Capital & Coast District Health Board

Annual Plan: 2021/2022

Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Issued under Section 38 of the New Zealand Public Health and Disability

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
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Tēnā koe David

Capital & Coast District Health Board 2021/22 Annual Plan

This letter is to advise you that we have jointly approved and signed Capital & Coast District Health Board's (DHB's) 2021/22 annual plan (Plan) for one year.

When setting expectations for 2021/22 it was acknowledged that your Plan would be developed in a period where our COVID-19 response, recovery and immunisation programmes remained a key focus and therefore planning requirements were streamlined towards your DHB's work to improve equity and to embed lessons and innovations from COVID-19. Thank you for providing a strong plan for these areas.

Your Plan for 2021/22 will be delivered in an environment where this work continues to be of critical importance and where our system transition process is underway. We acknowledge that providing clarity on the critical areas for improvement through transition is helpful and, on that basis, we are confirming the top challenges that will be of focus for us through 2021/22:

- Supporting readiness and management of COVID-19.
- Supporting the mental wellbeing of people, particularly of youth and young people.
- Ensuring child wellbeing, particularly through increased immunisation.
- Managing acute demand.
- Managing planned care.

More broadly, we also confirm the importance of your Board delivering on the Plan in a fiscally prudent way and acknowledge that an intensive support programme will be established for Capital & Coast DHB.

it is noted that Capital & Coast DHB now provides all but NGO specialist mental health services to Hutt Valley DHB. Hutt Valley DHB is $0.56 million below the ring fence expectation set by the Ministry of Health (the Ministry), and Capital & Coast DHB is $10.74 million above the ring fence expectation. As this is a combined service provision the Ministry accepts the proposed ring fence amount.

We invite you to work closely with your regional Chair colleagues to share your skills, expertise, and problem-solving efforts to ensure progress is achieved in these top challenges. As performance progress is discussed through the year, we will look forward to hearing about your joint efforts and progress.

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, including changes in FTE. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

Your 2021/22 Plan provides an important foundation to ensure our health system delivers for New Zealanders during the period of system transition and we expect all DHBs will be disciplined in delivery of their plans.

Please ensure that a copy of this letter is attached to any copies of your signed plan made available to the public.

Nāku noa, nā

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Fionnagh Dougan
Chief Executive of Capital & Coast and Hutt Valley DHBs

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SECTION ONE: Overview of Strategic Priorities

1.1. 2DHB Partnership

We are working in close partnership with Hutt Valley District Health Board (HVDHB) to align the strategic direction of both DHBs and better organise the delivery of our services across the Wellington region. We already have a joint Board chair and a 2DHB executive leadership team.

Across the two DHBs, we operate three hospitals (Wellington Regional Hospital, Kenepuru Hospital, and Hutt Hospital) and deliver integrated health services in five key localities (Wellington City, Porirua, Kapital Coast, Lower Hutt and Upper Hutt). By working together and combining our resources, we are improving the way we coordinate the specialist services provided by our three hospitals and the specialist, primary, and community services delivered in our five localities. We are using our combined resources to better coordinate our care, achieve more equitable outcomes, and make our communities stronger.

1.2. 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 Iwi and 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)
- New Zealand Public Health & Disability Act 2000
- the New Zealand Health Strategy
- He Korowai Oranga and Whakamaua 2020-25
- Ola Manuia 2020-2025: Pacific Health and Wellbeing Action Plan
- the New Zealand Disability Strategy
- the national Healthy Ageing Strategy.

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

1.3. Te Tiriti o Waitangi

Māori are the indigenous peoples of Aotearoa. We have particular responsibilities and accountabilities to Māori through Te Tiriti o Waitangi, the founding document of Aotearoa. The principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal,[1] underpin the DHB's commitment to Te Tiriti, and guide the actions outlined in this annual plan. The 2019 Hauora report[2] recommends a series of principles be applied to the primary health care system. These principles are applicable to the wider health and disability system as a whole. CCDHB values Te Tiriti and applies these the principles to our work across the health and disability system:

[1] *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641; *New Zealand Maori Council v Attorney-General* [1989] 2 NZLR 142; *New Zealand Maori Council v Attorney-General* [1991] WL 12012744; *New Zealand Maori Council v Attorney-General* [1992] 2 NZLR 576; *New Zealand Maori Council v Attorney-General* [2013] NZSC 6; *The Ngai Tahu report 1991* (Waitangi Tribunal 1991); *Report of the Waitangi Tribunal on the Orakei claim* (Waitangi Tribunal 1987); *Report of the Waitangi Tribunal on the Muriwhenua fishing claim* (Waitangi Tribunal 1988).

[2] *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Waitangi Tribunal* 2019).

- **Tino rangatiratanga**: Providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.
- **Equity**: Being committed to achieving equitable health outcomes for Māori.
- **Active protection**: Acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options**: Providing for and properly resourcing kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership**: Working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services – Māori must be co-designers, with the Crown, of the primary health system for Māori.

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. We aim to address this through targeting and driving our health services to create equity of health care for Māori, while developing partnerships with the wider social sector to support whole of system change.

Māori representation has been provided on all advisory committees and our Alliance Leadership Team, the Integrated Care Collaborative. We also have a 2DHB (HVDHB and CCDHB) Māori Council to formalise the relationship between local Iwi and the DHB, build on relationships, and share aspirations and strategic directions.

1.4. Planning

Out-year planning to support system sustainability

CCDHB and HVDHB work together on out-year plans to make our health system sustainable. Both DHBs are committed to a sustainability pathway that emphasises cross-organisation and system governance of financial and service delivery performance. Our investment approach 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.

We are prioritising investment in the use of contemporary Information Communication Technology (ICT) solutions that reduce the need for manual input and improve efficiency. There are multiple opportunities to invest in smart systems that will reduce manual work and duplicated effort in a number of areas, including better use of data to inform service planning and decision making, financial management, workforce planning, production planning, operating room utilisation, and telehealth services. We can also support access to digital solutions that will help people manage their own health, such as patient portals.

Clinical leadership

Clinical leadership supports us meet the health needs of our population. Our Clinical Council comprises hospital and primary care clinicians from different disciplines. It facilitates clinical engagement in organisational decisions and informs effective planning and commissioning based on clinical evidence and expertise. The Council's principal focus is on quality and safety, but it also provides advice on key proposed organisational service changes and measures to use organisational resources effectively and equitably.

We have also established clinical networks (or steering groups) to guide planning and provide oversight to our integration work programme. This work is focussed on improving how primary and secondary health services work together so patients experience well-coordinated and seamless healthcare. The clinical networks report to our Alliance Leadership Team, which is made up of senior DHB managers, clinical leaders and other experts, including representation from Pasifika and Māori Health Services and a mix of both hospital and community practitioners. The clinical networks make recommendations on the best use of resources to achieve the optimal outcomes.

1.5. 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 the 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 HSP includes a focus on the following key strategic goals:

- Promote health and wellbeing
- People-focused services in the community
- Timely effective care that improves health outcomes.

Achieving equity and providing an integrated seamless service is embedded throughout these strategic goals. Our HSP is designed to support people and whānau-led wellbeing with the system organised around the two elements: 'People' and 'Place'.

People

We are committed to developing people-focused service delivery models. There are 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 service 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 Pasifika Peoples, disabled people, refugees and people who are the socially and economically disadvantaged, and people with enduring mental illness or addiction.

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 the Health Care Home and the Kāpiti Health Centre
- Wellington, Hutt, and Kenepuru hospitals providing specialist care for the region.

1.6. Health Equity

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. 'Equity' recognises that different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

Achieving equity in health and wellness is a focus for CCDHB. We know that we do not do as well for Māori, Pasifika People, disabled people, 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. We will continue to deliver against:

- Taurite Ora: CCDHB's Māori Health Strategy 2019-2030
- the 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.

Our focus is on improving performance, ensuring we make the best use of our available resources, and achieving equity amongst our populations. Our sustainable and affordable approach to achieving equitable outcomes is to use a strategy of 'simplify and intensify' – meaning we will intensify resources and support for those who need us the most, and simplify for those who need us the least.

CCDHB has a fundamental role in enabling and facilitating the health system to achieve equitable health outcomes. 'Partnership' is key to success in achieving equitable health outcomes. We collaborate with our Māori Council, the Sub-Regional Pacific Strategic Health Group, and the Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent. We promote the routine use of the Health Equity Assessment Tool (HEAT) in all quality improvement and service development projects to ensure they have a focus on achieving equity.

We will contribute to equity priorities through the specific actions and milestones outlined in Section Two. Equity actions are identified with code 'EOA', which means 'equitable outcome action'. We will measure and report on our progress regularly.

1.7. 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. Disability is a significant issue for Māori. Nationally, approximately 200,000 Māori (26%) report having a disability.[3]

CCDHB, together with the Māori Council, 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.

[3] Ministry of Health. 2018. Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan. Wellington: Ministry of Health.

- 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 Council on behalf of all Māori in our district.

1.8. Te Upoko O Te Ika Māori Council

Te Upoko O Te Ika Māori Council (TUI MC) was established in 2021 to represent hauora Māori across by CCDHB and HVDHB. TUI MC replaces the both the Māori Partnership Board (CCDHB) and the Mana Whenua Relationship Board (HVDHB). The purpose of TUI MC is to accelerate hauora Māori gains by ensuring hauora Māori is at the forefront of planning, funding and service delivery activities within CCDHB, HVDHB, and the wider community.

TUI MC has the vital role of holding both DHBs to account for meeting their legislative and ethical obligations to Māori under Te Tiriti o Waitangi. This includes:

- enabling Māori to participate in decision-making processes
- achieving health equity for Māori
- identifying and progressing Māori aspirations and needs for wellbeing
- actively participating in and engaging with the 2DHB Board in the development of strategic priorities, and DHB funding and accountability mechanisms
- monitoring the performance of the 2DHB delivered and funded services, to ensure they are responsive to the aspirations and needs of Māori, and eliminate inequities
- promoting and enhancing whānau models of care that support whānau to determine their journeys toward wellness
- monitoring the experiences of whānau to ensure that Māori receive high-quality equitable health and disability care.

TUI MC comprises up to two representatives each of the following Iwi entities: Te Runanganui o Te Atiawa, Taranaki Whānui ki te Upoko o te Ika (PNBST)/ Wellington Tenths Trust, Ngāti Toa Rangatira, Te Atiawa Ki Whakarongotai, and Taurahere Iwi. The Chair is appointed by TUI MC members.

1.9. Whole of system integration

HVDHB and CCDHB have entered into a joint planning process. This supports a consistent approach across our five communities (Upper Hutt, Lower Hutt, Kāpiti, Porirua and Wellington) and three hospitals (Hutt, Kenepuru and Wellington) to improve system performance and sustainability, and achieve equity of access and outcomes. This approach will focus on regional and sub-regional service integration, leveraging and driving innovations, and improving patient/consumer experience.

Health and social outcomes are inter-related and can be improved by building strong effective partnerships with community groups, local councils, providers and agencies and a strong focus on population health. We support these partnerships through our locality-based approaches with our communities. We will be building on our successes of the last three years, developing our community health networks, and continuing locality service integration.

Regional Public Health (RPH) plays an essential role in this space. RPH is the public health unit for the 3DHB sub-region (HVDHB, CCDHB, and Wairarapa DHB). The three DHBs work in partnership with RPH in their work on health promotion/improvement, enhancing the effectiveness of prevention activities in other parts of the health system, and regulatory services. The integration of RPH's activity into the DHB's commissioning function has been completed and will help to ensure our efforts to improve health outcomes in our communities are aligned.

Our 3DHB Disability Group is also working to integrate a disability perspective into the development and delivery of health services. For example, the Disability Group has been working closely with our COVID vaccination managers to ensure that the voice of the disability community is incorporated into the development of the vaccination programme.

CCDHB's 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.

1.10. Managing 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, deep rooted inequities, and 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 our hospitals.

We continue to implement initiatives and make performance improvements to alleviate pressure on hospital services. These initiatives/improvements include:

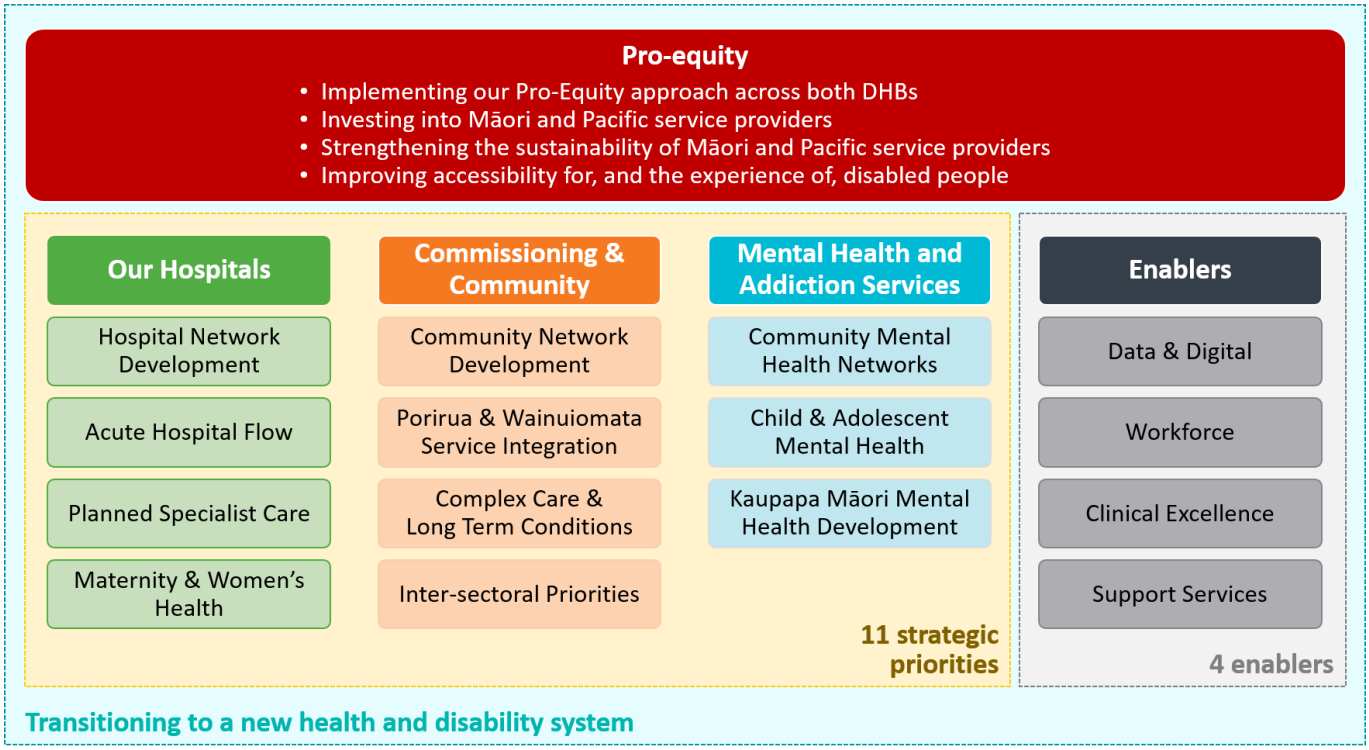
- Building a strong primary and community health care system providing closer-to-home care. We have progressed and embedded the Health Care Home (HCH) patient-centred model of care, which provides a strong basis for the integrated Community Health Networks.
- Increasing specialist support to general practices so they can access this advice for their patients when needed and potentially avoid hospitalisation. This includes the recent addition of a GP Liaison Service to provide specialist mental health and addictions advice to general practices across the Hutt Valley, Wairarapa and Wellington regions. The service strengthens our ability to initiate treatment for people in the community before their condition worsens or becomes acute.
- Inter-agency work to address underlying causes of health and wellbeing. To support implementation of Taurite Ora, we are progressively increasing the resources and capacity of our Māori and Pasifika community health providers to provide holistic health care in partnership with other social services. Regional Public Health is also working with early childhood centres, schools, workplaces, social support agencies, and local councils to encourage and support the development of health-focused policy and healthy environments.
- Working with healthcare providers to rethink what 'access' means for disabled people. Contracts now include a disability clause so providers report on what they are doing to improve access for people with a range of impairments in their services. This mechanism has encouraged collaboration with providers to make our services more accessible to disability communities.
- Health promotional activities to raise awareness and promote healthy choices across a range of topics. This includes media campaigns targeted at different ethnic groups that promote flu vaccination, which results in fewer hospitalisations for influenza.
- Contemporary 'closer to home' models of planned care services that improve early access to care and treatment. These include the use of telehealth for specialist appointments, the Mobility Action Programme (an early non-surgical intervention programme targeting musculoskeletal health conditions), skin lesion removals in primary care, and an alternative community-based Ophthalmology service to reduce patient travel and improve access.
- Improved inpatient flow through our hospitals. We have improved the flow of acute (unplanned emergency) patients with the introduction of capacity planner software has enabled us to track and predict daily acute demand, and better match expected demand with staff capacity (nursing rosters). Inpatient flow has been improved with the introduction and roll out of the Advancing Wellness at Home Initiative (AWHI), where patients are discharged from hospital with multidisciplinary team support and care provided in their own homes. Theatre efficiency and safety has been achieved through the introduction of electronic waitlist management software, which enables us to accurately track patients through their elective surgery journey.

While projects like these have alleviated some of the pressure on our hospitals, we are continually looking for new ways of meeting the current demands. Many of the prevention-focussed initiatives take time before the results materialise into reductions in hospital demand. A programme of transformational change is required so that all parts of the system are working together to create a more sustainable health system focused on prevention, early intervention, and achieving equity.

1.11. Our Priorities for 2021/22

Strategic Priorities

The following strategic and enabling priorities have been agreed to ensure we the needs of our populations are met during a period of change.



The Equity work plan is focused on creating a pro-equity organisation and involves:

- Implementing the Pro-Equity approach across both DHBs.
- Investment into Māori and Pacific providers (additional investment) across the two DHBs
- 2DHB Māori and Pasifika Service Providers Collaborative to strengthen our commitment to the sustainability of the providers.
- Improving accessibility for disabled people to all services and improving the experience of disabled people in accessing and using health services.

