CAPITAL & COAST DISTRICT HEALTH BOARD

Annual Plan

2020-2021

MA TINI, MA MANO, KA RAPA TE WHAI
BY JOINING TOGETHER WE WILL SUCCEED

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Annual Plan dated 29 July 2020

(Issued under Section 38 of the New Zealand Public Health and Disability Act 2000)

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Hon Andrew Little
Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

David Smol
Chair
Capital & Coast District Health Board
Dsmol31@gmail.com

Tēna koe David

Capital & Coast District Health Board 2020/21 Annual Plan

This letter is to advise you that we have approved and signed Capital & Coast District Health Board's (DHB's) 2020/21 Annual Plan (Plan) for one year.

We are pleased that your plan provides a strong platform to deliver on the priorities identified in the 2020/21 letter of expectation and focuses on equity, sustainability and addressing the population groups with the highest needs.

We are disappointed with your significant planned deficit position and agree to approve your DHB's Plan on the basis that it is a maximum anticipated deficit.

We expect that the DHB will:

- provide a verbal update to the Ministry of Health on the local governance and operational arrangements in place to ensure better financial performance management including financial controls, probity, compliance, reporting and scrutiny processes, at your next performance meeting
- provide a written report confirming these local assurance arrangements as part of quarter two reports due with the Ministry in January 2021.

We expect you to work with your fellow Chairs and continue discussions about how you can share skills and expertise in order to ensure that your performance is consistent with the agreed plan.

We particularly encourage you to ensure that your senior executives maintain the tight fiscal controls and implement planned service improvements that will be necessary to sustain financial performance in the out years. Good financial performance allows us to invest more in new models of care, both in hospitals and the community, improve population prevention, and to invest in better health assets.

The Ministry will have engaged with the DHB on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. If your DHB has not done so already, we encourage you to accept offers from the Ministry to utilise this funding.

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Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health, including changes in FTE. I expect you to continue to engage with the Ministry of Health to ensure you have a strong rationale for any adjustment to planned FTE during the year. 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 does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

We are aware that an extension was provided to the requirements for finalising DHB planning documents required by the Crown Entities Act 2004 due to the impacts of COVID-19. If required, please update your published Statement of Performance expectations and Statement of Intent (if applicable) to align with your approved Plan.

Thank you for the work you and your team are doing to support equitable health outcomes for New Zealanders, during a time when our system has faced additional pressures from COVID-19.

We look forward to seeing further positive progress as you deliver your Plan.

Ngā mihi nui

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Fionnagh Dougan
Chief Executive

SECTION ONE: Overview of Strategic Priorities

1.1. Our Vision & Strategic Direction

This Annual Plan articulates Capital & Coast District Health Board's (CCDHB) commitment to meeting the Minister of Health's expectations and our commitment to delivering CCDHB's vision of:

'Keeping our Community Healthy and Well'

To deliver on our vision, we are developing and implementing a health system that best meets the needs of our people and communities. This means applying our resources in the most effective manner to achieve equitable health outcomes and to advance improvements in health outcomes. To achieve this we are organising our system to ensure that service delivery occurs in the most appropriate setting for our people and communities.

We recognise the role of many people in our success: our communities, our families, our workforce, our provider partners, our Ministry, and our social service partners. Enabling people and their whānau to take the lead in their own health and wellbeing is at the heart of this approach.

In setting the strategic priorities necessary for achieving our vision, we are guided by core legislative and governmental strategic directions including:

- Te Tiriti o Waitangi (the Treaty of Waitangi)
- the New Zealand Public Health & Disability Act 2000
- the New Zealand Health Strategy
- He Korowai Oranga – the Māori Health Strategy
- Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan
- the UN convention on the Rights of Persons with Disabilities; and
- the Healthy Ageing Strategy

We are also guided by the Government's commitment to the United Nations Convention on the Rights of Persons with Disabilities.

1.2. Te Tiriti o Waitangi

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities through this founding document of Aotearoa. CCDHB values Te Tiriti and the principles of:

- *Partnership* – working together with iwi, hapū, whānau and Māori communities to develop strategies and services to improve Māori health and wellbeing
- *Participation* – involving Māori at all levels of decision-making, planning, development and service delivery
- *Protection* – working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

In planning and providing health services, we pay particular attention to the health needs and aspirations of our Māori population. There are well-documented and preventable inequities in the determinants of health between Māori and non-Māori, and these flow through to inequities in health outcomes.

Our intention is that we will target, plan and drive our health services to create equity of health care for Māori to attain good health and wellbeing, while developing partnerships with the wider social sector to support whole of system change.

Māori representation has been provided on all advisory committees and the Integrated Care Collaborative Alliance Leadership Team (ICC ALT). CCDHB has a Māori Partnership Board to formalise the relationship between local Iwi and the DHB, build on relationships, and share aspirations and strategic directions.

1.3. Health System Plan 2030

The CCDHB Health System Plan 2030 (HSP) outlines our vision and strategy to transform the health system to ensure equity amongst our populations and support better health and wellbeing throughout the lives of the people in our communities.

The HSP enables us to respond to the growing demand for healthcare, and increasing complexity of healthcare needs and is supported by this whakatauki:

Ma Tini, Ma Mano, Ka Rapa, Te Whai

By Joining Together We Will Succeed

The Health System Plan is organised around two elements: 'People' and 'Place'.

People

We are committed to developing people-focused service delivery models. The Health System Plan outlines three broad service delivery models for the main users of our health services:

- Core health care service users – those who require any form of urgent and planned care. The health system will be acting early to prevent illness and disability and save lives
- Maternity services users and children, young people, and their families and whānau – the health system will be providing support in these key life transitions, with a strong focus on children and young people where early action has benefits across the life course;
- People who require system coordination – including those who have long-term conditions, are becoming frail or are at the end of their life. These people have multiple needs from the health system and require the system to be easily and effectively navigated to enable them to lead their own health care.

This means recognising those who may need more help including: Māori and Pacific Peoples in our district, people with disabilities, the socially and economically vulnerable or with an enduring mental illness and/or addiction, and refugees.

Place

Using 'place' as the basis for health and social supports creates immediate links to a community's strengths; it makes it easier to recognise and value community diversity, while organising a consistent system across many groups.

Better information about the characteristics of the people being served, shared among those delivering services, is central to succeeding with this approach. It has the potential to reduce health care costs over time as communities increasingly support their own health and wellbeing.

Health care has always been delivered in a variety of settings. The places where care is organised and delivered, together with increased access to better and cheaper technologies, provide the platform for a comprehensive system of care.

The plan centres on the following three core care settings.

- People's homes and residential care facilities
- Community Health Networks, including Health Care Home and the Kāpiti Health Centre
- Wellington and Kenepuru hospitals providing specialist care for the CCDHB region.

1.4. Health Equity

Achieving equity is a priority for CCDHB and HVDHB. We know that we do not do as well for Māori, Pacific people, people with disabilities, those who have fewer resources available to them and those with enduring mental illness.

We are committed to improving their health outcomes and achieving equity for them.

Our focus is on improving performance ensuring we make best use of our available resources and ultimately achieving equity amongst our populations. We will continue to deliver against:

- Taurite Ora: CCDHB's Māori Health Strategy 2019-2030
- Sub Regional Pacific Health And Wellbeing Strategic Plan 2020-2025
- the Sub-Regional Disability Strategy 2017-2022
- Living Life Well – A Strategy for mental health and addiction 2019-2025.

We will develop models of care and commission services that achieve equity for our people and communities by optimising the configuration of existing investment and services, prioritising new investment when resources are available to services that have the greatest impact on health outcomes for Māori, Pacific people, people with disabilities, those who have fewer resources available to them, and those with enduring mental illness.

We will support having a workforce that is reflective of the populations we serve. We are prioritising a range of strategies with a particular focus on the recruitment and retention of Māori and Pacific staff as well as our staff with disabilities thereby ensuring the right mix of staff and skills in the places where they are needed most to achieve equitable health outcomes.

Partnership is key to success in achieving equitable health outcomes. We collaborate with our Māori Partnership Board, Sub-Regional Pacific Strategic Health Group, and Sub-Regional Disability Advisory Group, who provide advice on how we can achieve equitable health outcomes for the people and communities they represent. We will measure and report on our progress regularly.

We will contribute to equity priorities through the specific actions and milestones outlined in the section below. We will measure and report on our progress regularly.

1.5. Māori Health

Historical disadvantage and alienation, poverty and poor living environments lead to sustained poor health outcomes. This applies to many Māori individuals and whānau. Life expectancy for Māori males and females living in the CCDHB area continues to lag about five years behind non-Māori, and the evidence shows that Māori continue to be over-represented in a number of health care areas.

CCDHB, together with the Māori Partnership Board, has developed a Māori health strategy, Taurite Ora: CCDHB's Māori Health Strategy and Action Plan 2019-2030. Taurite Ora is supported by this wero:

Kua Takoto Te Rau Tapu

The challenge of health equity for Māori is laid down

Taurite Ora guides CCDHB activity to achieve health equity and optimal health for Māori by 2030. Our efforts to bring about changes in Māori health outcomes are part of a broader public health plan that is well described in the Ministry's *He Korowai Oranga: Māori Health Strategy*.

The framework and its underlying themes of Pae Ora (healthy futures) founded on Whānau Ora (healthy families), Mauri Ora (Healthy individuals), and Wai Ora (healthy environments), guide our activity.

Taurite Ora describes the critical need to improve health outcomes for Māori, yet its success will be dependent upon CCDHB working with communities to ensure simple solutions, where Māori, whānau, communities, DHB staff, and providers can see themselves as part of those solutions.

Taurite Ora is tailored to the identified health needs of Māori living in its district and describes the outcomes and impacts that will be measured against in achieving health equity for Māori. Taurite Ora highlights the most critical priorities to improve health outcomes for Māori.

The strategy focuses on **equity**, as a value which underpins everything we do; system change through **workforce** development; and, funding prioritisation through **commissioning** of services.

Taurite Ora has two outcomes:

- A stronger and more responsive CCDHB health system achieved by focusing on three strategic priorities: becoming a pro-equity health organisation; growing and empowering our workforce; and, strengthening our commissioning services.
- Improved health and wellbeing outcomes for Māori in two priority focus areas: maternal, child and youth; and mental health and addictions.

The pathway to achieving health equity for Māori requires significant shifts, not just in the way we operate and in the processes and policies we follow, but also in our attitude and our thinking. Delivering on the key outcomes outlined in Taurite Ora is fundamental to achieving equitable health outcomes for Māori. We will measure and report on our progress regularly to the Māori Partnership Board on behalf of all Māori in our district.

1.6. Whole of system integration

CCDHB and HVDHB have entered into a joint planning process. This supports a consistent approach across our five communities (Upper Hutt, Lower Hutt, Kāpiti, Porirua and Wellington), three hospitals (Hutt, Kenepuru and Wellington) and two District Health Boards to achieve equity and improve health outcomes.

This approach will focus on regional and sub-regional service integration, leveraging and driving innovations and patient/ consumer experience to achieve delivery of performance improvement and future sustainability. .

Health and social outcomes are inter-related and can be improved by building strong effective partnership with community groups, providers and agencies and supports a strong focus on population health.

Regional Public Health (RPH) plays an essential role in this space. RPH is the public health unit for the 3DHB sub-region. 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.

We will be building on our successes of the last three years, developing our community health networks, and continuing locality service integration. The integration of RPH's activity into our commissioning function has commenced and will ensure our efforts to improve health outcomes in our communities are aligned.

Achieving equitable health outcomes for our communities requires an approach broader than the traditional boundaries of health. Partnership with local councils, government agencies, NGOs and community organisations from other sectors is required to respond to variation in the distribution of social determinants of health and the resulting

inequitable health outcomes observed across the social gradient. We support these partnerships through our locality-based approaches with our communities of Upper Hutt, Lower Hutt, Kāpiti, Porirua and Wellington.

1.7. Our Priorities for 2020/21

Implementing the strategies and action plans is a priority for the two DHBs. This is associated with a programme of work that transforms our health system.

We are re-organising our health system to place **Community Health Networks** and **Community Mental Health and Wellbeing Hubs** at the centre of health care service delivery. We will continue to prioritise primary care development and leverage the capacity and capability of community and primary care developed through the Health Care Home model of care. We are also implementing **locality** placed strategies to improve connections with community capability.

The drivers for hospital cost growth

Cost growth is primarily a product of increasing demand and differences between the cost of service provision and price.

Demand is being driven by the impacts of ageing, the combination of multiple co-morbidities increasing patient complexity and non-communicable diseases.

Managing the clinical risk and patient safety created by demand and capacity mismatch is driving cost growth in the hospitals. Some of the current major clinical risks for CCDHB include:

Neonatal care – safe staffing;

Bowel screening – the backlog in surveillance and diagnostic cases.

Radiology – there has been a long term mismatch between demand and radiology capacity/service size. This has resulted in waiting lists and a high clinical risk for delayed diagnosis.

Specialty access – other risks that have been identified through clinical governance structures are: cardiothoracic/ICU capacity, pharmacy and ophthalmology. Often their is less for local patients in planned care setting as acute and inter-district tertiary patients are prioritised.

CCDHB is a relatively cost effect tertiary provider however there are still significant differences between the cost of providing care and the price in the inpatient settings. This leads to deficits as demand increases and limits investment choices in parts of the health sector that would see health gains for our local population.

CCDHB Performance Improvements

CCDHB has already delivered a range of projects to alleviate some of the pressure on provider services, including:

- Māori/Pacific Antenatal Care - Using a disruptive commissioning model three pilots are providing antenatal care to Māori and Pacific communities
- Kāpiti Acute Response - Acute response service with Wellington Free Ambulance and Primary Care
- Ophthalmology - Alternative model of care has been introduced to deliver services closer to home and reducing patient travel
- Discharge Ward - Early transfer to discharge ward to free up inpatient beds (increased utilisation)
- Maternity - Support programme to support mothers with higher needs.
- Outpatient Communications - Redesign of all outpatient communications to engage patients and their families.
- Health Care Homes (HCH) – HCH Model of Care has been implemented in over 80% of practices.
- The Advancing Wellness at Home Initiative (AWHI) Programme - Supporting people in their own homes with early discharge

These projects have alleviated some of the pressure on our hospitals, improved equity and outcomes. There remains significant opportunity.

Achieving Sustainability while meeting our obligations

We are committed to achieving sustainability while meeting our obligations. This means that in providing and commissioning health services we are:

- Optimising cost structure; and
- Reducing avoidable demand on our hospitals
- Improving equity and outcomes

Achieving equity for Māori and others in our communities

Overall, our residents are living longer and experiencing better health. However, inequities remain a significant challenge. Māori and Pacific Peoples, people with disabilities, as well as those

who have low socio-economic status or an enduring mental illness and/or addiction, and refugees experiencing the greatest burden of poor health. Inequity also drives avoidable utilisation of health services. Intensifying support to these populations improves health outcomes, and keeps people healthy and well in their community.

We remain focused on achieving equity, and that it is sustainable over time.

Achieving equitable health outcomes for our communities requires an approach broader than the traditional boundaries of health. Partnership with local councils, government agencies, NGOs and community organisations from other sectors is required to respond to variation in the distribution of social determinants of health and the resulting inequitable health outcomes. We support these partnerships through locality-based approaches with our communities of Upper Hutt, Lower Hutt, Kāpiti, Porirua and Wellington.

Key equity priority areas for 2020/21 include:

- Maternal, Child and Youth, including the 2DHB Maternal and Neonatal Health Model of Care (*Maternity and early years*)
- Mental Health and Addictions, including community mental health (*Mental Health And Addiction System Transformation*)
- Workforce, including workforce development for staff to build understanding of Māori health and Equity (*Workforce*)

Optimising Cost Structure

To ensure that we are optimising cost structure we need to ensure that:

- Our services are safe and risk is managed
- Funding for specialty services is fair and does not detract from community investment
- Our hospital and specialty providers are efficient and we are using resources well, and
- Our 2DHB health system network provides significant economies of scale whilst improving safety and access.

The purpose of the 2DHB Health System Network Programme is to provide the approach to design and implement the future personal health system across our five communities (Upper Hutt, Lower Hutt, Kāpiti, Porirua and Wellington), three hospitals (Hutt, Kenepuru and Wellington) and two District Health Boards to achieve equity and improve health outcomes.

Three streams of work underway are:

1. Infrastructure Planning (best use of Hospital Sites/Enabling Infrastructure)
2. Clinical Services Planning and Regional Care Arrangements
3. Health System design and implementation

The objectives of the programme are:

- Create service delivery models that improve equity and health outcomes
- Support great places to work
- Make effective use of resources
- Make effective use of workforce teams
- Avoid unnecessary duplication and maximise co-location
- Create clinically sustainable services
- Improve financial sustainability of services for both DHBs

The aim is to provide services that are as local as possible and as specialised as necessary.

Reducing avoidable hospital demand

There is overwhelming evidence and agreement that investment in drivers of equity, prevention and early intervention across the life course will reduce the burden of preventable and avoidable disease and poor health and improve the health of the community. This is partnered with an expectation that demand for acute care will be mitigated and enable health system sustainability and affordability.

The question is often raised as to why we do not invest more in equity, prevention and early intervention, and in the early years. The answer is in two parts; that existing services must serve Māori and other people who experience inequity well to reduce inequity (why we invest in pro-equity); that disinvesting in specialty and hospital services will cause direct harm to the community served.

It is therefore safer and more effective to purposefully direct resources to reduce the

proportional spend on specialty and hospital services through following approaches:

- Implementing pro-equity commissioning for all current and new investment to ensure that Māori, and other groups that experience inequity, receive care that meets their needs and redresses inequities in health outcomes;
- Managing specialty and hospital services provider performance to ensure it is as efficient and productive as safely possible;
- Implementing integrated models of care that provide care in lower cost settings achieving equity, and the same or better health outcomes using less resources;
- Investing in community and primary care services to increase greater capacity and capability to provide health services;
- Investing in prevention and early intervention within integrated models of care to reduce the burden of preventable and avoidable disease;

COVID-19 Recovery

COVID-19 had a significant impact on the delivery of health care services across the 2DHB region. During COVID-19:

- A significant number of planned care procedures were deferred, and
- Fewer people presented to primary care, accident & medical centres, and emergency departments.

This resulted in an influx of patients requiring care post COVID-19.

Implementing our COVID-19 recovery plan is a focus for 2020/21. For RPH, which is the lead public health agency in a pandemic response, this includes implementing national system changes to improve our capacity for contact tracking. For DHBs, the recovering plan includes embedding new ways of working that developed during COVID-19, such as greater use of telehealth and increasing the availability of specialist support and advice to primary care; working across agencies to look after our priority populations, including homeless people; and supporting our Māori and Pacific community providers to work alongside whānau and achieve equitable outcomes for our priority populations.

New ways of integrated working are also being explored to mitigate the growth of demand on hospital services. While such changes will help address the backlog of patients whose treatment was deferred during COVID-19, additional capacity will also be needed to clear the backlog through the use of private providers.

The recovery plan also includes a programme of work to support infection control practices across our wider community network, and update and strengthen our pandemic and emergency preparedness plans. We are capturing the learnings from COVID-19 so that we are even better prepared for future pandemics and other emergencies. Finally, we are prioritising the psychosocial response for our workforce and our communities to help mitigate the economic fallout from COVID-19. This is reflected in many of the activities throughout this Annual Plan, particularly under the Improving Mental Wellbeing section.

CCDHBs role as a regional care provider

CCDHB is the provider of tertiary service for the Central Region, as well as a specialist provider for our own population. As the provider of tertiary care for the Central Region, we are leading the implementation of Regional Care Arrangements and the delivery of a Tertiary Services Strategy.

