Capital & Coast District Health Board

Annual Plan 2017/2018

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Annual Plan dated 14 September 2017
(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

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Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

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

07 MAY 2018

Dear Mr Blair

Capital & Coast District Health Board 2017/18 Annual Plan

To formalise ongoing accountability and to provide surety, I have approved and signed your DHB's 2017/18 Annual Plan together with the Minister of Finance.

I would like to thank you, your board, and the DHB's staff for their efforts in developing your Annual Plan for 2017/18. I also appreciate your DHB's significant efforts to provide valuable health services to the public in a challenging environment, and I am confident that we can work together to improve outcomes for the population.

I understand your DHB has planned a deficit for 2017/18 and a track to breakeven in the out years. I encourage your Board to consider appropriate activities to ensure that you reduce the projected deficits in the coming years, and achieve your goal of returning to breakeven. This will require a concerted effort and I trust that you will continue to work with the Ministry of Health to evaluate and improve your financial performance.

As you deliver services for your population, keep in mind that I will shortly be providing a Letter of Expectations to DHBs for the 2018/19 financial year that will provide further clarity on my priorities for DHB planning, such as public provision of health services, improving access to primary care, reducing inequalities and improving mental health services.

Please note that approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

Please ensure that a copy of this letter is attached to any copies of your signed Annual Plan that are made available to the public. Thank you again for your leadership and efforts to deliver high quality and equitable health outcomes for your population.

I look forward to working with you in the future.

Yours sincerely

Hon Dr David Clark
Minister of Health

cc Dr Ashley Bloomfield, Acting Chief Executive, Capital & Coast District Health Board

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

SECTION 1: Overview of Strategic Priorities

Strategic Intentions and Priorities

This Annual Plan articulates Capital and Coast District Health Board's (CCDHB) commitment to meeting the previous Minister of Health's expectations to implement the New Zealand Health Strategy and continue the commitment to our Board's vision of "*Better health and independence for people, families and communities."*

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

To achieve our obligations to the Minister, the region and our communities, we will use our resources wisely and strategically to:

- **Promote health and wellbeing**
  - *(Encouraging healthy lifestyles and behaviour.)*
- **Prevent the onset and development of avoidable illness**
  - *(Supporting the identification of at risk populations and engaging in early intervention.)*
- **Strengthen the wellbeing and health of people who are unwell**
  - *(Ensuring those who need healthcare get the highest quality support.)*
- **Support people to achieve their life outcomes**
  - *(Ensuring the contribution of health services to life outcomes e.g. educational attainment and engagement in productive employment.)*
- **Enable the end of life with dignity**
  - *(Ensuring people receive the support they need without unnecessary intervention.)*

For the 2017/18 year, as well as delivering against the national Health and Better Public Service targets, CCDHB will especially focus on performance in emergency department wait times, access to elective procedures, raising healthy kids, immunisation, and mental health transition plans for children and youth. This includes a strong focus on equity amongst our population.

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

- Work with communities to improve health and wellbeing with a focus on preventing, or delaying the onset, of avoidable illness or disability
- Simplify service delivery for those people who have good health literacy and health behaviours
- Intensify service delivery for those who are more vulnerable and have greater health need to reduce inequalities and improve health gain
- Implement models of care that can intervene earlier, closer to home, with improved outcomes
- Organise technology and interdisciplinary teams in communities, people's homes, community health networks and our hospitals to ensure efficient use of resources by reducing duplication and improving integration

These approaches will strengthen CCDHB's ability to be people powered, provide services closer to home, operating as one team, using smart systems as well as ensuring value and high performance.

This Annual Plan includes the implementation of a plan to create a step change in the operational performance of the provider arms of CCDHB. It does this by using technology, analytics and change management processes that will ensure resources are used more effectively and transforms models of care that ensure more care is closer to home and reduce avoidable demand for hospital services. This programme drives the deficit reduction strategy over the next three years from $21m to $16m to $12m achieving breakeven in 2020/2021.

We are well placed to successfully deliver against these New Zealand Health Strategy objectives, as we implement our longer term view of how services will be delivered for our population (Health Systems Plan 2030), and by explicitly focusing on building organisation wide sustainability (CCDHB Sustainability Plan 2017-2021).

Message from the Chair and Chief Executive

We are pleased to present Capital & Coast District Health Board's Annual Plan for the 2017/18 financial year. This plan outlines our performance intentions for the next year, setting out the local, regional and national priorities to improve the health of our population, improve health equity for all populations and deliver value and high performance from our organisation.