There are four focus areas: Our Hospitals, Commissioning & Community, Mental Health & Addiction Services, and Enablers, and within those there are eleven strategic priorities – each of which is focused on providing equitable outcomes for the people of our region:

- Hospital Network Development – ensuring the best use of our hospitals and specialist services to achieve equitable outcomes for the people of our region
- Acute Hospital Flow–- timely and equitable access to acute care, and an integrated system to improve the management and care of older people with frailty
- Planned Specialist Care – timely and accessible planned care services to achieve equitable outcomes for the people of our region

- Maternity and Women's Health – mothers, babies, and families are supported to receive equitable access to services and outcomes, and children get the very best start to life
- Community Network Development – ensuring well-coordinated and integrated services with our primary and community providers for the people in our localities
- Porirua & Wainuiomata Service Integration – partnering with community leaders and providers to deliver locally coordinated services to create a thriving, healthy community that enables equitable outcomes
- Complex Care and Long Term Conditions – an integrated model of care for people with long term conditions, focused achieving equitable outcomes for our priority populations
- Inter-sectoral Priorities – working together to improve housing, prevent suicide and family violence, and reduce child uplifts – ensuring our priority populations have a 'Voice, Choice and Safe Prospects'
- Community Mental Health Networks – establishing Community Mental Health and Wellbeing Hubs within our region
- Child & Adolescent Mental Health –focusing on improving mental health service delivery to children and adolescents
- Kaupapa Māori Mental Health Development –focusing on developing and strengthening kaupapa Māori mental health services.

Four enablers are required to support implementation of the eleven strategic priorities:

- Data & Digital,
- Workforce (including organisational culture), and
- Clinical Excellence (which includes a focus on quality and safety), and
- Support Services (including corporate and financial services).

As represented in the diagram (above), the strategic priorities and enablers are underpinned by our approach to equity.

There are underlying work plans for each strategic priority and enabler, and an executive-level governance structure and performance reporting framework is being established. There are plans for quarterly reporting to the Boards on the performance and progress of work under each focus area.

Health and Disability System Reform

In June 2020 the final report of the Health and Disability System Review (the Review) was released. The Minister of Health commissioned the Review to make key recommendations to the Government on developing a more sustainable health system that improves health outcomes for Māori, shifts the balance from treatment of illness towards health and wellbeing, and responds to the needs of all New Zealanders.

In April 2021, the Minister of Health announced the new structure for the health and disability system in New Zealand:

- All 20 DHBs will be replaced with a new Crown entity, Health New Zealand, which will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.
- A new Māori Health Authority will have the power to commission health services, monitor the state of Māori health and develop policy.
- The Ministry of Health will be strengthened and will continue to monitor performance and advise Government on health and disability policy. Responsibility for public health issues will rest with a new Public Health Authority.

Reform of the health and disability sector will take a number of years to implement. However, changes are likely over 2021/22 and CCDHB and HVDHB expect to be fully engaged in the change process to help ensure the reforms are successfully implemented and achieve benefits for our populations.

Our strategic approach is aligned with the goals of the reform. We are focus on achieving equity for Māori and collaborating across the system to improve health and wellbeing outcomes. Our joint Board chair and 2DHB executive leadership team support Hutt Valley and Capital & Coast DHBs working as one where possible to gain efficiencies across our hospital services, workforce, and safety and quality processes. We work closely with the other DHBs in the Central Region to coordinate how we plan and deliver services across the region.[4]

COVID-19 Response and Recovery

COVID-19 is a public health emergency and global pandemic. Aotearoa New Zealand has a strategy for the elimination of COVID-19. The aims are to eliminate transmission chains and to prevent the emergence of new transmission chains originating from cases that arrive from outside the country.

COVID-19 has fundamentally changed the way the New Zealand public health system responds, especially in terms of what and how public health services are delivered. The COVID-19 response and associated activities delivered by the DHB-based public health units (such as Regional Public Health) are now integrated with the Ministry of Health (led by the COVID-19 directorate). For example, New Zealand now has a National Investigation and Tracing Centre and the use of a common IT platform (the National Contact Tracing Solution).

The Ministry has engaged with DHBs to design and implement a national public health response where we more effectively share limited resources, standardise operating procedures, avoid duplication and increase the agility with which we mount a surge response anywhere in the country and address future challenges.

The COVID-19 emergency response, while necessary, also created a backlog of patients waiting to be seen and treated in our system. This will take careful planning and increased effort over a number of years to correct. The demand for mental health services in our district is growing in line with planned development but also affected by the impact of COVID-19.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities. Distributing the vaccine and immunising the population will be an important focus for the health sector. CCDHB is committed to supporting the roll out and success of the COVID-19 vaccination programme.

Following vaccination of the region's Group 1 (border workers and their household contacts) and Group 2 (health workforce and long-term residential care residents and staff) populations, the focus for vaccination in 2021/22 will be the general population. We will offer every eligible person in our region vaccination by the end of 2021.

The vaccination programme is a successful example of how the DHB works with primary health, with our Community Vaccination Centres commissioned from primary health organisations and Māori providers. These relationships, strengthened through the COVID-19 experience, ensure our programme is reflective of our equity priorities and responsive to the needs of all of our communities.

Priorities for 2021/22 include working with the Ministry to continually improve the COVID-19 response system, roll out the COVID-19 immunisation programme, and implementing our COVID-19 recovery plans to ensure that our patients receive the care they need.

[4] Central Region comprises six DHBs (Capital & Coast, Hawkes' Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui).

Joint Message from the Chair and Chief Executive

One of the largest transformations the New Zealand health and disability system has experienced has commenced, with formal transition taking place from July next year. Over the next 12 months it is the responsibility of our DHBs to ensure that we continue to improve health outcomes for the people of our region, and to support the transition to Health New Zealand and the Māori Health Authority so that the new entities have strong foundations for the establishment of a more equitable and sustainable system.

We are excited by the potential of this change, particularly where equity is concerned—for Māori as Treaty partners, and also for Pacific people, the Disability community, and others who experience poor health outcomes.

This has been our direction of travel for some time, and will continue to be our focus for the next 12 months. We have carefully crafted a series of strategic priorities, which identify three inter-linked areas of focus. These are:

- a 2DHB hospital network supporting planned, acute, and specialist services
- commissioning more services in the community
- an enhanced focus on mental health and addictions services in our hospitals and in the community.

We have identified four enablers to help us deliver improvements in these areas: Data & Digital, Workforce, Clinical Excellence, and Support Services.

Our health system vision and focus areas put people, place, and partnership at the heart of what we do. With this in mind it is clear we need new models of service delivery to achieve our goal of eliminating health inequity by 2030. Unpinning this is our commitment to strengthen our financial position through strong fiscal management and optimising the use and distribution of resources.

Together these approaches will see us progress towards a single health system model and support more equitable outcomes.

We are—and will remain—focused on delivering services in the community, working collaboratively across our campuses, and creating a sustainable hospital network across our regions to make the best use of the resources we have.

In reflecting on the shape of the future healthcare system it is appropriate to acknowledge the incredible commitment of our staff, who have iteratively improved the way care is delivered. Our people have worked tirelessly through COVID-19 alert level changes, and are now delivering a vaccination campaign while maintaining business as usual.

Indeed, the rollout of our COVID-19 response and vaccination programme embodies the shape of the future healthcare system, through strong equity foundations, partnership with primary health organisations, continual innovation, and going the extra mile to connect with priority populations.

When we work to improve what we do, we think about people and their needs first. We think about the place that they are in and of the partnerships that we need to be part of to make things happen.

Hutt Valley and Capital & Coast DHBs have already seen the benefits of more unified healthcare delivery, led by a single Executive Leadership Team which now sits across both DHBs, helping share decision-making and knowledge. Over the last 12 months our 2DHBs have strived to work as one to gain efficiencies across our hospital services, workforce, sustainability, safety and quality, and this will continue to be our focus for the year ahead.

It is our privilege to introduce the latest, and final, annual plan as Hutt Valley and Capital & Coast DHBs.

Fionnagh Dougan
Chief Executive
Capital & Coast and Hutt Valley DHBs

David Smol
Chair
Capital & Coast and Hutt Valley DHBs

Message from the Chair, Te Upoko o te Ika 2DHB Māori Council

Kei aku iti, kei aku rahi.

Tēnei te tuku mihi ki ngā mahi kua mahia hei whakakotahi i a tātou katoa i raro i te whakaruruhau o te hauora me te oranga tonutanga o ngā iwi me ngā uri whakatipu e hāere tonu mai ana.

The next year holds great potential locally at our DHBs and across Aotearoa to bring about much-needed change to the way we support healthy whānau. This has come thanks to all those who have had the courage to challenge themselves and others to improve our health system for Māori.

In April 2021, the Minister of Health announced a new structure for the national health and disability system. This included the establishment of a new Māori Health Authority that will have the power to commission health services, monitor the state of Māori health and develop policy. The health system must work smarter to develop the strengths inherent in our communities. It is thanks to the flexibility of many Māori health providers, and their ability to connect with whānau, that our communities were largely protected from COVID-19 and will continue to be with the Pfizer vaccination rollout.

Our council, Te Upoko o te Ika Māori Council (TUI MC), was established in 2021 to represent hauora Māori across by CCDHB and HVDHB. TUI MC replaces the both the Māori Partnership Board (CCDHB) and the Mana Whenua Relationship Board (HVDHB). TUI MC comprises up to two representatives each of the following Iwi entities: Te Runanganui o Te Atiawa, Taranaki Whānui ki te Upoko o te Ika (PNBST)/ Wellington Tenths Trust, Ngāti Toa Rangatira, Te Atiawa Ki Whakarongotai, and Taurahere Iwi.

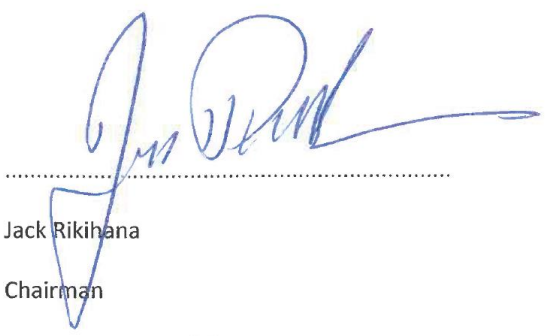
Our council is looking forward to working with the Māori Health Authority to drive rangatiratanga for Māori in our health system and ensuring Māori are deeply involved in its design.

Locally, Māori health development is undergoing bold change within our DHBs.

The appointment last year of Arawhetu Gray as 2DHB Director Māori Health was the first step to aligning the efforts of the Hutt Valley and Capital & Coast Māori Health teams. Her combined team will work to achieve accountability for delivering the DHBs' strategies to improve equity for Māori health: Te Pae Amorangi and Taurite Ora, including developing the Māori workforce.

Annual plans, such as this one, are important to TUI MC as a means of holding the DHBs to account for their planned actions and commitment to the Te Tiriti and achieving Māori health equity. I look forward to supporting their progress for all whānau in our region.

Ka pū te ruha, ka hao te rangatahi.



Jack Rikihana

Chairman

Te Upoko o te Ika Māori Council

1.12. Signature Page

Agreement for the Capital and Coast DHB 2021/22 Annual Plan between

Hon Andrew Little
Minister of Health
Date: 20 December 2021

Hon Grant Robertson
Minister of Finance
Date:

David Smol
Chair
Date: 6/10/2021

Roger Blakeley
Chair of the Finance Risk
and Audit Committee
Date: 6/10/2021

Fionnagh Dougan
Chief Executive
Date: 6/10/2021

SECTION TWO: Delivering on Minister 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. The focus for 2021/22 is on COVID-19 recovery / learnings and equity, and a shift away from business as usual.

2.1 Government Planning Priorities

Give practical effect to Whakamaua: Māori Health Action Plan 2020-2025

Engagement and obligations as a Treaty partner (A1-CC)		
Actions		**Milestones**
Whakamaua Action 1.1 – develop iwi partnerships that support local-level Māori development and kaupapa Māori service solutions.	The DHB will continue to work in partnership with Te Ātiawa ki Whakarongotai/Kāpiti on the development of Kapiti Community Health Network. Building on the success of the Kapiti Community Health Network, we will partner with mana whenua, community leaders and other agencies to transform the way we commission services in Porirua, our locality that experiences the greatest inequitable outcomes, particularly for Māori, Pasifika, and disabled people. We will commission integrated services that meet people's needs at the earliest and lowest cost opportunity. (EOA) **(CCDHB)**	Q1: Execute a single outcomes-based contract, underpinned by an Annual Investment Plan and Outcomes Framework. Q4: Prepare a revised Annual Investment Plan for 2022/23, including increased investment in community-based delivery.
Whakamaua Action 2.3 – Design and deliver professional development and training opportunities for Māori DHB board members and members of DHB/iwi/Māori Councils	Extend Te Kawa Whakaruruhau (our Māori cultural safety training programme) to include a short training programme for the Board focussed on Māori health equity, the Treaty of Waitangi, and Tikanga. **(2DHB)**	Q4: Narrative report on progress

Whakamaua: Māori Health Action Plan 2020-2021 (A2-CC)		
Actions		**Milestones**
Whakamaua Action 3.1 – Expand existing Māori health workforce initiatives aimed at encouraging Māori to enter health careers	Work with Kia Ora Hauora to provide work experience and exposure to health careers within the DHB. **(2DHB)**	Q2 and Q4: Status update
Whakamaua Action 4.4 – Increase access to and choice of kaupapa Māori primary mental health and addiction services.	Develop a '2DHB Māori and Pasifika Service Providers Collaborative' and engage in strategic planning with the collaborative to meet the needs of Māori and Pasifikaa populations. We will partner with the collaborative on the development of common goals to achieve equity, service development targeting high needs populations, and the development of common goals agreed with intersectoral partners.	Q2 and Q4: Status update

	The collaborative will be developed in partnership with local Iwi: Te Runanganui o Te Atiawa, Taranaki Whānui ki te Upoko o te Ika (PNBST)/ Wellington Tenths Trust, Ngāti Toa Rangatira, Te Atiawa Ki Whakarongotai, and Taurahere Iwi. **(2DHB)**	
Whakamaua Action 6.1 – Adopt innovative technologies and increase access to telehealth services	Implement ePrescriptions solution to allow outpatient prescriptions to be sent to the pharmacy of choice directly without need for paper forms or face to face contact when telehealth consults were used. **(2DHB)**	Implementation with integration with MoH ePrescription service for all outpatient clinics by Q1.
Whakamaua Action 3.3 – Support DHBs and the Māori health sector to attract, retain, develop and utilise their Māori health workforce effectively	Develop a 2DHB pro-equity approach to recruitment and onboarding, designed to attract an increased diversity of candidates (e.g. Māori, Pasifika, disabled) and ensure a positive candidate experience for all. **(2DHB)** (EOA for Māori, Pasifika, disabled people)	Q1. Identify working group, scope and Terms of Reference for development of the approach. Q2. Exploration and design process. Q3. Develop framework and approach. Q4. Launch.
Whakamaua Action 4.7 – Please include the most significant **one or two** actions the DHB is undertaking to Invest in innovative tobacco control, immunisation and screening programmes to increase equitable access and outcomes for Māori.	Complete an audit of referrals to smoking cessation services, including analysis of referral sources, volumes and a view by ethnicity and locality. This is intended to address the gap in smoking rates for Māori and Pasifika by ensuring appropriate referral processes and behaviours are in place. (EOA) **(2DHB)**	Q1
Whakamaua Action 8.2 – Publish plans and progress in achieving equitable health outcomes for Māori.	Report against five key measures of equity (avoidable hospital admissions, amenable mortality, accessible appointments, primary care utilisation, and community-based services) and make these reports available to the public on the DHB's website. **(2DHB)**	Q2 and Q4: Status update
Whakamaua Action 1.4 – Engage with local Iwi, using the engagement framework and guidelines, when developing major capital business cases. (for DHBs with a major capital project underway)	CCDHB will engage with the Māori Council during the design and build of Wellington's Regional Children's Hospital to ensure the design is accessible and culturally appropriate for Māori **(CCDHB)**	Q2 and Q4: Status update
Whakamaua Action 4.9 – Invest in growing the capacity of iwi and the Māori health sector as a connected network of providers to deliver whānau-centred and kaupapa Māori services to provide holistic,	Identify and facilitate funding / training opportunities for Māori health providers and DHB Māori staff 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 (c) Connecting to Hauora Māori scholarships	Q2 and Q4: Status update (including module completion)

locally-led, integrated care and disability support	(d) Promoting other development opportunities. **(2DHB)**	
Whakamaua Action 5.6 – Support the delivery of Whāia te Ao Mārama 2018-2022: The Māori Disability Action Plan	Implement the Disability Equity E-learning module to strengthen cultural competency within the 3DHBs. (EOA) **(3DHB)**	Q2 and Q4: Status update (including module completion)
Whakamaua Action 8.5 – Ensure that major system funding frameworks consider and adjust for unmet need and the equitable distribution of resources to Māori.	The DHB will continue to work in partnership with Te Ātiawa ki Whakarongotai/Kāpiti on the development of Kapiti Community Health Network. Building on the success of the Kapiti Community Health Network, we will partner with mana whenua, community leaders and other agencies to transform the way we commission services in Porirua, our locality that experiences the greatest inequitable outcomes, particularly for Māori, Pasifika, and disabled people. We will commission integrated services that meet people's needs at the earliest and lowest cost opportunity. (EOA) **(CCDHB)**	Q1: Execute a single outcomes-based contract, underpinned by an Annual Investment Plan and Outcomes Framework. Q4: Prepare a revised Annual Investment Plan for 2022/23, including increased investment in community-based delivery.

Improving sustainability (confirming the path to breakeven)

Short term focus 2021/22 (B1) and Medium term focus (three years) (B2) - 2DHB

CCDHB and HVDHB are committed to making sure we are in a sustainable financial position. Work is progressing across a number of areas to improve clinical and financial sustainability and meet our obligations to continue to deliver good quality care. Expected savings over 2021/22 and 2022/23 are shown below.

