**257,058**	**755,748**	**130,101**	**1,154,802**
Net Surplus/(Deficit)	**(0)**	**0**	**(8,000)**	**0**	**(8,000)**

Capital & Coast DHB Statement of Objectives and service performance Budget for the Year Ending 30 June 2021 Statement of revenue and expenses by output class	Prevention (000s)	Early Detection and Management (000s)	Intensive Assessment and Treatment (000s)	Rehabilitation and Support (000s)	Total DHB (000s)
REVENUE					
Crown	11,980	258,887	730,833	131,027	**1,132,726**
Other	-	-	22,077	-	**22,077**
Total Revenue	**11,980**	**258,887**	**752,909**	**131,027**	**1,154,803**
EXPENDITURE					
Personnel	194	3,718	497,271	1,988	**503,171**
Depreciation			34,200		**34,200**
Capital charge			24,701		**24,701**
Provider Payments	9,968	205,769	82,777	103,681	**402,196**
Other	1,818	49,400	113,959	25,357	**190,534**
Total Expenditure	**11,980**	**258,887**	**752,908**	**131,026**	**1,154,802**
Net Surplus/(Deficit)	**(0)**	**(0)**	**0**	**0**	**(0)**

SECTION 3: Service Configuration

3.1 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 Peoples 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.

3.2 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.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Contract Changes for Non-Devolved Services	A number of contracts, currently funded through direct contracts with MoH / other agencies or CFA obligations, reviewed if funding is not approved for 2018/19.	– Decisions not under CCDHB control unless DHB decides to prioritise funding to the services	National
Community Pharmacist Services	Implement the national pharmacy contracting arrangement. Review local service delivery through Community Pharmacies and the Pharmacy Facilitation Service.	– 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.	National
Bowel Cancer Screening Programme	Tranche 2 implementation of bowel cancer screening service in line with national programme.	– Improved detection and management of people with bowel cancer	National
Cancer Services	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.	– To manage demand and ensure the provision of affordable, high quality and safe services into the future.	Regional

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	– Implement a sustainable performance improvement process, including improved access to performance information.		
Oral Maxillofacial	Develop a single acute service model for Lower North Island as part of the Central Region Service.	– Improve service sustainability	Regional
Central regional cardiology STEMI Model	Establish Local/Central coordination for a regional pathway	– Improved access to PCI	Regional
Radiology Demand	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).	– Improve service sustainability – Improve efficiency – Improve waiting times	Regional (3DHB service capacity and scheduling)
MHAIDS Integration	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	– Equitable outcomes – More integrated services	3DHB Sub-regional
Sub-Regional Breast Disease Services Review	To develop an integrated, coherent model of service delivery and care for the management of breast cancer patients for the Wellington 3DHB sub-region	– 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	3DHB Sub-regional
National Transport Agreement	Change to taxi transport for patients undergoing renal dialysis. Provider change and also patients supported may change depending on patient's clinical need.	– Appropriate usage of NTA using the national criteria	Hutt Valley DHB and CCDHB
Home and Community Support Services	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.	– Improved health outcomes – Address health inequities – Improved responsiveness to older persons – Supports Ageing in place	Hutt Valley DHB and CCDHB
Sub-Regional Clinical Services Planning	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.	– Value for money – Improved clinical capacity and sustainability – Improved health outcomes	Hutt Valley DHB and CCDHB

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
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

4.1.1 *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.

4.1.2 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.

4.1.3 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.

4.1.4 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.

4.1.5 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 managing H&S 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.

4.1.6 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

4.2.1 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.
- The Wellington Regional Hospital domestic hot and cold water systems are exhibiting signs of failure. Plans are being developed to resolve this issue.
- A project to build a new Children's Hospital is in progress due to the generosity of a benefactor who has offered a $50 million contribution including design and construction management. Preparatory works including the replacement of sewage and storm water pipes and demolition of old buildings is complete or underway.
- Development of a six bed facility/extension to Haumietiketike, the National Intellectual Disability Inpatient Unit, has been approved by the Minister. The projected capital cost of the six bed unit is $8.4m. This includes all costs of construction for the Individualised Specialised Units extension to Haumietiketike.
- Maturity of asset management planning is improving following a review, which was an element of the Treasury ICR review in 2017. Three separate streams of work are in progress for each: ICT, clinical equipment and facilities.

4.2.2 Information technology and communications systems

Information and Communication Technology (ICT) can improve efficiency, quality and safety of services, improve care in the community, reduce avoidable demand for emergency and inpatient care in the DHB's provider arm and manage resources more efficiently.

We have identified focus areas for strategic investment to deliver a step change in our ability to create and operate models of care that fundamentally changes our current trajectory:

- Digital & Mobile Inpatient Care
- Mobility in the community
- Integrating whole system of care
- The Engine (ICT Platforms & Delivery Model)

These are not the only ICT investments. Investment needs to balance transformational and operational need. There will be linkages to key programmes and projects to maximise the potential benefits of the investments being made and avoid poor investment choice.

4.2.3 *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:

Principle	Strategic Intent
Strong foundations	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.
Trust and partnership	Support open respectful communication, shared decision making, easy processes, transparency and individual accountability.
Promoting wellbeing	Work together for the health and wellbeing of our people and the community we serve.
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 and 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 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, HSP2030, 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.

- **Understanding our workforce** - We will continue to build our understanding of our workforce. We will be developing our ability to integrate workforce intelligence and utilise forecasting tools.
- **RMO Postgraduate Year 1 and 2** - Continue to build capability through our commitment to workforce initiatives and high quality training for PGY 1s and 2s.

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 Māori people, Pacific Peoples and people from other ethnic or minority groups. We will prioritise a range of strategies with a particular focus on the retention of Māori and Pacific staff. We also provide opportunities for individual employee development and career advancement, including cultural competency training.

4.2.4 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).