As a relatively small regional and tertiary service, we work with other regional centres through the Tertiary Provider Network to manage specialisation and improve our nationwide role. We will work with the nationwide tertiary providers to ensure CCDHB only provides tertiary services that are appropriate for our role in the Central Region. We also collaborate with our partner DHBs in the Central Region to organise regional care delivery and ensure access to services. This includes networked centres to maximise efficiency and outcomes for patients

1.8. Joint Message from the Chair and Chief Executive

It is our privilege to introduce the Annual Plan for 2020/21 which articulates our ongoing commitment to the CCDHB vision: “keeping our community healthy and well”.

2020 has been an extraordinary year to date and will have a far reaching impact on the way we deliver services and work with our people and communities.

We have been working to bring our partnership as a 2DHB organisation to fruition, beginning with a joint CE, and the recruitment of a number of 2DHB Executive Leadership Team positions, along with the appointment of a joint Chair and the alignment of the two boards.

The release of the Health and Disability System Review, commonly known as the Simpson Review, has signalled change for DHBs. Our strategic approach which supports Hutt Valley and Capital & Coast DHBs working as one where possible to gain efficiencies across our hospital services, workforce, sustainability, safety and quality is aligned with the direction articulated in the recommendations.

The DHBs in our region have led a strong regional health response to COVID-19 through all alert levels. People rose to the challenge to find new ways of working together in hospitals and with community providers. It has been a time of collaboration across multiple agencies, and of recognising what is important and what stands in our way.

We are proud of how our team of many thousands stood strong and supported New Zealand’s team of five million to eliminate COVID-19 from community transmission. We continue to maintain our readiness to respond should anything change, and our learning and experience has put us in good stead to lead the health response for the managed isolation facilities across the greater Wellington region.

Embedding the new ways of working that developed during COVID-19 includes greater use of telehealth and increasing the availability of specialist support and advice to primary care. It means working across agencies to look after our priority populations, including homeless people, and supporting our Māori and Pacific community providers to work alongside whānau and achieve equitable outcomes for our priority populations.

We continue to explore new ways of integrated working to mitigate the growing demand on hospital services.

We are capturing what we have learned from COVID-19 so that we are even better prepared for future pandemics and other emergencies, particularly with regard to the psychosocial wellbeing of our workforce and the population they serve.

People and place are at the heart of all we do and our two key drivers. We are committed to ensuring all of our people have equitable access to health care, and in particular, that they can access care where they need it. We are committed to the beliefs and values of te Tiriti o Waitangi, and to creating an accessible environment for people with disabilities.

What we can be sure of, is that new territory is opening up for us all the time. We have seen it is possible to be more agile and responsive. We have an amazing team of people at our DHBs who we know are ready to meet the challenges before us. None of what we do would be possible without our hardworking and dedicated staff who are going to extraordinary lengths to make a difference in the lives of thousands of people every day.

We value all of our partnerships throughout our hospitals and our communities, and we are committed to delivering the health system the people of our region are asking us for.

Fionnagh Dougan
Chief Executive
Capital & Coast and Hutt Valley DHBs

David Smol
Chair
Capital & Coast and Hutt Valley DHBs

1.9. Signature Page

Agreement for the Capital and Coast DHB 2020/21 Annual Plan between

Hon Andrew Little
Minister of Health
Date: 18 December 2020

Hon Grant Robertson
Minister of Finance
Date: 18 December 2020

David Smol
Chair
Date: 29/7/20

Ayesha Verrall
Deputy Chair
Date: 29/7/20

Fionnagh Dougan
Chief Executive
Date: 5/8/20

SECTION TWO: Delivering on Priorities

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

2.1. Government Planning Priorities

Give practical effect to He Korowai Oranga – the Māori Health Strategy

Engagement and obligations as a Treaty partner		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori **Government priority outcome:** Ensure everyone who is able to, is earning, learning, caring or volunteering		
Activity	**Milestone**	**Measure**
1. Develop and commit to a pro-equity programme of work that delivers: (a) A clear CCDHB equity goal and direction (b) An agreed set of equity principles (c) An operational framework that translates principles into policies and practices (d) A performance framework to monitor and guide progress (e) An agreed target-staged implementation. *Also an activity under 'Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori' and 'Delivery of Whānau Ora'*	Q2&Q4: Narrative Report	SS12 Status Update Report
2. Engage with the CCDHB Māori Partnership Board (MPB), including: (a) MPB attendance and agenda item at each Board meeting (b) Regular Board member and CE attendance at MPB meetings, and (c) Facilitate MPB representation on all statutory and organisational boards.	Q2&Q4: Narrative Report	
3. Provide training opportunities for Board members (as required) in Te Tiriti o Waitangi and Māori health and disability outcomes.	Q2&Q4: Narrative Report	
4. Design and implement a policy to provide guidance on strengthening relationships with a range of Māori stakeholders (including Māori health and health equity experts) at every level of the organisation, including enhanced representation on governance and advisory groups. *Also an activity under 'Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services' and 'Māori Health Action Plan – Strengthening system settings'.*	Q4: Policy developed and implemented	

Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori **Government priority outcome:** Ensure everyone who is able to, is earning, learning, caring or volunteering		
Activity	**Milestone**	**Measure**
1. Facilitate Māori health providers seeking to expand capacity and strengthen capability by: (a) Supporting Māori Provider Development Scheme (MPDS) applications (b) Supporting Health Workforce New Zealand Hauora Māori applications	Q4: Narrative Report	Status Update Report

(c) Connecting to Haoura Māori scholarships (d) Promoting other development opportunities.		
2. Design and implement a policy to provide guidance on strengthening relationships with a range of Māori providers at every level of the organisation, including more representation on governance and advisory groups. *Also an activity under 'Engagement and obligations as a Treaty partner' and 'Māori Health Action Plan – Strengthening system settings'.*	Q4: Policy Developed and Implemented	

Māori Health Action Plan – Shifting cultural and social norms		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
1. Re-establish and update the Tū Pounamu Workforce Programme, including: (a) Aspirations and targets for the recruitment, retention and professional development of Māori staff (b) Workforce development for all staff in Māori health and equity, including cultural leadership, safety and competency, anti-racism and health literacy.	Q2 & Q4: Narrative Report	Status Update Report
2. Coordinate workforce development programmes including: Hauora Māori Training, Kia Ora Hauora, TAS Workforce	Q4: Narrative Report	
3. Implement a range of actions focused on equipping our workforce to improve Māori health outcomes, and quality improvement, across the organisation	Q4: Narrative Report	
4. **Workforce Equity**: Supporting our workforce to achieve increased equity outcomes, particularly for Māori, Pacific and people with disabilities. (EOA) – *also an activity under 'Workforce'.* Milestones include: (a) Te Reo used in job titles (b) Workforce understanding of Māori health and equity increased (c) Workforce development focussed on cultural leadership, safety and competency embedded	(a) Q1; (b) Q1-Q2; and (c) Q3	

Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
1. Develop and commit to a **pro-equity programme of work** with a focus on Māori Health (EOA) – *also an activity under 'Engagement and obligations as a Treaty partner' and 'Delivery of Whānau Ora'*	Q2 & Q4: Narrative report	Status Update Report
2. **Maternity:** Co-design innovative models of care with Māori and Pacific women in order to improve outcomes. This will include exploring midwifery practice continuity models that fit the cultural context for Māori and Pacific women, and examining the feasibility resourcing (including financial) of potential new case loading models of care, and the impacts on Lead Maternity Carers of different case loading model approaches. (EOA) – *also an activity under 'Maternity and early years' and 'Working with sector partners to support sustainable system improvements'*	Q2 & Q3	
3. **Mental Health and Addictions:** Support and contribute to the development of a collaborative between the Māori and Pacific service providers across CCDHB and HVDHB.	Q2	

The collaborative will develop and implement culturally appropriate and community-based models of care. The goal of the collaborative is to work together to support service development and delivery, share information, build service resilience, and improve the sustainability of services. (EOA) – *also an activity under 'Mental Health And Addiction System Transformation' and 'Working with sector partners to support sustainable system improvements'*		

Māori Health Action Plan – Strengthening system settings		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori **Government priority outcome:** Ensure everyone who is able to, is earning, learning, caring or volunteering		
Activity	**Milestone**	**Measure**
1. Design and implement a policy to provide guidance on strengthening relationships with a range of Māori providers at every level of the organisation, including more representation on governance and advisory groups. *Also an activity under 'Engagement and obligations as a Treaty partner' and 'Māori Health Action Plan – Accelerate the spread and delivery of Kaupapa Māori services'.*	Q4: Policy Developed and Implemented	Status Update Report
2. The DHB will implement the locality commissioning plan to address equity and place-based initiatives in Porirua, Wellington and Kāpiti. This will include all community activation engagements and stakeholder partnership relations. (EOA) – *also an activity under 'Working with sector partners to support sustainable system improvements'*	Q1	

Improving sustainability

Improved out year planning processes		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
Part One: Financial		SS18 SS19 Status Update Report Planned Care Reporting
1. 2DHB Provider Hospital Network Planning: (a) Strategic Infrastructure Brief (b) Site-wide Master Site Planning (c) Clinical Services Planning Implemented (services to be prioritised)	(a) Q1 (b) Q2 (c) Q3	
2. More Affordable Models of Care: (a) Expansion of AWHI (early supportive discharge) (b) Implementation of the Planned Care Plan – *also an activity under 'Planned Care'*	(a) Q2 (b) Q4	
Part Two: Workforce (2DHB)		
3. Align 2DHB People, Culture and Capability (PCC) services and activities. Activities include: (c) Proposal of future state PCC refined; (d) Consultation for formal change process; (e) Future state proposal confirmed and implemented; and (f) Future state PCC embedded.	(a) Q1; (b) Q2; (c) Q3; and (d) Q4.	

4. Implement 2DHB Quality and Safety Framework (patient and staff safety, developed in 2019-2020 year). Activities include: (a) Implement the 'prevention of bullying harassment, victimisation and discrimination' policy (b) Establish a 2DHB wellbeing vision and objectives, leading to a work programme; (c) Align staff safety frameworks 2DHB.	(a) Q1; (b) Q3; and (c) Q4	
5. Identify effective people management systems to support increased data analytics and planning. Activities include: (a) Exit interview reporting; (b) Refine the dashboard of people data; and (c) People metrics to support business partners.	(a) Q1; (b) Q3; (c) Q4	

Savings plans – in-year gains

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Savings	Measure
1. **Patient Flow**; reducing demand on emergency and hospital so our communities only using the hospital when they really need to, and getting people home sooner. The objective is to manage ED occupancy and avoid the need to open 30 additional beds at Wellington Regional Hospital. *– also an activity under 'Acute Demand'* (a) Development of acute frailty pilot within existing beds (b) Roll out early supported discharge, enabled by Advanced Wellness at Home Initiative (AWHI) (c) Focus on patients with length of stay >10 days and increase proportion dischargers earlier in the day (d) Increase specialist rounding at weekends (e) Increase flow out of ED into Child Acute Assessment Pathway in ED	Q2 & Q4	$22.34 million	SS18 Status Update Report
2. **Provider Performance**; Effective and efficient use of our resources will maximise delivery to our communities. Objectives are to ensure service delivery to plan, and efficient use of resources. Activities include: (a) Productions Planning (b) Operating Room Utilisation	Q2 & Q4		
3. **Community Performance**; Reduce admissions to Wellington Regional Hopsital. Activities include: (a) Develop options for Kenepuru A&M including reducing overnight staffing requirements. (b) Implement community health network capability to improve local urgent care capacity through integrated primary care, pharmacy and allied health care. (c) Deliver community based planned care through Community Health Networks	Q2 & Q4		
4. **Financial;** control expenditure and manage costs. The objectives are: (a) Infrastructure and Support Services (b) Effective Use of Workforce (c) Community Commissionin	Q2 & Q4		

Savings plans – out year gains; and Consideration of innovative models of care and the scope of practice of the workforce to support system sustainability			
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities			
Activity	**Milestone**	**Savings**	**Measure**
Part One: Savings plans – out year gains		$12.2 million	SS18 Status Update Report
1. **Infrastructure and Support Services.** Activities include: (a) Transport and Supply; centralise transport and supply functions across 2 DHBs (b) Communications; develop integrated call centre across 2 DHBs (a) Transcription services; transition to working from home; and integrated medical typing pool across 2DHBs	Q4		
2. **Health System Plan Implementation – improving community care options.** Activities include: (a) Operating a single health service commissioner in Porirua in partnership with Ngati Toa (b) Implementing integrated service delivery models for communities	Q4		
3. **2DHB Hospital Network Implementation.** Activities include: (a) Early movers for clinical services planning include: Cardiology, Tertiary Surgery, ENT, and Ophthalmology	Q4		
4. **3DHB MHAIDS Implementation.** Activities include: (a) Established commissioning Board (b) Implementation of Living Life Well Strategy improving community service delivery. (c) Implementation of He Ara Oranga Strategy and expansion of community and primary mental health.	Q4		
Part Two: Consideration of innovative models of care and the scope of practice of the workforce to support system sustainability (2DHB)			
5. Workforce capability developed to support inter-professional (InterPro) working. Activities include: continue to support the implementation of Advanced Wellness at Home Initiative (AWHI) across sites; review pilot of the Allied Health, Scientific and Technical (AHS&T) new graduates; and current practices in the use of resources and improving patient outcomes; implement review recommendations and embed new graduate programme; explore InterPro dedicated education units; review and implement changes to Student InterPro practice learning; provide capability programmes that build InterPro competencies for organisational projects; pilot an InterPro practice programme for AHS&T student placements; provide capability programmes that build InterPro practice for organisational projects; and interPro new graduate programme	Q1-Q4: Narrative Report	N/A	
6. Workforce modelling to understand and support Model of Care changes which may impact settings of care and scope of practice. Activities include: identify a resource to provide additional strength in the decision support unit; and build on QLIK to create a demographic model of key workforce variables (e.g. ageing, ethnicity) and align with TAS and other DHBs reporting	Q1-Q4: Narrative Report	N/A	

7. Build Māori and Pacific leadership networks. Activities include: Seek and apply privacy approval for all staff to upgrade ethnicity data, use that data to target activities to support Māori and Pacific staff; and Māori and Pacific leadership networks set up and supported. (EOA)	Q1-Q4: Narrative Report	N/A	
8. All vacancies reviewed for appropriate skill mix/profession to ensure position is configured for top of scope practice. Activities include: Analyse recruitment business case (RBC) process; Vacancy and time to hire reporting established; and sharpen the RBC process and simplify HR administration processes to reduce administration overhead.	Q1-Q4: Narrative Report	N/A	

Working with sector partners to support sustainable system improvements

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. The DHB will implement its locality commissioning plan to address equity and place-based initiatives in Porirua, Wellington and Kāpiti. This will include all community activation engagements and stakeholder partnership relations. (EOA) – *also an activity under 'Māori Health Action Plan – Strengthening system settings' and 'Cross Sectoral Collaboration including Health in All Policies'*	Q1	Status Update Report
2. CCDHB will implement its Programme Plan (which includes a targeted communications plan) with specific locality based work streams to provide improved health outcomes for Māori, Pacific, Older People, and People with Disabilities in Porirua, Wellington and Kāpiti. (EOA)	Q1-4	
3. CCDHB will review Programme implementation for impact on outcomes.	Q4	
4. **Maternity:** Co-design innovative models of care with Māori and Pacific women in order to improve outcomes. This will include exploring midwifery practice continuity models that fit the cultural context for Māori and Pacific women, and examining the feasibility resourcing (including financial) of potential new case loading models of care, and the impacts on Lead Maternity Carers of different case loading model approaches. (EOA) – *also an activity under 'Maternity and early years'* and '*Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori*'	Q2 & Q3	
5. **Mental Health and Addictions:** Support and contribute to the development of a collaborative between the Māori and Pacific service providers across CCDHB and HVDHB. The collaborative will develop and implement culturally appropriate and community-based models of care. The goal of the collaborative is to work together to support service development and delivery, share information, build service resilience, and improve the sustainability of services. (EOA) – *also an activity under 'Mental Health And Addiction System Transformation' and 'Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori*'	Q2	
6. **Family Violence Prevention:** Work in partnership with Māori, HVDHB, and community providers to co-design and develop a joint 2DHB Family Violence Prevention Action Plan for our communities, with a particular focus on at-risk population groups. This approach will include a range of prevention, early intervention and specific interventions to enhance safety for families and whānau. Q1- confirm scope project; Q2 – complete interviews, research, and analysis; Q3 - co-design and draft plan; Q4 - test, refine and approve plan. (EOA) (2DHB) – *also an activity under 'Family violence and sexual violence'*	Q1-4	

Improving Child Wellbeing - improving maternal, child and youth wellbeing

Maternity and Midwifery workforce

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Make New Zealand the best place in the world to be a child

Activity	Milestone	Measure
1. Addressing specific population needs through focused maternity care across the region in partnership with Māori (2DHB): (a) Participate in the Maternity Quality Safety programme (MQSP), which will develop an action to reduce pre-term births. The action will be informed by retrospective data collection and research undertaken in 2019/20 on reducing the preterm birth rate for Māori women over a 5-year period. (EOA) (b) Implement the recommendations from a recently completed breast feeding review aimed at improving breast feeding rates for Māori and Pacific women. This builds on the work done in 2019/20 around data collection, mapping of current supports, consumer hui and engagement in service design, and use of the HEAT tool to determine the responses needed. (EOA)	Q2 & Q4	Status Update Report
2. Deliver integrated Midwifery workforce planning against the 2019-2023 DHB midwifery workforce strategies (CCDHB/HVDHB) to achieve a sustainable future in the provision of safe maternity care. Key actions below are some of the deliverables we will undertake in 2020-2021 (2DHB): (a) CCDHB and HVDHB to work with local education providers to ensure that undergraduates are placed in clinical settings that align with undergraduate workforce planning and support optimal learning. Provide appropriate practice settings for learning to support, encourage, and prepare new midwives for practice in New Zealand. (b) CCDHB and HVDHB to finalise a shared MOU to agree a joined up application process for new graduate placements across the region. This will include sharing education resource, joint education sessions and advertisement, and streamlining the appointment and recruitment process to reduce competition and help us attract midwives to the region to meet our current and future clinical need. (c) CCDHB will introduce a Māori continuity of care model within the community midwifery team. This will ensure more capacity within the community midwifery team to manage seasonal changes in work and ensure there is a dedicated Māori team of midwives in the community (EOA) (d) Ongoing predicting of service demands continues. This allows us to focus midwifery resources to service demands. We are exploring options of managing December/January high service demands through formal rostering of senior nurses.	Q2 & Q4	

Maternity and early years

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Make New Zealand the best place in the world to be a child

Activity	Milestone	Measure
1. CCDHB and HVDHB to work together to develop and implement a reformed **2DHB maternal and neonatal health system plan** that will deliver equitable outcomes for all women, babies and families living in Wellington, Porirua, Kāpiti, Lower Hutt and Upper Hutt. This work will consider the clinical and social risk factors (including mental health)	Q4	CW07 CW08 CW09

impacting the way people access services. (EOA) (2DHB) – *also an activity under 'Maternal mental health services'*		Status Update Report
2. Redesign a breastfeeding service, to provide a responsive, culturally appropriate, 7 day service to support to Māori and Pacific mothers, babies and whānau antenatally, on the ward and postnatally. (EOA)	Q1	
3. Review the impact of the Matua, Pepi, Tamariki service in Porirua in connecting Māori and Pacific families in Porirua with health and social services. This will include assessing impact on early engagement with Lead Maternity Carers (LMCs), completion of antenatal education, Sudden Unexplained Death in Infancy (SUDI) messages, smoking cessation support for the whole whānau and enrolment to Well Child/ Tamariki Ora services. (EOA)	Q4	
4. Co-design innovative models of care with Māori and Pacific women in order to improve outcomes. (EOA) This will include: (a) Exploring midwifery practice continuity models that fit the cultural context for Māori and Pacific women; (b) Explore options to improve access to ultrasound scanning (c) Examining the feasibility resourcing (including financial) of potential new case loading models of care; and (d) The impacts on Lead Maternity Carers of different case loading model approaches *also an activity under 'Working with sector partners to support sustainable system improvements' and 'Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori'*	Q2 & Q3	

Immunisation

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Make New Zealand the best place in the world to be a child

Equitable childhood immunisation coverage continues to be a priority for CCDHB. As outlined in our report we have a range of initiatives working with our Māori and Pacific providers to achieve this. These activities are guided by our strategic frameworks plans of Taurite Ora (Māori Health Strategy) and the CCDHB Health System Plan 2030 which both highlight the importance of equitable childhood immunisation coverage as priorities.