Actions (all 2DHB) - all these actions are included in CCDHB's and HVDHB's path to breakeven over the next three years.		**Expected Savings 2021/22**	**Expected Savings 2022/23**	**Milestones**
Action supported by sustainability funding initiatives (Corporate Sustainability Fund)	Benefits of 2DHB management structure & back office efficiencies (eg ELT and RMO office, cleaning, security, fleet management)	1,255,000	$2,725,000	Q2 and Q4 reports
Action supported by production planning	Benefits of 2DHB clinical networks		$230,000	Q2 and Q4 reports
Action from the set of actions that the DHB is embedding as a result of COVID-19 learning/innovation that is expected to have the most significant impact on medium term sustainability	Property, Procurement, Logistics & Supply Chain efficiencies One of the biggest successes of COVID-19 was the ability to flexibly and responsively mobilise investment in Maori, Pasifika and disability providers. We will apply these learnings to develop more streamlined community commissioning processes across the 2DHBs. We will also apply these learnings to our rollout of the COVID-19 immunisation campaign for Māori, Pasifika and disability communities.	$573,000	$1,395,600	Q2 and Q4 reports

Action supported by national analytics (Workforce Planning and Forecasting) that will contribute the most to a reduction in cost growth over the next three years.	Operating efficiencies (eg ICT licences, rostering, leave, vacancies)	30,798,809	$32,993,252	Q2 and Q4 reports
	Environmental sustainability		$473,600	Q2 and Q4 reports
	Revenue enhancement (eg clinical coding)		$570,000	Q2 and Q4 reports
	Total	$32,626,809	$38,387,452	

Improving maternal, child and youth wellbeing

Maternity care (C1-CC)		
Actions		**Milestones**
Ambulatory sensitive hospitalisations for children age 0-4 years	Trial the provision of an after-hours GP video service as a way of providing services outside of the hospital. **(CCDHB)**	Q2 and Q4 status updates
	Review the relevant respiratory Health Pathways to reflect best practice and ensure effective and efficient prompts and links to the Porirua Asthma Service or Asthma NZ, Well Homes – Healthy Homes Initiative, and other community health and social services. **(2DHB)**	Q3
Supporting home and primary birthing	CCDHB and HVDHB will work together to develop a 2DHB maternal 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 include: a) A focus on midwifery models of care that support home birthing, primary birthing and traditional birthing practices. (EOA) b) A review of access to services including ultrasounds and screening programmes (in both primary and secondary care) to ensure equitable access. Incorporating learnings from COVID to ensure our maternity system is able to respond appropriately. **(2DHB)**	Q1: Establishment of steering group Q3: Status update
Integrated service models	CCDHB and HVDHB will deliver an integrated maternal and child health system. This will include: a) Ensuring women and whānau have access to a targeted, pro-equity approaches to antenatal parenting education. (EOA) b) Redesign our WCTO collaboration forums with WCTO, Pasifika providers, primary care and child health leaders. Meetings are focused on quality and service integration. Invest in proactively co-ordinated maternal health services including strengthening referral pathways to social services within maternity systems. **(2DHB)**	Q1: • Launch online platform to support integrated maternity services • Review membership of WCTO collaboration forums • Execute contracts for parenting education Q3: Status reporting on access to pro-equity approaches to antenatal parenting education, uptake of online

		platform, attendance at WCTO collaboration forums.
Sustainable workforce	Develop initiatives to support a sustainable workforce through a positive culture. This will include: a) Midwifery workforce strategies will continue to be progressed b) Engagement with MERAS and NZNO will be in place as per the Midwifery Accord c) Embed Te Ao Marama midwifery group to provide pastoral and clinical support to Māori and Pasifika student / graduate midwives. (EOA) Maternity Quality Safety programme (MQSP) will develop a comprehensive cultural competency programme that will support mana enhancing and mana protecting midwifery practice. (EOA) **(2DHB)**	Q1: Status update Q3: Report on progress against Midwifery workforce strategy
Perinatal and Maternity Mortality Review Committee	Our Maternity Quality Safety Programme (MQSP) has developed actions to address recommendations from the PMMRC 14th Annual Report. a) Increase uptake of fetal surveillance education for all midwives, including LMC. b) Strengthen links with local communities of Indian ethnicity through organisations such as the Wellington Indian Association and Skakti to better understand models of care that meet the need of mothers of Indian ethnicity. **(CCDHB)** c) Working with our Māori Health Unit, we will facilitate educational opportunities for DHB staff to improve our workforce's cultural competency appropriateness and awareness. **(2DHB)**	Q1: Status update Q3: Status update

Immunisation (C2-CC)

Actions		**Milestones**
Improving Immunisation Coverage (0-5 years)	The following actions will be implemented to improve childhood immunisation coverage from infancy to age 5: a) More frequent (monthly) PHO performance monitoring and management to assess MMR 'catch-up' progress and to ensure primary care is prioritising childhood immunisations for all milestone ages; b) Improving Newborn Enrolment processes and performance to increase the number of children enrolled with general practice; c) Strengthening the linkages and referral processes between our B4 School Check provider and primary care/general practices to ensure children are followed-up with by their GP; d) PHOs proactively collaborating with Māori and Pacific providers to promote childhood immunisations at upcoming community events. **(2DHB)** Contributory measures to indicate improvements in 2 year old immunisations include enrolment in Well Child/Tamariki Ora services and enrolment with general practice.	Q2 and Q4: Status update
Promoting Immunisation	CCDHB and HVDHB to work together to implement an communication plan that delivers culturally appropriate and consistent messaging that promotes immunisations and increase education around the importance of immunisation. **(2DHB)**	Q2 and Q4: Status update

Māori Influenza Immunisation Programme	CCDHB and HVDHB to work together to develop a Māori Influenza Immunisation Programme that is that Māori-led, Māori-focused and contribute to improving equitable immunisation coverage for Māori. This work will include: a) Undertake a geo-mapping process to identify target areas of Māori 65+, Māori living in areas of high deprivation and Māori 50+ with high health need b) Implement a co-designed, co-led Māori Influenza Immunisation Programme that contributes to improving equitable immunisation coverage for Māori (MOH Funding dependant). Activities listed here also align with Whakamaua: Māori Health Action Plan 2020-2021 - A2. (EOA) **(2DHB)**	Q2 and Q4: Status update
Maintaining immunisation coverage during the COVID-19 immunisation programme	CCDHB and HVDHB will design and manage separate but connected immunisation campaigns across Covid-19, influenza and MMR. Each project has separate budgets, contracts, and governance mechanisms to track the vaccinator capacity available and performance of each campaign, to ensure capacity in 'BAU' childhood immunisation teams is not disrupted. Individual campaigns will be supported by robust analytics and communications expertise, to ensure the campaigns are working in a complementary way to achieve immunisation coverage targets. Our 2DHB (childhood) Immunisation Network remains in place as the mechanism to monitor immunisation coverage and system performance for childhood immunisation. **(2DHB)**	Q2
Outreach Immunisation	The Outreach Immunisation Service (OIS) is fundamental service to ensure we achieve our childhood immunisation targets across the population. a) Exploration of the current OIS service delivery model that considers its effectiveness, service gaps, opportunity for change, growth and innovation that best suit the community. b) Develop collective strategies with child immunisation providers to work with people who have not been immunised through general practice, and people who may find accessing childhood immunisations harder as a result of COVID-19. (EOA) c) Undertake activities to strengthen relationships between OIS partners, to ensure effective collaboration and support for delivery of the service. Contributory measures include newborn enrolment and referral to Well Child Tamariki Ora provider by 28 days of age. **(2DHB)**	Q2 and Q4: Status update

Youth health and wellbeing (C3-CC)

Actions		**Milestones**
Priority youth populations	Provide narrative reports on the actions of the 2DHB Youth Integrated Care Collaborative (ICC) to improve the health of the DHB's priority youth populations with a focus on Māori populations and Pacific populations as well as disabled youth, LGBTQI+, refugee/migrant families and those living in higher levels of deprivation. The ICC focuses on projects and initiatives that will drive equity improvements including updates on the System Level Measures (SLM); improving access to sex and gender diverse healthcare, the integration of youth services in Porirua, activity and initiatives through the existing Youth One Stop Shops, and any other pieces of work discussed at the Youth ICC. (EOA) **(2DHB)**	Status update: Q1, Q2, Q3, Q4
Quality improvement	Implement the Youth Health Care in Secondary Schools framework by creating a formal youth engagement process in co-design with young people to support future DHB work. Once complete the process will be applied across the youth work programme. **(2DHB)**	Q1: Co-design Q2: Process agreed Q4: Implementation

Access to telehealth	CCDHB will meet with Evolve, KYS and Tu Ora Compass Health, the providers of school-based health services (SBHS) to confirm that students will continue to have access to telehealth and other forms of virtual consultations/appointments 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). The narrative report in Q2 and Q4 will include confirmation of the availability and type of telehealth/other virtual options for students. **(CCDHB)**	Q2 and Q4: Status update

Family Violence and Sexual Violence (C4-CC)	
Actions	**Milestones**
Develop a joint 2DHB Family Violence Strategic Work Programme to re-design the way the 2DHBs respond to people experiencing family violence so we can reduce its impact, improve outcomes, and support safer communities. This work will focus on DHB responses for Māori whānau and Pasifika families. (EOA) **(2DHB)**	Q2 and 4 Progress reporting.
Increase Violence Intervention Programme (VIP) training rates by adopting 2DHB approaches to refine and deliver the 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. **(2DHB)**	Q2 and 4 Progress reporting.
To better understand the equity impact of the VIP programme, we will include ethnicity data in all VIP audits of routine enquiry and disclosure rates in priority services. **(CCDHB)**	Q2 and 4 Progress reporting.

Improving mental wellbeing

Improving Mental Health (D1-CC and HV)		
Actions		**Milestones**
COVID-19 response **(3DHB)**	1. All MHAIDS COVID resurgence plans will be updated by end of Q1 and will be updated as 'living documents' in cases of re-emergence or alert level response changes. 2. Review the protocols and agreements with all providers involved in the collective provider and stakeholder forum that was implemented to respond to the COVID 19 and lockdown early in 2020. 3. MHAIDS leadership team will continue to be engaged with the wider 3DHB data and digital, including telehealth, on the development of updated applications and technologies from the learnings of the DHBs COVID response in 2020. 4. Surveys were conducted post lockdown with service users and staff. The findings of these surveys will be reviewed in Q1 to determine the next steps. 5. Marama Real Time Feedback has been rolled out across MHAIDS and is now our BAU service user family/whanau feedback tool. Due to COVID lockdown, as well as wanting to ensure we have appropriate methods of collection for our different consumer demographics, we will now implement a number of different collection methods in Q1 e.g. paper surveys, QR codes, posters and automated text/emails following attended appointments.	1. Q1 2. Q1 3. Q1-4 4. Q1 5. Q1
Integration of primary and	1. Implement 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. In 2021/22 we will to use a co-design approach to design a service model and the	1. Q1-4

specialist services	completion of an investment business case to implement the model. The proposal is to target a collaborative approach with a strong kaupapa Māori focus and high needs areas. The current priority localities are Porirua and Naenae. **(2DHB)** 2. The MHAIDS GP Liaison Service's dedicated Senior Medical Officer, who can be contacted directly by GPs for advice, will provide 1:1 advice and education on Special Mental Health via Video Conference sessions to GPs across the 3DHBs. **(3DHB)**	2. Q1-4
Improve our cultural response, focussing on Māori and Pasifika	1. Develop a '2DHB Māori and Pasifika Service Providers Collaborative' and engage in strategic planning with the collaborative to meet the needs of Māori and Pacifica populations. We will partner with the collaborative on the development of common goals to achieve equity, service development targeting high needs populations, and the development of common goals agreed with inter-sectoral partners. (EOA) **(2DHB)** 2. MHAIDS will continue to participate in the national project "Toward Zero Seclusion'. Maori are over represented in seclusion figures and this project aims to reduce and stop the incidence of seclusion. (EOA) **(3DHB)**	1. Q2 & Q4 status updates 2. Q2 & Q4 status updates
Follow-up within seven days post-discharge **(3DHB)**	1. Adult Community Mental Health and Addiction Services will monitor all inpatient discharges to ensure a community service contact is made and recorded in the seven days immediately following that discharge. 2. Implement a policy and pathway that embeds practices to monitor and respond to any variation/issues in post-discharge. 3. Focus on data quality and completeness aiming for 100% PRIMHD data quality compliance by Q4. 4. Action to implement appointment reminder automation at WrDHB/CCDHB by Q2. **Two locally selected contributory measures:** • DNA rates – focus and target to reduce DNA rates as a measure of improving service user engagement. Approximately 9 percent of all scheduled MHAIDS community appointments result in a 'Did Not Attend' (DNA). MHAIDS has set a focus on reducing its DNA rate to a target of 5 percent. DNA rate is one way of measuring service user engagement with MHAIDS. By focusing on DNAs we can identify barriers for our service users and make improvements for accessibility. Fewer DNAs will have a positive impact on wait times and less clinical time will be lost. Our Hutt Valley based services send automated appointment reminders to service users. Action to implement this automation at WrDHB/CCDHB by Q2. • Pre-admission care - Adult Community Mental Health and Addiction Services monitor this measure along with the seven day follow up measure. Additional MoH advised measure: MH03: Transition/discharge planning. Compliance and quality audits will be completed quarterly.	1. Q1-Q4 2. Q1-Q4 3. Q4 4. Q2

Improving wellbeing through prevention

Communicable Diseases (E1-CC)	
Actions	**Milestones**
The RPH Māori and Pasifika COVID-19 Response leads will support Māori communities and Pasifika communities to identify and lead COVID-19 recovery projects/plans, including those to improve access to infectious disease related services for Māori and Pasifika Peoples (RPH -core function: health promotion) (EOA). This is a cross service opportunity. **(3DHB)**	Q2 & Q4

Provide a notifiable communicable disease programme to reduce the impact of illness and reduce avoidable hospital admissions of our priority populations including, Māori, Pasifika, recently arrived refugees, elderly, immuno-compromised, and young children. Prevent, identify and respond to existing/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)**	Q2 & Q4

Environmental Sustainability (E2-CC)	
Actions	**Milestones**
During COVID-19 alert level 4, Metlink reduced public transport services. This impacted the ability of key staff to get to work using their normal travel mode. In response CCDHB partnered with Metlink to selectively reintroduce specific services, as well as offering loan e-bikes and fleet vehicles to ensure staff could continue to get to work. Formalising this response and preparing communications for staff will enable CCDHB to more quickly and effectively ensure that staff are able to get to our hospital sites should public transport timetables be altered in response to another COVID-19 outbreak or other emergency. **(CCDHB)**	Q2: Staff travel included in emergency response planning
Develop a 2DHB Sustainability Strategy and implementation plan. We will engage with our Māori Council during the development of this plan to ensure that it is culturally appropriate and meets the needs of mana whenua. (EOA) **(2DHB)**	Q1 - Engage with Māori and Pasifika partners, including the Māori Council Q2: Sustainability strategy approved Q4: Sustainability implementation plan completed
Implement 2DHB emissions reporting and verification by December 2021, including forecasting of potential offsetting liabilities to decision makers. We will target monthly emission data for at least 80% of gross emissions. We will also develop a 2DHB emissions reduction strategy that includes a pipeline of work and indicative costs for budgeting purposes to be completed by June 2022. **(2DHB)**	Q2: Implement 2DHB emissions reporting a verification Q4: Confirm 2DHB emission reduction strategy

Antimicrobial Resistance (E3-CC)		
Actions		**Milestones**
COVID-19 recovery and learnings	Update of Empiric Antibiotic Guidelines with revision of Community Acquired Pneumonia guideline. **(2DHB)**	Q3 – availability online and on mobile app
	Hand hygiene audit programme implemented and reported in Emergency department & EDOU and in non-ED adult admitting units: MAPU, SAPU. **(2DHB)**	Q1-Q4 – reporting as per HQSC cycles
National AMR action plan	Antimicrobial stewardship – AMS rounds three times week. **(2DHB)**	Q1-Q4 – reporting to AMS committee
Community and primary care	Increase awareness and understanding – facilitate at least two educational activities in ARC facilities specifically targeting AMR and AMS via IPC team **(2DHB)**	At least two targeted education/awareness activities undertaken by end Q4

Drinking Water (E4-CC)	
Actions	**Milestones**
Facilitate the transfer of drinking water regulatory work to the new drinking water regulator Taumata Arowai. **(3DHB)**	Transfer all water supplier records to Taumata Arowai within agreed timeframes
The RPH Māori and Pasifika COVID-19 Response leads will support Marae, schools and high need communities (including communities with high Māori and Pasifika Peoples populations) with their own water supplies to identify and lead COVID-19 recovery projects/plans around drinking water (EOA) (RPH) (Core function-health protection) or any other post COVID-19 public health issue. This is a cross service opportunity. **(3DHB)**	Q2 & Q4
Annual review compliance reporting for 2020/21 is completed.	Q1

Environmental and Border Health (E5-CC)	
Actions	**Milestones**
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
Assess the DHB/RPH's ability and processes in relation to encouraging Territorial Authorities (TAs) to always consider improvement of Māori and Pacific health and achievement of equity when the TAs are developing their district and long-term plans so that the DHB/RPH can optimise its input into the TA planning processes in relation to improving Māori and Pacific health and achieving equity. **(EOA) (3DHB)**	Q2 & Q4
Primary health care is the cornerstone to our delivery approach across the Capital and Coast and Hutt Valley districts to support the COVID-19 vaccination programme. Our three Primary Health Organisations (PHOs), Ora Toa PHO, Tu Ora Compass and Te Awakairangi, will scale up and down as required to provide a range of community vaccination centres across the region to meet the demand for all priority groups. Our other PHO (COSINE) will provide supplementary capacity to the delivery of our vaccination programme. **(2DHB)** The CCDHB and HVDHB sequencing is as follows: Phase One – Initial Supply (Nov 20 – May 21): • Completion of Group One (people who work at the border or at one of the Managed Isolated and Quarantine facilities in Wellington), and • Roll out for Group Two (people working in the health system, frontline emergency service workers, everyone living in long-term residential care, and older Māori and Pasifika people living in the community and the people who live with them). Phase Two – Ramp up (May – August 21): • Completion of Group Two, and • Roll out for Group Three (people aged over 65, anyone who is disabled, people with particular health conditions that put them at higher risk if they were to catch COVID-19, and pregnant women) Phase Three – Open Access (August – December 21): • Completion of Group Three, and • Roll out for Group Four (everybody else who is at least 16 years old). Phase Four – Wash Up (December 21 – February 22). • Completion of Group Four, • Competition of any follow up vaccinations as required, and • Preparation of next vaccination roll out, if required.	Q2 & Q4

Regularly review all relevant Border Health Standard Operating Procedures against COVID-19 Standard Operating Procedures and the Health Equity Assessment Tool (HEAT), and up-date our procedures as required to ensure they continue to promote equity and protect at-risk populations (including communities with high Māori and Pacific Peoples populations). **(CCDHB)**	Q2 & Q4

Healthy Food and Drink Environments (E6-CC)	
Actions	**Milestones**
Support the appointment of a new Chair of the 3DHB Healthy Foods and Drink Environments Implementation Group. **(3DHB)**	Q2
Ensure all food service providers operating on CCDHB sites are 100% compliant with the Food and Beverage Guidelines. **(CCDHB)**	Q2 & Q4
Ensure that all relevant contracts and licences to occupy contain clauses regarding service providers/tenants obligation to be 100% compliant with the guidelines. **(CCDHB)**	Q2 & Q4
The RPH Māori and Pasifika COVID-19 Response leads will support Māori and Pasifika communities to identify and lead COVID-19 recovery projects/plans, including those to improve access to reliable healthy food options (RPH -core function: health promotion) (EOA) This is a cross service opportunity. **(3DHB)**	Q2 & Q4
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 Pasifika 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)**	Q4