4.2.5 Regional Public Health

Regional Public Health (RPH) is the public health unit for the sub-region (Wairarapa, Hutt Valley, and Capital & Coast DHBs). Organisationally, RPH is part of Hutt Valley DHB. The three DHBs work in partnership with RPH in their work on health promotion/improvement, enhancing the effectiveness of prevention activities in other parts of the health system, and regulatory services. The details about the activities of RPH are contained in the Regional Public Health 2018/19 Annual Plan.

A key focus for 2018/19 is collaboration on the development of a sub-regional health promotion work programme. The programme will demonstrate how RPH, the DHBs, PHOs, and community providers are leveraging their investment and coordinating their health promotion activities, both locally and sub-regionally, to deliver collective impact on national and local priorities. Improving equity of outcomes for Māori, Pacific Peoples, and people on low incomes will be a focus throughout the work programme.

4.3 Workforce

4.3.1 Healthy Ageing Workforce

During 2018/19 CCDHB will work closely with regional DHB shared services to identify the workforce requirements for service delivery 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. The work will include the ongoing implementation of pay equity, guaranteed hours, in-between travel and regularisation. The work will enable development of a workforce plan to ensure ensures that those working with older people have the training and support they require to deliver high-quality, person-centred care. The plan will:

- focus on primary, secondary and tertiary requirements and aim to bring together workforces needed to deliver these services effectively at the DHB, sub-regional and regional levels
- develop strategies for specialist workforces to deliver education to 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 work programme to shift our organisation's culture, in how our people work together, with our communities and with patients and whānau. Improving health literacy and achieving greater empowerment for patients will be informed by this work to enable our people.

CCDHB will build our approach for supporting health literacy through our Optimal Ward project. With a co-design process at its heart, we will gather guidance from patient and whānau groups, specifically Māori and Pacific Peoples. Through optimising the environment, processes, tools, and staff capability, we will 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 Māori Health Development Group and Pacific Health Unit, building 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 Māori Health Development Group and Pacific Directorates. 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 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.

4.3.3 Care Capacity Demand Management

CCDHB is on track to deliver the full implementation of Care Capacity Demand Management Programme (CCDM) by June 2021. This is reflected in the annual and three year plans which are fully operational and on schedule. The CCDM programme is meeting all reporting requirements required by the national Safe Staffing Healthy Workforce Unit CCDM governance group.

The governance and oversight is provided by the CCDM Council enabling strong partnership with our health unions. The partnership and whole of organisation commitment to CCDM has been a key factor in contributing to the good progress to date.

4.4 Information Technology

Work Programme	Activity for 2018/19	Milestones
National Maternity System: implementation of the National Maternity System	Complete the planning for adoption of the National Maternity System with a view of implementation in 2019/20.	Q4: Completion of the planning
Digital Health Services: Provision of health services via digital technology across the health system; for example telehealth,	(i) Complete transition to the Indici Shared Care Record; (ii) Expand the use of cloud based tools to support team 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;	Q2: Completion Q1-Q4: Ongoing Q4: Completion Q3: Implementation Q2: Implementation

integrated care and working remotely	(v) Implement 1-Click Access for GPs to their patient's hospital record; and (vi) Implement a Shared Care Planning tool using Indici.	Q4: Implementation
Patient Observations : implementation of establishing a platform for deployment of eVitals	(i) Business Case and pilot for a Patient Observations Platform; and (ii) Plan for the rollout of Patient Observations.	Q3: Business Case signed off/pilot and assessed Q4: Plan completed
Medication Management: implementation of access to eNZPS community dispensed medicines for medicines reconciliation	(i) Implement hospital access to eNZPS (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.	Q3: Implementation Q2: eMedication Management Roadmap Developed Q4: Business Case and RFP developed
MHAIDS: sharing of data between secondary and primary providers in the Mental Health & Addiction service	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.	Q4: Phase 2 completed
IT Planning: demonstrate how they plan to implement Application Portfolio Management including the lifecycle for IT systems i.e., planned upgrades, support, licence renewal, etc.	(i) Develop a reference architecture; (ii) Implement Asset Management and Application Catalogue systems for ICT systems & applications, linked to the reference architecture; and (iii) Updated Long Term Investment Plan for DHB critical assets (Category 1 & 2) with upgrade dates and plans.	Q2: reference architecture developed Q2: Implementation Q4: LTIP Updated
IT Security: Commit to constructively engage with the Ministry and other health sector members in the establishment of a projected programme of IT Security maturity activities.	(i) Assessment of security controls against the NZ Information Security Manual, including risks and mitigations; (ii) Develop a joint Wairarapa, Hutt Valley and Capital & Coast Security Work Programme for 2018-20; and (iii) Engagement in the National Health Security Forum.	Q2: Security controls assessed Q3: Work programme developed Q1-Q4: Ongoing
National/Regional Alignment: Demonstrate National/Regional Alignment and where they are leveraging investments	(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 Single Electronic Health Record; and v) National Maternity Clinical Information System.	Q3: data replication completed Q4: migration completed Q4: scope and planning initiated (dependent on Ministry of Health)
Medical Oncology System: CCDHB to implement the new oncology information system ensuring any configuration alignment with the existing MDHB oncology information system is leveraged	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.	Q2: Mosaiq implemented
Digital Capability: Demonstrate plan and initiatives aimed at improving the digital	(i) Pilot of Electronic desk-based and Mobile Laboratory Ordering; (ii) Further development of Ward and Service Electronic Whiteboards;	Q4: Pilot initiated Q4: Development of whiteboards initiated Q2: capacity planning tool implemented

capabilities within their organisation.	(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.	Q4: Mobile application development programme initiated Q1: scanning capability implemented Q4: office 365 implemented

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 (Outputs).