Executive oversight of Māori and Pacific childhood immunisation coverage is delivered through the childhood immunisation portfolio manager's close working relationship with the DHB Māori and Pacific leads who report to Director Māori Health. Childhood immunisation coverage is woven into their work programmes and we meet regularly to discuss progress towards equitable outcomes. Pre-COVID-19 we would meet three weekly to discuss our work programmes and these are scheduled to be restarted.

Activity	Milestone	Measure
1. Develop a guide for primary care and other providers/practitioners to guide conversations with families declining immunisations, with a focus on co-designing with Māori and Pacific families and providers. (EOA)	Q1 & Q3	CW08 Status Update Report
2. Optimise the links between maternity information systems, PHOs and the NIR. Close interface between secondary maternity, primary care information systems, and NIR will support timely precall and recall of children for immunisation. Currently some data from the maternity system does not correctly map to the NIR and PHO datasets, which means that outreach immunisation teams may not have access to the correct contact details and next of kin information to contact whānau. This will increase the likelihood of making timely contact and ultimately completing immunisations. This activity is expected to disproportionately support Māori and Pacific children, as they are less like to be enrolled and/or engaged with primary care. (EOA)	Q4	

School-Based Health Services (SBHS)

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Make New Zealand the best place in the world to be a child

Activity	Milestone	Measure
1. CCDHB will provide quantitative reports on the implementation of **school-based health services (SBHS)** in decile 1-5 secondary schools, teen parent units and alternative education facilities, as well as an additional five schools, Rongotai College, Tawa College, Wellington East Girls College, Kāpiti College and Paraparaumu College (EOA)	Q2 & Q4	CW12 Status Update Report Quantitative status update report provided on the implementation of SBHS. CCDHB will provide qualitative reports on the actions of the Youth Health Steering Group.
2. CCDHB will work with SBHS providers to ensure psychosocial assessments delayed because of COVID-19 restrictions will be up to date by the end of the 2020 school year. This will be achieved with the additional mental health support made available to all Colleges up to decile five. CCDHB will provide a narrative report including the outstanding number of assessments.	Q1 & Q2	
3. CCDHB will provide narrative reports on the actions of the **Youth Integrated Care Collaborative (ICC)** to improve the health of the DHB's youth population. These reports will include updates on the System Level Measures (SLM) for Sexual and Reproductive Health; sex and gender diverse healthcare, the integration of youth services in Porirua and any other pieces of work discussed at the Youth ICC.	Q1-Q4	
4. CCDHB will provide **additional mental health support** to work across the five secondary schools in Porirua which have higher Māori and Pacific populations. This will increase the ability to undertake HEEADSSS assessments as well as providing extra support as required. Narrative reports will be provided on progress and benefits of the additional mental health nurse capacity. (EOA)	Q2 & Q4	
5. CCDHB will implement **Youth Health Care in Secondary Schools** by continuing to work in co-design with the #YouthQuake panel to develop and implement the #YouthQuake Youth One Stop Shop for young people in Porirua subject to Board approval. Activities include: (a) update on the RFP progress (b) confirm provider for the #YouthQuake YOSS, (c) progress report on the new YOSS. (EOA) – *also an activity under 'Cross Sectoral Collaboration including Health in All Policies'*	(a) Q1; (b) Q2; (c) Q4	

Family violence and sexual violence

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have improved quality of life

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Work in partnership with Māori, HVDHB, and community providers to co-design and develop a joint **2DHB Family Violence Prevention Action Plan** for our communities, with a particular focus on at-risk population groups. This will include a range of prevention, early intervention and specific interventions to enhance safety for families and whānau. Q1- confirm scope project; Q2 – complete interviews, research, and analysis; Q3 - co-design and draft plan; Q4 - test, refine and approve plan. (EOA) (2DHB) – also an activity under '*Working with sector partners to support sustainable system improvements*'.	Q1-4	Complete the action plan
2. Continue the roll out of **Violence Intervention Programme** (VIP) training to DHB clinicians (medical, nursing and allied health) in designated services (Emergency Department, Women's Health, Children's Health, Community Mental Health Teams and Addictions Services). Target: 60% of clinicians completed VIP training	Q1-4	60% training rate

3.	Maintain (and where required increase) Routine Enquiry relating to Intimate Partner Violence (IPV) for eligible patients. Targets are: (a) 35% Emergency Department (b) 50% Children's Health (inpatient) (c) 80% Women's Health, Community Mental Health Teams and Addictions Service	Q1-4	As outlined in activity statement
4.	Maintain (and where necessary increase) disclosure rates (associated with Routine Enquiry) in line with the VIP clinical audit benchmarks in designated services; target: increase Routine Enquiry Disclosure Rates to >5%.	Q1-4	>5% disclosure rate
5.	Implement actions to strengthen the Maternity Wellbeing and Child Protection Group (MWCPG), in response the 2019/20 stakeholder review of the MWCPG	Q2	ToR implemented

Improving mental wellbeing

Mental Health And Addiction System Transformation

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have improved quality of life

Government priority outcome: Ensure everyone who is able to, is earning, learning, caring or volunteering

Activity	Milestone	Measure
Placing people at the centre of all service planning, implementation and monitoring programmes		MH01 MH02 MH03 MH05 MH06 Status Update Report
1. Work with co-design principles to ensure lived experience from service users and family / whānau is incorporated into planning and development. Seek regular input into key strategic and transformational projects from the 3DHB Lived Experience Advisory Group (LEAG). The LEAG membership is diverse and includes members who represent Māori, Pacific, youth and rainbow communities. In addition to providing feedback into key pieces of work the Co-chairs have agreed to add a recruitment function (for key roles) to their work programme for 20/21. (3DHB) We will strengthen the link between LEAG and provider arm clinical services consumer advisor roles with a specific goal of supporting greater service user leadership in monitoring consumer rights in clinical services.	Q1-Q4	
2. Expand CCDHB's mental health and AOD provider forum which includes primary care, NGO mainstream and kaupapa Māori services, to also include inter-sectoral representation. The forum will become a wider cross-sector network that can better address the underlying causes of poor mental health through co-ordinated cross-sector activity and inter-sectoral service linkages across the continuum. (EOA)	Q4	
3. Continue to work closely with the Māori, Pacific and Disability directorates to support the delivery of their respective strategic priorities in relation to Mental health & Addictions. (EOA)	Q1-Q4	
Embedding a wellbeing and equity focus		
4. Support and contribute to the development of a **collaborative between the Māori and Pacific service providers across CCDHB and HVDHB**. The collaborative will develop and implement culturally appropriate and community-based models of care. The goal of the collaborative is to work together to support service development and delivery, share information, build service resilience, and improve the sustainability of services – *also an activity under 'Working with sector partners to support sustainable system improvements' and 'Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori'* (EOA) (2DHB)	Q4	
5. In response to the MoH RFP 'Expansion and/or Replication of Existing Māori and Pacific Primary Mental Health and Addiction' CCDHB supported proposals on behalf of Maraeroa Marae, Te Waka Whaiora, Ora Toa PHO and Vaka Tautua. If the proposals are successful we will work alongside these services to implement the services. We also intend to support the Māori and Pacific providers with the next RFP for new services/innovations. These actions are subject to MoH funding. (EOA)	Q4	

6. Introduce a new flexi fund to the existing provider (Atareira) in order to increase the number of Children of parents with mental illness and or addiction **(COPMIA)** individual and group sessions delivered. (EOA)	Q4	
7. Continued collaboration with MoH, Councils and intersectoral agencies to deliver transformational change outlined in He Ara Oranga and Every Life Matters including the implementation of new primary mental health, Māori, Pacific and suicide post-vention services. (EOA)	Q2 & Q4	
8. The Te Ara Pai service model includes delivery of Individual Placement and Support (IPS), an evidence-based approach to employment support, provided by Workwise (Mental Health Solutions). This includes supporting clients into training or paid/unpaid employment or voluntary work. Te Ara Pai has been reviewed and we are now working on implementation of the recommendations to strengthen the model. (EOA)	Q2 & Q4	
9. Extend the **Primary Mental Health Liaison** services (free GP visits for people with severe and enduring diagnosed conditions) to include youth (18-24 yr olds) and people with substance use disorder. (EOA)	Q4	
Increasing access and choice of sustainable, quality, integrated services across the continuum		
10. Support and participate in the recently established **3DHB Greater Wellington Regional Collaborative** (GWRC) established to support the implementation of the integrated primary mental health and addictions service (Te Tumu Waiora model). The model aims to improve access into general practice services. General practices with high Māori, Pacific, youth and rural populations will be prioritised in the first tranche. (3DHB)(EOA)	Q2-Q4	
11. Implement the **3DHB 'Acute Continuum of Care'** to better match need to service provision, enhance coordinated service provision across a range of providers, and improve integration and patient flow through the system. This will include supporting prioritised pathways for responding to Māori mental health needs. Implementation of the model of care will address legacy barriers to NGO services meeting acute needs such as setting pricing to afford better levels and types of resource, and improved sustainability through improved volumes of clustered services. (3DHB)	Q4	
12. Develop an **integrated community mental health and wellbeing hub** model that will provide a timely response at a local community level to those who present in distress. Deliverable in 20/21 are twofold, to use a co design approach to design a service model and the completion of an investment business case to implement the model	Q4	
13. Redesign the existing **GP Primary Care Liaison service** to better align with the additional psychological therapies services in primary care (Piki, Te Tumu Waiora, Primary Solutions). This will include strengthening the team by bringing all team members together under one management structure, reviewing core business and best practice and growing the current team to ensure better coverage across the sub-region. (3DHB)	Q4	
14. Appoint 1FTE SMO to provide timely/easily accessible specialist advice and support to primary care.	Q2	
15. A **Co-Response team** pilot is underway to respond to mental health and addictions callers of 111. They work in partnership with Police and Ambulance emergency services to provide early response. Mental Health support workers have been employed to work and support the Crisis team by providing one to one care for clients awaiting crisis intervention. MHAIDS casual staff are being deployed to assist NGO respite facilities to manage clients in need of additional support. Duty managers are now employed to assist with the facilitation and management of clients requiring admission to either in patient units or crisis respite facilities after hours to 10pm seven days per week. An MHAIDS nurse has been located in ED to provide rapid assessments and facilitate access to mental health services to reduce waiting times.	Q2	
Suicide prevention		
16. Develop and begin implementation of a **3DHB suicide prevention and post-vention plan.** This plan and subsequent actions will incorporate goals from the national suicide prevention strategic plan 'Every Life Matters', and will focus on population groups at higher risk of suicide. (EOA) (3DHB)	Q1-Q4	

17. Establish post-vention interagency groups and/or processes to strengthen organisational responses where we see suicide numbers increasing (such as Ministry of Education, Tertiary institutions, communities and government departments) – *also an activity 'Cross Sectoral Collaboration including Health in All Policies'*	Q3	
18. Scope a "zero tolerance to suicide" project in partnership with the Emergency Department (ED), Whānau Care services, Pacific services and the hospital volunteers to improve responses and follow up for people who present to ED in distress (suicidal, self-harm). (EOA)	Q4	
19. Streamline and improve data collection and reporting on suicide numbers/self-harm presentations across the 3DHBs. This will include standardising documentation and electronic data capture to reflect sector standards. (3DHB)	Q1-Q4	
20. Recruit additional postvention capacity to the existing suicide prevention and post-vention team across the sub-region in line with the new funding from the Suicide Prevention Office.	Q2	
21. Transition the existing suicide prevention and post-vention team (which currently sits within the DHB's Strategy, Innovation and Performance team) out to a suitable provider in the community/primary care, in line with the strategic direction.	Q2	
Workforce		
22. Undertake workforce planning in partnership with NGO providers, including the development of a collective workforce development plan that will consider opportunities for investment. The plan will also include support for NZQA recognised peer support training and links with training institutions. The collective NGO workforce group will engage with workforce centres, including Central TAS to plan for our future workforce and include the "Let's get Real" framework. Plans will focus on retention, recruitment and training and the health and wellbeing of our workforce (2DHB)	Q1-Q4	
Forensics		
23. Work with the MoH to improve and expand the capacity of forensic responses from Budget 2020.	Q1-Q4	
24. Contribute to the National Forensic Framework project to improve the consistency and quality of services and to guide development of future services.	Q1-Q4	
Commitment to demonstrating quality services and positive outcomes		
25. Support and contribute to the **National KPI programme** established to focus on improvements in specific Key performance indicators. Whānau engagement – Adult services are focusing on improving whānau engagement across the services by establishing practise standards, auditing against those standards and using data to inform improvement work.	Q2-Q4	
26. Undertake a **Connecting Care project** which focuses on service transitions and the coordinated transfer of care between one health care or social service provider and another. The project aims to ensure that mental health and addiction service consumers receive continuous quality care between providers. (2DHB)	Q2-Q4	
27. Implement a **Creating Safety through Practice project** to improve the way we learn from adverse events. This project will engage all stakeholders and improve the experience of consumers, whānau and staff involved in an adverse event as well as supporting DHB's to define a consistent approach to responding to events which result in harm or have the potential to. The focus is on improving the review process to ensure we review events appropriately and in a timely way. We will also be looking at how we action any resulting recommendations. (2DHB)	Q2-Q4	
28. Ongoing quality assurance programme will ensure providers who use PRIMHD are providing accurate and timely reports by reducing duplication of data capture and improving the ability to monitor contract deliverables more effectively. (3DHB)	Q1-Q4	

Mental health and addictions improvement activities

Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
1. **Toward Zero Seclusion (TZS):** Complete TZS the National collaborative between DHB teams, mental health and addiction service consumers, the Health Quality & Safety Commission and Te Pou o te Whakaaro Nui (Te Pou), towards the elimination of seclusion by 2020	Q1-Q4	MH02 MH05 Status Update Report
2. **Improving Māori and Pacific Health Workforce:** Grow the Māori and Pacific workforce by increasing the number of scholarships offered to support workers and administrators to engage in the Bachelor of Nursing Programme. Increase the number of New Entrant to Specialist MH positions in Mental Health and Addictions and target Māori and Pacific graduates. (EOA)	Q2 & Q4	
3. **Marama RTF:** Complete implementation of the Marama Real Time Feedback project to collect client and whānau experience of the service in real time. Data collected will inform service performance and improvements.	Q2	
4. **Client Pathway:** Continue to develop and implement quality improvements for the He Ara Oranga (client pathway), ensuring best practise standards and high quality care for clients while providing visibility of digital client records that are accessible to GPs	Q3	
5. **ICT:** Implementation of the MH digital and data Intelligence projects, advancing and enabling an integrated system across the three DHBs, improved visibility, monitoring, and reporting through technology.	Q2	
6. **Learning from Adverse Events:** Creating safety through practice – improving the way we learn from adverse events. This project is to engage all stakeholders and improve the experience of consumers, family and whānau and staff involved in an adverse event, as well as supporting DHBs to define a consistent approach to responding to events which result in harm or have the potential to. Focus is on improving the review process to ensure we review events appropriately and in a timely way. We will also be looking at how we action any resulting recommendations.	Q4	
7. **Talking Therapies:** A project to increase the skills of current staff to deliver strong evidence based talking therapies and to improve access for clients to those therapies	Q2 & Q4	
8. **Supporting Parents Healthy Children:** A project that aims to support MHAIDS to develop a workforce that is confident and competent to have conversations with people about their parenting and their children; knows about the SPHC resources and links to local parenting and community supports and services; is able to recognise and respond to the needs of children and their family and whānau	Q2 & Q4	
9. **DNA:** Younger Persons services are focusing on reducing the number of Did Not Attend (DNA)	Q2 & Q4	

Addiction

Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities
MHAIDS provides community alcohol and drug assessment and treatment for adults living in the HVDHB region who have or are concerned they may have moderate to severe mental health and substance use disorders. The MHAIDS Opioid Treatment Service is based in Wellington and provides satellite clinics in Porirua, Kāpiti, Lower Hutt and Upper Hutt.

Activity	Milestone	Measure
1. Establish the AOD Collaborative Network to ensure key stakeholders remain engaged and participate in the co design and implementation of the Model of care. (3DHB)	Q4	Status Update Report
2. Complete the 3DHB Model of care and priority pathways for Māori, Pasifika, Youth, Rural and Remote areas, and Severe AOD. (EOA) (3DHB)	Q3	
3. Undertake a **Connecting care project** which focuses on service transitions and the coordinated transfer of care between one health care or social service provider and another. The project aims to ensure that mental health and addiction service consumers receive continuous quality care between providers. *Also an activity under 'Mental Health And Addiction System Transformation'*	Q2-Q4	
4. Continue the roll out of **Violence Intervention Programme** (VIP) training to DHB clinicians (medical, nursing and allied health) in designated services (including Community Mental Health Teams and Addictions Services); target: 60% of clinicians completed VIP training. *Also an activity under 'Family violence and sexual violence'*	Q1-4	
5. Maintain (and where required increase) Routine Enquiry relating to Intimate Partner Violence (IPV) for eligible patients presenting to designated as outlined below: (a) 80% Community Mental Health Teams and Addictions Service *Also an activity under 'Family violence and sexual violence'*	Q1-4	

Maternal mental health services

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have improved quality of life

Government priority outcome: Make New Zealand the best place in the world to be a child

In 2020/21, we will develop and expand existing maternal mental health services through the outlined activities

Activity	Milestone	Measure
1. Develop options to improve access to maternal mental health services supporting mild to moderate presentation, particularly for Māori, Pacific and those living in deprivation.(EOA) Consideration of options will include assessment of benefits using the Health Equity Assessment Tool, and any proposal evaluated for links between services such as early parenting support and infant mental health.	Q1-Q4	Status Update Report
2. Consider options to improve effective access to services according to presenting need, and enhance service integration to ensure the seamless transition of women between services.	Q1-Q4	
3. Continuing review of assessment and consultation clinic provided by Specialist Maternal Mental Health Service (SMMHS) for pregnant women who present to midwifery and Obstetric, where need for mental health support during perinatal period is indicated. SMMHS remain flexible in providing clinic services to support continuum of care and responsiveness for pregnant women and their whānau.	Q2 & Q4	
4. Attendance at the fortnightly meeting Maternal Care and Child Wellbeing meeting with other Maternity and Care Team providers in the DHB and community, to provide wrap around services to vulnerable women. These relationships assist with the access issues by working closely alongside professionals who have developed a relationship with a client who is struggling to engage.	Q1-Q4	
5. CCDHB and HVDHB to work together to develop and implement a reformed **2DHB maternal and neonatal health system plan** that will deliver equitable outcomes for all women, babies and families living in Wellington, Porirua, Kāpiti, Lower Hutt and Upper Hutt. This work will consider the clinical and social risk factors (including mental health) impacting the way people access services. (EOA) (2DHB) *Also an activity under 'Maternity and early years'*	Q4	

Improving wellbeing through prevention

Environmental sustainability

Government theme: Improving the wellbeing of New Zealanders and their families; Build a productive, sustainable and inclusive economy

System outcome: We live longer in good health

Government priority outcome: Make New Zealand the best place in the world to be a child

Activity	Milestone	Measure
1. Toitū CarbonReduce (formerly CEMARS) Audit	Q4	Status update report (Environmental and Border Health reporting template)
2. Travel Demand Management Improvements (Staff); Travel Demand Management Plan completed and implemented	Q4	
3. Organisation-wide Sustainability Reporting; First report for FY 2020/2021	Q4	

Antimicrobial Resistance (AMR)

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have improved quality of life