This 2017/18 plan signals our conscious move to deliver better care and outcomes to our communities. With our partners using data and evidence from smart systems to inform our choices we will simplify care and improve overall sustainability by improving infrastructure, operational management, models of care and moving to whole of system commissioning.

We are committed to strengthening our operational and clinical management systems, using tools and technology to support integrated service delivery and working more closely with patients and communities to support greater health and wellbeing closer to home and communities.

We are focused on achieving the responsibilities set for us by the previous Minister of Health and delivering on the New Zealand Health Strategy. We have prioritised our efforts and resources to lift our performance in key areas including: expanding the delivery of integrated services closer to home via Health Care Homes, improving the care for our vulnerable children - working with Oranga Tamariki, better meeting the mental health and wellbeing needs of our populations. Along with these, we will ensure patients have appropriate access to safe effective complex clinical care in our tertiary services as well as working with our community and intersectoral partners in localities to improve both health and social outcomes.

Our plan reflects both the local CCDHB and broader interdependent planning and delivery of health services across the Wellington sub-region and the wider Central Region. CCDHB will continue to partner with Hutt Valley DHB and Wairarapa DHB where it best serves our communities and makes best use of resources. Our plan should also be read in conjunction with the Regional Service Plan for 2017/18.

We have started to develop and apply these new ways of working and have established some sound building blocks including the development of a long term health services strategic plan (Health Systems Plan 2030), integrated support services key projects and a financial sustainability plan (Sustainability Plan 2017-2021).

These new ways leverage on the existing strengths in our organisation including our strong relationships within and across our communities, a committed and involved clinical workforce, and our equity focus.

Andrew Blair
Board Chair, Capital & Coast District Health Board

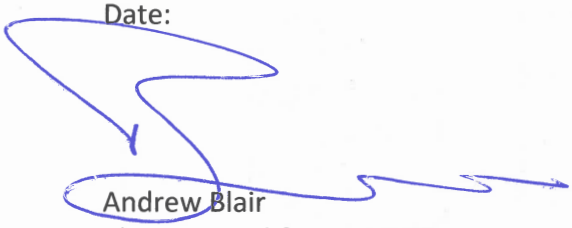
Debbie Chin
Chief Executive, Capital & Coast District Health Board

Signatories

Agreement for the Capital & Coast DHB 2017/18 Annual Plan between

Hon. Dr. David Clark
Minister of Health
Date:

Hon. Grant Robertson
Minister of Finance
Date:



Andrew Blair
Chair, Capital & Coast DHB
Date:

Debbie Chin
Chief Executive, Capital & Coast DHB
Date:

SECTION 2: Delivering on Priorities and Targets

Government Planning Priorities

Equity actions include the code "EOA" for "equitable outcomes action" immediately following any action that is specifically designed to help reduce health equity gaps.