Performance measure	Performance expectation	
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes.	
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	≤0.49
	Year 2	≤0.49
PP11: Children caries-free at five years of age	Year 1	≥69%
	Year 2	≥69%
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 and accessing the Community Oral Health Service		
Number of Pre-School Children Enrolled in DHB-funded Oral Health Services	Year 1	≥95%
	Year 2	≥95%
Number of Enrolled Pre-School and Primary School Children Overdue for their Scheduled Examinations	Year 1	≤10%
	Year 2	≤10%
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)		
Focus Area 1: Long term conditions	Report on activities in the Annual Plan.	
Focus Area 2: Diabetes services	Implement actions from Living Well with Diabetes.	
	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.	
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF	
	>85%: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and those with LVEF<40% should also be on a beta-blocker (5-classes).	
Focus Area 5: Stroke services	≥10% or more of potentially eligible stroke patients are thrombolysed 24/7.	
	≥80% of stroke 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
		Report on activities in the Annual Plan
PP22: Delivery of actions to improve system integration including SLMs		Report on activities in the Annual Plan.
PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan.	
	Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4–6 for assessment urgency	Baseline to be established: MOH will work with DHBs in 2018/19 to establish baseline.
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 per 100,000	
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		70% 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	
PP44: Maternal mental health		Report on activities in the Annual Plan	
PP45: Elective surgical discharges		11,205 publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	
SI1: Ambulatory sensitive hospitalisations		0-4	See System Level Measure Improvement Plan
		45-64	≤3,000
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.	≤1.53
	Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.	≤2.31
OS8: Reducing Acute Readmissions to Hospital		≤12.0%
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections		
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	Group A >2% and <= 4%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% and <= 2%
	Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and <= 2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and <= 85%
	Invalid NHI data updates	TBA
Focus Area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	>= 97% and <99.5%
	National Collections File load Success	>= 98% and <99.5%
	Assessment of data reported to NMDS	>= 75%
	Timeliness of NNPAC data	>= 95% and <98%

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.

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.

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

***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.

Measure	Class / Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19 – 19/20
Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	Prevention / Quantity		17	17	17
The percentage of infants fully or exclusively breastfed at 3 months	Prevention / Coverage	Total	62%	65%	≥60%
		Māori	43%	47%	
		Pacific	49%	58%	
Number of new referrals to Public Health Nurses in primary/intermediate schools*	Prevention / Quantity	Total	1,126	1,126	1,126
		Māori	475	475	475
		Pacific	411	411	411
The number of adult referrals to the Green Prescription programme (CCDHB component)	Prevention / Quantity	Total	1,922*	2,777+	≥600
		Māori & Pacific	N/A	924+	≥360
The number of adult referrals to the Green Prescription Plus programme (CCDHB component)	Prevention / Quantity	Total	250*	1,020+	≥600
		Māori & Pacific	N/A	298+	≥360

Measure	Class / Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19 – 19/20
The number of children (5 -18 yrs.) referred to the Active Families programme (CCDHB component)	Prevention / Quantity	Total	120	163[+]	≥120
		Māori & Pacific	N/A	153[+]	≥72
The number of pregnant women referred to the Maternal Green Prescription programme (CCDHB component)	Prevention / Quantity	Total	N/A	79[+]	≥66
		Māori & Pacific	N/A	38%[+]	≥70%
The number children (3 - 5 yrs.) referred to the Pre-School Active Families programme (CCDHB component)	Prevention / Quantity	Total	148	103[+]	≥111
		Māori & Pacific	N/A	59%[+]	70%
The number of primary schools enrolled in the Project Energize Programme	Prevention / Quantity	Total	25	25	≥25

[*]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.

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

***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: **A**sk all patients whether they smoke and document their response; if the patient smokes, provide **B**rief advice to quit smoking; and if patient agrees, provide **C**essation 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.

Measure	Class / Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19 – 19/20
The percentage of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	Prevention / Coverage	Total	89%	91%	≥90%
		Māori	88%	93%	
		Pacific	87%	92%	
The percentage of hospitalised smokers receiving advice and help to quit	Prevention / Coverage	Total	91%	88%	≥95%
		Māori	91%	88%	
		Pacific	90%	86%	
The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity	Prevention / Coverage	Total	100%	100%	≥90%
		Māori	100%	100%	

Measure	Class / Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19 – 19/20
Carer being offered brief advice and support to quit smoking		Pacific	100%	100%	

***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.

Measure	Class/Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19-19/20
The percentage of eligible children receiving a B4 School Check	Prevention / Coverage	Total	90%	86%	≥90%
		Māori	78%	77%	
		Pacific	89%	79%	
		High need	95%	84%	
The percentage of eligible women (25-69 years old) having cervical screening in the last 3 years	Early Detection & Management / Coverage	Total	77%	77%	≥80%
		Māori	62%	61%	
		Pacific	67%	67%	
The percentage of eligible women (50-69 years old) having breast screening in the last 2 years	Early Detection & Management / Coverage	Total	73%	73%	≥70%
		Māori	68%	67%	
		Pacific	70%	70%	

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.

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

***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.

Measure	Class / Type	Group	Baseline 2016	Forecast 2017	Target/Est. 18/19-19/20
The percentage of children under 5 years enrolled in DHB-funded dental services*	Early Detection & Management / Coverage	Total	97%	94%	≥95%
		Māori	70%	67%	
		Pacific	86%	80%	
The percentage of adolescents accessing DHB-funded dental services**	Early Detection & Management / Coverage	Total	77%	77%	≥85%
		Māori	New	55%	
		Pacific	New	78%	

***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.

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

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.