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Implementation of Antimicrobial Stewardship initiatives at CCDHB: (a) Antimicrobial stewardship rounds three times weekly (continuous) (b) Update of Empiric antimicrobial guidelines (published in Q3) (c) Point prevalence surveys on antimicrobial use carried out (Q2 & Q4) (d) Development and implementation of antibiotic de-labelling programme (development Q1, implementation and audit Q4) (e) Development and implementation of antifungal stewardship programme (Q4) (f) Provision of education to prescribers in primary care on antimicrobial prescribing – milestone – Q3 (in line with World antibiotic awareness week); report in Q4 (g) Proposal for increased AMS resource to facilitate community antimicrobial stewardship initiatives focused on high needs areas within DHB and on Aged and Residential Care facilities. Q1: business case to be submitted. (EOA)	Q2 - Q4 (a) Q1: AMS rounds; (c) Q2 and Q4: Point prevalence surveys	Status Update Report (on progress against the activities)
2. Initiatives for Surveillance & Research: (a) Continuous surveillance for multi-drug resistant organisms and hospital associated cases of CDI (report Q2 & Q4) (b) Hand hygiene (HH) auditing across all inpatient areas (continuous, report Q 2 & Q4) (c) Involvement in research on optimal antimicrobial treatment for serious infections (including various COVID-19 related audits)	Q2 & Q4 Q2 and Q4: Continuous surveillance; Q2 and Q4: HH auditing to include all inpatient areas;	
3. Initiatives for Awareness and Understanding: (a) Facilitate educational activities in age-related residential care (ARRC) sector during WHO World Antibiotic Awareness Week November 2020 to educate staff about Antimicrobial Resistance (AMR) (b) Celebrate World Hand Hygiene Day (5th May) in ARRC sector.	Q2 & Q4	

4. Initiatives for Infection, Prevention and Control: (a) Proposal for increased IPC CNS to specifically address gaps in IPC support and training for community including Aged and Residential facilities (b) Review and update of Aged and Residential care policies on outbreak and pandemic management (c) Work with ARRC Infection Prevention and Control (IPC) team members to ensure that national and/or local guidelines including those titled "Infection Prevention and Control and Management of Carbapenemase-producing Enterobacteriaceae" (MoH 2018) can be implemented in their setting	(a) Q2 (b) Q2 (c) Q4	
5. Initiatives for Governance, Collaboration and Investment: (a) Provide a notifiable communicable disease programme to prevent, identify and respond to exiting/emerging communicable diseases including prompt follow up of notifiable communicable diseases; detect and control of outbreaks; facilitate TB drug regimens completion; and promote infection prevention, control and immunisation in community and healthcare settings. (RPH) (core function – Health Promotion, Health Protection, Health Assessment & Surveillance, Public Health Capacity Development and Preventive Interventions) (3DHB) *also an activity under 'Communicable Diseases'* (b) Improve access to infectious disease related services for Māori and Pacific peoples (RPH) (core function – health promotion) (EOA) (3DHB) *also an activity under 'Communicable Diseases'* (c) Coordinate, co- deliver and enhance the Well Homes service in partnership with Tu Kotahi Māori Asthma Trust, He Kāinga Oranga (Otago University) and the Sustainability Trust; including assessments, intervention planning and delivery for families at risk of housing related illnesses (e.g. respiratory diseases and rheumatic fever) with priority to Māori, Pacific families. Provide a narrative report in Q2 and Q4. (EOA) (RPH) (2DHB; core function - health promotion) *also an activity under 'Cross Sectoral Collaboration including Health in All Policies'*	Q2 & Q4	

Drinking water

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Provide a drinking water programme as per the Environmental and Border Health Exemplar for Public Health Units. (RPH) (Core function-health protection) (3DHB)	Q2 & Q4	Status Update Report (Environmental and Border Health reporting template)
2. Use public health risk assessment to identify and target vulnerable populations (including communities with high Māori and Pacific Peoples populations. (EOA) (RPH) (Core function-health protection) (3DHB)	Q2 & Q4	

Environmental and Border Health

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Undertake activities as per the Environmental and Border Health Exemplar for Public Health Units including hazardous substances; border health; emergency planning and response; resource management, regulatory environments and sanitary works; and other regulatory issues. (RPH) (Core function - health protection) (3DHB)	Q2 & Q4	Environmental and Border Health report template

2. Use public health risk assessment to identify and target vulnerable populations (including communities with high Māori and Pacific Peoples populations. (RPH) (Core function -health protection) (EOA) (3DHB)	Q2 & Q4	

Healthy food and drink

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Ensure that the CCDHB Food and Beverage Guidelines are aligned with the National Healthy Food and Drink Policy (including RPH)	Q2	Status Update Report CW02
2. Ensure all food service providers operating on CCDHB sites are 100% compliant with the **Food and Beverage Guidelines**	Q4	
3. Ensure that all relevant contracts and licences to occupy contain clauses regarding service providers/tenants obligation to be 100% compliant with the guidelines	Q4	
4. In partnership with Sport Wellington and the Ministry of Education provide the **Healthy Active Learning** programme to schools and early learning services, with a continued emphasis on (a) water-only and (b) low decile schools with higher numbers of Māori and Pacific students. We will report on the number of Early Learning Services, primary, intermediate and secondary schools that have current water-only (including plain milk) policies and healthy food policies. (core function - health promotion). (EOA) (3DHB)	Q2 & Q4	

Smokefree 2025

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Undertake compliance and enforcement activities relating to the Smokefree Environments Act 1990. (RPH) (core function – health protection) (3DHB)	Q2 & Q4	SS06 CW09 PH04 Status Update Report
2. Advocate for and support Councils to investigate tobacco retailer regulation (RPH) (core function – health promotion) (3DHB)	Q2 & Q4	
3. Continue to support Māori and Pacific mothers/primary caregivers of children aged 0-1 living in Porirua to quit smoking through CCDHB's Hāpu Mama incentives programme (EOA)	Q4	
4. Promote access to stop smoking services, particularly for priority populations including both Ministry and DHB funded cessation services (DHB including RPH) (core function – health promotion) (EOA) (3DHB)	Q2 & Q4	
5. Working with Takiri Mai te Ata Regional Stop Smoking Service and community providers on strategies to improve smoking cessation, especially hāpu wāhine and other Māori women. To achieve this objective, we will establish regular meetings with Takiri Mai Te Ata Regional Stop Smoking service to collaborate on innovations, review service gaps, and develop actions together to improve the service for priority populations. (EOA)	Q2 & Q4	
SLM Improvement Plan		
6. Ongoing monitoring and support for Well Child Tamariki Ora Providers to embed data recording and collection to support babies living in smokefree homes (EOA)	SLM Reporting	

7. Increase utilisation of the Hapū Ora Smoking Cessation Incentive programme and Regional Stop Smoking Service by promoting these services through our antenatal education, LMC, breastfeeding services and primary care. (EOA)		
8. Continue to invest and evaluate the impact of non-traditional approaches to antenatal education including wahakura wānanga, which will deliver smokefree messages and support. (EOA)		

Breast Screening

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

CCDHB continues to work with the Regional Screening Services to achieve the 70% screening target for Māori and Pacific women.

Activity	Milestone	Measure
1. Regional Screening Services will continue to provide six **weekend breast-screening** clinics at each of the DHBs and aim to screen a target of 40 women at each clinic (dependent on medical imaging technologist resource). (2DHB) – *also an activity under 'New Zealand Cancer Action Plan 2019 – 2029'*	Q2 & Q4	PV01 Status Update Report Breast screening and DNA rates by ethnicity will be reported against
2. Regional Screening Service will implement more regular monthly evening breast-screening clinics during the working week and aim to screen a target of 15-20 women at each clinic (dependent on medical imaging technologist resource). (2DHB)	Q2 & Q4	
3. To support the national (BreastScreen Aotearoa) two-year pathway to achieve the 70% **screening target for Māori and Pacific women**, Regional Screening Services' recruitment and retention team will aim to support as many additional Māori and Pacific women as possible who are overdue or unscreened to attend a breast screening clinic (EOA) (2DHB)	Q2 & Q4	
4. Regional Screening Services will use the results of the BreastScreen Central Mammography Project for the most effective and efficient way of **increasing access to breast screening services** with a particular focus on improving access for Māori and Pacific women. The project will look at additional fixed sites and/or a replacement mobile unit. (EOA) (2DHB)	Q2 & Q4	
5. Regional Screening Services will continue to trial same **day biopsies and first specialist appointments** at the breast symptomatic clinic to facilitate access and faster cancer treatments depending on surgeon and radiologist resource. (2DHB) – *also an activity under 'New Zealand Cancer Action Plan 2019 – 2029'*	Q2 & Q4	
6. Regional Screening Services will work in partnership with local Māori and Pacific health providers, PHOs, and primary care and community health services, including multidisciplinary meetings and teleconferences, use of local clinics, and organising education and health promotional events. (EOA)	Q1-Q4	

Cervical Screening

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Support healthier, safer and more connected communities

CCDHB aims to achieve at least 80 percent participation of women aged 25-69 years in the most recent 36 month period, and eliminate equity gaps for Māori, Pacific, and Asian women

Activity	Milestone	Measure
1. **Free cervical screening clinics:** (a) Regional Screening will continue to provide weekend free cervical screening clinics, four per annum at Wellington Hospital and four at Hutt Hospital and aim to screen 35 women at each clinic to improve Māori and Pacific screening rates. These clinics will be combined with breast screening where possible. (2DHB) (EOA) (b) Regional Screening Services will provide approximately 16 free cervical screening clinics per annum in high-needs communities across the CCDHB region targeting Māori, Pacific, and Asian women. (EOA) – *also an activity under 'New Zealand Cancer Action Plan 2019 – 2029'*	Q2 & Q4	PV02 Status Update Report
2. **Primary Care:** (a) Regional Screening Services will increase linkages with general practices in the CCDHB region and will work with them using data matching reports to identify and offer support to priority group Māori, Pacific, and Asian women who are unscreened and under screened. (EOA) – *also an activity under 'New Zealand Cancer Action Plan 2019 – 2029'* (b) Regional Screening Services will partner with general practices with a high proportion of overdue or unscreened women and report the number of women who attend the four combined cervical and breast screening clinics for priority women. (EOA) (c) Regional Screening Services will work with Tū Ora Compass Health, Ora Toa PHO and Cosine PHO to identity general practices with high volumes of Māori, Pacific and Asian women overdue or underscreened. We will collaborate with these practices to support these women into a 'Free Cervical Screening Clinic'. (EOA)	Q2 & Q4	
3. Regional Screening Services will continue to promote key messages around the importance and benefits of cervical screening by attending events where priority populations gather, and educating and supporting women into the screening pathway. (2DHB) (EOA)	Q2 & Q4	

Reducing alcohol related harm

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. RPH continues to develop and improve our local knowledge of how alcohol adversely affects local communities, including using hospital and emergency department data. (3DHB) (RPH: core function – health assessment and surveillance)	Q2 & Q4	Reducing Alcohol Related Harm: Health Protection Planning/ Reporting template
2. Provide health protection activities relating to the Sale and Supply of Alcohol Act 2012. (3DHB) (RPH: core function – health protection)	Q2 & Q4	
3. Influence policies related to reducing alcohol related harm, e.g. Councils' local alcohol policies. (3DHB) (RPH: core function – health promotion)	Q2 & Q4	
4. Support communities to have a voice in local alcohol licensing decisions, alcohol and drug policy and legislation development. We engage with Māori and local community leaders to support them to advocate with their communities from their own lived experiences. (EOA) (3DHB) (RPH: core function – health promotion)	Q2 & Q4	

Sexual Health

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Provide information and advice to communities and health providers for sexually transmitted infections (STIs) outbreaks. (RPH: core function – health promotion)	Q2 & Q4	Status Update Report
2. Lead collaboration with relevant sexual health services and stakeholders to support the sexual health workforce to be able to respond to the sexual health issues identified by Māori and Pacific populations. (EOA) (RPH: core function – health promotion)	Q2 & Q4	
3. Support stakeholders to respond to sexual health issues identified by Māori and Pacific populations by providing advice, information and linking with relevant agencies and experts. (EOA) (3DHB) (RPH: core function – health promotion)	Q2 & Q4	
4. Implement the National Syphilis Action Plan. (3DHB) (including RPH: core function - health promotion)	Q2 & Q4	
5. Provide contact tracing/partner notification (3DHB) (RPH: core functions: health assessment & surveillance)	Q2 & Q4	

Communicable Diseases

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Provide a notifiable communicable disease programme to prevent, identify and respond to exiting/emerging communicable diseases including prompt follow up of notifiable communicable diseases; detect and control of outbreaks; facilitate TB drug regimens completion; and promote infection prevention, control and immunisation in community and healthcare settings. (3DHB) (RPH: core function – Health Promotion, Health Protection, Health Assessment & Surveillance, Public Health Capacity Development and Preventive Interventions) *also an activity under 'Antimicrobial Resistance (AMR)'.*	Q2 & Q4	Status Update Report
2. Improve access to infectious disease related services for Māori and Pacific peoples (EOA) (3DHB) (RPH: core function - health promotion) *also an activity under 'Antimicrobial Resistance (AMR)'.*	Q2 & Q4	
3. Provide BCG vaccination to children according to the Ministry of Health's eligibility criteria and vaccine availability. (2DHB) (RPH: core function - early intervention)	Q2 & Q4	

Cross Sectoral Collaboration including Health in All Policies

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have improved quality of life

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Co-plan and implement activities as a member of the Wellington Regional Healthy Housing Group. (3DHB) (RPH: core function – health promotion)	Q2 & Q4	Status Update

2. Provide the **Health in All Policies** programme (HiAP) focusing on influencing Councils' spatial planning and district plan reviews. (EOA) (RPH: core function – health promotion) (3DHB)	Q2 & Q4	Report - provide a qualitative status update report on progress of all activities
3. Coordinate, co-deliver and enhance the **Well Homes service** in partnership with Tu Kotahi Māori Asthma Trust, He Kāinga Oranga (Otago University) and the Sustainability Trust; including assessments, intervention planning and delivery for families at risk of housing related illnesses (e.g. respiratory diseases and rheumatic fever) with priority to Māori, Pacific families. (EOA) (2DHB) (RPH: core function - health promotion) *also an activity under 'Antimicrobial Resistance (AMR)'.*	Q2 & Q4	
4. The DHB will implement its **locality commissioning plan** to address equity and place based initiatives in Porirua, Wellington and Kāpiti. This will include all community activation engagements and stakeholder partnership relations. (EOA) – *also an activity under 'Working with sector partners to support sustainable system improvements'*	Q1	
5. **Suicide Prevention**: Establish postvention interagency groups and/or processes to strengthen organisational responses where we see suicide numbers increasing (such as Ministry of Education, Tertiary institutions, communities and government departments) – *also an activity under 'Mental Health And Addiction System Transformation'*	Q3	
6. CCDHB will implement **Youth Health Care in Secondary Schools** by continuing to work in co-design with the #YouthQuake panel to develop and implement the #YouthQuake Youth One Stop Shop for young people in Porirua. Activities include: (a) confirm provider for the #YouthQuake YOSS, (b) progress report on the new YOSS. (EOA) – *also an activity under 'School-Based Health Services'*	(a) Q1; (b) Q3	

Better population health outcomes supported by strong and equitable public health and disability system

Delivery of Whānau Ora

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Develop an equity plan with a focus on Māori health. – *also an activity under 'Engagement and obligations as a Treaty partner' and 'Māori Health Action Plan – Reducing health inequities- the burden of disease for Māori'*	Q2 & Q4: Narrative Report	SS17 Status Update Report
2. Design and implement a CCDHB policy to provide guidance on strengthening relationships with a range of Māori providers at every level of the organisation, including more representation on governance and advisory groups	Q4: Policy Developed	
3. Collaborate with Whānau Ora Commissioning Agency, Pasifika Futures and Whānau Ora providers within CCDHB to implement and identify opportunities for service change and possible investment	Q4: Narrative Report	

Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure

1. CCDHB commits to supporting delivery of the new Pacific health plan - Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan. (EOA)	Q4	Status Update Report

Care Capacity Demand Management (CCDM)

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Ensure everyone who is able to, is earning, learning, caring or volunteering

Activity	Milestone	Measure
1. Overarching annual and high level three year work plans in place and on schedule. All CCDM Work plans for each programme will be underpinned by existing CCDHB systems and processes focused on achieving equity for Māori, Pacific, People with disabilities, People with enduring mental illness, and People from lower socioeconomic and disadvantaged communities. Work plans for each programme standard in place. Review annual and 3 year work plans to ensure on schedule.	Q2 & Q4	Status Update Report
2. Governance (update on governance arrangements) (a) Continue to work in partnership with Unions (NZNO, PSA and MERAS) across all aspects of the programme. (b) Ensure CCDM Council meetings and all work stream meetings continue monthly and maintain oversight of all aspects of the CCDM programme.	Q2 & Q4	
3. Validated patient acuity (a) Implement TrendCare upgrades within three months of release. (b) Continue with monthly accuracy checks for all TrendCare using wards/units in readiness for FTE calculations. (c) Undertake improvement plans as required to achieve accurate data. (d) Inter rater reliability (IRR) testing annually and for all new staff to ensure compliance with the tool.	Q1	
4. Core data set (Continuous assessment of programme success through the core data set): (a) Continue to use the core data set to support data driven decision making (b) Implement customer and staff satisfaction measures when available (end of shift survey and HQSC patient experience data). (c) Measure success of the programme through the core data set.	Q1-Q4	
5. Staffing Methodology (EOA) (a) Undertake FTE calculations in all TrendCare using wards/units throughout the 2020 calendar year (dependant on TrendCare accuracy) as per the current CCDM work plan. (b) Increase the number of Māori and Pacific health professionals –where an increase in FTE is identified this provides an opportunity for employment for Māori and Pacific health professionals.	Q1-Q4	
6. Variance Response Management (a) Continue with current escalation plan development and implementation for speciality areas – Emergency Department, Maternity, NICU, and ICU. (b) Continue with development for Capacity at a Glance (CaaG) and variance indicator scoring (VIS) system. (c) Pilot CaaG and VRM system followed by full implementation across all wards/units.	Q1-Q4	

Disability Action Plan

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Ensure everyone who is able to, is earning, learning, caring or volunteering

Activity	Milestone	Measure
There is a 3DHB Strategy that is in place 2017-2022		Status Update Report
1. Extend data governance working group.	Q1	
2. Source and secure Data points across the 3 DHBs and external partners.	Q2	
3. Redesign information requirements of referrals ensuring disability is detailed and appropriate to inform a data strategy for the purpose of improving health outcomes.	Q4	
4. Education processes to enhance data capture are developed and actioned across the DHBs.	Q4	
5. Encourage stakeholders to work in partnerships to address challenges experienced by Pacific disabled people and their families by ensuring representation of Pacifica on the Sub Regional Disability Advisory Group, and ensuring data planning includes Pacific disabled people. (EOA - Faiva Ora Outcome)	Q2	

Disability

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Ensure everyone who is able to, is earning, learning, caring or volunteering

Activity	Milestone	Measure
1. Provide a human rights-based staff training framework, one that promotes equity and barrier free engagement with health services by disabled people. This will result in significant attitudinal change across the DHB's. Core disability responsive education will comprise of an initial e-learning programme of three modules that all staff must complete. This programme will ensure that all staff have foundational knowledge about disability, the rights based approach, the importance of attitude and how to make reasonable accommodations. Once this core learning has been completed additional modules can be provided that gradually build on knowledge and information as required - this can be taken to advanced levels.	Q2	Status Update Report
2. Deployment of effective disability alert system that is evident on all patient records. This will include a launch and education program for the workforce.	Q4	
3. Collaborate with the Ministry on targeted engagement by DHB's with disabled people in each region.	Q2	
4. Health information is to be accessible for disabled people in ways that promote their independence and dignity. The DHB is committed to working progressively to ensure all information intended for the public is accessible to everyone and that everyone can interact with services in a way that meets the individual need to promote their independence and dignity. NZSL will be used to convey public alerts across the DHB.	Q4	
5. Finalise the revised hard copy Health Passport and launch, with education program for public and staff across the 3 DHBs: (a) Agree version of prototype e-version of Health Passport	Q3; (a) Q4	