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	**Value and high performance**	**1. School based health services (SBHS):** Review SBHS interventions to identify which interventions have been effective and can be expanded (Refer to Mental Health 1,2)	Q3; Plan for review. Q4; Conduct review & identify interventions for expansion.	PP25: Prime Minister's Youth Mental Health Project
			2. Primary care follow-ups: Review 2016/17 Annual Plan actions to improve follow-up in primary care of youth aged 12 to 19 years discharged from secondary mental health and addiction services (Refer to Mental Health 2, 3).	Q4; Increase by 10% the number of follow-up care plans to primary care providers.	
			3. Model of care: Identify where resources can make the greatest impact on the greatest number of young people and use this information to develop a model of care (Refer to Mental Health 3,4) (EOA)	Q3; Plan for investigation. Q4; Identify areas of greatest impact & develop model of care.	
			4. Sex & Gender Diverse Pathway: Improve access to endocrinology and CAMHS services for gender diverse youth through the development of a 'Sex and Gender Diverse Health' pathway (Refer to Mental Health 1,2) (EOA)	Q1-Q2; Assess and implement solution to current endocrinology waitlist issues Q1; Consolidate past work on Health Pathways and develop action plan Q3-Q4; Implementation action plan	
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	**People powered**	*These activities continue to improve the health and wellbeing of the DHB's youth population, particularly supporting the primary sexual health workforce, understanding gaps in sexual health services and the impact of initiatives.*		PP38: Delivery of response actions agreed in annual plan (section 1)
			1. General practice investment: Improve access to free sexual health services through investment in additional FTE at Evolve Wellington Youth Service (Youth One Stop Shop) for young people.	Q1; Investment and FTE appointed	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			2. The Outcomes Measurement Model (TOMM): Implement the TOMM tool in Evolve Wellington Youth Service to monitor and measure the outcomes of the Youth One Stop Shop's services for young people, including equitable outcomes for Māori, Pacific and other vulnerable groups. (EOA)	Q1; Implement TOMM tool	
			3. Access to services: Review current activities to improve access to services, including equitable access for Māori and Pacific, and identify an action plan to improve access to services. (EOA)	Q2; Review activities Q3-4; Action plan identified	
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team	**1. Shaken Baby Prevention Programme:** Evaluate rollout of the 2016 Shaken Baby Prevention Programme to identify any further improvement opportunities. (EOA)	Q1; Evaluate Shaken Baby Prevention Programme. Q2-Q4; Plan for & implement improvement activities.	PP27: Supporting Vulnerable Children
			2. Violence Intervention Programme (VIP): Continue the rollout of the Violence Intervention Programme (VIP) training to all DHB health professionals. (EOA)	Q4; 60% of clinical staff received VIP Training across hospital health services.	
			3. Alignment and integration of child protection services: Continue to work with local agencies to promote better alignment and integration of child protection services. Coordination of partner and child abuse and neglect programmes to support increased identification of vulnerable children. (EOA)	Q4; Memorandum of understanding across CCDHB child protection services.	
			4. Seamless services: Continue service planning and development activities to provide an effective continuum of services across primary and referred health services to meet the needs of pregnant women with complex needs, vulnerable children and the families/whānau, children referred to the Gateway Programme and vulnerable women and unborn baby multidisciplinary teams. (EOA)	Q1-Q4; Plan for and develop activities to provide an effective continuum of services.	
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be	One team	**1. Assess workforce:** Assess the midwife workforce capability, including Māori and Pacific midwife capability. (EOA)	Q2; Assess workforce capability. Q3; Implement action 2.	PP38: Delivery of response actions agreed

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
	undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.		**2. Find a midwife:** Assess the capability of the Health Care Home (HCH) model of care to maximise registration of pregnant women with Lead Maternity Carers from the GP Practice.	Q3; Assess HCH capability. Q4; Devise approach to support registration with LMC.	in annual plan (section 1)
			3. Maternity Quality & Safety: Expand the current campaign run by the MQSP programme, incorporating a review of the 2016 campaign. Implement any recommendations for improvement, including cultural relevance for Māori and Pacific. (EOA)	Q3; Review the 2016 MQSP campaign Q4; Expand current campaign & implement recommendations for improvement from review	
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team	**1. Equity within DHB, 0-4 years:** Implement the agreed ICC Child Health projects to achieve equity within DHB for ASH rates by 2021; in 2017/18, reduce ASH admissions for Pacific by 9% from Sep 16/17 baselines. (EOA)	Q2; Implement Project 1 Q4; Implement Project 2 and assess Project 1	PP38: Delivery of response actions agreed in annual plan (section 1)
			2. Oral health: Work with Bee Healthy Regional Dental Service to develop and support the implementation of actions to improve pre-school enrolment in oral health services as well as reduce DNA and examination arrears, through school holiday drop in clinics and increased visibility in Te Kohangas and Kindergartens. (EOA)	Q1-2; Develop actions Q3-4; Implement actions	
			3. Housing Sensitive Hospitalisations: Assess housing sensitive hospitalisations and work with providers to ensure Healthy Housing referral pathways are meeting greatest need (i.e. Māori, Pacific and Q5). (EOA)	Q1; Assess housing sensitive hospitalisations Q2; Work with providers to ensure pathways meet greatest need Q4; Assess outcomes	
Reducing Rheumatic Fever BPS Target	Improve community awareness of rheumatic fever and sore throat management services.	Closer to home	**1. Rheumatic Fever Prevention Plan:** Implement the CCDHB Rheumatic Fever Prevention Programme**.**	Q1-Q4; Implement programme to schedule agreed with MOH.	PP28: Reducing Rheumatic Fever
Increased Immunisation Health Target 	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage	Value and high performance	**1. Raising awareness:** Investigate the socio-demographics and circumstances of children who are not immunised at the milestone age and 'hard-to-find' children. Devise a plan to ensure these children are immunised to maintain or improve achievement of the Health Target. (EOA)	Q2; Conduct investigation Q3; Develop plan Q4; Implement Plan Q1-Q4; Maintain Health Target	Immunisation Health Target PP21: Immunisation Services