Measure	Class / Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19 – 19/20
The percentage of patients admitted, discharged or transferred from Emergency Department within six hours	Intensive Assessment & Treatment / Timeliness	Total	90%	92%	≥95%
		Māori	90%	92%	
		Pacific	89%	91%	
The number of surgical elective discharges	Intensive Assessment & Treatment / Quantity		10,785	11,166	11,205
			New	New	
			New	New	

The standardised inpatient average length of stay (ALOS) in days, Acute	Intensive Assessment & Treatment / Timeliness		2.31	2.30	2.31
			New	New	
			New	New	
The standardised inpatient average length of stay (ALOS) in days, Elective	Intensive Assessment & Treatment / Timeliness		1.57	1.55	1.57
			New	New	
			New	New	
Number in-hospital cardiopulmonary arrests in adult inpatient wards (total and by ethnicity) Deteriorating Patient	Intensive Assessment & Treatment / Quality	Total	New	New	35
		Māori	New	New	5
		Pacific	New	New	5
The rate of identified opioid medication errors causing harm, per 1,000 bed days.	Intensive Assessment & Treatment / Quality	Total	New	New	≤5
		Māori	New	New	≤1
		Pacific	New	New	≤1
The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Intensive Assessment & Treatment / Quality	Total	0.8	0.4	≤0.3
		Māori	New	New	≤0.1
		Pacific	New	New	≤0.1
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).	Intensive Assessment & Treatment / Quality	Total	New	New	≤0.2
		Māori	New	New	≤0.1
		Pacific	New	New	≤0.1
The weighted average score in the Inpatient Experience Survey by domain.	Intensive Assessment & Treatment / Quality	Communication	8.3	8.0	8.4
		Coordination	8.4	7.9	8.4
		Partnership	8.8	7.9	8.6
		Physical & Emotional Needs	8.5	8.1	8.5
The percentage of "DNA" (did not attend) appointments for outpatient specialist appointments	Intensive Assessment & Treatment / Quality	Total	7.2%	7.5%	7%
		Māori	15.5%	15.4%	15.3%
		Pacific	15.3%	17.5%	17%

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.

Measure	Class / Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19-19/20
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	Intensive Assessment & Treatment / Timeliness	Total	81%	91%	≥90%
		Māori	New	New	
		Pacific	New	New	

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.

Measure	Class / Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19-19/20
		Total	10,080	10,683	≥10,683

Measure	Class / Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19-19/20
The number of people accessing secondary mental health services	Intensive Assessment & Treatment / Quantity	Māori	2,046	2,287	≥2,287
		Pacific	718	729	≥729
The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks	Intensive Assessment & Treatment / Timeliness	Total	87%	90%	≥95%
		Māori	New	New	
		Pacific	New	New	
The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	Intensive Assessment & Treatment / Timeliness	Total	77%	88%	≥95%
		Māori	New	New	
		Pacific	New	New	
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	Intensive Assessment & Treatment / Quality	Total	57%	57%	≥75%
		Māori	New	New	
		Pacific	New	New	
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	Intensive Assessment & Treatment / Quality	Total	63%	64%	≥90%
		Māori	New	New	
		Pacific	New	New	

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.

Measure	Class / Type	Group	Baseline 2016/17	Forecast 2017/18	Target/Est. 18/19-19/20
The number of sub-regional and CCDHB Disability Forums	Rehabilitation and Support / Quantity		CCDHB:2 3DHB:2	1	≥1
The number of sub-regional Disability Newsletters	Rehabilitation and Support / Quantity		12	12	≥3
The total number of hospital staff that have completed the Disability Responsiveness eLearning Module	Rehabilitation and Support / Quality		718	949	1,513
The total number of people with a Disability Alert	Rehabilitation and Support / Quality	Total	7,165	7,667	≥9,000
The percentage of the Disability Alert Population who are Māori or Pacific	Rehabilitation and Support / Quality	Māori	New	10.4%	≥11.4%
		Pacific	New	5.9%	≥7.0%

***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.					
Measure	**Class / Type**	**Group**	**Baseline 2016/17**	**Forecast 2017/18**	**Target/Est. 18/19 – 19/20**
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	Rehabilitation and Support / Coverage	Total	100%	100%	100%
		Māori	100%	100%	
		Pacific	100%	100%	
The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home	Rehabilitation and Support / Coverage	Total	63%	62%	≥63%
		Māori	New	New	
		Pacific	New	New	
The percentage of the population 65+ who are in Aged Residential Care (at all levels; subsidised & non-subsidised)	Rehabilitation and Support / Coverage	Total	4.9%	4.9%	4.9%
		Māori	New	New	
		Pacific	New	New	
The percentage of residential care providers meeting three or more year certification standards	Rehabilitation and Support / Quality	Total	100%	97%	100%
The percentage of residential care providers meeting four year certification standards	Rehabilitation and Support / Quality	Total	N/A	45%	≥48%

Output Class – Financials

Capital & Coast DHB **Statement of Objectives and service performance** **Budget for the Year Ending 30 June 2019** **Statement of revenue and expenses by output class**	**Prevention** **(000s)**	**Early Detection and Management** **(000s)**	**Intensive Assessment and Treatment** **(000s)**	**Rehabilitation and Support** **(000s)**	**Total DHB** **(000s)**
REVENUE					
Crown	11,735	253,598	715,907	128,349	**1,109,589**
Other	-	-	30,028		**30,028**
Total Revenue	**11,735**	**253,598**	**745,935**	**128,349**	**1,139,617**
EXPENDITURE					
Personnel	186	3,573	497,501	1,911	**503,171**
Depreciation			34,200		**34,200**
Capital charge			24,701		**24,701**
Provider Payments	9,744	201,011	72,279	101,281	**384,315**
Other	1,805	49,013	133,118	25,158	**209,094**
Total Expenditure	**11,735**	**253,598**	**761,799**	**128,349**	**1,155,480**
Net Surplus/(Deficit)	**-**	**-**	**(15,864)**	**-**	**(15,864)**

Capital & Coast DHB **Statement of Objectives and service performance** **Budget for the Year Ending 30 June 2020** **Statement of revenue and expenses by output class**	**Prevention** **(000s)**	**Early Detection and Management** **(000s)**	**Intensive Assessment and Treatment** **(000s)**	**Rehabilitation and Support** **(000s)**	**Total DHB** **(000s)**
REVENUE					
Crown	11,895	257,058	725,671	130,101	**1,124,726**
Other	-	-	22,077	-	**22,077**
Total Revenue	**11,895**	**257,058**	**747,748**	**130,101**	**1,146,803**
EXPENDITURE					
Personnel	190	3,645	497,388	1,949	**503,172**
Depreciation			34,200		**34,200**
Capital charge			24,701		**24,701**
Provider Payments	9,905	204,502	84,742	103,046	**402,196**
Other	1,800	48,911	114,717	25,106	**190,534**
Total Expenditure	**11,895**	**257,058**	**755,748**	**130,101**	**1,154,802**
Net Surplus/(Deficit)	**(0)**	**0**	**(8,000)**	**0**	**(8,000)**