Planned Care

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
Improve understanding of local health needs.		SS07 SS08 Status update report *Data will always be disaggregated by ethnicity possible.*
1. Analyse current and forecast service capacity against population health needs, including an equity assessment, to identify the future investment requirements for planned care services.	Q4	
Balance national consistency and the local context		
2. HealthPathways will be localised or developed to support implementation of changes in care pathways including settings of care.	Q4	
Support consumers to navigate their health journeys		
3. Embed the Health Care Home programme which supports 80% of people enrolled with a primary care practice in the DHB area.	Q4	
4. Development of the Community Health Network programme of integrated care.	Q2 & Q4	
Optimise sector capacity and capability		
5. Work with clinical services, primary care and community partners to identify opportunities to shift services closer to home, ensuring all parts of the system are working to the top of their capability. The first example of this that will be delivered in 2020/21 is intra-vitreal injections in non-hospital settings.	Q2 & Q4	
Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.		
6. Progress the 2DHB Joint Health System Planning programme with Hutt Valley DHB to ensure our services are clinically and financially sustainable. This includes analysing and modelling different configurations of services that could operate at Wellington, Kenepuru and Hutt Hospitals – and assessing their future impact in terms of cost, equity, and health outcomes.	Q2 & Q4	

Acute Demand

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have health equity for Māori and other groups
Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. Agree with the Ministry of Health our plans to implement SNOMED coding in the Emergency Department by 1 July 2021. Activities include: (a) Complete an analysis of currently used ICD-10 codes and how they will map to the new SNOMED CT codes; (b) Review the three reference sets and determine which codes are appropriate to use; (c) Vendor complete programming changes in EDIS; and (d) Training ED staff in use of SNOMED CT	(a) Q1; (b) Q2; (c) Q3; and (d) Q4	Status Update Report
2. Reducing Acute Demand in ED by addressing the growth in acute inpatient admissions. Report in Q1 and Q3 on progress against the following activities:	Q1 & Q3	

(a) Decrease the time between referral and assessment for those patients who are referred to the MHAID service (Psych Geriatric, Crisis resolution, consult liaison) who either present to ED or are inpatients at either Wellington, Hutt or Kenepuru Hospitals. Activities include: recruit nursing staff to implement MH in ED model of care and co-response team and implement MH in ED MoC. (EOA) (b) Expand the implementation of Community Health projects aimed at reducing acute demand in ED and inpatient admissions.		
3. **Patient Flow**; reducing demand on emergency and hospital so our communities only using the hospital when they really need to, and getting people home sooner. The objective is to manage ED occupancy and avoid the need to open 30 additional beds at Wellington Regional Hospital. *– also an activity under 'Savings plans – in-year gains'* (a) Development of acute frailty pilot within existing beds (b) Roll out early supported discharge, enabled by Advanced Wellness at Home Initiative (AWHI) (c) Focus on patients with length of stay >10 days and increase proportion dischargers earlier in the day (d) Increase specialist rounding at weekends	(a) Q1; (b) Q3; (c) Q4; (d) Q2; and (e) Q4	

Healthy Ageing

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have improved quality of life

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. work with ACC, HQSC and the Ministry of Health to promote and increase enrolment in **Strength & Balance programs** and improve data driven osteoporosis management, using our alliance to promote and facilitate attainment of the target for fragility fracture protocol	Q1-Q4	SS04 Status Update Report
2. Develop an implementation approach for wider roll out of the **Advancing Wellness at Home Initiative (AWHI)** pilot programme led by Allied Health and involving community nursing and other community services to help older people who are medically fit for discharge but might need help to get home and to return to their functional and social activities.	Q2 & Q4	
3. Work with our two **Home and Community Support Services (HCSS)** providers to ensure consistent delivery of service across CCDHB and HVDHB, in line with the national service specifications and the National Framework (following a transition from one to two HCSS providers during 2019, and a shared contract between CCDHB and HVDHB). (2DHB)	Q2 & Q4	
4. Develop responsive **end of life care** for whānau and families informed by engagement and research undertaken during 2019/20 that includes a specific focus on meeting the needs of Māori whānau and Pacific families (EOA): • All referrals for providing last days of life community care will move from multiple nursing agencies to Mary Potter Hospice. • Staff providing this service will be employed by Mary Potter. They will have specialist training and immediate access to support from the wider hospice team. • The service offered can be tailored and responsive to the needs of each family, who may require RN input and/or care giver support. • This change enables Mary Potter to respond flexibly and to maintain a larger casual pool of trained staff who can work across the spectrum of services they provide.	Q2 & Q4	
5. Develop and implement a Model of Care (Moc) for older people with frailty to reduce the need for acute hospital admissions. The MoC will include teams within the community to	Q4	

support GPs as well as an allied health team that supports timely return home from hospital. The MoC moves between hospital and community. (EOA)		
6. Regional Dementia Service Approach: priorities for 2020/21 include: • Supporting the development of ACP within the dementia community through additional funding and 3DHB Advance Care Planning Facilitator • Participate in, and contribute to the Māori Equity Forum	Q4	

Improving Quality

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have health equity for Māori and other groups

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
Improving equity		PH01 SS05 Status Update Report SLM Reporting
1. Gout: Complete the project implementation with community pharmacies in Porirua to measure urate levels and adjust medication dosage where appropriate to prevent Gout, with a focus on Māori and Pacific (EOA).	Q4	
Improving Consumer engagement *Working within SURE (Supporting, Understanding, Responding, Evaluating) Framework. The aim of this framework is measure how District Health Boards are listening, responding to and partnering with consumers, and how they honour Te Tiriti o Waitangi in their consumer engagement planning and activities.*		
2. Supporting: Establish a CCDHB oversight group (CCDHB staff and consumers) for the Health Quality & Safety Commission (HQSC) Health Quality Safety Marker (QSM). The oversight group membership will reflect the priority populations of CCHDB (Māori, Pacific Peoples and People living with a disability). (EOA)	Q2 & Q4	
3. Understanding: Review and improve consumer data collection and entry in the feedback system (SQUARE) system with an emphasis on improving the quality of the data, in particular ethnicity and disability data. This aim links to "Taurite Ora Māori Health Strategy 2019-2030 'Specific patient- and service-focussed initiatives will ensure patient-experience information is collected, analysed and reported by ethnicity, including: a) a complaints/complements procedure' and the 'Sub-Regional Disability Strategy 2017 – 2022 Wairarapa, Hutt Valley and Capital & Coast District Health Boards Enabling Partnerships: Collaboration for effective access to health services' which puts disability data collection as an action point	Q2 & Q4	
Patient Experience of Care – see *Appendix: System Level Measures Improvement Plan*		
4. DHB Patient Experience Quality Safety Marker (QSM) oversight group established to oversee the implementation and delivery of consumer engagement and the QSM	SLM Reporting	
5. Process and template developed for acting on the consumer voice that is already collected and feeding this into the quality improvement cycle		
6. Support implementation of the new patient experience survey by establishing a process to highlight the importance of the survey and to monitor the uptake by populations we know we don't serve so well and try to fill the gap		
7. Implement a process to capture feedback from our least heard from consumers		
8. Work with the provider of the new patient experience survey to ensure we are capturing the voice of all the consumers – especially those in priority groups		

New Zealand Cancer Action Plan 2019 – 2029

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. On-going work to maintain and improve FCT performance measures (as per existing quarterly reporting). Activities include: Review service arrangements with regional DHBs supported by CCDHB to provide Oncology services; ensuring equity of access to services and treatment. (EOA)	Q1-Q4	SS01 SS11 Status Update Report Breast screening and DNA rates by ethnicity
2. Regional Screening Services will continue to provide six **weekend breast-screening** clinics at each of the DHBs and aim to screen a target of 40 women at each clinic (dependent on medical imaging technologist resource). (2DHB) – *also an activity under 'Breast Screening'*	Q2 & Q4	
3. To improve Māori and Pacific screening rates and achieve at least 70% coverage, Regional Screening Services will continue to provide **weekend breast screening clinics and cervical screening clinics**, and monthly evening sessions, rotated to different sites across the sub-region. (2DHB) – *also an activity under 'Breast Screening' and 'Cervical Screening'*	Q2 & Q4	
4. Regional Screening Services will continue to trial same **day biopsies and first specialist appointments** at the breast symptomatic clinic to facilitate access and faster cancer treatments depending on surgeon and radiologist resource. (2DHB) – *also an activity under 'Breast Screening'*	Q2 & Q4	
5. Regional Screening Services will provide approximately 16 free cervical screening clinics per annum in high-needs communities across the CCDHB region targeting Māori, Pacific, and Asian women. (EOA) – *also an activity under 'Cervical Screening'*	Q2 & Q4	
6. Regional Screening Services will increase linkages with general practices in the CCDHB region and will work with them using data matching reports to identify and offer support to priority group Māori, Pacific, and Asian women who are unscreened and under screened. (EOA) – *also an activity under 'Cervical Screening'*	Q2 & Q4	
7. Regional Screening Services will work in partnership with local Māori and Pacific health providers, PHOs, and primary care and community health services, including multidisciplinary meetings and teleconferences, use of local clinics, and organising education and health promotional events.	Q2 & Q4	

Bowel Screening and colonoscopy wait times

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have health equity for Māori and other groups
Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. CCDHB will implement the **National Bowel Screening Programme** in 2020/21, subject to passing the Ministry of Health Readiness assessment.	Q1-Q4	SS15 Status Update Report
2. CCDHB will endeavour to ensure **colonoscopy wait time** indicators are consistently met. Our waitlists are continuously prioritised for clinical acuity, wait time, and length of time waiting by ethnicity. To reduce waiting times we are continuing to outsource	Q1-Q4	

colonoscopies. Māori and Pacific patients will be prioritised for outsourcing and supported with their travel. (EOA)		
3. CCDHB will continue to endeavour to ensure **equitable access** throughout the screening pathway: Establish the provision of colonoscopy services at Kenepuru Community Hospital (to promote Māori and Pacific attendance). This facility will also enable CCDHB to reduce waiting lists and support screening once the National bowel screening programme commences (EOA)	Q2	

Workforce

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
CCDHB Workforce Priorities		
1. **Workplace culture:** Creating a workplace culture that aligns with our strategy, keeps our values at the heart of everything we do and drives high performance. Milestones include: (a) Values embedded into people systems and processes (e.g. role descriptions, recruitment processes); (b) Mechanisms in place to empower people to enact values (c) Areas where values conflict identified and strategies for resolution identified (d) Values embedded into high performance system.	(a) Q1; (b) Q2; (c) Q3; and (d) Q4	Status Update Report
2. **System Capability**: Ensuring that our people are supported by robust data, that the skills and capabilities of our leaders and our people reflect the clinical and operational needs of our health system. Milestones include: (a) Leadership framework defined (b) Coaching for leaders as agents and examples of values engagement and culture in place (c) Networks, forums and development plans to support Māori and Pasifika leaders established (d) Mechanisms to strengthen our ability to identify talent and create a leadership talent pipeline in place.	(a) Q1; (b) Q2; (c) Q3; and (d) Q4	
3. **Equity**: Supporting our workforce to achieve increased equity outcomes, particularly for Māori, Pacific and people with disabilities. (EOA) – *also an activity under* '*Māori Health Action Plan – Shifting cultural and social norms*' Milestones include: (a) Te Reo used in job titles (b) Workforce understanding of Māori health and equity increased (c) Workforce development focussed on cultural leadership, safety and competency embedded	(a) Q1; (b) Q1-Q2; and (c) Q3	
4. **Employee experience**: Enhancing our employee experience by valuing wellbeing, delivering practical, easy to navigate people systems and processes, and ensuring our people have clear roles and accountabilities. Milestones include: (a) 2DHB high performance and development framework defined (b) Framework piloted	(a) Q1-Q2; and (b) Q3-Q4	
Workforce Diversity: The diversity of our workforce needs to reflect the communities we serve. Specific strategies to attract, recruit and retain our Māori, Pacific and disability workforce are key priorities.		

5. We will build our understanding of our workforce through better use of workforce data, and ongoing use of survey tools. We will develop our ability to integrate workforce intelligence and utilise forecasting tools. Milestones include: (a) Include high quality diversity data in all our recruitment data collection and reporting (b) Upgrade existing workforce diversity data to enable enhanced accuracy of diversity data reporting. (c) Integrate the recruitment data into our payroll data base, involves upgrading payroll system	(a) Q1; (b) Q2; and (c) Q3	
6. We will continue to build the capability of our new graduates through our commitment to workforce initiatives and high quality training for groups such as; RMO Postgraduate Year 1 and 2 (PGY 1s and 2s), our New Entry to Specialist Practice programme for nursing, nurse practitioner talent mapping, and Community Based Assignments for medical trainees. Activities include: (a) Work with clinical leads to provide structured new entry to practice programmes for nursing, medical and allied health graduates. (b) In consultation with clinical leads and tertiary providers monitor the effectiveness of the transition between training and workplace to ensure a positive experience for all trainees.	Q2 & Q4	
Health Literacy: To achieve gains in equity of outcomes, a focus on health literacy will be important. This includes our workforce having effective understanding of responsibilities under Te Tiriti O Waitangi and ability to enact Te Tiriti.		
7. Taking a planned approach to embedding and extending programmes already initiated will be important in the coming year. Activities include: (a) Extend uptake of health literacy eLearning across workforce. (b) Embed health literacy focus into on boarding for all new staff.	Q2 & Q4	
Cultural Safety		
8. Focus this year will be to enact the intentions outlined in the Māori Health strategy (2019) and Central Region Equity Framework. This will include a focus on increasing the cultural intelligence and safety of our workforce, with a particular emphasis on understanding and challenging bias. Activities include: (a) Extend uptake of equity eLearning across workforce. (b) Embed equity focus into on boarding for all new staff. (c) Commence the education of our workforce about recognising and addressing unconscious bias using eLearning modules.	(a) Q2 & Q4; (b); Q3 & Q4; and (c) Q4	
9. This also includes ensuring that our attraction and recruitment processes are culturally safe. In the first instance, this means being able to provide accurate ethnicity data from our people systems. Activities include: (a) All job titles expressed in Te Reo and English. (b) Project to revise attraction, recruitment and on boarding to ensure cultural safety and to attract Māori workers.	(a) Q1; and (b) Q2	
Leadership		
10. Leadership activities in the coming year will focus on adapting our current approach of developing individual leaders to strengthening leadership as a core capability and an enabler for achieving organisational priorities. Milestones include: (a) Leadership framework designed; (b) Leadership framework piloted implementation; (c) Leadership framework implementation commences.	(a) Q1; (b) Q3; and (c) Q4	

11. We will put support mechanisms in place for our senior leaders to role model and to actively develop leadership capability in their leaders and across the DHBs. Milestone includes: (a) Design a leadership pipeline that includes an approach that will support us to identify future leaders and manage this talent.	(a) Q2	
12. Work with Māori, Pacific and people with disabilities to identify how to enhance mana to empower full participation in leadership and governance within the DHBs. Milestones include: (a) Reference group of Māori and Pasifika leaders established to provide guidance on the development of leadership initiatives. (b) Networks to support Māori and Pasifika leaders established.	(a) Q1; (b) Q2	
Pandemic Preparedness		
13. A 2DHB health system Workforce Office was set up to support coordinated workforce planning and deployment for COVID-19 during the response. A 'virtual' workforce office continues to monitor requests and can be stood up if required. The virtual office continues to hold a database of staff who may be available for redeployment during any future response. Milestones include: (a) Review carried out (b) Systems and processes used by the Office are documented so they can be retrieved and used.	(a) Q1; (b) Q2	
14. HVDHB and CCDHB have developed an Aged Residential Care (ARC) Contingency Plan as part of the COVID-19 Response. The Plan sets out how the HVDHB and CCDHB will support the management of a COVID-19 outbreak in an Aged Residential Care (ARC) facility (including workforce considerations).	Q1: Plan finalised	
15. A 20DHBs Emergency Response Function was established to support coordinated workforce response for COVID-19. The structure and operating model were identified and stood up during the response. This function remains on standby, to enable rapid response for future pandemic events.	Q1: Function enabled for standby status.	

Data and Digital

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Support healthier, safer and more connected communities

Activity *(strategic intentions of the 3DHB ICT services outlined in Building Capability)*	**Milestone**	**Measure**
1. **Achieving stability of critical systems - Concerto clinical portal consolidation:** This 3DHB initiative will bring Concerto back into support, provide consistent features and enable sharing of patient information across the three DHBs. This will reduce long run costs of the clinical portal, and enable migration to regional infrastructure. This will also ensure that there is consistent clinical service experience for Māori and other groups across the three DHBs. The software component of this project is an enabler for electronic referrals. CCDHB migrated onto the new Concerto software 01 June 2021. (EOA)	Q4	Status Update Report
2. **Significant improvement to operational efficiency and patient care – Mobile Electronic Patient Observations:** This project is delivering the implementation of a platform for Patient Observations, Early Warning Score Management and Nursing Documentation across our three DHBs. First deployment into the CCDHB children's ward by Q4.	Q4	

3. **Transforming services to be fully digital - Digital Workplace** The goal of this programme of work is to minimise digital boundaries so staff can securely connect to DHB information anywhere, anytime, anyway. This will transform how our people operate enabling more effective and efficient service delivery. The work is a multi-year change programme based on digital workplace tools such as Information Management, Microsoft Teams, increasing mobility of our workforce, and providing a single interface where a person can access everything they need to do their job. Activities include: first iteration of modern desktop Q2; First delivery of communication tools (i.e. exchange online) Q2; Implemented knowledge management framework Q3.	Q3	
4. **Mandated outcome - Fax end of life** The Ministry of Health have mandated phasing out the use of analogue fax by health sector agencies by December 2020. The MOH mandate is to support secure digital communication within the NZ health and disability sector. First use case made fax free September 2020. Many fax use cases have work arounds or is on new technology by Q4.	Q4	
5. **Submit quarterly reports on the DHB ICT Investment Portfolio to the Ministry of Health**	Q1-Q4	

Implementing the New Zealand Health Research Strategy

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We live longer in good health

Government priority outcome: Ensure everyone who is able to, is earning, learning, caring or volunteering

Activity	Milestone	Measure
1. Implementation of NZ Health Research Strategy (a) Develop 2DHB Research Strategy that aligns with the MOH NZ Health Research Strategy. (b) Collaborate with National Research Managers group to engage and provide support to the successful HRC grant applicants (Health Delivery Grant and other DHB specific grants as part of the Health Research Strategy)	(a) Q2; (b) Q1-Q4	Research Strategy developed and approved by the ELT and the Board in Q2
2. Work regionally to further develop research & analytics networks: (a) Attend monthly regional research collaboration meetings (b) Work with our regional research collaborators and partners to create research, support and further develop existing research networks. (c) Support and develop research leaders who prioritise collaborative team science—aligning basic, clinical and health services research with a shared aspirational vision of a healthier region (d) Support new researchers to build capacity and to be more proactive about succession planning (e) Build symbiotic relationships with local universities and health partners.	Q1-Q4	Provide monthly stat clinics to 2DHB staff as part of the analytical support and collaboration with Victoria University of Wellington.
3. Policy and procedure development: (a) Research procedure and policy development and implementation to ensure that is a live document; update the 2DHBs research policy in line with new HDEC guidelines 2020 and other regulatory bodies as required	Q1-Q4	Provide a status update report outlining progress
4. Produce and Annual Research Report and Summary Report to MoH and Board at end of Q4	Q4	Completed Annual Research Report and Summary Report by Q4