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
	rates for all immunisation milestones.		**2. National Immunisation Register:** Advocate for improvements to the NIR IT systems to support providers in achieving the Health Target, and immunisation coverage by ethnicity to be added to monthly coverage reports from MOH. (EOA)	Q1; Advocate for improvements to NIR IT systems and ethnicity to be included in monthly reports	
			3. Well Child Quality Improvement: Work collaboratively with providers to review effectiveness of Core 1 check coverage follow up services and develop an improvement action plan to improve the immunisation rate of Māori, Pacific and new migrant babies. (EOA)	Q2; Engage providers to review Core 1 check follow up services Q3; Action plan identified Q4; Implement action plan	
			4. Varicella vaccine: Implement Varicella vaccine rollout; review maintenance of current immunisation target at 15 months as a consequence of rollout; review equity of Varicella vaccine coverage. (EOA)	Q1; Implement vaccine Q3; Review immunisation coverage and equity	
Shorter Stays in Emergency Departments Health Target Shorter Stays in Emergency Departments	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	**Value and high performance**	**1. Improve flow in ED:** Continue to trial new models of care. Implement early senior assessment and streaming in Emergency Department ED.	Q2; Implement new model of care in ED by Winter 2018; 95% of patients referred to senior assessment are seen within two hours.	ED Health Target
			2. Integrated Operation Centre: Further develop and implement an Integrated Operations Centre (IOC) to provide better visibility and oversight of demands and capacity planning needs. Development of capacity planning business case and implementation. Ensure tools available to accurately forecast and manage hospital demand and capacity and plan for seasonal bed use	Q1; Roll out and implement inpatient module of capacity planner Q2; Roll out and implement ED module of capacity planner. Commence winter planning and forecasting using capacity planner Q3; Roll out and Implement staffing module of capacity planner	
			3. Specialty response to ED: <u>General medical</u> • Increase identification of and transfer of appropriate patients • Increase same day discharges from MAPU <u>Surgical Services</u> • Improve response times to meet internal professional standards in Surgical, Orthopaedic and Paediatric medicine.	<u>General medical</u> Q2; Increase by 5% the number of safe discharges from MAPU on the day of presentation. Improve specialty service response times of <60 minutes. <u>Surgical Services</u> Q2; Improve specialty service response times of <60 minutes.	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			Crisis Resolution Team • Develop and implement MHAID service improvement plan to respond within agreed internal professional standard time frames Frail Elderly • Improve screening of elderly for frailty at admission.	Crisis Resolution Team Q1; Develop and implement MHAID plan to respond within agreed time frames. Frail Elderly Q4; Achieve 80% screening of elderly for frailty at admission.	
			4. Acute inpatient bed availability: • Implement Timely Discharge Project in general medical services to remove barriers to patient discharges earlier in the day • Implement criteria lead discharges for weekend discharges • Implement programme to improve management of care for long stay patients • Implement an organisation wide and consistent ward discharging project with a focus on earlier discharge	Q1-Q4; Improved compliance with Shorter Stays in ED Health Target. Q4; Increase discharges before 1100 hours to 25%. Q4; Achieve reduced average occupancy of hospital over peak times.	
Improved Access to Elective Surgery Health Target 	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	Value and high performance	**1. Health Target:** Achieve Improved Access to Elective Surgery Health Target.	Q1-Q4: On track to achieve Health Target Q4; Health Target achieved (10,852)	Electives Health Target SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators
			2. Access to electives: Review actions implemented in 2016/17 to improve access to electives including equity, quality of care, patient flow management, outpatient follow ups and utilisation of capacity and resources. Work with local Alliance Leadership Team (ALT) to improve referrals from primary care working in isolated and/or poor areas for minor orthopaedic procedures and expand to other specialities as capacity increases. (EOA)	Q1; Review 2016/17 actions Q2; Work with ALT and devise programme to improve referrals Q3; Implement programme to improve referrals.	
			3. Reducing displaced electives: Trial additional weekend acute operating sessions aiming to reduce the frequency of elective cases being displaced by acute cases during the week.	Q1; Implement trial Q2; Review outcomes of trial Q3; Respond to outcomes of review	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	**Milestones**	
			4. Working with private providers: Identify appropriate electives best delivered by private providers. Work with private providers to develop a service delivery model for electives.	Q1; Identify electives. Q2-3; Engage private providers in developing service delivery model Q4; Implement model	