Capital & Coast DHB **Statement of Objectives and service performance** **Budget for the Year Ending 30 June 2021** **Statement of revenue and expenses by output class**	**Prevention** **(000s)**	**Early Detection and Management** **(000s)**	**Intensive Assessment and Treatment** **(000s)**	**Rehabilitation and Support** **(000s)**	**Total DHB** **(000s)**
REVENUE					
Crown	11,980	258,887	730,833	131,027	**1,132,726**
Other	-	-	22,077	-	**22,077**
Total Revenue	**11,980**	**258,887**	**752,909**	**131,027**	**1,154,803**
EXPENDITURE					
Personnel	194	3,718	497,271	1,988	**503,171**
Depreciation			34,200		**34,200**
Capital charge			24,701		**24,701**
Provider Payments	9,968	205,769	82,777	103,681	**402,196**
Other	1,818	49,400	113,959	25,357	**190,534**
Total Expenditure	**11,980**	**258,887**	**752,908**	**131,026**	**1,154,802**
Net Surplus/(Deficit)	**(0)**	**(0)**	**0**	**0**	**(0)**

Financial Performance

The prospective planned result for Capital and Coast DHB 2018/19 annual plan is a deficit of $15.9 million. The final result for 2017/18 was a deficit of $18.2 million.

Financial Performance

CCDHB Summary Financial Table

Capital & Coast DHB Budget for the Four Years Ending 30 June 2022	2016/17 $'M	2017/18 $'M	2018/19 $'M	2019/20 $'M	2020/21 $'M	2021/22 $'M
Funding (excluding IDF inflows below)	823.9	866.1	902.2	909.6	917.6	917.6
Services provided for Other DHBs (IDF Inflows)	215.4	225.3	237.4	237.2	237.2	237.2
Total Funding	**1,039.2**	**1,091.4**	**1,139.6**	**1,146.8**	**1,154.8**	**1,154.8**
DHB Provider Arm	698.4	736.9	764.0	763.3	763.3	763.3
Funder Arm	264.0	266.7	285.2	285.2	285.2	285.2
Governance Arm	8.8	9.6	11.7	11.7	11.7	11.7
Services Purchased from Other DHBs (IDF Outflows)	92.7	96.4	94.6	94.6	94.6	94.6
Total Allocated	**1,064.0**	**1,109.7**	**1,155.5**	**1,154.8**	**1,154.8**	**1,154.8**
Surplus / (Deficit)	**(24.8)**	**(18.2)**	**(15.9)**	**(8.0)**	**0.0**	**0.0**

CCDHB Prospective Financial Performance

Capital & Coast DHB Statement of Comprehensive Income & Expenditure Budget for the Four Years Ending 30 June 2022	Actual 2016/17 (000s)	Actual 2017/18 (000s)	Plan 2018/19 (000s)	Plan 2019/20 (000s)	Plan 2020/21 (000s)	Plan 2021/22 (000s)
REVENUE						
Government and Crown Agency Sourced	1,008,507	1,059,652	1,109,589	1,116,999	1,124,999	1,124,999
Patient / Consumer Sourced	4,452	5,245	4,205	4,205	4,205	4,205
Funder Arm Sourced	-	-	-	-	-	-
Other Income	26,282	26,529	25,822	25,598	25,598	25,598
TOTAL REVENUE	**1,039,241**	**1,091,425**	**1,139,617**	**1,146,803**	**1,154,803**	**1,154,803**
OPERATING COSTS						
Personnel Costs						
Medical Staff	148,155	150,607	163,371	163,371	163,371	163,371
Nursing Staff	181,535	193,129	201,960	201,960	201,960	201,960
Allied Health Staff	54,326	55,602	59,489	59,489	59,489	59,489
Support Staff	7,436	7,903	8,055	8,055	8,055	8,055
Management / Administration Staff	59,578	60,531	70,296	70,296	70,296	70,296
Total Personnel Costs	**451,030**	**467,771**	**503,171**	**503,171**	**503,171**	**503,171**
Clinical Costs						
Outsourced Services	23,650	25,808	20,136	19,458	19,458	19,458
Clinical Supplies	118,191	123,130	123,648	124,201	124,201	124,201
Total Clinical Costs	**141,842**	**148,938**	**143,784**	**143,659**	**143,659**	**143,659**
Other Operating Costs						
Hotel Services, Laundry & Cleaning	18,510	19,171	21,917	21,917	21,917	21,917
Facilities	41,042	40,597	41,699	40,145	40,145	40,145
Transport	2,834	2,995	2,936	2,936	2,936	2,936
IT Systems & Telecommunications	13,068	12,435	13,233	14,234	14,234	14,234
Interest & Financing Charges	14,109	24,414	24,735	24,735	24,735	24,735
Professional Fees & Expenses	7,738	7,897	2,174	2,174	2,174	2,174
Other Operating Expenses	7,651	11,308	10,311	10,311	10,311	10,311
Democracy	860	397	517	517	517	517
Provider Payments	356,741	363,160	379,811	379,811	379,811	379,811
Recharges	8,584	10,576	11,193	11,193	11,193	11,193
Total Other Operating Costs	**471,137**	**492,950**	**508,525**	**507,972**	**507,972**	**507,972**
TOTAL COSTS	**1,064,009**	**1,109,660**	**1,155,480**	**1,154,802**	**1,154,802**	**1,154,802**
NET SURPLUS / (DEFICIT)	**(24,768)**	**(18,235)**	**(15,864)**	**(8,000)**	**0**	**0**
*Asset Revaluation (Equity movement - IRFS requirement)	-	113,105	-	-	-	-
TOTAL COMPREHENSIVE INCOME SURPLUS/(DEFICIT)	**(24,768)**	**94,870**	**(15,864)**	**(8,000)**	**0**	**0**

* Please note that for IFRS purposes, any movement in the Revaluation Reserves now needs to be displayed in the Statement of Comprehensive Income (above), as well as in the balance sheet as per normal. This is purely for presentational purposes, and doesn't change the target the DHB is working to. The DHB is still working to the 'Net Surplus / (Deficit) target above, rather than the 'Total Comprehensive Income' amount.