Delivery of Regional Service Plan (RSP) priorities and relevant national service plans		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
CCDHB will support the region to deliver the RSP:		Status Update Report
1. Support work in our region's identified priority areas (Cancer, Cardiac, Radiology, and Regional Care Arrangements)	Q1-Q4	
2. Hepatitis C: support work in the region to encourage optimal Hepatitis C virus care in general practice, including encouraging primary health staff to request more Hepatitis C tests, and implementing and publicising the new regional pathways for Hepatitis C.	Q1-Q4	

Better population health outcomes supported by primary health care

Primary health care integration		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
1. Embed telehealth models of care that began during COVID to enable patients to appropriately receive primary and secondary care services.	Q2 & Q4	PH01; PH03 Status Update Report
2. Co-design and establish at least one Community Health Network in Porirua, guided by ethnicity and outcome based analysis. (EOA)	Q2 & Q4	

Air Ambulance Centralised Tasking		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**
1. CCDHB remains committed to the 10 year plan to achieve a high functioning and integrated National Air Ambulance service and will participate through the National Ambulance Collaborative to achieve this. CCDHB will support the implementation of changed Governance arrangements to include DHBs to effect improved partnership with MoH and ACC in all elements of leadership of the National Ambulance Sector Office (NASO) work programme, and supports the development of a robust national process to scope the requirements of a national tasking service.	Q4	Status Update Report

Pharmacy		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
Activity	**Milestone**	**Measure**

1) Support the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA) and prioritise local need and support equitable health outcomes: the major focus of new Pharmacy investment within CCDHB through Community Pharmacies, and of Pharmacy Facilitation services, will be activities in areas of both high deprivation and high Māori and Pacifica populations. Specifically: (a) Complete the project implementation with community pharmacies in Porirua to measure urate levels and adjust medication dosage where appropriate to prevent Gout, with a focus on Māori and Pacific (EOA). (b) Complete a review and trial a replacement for Long Term Conditions (LTC) services for complex patients in the community, including a clinical pharmacist service. (c) Encourage and support Pharmacies to provide funded influenza immunisation. Increase both the number of pharmacies delivering such a service and the total population vaccinated by pharmacies. Use of web based publicity and signage within the community to inform the public about subsidised immunisation. (d) Survey community pharmacies on the impact of COVID-19 to identify the opportunity for service development and DHB support in the post-COVID period. (e) Continue funding of clinical pharmacists in practices with a high numbers of older persons in order to reduce polypharmacy.	(a) Q4; (b) Q4; (c) Q1; (d) Q2; and (e) Q4	Status Update Report

Long-term conditions including diabetes

Government theme: Improving the wellbeing of New Zealanders and their families

System outcome: We have improved quality of life

Government priority outcome: Support healthier, safer and more connected communities

Activity	Milestone	Measure
1. The DHB and Primary Care will continue to implement support for people to **live healthy lifestyles** through behavioural change support, health coaches and health improvement practitioners (EOA)	Q2 & Q4	SS13 Status Update Report
2. The DHB and RPH will work with communities to deliver initiatives that **promote healthy nutrition and physical activity** with a localities focus (eg, via the Porirua regeneration project). (EOA)	Q2 & Q4	
3. The DHB will continue to work with PHOs to share best practices for early **cardiovascular risk assessment** and management for people with moderate to high cardiovascular risk across general practices from those delivering the most equitable outcomes (EOA); Increase the number of people with high cardiovascular risk who have had an annual review	Q4	
4. Implement initiatives to improve equitable access to and outcomes from **culturally appropriate self-management education** and support services as identified during 2019/20 assessment against the Quality Standards for Diabetes Care.	Q2 & Q4	
5. Our Diabetes Clinical Network will use **practice level data** to identify inequitable service provision and inform quality improvement initiatives (EOA)	Q2 & Q4	
6. Implement initiatives that **improve access to retinal screening** (TBC depending on investment) (EOA)	Q4	

2.2. Financial performance summary

The prospective planned result for Capital and Coast DHB 2020/21 annual plan is a deficit of $39.8 million. The forecast result for 2019/20 is a deficit of $44.2 million. This includes $8 million related to COVID-19 costs plus a Holiday Act revaluation addition of $12.4m. The planned result for 2021/22 includes a donation of $60 million towards the building of the new Children's Hospital. The DHB is working towards a break even position by 2022/23.

Financial Performance Summary

Capital & Coast DHB Annual Plan Budget for the Four years ending 30 June 2024	2018/19 $'M	2019/20 $'M	2020/21 $'M	2021/22 $'M	2022/23 $'M	2023/24 $'M
Funding (excluding IDF inflows below)	943.5	990.9	1,032.3	1,136.6	1,129.2	1,184.1
Services provided for Other DHBs (IDF Inflows)	218.2	227.3	242.2	251.9	262.0	272.5
Total Funding	**1,161.6**	**1,218.2**	**1,274.6**	**1,388.5**	**1,391.2**	**1,456.6**
DHB Provider Arm	860.2	841.5	879.2	903.9	926.2	976.5
Funder Arm	290.3	312.0	321.6	334.3	343.8	353.6
Governance Arm	11.0	10.8	10.6	10.8	11.0	11.3
Services Purchased from Other DHBs (IDF Outflows)	96.4	98.1	103.1	106.2	109.3	112.6
Total Allocated	**1,258.0**	**1,262.4**	**1,314.4**	**1,355.2**	**1,390.4**	**1,454.0**
Surplus / (Deficit)	**(96.4)**	**(44.2)**	**(39.8)**	**33.3**	**0.9**	**2.6**

CCDHB Prospective Financial Performance

Capital & Coast DHB Statement of Comprehensive Income & Expenditure Plan for the Four Years ending 30 June 2024	Actual 2018/19 * (000s)	Forecast 2019/20 ** (000s)	Plan 2020/21** (000s)	Plan 2021/22 (000s)	Plan 2022/23 (000s)	Plan 2023/24 (000s)
REVENUE						
Government and Crown Agency Sourced	1,126,347	1,187,473	1,244,451	1,297,846	1,359,900	1,424,614
Patient / Consumer Sourced	5,238	5,527	4,965	5,064	5,166	5,269
Other Income	30,036	25,189	25,143	85,637	26,141	26,703
TOTAL REVENUE	**1,161,621**	**1,218,189**	**1,274,560**	**1,388,548**	**1,391,207**	**1,456,586**
OPERATING COSTS						
Personnel Costs						
Medical Staff	187,670	175,829	185,399	189,261	193,217	199,767
Nursing Staff	238,301	233,986	234,861	244,244	249,342	257,752
Allied Health Staff	63,990	63,729	69,242	70,684	72,162	74,611
Support Staff	10,930	9,759	10,977	11,208	11,442	11,830
Management / Administration Staff	72,008	71,657	77,509	79,128	80,783	83,527
Total Personnel Costs	**572,898**	**554,959**	**577,988**	**594,525**	**606,946**	**627,486**
Clinical Costs						
Outsourced Services	24,601	28,267	31,922	32,476	33,040	33,843
Clinical Supplies	130,291	131,045	139,820	144,967	150,182	156,410
Total Clinical Costs	**154,891**	**159,312**	**171,742**	**177,443**	**183,221**	**190,253**
Other Operating Costs						
Hotel Services, Laundry & Cleaning	23,809	25,054	25,819	26,310	26,810	27,461
Facilities	43,401	43,363	45,016	45,872	48,243	50,879
Transport	3,157	2,537	3,029	3,086	3,145	3,221
IT Systems & Telecommunications	13,454	16,336	15,536	15,831	16,132	16,524
Interest & Financing Charges	29,850	24,485	22,836	23,270	23,712	24,289
Professional Fees & Expenses	7,258	7,637	108	110	112	115
Other Operating Expenses	10,886	6,303	17,286	17,614	17,949	36,385
Democracy	432	776	505	515	524	537
Provider Payments	386,764	410,103	424,626	440,502	453,187	466,252
Recharges	11,193	11,497	9,884	10,124	10,370	10,622
Total Other Operating Costs	**530,204**	**548,091**	**564,646**	**583,234**	**600,185**	**636,285**
TOTAL COSTS	**1,257,993**	**1,262,362**	**1,314,375**	**1,355,202**	**1,390,352**	**1,454,024**
NET SURPLUS / (DEFICIT)	**(96,373)**	**(44,173)**	**(39,815)**	**33,345**	**855**	**2,562**

***Asset Revaluation (Equity movement - IRFS requirement)	(5,350)	(702)	-	-	-	-
TOTAL COMPREHENSIVE INCOME SURPLUS/(DEFICIT)	**(101,723)**	**(44,875)**	**(39,815)**	**33,345**	**855**	**2,562**

* Please note that the 2018/19 and 2019/20 actuals include adjustments for year end provisions i.e. Holidays Act and write offs.

** Please note that final audited actuals for the 2019/20 year are pending. Plan for 2021/22 includes a donation of $56m from benefactor towards the Children's Hospital

*** 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 presentation purposes, and doesn't change the target the DHB is working to. The DHB is still working to the 'Net Surplus / (Deficit), rather than the 'Total Comprehensive Income' amount.

Prospective Financial Position

Capital & Coast DHB **Statement of Financial Position** **Plan for the Four Years ending 30 June 2024**	**Actual 2018/19 * (000s)**	**Forecast 2019/20 ** (000s)**	**Plan 2020/21** (000s)**	**Plan 2021/22 (000s)**	**Plan 2022/23 (000s)**	**Plan 2023/24 (000s)**
Non Current Assets						
Land	41,165	40,352	40,352	40,352	40,352	40,352
Buildings	447,637	429,528	505,581	605,881	636,263	648,148
Clinical Equipment	33,611	32,635	46,756	65,251	84,618	98,317
Information Technology	14,921	17,416	31,146	44,804	58,389	71,880
Work in Progress	42,115	68,943	64,943	69,643	56,843	56,843
Other Fixed Assets	4,374	4,196	6,385	8,553	10,699	12,816
Total Non Current Assets	583,823	593,071	695,163	834,484	887,164	928,356
Current Assets						
Cash	33	6,554	31	31	31	31
Trust/Investments	10,754	11,683	11,683	11,683	11,683	11,683
Prepayments	4,197	6,257	6,257	6,257	6,257	6,257
Accounts Receivable	58,394	48,571	49,375	49,375	49,375	49,375
Inventories	9,046	8,995	8,995	8,995	8,995	8,995
Other Current Assets	(6,528)	804	-	-	-	-
Total Current Assets	75,896	82,864	76,341	76,341	76,341	76,341
Current Liabilities						
Bank overdraft	2,704	-	39,739	79,844	110,554	137,168
Payables & Accruals	215,766	251,678	239,579	239,579	239,579	239,579
GST & Tax Provisions	9,642	9,820	9,820	9,820	9,820	9,820
Current Private Sector Debt	55	-	-	-	-	-
Capital Charge Payable	-	(252)	-	-	-	-
Total Current Liabilities	228,167	261,246	289,137	329,242	359,952	386,566
Net Current Assets	(152,271)	(178,382)	(212,796)	(252,901)	(283,611)	(310,225)
NET FUNDS EMPLOYED	**431,552**	**414,689**	**482,367**	**581,583**	**603,553**	**618,132**
Term Liabilities						
Restricted & Trust Funds Liability	72	95	95	95	95	95
Non Current Provisions & Payables Personnel	6,958	7,169	7,169	7,169	7,169	7,169
Total Term Liabilities	7,029	7,264	7,264	7,264	7,264	7,264
Net Assets	**424,523**	**407,424**	**475,102**	**574,318**	**596,288**	**610,867**
General Funds						
Crown Equity	774,716	812,773	920,266	986,137	1,007,253	1,019,269
Revaluation Reserve	131,361	130,660	130,660	130,660	130,660	130,660
Trust & special funds no restriction	10,648	-	-	-	-	-
Retained Earnings						
Retained Earnings - DHB	(492,203)	(536,008)	(575,823)	(542,478)	(541,624)	(539,062)
Total Retained earnings	(492,203)	(536,008)	(575,823)	(542,478)	(541,624)	(539,062)
Total General Funds	424,523	407,424	475,102	574,318	596,287	610,867
NET FUNDS EMPLOYED	**431,552**	**414,689**	**482,367**	**581,583**	**603,553**	**618,132**

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 $134 million is planned for 2020/21. This includes $67.7 million for equity funded capital projects.

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;
- Pharmaceutical costs for cancer related treatments;
- COVID-19 related pressures and risks

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 2020/21 is $62 million. Baseline CAPEX is required to be funded internally.

Equity Drawing

Additional deficit support may be requested for the 2020/21 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.

SECTION THREE: 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 2019/20.

3.2 Service Change

The table below describes all service changes that are for implementation at CCDHB in 2019/20. Sub-regional service changes that do not affect the CCDHB domiciled population are excluded.

Summary of Service Changes for 2020/21:

Change	Description of Change/Initiatives	Benefits of Change	Change for local, regional or national reasons
MHAIDS Structural Review	Following multiple consultation processes, decisions have been taken to introduce a Tier 2 Clinical Partnership Model within MHAIDS. This will see the leadership of MHAIDS being jointly delivered by an Executive Clinical Director and an Executive Operations Director. Both positions will sit on the DHBs Executive Leadership Teams and report to the joint Chief Executive of CCDHB and HVDHB. Once these positions are in place there will be further work undertaken to determine what if any further changes are required to strengthen local leadership, improve equity outcomes and embed clinical and operational partnership throughout the service. The three sub-regional Boards have also agreed that the MHAIDS service should be delivered by CCDHB on their behalf. Therefore all MHAIDS staff, including Wairarapa and Hutt Valley based people, will become CCDHB employees. This will significantly simplify operations and ensure maximum efficiency.	• Improved governance structures, strengthened clinical and operational partnership, and stronger locality leadership presence.	3DHB - Hutt, Capital & Coast, and Wairarapa
Patient Flow: Managing Acute Flow at Wellington regional and	• Development of acute frailty pilot within existing beds • Roll out early supported discharge, enabled by Advanced Wellness at Home Initiative (AWHI) • Focus on patients with length of stay >10 days and increase proportion dischargers earlier in the day	• Avoid the need to open additional beds at WRH and ensure ongoing length of stay management. • Reduce avoidable readmissions and ensure	Sub regional

Change	Description of Change/Initiatives	Benefits of Change	Change for local, regional or national reasons
Kenepuru Hospital	• Increase specialist rounding at weekends • Increase flow out of ED into Child Acute Assessment Pathway in ED	people are well supported in the community reducing overall bed days especially for older people. • Improved patient flow through ED and reduce nursing demand	
Hospital Provider Performance	Production Planning: CCDHB and HVDHB have created a single approach to Planned Care delivery; • Joint 2DHB plan to deliver local volumes and manage through peak occupancies • Robust outsourcing including price management • Electronic referrals management programme • Embedding virtual outpatient assessments and virtual advice to GPs Operating Room Utilisation: • Maximise use of Kenepuru hospital operating rooms – focus on day stay • Develop further capacity in one current underutilised theatre on Wellington site (OR13)	• Improved control of planned care contributing to maximisation of planned care revenue • Optimising use of outsourcing to deliver planned care efficiently. • Improved productivity of surgical and procedure delivery optimising cost of service delivery.	Sub-regional
Health System Plan Implementation: improving community care options	Acute and urgent care management in the community: • Develop options for Kenepuru A&M • Implement community health network capability to improve local urgent care capacity through integrated primary care, pharmacy and allied health care. Community Health Networks: • Deliver community based planned care through Community Health Networks	• Reduced operating costs of A&M services • Reduced admissions of Kāpiti residents to Wellington Regional Hospital • Reduced admissions of Kāpiti residents to Wellington Regional Hospital	Sub-regional
Bowel Screening	CCDHB is planning to implement the National bowel screening programme in February 2021	Bowel Screening aims to reduce the mortality rate from bowel cancer by diagnosing and treating bowel cancer at an early curable stage, as well as identifying and removing pre-cancerous adenomas from the bowel before they become cancerous.	Local
Service changes as a result of the COVID-19 response			
Ophthalmology	Minor procedures and associated visits shifted into community settings from hospital sites (e.g. intraocular injections).	People can access to care closer to home, and there is efficient use of resources across the health system.	Local (2DHB)

Change	Description of Change/Initiatives	Benefits of Change	Change for local, regional or national reasons
Telehealth	Telehealth will continue to be embedded in both primary and secondary services were appropriate.	Improve access, improve timeliness, more convenient for people.	Local
COVID-19 Reviews			
Pandemic Plans	The Health Emergency Plan and the Pandemic Plans (both hospital and community) have been reviewed across the three DHBs to incorporate learnings from the COVID-19 response, with a draft 3DHB Health Emergency Plan developed.	These reviews will inform our planning and response to any public health need, such as COVID-19	Sub-Regional
Telehealth	The effectiveness of telehealth during the COVID-19 period for both clinicians and patients will be evaluated.		Local (2DHB)
Patient, Visitor and Staff Survey	2DHB are developing a patient, visitor and staff survey on the impact of the changes that were implemented due to COVID-19.		Local (2DHB)
Adverse Events	A review into adverse events and complaints over the COVID-19 period was undertaken		Local

FTE Reconciliation

The maintenance of safe service delivery has required investment, including in service delivery. These FTE are detailed below and relate directly to safe service delivery.

Full Time Equivalent (FTE)	2019/20 Plan	2020/21 Plan	Change
Medical Personnel	915	1004	89
Nursing Personnel	2478	2563	85
Allied Health Personnel	735	773	38
Support Personnel	154	164	10
Management/Administration Personnel	912	945	33
Total FTE	**5194**	**5449**	**255**

SECTION FOUR: Stewardship

4.1. Managing our Business

2DHB ELT Structural Change

Following the appointment in 2019 of the Capital & Coast and Hutt Valley District Health Board's (CCDHB and HVDHB) single Chief Executive, to lead both DHBs, three key priorities were identified as a first step in strengthening executive leadership in the region and driving better population health outcomes for the region's families, whānau and communities:

1. Improving organisational performance and delivery of services at and across both DHBs;
2. Planning for, and implementing, sustainability plans to ensure the best possible use of every dollar of public funding that we receive; and
3. Taking every opportunity to pro-actively integrate our services in as timely a manner as possible across sub-regional patient-centred pathways.

To give effect to these priorities, a new 2DHB Executive Leadership Team (ELT) structure was created to support the development and recruitment of a core group of executive leaders whose roles would mirror and support the dual accountabilities of the 2DHB CEO. A number of appointments were made throughout 2019 to these ELT positions. Recruitment will conclude in 2020, with the appointment of a new 2DHB CFO in August.

Organisational performance management

CCDHB's performance is assessed on both financial and non-financial measures. Internally, performance is presented to the Executive Leadership Team (ELT), Clinical Council, Māori Partnership Board (MPB), Sub-Regional Pacific Strategic Health Group (SRPSHG), Sub-Regional Disability Advisory Group (SRDAG), the Health System Committee (HSC), 3DHB Disability Support Advisory Group (DSAC), Finance and Risk Assessment Committee (FRAC), and the Board. CCDHB reports to the Ministry on a monthly, quarterly, six-monthly or annual basis.

Funding and financial management

CCDHB's key financial indicators are spend against budget and budget against deficit. These are assessed against and reported through CCDHB's performance management process to the ELT and the Finance and Risk Assessment Committee (FRAC).

Investment and asset management

CCDHB is committed to a sustainability pathway 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.

CCDHB and HVDHB have entered into a joint sub-regional clinical planning process. The 2DHB Provider Network Programme is an input into joint long-term investment planning, which will inform 'what' investments are needed across the 2DHBs to implement the strategic vision and associated strategies of both DHBs. These investments have to deliver on ensuring the safety and quality of our services, the impact on equity and outcomes amongst our populations and the sustainability of our health system.

Shared service arrangements and ownership interests

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

Risk management

The CCDHB Risk Management Framework provides principles and processes 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 risks 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.

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

Quality assurance and improvement

Clinical Governance is the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.[1] A shared commitment is required from all clinical and non-clinical staff to provide high quality and safe care, and organisational support from board to the ward.