			5. Maximise utilisation of all operating theatres: • Assess impact, cost and risks of utilising additional operating theatres. • Model impact, cost, risk and acceptability of extending operating hours	Q1; report prepared. Q3; Modelling complete	
Faster Cancer Treatment Health Target	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	**One team**	**1. Improving diagnostic services:** Implement agreed initiatives with Regional Radiology Group to improve access to diagnostics. (EOA)	Q1; Prioritise agreed initiatives Q2; Improve visibility of these patients in IT systems including RIS Q3-4; Improve data collection and develop KPI	Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
			2. Faster Cancer Treatment in primary care: Implement agreed initiatives to increase primary care responses to Faster Cancer Treatment.	Q3; Implement agreed initiatives.	
			3. Cancer models of care: Implement recommendations from cancer model of care reviews to improve access to services closer to home. (EOA)	Q1; Finalise arrangements for chemotherapy delivery in Wairarapa DHB Q2; Commence outreach chemotherapy delivery in Wairarapa DHB Q4; Review potential to deliver chemotherapy at Hutt Valley DHB	
			4. Improving capacity: Model demand and implementation approach to maximise current treatment capacity and to understand where service capacity may need to be expanded.	Q4; Model demand and approach to maximise capacity	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Better Help for Smokers to Quit Health Target 	Provide an integrated approach to delivery of ABC between primary care services.	One team	**1. ABC Training:** Maintain a programme of ABC training for health care professionals across primary and secondary care to support achievement of the health target in primary care and the KPI for hospital maternity services, including equity for Māori and Pacific. (EOA)	Q1-Q4; Achieve Better help for Smokers to Quit Health Target for primary care and maternity and PP31 target.	Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals
			2. Realignment of Tobacco Control plans: Participate in the national realignment of DHB tobacco control and stop smoking services and implement new services as agreed.	Q3; Realign Tobacco Control Plan to National specifications Q4; Implement new services	
			3. Stop Smoking Services: Review referral pathways to the cessation support services and take action on where pathways are not working. (EOA)	Q1; Review referral pathways Q2-Q4; Respond to outcome of reviews	
			4. Hapū Ora: Monitor and assess the Hapū Ora service for young pregnant women to ensure responsiveness and outcomes aligned with expectations. (EOA)	Q1; Assess gaps in service Q2-3; Respond to gaps in service Q3; Devise approach to monitor long term outcomes of service for pregnant women to quit smoking successfully	
Raising Healthy Kids Health Target 	Identify what actions you will take to ensure that the clinical referral pathway and processes established in 2016/17 achieves the Raising Healthy Kids target by December 2017.	Closer to home	**1. Raising Healthy Kids Administrator:** Invest in a 0.5 FTE for a Raising Healthy Kids Administrator so that CCDHB achieves the Health Target, including equitable outcomes for Māori and Pacific. (EOA)	Q1; Invest in administrator Q2; Assess outcome of investment on Health Target Q2; Achieve Health Target by December 2017	Healthy Kids Health Target SI5: Delivery of Whānau Ora
			2. Uptake of referrals: Assess the pathway, uptake and follow through of referrals, including the number of declines, to Pre-school Active Families (PSAF) for Māori and Pacific children. Develop an approach to improve equitable outcomes for Māori and Pacific children. (EOA)	Q1; Assess pathway, uptake and follow through of referrals. Q2; Develop approach to improve uptake and reduce inequities. Q3; Implement approach Q4; Assess outcomes	
			3. B4SC: Assess the achievement of the B4SC target for high needs children (Māori, Pacific and Q5). Work with the B4SC provider to develop their continuous improvement plan that ensures the high needs target for B4SC is met.	Q1; Assess achievement of target Q2-4; Work with providers Q4; Achieve the high needs target for B4SC	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			4. Procurement: Undertake a procurement process for the B4SC programme to ensure the provider(s) is the most qualified in our region and will deliver outcomes for children, including equitable outcomes for Māori, Pacific and Q5 children. (EOA)	Q3; Undertake procurement	
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	**Value and high performance**	**1. National Bowel Screening Programme:** Establish a cross-sectoral project to design and implement the local roll out of the National Bowel Screening programme, utilising lessons learned from service roll out nationally and within the Central region. The project will utilise a prioritised roll out approach to ensure that those most at risk (ie Maori, Pacific, and lower socio-economic groups) and with the greatest disparity of access to screening and intervention are targeted. (EOA)	Q1-Q4; Establish project to design and implement local roll out of NBSP. Q1-Q4; Implement Action 2 Q4; Finalise approach to implement NBSP	PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