Capital & Coast DHB **Statement of Financial Position** **Budget for the Four Years Ending 30 June 2022**	**Actual 2016/17 (000s)**	**Actual 2017/18 (000s)**	**Plan 2018/19 (000s)**	**Plan 2019/20 (000s)**	**Plan 2020/21 (000s)**	**Plan 2021/22 (000s)**
Non Current Assets						
Land	25,705	41,165	41,165	41,165	41,165	41,165
Buildings	396,986	474,112	456,010	460,977	463,327	465,676
Clinical Equipment	29,049	26,550	31,634	30,094	30,094	30,094
Information Technology	11,938	11,208	16,380	15,384	15,384	15,384
Work in Progress	23,090	37,710	45,710	42,227	38,744	35,261
Other Fixed Assets	2,600	1,715	2,773	2,773	2,773	2,773
Total Non Current Assets	489,368	592,460	593,672	592,620	591,487	590,353
Current Assets						
Cash	20,403	17,602	14,110	11,760	9,410	7,060
Trust/Investments	8,409	9,693	10,193	9,693	9,693	9,693
Prepayments	5,632	3,075	3,075	3,075	3,075	3,075
Accounts Receivable	40,217	43,580	50,190	50,190	50,190	50,190
Inventories	8,602	8,067	8,067	8,067	8,067	8,067
Other Current Assets	3,745	5,610	-	-	-	-
Total Current Assets	87,009	87,627	85,636	82,786	80,436	78,086
Current Liabilities						
Payables & Accruals	136,335	148,505	151,928	151,939	151,939	151,939
GST & Tax Provisions	8,618	9,351	9,351	9,351	9,351	9,351
Current Private Sector Debt	326	247	247	247	247	247
Total Current Liabilities	145,279	158,104	161,526	161,537	161,537	161,537
Net Current Assets	(58,270)	(70,476)	(75,890)	(78,751)	(81,101)	(83,451)
NET FUNDS EMPLOYED	**431,098**	**521,984**	**517,782**	**513,868**	**510,385**	**506,902**
Term Liabilities						
Non Current Crown Debt - CHFA	302	55	55	55	55	55
Restricted & Trust Funds Liability	8,488	9,746	10,176	9,746	9,746	9,746
Non Current Provisions & Payables Personnel	6,473	6,247	6,247	6,247	6,247	6,247
Total Term Liabilities	15,263	16,048	16,478	16,048	16,048	16,048
Net Assets	**415,835**	**505,936**	**501,304**	**497,821**	**494,338**	**490,854**
General Funds						
Crown Equity	769,751	765,362	776,594	781,110	777,627	774,143
Revaluation Reserve	23,606	136,711	136,711	136,711	136,711	136,711
Trust & special funds no restriction	71	(307)	(307)	(307)	(307)	(307)
Retained Earnings						
Retained Earnings - DHB	(377,593)	(395,830)	(411,694)	(419,694)	(419,694)	(419,693)
Total Retained earnings	(377,593)	(395,830)	(411,694)	(419,694)	(419,694)	(419,693)
Total General Funds	415,835	505,936	501,304	497,821	494,338	490,854
NET FUNDS EMPLOYED	**431,098**	**521,984**	**517,782**	**513,868**	**510,385**	**506,902**

Prospective Cash Flow

Capital & Coast DHB Statement of Cashflows Budget for the Four Years Ending 30 June 2022	Actual 2016/17 (000s)	Actual 2017/18 (000s)	Plan 2018/19 (000s)	Plan 2019/20 (000s)	Plan 2020/21 (000s)	Plan 2021/22 (000s)
Operating Activities						
Government & Crown Agency Revenue Receiv	1,038,337	1,073,627	1,117,851	1,124,842	1,124,842	1,124,842
All Other Revenue Received	21,301	15,512	15,512	15,512	15,512	15,512
Total Receipts	**1,059,638**	**1,089,139**	**1,133,363**	**1,140,354**	**1,140,354**	**1,140,354**
Payments for Personnel	(436,835)	(453,548)	(481,233)	(487,733)	(487,233)	(487,233)
Payments for Supplies	(206,053)	(195,517)	(206,525)	(206,875)	(206,875)	(206,875)
Capital Charge	(5,662)	(24,373)	(24,373)	(24,373)	(24,373)	(24,373)
GST (net)	(3,099)	(1,535)	(1,535)	(1,535)	(1,535)	(1,535)
Other Payments	(379,649)	(385,318)	(399,851)	(399,851)	(399,851)	(399,851)
Total Payments	**(1,031,298)**	**(1,060,291)**	**(1,113,517)**	**(1,120,367)**	**(1,119,867)**	**(1,119,867)**
Net Cashflow from Operating	**28,340**	**28,848**	**19,846**	**19,987**	**20,487**	**20,487**
Investing Activities						
Interest Receipts from 3rd Party	1,436	1,557	1,557	1,557	1,557	1,557
	1,436	**1,557**	**1,557**	**1,557**	**1,557**	**1,557**
Capital Expenditure						
Land, Buildings & Plant	(8,997)	(11,436)	(11,436)	(11,436)	(11,436)	(11,436)
Clinical Equipment	(3,198)	(7,122)	(11,372)	(12,372)	(12,372)	(12,372)
Other Equipment	(941)	(3,191)	(4,191)	(3,191)	(3,191)	(3,191)
Informations Technology	(1,955)	(4,778)	(8,000)	(8,000)	(8,000)	(8,000)
Total Capital Expenditure	**(15,091)**	**(26,528)**	**(35,000)**	**(35,000)**	**(35,000)**	**(35,000)**
Increase in other Investments	(840)	(1,584)	(1,584)	(1,584)	(1,584)	(1,584)
Net Cashflow from Investing	**(14,495)**	**(26,555)**	**(35,027)**	**(35,027)**	**(35,027)**	**(35,027)**
Financing Activities						
Deficit Support	10,000	-	16,000	16,000	16,000	16,000
Interest Paid	(11,324)	-	-	-	-	-
Other Financing Activities	(3,809)	(3,810)	(3,810)	(3,810)	(3,810)	(3,810)
Total Financing Activities	**(5,133)**	**(3,810)**	**12,190**	**12,190**	**12,190**	**12,190**
Net Cashflow	8,713	(1,517)	(2,991)	(2,850)	(2,350)	(2,350)
Plus: Opening Cash	20,100	28,812	27,295	24,304	21,454	19,104
Closing Cash	**28,812**	**27,295**	**24,304**	**21,454**	**19,104**	**16,754**
Closing Cash comprises:						
Balance Sheet Cash	28,812	27,295	24,304	21,454	19,104	16,754
Total Cashflow Cash (Closing)	**28,812**	**27,295**	**24,304**	**21,454**	**19,104**	**16,754**