The CCDHB Clinical Governance Framework has been updated. This framework aims to bring individual elements together to strengthen and sustain ongoing improvement around the six dimensions of quality; safe, timely, equitable, effective, efficient and people centred (STEEEP).

CCDHB's clinical governance framework has four components[2]. These are:

- consumer engagement and participation
- clinical effectiveness
- quality improvement and patient safety
- engaged effective workforce

They provide a structure to implement strategies for improving and enhancing the quality of care.

4.2. Building Capability

Capital and infrastructure development

CCDHB has a significant investment in capital assets particularly property, ICT and clinical equipment. Plans for capital investment are outlined in our Asset Management Plan (AMP). The AMP consists of three separate work streams: ICT, clinical equipment and facilities.

Key issues with our current assets include:

- CCDHB has a number of older properties which are not suitable for use. Options for these properties are being considered.
- Deferred maintenance of facilities and equipment.
- Poor utilisation of assets due to historic design. Options are being investigated to improve utilisation.

Key activities for 2020/21 include:

- Progressing the build of the new Children's Hospital which commenced in 2018. The project is funded by the Crown, donations and depreciation funding.
- Replacement of the Wellington Regional Hospital's Neonatal Bedside and Centralised Monitoring systems. Crown funding has been sought for this.
- Replacement of one of three linear accelerators for Wellington Regional Hospital. Crown funding has been made available for this.
- Replacement of the interventional imaging equipment plus related facilities works in the Angiography and Fluoroscopy rooms at Wellington Regional Hospital
- Ongoing work to remediate the copper pipes at Wellington Regional Hospital to reduce the risk of failure with consequent impact on service delivery. A programme business case has been submitted seeking Crown funding.
- Development of a single new secure facility integrated with Haumietiketike with six units, the National Intellectual Disability Inpatient Unit[3]
- Facilities works at Kenepuru Community Hospital and endoscopy equipment purchase for the National Bowel Screening Programme

[1] National model Clinical Governance Framework. Australian Commission on safety and Quality in Healthcare. Nov 2017

[2] Clinical Governance Guidance for Health and Disability Providers. Health Quality and safety Commission. Feb 2017

[3] This is currently on hold awaiting extra Crown Funding approval

- Upgrade of the lifts within the Clinical Services Block adjacent to the Wellington Regional Hospital
- Continuation of the multi-year deferred maintenance programme of the CCDHB's facilities that commenced in 2018

The outlined key activities for 2020/21 are essential programmes of work to enable CCDHB to deliver secondary and tertiary services for the local, sub-regional and regional patients. The 2DHB Provider Network Programme which will be carried out in 2020/21 is likely to identify further asset requirements for the region.

Information technology and communications systems

3DHB ICT is developing a new digital and data strategy that will describe the six key core digital and data themes that we will use to prioritise our portfolio of work across the three DHBs. These themes will support the achievement of the CCDHB, HVDHB, and Wairarapa DHB priorities. The draft themes of our strategy are:

1. Place-based and virtual health options in our communities
2. Empowering people as partners in their own care.
3. Seamless collaboration across our Greater Wellington sub-region and wider health ecosystem.
4. Equity of access and health outcomes, including for Māori, Pacific peoples and people with disabilities
5. Empowering our workforce to deliver high quality, efficient specialist care

These five themes inform our operating model change towards a modern ICT business unit that lifts portfolio management, a move to product and service management, and an effective support model of operation. This business change journey commenced in 2019 and is planned for completion in 2021.

We have legacy technology debt to overcome as we shift towards enabling better health care for our region. This means improving the resiliency of our supporting infrastructure in the advent of a disaster, shifting away obsolete voice technology towards unified communications, addressing gaps in cyber security to protect our systems and information, as well as increasing awareness of cyber security risks

Key Activities for 2020/21

3DHB ICT has selected its four critical initiatives for inclusion in the 2020/21 annual plan (see *Data and Digital*). These initiatives are focused on achieving stability of existing critical clinical and corporate systems, bringing significant improvements to operational efficiency, improving patient care, and transforming services to be fully digital.

Workforce

Our vision: A caring, connected and responsive team where excellence thrives, which works to enhance the health and wellbeing of our communities.

The Quadruple aim guides us to focus on ensuring that we have a workforce that can deliver improved patient safety and experience, improved health equity of outcomes and best value for health resources. In order to achieve this a key priority is improving staff safety and experience to support health system sustainability and a strong and equitable health and disability system.

Nationally, the People Force 2025 developed by the Workforce Strategy group continues to guide investment in workforce development and to promote a strategic approach to people activities (e.g. MECA negotiations providing a setting for a wider conversation about workforce development).

We work collaboratively with our Central Region partners to deliver regional workforce priorities and to identify potential efficiencies through closer alignment.

CCDHB as an employer

CCDHB is a good employer and aims to ensure that our employment practices attract and retain top health professionals and support staff, who embody our values and culture.

CCDHB employs over 6,100 people, making us the largest employer in the region, comprised of over 3,100 nurses, 1,750 Medical and Allied Health personnel, and 1,100 support, management and administration personnel.

Workforce priorities for 2020/21:

1. Workplace culture: Creating a workplace culture that aligns with our strategy, keeps our values at the heart of everything we do and drives high performance.
2. System Capability: Ensuring that our people are supported by robust data, that the skills and capabilities of our leaders and our people reflect the clinical and operational needs of our health system.
3. Equity: Supporting our workforce to achieve increased equity outcomes, particularly for Māori, Pacific and people with disabilities.
4. Employee experience: Enhancing our employee experience by valuing wellbeing, delivering practical, easy to navigate people systems and processes, and ensuring our people have clear roles and accountabilities.
5. Workforce Agility: Developing our capability to be flexible and agile in response to the changing nature and context of work, and the resultant changing workforce profiles and requirements.

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 locality approach is commencing in Porirua with the support of young people with mental health needs.

CCDHB provides services to the populations of HVDHB and the wider Central Region. CCDHB and HVDHB serve populations that are geographically co-located. A greater proportion of the HVDHB population receive services at CCDHB, than any other population as there are a large number of services that are provided by CCDHB for the HVDHB population as well as services where there is collaboration across the two DHBs. There are very few services that are jointly provided. They include advance care planning and the disability strategy. The most significant clinical service is Mental Health, Addiction and Intellectual Disability Services (MHAIDS).

The 2DHB Provider Network Programme will support the development of a hospital network that serves the Wellington, Kāpiti, Porirua and Hutt Valley communities. Identifying services that would benefit clinically, and financially, from joint provision across the network could significantly improve the ability of both DHBs to improve health outcomes with available resources.

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 HVDHB for services that may be shared.

In the delivery of MHAIDS 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, and the Integrated Care Collaborative (ICC).

SECTION FIVE: Performance Measures

5.1. 2020/21 Performance Measures

The health and disability system has been asked to focus on the following priorities:

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention.
- Better population health outcomes supported by strong and equitable public health and disability system
- Better population health outcomes supported by primary health care.

The DHB monitoring framework and accountability measures have been updated for 2020/21 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governance.

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Target set in annual plan	Year 1	≥71%
			Year 2	≥71%
CW02	Oral health: Mean DMFT score at school year 8	Target set in annual plan	Year 1	<0.43
			Year 2	<0.43
CW03	Improving the number of children enrolled and accessing the Community Oral Health Service (COHS)	95% of children (0-4) enrolled	Year 1	95%
			Year 2	95%
		≤10% of children (0-12) enrolled with the COHS will be overdue for their scheduled examinations with the COHS.	Year 1	≤10%
			Year 2	≤10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	85% of adolescents receive DHB-funded oral health services	Year 1	85%
			Year 2	85%
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month-olds olds fully immunised.		
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five year of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two years	95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years,		
CW09	Better help for smokers to quit (maternity)	90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.		
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to four (and decile five after January 2020) 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.		
		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.		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19)	Māori	6.0%
			Other	3.4%
			Total	3.9%
		Age (20-64)	Māori	8.5%
			Other	3.1%
			Total	3.6%
		Age (65+)	Māori	2.1%
			Other	1.2%
			Total	1.2%
MH02	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.		
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm		80% of people seen within 3 weeks.
				95% of people seen within 8 weeks.
		Addictions (Provider Arm and NGO)		80% of people seen within 3 weeks.
				95% of people seen within 8 weeks.
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified		
MH05	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.		
MH06	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.		
MH07 (tbc)	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	MoH to confirm		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.		
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	≤2,623		

SS06	Better help for smokers to quit in public hospitals (previous health target)	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.		95%
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*		TBC
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)
			ESPI 5	0% - zero patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned Care Measure 3: *Diagnostics waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	0% of patients wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 5: *Cardiac Urgency Waiting Times*	100% of patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	
		Planned Care Measure 6: *Acute Readmissions*	The proportion of patients who were acutely re-admitted post discharge improves from base levels.	Base level: 12.4%
		Planned Care Measure 7: Did Not Attend Rates	No Target Rate - Establishing baseline rates in the 2020/21 year.	

		(DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)		
SS08	Planned care three year plan	Provide reports as specified		
SS09	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)	>2% and < or equal to 4%
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	MoH to confirm
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95 %
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %
			Assessment of data reported to the NMDS	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions, milestones and measures to: Support people with LTC to self-manage and build health literacy.	

		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*
			Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months.
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified
		Focus Area 4: Acute heart service	**Indicator 1: Door to cath** - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram**.**
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b:** ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator in the absence of a documented contraindication/intolerance ≥85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge ii. Aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes) iii. ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), iv. Beta-blocker if LVEF<40% (5-classes). * An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5: Device registry completion ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS-QI Device PPM forms completed within 2 months of the procedure.
			Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
		Focus Area 5: Stroke services Provide confirmation report according to the template provided	**Indicator 1** ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital
			Indicator 2 Reperfusion Thrombolysis /Stroke Clot Retrieval

			12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP IT system.	
SS17	Delivery of Whānau ora	Appropriate progress identified in all areas of the measure deliverable.	
SS18	Financial outyear planning & savings plan	Provide reports as specified	
SS19	Workforce outyear planning	Provide reports as specified	
PH01	Delivery of actions to improve SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90%.	
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95% or above	
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	
Annual plan actions – status update reports		Provide reports as specified	

Appendix: System Level Measures Improvement Plan 2020/21

Signatories for the 2020/21 CCDHB SLM Plan

Fionnagh Dougan, Chief Executive
Capital & Coast and Hutt Valley DHBs

Dr Bryan Betty
Chair, Integrated Care Collaborative

Jeff Lowe
Cosine Primary Care Network Trust

Teresa Wall
Chair, Ora Toa PHO

Martin Hefford
CE, Tū Ora Compass Health

Rachel Haggerty
Director, Strategy Innovation & Performance. CCDHB

The Capital and Coast Health System Plan 2030 outlines our strategy to improve the performance of the region's healthcare system. The Plan supports CCDHB aims to improve health outcomes, prevent avoidable demand for healthcare, and improve the use of healthcare services.

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 others to plan and coordinate at local, regional and national levels, to ensure effective and efficient delivery of health services.

The Integrated Care Collaborative (ICC) Alliance is a key mechanism through which the CCDHB HSP will be realised. The ICC Alliance includes primary care, hospital services, planning and funding, ICT, pharmacy, ambulance, consumers and other key partners. The ICC has overseen the implementation of the Health Care Homes, which has enabled initiatives to better integrate community and specialist services. Enablers such as Health Pathways, patient portal, access to patient records across the sector have also been part of the ICC focus. Benefits are monitored through process, quality and impact measures that include some of the national System Level Measures (SLMs).

The COVID-19 response has created opportunity for transformation of models of care. The ICC will champion and progress these over the next year. Some of these opportunities will contribute to achieving the milestones set in the SLM Plan.

The ICC ALT agreed that the milestones for the SLMs should take into consideration the strategic priorities across the sector and focus on equity. All measures within the plan are stratified for Māori, Pacific and non-Māori/Pacific. This is in line with the ICC focus on progressing the pro-equity approach.

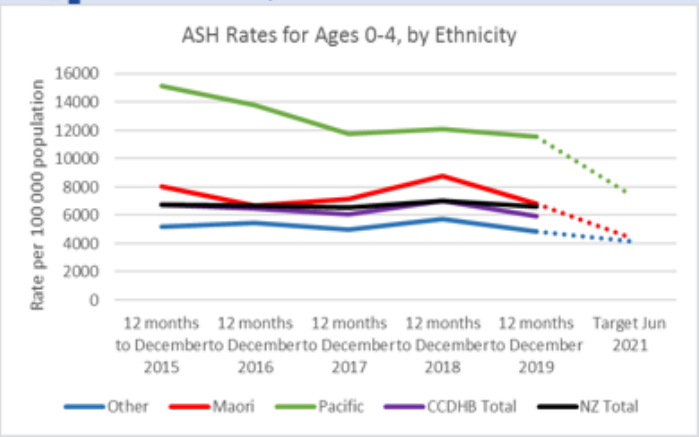
The CCDHB SLM Plan has been developed with the following principles:

- Linked to current strategic priorities
- Build on transformation opportunities created through COVID-19
- Relevant to family & whanau; clinicians; managers
- Focus that improves equity
- Evidence based interventions
- Balancing a mix of outcomes and outputs
- Performance can be influenced through stakeholders and partners
- Return on investment

CCDHB SLM Plan compiled by Dorothy Clendon
Interim Manager – Integrated Care. Strategy Innovation & Performance. CCDHB, on behalf of the CCDHB Integrated Care Collaborative (ICC) Alliance.

Ambulatory Sensitive Hospitalisations 0-4 Years

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

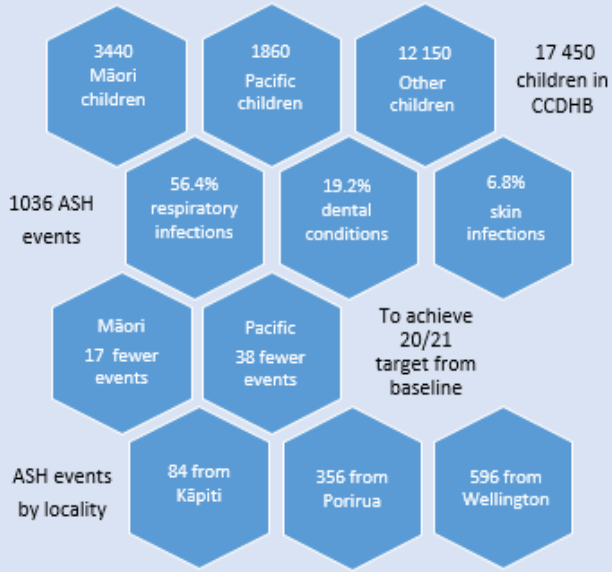


Ambulatory Sensitive Hospitalisation (ASH) 0-4yo 2020/21 milestone: 6% reduction in ASH events for Māori and Pacific, 2% reduction in ASH events for non-Māori/Pacific.

CCDHB's ASH rate for 0-4yo is 10% lower than the national average; however, nationally there has been an increase in the childhood ASH rate. Of the eight DHBs monitored for Pacific ASH rates, CCDHB has the 3rd lowest rate nationally. For Māori children, CCDHB has the 7th lowest ASH rate nationally.

To reduce the equity gap and reduce ASH events, across all populations, will require health & cross sector services to work together. The DHB, PHOs, WCTO providers, dental services, public health, immunization services and hospital teams are partners in the ICC Child & Maternal Network and will oversee SLM plan initiatives.

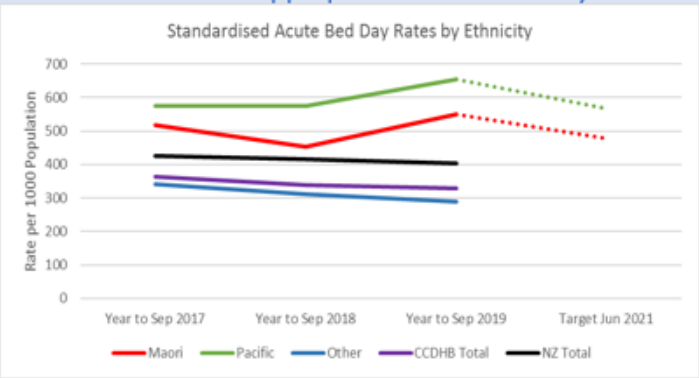
The longer term aim is to ensure that ASH rates for these populations reduce to at least the rates of the non-Maori & non-Pacific population group.



Opportunity	Actions	Contributory Measures
Respiratory conditions contribute the majority of ASH conditions in CCDHB, particularly repeat ASH events. Prevention, effective treatment plans and support during acute episodes will support these children in the community.	• Increase the uptake of influenza vaccination of 6 month - 4 year olds across the DHB. PHOs to continue to generate lists of eligible patients for practices to proactively contact. • Increase the uptake of influenza vaccination of 6 month - 4 year olds across the DHB. The DHB will explore opportunistic influenza vaccination in out-patients at WRH and Kenepuru. • Explore implementing an automated referral process for eligible children to be referred to Porirua Asthma Service or Asthma NZ. • Review the relevant respiratory Health Pathways to reflect best practice. Support prescribers and practice nurses to implement these changes through focussed education sessions and reviewing prescribing practice.	Childhood influenza rate Frequency of repeat ASH events for asthma and wheeze for Porirua 0-4 year olds
Create more opportunities for children to access health care in Porirua through ECEs, Kohangas and extending the Porirua Children Ear Service.	• Pilot an extension to the RPH Porirua Children's Ear Service to include skin infections. This service provides free checks for children from 0 to 18 years old and is provided by a registered nurse who has special training in ear health and skin care.	ASH rate 0-4 year olds for skin infections in Porirua
Improved access to primary care, particularly for Māori and Pacific children and families, is central to achieving equity in childhood ASH.	• PHOs to implement National Hauora Coalition programme 'Equity generation 2040' (early pregnancy assessments) and measure the number of early pregnancy assessments completed(by Māori/Pacific/other) • Trial the provision of an after hours GP video service as a way of providing services outside the hospital.	Immunisation rates (8 months, 2 years) Newborn enrolment rate

Acute Bed Days

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

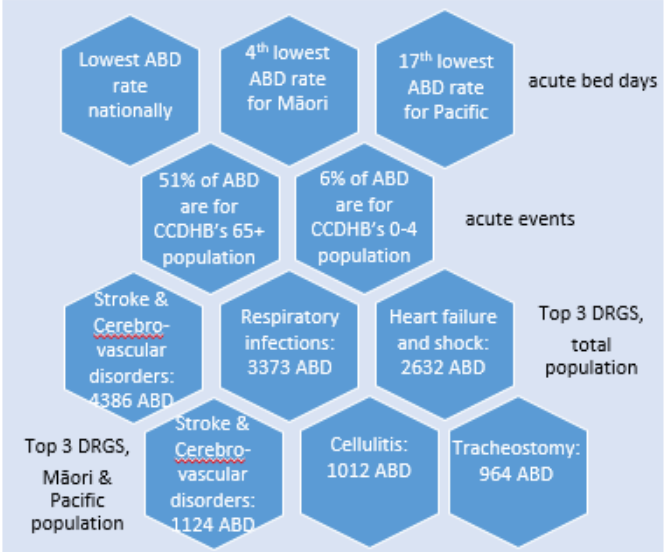


Acute Bed Day (ABD) 2020/21 milestone: 2% reduction in actual acute bed day rate for Māori and Pacific. This equates to a reduction of 466 acute bed days.

The number of acute bed days is complex and attributable to many factors.

The ICC Alliance is providing oversight of a range of initiatives to improve bed occupancy across the system. A newly established Health of Older People (HOP) Steering Group's initial focus is on initiatives to reduce length of stay for older people – namely Allied Health led early supported discharge and a new acute frailty assessment unit.