Smokefree 2025 (E7-CC and HV)	
Actions	**Milestones**
CCDHB and HVDHB will develop responses that support smokers with mild to moderate mental health issues who have been impacted by Covid-19. This may include providing easy access to NRT from home. **(2DHB)**	Q1 & Q4: Status update
Through partnering with PHOs, DHB services, Māori, Pasifika and NGO providers, prioritise a focus on lifting the referrals rates to smoking cessation services to pre-Covid-19 levels. (EOA) **(2DHB)**	Q1 & Q4: Status update
Complete an audit of referrals to smoking cessation services, including analysis of referral sources, volumes and a view by ethnicity and locality. This is intended to address the gap in smoking rates for Māori and Pasifika by ensuring appropriate referral processes and behaviours are in place. (EOA) **(2DHB)**	Q1
Develop a 2DHB tobacco control and smoking cessation investment plan, that matches agreed government, DHB and community priorities and commitments for smoking cessation to funding commitments. **(2DHB)**	Q2
Takiri Mai Te Ata (Regional Stop Smoking Service) will work in partnership with 2DHB Pacific Director to develop a Regional Stop Smoking Pacific Plan. **(2DHB)**	Q1 & Q4: Status update

Breast Screening (E8-CC)		
Actions		**Milestone**
CCDHB continues to work with the Regional Screening Services to achieve the 70% screening target for Māori and Pasifika women.		
Māori and Pasifika wāhine prioritised through COVID-19 recovery	Regional Screening Services will progress the work of the 2020 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 Pasifika women. The project will look at additional fixed sites and/or a replacement mobile unit. **Progress will be measured using data from the ethnicity coverage report to measure target success** (EOA) **(2DHB)**	Q2 and Q4: Status update
Eliminate equity gaps	Regional Screening Services will work in partnership with local Māori health providers, Pasifika health providers, PHOs, and primary care and community health services, identifying priority women with PHO data matching activity, use of local clinics, and organising education and health promotional events. We will also engage with our Māori Council to discuss how we can better reach our priority populations. **Progress will be measured using data from the PHO data report against the new enrolment data of Maori & Pacifica** (EOA) **(2DHB)**	Q2 and Q4: Status update
Improve participation for Māori and Pasifika women	To support the national (BreastScreen Aotearoa) two-year pathway to achieve the 70% screening target for Māori and Pasifika women, Regional Screening Services' recruitment and retention team will aim to support as many additional Māori and Pasifika women as possible who are overdue or unscreened to attend a breast screening clinic. Māori and Pasifika women are given first priority when BreastScreen appointments are scheduled. **Progress will be measured using data from the coverage report by ethnicity and success will be measured from the priority day clinics** (EOA) **(2DHB)**	Q2 and Q4: Status update
Note: all data used for monitoring and reporting is provided by the BreastScreen Aotearoa (BSA) data reporting services. Our BreastScreen Central data is collected from the BSA information systems and fed into the national database. All monitoring reports are generated from this national database. The Q2 and Q4 reporting is based on the DHB national coverage report produced by the National Screening Unit. Six monthly reporting is also a requirement for BSA. Data from the Ministry (BSA) is supplied for BreastScreening Central using population estimates from the 2013 consensus for regional coverage. Further data for coverage by ethnicity and the target of 70% is used to measure indicator targets and measure performance and progress of the service. Indicator targets are reported in the 6 month Narrative report framework supplied by BSA. Development of a production plan for the Regional Screening services is in development to forecast service demands, meeting targets against resources.		

Cervical Screening (E9-CC)		
Actions		**Milestones**
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, Pasifika, and Asian women		
Improve Māori coverage and Pasifika coverage	Regional Screening Services will work in partnership with local Māori health providers and Pasifika health providers to attend events where priority populations gather and promote key messages around the importance and benefits of cervical screening. We will provide education and support for women into the screening pathway. We will also engage with our Māori Council to discuss how we can better reach our priority populations. (EOA) **(2DHB)**	Q4

Actions to reduce the equity gap	Regional Screening Services will partner with Tū Ora Compass Health, Ora Toa PHO Cosine PHO to identity general practices with high volumes of Māori, Pasifika and Asian women overdue or under-screened. We will partner with these practices to support these women into a 'Free Cervical Screening Clinic'. (EOA) **(CCDHB)**	Q2 & Q4: Status update
	Regional Screening Services will provide four weekend free cervical screening clinics at Wellington Hospital and four at Kenepuru Hospital per annum to improve Māori and Pasifika screening coverage. These clinics will be combined with breast screening where possible. **(CCDHB)** (EOA)	Q2 & Q4: Status update
	Regional Screening Services will provide support to cervical screening clinics run in in high-needs communities across the CCDHB and HVDHB region targeting Māori, Pasifika, and Asian women. (EOA) **(2DHB)**	Q2 & Q4: Status update
Equitable access to diagnostic and treatment colposcopies	Regional Screening Services will work with the colposcopy unit to ensure women who did not attend diagnostic and treatment colposcopy services are actively followed up and referred to service providers. Regional Screening Services will also facilitate two 3DHB Colposcopy meetings per annum to enhance collaboration and share ideas. **(2DHB)**	Q2 & Q4: Status update

Reducing Alcohol Related Harm (E10-CC)	
Actions	**Milestones**
RPH continues to develop and improve our local knowledge of how alcohol adversely affects local communities, including using hospital and emergency department data. (RPH: core function – health assessment and surveillance) **(3DHB)**	Q2 & Q4: Status update
Provide health protection activities relating to the Sale and Supply of Alcohol Act 2012. (RPH: core function – health protection) **(3DHB)**	Q2 & Q4: Status update
Influence policies related to reducing alcohol related harm, e.g. Councils' local alcohol policies. (RPH: core function – health promotion) **(3DHB)**	Q2 & Q4: Status update
The RPH Māori and Pasifika COVID-19 Response leads will support Māori and Pasifika communities to identify and lead COVID-19 recovery projects/plans, including those to reduce alcohol related harm. We will also 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) (RPH: core function – health promotion) **(3DHB)**	Q2 & Q4: Status update

Sexual and Reproductive Health (E11-CC)	
Actions	**Milestones**
STI rates increased during the time of the COVID-19 lockdown. RPH will assess the ongoing impact of COVID-19 on STI incidence as part of providing information and advice to communities and health providers for sexually transmitted infections (STIs) outbreaks. (RPH: core function – health promotion) **(3DHB)**	Q2 & Q4: Status update
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, Pasifika, and disabled people. (EOA) (RPH: core function – health promotion) **(3DHB)** Māori Council: The above suggests that work has already been done to identify the sexual health issues identified by Māori, Pasifika, and disabled people. There is a greater need for transparency here. If work has been done, please name and reference this. If work has not been done, please be clear about this.]	Q2 & Q4: Status update

Cross-Sectoral Collaboration, including Health-in-all-Policies (E12-CC)	
Actions	**Milestones**
Provide equity focused (Māori, Pasifika, disabled people) and COVID-19 recovery informed public health input as a member of the Wellington Regional Healthy Housing Group (WRHHG) steering group and working group(s) to implement the 2021 and 2022 WRHHG strategy and action plan. (RPH: core function – Health Promotion). **(3DHB)**	Q1-4
Deliver the Health in All Policies programme (HiAP) providing public health input to local, regional and central government policy processes with significant potential for equity focused health impact. This is a cross service opportunity that links to other actions to enhance tino rangatiratanga and achieve equity including for Pacific populations. (RPH: core function – Health Promotion). **(3DHB)**	Q1-4

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

Delivery of Whānau Ora (F1-CC)		
Actions		**Milestones**
COVID Recovery	One of the biggest successes of COVID-19 was the ability to flexibly and responsively mobilise investment in Maori, Pasifika and disability providers. We will apply these learnings to develop more streamlined community commissioning processes across the 2DHBs. We will also apply these learnings to our rollout of the COVID-19 immunisation campaign for Maori, Pasifika and disability communities. **(2DHB)**	Q1: Confirmed delivery model for reach to Maori, Pasifika and disability community Q3: Status update
Equity focussed actions	The DHB will continue to work in partnership with Te Ātiawa ki Whakarongotai/Kāpiti on the development of Kapiti Community Health Network. Building on the success of the Kapiti Community Health Network, we will partner with mana whenua, community leaders and other agencies to transform the way we commission services in Porirua, our locality that experiences the greatest inequitable outcomes, particularly for Māori, Pasifika, and disabled people. We will commission integrated services that meet people's needs at the earliest and lowest cost opportunity. (EOA) **(CCDHB)**	Q1: Execute a single outcomes-based contract, underpinned by an Annual Investment Plan and Outcomes Framework. Q4: Prepare a revised Annual Investment Plan for 2022/23, including increased investment in community-based delivery.
	CCDHB and HVDHB will work together to develop and implement a cultural competency framework to improve cultural responsiveness and increase the capability of the non-Pasifika health workforce to respond appropriately to the needs of Pasifika people. **(2DHB)**	Q3 Develop a cultural competency framework Q4 Implement cultural competency training with the Capability and Development Unit

Ola Manuia: Pasifika Health and Wellbeing Action Plan 2020-2025 (F2-CC and HV)		
Actions		**Milestones**
Supporting contact tracing	Appoint and retain a Pasifika COVID-19 Response Lead within RPH to oversee case investigation and contract tracing from a Pasifika perspective. **(2DHB)**	Q2 and Q4
Improve communications	RPH in collaboration with our Pasifika Health Unit will co-create COVID-19 public health communications to ensure that these	Q2 and Q4

	communications are effective and targeted to our Pasifika communities. **(2DHB)**	
Access to wrap around services	CCDHB and HVDHB will work together with primary care and key stakeholders to develop an implementation plan focused on ensuring access to wrap around health and social services for Pasifika families, especially those with complex needs. **(2DHB)**	Q3 Develop the 2DHB Pasifika Health and Wellbeing Strategic implementation plan Q4 Status report on progress
Maintain good relationships	CCDHB and HVDHB will work together to develop and implement a cultural competency framework to improve cultural responsiveness and increase the capability of the non-Pasifika health workforce to maintain good relationships and respond appropriately to the needs of Pasifika people. **(2DHB)**	Q3 Develop a cultural competency framework Q4 Implement cultural competency training with the Capability and Development Unit
Pasifika health workforce	CCDHB and HVDHB will work together to develop and implement a 2DHB Pasifika Health Workforce Strategy. **(2DHB)**	Q3 Develop a 2DHB Pasifika Workforce Strategy. Q4 Implement a 2DHB career pathway for Pasifika graduates with HR and Recruitment, linked to career opportunities for secondary and tertiary education providers.

Health Outcomes for Disabled People (F3-CC and HV)

Actions	Milestones
Collaborate with the Ministry, DHB staff, community stakeholders and disabled people in each region to develop new Sub Regional Disability Strategy for 2023 – 2028, which will include a specific focus on embedding the learnings from COVID-19. Development of the revised strategy will include targeted engagement with Māori disabled people and Pasifika disabled people to advise and help develop tailored actions to achieve equable outcomes. (EOA). **(3DHB)**	Q4
Work with the Disability Support Advisory Committee to implement a process to collect information (eg standardised disability question) from people with disabilities that enables health services to respond to people with disabilities and be culturally responsive to Māori people and Pacific people. **(3DHB)**	Q2 & Q4 Narrative report
Deliver core disability responsive education with the newly completed 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 building on the gap identified during the COVID response. **(3DHB)**	Q2 & Q4 Narrative report

Planned Care (F4-CC)

Strategic Priority	Actions	Milestones
1: Improve understanding of local health needs	Develop a framework to assist services to change service delivery model and move settings of care from Hospital to community. **(2DHB)**	Q1 Frame work for redesigning models/settings of care is developed Q1-Q4 Models of care/settings of care for prioritised services are redesigned using the framework developed in Q1

2: Balance national consistency and the local context	Implement a sub-regional ENT service that aligns access criteria across the 2DHBs. **(2DHB)**	Q1-2: standardisation of referral prioritisation is achieved and management of FSAs across both DHBs commences. Q3: Align employment model with service provision across the DHBs. Q4: Both CCDHB and Hutt DHB are ESPI 2 and 5 compliant.
3: Support consumers to navigate their health journeys	Reducing travel for people in Kapiti is a priority for the newly established Kapiti Community Health Network. We will continue to work in partnership with Te Ātiawa ki Whakarongotai/Kāpiti to identify three opportunities to deliver services currently delivered at Wellington Regional Hospital in Kapiti instead, through the Kapiti Health Network This may use new workforces and/or telehealth. **(CCDHB)**	Q1. Identify 3 priorities Q2 Plan for service change developed and underway Q4 New service models implemented.
4: Optimise sector capacity and capability	A 2DHB elective outsourcing contract is established to increase patient access to elective service provision. **(2DHB)**	Q1 Negotiate contract Q2 Contract implemented
5: Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.	Pending MoH approval, procure a mobile CT scanner on a truck) to serve populations living in north Wellington, Porirua, and the Kāpiti Coast (the Northern corridor). This assumes MoH approval by Q3 2020/21. **(CCDHB)**	Q1 Complete RFP Q3 Signed agreement with provider
Supporting COVID recovery	Our CT and MRI waiting lists, post-COVID-19, require improvement. We are therefore prioritising radiology in our Planned Care Improvement Action Plan investment from MoH to reduce waiting times and ensure people access diagnostics in a timely manner. This investment will be to maximise local private radiology capacity to support sustained improvement for Planned Care Measure Three; diagnostic waiting time indicator for CT and MRI. **(CCDHB)**	Q1 –Production plan requirements Q2 – Provide plan to MoH for Approval Q3-4 implementation
Acute Readmissions and Diagnostics waiting times. Two locally selected contributory measures: Acute Readmissions (as agreed with MoH through PCI) and Diagnostics waiting times (as per Planned Care definitions).		

Acute Demand (F5-CC)		
Actions		**Milestones**
Using ED data to improve service design and planning	SNOMED codes enable the DHB's raw patient and service data to be coded consistently with a national standard thereby allowing DHB service managers and the Ministry of Health to better understand patient population trends, service pathways and identify patient needs. Collated data will be used to develop performance dashboards to inform how our services can be streamlined to better meet patient	Q2 and Q4 (Aligned with Primary Health Care milestones – G1)

	and community needs and demand. This level of business intelligence supports service design and planning, particularly within primary and community care, to reduce demand on hospital services. **(2DHB)**	
COVID recovery / learning Improving wait times for patients	MHAIDS, in partnership with Hospital Flow Services, will improve performance of services to provide timely assessments for priority populations (i.e. Mental Health, Maori, Pasifika). Reduce acute assessment wait-times (specifically showing service improvement for Mental Health, Maori, Pasifika). **(2DHB)**	Q1: Increased nurse-led resource in ED to complete timely assessments Q2: Understand physical capacity learnings and use these to improve capacity to provide timely assessments Q3 &Q4: Improve escalation pathways for responsive services including MHAIDS
Acute care equity action	Work with the ED Māori advisory group to develop a flip chart to guide staff on Tikanga Māori approaches to care to help ensure we provide culturally appropriate care to Māori and their whanau who attend ED. (**2DHB)** (EOA)	Q2 – Flip chart developed and provided to ED staff.
Partnering with primary care to achieve equity	Specialist staff will participate in the development of the Community Health Network in an area with high Māori/Pasifika population. Integration with primary care will build relationships and networks between primary and secondary care and result in appropriate development of services and workforce to deliver care closer to home. The Community Health Network is expected to improve care coordination and reduce potentially avoidable hospitalisations. **(2DHB)**	Q2 Framework for implementation signed off by Board Q4 At least one new Network established.
Acute Hospital Bed Days per capita	Please refer to our System Level Measures Plan attached.	

Implementation of the Healthy Ageing Strategy 2016 & Priority Actions 2019-22 (F6-CC)		
Actions		**Milestones**
COVID Preparedness / Learnings	Work with our aged care provider network to review and consolidate what was learnt during the initial stages of COVID-19 including infection prevention and control measures and refresh systems, processes and workforce capacity in Aged Care Facilities. **(2DHB)**	Q1 complete review of learnings Q2 work with sector to refresh systems and processes Q4 Identified changes are implemented
Age-Related Frailty	a) Establish a sustainable Fracture Liaison Service with a particular focus on earlier and preventative intervention such as decreased polypharmacy, osteoporosis screening, falls prevention, and strength and balance programmes. **(2DHB)** b) Investigate culturally responsive tools, with a focus on Māori and Pasifika communities, to identify signs of frailty earlier and connect with appropriate community supports in a timely way. **(2DHB)**	Q1-Q2 Implement refreshed FLS Q4 Culturally responsive tools endorsed

Dementia services	a) Develop approaches to address gaps in service across the dementia journey from early diagnosis to end of life care and support that improves equity, availability and access to dementia services. This will include the development of flexible models for respite care for example increased access to respite care hours by Home and Community Support Services and review of day programmes. **(2DHB)** b) Review and refresh approaches to increase workforce knowledge and skills specific to dementia to decrease stigma, assist timely diagnosis, support and care planning. **(2DHB)**	Q2: Service gaps identified Q3: Flexible respite models developed Q4: Implementation of models Q4: Workforce capability approaches developed
Community-based support and restorative services	a) Expand on early supported discharge services for older people with further focus on stroke services. **(2DHB)** b) Develop pathways that enable access to appropriate and responsive services for Māori, Pasifika and people with disabilities. **(2DHB)**	Q2 – Early supported discharge implemented Q4 Responsive pathways developed and implemented

Health Quality & Safety (F7-CC)

Actions		**Milestones**
COVID Learnings	Hand hygiene audit programme implemented and reported in Emergency Department. **(2DHB)**	Q1 and Q4 as per HQSC requirements
Improving equity	The DHB will develop integrated approaches working with Māori and Pasifika providers and primary care to prevent and manage long-term conditions with a focus on CVD/Diabetes, Gout and respiratory disease. (EOA) This work will include: • Developing pathways to link with community providers of physical health and wellbeing services, education and health literacy • Developing better links between primary care and smoking cessation services across the region • Further developing opportunistic screening services to complete CardioVascular Disease Risk Assessment (CVDRA) checks in high risk Māori and Pasifika people working with a wider workforce. • Review clinical pharmacist service to ensure it places emphasis on polypharmacy, reducing the risk and impact of fragility fractures, and addressing poorly managed, equity-focused conditions such as gout and diabetes. **(2DHB)**	Q2, Q4
Improving Consumer engagement	We will work within the SURE Framework, which stands for Supporting, Understanding, Responding, and Evaluating. The aim of this framework is to 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. Actions for 2021/22: a) Continue to support and develop the newly established Consumer Advisory Group (comprising CCDHB staff and consumers) that will monitor the Health Quality & Safety Commission (HQSC) Health Quality Safety Marker (QSM). b) Arrange two workshops for the Consumer Advisory Group by Q4 to support their work and develop capability. c) Report against the SURE Framework to the Health Quality and Safety Commission with active involvement of the Consumer Advisory Group. (Q1 & Q4 as per HQSC requirements) d) Consumer engagement integration into Quality Improvement: The principles of consumer engagement will be integral to the Quality Improvement training for health staff at CCDHB. The consumer engagement manager will develop and deliver	Q1 and Q4 as per HQSC requirements

	sessions, with a focus on co-design and equity, as part of the scheduled Quality Improvement training. Completed projects will be reviewed for evidence of consumer engagement and equity principles and the results of this will reported to the Consumer Advisory Group for review. Milestones: Project review in Q1 and Q3. **(CCDHB)**	