Financial Assumptions

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

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

Revenue

- PBFF Increase as per Funding Envelope.
- IDF levels based on Funding Envelope or agreed changes within the sub-region.

Expenditure

- Personnel expenditure increase in line with wage cost of settlement expectations
- Trendcare model for nursing staff rosters across all Directorates
- Supplies and expenses based on current contract prices where applicable
- Depreciation to include base, plus work in progress, plus new purchases
- Capital Charge at 6% payable half yearly
- Total Capital Expenditure of up to $35 million per annum is planned from 2018/19

Financial Risks

There has been good progress over the last year on many of the initiatives that were included in the savings plan however the pressure continues and further change is required to ensure the DHB meets the fiscal targets. The savings strategies underpin the DHB getting to a surplus position in the future. The key risks and assumptions associated with this financial plan are;

- Wage settlement increases higher than the funding increase;
- Not meeting elective targets;
- Acute demand exceeding plan;
- Inter-district inflows being below plan;
- Not realising the financial savings associated with change initiatives;
- Additional cost in RHIP and NZ Health Partnerships initiatives;
- Demand for aged residential care above plan;

Capital Plan

The operational capital funding requirements for the Provider Arm will be met from cash flow from depreciation expense, and they are prioritised with the clinical leaders and managers both within the Directorates and across the Provider Arm. Items with compliance, health & safety and a risk to patient care elements, or essential to support the District Annual and Strategic Plans, or yielding a fast payback have been included to be funded from the internal cash flow. The baseline CAPEX for 2018/19 is $35 million. CAPEX is required to be funded internally.

Equity

Equity Drawing

Additional deficit support may be requested for the 2018/19 financial year.

Working Capital

CCDHB has a working capital facility limit with BNZ bank. This is part of the "DHB Treasury Services Agreement" between New Zealand Health Partnerships (NZHP) and the participating DHBs. The agreement enables NZHP to "sweep" DHB bank accounts daily and invest surplus funds on their behalf. The working capital facility is limited to one month's provider revenue, to manage fluctuating cash flow needs for the DHB.

Gearing and Financial Covenants

No gearing or financial covenants are in place.

Asset Revaluation

Land and buildings are valued to fair value as determined by an independent registered valuer with sufficient regularity. This is to ensure the carrying amount is not materially different to fair value and the valuation is done at least every five years. The latest revaluation was carried out in June 2018.

Strategy for disposing of assets

The DHB regularly reviews its fixed asset register, and undertakes fixed asset audits in order to dispose of assets which are surplus to requirements. This ensures that the DHB reduces its level of capital to the minimum consistent with the supply of contracted outputs.

Disposal of Land

All land that has legally been declared to be surplus to requirements will be disposed of following the statutory disposal process defined in the Public Works Act 1991, the Health Sectors Act 1993, the New Zealand Public Health and Disabilities Act 2000, the Reserves Act 1977 and the Maori Protection Mechanism Regulations set up to fulfil the Crown's obligations under the Treaty of Waitangi. No land has been identified as surplus to requirements within this plan.

APPENDIX B: System Level Measures Improvement 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

SLM Final

Signatories

Capital & Coast DHB	Julie Patterson, Chief Executive (Interim)
Integrated Care Collaborative	Dr Bryan Betty, Chair
Tū Ora Compass Health	Martin Hefford, Chief Executive
Cosine Primary Care Network Trust	Dr Peter Moodie, Director
Ora Toa PHO	Teiringa Davies, Manager

Table of Contents

Introduction

Background

The Capital and Coast Health System Plan 2030 outlines our strategy 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.

CCDHB HSP Outcomes

Strengthened communities and families so they can be well

It is easier for people to manage their own health needs

We have equal health outcomes for all communities

Long term health conditions and complexity occur later in life and for shorter duration

Expert specialist services are available to improve health gain.

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 and the integration of Community District Nurses with practices.
The ICC has also led the expansion of primary care packages of care, implementation of Health Pathways, drives to increase patient portal utilisation, diabetes consultant's 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 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 SLMs are another lever to support improvements aligned with the CCDHB Health System Plan.

The six System Level Measures (SLMs) being implemented in 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

CCDHB SLM Plan Development 2018/19

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 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

The draft SLM plan has also been reviewed by the CCDHB Health System Committee.