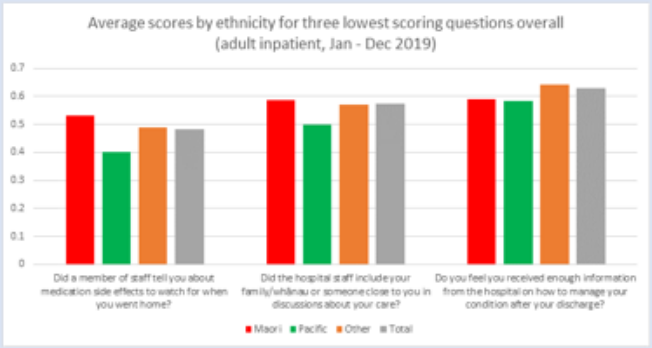
The long-term aim is to ensure that ABD rates for Māori and Pacific populations reduce to at least the same rates of the non-Maori & Pacific population groups.



Opportunity	Actions	2019/20 Contributory measure
Increasing the uptake of flu vaccinations for at risk populations will impact acute bed days over winter months. Achieving a high rate of vaccinations for the health workforce across hospital and community will also minimise spread and subsequent admissions.	• Engage with RPH, Tamariki Ora, ARC and PHOs to confirm/implement the 2020/2021 influenza plan • Standardise health system response when demand increases • Publicise role of pharmacies in providing immunisations • Implement the Increasing Māori Flu Vaccinations Programme	Population vaccinated: • vulnerable children 0-4y– 11% Maori and 10% Pacific • 75% of Maori people 55yrs+ • ARC, PHO - 75% people 65yrs+
Growth in ED presentation numbers continue and have exceeded capacity. Enhancing the management of people in primary care via community based acute response services will support people to receive care in the community. Current age-standardised ED presentation rates to sub-regional hospitals are 212 for Māori, 244 for Pacific and 140 for other ethnicities.	• Review POAC programme for Porirua to increase uptake. • Explore options to extend ambulance diversion into Porirua. • Establish Community Health Network/s in Porirua.	Age-standardised ED presentation rates in sub-regional hospitals for Porirua-domiciled population
Frail older people contribute to a significant volume of bed occupancy due to their complex health and social circumstances. Current age-standardised acute events in sub-regional hospitals for CCDHB-domiciled people aged >65 years are 331 Māori, 411 Pacific and 199 for other ethnicities.	• Implement AWHI (Advancing Wellness at Home Initiative) to support earlier discharge for all CCDHB residents • Establish an Acute Frailty Unit in Wellington Regional Hospital, and reconfigure the CAREFul service to provide comprehensive geriatric assessment and interventions earlier in the patient journey • Extend the reach of the Community Health of Older People Initiative (CHOPI – specialist advice and assessment for Primary Care) across the DHB. • Establish a Community Health Network in Kapiti.	Age-standardised acute admission rates in sub-regional hospitals for CCDHB-domiciled people aged >65 years

Patient Experience of Care

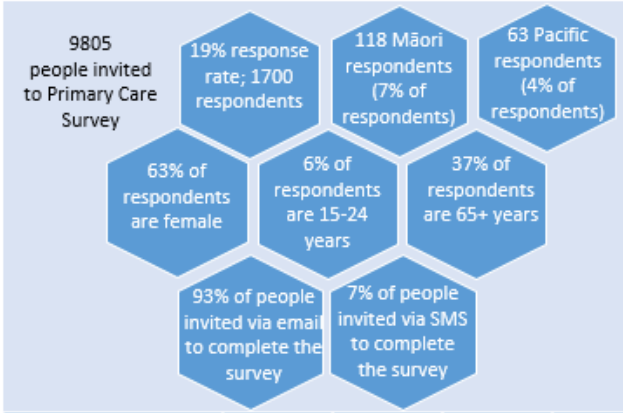
It is vital that patients are involved and partnered with in their care.



The CCDHB health system encourages patients to provide feedback about their experience of care through its complaints and compliments process. New national inpatient and primary care surveys provided by IPSOS are about to be rolled out. This impacts on our ability to monitor change from last year to this year, however it should be noted that there is very little variance from year to year in our results, or results nationally. IPSOS promises a more targeted and therefore better response rate from our prioritised populations and this will be of interest to note and to compare with historic data..

The monitoring of results and feedback of the new surveys will be prioritised and used to inform initiatives that will lead to improved patient experience and outcomes. Meanwhile actions are intended to improve people's experience of cleanliness in Hospital, and contact following treatment in Primary Care, and we will aim for an improvement of 2% for the lowest scoring question for the Primary Care Survey.

Combined reviews between Primary Care and Adult Inpatient have been difficult and hard to compare easily due to different questions. In July, when the new surveys become available, a review will be undertaken to consider how a comparison can be achieved more effectively for the 2020-21 year.



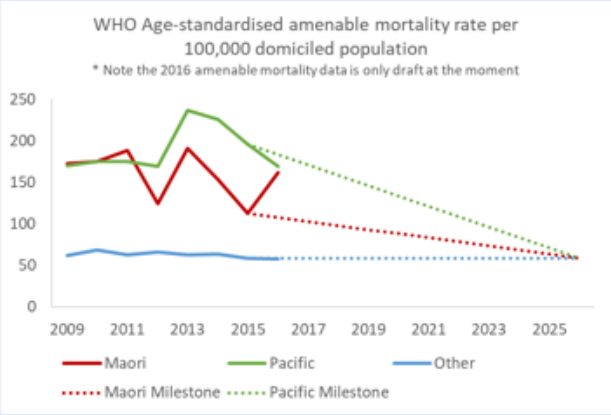
		Communication	Partner-ship	Physical & Emotional Needs	Coordination
Primary Care (Aug 2019)	Māori	8.19 ▬	7.33 ▬	7.73 ▬	8.16 ▼
	Pacific	8.13 ▬	7.40 ▬	7.52 ▼	7.77 ▼
	Other	8.27 ▬	7.51 ▬	8.26 ▬	8.40 ▬
Inpatient (Sep 2019)	Total	8.75 ▲	8.88 ▲	8.83 ▲	8.83 ▲

▲ Above National Average ▼ Below National Average ▬ Same as National Average

Opportunity	Actions	Contributory measure
The new Patient Experience survey is being rolled out in 20/21. This will provide better information about people's experiences with our hospital services. In the 20/21 year there will be a focus on the cleanliness question which directly links to our COVID 19 precaution strategy.	▪ DHB Patient Experience Quality Safety Marker (QSM) oversight group established to oversee the implementation and delivery of consumer engagement and the QSM ▪ Process and template developed for acting on the consumer voice that is already collected and feeding this into the quality improvement cycle ▪ Support implementation of the new patient experience survey by establishing a process to highlight the importance of the survey and to monitor the uptake by populations we know we don't serve so well and try to fill the gap ▪ Work with the provider of the new patient experience survey to ensure we are capturing the voice of all the consumers – especially those in priority groups ▪ Working in conjunction with the cleaning services monitor and improve the response to the 'Were the hospital rooms or wards (including bathrooms) kept clean from median of 72% to 75% for 'Yes Always' responses.	% of patients with a disability who receive and complete the survey Response rates for the ' Were the hospital rooms or wards (including bathrooms) kept clean?
The Primary Care PES will provide improvement opportunities for all practices. In the 20/21 year there will be a focus on 2 questions in the new survey for improvement purposes. The key areas of focus will be on questions related to access and long-term conditions.	▪ Familiarise with the new survey, its format and reporting structure, and develop baseline measures of participation rates. Health improvement practitioners, health coaches and primary care assistants will be involved in the implementation process. Themes and results will be shared and readily visible to all patient-facing staff. ▪ Following the July 2020 rollout of the new 'primary care survey' a focus will be placed on 2 questions (access and long-term conditions) for improvement purposes. ▪ Progress Health Care Home practice development to increase % of year of care plans to improve the response rate by 2% to question "After a treatment or care plan was made were you contacted to see how things were going? "	% of pts with email addresses recorded in the patient management system. commitment to undertake 2 quarterly reviews for 2020. % of YOC plans

Amenable Mortality

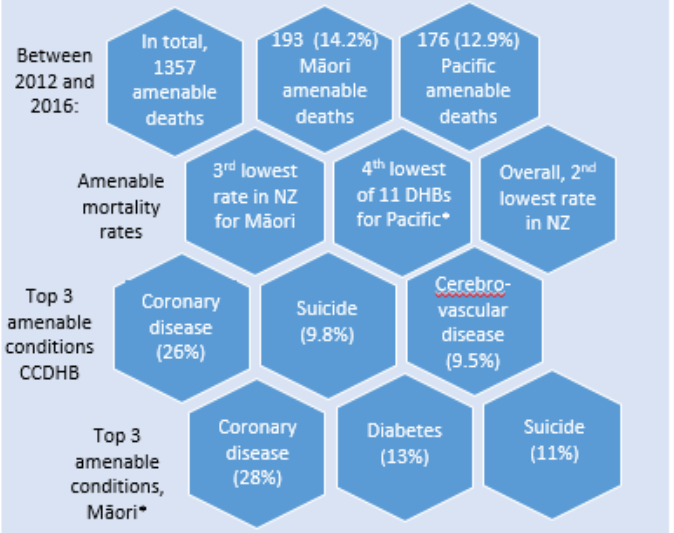
The CCDHB HSP outlines that supporting population interventions to create healthier communities and preventing the onset of long term conditions is a priority in reducing amenable mortality.



Amenable Mortality (AM) 2020/21 milestone: Based on the most recent (2012-2016) data, we aim to reduce Māori AM rate by 3% to 143 per 100, 000; in particular, to reduce the rate of death from CVD by 3% to 81 per 100, 000 by 2022-2026. The long term milestone is that Māori and Pacific AM rates will be equal to Other. In 2014 and 2015, AM rates improved for Māori and Pacific. However, rates have fluctuated due to the relatively small population size and data for 2016 is currently in draft. 2016 draft data suggests more action is required to achieve set milestones.

The time to influence the change in the AM rate and current delay in the reported data are barriers to establishing time relevant milestones for this SLM. In 2014 and 2015, AM rates improved for Māori and Pacific. However, rates have fluctuated due to the relatively small population size.

To achieve Equity in AM rates, requires focus on prevention and pro active care approach to the long term conditions are managed well and people receive the care the need to self manage at home, particularly focusing interventions for Māori and Pacific populations. The CCDHB has taken a long term Equity approach to reduce AM rates to the rate of other, which means the actions taken today will be realised in the future.

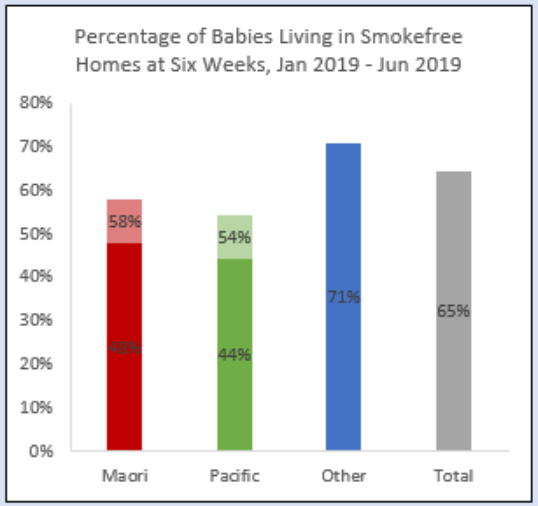


*Rates suppressed due to low numbers; Conditions for Pacific population not published by MOH

Opportunity	Actions	Contributory measure
Effective long term condition management requires a wide range of approaches and increasingly requires an approach that supports a range of co-existing long term conditions. The creation of Community Health Networks which build on the Health Care Home model will enable expand the menu of services delivered closer to home and support better management of long term conditions.	• Enable and extend telehealth options for long-term conditions management in primary care • Establish at least two Community Health Networks in CCDHB • Implement the DHB long term conditions investment plan to develop new models of care to address Māori cardiovascular disease and those at risk of developing LTCs (prevention) • Collaborate to deliver targeted speciality clinical nursing and system navigation for Māori patients and whānau with cardiac and/or long-term conditions • Develop methods to capture ethnicity of primary and community workforce.	Ratio of virtual to face to face consultations in primary care. % enrolled with Manage My Health portal % of Māori hospitalised for diagnosed long-term conditions. DHB Māori workforce proportional to the population. % of Primary and Community workforce who are Māori
Improving CCDHB smoking quit rates will significantly reduce the risk related to a number of long term conditions, the related morbidity and future mortality. Supporting smokers and their families to quit continues to be a focus across the CCDHB system. Smoking quit rates are 8% for Māori, 8% for Pacific and 14% for other ethnicities.	• Use of vaping approaches to support Māori to quit smoking • Support the Whanau Care Services smoking cessation project – working with Māori patients, whanau and staff and addressing system barriers to improve access and uptake	Smoking quit rate Māori quit rate
Cardiovascular disorders and diabetes continue to be the largest causes of amenable mortality for the total population and Māori. Implementing the new screening guidelines that recommend expanded target age bands will activate earlier care for people at higher risk of these conditions.	• PHOs will work with practices with large volumes of people who require screening with a range of activities such as establishing targeted clinics, funding Māori and Pacific men's breakfast event and facilitating men's health groups • Cardiovascular screening practice level data to be included in the Diabetes Clinical Network. The Network will drive cyclical improvement activities to improve screening, including the identification of three key healthy heart messages that can be promoted across the DHB.	Percentage of PHO enrolled population identified as high risk of CVD and not on statin

Babies Living in Smokefree Homes

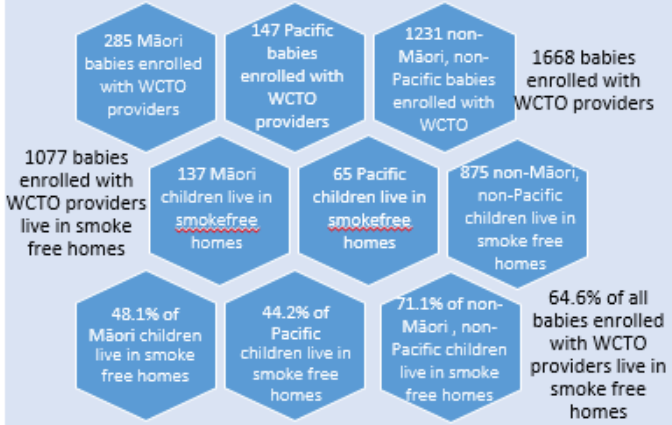
Supporting our whanau and their children, giving them the best start in life, is a CCDHB priority and linked to the national SUDI prevention programme.



Babies Living in a Smokefree Home 2020/21 milestone: 10% improvement in percentage of Māori and Pacific babies live in smokefree homes. This will result in an additional 14 Māori babies and 7 Pacific babies living in smokefree homes.

As the HSP 2030 is implemented, it is expected that all services that support women and children to live well will be connected within a defined locality and linked with their primary health care team. A focus on the first 1000 days for our mātua, pepi and tamariki aligns with the focus early in the population life course approach.

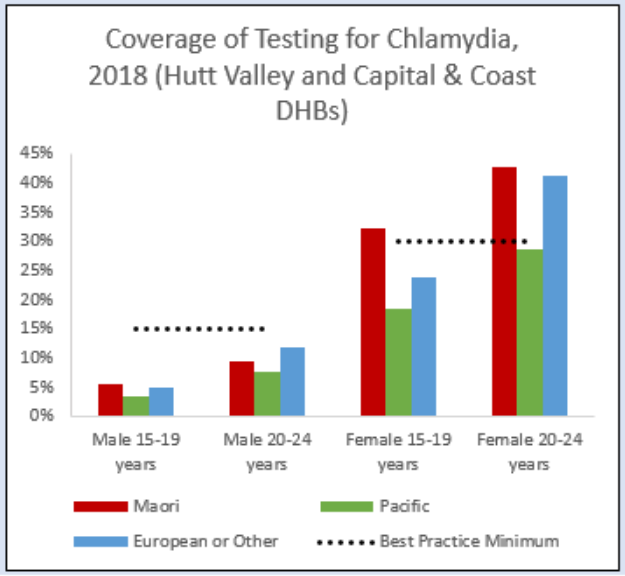
Reducing babies' exposure to tobacco smoke through collaboration between the services focussed on child health and smoking cessation is a key aspect of wellness. The DHB, PHOs, WCTO providers, dental services, public health, immunization services and hospital teams will work in partnership to oversee these SLM plan initiatives.



Opportunity	Actions	Contributory measure
Give our pepi the best possible chance of living in a smoke free household with wrap around support for our mātua, pepi and tamariki aligns	• Increase utilisation of the Hapū Ora Smoking Cessation Incentive programme and Regional Stop Smoking Service by promoting these services through our antenatal education, LMC, breastfeeding services and primary care. • Continue to invest and evaluate the impact of non-traditional approaches to antenatal education including wahakura wānanga, which will deliver smokefree messages and support. • PHOs to strengthen relationships with WCTO providers and collaborative initiatives on health and wellness (which includes smoking cessation).	Utilisation of smoking cessation programmes Mothers who are smokefree at two weeks post-natal
Increasing our focus and support for the whanau surrounding our pepi to be smoke free.	• Education session with prescribers and practice nurses on the effectiveness of smoking cessation treatments and encouraging prescribing of these treatments.	Uptake of cessation service by hapū mama and their whanau

Youth access to & utilisation of youth appropriate services

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

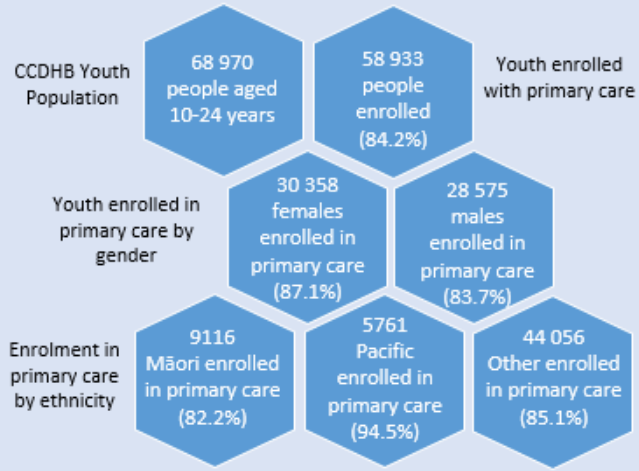


In 2020/21, CCDHB will continue to focus on the sexual health domain of the Youth SLM and aim to support young people to manage their sexual and reproductive health safely by giving them access to youth friendly healthcare.

The 2020/21 milestone is to improve male coverage of testing for Chlamydia by 5%, across all ethnic groups and maintain 32% coverage of testing for females. This will increase tests in males by 2022 and improve testing rates in Māori and Pacific by 11%

Chlamydia is the most commonly reported STI and screening rates vary considerably between gender and ethnicity. Increasing the coverage of chlamydia testing will improve youth engagement with healthcare services. Enrolment in primary care will increase as will utilisation of healthcare services. An improvement in testing coverage will also have positive impacts on unwanted pregnancy rates and mental health conditions.

CCDHB have current projects aimed at improving healthcare services for youth which will positively impact on screening rates.



Opportunity	Actions	Contributory measure
Providing youth with appropriate health services and enrolling youth early in primary care will lead to better health outcomes throughout life.	• Complete data matching exercise between the existing YOSS's and primary care to reflect actual enrolments in primary care. • Work with the SBHS, YOSS's and primary care to ensure youth who are accessing services are enrolled in a practice as well.	Youth enrolment in primary care by ethnicity
Youth often cope with health issues by connecting with friends and whānau and use primary care as a last resort. Engagement in primary care supports health literacy and promotes improved health outcomes.	• Establish a YOSS for Porirua. • Continue to work with primary care to use vaccinations as a method of providing opportunistic testing. • Develop a quick test kit in co-design with youth.	Utilisation of primary care health services
Youth can feel worried or anxious about sharing sensitive information especially if it may impact on how they are perceived. Providing a platform to share important information confidentially will improve outcomes.	• Trial the SXT anonymous contact tracing app in the sexual health service	Utilisation of primary care health services