Cancer Control Agency (F8 - CCDHB and HVDHB)		
Actions		**Milestones**
Actions to ensure the regional Radiation Oncology Model of Service is fit for purpose to meet the current and future needs	Development of medical physics professional development standards	Q1-4 Medical Physics professional framework implemented
	Implementation of new radiation safety standards.	Q1-4 compliant with recently amended radiation safety standards
Action regarding outreach radiation treatment services Radiation Therapy Linac planning for the region in 2021/22.	Options paper for CCDHB and HVDHB board to be developed in 21/22 financial year to examine options for a 4th LINAC and whether that is delivered via a satellite unit. Project lead to be appointed, 2DHB steering committee and TOR developed to commence work. Analysis of population needs and options for service delivery completed Paper for 2DHB Board delivering options for outreach radiation service provision completed.	Q1- steering committee overseeing the development of an options paper for the outreach radiation services. Q2 analysis of HVDHB and Wairarapa DHB population and radiation therapy needs requirements completed. Q3- 4: In 2022 joint CCDHB & HVDHB boards will approved a timeline of when HVDHB & WaiDHB will have improved access to radiation therapy by the CCDHB radiation therapy service.
Actions to address inequalities and access to diagnosis and care for Māori and Pacific patients	Improve access to locally provided cancer treatments	Q3-4 Completion of fit for purpose dayward at Kenepuru hospital to facilitate closer to home treatment where clinically suitable
	Review of Maori Cancer Nurse Coordinator position to identify opportunities to improve equity of access including diagnostics	Q1-4 act upon recommendations identified in review of Maori Cancer Nurse Coordinator role to improve access, diagnostics and participation in treatment.
Performance improvement actions	Monitor referrals to Oncology services with advanced disease. **(2DHB)**	Q1-4: By the end of 21/22 there will be a reduction in patient presentations with advanced disease at time of referral
	Monitor referrals by reviewing diagnosis of cancer occurring in ED. **(2DHB)**	Q1-4: By the end of 21/22 there will a reduction in

		diagnosis of cancer occurring in ED.
Tobacco control	Complete an audit of referrals to smoking cessation services, including analysis of referral sources, volumes and a view by ethnicity and locality. This is intended to address the gap in smoking rates for Māori and Pasifika by ensuring appropriate referral processes and behaviours are in place. (EOA) **(2DHB)**	Q1
Reducing alcohol-related harm	Influence policies related to reducing alcohol related harm, e.g. Councils' local alcohol policies. (RPH: core function – health promotion) **(3DHB)**	Q2 & Q4: Status update
Improving nutrition	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 Pasifika 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)**	Q4
DHB Bowel Cancer Service Improvement Plan	Following publication of the second national bowel cancer QPI report, we will engage with our Māori Partnership Board, the Sub-Regional Pacific Health Advisory Group, and the CCDHB Consumer Advisory Group/HVDHB Consumer Council to inform revision of our Bowel Cancer Service Improvement Plan. **(2DHB)**	Q4
Action to improve FCT data quality	We are focussed on improving visibility of patients with an inpatient admission (via ED) resulting in cancer diagnostics. This will reduce 31 day FCT breaches (data quality). **(2DHB)**	Status update report in Q2 and Q4.
Lung cancer	Quality improvement project to review process and develop guidelines for Māori patients with a high suspicion on cancer presenting to ED. This will improve diagnostics and reduce FCT breaches (data quality). **(2DHB)**	Status update report in Q2 and Q4.
Prostate cancer	Explore a method to report on patients offered a FSA in radiation oncology by Urology team **(2DHB)**	Status update report in Q2 and Q4.
Action from the Māori Cancer Community Hui	MDM templates to include ethnicity to improve access and timeliness to our most vulnerable patients. **(2DHB)**	Status update report in Q2 and Q4.
Implementation of the HISO standards (including MDM and ACT-NOW)	Implement cancer specific Health Information Standards Organisation (HISO) standards issued by the Ministry of Health, including the Cancer Multidisciplinary Meeting Data Standard and the ACT-NOW data standards. **(2DHB)**	Status update report in Q2 and Q4.
Support of the national travel and accommodation project	Support and participate, as requested, in Te Aho o Te Kahu travel and accommodation project, which aims to improve cancer patient equity of access and treatment. **(2DHB)**	Status update report in Q2 and Q4.
Effective screening programmes that detect cancers early across all population groups and acheive equitable health outcomes	Refer to other sections of this plan: - Breast Screening (E8) - Cervical Screening (E9), and - Bowel Screening and Colonoscopy Wait Times (F9) Actions include: - Māori and Pasifika women are given first priority when BreastScreen appointments are scheduled	NA – please refer to other relevant sections of this plan.

	- Free cervical screening clinics run in high-need communities. Outreach services to priority populations who do not initially return a bowel screening kit.	

Bowel Screening and Colonoscopy Wait Times (F9-CC)	
Actions	**Milestones**
Commencement of National Bowel Screening Programme with a strong equity focus. CCDHB has developed a 'Bowel Screening Programme Equity Plan' that outlines ways in which we will communicate and engage with priority populations to ensure equitable participation in the programme. A dedicated equity working group – which includes Māori, Pasifika, and disabilities representation – will help oversee implementation of the equity plan. (EAO) **(CCDHB)**	Q1
Increased utilization of lists - we will recruit a Health Care Assistant in the gastroenterology department to help improve patient flow through the unit and enable more volume per list. **(CCDHB)**	Q2
To ensure equitable priority population participation, we will fund our PHOs to work directly with their priority populations to promote bowel screening and to provide outreach and encouragement to those who do not initially return a kit. General practices know their patients best, and this is the most likely route to encourage priority patients to take part in bowel screening. Practices will be reimbursed for attempting to contact a priority patient who has not returned a kit. (EOA) **(CCDHB)**	Q1
We will continue to recruit and train staff to support bowel screening colonoscopies. We will actively monitor our bowel screening and symptomatic colonoscopy performance on a weekly basis We will outsource work to the private sector as required to ensure all symptomatic recommended and maximum colonoscopy wait time targets are met. **(CCDHB)**	Q2 and Q4 Q1 – Q4 Q2

Health Workforce (F10 – 2DHB)		
Priority	**Actions**	**Milestones**
Using the workforce differently	We will develop a shared and consistent approach to workforce planning across the health system that is aligned to future service development, using the workforce differently as a result of the learnings from COVID, and health system transformation. **Activities:** • Programme of work in collaboration with unions to identify and develop policies and systems that enable increased flexibility in assigning and redeploying staff to different roles. • Implementation of flexible working, activity based space utilisation and digital workplace. • Review occupational health responsiveness to workforce needs for flexible assignment/redeployment due to health needs. **Expected outcomes:** • Staff are prepared and able to meet changing requirements over time. • Staff are enabled to work optimally in any place and at any time to meet the needs of the service and patients.	Q1&2. Review current people policies and processes for alignment for future service development. Q3. Report findings and agree workforce plan. Q4. Implement plan. Q1. Monitor and evaluate success of the current Nursing and Midwifery Recruitment and Retention Strategy. Q2. Apply learnings to other vulnerable workforces Q3. Continue implementation of learnings Q4. Review and make recommendations for improvements

	• Staff who are no longer able to continue to work in their substantive role, have options to be redeployed to a different role that aligns with their current needs.	
Learning from COVID	Working with our union partners, develop an employment relations strategy to support learnings from COVID, emerging models of care, and innovations in service delivery that use the health workforce differently. **Activities:** • Identify recruitment criteria that can be introduced to enable increased diversity in recruitment to leadership positions. • Further develop and strengthen the Māori and Pasifika nurse and midwifery leadership group. (EOA) • The leadership development framework is developed in partnership with Māori, to ensure it enhances the ability of Māori to see themselves as leaders, access opportunities for development and be successful in leadership roles. (EOA) **Expected outcomes:** • Increased diversity of candidates at interview. • Māori and Pasifika nurse and midwife leaders experience ongoing support to lead. • The number of Māori and Pasifika engaging and developing to take up leadership and decision-making roles is increased.	**Employment Relations Strategy** Q1.Using the existing mechanisms for engagement with our union partners (BAG and JCC) collaboratively focus on analysing the learnings from Covid and apply to the future taking into account the health system transformation. Q2. Develop and agree the resulting employment relations strategy taking into account the recruitment and retention strategy work already underway. Q3&4. Implement the strategy. **Recruitment Practices** Q1. As a result of the pilot of new pro equity recruitment practices across Allied Health develop a new model of pro equity recruitment across all workforces that results in increased diversity especially in leadership. Q2. Commence implementation of the new pro equity recruitment practices and set review criteria Q3. Continue implementation and put review mechanisms in place Q4. Review, make recommendations for improvements **Māori and Pasifika nurse and midwifery leadership** Q1&2. Through the networks already in place develop further strategies for supporting the Māori and Pasifika nurse and midwifery leadership 3&4. Implement strategies. **Leadership Development Framework** Q1. Continue design of a leadership development framework in partnership with Māori to ensure it allows Māori to see themselves in leadership roles. Q2&3. Implement a suite of development opportunities.
Build the swabbing / vaccinator workforces	We will develop/use the swabbing and vaccinator workforce differently and increase the number of vaccinators. **Activities:** • We have a programme of work planned to increase the number of vaccinators.	Q2 and Q4: Update report of progress.

	• Utilisation of technology to support future mobility and flexibility in terms of where the workforce work. • Establish a COVID vaccination workforce office to: - Identify, recruit and upskill clinicians currently not in the vaccination workforce (e.g. recently retired, registered health professionals eligible to extend scope of practice into vaccination) - Set up and maintain an easily identified pool of appropriately skilled staff who can provide surge capacity as and when needed. **Expected outcomes:** • Address concerns about workforce pressures on the swabbing/vaccinator workforces because of the pandemic. • Build a sustainable swabbing/vaccinator workforce.	
Increased diversity of representation in leadership or decision-making roles	In partnership with the Māori Council, develop and launch equity focussed leadership development and talent pipeline approach which grows Māori, Pasifika and disabled people leadership and increases diversity in leadership and decision-making roles. (EOA)	Q1. Develop capability statements for equity focussed leadership in all leadership roles. Q2. Ensure people processes reflect the achievement of equity focussed leadership. Q3. A talent pipeline is developed that increases diversity in leadership. Q4. Embed the priority capability in people /workforce strategies, learning programmes and leadership programmes.
Cultural competence and safety	In partnership with the Māori Council, develop a comprehensive learning programme that supports cultural safety and competency, and increases workforce capability to enact the enablers to achieving equity or outcomes. (EOA)	Q1. Identify cultural safety and capability expectations for all staff, and complete a gap analysis. Q2. Develop a staged capability building programme including a core learning programme for all new staff. Q3. Launch the programme. Q4. Monitor and review.
Ensuring work health and safety, and increased sustainability, health and wellbeing of workforces.	Implement a wellbeing programme designed to value diversity, reduce stigma around mental distress and build a supportive culture for staff.	Q1&2 Deliver capability development programme to build understanding, reduce stigma around mental distress and to increase people leader confidence and capability regarding mental wellbeing at work. Q3&4. Communications and culture campaign focussed on: Mental health and wellbeing. Diversity and inclusion. Interpersonal behaviour, prevention of bullying.

Data and Digital (F11-2DHB)		
Actions		**Milestones**
COVID Recovery / Learnings[5]	1. Continued support, as required, to enhance our response to COVID – for example enablement of the COVID immunisation register and integration to support national rollout. **(3DHB)**	Alignment with the national rollout programme.
	2. Implement ePrescriptions solution to allow outpatient prescriptions to be sent to the pharmacy of choice directly without need for paper forms or face to face contact when telehealth consults were used. **(2DHB)**	Implementation with integration with MoH ePrescription service for all outpatient clinics by Q1. (The solution for the Addictions Service of MHAIDS is a separate project and completion is expected within 1-2 years.)
Most impact on improved outcomes	3. Implement the 3DHB Clinical Portal – a new clinical portal shared by all three DHB's. Patient safety and care quality improved by: • 3DHB patient data accessible in one location. • 3DHB patient data accessible in Central Region. • Cost reductions for the DHBs due to a shared infrastructure and simplified, supported solutions. • 3DHB improved system resilience, availability and disaster recovery capability. **(3DHB)**	Q3 20/21 - Business case signoff from MoH/DHB Q3 21/22 - Hutt Valley module live Q4 21/22 - CCDHB module live
	4. Implement 3DHB Smart eReferrals, intelligent scheduling and appointments platform. Consolidate to common e-referrals platform between primary, community and ambulatory care services across 3DHB. Deliver smart referrals connected to health pathways and consider acute, equity and disability context of patient journey. **(3DHB)**	Q4 21/22 - Deliver ICT foundation capabilities and master data synchronisation End-to-end service enablement process design Implement primary and community referrals
	5. Implement Mobile Electronic Patient Observations. Patient safety and care quality improved by: • Reducing errors by removing paper charts and manual calculations • Immediate escalation of concerns based on observations to relevant clinicians • Reduction in effort required to capture observations. • Improved efficiency, as the mobile platform can be extended to other uses, such as drug charting, ordering, task management, results viewing and signoff.	Q1 21/22 - Business case submitted Q2 21/22 - Rollout to pilot teams Q3 21/22 - Rollout to all services Q3

[5] 3DHB ICT were able to respond to the needs of the DHB with regard to our COVID-19 response without any significant delays to strategic initiatives and other work programmes.

Most important for improving digital inclusion	6. We will co-design healthcare access points and services with community and advocacy groups so that digital services are more widely accessible to all groups.	Q2 21/22 - Mobilising our community workforce to ensure the right enablers are available
Most important for improving equity	7. ICT solutions will support implementation of the Community Health Networks by: • partnering with community groups and leaders to link into targeted, trusted sources of information so that patients can find content that makes sense to them, and they know what they need to do to stay healthy • providing a more joined up view of patient care records, care plans and care participants • enabling mobile solutions for the health workforce • providing access to referral and clinical systems. The Community Health Networks are focussed on improving equitable access and outcomes. They are designed to deliver coordinated health care closer to the community, address population specific needs, and avoid unnecessary visits to ED or the hospital.	Initiate primary care and 3DHB working group for shared electronic health record vision and plan. Frame capability requirements for supporting community network initiatives. Community Nursing & Allied Health Mobility in the Community requirements. Q2 - Q4: Creation and maturity of locality based hubs and community networks (Kapiti, South Porirua, Wainuiomata &, Hutt Region) Q2 – Q4: Enablement of mobility tools for community care workforce Q4: Shared care planning framework and toolkit, in conjunction with shared care records work Q4: Initiation National child development services operating model. (MoH led)

Implementing the New Zealand Health Research Strategy (F12 – 2DHB)

Actions		**Milestones**
COVID Recovery / Learnings	Action 1 Time critical COVID-19 research will be given a high priory for institutional review via an expedited process. CCDHB will be well positioned to participate in crucial COVID-19 research and uptake learnings from that work. **(2DHB)**	Q1-Q4
	Action 2 Impacts of COVID-19 on clinical trial activity will continue to be monitored for risk assessment. Innovative strategies introduced as a result of Covid will be assessed and implemented as appropriate. **(2DHB)**	Q4
Working with regional research networks	Action 1 Participate and Support funded by the HRC in 2020 Enhancing New Zealand's Clinical Trials (*Towards a national, equitable and sustainable clinical trial system in Aotearoa New Zealand).* **(2DHB)**	Q2
	Action 2 Establish 2021/2022 work plan for the national DHB research officers' collaboration (ROMA). Discuss and support development of national procedures and policies related to research across all DHBs. **(2DHB)**	Q1-4
Building DHB capacity and capability to enhance	Action 1 Coordinate Māori consultation to guide proposal development for funding bids to Health Research Council in 2021 in collaboration with Research Advisory Group - Māori. Involvement of Māori at the earliest stage (and throughout) will enhance potential for the research to achieve Māori health advancement. **(2DHB)**	Q1-4

research and innovation	Action 2 Establish a priority setting framework for specialties to identify and encourage research that will have maximal impact on CCDHB strategic goals. **(2DHB)**	Q4
Providing staff with professional development opportunities	Action 1. Support CCDHB applications for Health Research Council Career Development Awards. **(2DHB)**	Q2
	Action 2. Regular communication of national and international health research funding and training opportunities. **(2DHB)**	Q1-4

Care Capacity Demand Management (F13 - CC)

Actions	**Milestone(s)**
Governance	
Overarching annual and high level three year work plans in place and on schedule.	Q1 – Q4
Work plans for each programme standard in place and on schedule.	Q1 – Q4
All CCDM work plans for each programme standard 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.	Q1 – Q4
CCDM Council meetings held monthly to monitor progress against the annual work plan and maintain oversight of all work streams.	Q1 – Q4
Develop a plan for CCDM business as usual post implementation.	Q4
Complete all reporting requirements as per the CCDM programme.	Q1 – Q4
Maintain partnership with NZNO, MERAS and PSA throughout all aspects of the programme.	Q1 – Q4
Validated patient acuity	
Implementation of TrendCare vendor upgrades within 3 months of release.	Q1 – Q4
Complete annual Inter Rater Reliability (IRR) testing for all staff and 2 weeks post orientation for all new staff to ensure compliance.	Q1 – Q4
Undertake TrendCare Gold Standards assessment annually.	Q1
Compliance and accuracy checks weekly and monthly to ensure quality and integrity to support CCDM progress.	Q1 – Q4
Expand TrendCare into all nursing and midwifery areas as able – dependant on TrendCare vendor module release.	Q1 – Q4
Core Data Set	
Implement remaining 5 core data set metrics as able • Staff satisfaction (awaiting national consensus) • Care rationing (awaiting national consensus) • Patient satisfaction (low patient responses) • Professional development (in development) • Variance Indicator Score (VIS) (in development).	Q1 – Q4
Facilitate a core data set overview to CCDM Council and Executive Leadership Team (ELT) monthly.	Q1 – Q4
Utilise core data set to drive quality improvement through local data councils, support FTE calculations and review impact of same, measure impact of variance response management measures and overall programme implementation.	Q1 – Q4

Facilitate the use of the core data set to achieve data driven decision making.	Q1 – Q4
Staffing Methodology	
Monitor ongoing recruitment of FTE calculation outcomes and report to CCDM Council, ELT and MoH (through quarterly reporting).	Q1 – Q4
Implement outcomes of FTE calculations to inform the 2021/22 financial year.	Q1 – Q4
Undertake FTE calculations for all inpatient units (dependant on TrendCare accuracy) to inform the 2022/23 financial year.	Q1 – Q4
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
Variance Response Management (VRM)	
Ongoing evaluation of the impact of the VRM tools and processes including escalation incidences, periods of time and drive standardised responses.	Q1 – Q4
Further development of Capacity at a Glance (CaaG) screens to include MHIADS overarching view, community and allied health.	Q1 – Q4
Provide support to develop the solution for a 3DHB Capacity at a Glance (CaaG) platform.	Q1 – Q4

Better population health outcomes supported by primary health care

Primary Health Care Integration (G1-CC)	
Actions	**Milestones**
Community Health Networks 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, alongside increased investment in Māori health providers and Pasifika health providers. The Community Health Networks / Wellbeing Hubs will become the central organising point for delivering effective and efficient health care. They will support people to use home-based health services and technologies that treat and support people in the community, and connect people to specialist services and social support services when required.	
The DHB will continue to work in partnership with Te Ātiawa ki Whakarongotai/Kāpiti on the development of Kapiti Community Health Network. Building on the success of the Kapiti Community Health Network, we will establish a Community Health Network in an area with high Māori/Pacific populations.(EOA) **(2DHB)**	Q2 Framework for implementation signed off by Board Q4 At least one new Network established.
Establish equity weighted sustainable funding for practices to maintain Health Care Home certification (which contains practice level equity expectations) after Year 5 of the change programme. **(CCDHB)**	Q1 Funding approach agreed and implemented. Q2 establish ongoing monitoring framework.
Enable virtual appointments in all practices in CCDHB. **(CCDHB)**	Q1 Stocktake of current position and development of plan to ensure virtual appointments available in every practice Q4 Virtual appointments available in every practice.