Principles for Improvement

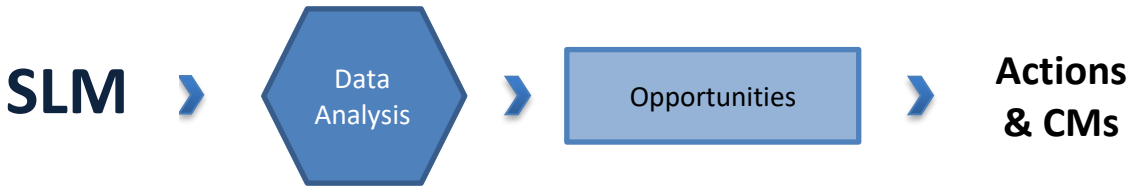
The ICC ALT and the SLM development team agreed that the milestones for the SLMs should take into consideration the strategic priorities across the sector and focus on equity.

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 population size
- Evidence based interventions
- Balancing a mix of outcomes and outputs
- Performance can be influenced through stakeholders and partners engaged with the DHB
- Return on investment

Improvement Methodology

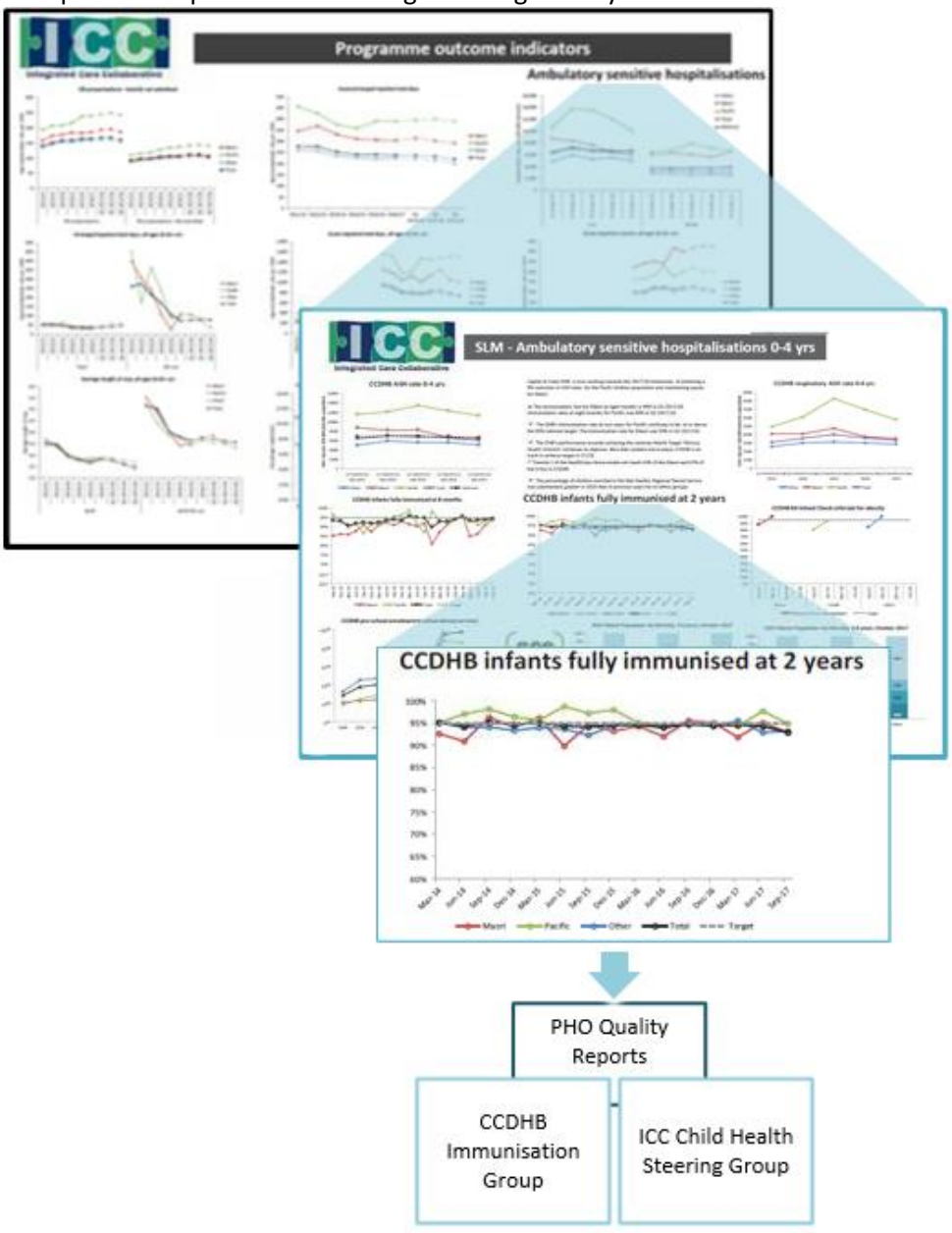
The CCDHB SLM Plan has been developed with the improvement methodology: Plan-Do-Study-Act. This planning stage has included the analysis of each SLM to understand progress and further opportunities for improvement. In particular, analysis of performance with an equity lens has been completed to ensure that improving outcomes for Māori and Pacific populations remains a focus. The plan identifies and defines our goals for each SLM, as well as the key opportunities for improvement as identified by the actions and 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 programme outcome dashboard. 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 improvement activities, particularly the PHO Clinical Quality Board and support groups within the CCDHB system.

Example of SLM performance linkages through the system:



Eg. Ambulatory Sensitive Hospitalisation 0-4yo is one of the nine measures included in the ICC ALT programme outcome indicators. The other national SLMs are included on the ICC ALT programme dashboard.

Eg. The ASH 0-4yo SLM has a dashboard is that includes each of the CMs with an overview of progress in the related activities. Each SLM have similar dashboards.

Eg. Monitoring of child immunisation is also done by the PHO quarterly boards, DHB immunity group and child ICC group. These groups jointly enable improvements.

The DHB is also progressing its maturity as a data driven organisation through the development of system dynamic modelling processes, 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 support the ongoing maturity of the improvement processes for overall CCDHB system and SLM performance.