Pharmacy (G2-CC)	
Actions	**Milestones**
Implement ePrescriptions solution to allow outpatient prescriptions to be sent to the pharmacy of choice directly without need for paper forms or face to face contact when telehealth consults were used. **(2DHB)**	Implementation with integration with MoH ePrescription service for all outpatient clinics by Q1. (The solution for the Addictions Service of MHAIDS is a separate project and completion is expected within 1-2 years.)
Boost immunisation capacity by increasing the number of pharmacies involved in immunisation activity. **(2DHB)**	Increase the number of pharmacies ready to provide immunisation services by 4 by Q3.
Identify opportunities for the pharmacy workforce to contribute to activities to increase more equitable influenza vaccine uptake. **(2DHB)**	Engagement with Maori and Pasifika communities and providers completed by Q3. Four community based flu-vax clinics completed by Q4.
Review clinical pharmacist service to ensure it places emphasis on polypharmacy, reducing the risk and impact of fragility fractures, and addressing poorly managed, equity-focused conditions such as gout and diabetes. **(2DHB)**	Engagement with primary care completed by Q1. Revised action plan developed and started by Q3.
Improve medicine information access to improve patient safety and reduce search time. **(2DHB)**	Access to Concerto and Conporto enabled for all pharmacies by Q1. Undertake pharmacist training on Concerto and Conporto by Q2.

Reconfiguration of the National Air Ambulance Service Project – Phase Two (G3-2DHB)	
Actions	**Milestones**
CCDHB/HVDHB supports the aims of a world-class integrated aeromedical transport system that provides timely and excellent care to patients and reduces health inequities. CCDHB/HVDHB supports Phase Two of the process and outcomes with a focus on recognition that inter hospital transport involves DHB patients being moved by and under the supervision of DHB clinicians. Reconfiguration of this system must include; a) The expertise of flight nurses and intensive care doctors who are skilled in assessment, management and co-ordination of the critically ill. b) Continuity of the clinical expertise involved in the process of coordinating inter hospital transport of critically ill patients. c) Interoperability and compatibility of aircraft and stretcher systems used by DHB (ICU, NICU and PICU) teams, which is different to those in use in the prehospital domain. d) Provision of tertiary critical care at the bedside within resource-limited in-patient secondary Hospital facilities.	Q4 Status Update report

Long-Term Conditions (G4-CC)		
Actions		**Milestones**
COVID Recovery / Learning	1. The DHB will work with primary care to implement identified opportunities from COVID-19 to increase the accessibility of primary care services, particularly for our Māori and Pasifika populations. (EOA) **(2DHB)** This work will include: • Working with Māori and Pasifika providers to ensure COVID-19 vaccine uptake is accessible for Māori and Pasifika peoples with long term conditions	Q2, Q4

	• Review access to after/hours services across the region with a particular focus on access for Māori and Pasifika and people with disabilities.	
Nutrition and physical activity	2. The DHB and Regional Public Health will work with communities to increase awareness and promote healthy nutrition and physical activity to prevent onset and promote the education and management of long term conditions. (EOA) **(CCDHB)** This work will include: • Support 'Project Energise' in their work to engage with low decile, high Māori and Pasifika schools with healthy education and activities.	Q2, Q4
Early risk assessment	3. Review and strengthen system pathways that support people living with diabetes, particularly Māori, Pasifika, and South East Asian. **(2DHB)** This work will include: • Identifying and prioritising practices with high rates of diabetes • Identifying and addressing gaps in provider education that will improve patient management • Improving referral pathways for specialist services	Q2 – Q4
Management of Long Term Conditions	4. The DHB will develop integrated approaches working with Māori and Pasifika providers and primary care to prevent and manage long-term conditions with a focus on CVD/Diabetes, Gout and respiratory disease. **(2DHB)** This work will include: • Developing pathways to link with community providers of physical health and wellbeing services, education and health literacy • Developing better links between primary care and smoking cessation services across the region • Further developing opportunistic screening services to complete CardioVascular Disease Risk Assessment (CVDRA) checks in high risk Māori and Pasifika people working with a wider workforce.	Q2, Q4
Hepatitis C	5. The DHB will work with primary care and wider community providers to identify opportunities to improve the health of the DHB population through access to hepatitis C treatments. This work will be ongoing and further refined as information is released from the draft National Hepatitis C Action Plan. (TBD on release of National Hepatitis C Action Plan). **(2DHB)**	Q4
Improving ASH rates (SS05)	6. The DHB will identify opportunities to reduce ASH rates in top presenting conditions. This action will have a particular focus on our Māori and Pasifika populations. **(CCDHB)** This work will include: • Working with our Pasifika providers to collaboratively address inequities and high unmet needs in the Pasifika community. • Promotion of Primary Options for Acute Care (POAC) uptake for Māori and Pasifika patients. • Development of Kāpiti Community Health Network operational guidelines.	Q2, Q4
	7. The DHB will work with Primary Care to develop a new action model to deliver our ABC targets for offering brief advice to quit smoking. This model will support greater interactions in primary care and place greater emphasis on referral to smoking cessation services. **(2DHB)** This work will include: • Strengthening the relationships between primary care services and Takiri Mai Te Ata Regional Stop Smoking Service. • Evaluating the smoking targets and developing a plan to increase referrals to smoking cessation services.	Q2

	8. The DHB will develop and implement initiatives to improve access to podiatry services for people living with diabetes. **(2DHB)** This work will include: • Establishing podiatry pathways • Developing approaches for prioritising high risk patients particularly Māori and Pasifika to ensure timely access to services.	Q2, Q4
	9. Provide pro-equity focused (Māori, Pasifika, disabled people) and COVID-19 recovery informed public health input as a member of the Wellington Regional Healthy Housing Group (WRHHG) steering group and working group(s) to implement the 2021 and 2022 WRHHG strategy and action plan. (RPH: core function – Health Promotion). **(3DHB)**	Q1-4
	In addition to the above actions, please refer to our 2021/22 System Level Measure Plan, which includes actions to reduce ASH rates for 0 to 4 year olds, with a particular focus on Māori children and Pasifika children.	
Contributory Measures:	a) Percentage or number of enrolled people in the PHO within the eligible population with a record of a Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64mmol/mol or less b) Primary Health Organisation (PHO) enrolled people within the eligible population who have had a Cardiovascular Disease (CVD) risk recorded within the last five years.	

2.2 Financial Performance Summary

The prospective planned result for Capital and Coast DHB 2021/22 annual plan is a surplus of $7m. The planned result includes a donation of $60m for the Children's Hospital. If this is excluded then the underlying deficit is $53m. The forecast result for 2020/21 is a deficit of $55.4 million. This includes a Holiday Act revaluation provision of $8m. The Holiday Act provision in 2021/22 is $11m.

Financial Performance Summary

Capital & Coast DHB Annual Plan Budget for the Four years ending 30 June 2025	2019/20 $'M	2020/21 $'M	2021/22 $'M	2022/23 $'M	2023/24 $'M	2024/25 $'M
Funding (excluding IDF inflows below)	1,000.0	1,120.1	1,211.7	1,204.2	1,250.0	1,297.9
Services provided for Other DHBs (IDF Inflows)	218.2	227.3	242.2	251.9	262.0	272.5
Total Funding	**1,218.2**	**1,347.4**	**1,453.9**	**1,456.1**	**1,512.0**	**1,570.3**
DHB Provider Arm	841.5	949.5	986.1	1,015.2	1,039.5	1,065.8
Funder Arm	313.7	345.3	346.9	354.6	362.6	370.8
Governance Arm	10.8	9.8	10.8	11.0	11.3	11.6
Services Purchased from Other DHBs (IDF Outflows)	96.4	98.1	103.1	106.2	109.3	112.6
Total Allocated	**1,262.4**	**1,402.8**	**1,446.9**	**1,487.1**	**1,522.8**	**1,560.9**
Surplus / (Deficit)	**(44.2)**	**(55.4)**	**7.0**	**(31.0)**	**(10.8)**	**9.5**

CCDHB Prospective Financial Performance

Capital & Coast DHB Statement of Comprehensive Income & Expenditure Plan for the Four Years ending 30 June 2025	Actual 2019/20 ** (000s)	Forecast 2020/21** (000s)	Plan 2021/22** (000s)	Plan 2022/23 (000s)	Plan 2023/24 (000s)	Plan 2024/25 (000s)
REVENUE						
Government and Crown Agency Sourced	1,187,473	1,270,054	1,352,150	1,413,335	1,468,221	1,525,469
Patient / Consumer Sourced	5,527	5,122	4,992	5,113	5,237	5,365
Other Income	25,189	72,242	96,748	37,640	38,555	39,492
TOTAL REVENUE	**1,218,189**	**1,347,418**	**1,453,890**	**1,456,088**	**1,512,014**	**1,570,326**
OPERATING COSTS						
Personnel Costs						
Medical Staff	175,829	189,837	198,568	203,393	208,336	213,398
Nursing Staff	233,985	255,012	264,362	270,786	277,366	284,106
Allied Health Staff	63,730	75,124	81,076	83,046	85,064	87,131
Support Staff	9,759	10,817	11,784	12,071	12,364	12,665
Management / Administration Staff	71,657	84,382	95,059	97,369	99,735	102,159
Total Personnel Costs	**554,959**	**615,173**	**650,849**	**666,665**	**682,865**	**699,459**
Clinical Costs						
Outsourced Services	39,765	45,292	47,900	49,364	50,564	51,793
Clinical Supplies	131,045	141,108	146,620	151,203	154,877	159,241
Total Clinical Costs	**170,809**	**186,400**	**194,520**	**200,567**	**205,441**	**211,033**
Other Operating Costs						
Hotel Services, Laundry & Cleaning	25,054	26,037	27,445	28,352	29,040	29,746
Facilities	43,363	46,796	52,194	55,248	56,162	57,786
Transport	2,537	2,636	3,600	3,687	3,777	3,869
IT Systems & Telecommunications	16,336	28,346	21,526	22,050	22,585	23,134
Interest & Financing Charges	24,485	19,814	17,836	18,270	18,714	19,169
Professional Fees & Expenses	7,637	7,687	4,090	4,189	4,291	4,395
Other Operating Expenses	6,303	26,098	24,322	26,713	27,362	28,252
Democracy	776	341	519	532	544	558
Provider Payments	410,102	443,445	449,959	460,789	471,987	483,456
Total Other Operating Costs	**536,593**	**601,201**	**601,492**	**619,829**	**634,463**	**650,364**
TOTAL COSTS	**1,262,361**	**1,402,774**	**1,446,861**	**1,487,062**	**1,522,769**	**1,560,856**
NET SURPLUS / (DEFICIT)	**(44,172)**	**(55,356)**	**7,028**	**(30,974)**	**(10,755)**	**9,470**
***Asset Revaluation (Equity movement - IRFS requirement)	(702)	-	-	-	-	-
TOTAL COMPREHENSIVE INCOME SURPLUS/(DEFICIT)	**(44,874)**	**(55,356)**	**7,028**	**(30,974)**	**(10,755)**	**9,470**

** Please note that the 2019/20, 2020/21 actuals and 2021/22 plan include adjustments for year end provisions i.e. Holidays Act and write offs.

*** 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.

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, which 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. HVDHB 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 2021/22.

3.2 Service Change

Service Changes 2021/22

For 2021/22 please include a commitment statement confirming the DHB will manage its functions in a way that supports the intended direction and anticipated system change programme.

The table below describes all active service changes that have been approved or proposed for implementation in 2021/22.

Summary of Service Changes for 2021/22

Change	Description of Change/Initiatives	Benefits of Change	Location
National Agreements	Hutt Valley DHB will implement service changes arising out of national agreement processes including: • Integrated Community Pharmacy Services Agreement • PHO Services Agreement • Age Related Residential Care • Combined Dental Agreement.	The agreements are developed using annual processes to identify priorities for service change in with consultation with the respective sector and DHB representatives.	National
FACT accreditation	CCDHB will be a FACT (Foundation for the accreditation of Cellular Therapies) service by the end of 21/22. FACT accreditation is the international certification required for Stem cell transplantations units to confirm they are running a high-quality clinical service.	• FACT is important for allogeneic transplant units such as at CCDHB because the international donor registries are imminently moving to only collect stem cells for units that are FACT accredited. Not being FACT accredited is a threat to ongoing viability of the Stem cell transplantation unit.	Regional
Hospital Provider Performance	• Joint 2DHB planning to deliver local volumes and manage through peak occupancies • Increasing specialist support for primary care to lower unnecessary hospitalisation • Establishing robust outsourcing arrangements • Embedding virtual outpatient assessments and virtual advice to GPs	• 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	Sub-regional

Change	Description of Change/Initiatives	Benefits of Change	Location
	Developing procedure rooms at the Hutt campus for those non-theatre procedures currently done in theatre.	optimising cost of service delivery.	
Acute and urgent care management in the community	• Partnering with Mana Whenua and community leaders to commission integrated services in Porirua and Wainuiomata • Working in partnership with other agencies to address the underlying determinants of health, including cross-agency work on improving housing, suicide prevention, and preventing family violence. • Community activities to increase the uptake of flu vaccinations • Working with the Ministry to continually improve the COVID-19 response system, roll out the COVID-19 immunisation programme (once developed), and implement our COVID-19 recovery plans to ensure that our patients receive the care they need. Improving access to primary care, especially after-hours services, particularly for Māori and Pasifika children and families.	• Improved access to care closer to home • Reduce avoidable admissions to hospital • Reduced operating costs	Sub-regional
Joint 2DHB Clinical Networks	We are establishing 2DHB clinical networks to maximise the effective use of resources and workforces across the two DHBs (HVDHB and CCDHB) and three hospital site (Wellington, Kenepuru and Hutt Valley). This supports clinically sustainable services and improves the financial sustainability of both DHBs, and infrastructure that enables ongoing sustainable care provision.	• Improved local access to services • More equitable health outcomes • Improved clinical pathways and service alignment across the region • Enhanced service sustainability and resource utilisation • Networked services which maximise resource utilisation to make best use of capacity • Enhanced training opportunity	CCDHB and HVDHB
Community Health Networks	Building on the Kāpiti Community Health Network (CHN) prototype established in 2020, Community Health Networks will be rolled out across both districts to improve access, experience of care, and outcomes for people living in defined local areas. The CHNs are community teams of nurses and allied health staff supporting GP practices. The CHNs will become the central organising point for delivering effective and efficient health care. They will support people to use home-based health services and technologies that treat and support people in the community, and connect people to specialist services when required. In 2021/22 we will establish at least one CHN in CCDHB and at least one in HVDHB. Both CHNs will be located in areas with high Māori/Pasifika populations.	• Improved equity of access and outcomes for Māori and Pasifika populations. • Improved access to care closer to home. • Improved management of frailty and avoidable hospitalisation. • Improved patient experience and outcomes.	CCDHB and HVDHB
Community mental health and wellbeing hubs	In 2021/22 we will co-design a service model and complete an investment business case to implement an integrated community mental health and wellbeing hub in high deprivation areas. The current priority localities	• Improved equity of access and outcomes for Māori and Pasifika populations. • Improved access to care closer to home.	CCDHB and HVDHB

Change	Description of Change/Initiatives	Benefits of Change	Location
	are Porirua and Naenae. The will be a collaborative process with a strong kaupapa Māori focus.	• Improved management of mental health conditions and avoidable hospitalisation. • Improved patient experience and outcomes.	
Community Radiology	We expect to make eligibility changes to community radiology to put greater emphasis on equity.	• Improve overall access to community radiology • Greater emphasis on equity • More equitable health outcomes	CCDHB and HVDHB

FTE Reconciliation - CCDHB

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)	2020/21 Plan	2021/22 Plan	Change
Medical Personnel	1004	1040	36
Nursing Personnel	2563	2839	276
Allied Health Personnel	773	909	136
Support Personnel	164	173	9
Management/Administration Personnel	945	1091	146
Total FTE	**5449**	**6051**	**602**

The DHB has been following a pathway to breakeven over three years, premised on a 2DHB Hospital Network and back office consolidation, this has been impacted by the lower revenue increase than expected in 21/22, versus cost pressure remaining at the levels predicted and impact of risk that has built up over years of successive deficits. FTE numbers have been tightly controlled and the increase is minimal excluding transfer from other DHB's and Care Capacity Demand Management required increases for risk.

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 Boards' (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.

Organisational performance management

CCDHB's performance is assessed on both financial and non-financial measures, which are reported at all levels of the organisation. These are reported daily, weekly, fortnightly or monthly as appropriate.

Funding and financial management

CCDHB's key financial indicators include performance against the DHB operating budget, FTE management within the FTE budget, and DHB cash position. These are assessed and reported through CCDHB's performance management process to the Executive Leadership Team, the Finance Risk and Audit Committee and the Board on a monthly basis. The DHB's cash position is also monitored on a daily basis by the DHB finance team. Further information about CCDHB's planned financial position for 2020/21 and out years is contained in the Financial Performance Summary section of CCDHB's 2020/21 Statement of Performance Expectations.

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.

HVDHB and CCDHB 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 two DHBs 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 Allied Laundry and NZ Health Partnerships. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

CCDHB has a formal risk management and reporting system, with monthly reporting to the HVDHB Finance, Risk and Audit Committee via the Executive Leadership Team. HVDHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement

CCDHB's approach to quality assurance and improvement is in line with Triple Aim plus One:

- For our patients – improved quality, safety and experience of care and a better patient journey
- For our populations – improved health and equity for all populations
- For the public – best value for health system resources and sustainable management of resources
- For our organisation – a thriving, socially responsible, organisation as a result of our culture, clinical leadership, engagement and workforce development.

CCDHB's clinical and corporate governance structure ensures that systems are in place to optimise patient care and minimise risks, whilst continuously monitoring and improving the quality of clinical care. The framework for reporting on quality assurance activity occurs at every level across the hospital, with our primary care partners, and across the sub-region. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

CCDHB also has a strong culture of continuous improvement. Our quality goals are underpinned by a culture of working together at all levels across the health system and with our neighbouring DHBs. Our culture encourages openness and transparency, learning from error or harm, and ensuring that the contribution of staff from all levels of the DHB for quality improvement and innovation are truly valued. We are working to strengthen multi-disciplinary team-based structures within the DHB to ensure that care and treatment options are well considered and patient centred. Quality improvement training and 'improvement clinics' are also provided to build understanding of quality improvement throughout the organisation.

Regional Public Health

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

The DHB and RPH continue to collaborate with Te Hiringa Hauora (the Health Promotion Agency), Healthy Families, PHOs and other community providers to leverage the investment and coordinate our health promotion activities to deliver collective impact on national and local priorities. Improving equity of outcomes for Māori, Pasifika, and people on low incomes is a key focus of this work.

Work health and safety

Work health and safety is integral to DHB operations. We are committed to improving health and safety across the health workforce as is evidenced with the introduction of a 2DHB Quality and Safety framework. This is an overarching framework that drives our programmes of quality and safety, reduced harm, clinical excellence and reflects the interdependencies between staff and patient safety. The framework supports 2DHB to meet or exceed is legislative obligations under the Health and Safety at Work Act 2015. The framework principles mirror those held within the Quadruple aim and are:

- Commitment to deliver safe, quality care to patients and whanau, and ensuring staff safety.
- Strengthen quality and safety at every level through effective leadership, integrated governance and defined accountabilities across health and disability

- Build staff resilience through leadership, professional development and mentorship for staff.
- Making safety and quality the accountability of each and every employee so as to lead a culture where organisational values drives actions and teams work together to keep patients and staff safe.

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.

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.
- A lack of asset information to inform future planning.

Key activities for 2021/22 include:

- Completion of the build of the new Children's Hospital, which commenced in 2018. The project is funded by the Crown, donations and depreciation funding.
- Planning for linac 4 project works for Wellington Regional Hospital Replacement of the interventional imaging equipment plus related facilities works in the Angiography and Fluoroscopy rooms at Wellington Regional Hospital
- Progressing the upgrade of end of life generators, high voltage network and associated Total Energy Centre projects
- Working with the MoH on upgrades and Improvements to our Oxygen Supply and Environmental Conditions following the COVID-19 pandemic (Ministry of Health funded)
- Ongoing work to remediate the copper pipes at Wellington Regional Hospital to reduce the risk of failure with consequent impact on service delivery. Construction of a single new secure facility integrated with Haumietiketike with six units, the National Intellectual Disability Inpatient Unit[6]
- Asbestos surveying and removal across the campuses
- Continuation of the multi-year deferred maintenance programme of the CCDHB's facilities that commenced in 2018. (Multiple projects in addition to those mentioned above)
- Refreshment of outdated detailed seismic assessments for key buildings. The outcomes may result in seismic upgrade works.
- Investment in asset data/information and in our asset management systems to inform future work programmes.

[6]

The outlined key activities for 2021/22 are essential programmes of work to enable CCDHB to deliver secondary and tertiary services for the local, sub-regional and regional patients.

Workforce

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.

Our health and disability system is poised for significant transformation. Our workforce priorities for the coming period focus on sustaining high quality healthcare provision and achieving increased equity outcomes in the context of complex change. Building readiness to realise the improved health outcomes includes; increasing diversity of representation, cultural competence and safety and ensuring that we have a sustainable and robust workforce.

The arrival of COVID-19, means that the context for this change is one of volatility and uncertainty. Key capabilities for our health workforce and systems will include the ability to forecast proactively and respond rapidly and flexibly to future challenges, through development of a technologically capable workforce that is supported to excel.

A collaborative whole of system approach will be essential in navigating these challenges, connecting local activity with regional and national planning priorities, developing cross-functional professional and structural relationships and in partnership with unions to enhance workforce capability and wellbeing.

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 2021/22:

- Grow our Māori, Pasifika, and disability workforce, to increase the diversity of representation in leadership and decision making roles, and to reflect the communities we serve
- Increase the capability of our workforces to provide culturally safe care
- Create the conditions for innovative ways of working, to ensure that the expertise and skills of the whole workforce are utilised optimally (right skill, right time, right place)
- Articulate accurate workforce data and analytics, which enable enhanced understanding of workforce dynamics to support pro-equity initiatives
- Develop sustainable workforce plans to address workforce vulnerabilities (that impact access and sustainability of services)
- Training for Postgraduate Year One and Two resident doctors (PGY1s and PGY2s).

Organisational Culture priorities for 2021/22

- Create an organisation culture and systems that are pro-equity
- Enable a technologically capable workforce
- Build a culture of collaborative relationships with and between professional groups to work together to achieve improved patient outcomes
- Enable people to excel and achieve transformation goals
- Learn from COVID-19 experiences to identify opportunities to use workforces differently and to increase workforce flexibility and mobility
- Support and strengthen system resilience and staff health, safety and wellbeing, including mental wellbeing.

Information technology and communications systems

Over the next financial year and beyond, 3DHB Data and Digital will continue to deliver high quality, fit for purpose digital tools to the DHBs and the wider health community. 3DHB Data and Digital supports the DHB to deliver its strategic goals as well as the expectations of the Minister of Health and the Ministry.

3DHB Data and Digital have developed a new digital strategy, consisting of five major themes that inform our operating model for a modern data and digital business unit:

3DHB Data and Digital works at a national level and with regional partners to ensure that we leverage good thinking and existing solutions to reduce the national complexity and variety of Heath ICT solutions. A critical success factor will be the co-development of national health data interoperability standards. These standards will enable sharing of information across all DHBs thus achieving a virtual national health record.

The table below shows how the 3DHB Data and Digital strategic themes are related to meeting the government's planning priorities and the DHB's strategic priorities.

Government Priority	DHB Strategic Priority	Data and Digital Strategic Theme
Giving practical effect to the Maori health action plan	Intensify service delivery for those who are vulnerable to reduce inequalities	Theme 4: Equity of access and health outcomes, especially for Maori, Pasifika peoples and people with disabilities
Improving sustainability	Organise technology and interdisciplinary teams in homes, communities and hospital to ensure efficient use of resources Implement models of care that intervene earlier in lower cost settings	Theme 5: Empowering our workforce to deliver high quality, efficient care
Improving child wellbeing	Work in communities to improve health and wellbeing and prevent or delay the onset of illness	Theme 1: Health Options in our Communities
Improving mental health wellbeing	MHAIDS Service Improvement	Theme 1: Health Options in our Communities Theme 2: Empowering people as partners in their care
Improving wellbeing through prevention	Work in communities to improve health and wellbeing and prevent or delay the onset of illness	Theme 1: Health Options in our Communities Theme 2: Empowering people as partners in their care Theme 3: Seamless collaboration across our greater Wellington sub-region and wider health ecosystem
Better population outcomes supported by a strong and	Intensify service delivery for those who are vulnerable to reduce inequalities	Theme 3: Seamless collaboration across our greater Wellington sub-region and wider health ecosystem

equitable public health and disability system		
Better population health and outcomes supported by primary care	Work in communities to improve health and wellbeing and prevent or delay the onset of illness	Theme 2: Empowering people as partners in their care

3DHB Data and Digital continues to upgrade and update our legacy technology 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.

We continue to progress our programme of consolidation of disparate bespoke solutions across the Wellington regional DHBs. Key initiatives, such as patient administration systems (WebPAS) consolidation, will enable centralised and consistent patient management. We are also consolidating the clinical portals (Concerto) that will enable better patient care and cost efficiencies. There is also an increased focus on the corporate systems and the tools needed to run an effective health service. We are working with the corporate functions across the three DHBs to standardise the tools and systems.

3DHB Data and Digital also actively supports the DHBs with regard to their Covid-19 response and improving systems to support any further community outbreaks and potential lockdowns. The Digital Workplace programme is particularly important in this area as this will further our workforce to work remotely.

There are four key programmes of work aimed at improving the stability and resiliency of our existing clinical and corporate systems, improving operational efficiency, and enhancing patient care. The key programmes of work are described below.

Clinical Workspace Programme

The Clinical Workspace programme includes five primary projects designed to modernise and mobilise systems and processes within the health sector. These projects are:

- **3DHB Clinical Portal** – a new clinical portal shared by all three DHBs. The value to the business and to our communities by ensuring patient data is accessible in one location and able to be accessed through the central region clinical portal, supported by increased resilience, availability and disaster recovery.
- **3DHB Éclair** – consolidating 3DHB laboratory ordering, processing and sign-off, which provides value through laboratory data accessible in one location via the 3DHB Clinical Portal and available to the central region. Reduced costs for the DHB through shared infrastructure and increased resilience.
- **ePrescribing for Outpatients** an electronic prescribing tool whose value includes, patient safety and care quality improvement and more convenience for patients when collecting prescriptions combined. The tool also ensures our compliance with the Medicines Act and is integrated into our 3DHB Clinical Portal.
- **3DHB Regional Radiology Information System** replacing our existing aging and out of support radiology information system which is currently posing significant risk and adds additional value through shared infrastructure and simplified, supported solutions and the ability to outsource clinical investigations and/or reporting between both DHB's and external partners.
- **Mobile Clinical Platform (MEPO)**, a new mobile platform, initially for the purposes of electronic observations, early warning scores, nursing assessments and clinical photography – but with the scope to replace other manual and paper based systems though a mobile phone interface. Expected to deliver new value to the DHB's though clinical efficiencies, reduction in errors seen with manual paper charts and provides extensibility to other functions such as ordering, results viewing and signoff, electronic drug charting and administration.

- **3DHB eReferrals for Primary, Community and Ambulatory Care** provides a smart eReferrals, intelligent scheduling and appointment platform, this provides for patient safety and care quality improvements, shared infrastructure and simplified, supported solutions, integration into the 3DHB Clinical Portal as a single source of digital information.

Digital Workplace Programme

The Digital Workspace Programme aims are to deliver modern digital desktop and devices, with robust information management practices, together with modern collaboration and communication tools. The programme includes four focus areas to transform the digital environment within the organisation:

- **Modern Devices, Desktops and Office**: delivers devices to staff which meet their requirements with regard to form factor and capability. Implements managed, modern Windows 10 environment with O365 including Teams, SharePoint and OneDrive. Allows for access to the same IT resources across multiple device types, enhanced user experiences with information easy to find and provides for flexible working options creating better outcomes for pandemic response, staff mobility, morale and operational efficiency.
- **Digital Foundations**: delivers the foundational infrastructure and improved policy and system configuration to support the rollout of the new modern way of working through new remote access solutions to support seamless end user experience whether working in the office or remotely, improved on campus Wi-Fi to support predominantly mobile workforce with high degree of security and ensuring that the right individuals have the appropriate access to technology resources together with improved protection of our data assets and our Identities from malicious actors.
- **Unified Communications:** replaces legacy PBX systems with cloud based contact centre platform, new IP based telephony end points for critical areas and MS Teams based Telephony (chat, calling, and conferencing) for individual users by de-risking the DHB's communications systems failure by replacing aged telephony systems (PBXs), improving availability and functionality of critical communication services and enhances organisational resilience and ability to respond to emergency scenarios (e.g. pandemic/earthquake) with capability to support fully mobile workforce.
- **Information Management:** implements good Information Management practice ensuring data is correctly categorised, retained and easily searchable where, staff are able to access and locate the right information they need and when they need it. Makes the data easily searchable and accessible to relevant staff and solution that meets our obligations under the Public Records act. Reduces the number of duplicated tools which will reduce costs to maintain, update and support and increases the ability to utilise cross-functional and cross sector teams to address health system challenges.

Resilient Systems

To ensure that DHB systems continue to function with minimal downtime and that data on these systems is can be restored in the event of data loss 3DHB data and digital have a number of projects currently underway and planned for the next financial year. These projects include:

- Improving resilience of clinical and corporate systems and staff productivity through replacement and increasing the availability of PCs, Tablets, Laptops, Terminals, & Screens.
- Improve information security through implementation of tools such as threat detection and auditing, this includes all security systems with an ICT component, improving resilience and performance of clinical and corporate systems through replacement of aged ICT servers and a planned migration of DHB systems as a service offerings.

Additionally we will maintain stable, secure systems by ensuring our aged network equipment is replaced. We are in the process of updating our backup and recovery system so ensure that our data is safe and can be easily retrieved in a reliable and cost effective manner. We also have a programme for the continuous upgrading of clinical and corporate systems to ensure they are up to date.

Regional/National Systems

3DHB ICT continue to contribute to regional and national systems and, in particular, the regional clinical portal via data sharing, regional WebPAS and Regional Radiology Information System (RRIS) work. The DHB will be supporting and aligning our technology decisions to support national programmes, including the National Health Informatics Platform (NHIP HIRA) as well as the NHI and HCP systems through the adoption of Application Programming Interface (API's) and the use of interoperability standards such as FHIR (Fast Healthcare Interoperability Resources).

Co-operative developments

CCDHB works and collaborates with a number of external organisations and entities on delivery of programmes and initiatives contributing to the health system. These organisations and entities have a role in delivering the priority action areas noted in CCDHB's Annual Plan.

CCDHB has entered into a co-operative arrangement with the Medical Research Institute of New Zealand (MRINZ).

SECTION FIVE: Performance Measures

5.1 2021/22 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 services
- Better population health outcomes supported by primary health care.

The DHB monitoring framework and accountability measures have been updated for 2021/22 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	Year 1	≥71%	
		Year 2	≥71%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	<0.43	
		Year 2	<0.43	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled	Year 1	>=95%
			Year 2	>=95%
		Children (0-12)not examined according to planned recall	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	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 and by 3 months of age 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 Pasifika population group, for both targets. Measure 1: 55% of newborns enrolled in General Practice by 6 weeks of age. Measure 2: 85% of newborns enrolled in General Practice by 3 months of age. Achieved significant progress for the Māori population group, and the Pasifika 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 percent 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	Focus area 1 (Youth SLAT): Provide reports as required	
		Focus area 2 (School Based Health Services): Provide reports as required	
		Focus area 3: (Youth Primary Mental Health services) refer MH04	
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Maori, other & total	Māori: 6.0% Other: 3.4% Total: 3.9%
		Age (20-64) Maori, other & total	Māori: 8.5% Other: 3.1% Total: 3.6%
		Age (65+) Maori, other & total	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 (0-24 year olds)	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	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Provide rates and narrative around what the data is telling us	
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.	
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: 45-64 year olds)	≤2,655	
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 (PCM 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*	No patient will 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*	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	

		(Only the Five Cardiac units are required to report for this measure)		
		Planned Care Measure 6: *Acute Readmissions*	≤12.8%	
		Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2021/22 year.	
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 <=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	Still to be confirmed
		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 than95 %
			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 85% and less than 95%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		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 4: Improving the quality of ethnicity data.		
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 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.*
			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 - 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 - Aspirin*, a 2nd anti-platelet agent*, and an statin (3 classes) - ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), - 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	**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 who 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 participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days 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 out-year planning & savings plan	Provide reports as specified	
SS19	Workforce out-year 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 percent.	
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95 percent 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 2021/22

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Ora Toa PHO

Cosine
Primary Care Network

Tū Ora
COMPASS HEALTH

System Level Measures Improvement Plan 2021/22

Submission 15 July 2021

ICC

Signatories for the 2021/22 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

Te Iringa Davies - signature
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Acting CE, Tū Ora Compass Health

Rachel Haggerty
Director, Strategy Innovation & Performance. CCDHB

The Capital and Coast Health System Plan (HSP) 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, and other key partners.

Capital and Coast and Hutt Valley DHBs are increasingly taking a 2DHB approach to addressing health need, creating improvements and delivering health care. Both DHBs are focusing on developing local Networks – a theme you will see throughout this plan.

In 2020 COVID-19 both progressed model of care transformation and delayed some parts of our 20/21 SLM delivery. We have reviewed and updated the plan, introducing new actions to reflect current priorities where appropriate. In addition, the Patient Experience activity will focus on questions prioritised by the Ministry of Health in its SLM guidance.

The ICC ALT continue to drive a focus on equity through the SLM. 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.

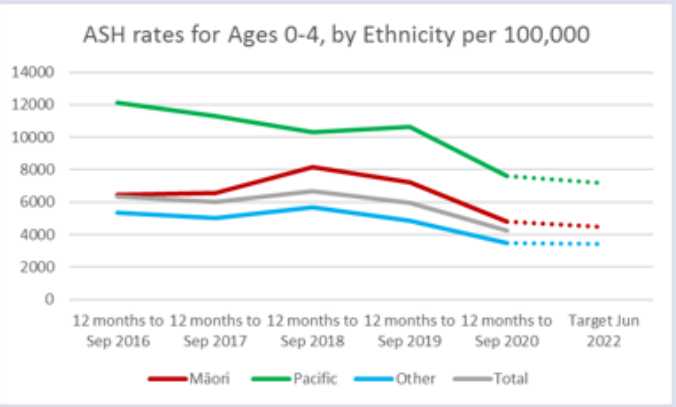
The CCDHB SLM 21/22 Plan has been developed with the following principles:

- Focus that improves equity
- Linked to current strategic priorities
- Progress initiatives delayed due to COVID-19
- Build on transformation opportunities created through COVID-19
- Evidence based interventions

CCDHB SLM Plan compiled by Dorothy Clendon
Senior System Development Manager – Design and Implementation, Strategy, Planning and Performance
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.

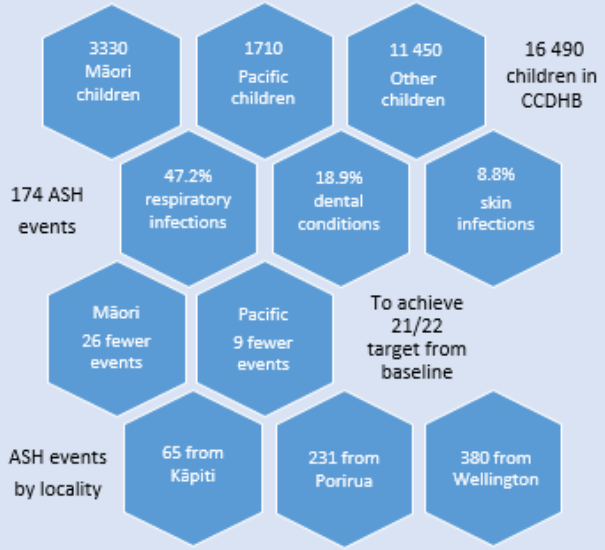


Ambulatory Sensitive Hospitalisation (ASH) 0-4yo 2021/22 milestone: 6% reduction in ASH events for Māori and Pacific, 2% reduction in ASH events for non-Māori/Pacific.

CCDHB's ASH rate for 0-4yo is 4% lower than the national average. Of the eight DHBs monitored for Pacific ASH rates, CCDHB has the 3rd highest rate nationally. For Māori children, CCDHB has the 9th highest 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.

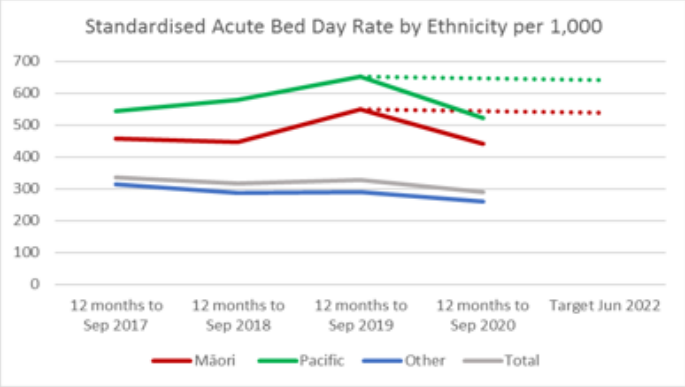
The longer term aim is to ensure that ASH rates for these populations reduce to at least the rates of the non-Māori & non-Pacific population group.



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.	• DHB to develop and implement a Māori communications programme that includes a focus on child health and messaging that promotes immunisations. • Improve referral pathways for eligible children to be referred to Porirua Asthma Service or Asthma NZ. • Review the relevant respiratory Health Pathways to reflect best practice.	Influenza immunisation coverage, 0-4 year olds ASH rate for asthma and wheeze, 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.	• Continue the pilot to expand the pre-school health service to include skin infections for Porirua.	ASH rate for skin infections, Porirua 0-4 year olds
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.	Newborn enrolment in general practice

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.

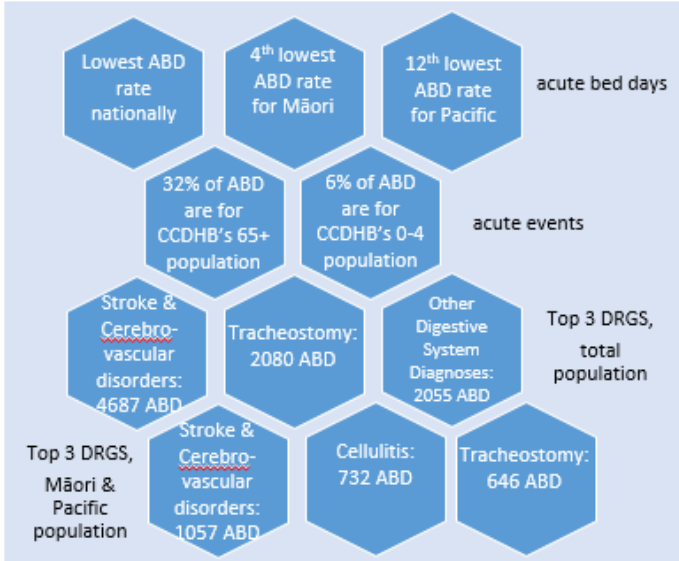


Acute Bed Day (ABD) 2021/22 milestone: 2% reduction in actual acute bed day rate for Māori and Pacific. This equates to a reduction of 405 acute bed days.

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.

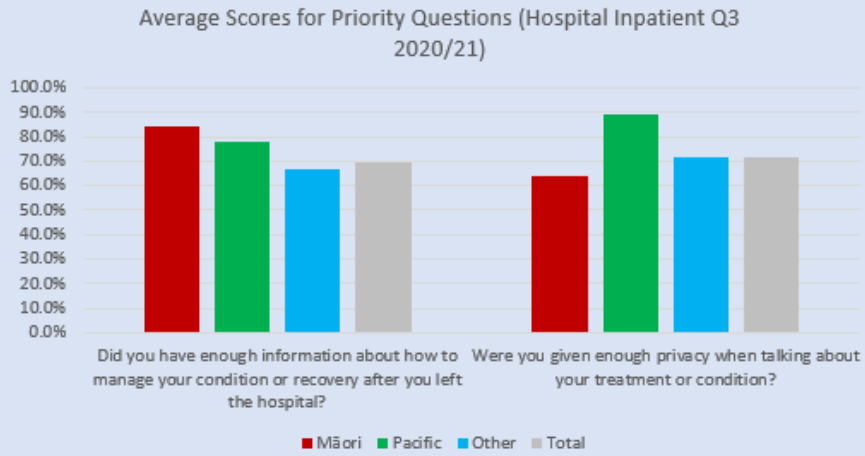
The long-term aim is to ensure that ABD rates for Māori and Pacific populations reduce to at least the same rates of the non-Māori & Pacific population groups.



Opportunity	Actions	2021/2022 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 2021/2022 influenza plan • Implement the Increasing Māori Flu Vaccinations Programme – MOH funding dependent • Develop and extend the vaccination workforce through COVID vaccination programme.	Influenza immunisation coverage, 65+ year olds
Growth in ED presentation numbers continue and have exceeded capacity. Enhancing the management of people in primary care via community based services will support people to receive care in the community. Current age-standardised ED presentation rates to sub-regional hospitals are 197 for Māori, 208 for Pacific and 142 for other ethnicities.	• Actively monitor POAC for Cellulitis following health pathway changes • Establish Community Health Network/s in Porirua. • Improve access to primary and community care for people living in temporary accommodation in Kāpiti by providing regular outreach clinic/s within the accommodation centres.	Age-standardised ED presentation rate
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 277 Māori, 311 Pacific and 180 for other ethnicities.	• Extend the reach of the Community Health of Older People Initiative (CHOPI – specialist advice and assessment for Primary Care) across the DHB. • The Kāpiti Community Health Network will prioritise older people and frailty and progress at least three initiatives to improve health outcomes for this population.	Age standardised acute admission rate, 65+ year olds

Patient Experience of Care

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

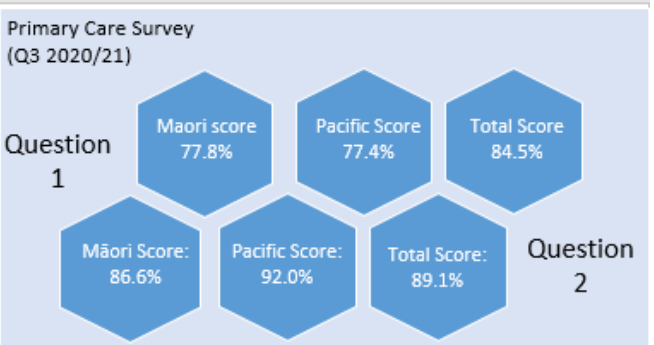


The CCDHB health system encourages patients to provide feedback about their experience of care through its complaints and compliments process. The Hospital and Primary Care Patient Experience Surveys provide opportunities for improvement.

Engaging consumers is a key focus for improving our patients experience of hospital services.

In Primary Care, we will focus on improving access and sharing decision making.

In both areas we will seek an improvement of 2% on these priority questions across all ethnicities.



Priority Questions

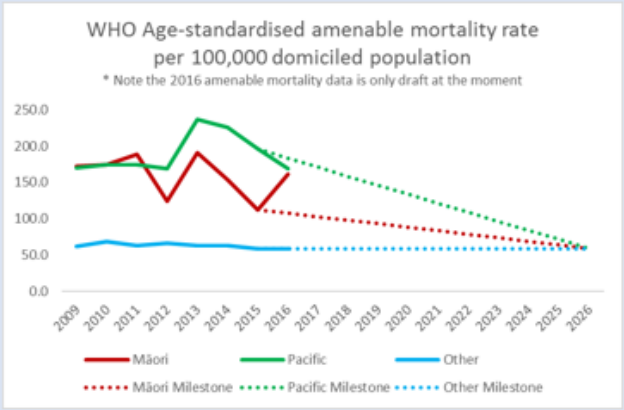
1. In the last 12 months, was there ever a time when you wanted health care from a GP or nurse, but you couldn't get it? Answered No.

2. Did the health care professional involve you as much as you wanted to be in making decisions about your treatment and care?

Opportunity	Actions	Contributory measure
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.	▪ Delivery of two workshops to the consumer advisory group by Q4 to support their work and develop capability. ▪ Reporting against the SURE Framework to the Health Quality and Safety Commission with active involvement of the consumer Advisory Group.	Number of workshops completed
Using hospital based improvement projects we will aim to improve patient experience of both privacy and discharge information.	▪ Trial a new inpatient allied health model of care for major trauma patients, with a focus on discharge planning ▪ Undertake a quality improvement programme to improve completion rates of goals of care, which include important information for people following their discharge. ▪ Undertake a quality improvement programme to improve appropriate assigning of bed locations for inpatients, with a focus on patient privacy.	Number of inpatient areas using Goals of Care form Proportion of patients in gender appropriate beds within 24 hours of admission.
The Primary Care PES will provide improvement opportunities for all practices. In the 21/22 year there will be a focus on two areas – improving access and sharing decision making	▪ Roll out the HCH programme to three more practices ▪ Increase the number of Year of Care plans implemented across the district as a key tool for shared decision making with patients ▪ Enable virtual appointments in all practices	Patient Portal uptake % increase in active Year of Care plans compared with 2020/21

Amenable Mortality

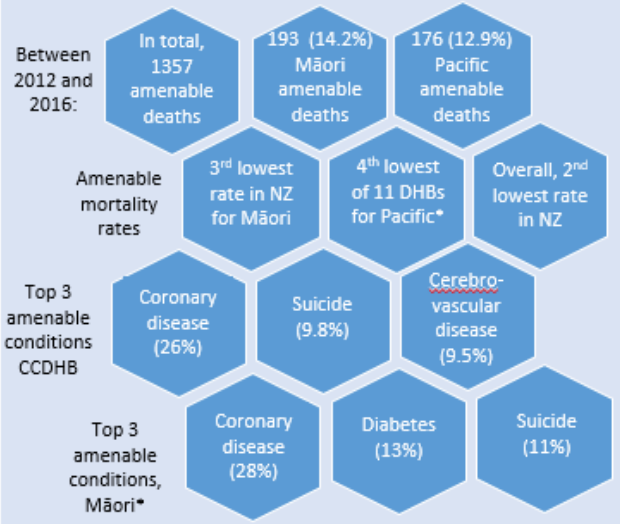
The CCDHB HSP outlines that supporting population interventions to create healthier communities and preventing the onset of long term conditions is a priority in reducing amenable mortality.



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.

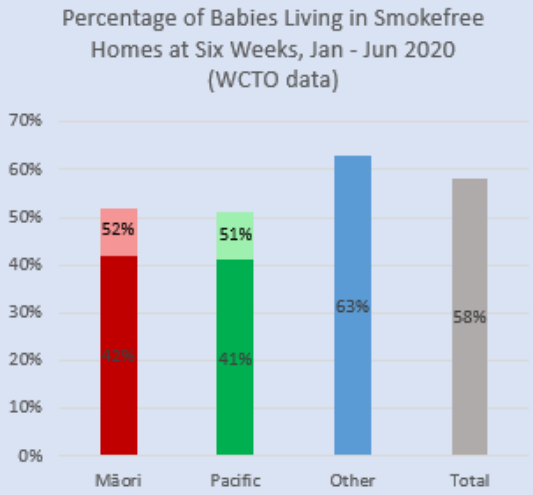


*Rates suppressed due to low numbers; Conditions for Pacific population not published by MOH

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 more Community Health Networks in CCDHB	Ratio of virtual to face to face consultations in primary care. ASH rate, 45-64 year olds
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 9% for Māori, 10% for Pacific and 13% for other ethnicities.	• Framework for Health Coaches developed which includes smoking cessation in(TOCH) • Enhanced stop smoking messaging at community engagements for health promotion teams (TOCH) • Train auxiliary staff in smoking cessation (Cosine).	PHO smoking 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 their General Practices identified as having lower than expected numbers of CVDRAs for the population to increase the number of CVD risk assessments undertaken. • Improve visibility to clinicians of their CVD at risk patients by embedding the new CVD risk assessment so that appropriate interventions such as statin prescribing increase • Primary Care Quality Peer Groups will focus on LTC management including optimising CVD and Diabetes treatment options (eg, Empagliflozin prescribing for eligible people including Special Authority application https://schedule.pharmac.govt.nz/2021/06/01/SA2029.pdf	Percentage of PHO enrolled population identified as high risk of CVD and not on statin Dispensing rates of Empagliflozin in CCDHB district % of people with diabetes aged 15-74 enrolled with a PHO with HbA1cs64mmol/mol

Babies Living in Smokefree Homes

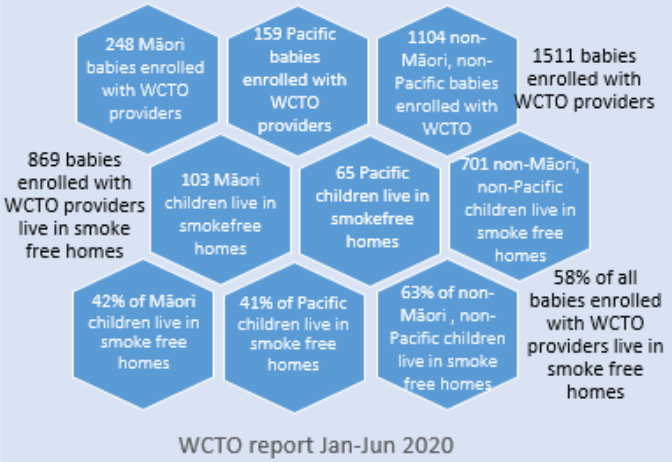
Supporting our whanau and their children, giving them the best start in life, is a CCDHB priority and linked to the national SUDI prevention programme.



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 26 Māori babies and 17 Pacific babies living in smokefree homes over the year.

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.

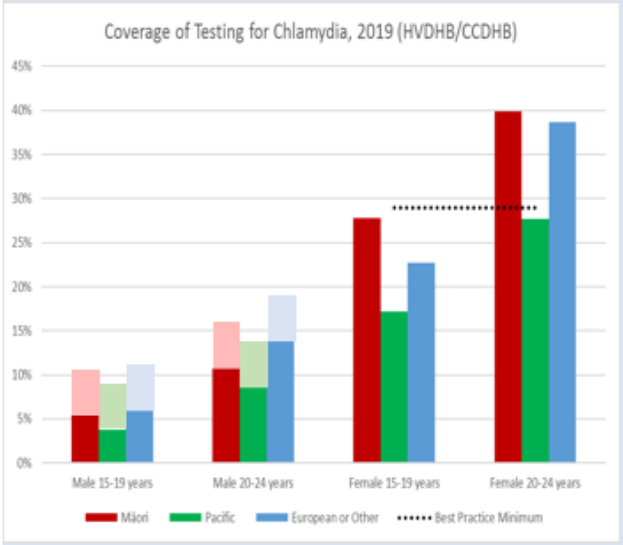
Reducing babies' exposure to tobacco smoke through collaboration between the services focussed on child health and smoking cessation is a key aspect of wellness. The DHB, PHOs, WCTO providers, dental services, public health, immunization services and hospital teams will work in partnership to oversee 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.	• Continue to strengthen referral pathways to Ora Toa PHO Hapū Ora Smoking Cessation Incentive programme and Regional Stop Smoking Service including strengthen electronic pathways and investigating postnatal ward visits. • PHOs to embed the Generation 2040 initiative, (which offers pregnant women an Early Pregnancy Assessment including smoking cessation support) including linking in to other services.	Utilisation of smoking cessation programmes
Increasing our focus and support for the whanau to be smoke free.	• Framework for Health Coaches developed which includes smoking cessation (TOCH). • Enhanced stop smoking messaging at community engagements for health promotion teams (TOCH). • Train auxiliary staff in smoking cessation (Cosine).	PHO smoking quit rates by ethnicity.

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.

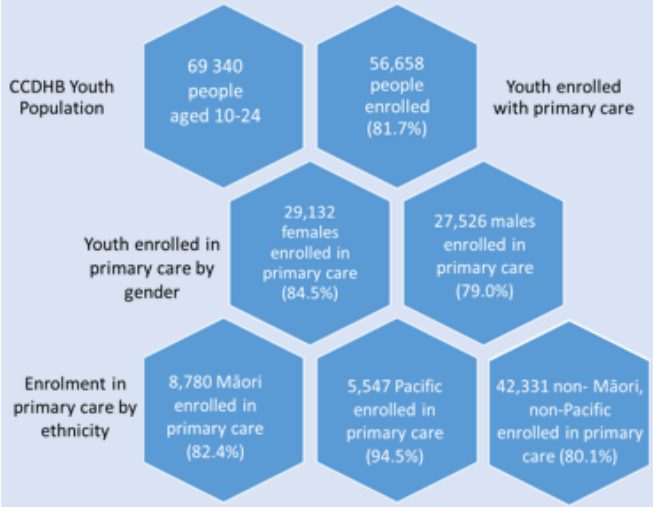


In 2021/22, CCDHB will continue to focus on the sexual health domain of the Youth SLM and aim to support young people to manage their sexual and reproductive health safely by giving them access to youth friendly healthcare.

The 2021/22 milestone is to improve male coverage of testing for Chlamydia by 5%, across all ethnic groups and maintain 29% coverage of testing for females. This will increase coverage for Māori males to 13% and coverage for Pacific males to 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.	• Work in partnership across DHB, government agencies, the Porirua community and providers to implement and strengthen the new service. • Continue to work with primary care to use vaccinations as a method of providing opportunistic testing. • Complete a project to understand the costs and benefits of introducing a quick test for young people.	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.	• Track the number of people using the SXT anonymous contact tracing app to measure success and uptake	Utilisation of primary care health services