			2. IT support NBSP: Work with 3DHB IT to assess and plan for implementation of IT systems in support of National Bowel Screening Programme scheduled to start at CCDHB in 2018/19. (Refer to IT Planning Priority)	Q1-Q4; Work with 3DHB IT to assess and plan for implementation of IT (refer to Action 1).	
			3. Regional Bowel Screening Service Plan: Contribute to establishment of regional governance structure for Regional Bowel Screening Programme.	Q1; Participate in governance structure for Regional Bowel Screening Programme	
			4. Capacity & Capability: Utilise regional governance structure to identify regional capacity and capability requirements including workforce, diagnostics, capital, IT and service integration dependency. Implement plan for roll out of Bowel Screening in 2018.	Q1-Q3; Identify and budget for capacity and capability requirements for NBSP Q4; Implement plan	
			5. Colonoscopy wait time indicator: Review performance on colonoscopy wait time indicator and devise an approach to meet the sustainable achievement of targets.	Q1; Review performance Q2; Devise approach Q3; Implement approach Q4; Assess outcomes	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	**Milestones**	
Mental Health	Improve the quality of mental health services, including improving the rate of child and youth with transition plans.	**One team**	*Youth, and their families, frequently access multiple mental health and/or addiction services. Entry points into those services can vary from primary care to secondary care and respite care. To ensure that youth and their families receive the most appropriate treatment and support, a transition plan is essential. The transition plan links all of these actions as they form the basis of best practice underpinned by good investment planning.*		PP7: Improving mental health services using transition (discharge) planning
			1. Youth services: Develop a 3DHB system that empowers families and youth to maximise their potential and ensure equitable outcomes; immediate focus on youth respite options and ICAFs.(EOA)	Q2-3; Develop 3DHB system Q4; Implement system	
			2. Primary Health and Primary Mental Health/NGOs: Improve integration of primary health, primary mental health and NGO services with an immediate focus on developing client pathways and improving linkages with services providing a social investment approach.	Q3; Develop an approach to improving integration Q4; Implement approach	
			3. Timely access to services: Co-design a whole of system model of care for child and youth services focused on crisis response for young people experiencing acute mental health issues. (EOA)	Q3; Plan co-design approach Q4; Implement approach to co-designing whole of system model of care	
			4. Value for money: Complete the 3DHB Strategic Framework and plan for the design and delivery of integrated Mental health and Addiction services across the sub-region to 2030, with an emphasis on actions to be taken in the next five years including a strong focus on achieving equitable outcomes for all. (EOA)	Q4; Complete the 3DHB Strategic Framework and plan for the design and delivery of integrated Mental health and Addiction services across the sub-region to 2030	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance	**1. Investment approach:** Develop a whole of system approach for Mental Health, Addictions and Intellectual Disability that supports the Closing the Loop approach, develops integrated health and social service approaches and guides earlier interventions using a locality based approach commencing in the Porirua area. (EOA)	Q4; Complete the whole of system approach for delivery of Mental Health, Addictions and Intellectual Disability services in the Porirua area.	PP38: Delivery of response actions agreed in annual plan (section 2)
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home	**1. IBT settlement agreements:** Participate in national developments relating to the implementation of the outcomes of IBT settlement agreements and the equal pay negotiations.	Q1; ensure pay parity implemented in contracts Q1-Q4; respond to national developments and issues arising from implementation	PP23: Improving Wrap Around Services – Health of Older People
			2. Regional Service Plan: Implement relevant actions from the Central TAS Regional Service Plan (RSP) for Healthy Ageing.	Q1-Q4; Implement actions to schedule agreed with MOH in RSP.	
			3. Ageing safely and independently: Support older people to age safely and independently at home and in their community • <u>Enduring Power of Attorney (EPOA):</u> Increase uptake of having EPOA arrangements through education and promotion. • <u>interRAI:</u> Use interRAI data to identify carer stress and matching allocation and usage of services. Use data to include ethnic information of carers who have triggered the CAPS for P2a, b & c. If/as inequities are identified we will analyse the reasons why and develop a plan to address these inequities. (EOA) • <u>Falls Prevention:</u> Implement the Falls Prevention and Management Model in partnership with ACC.	<u>EPOA</u> Q4; Achieve ≥8% uptake of EPOA <u>interRAI</u> Q1-Q2; Include ethnicity data and conduct investigation Q3; Develop a plan to respond to outcomes of investigation Q4; Implement plan <u>Falls Prevention</u> Q1; Finalise business case Q1-Q4; Implement model and monitor outcomes	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			4. Palliative Care: Implement strategic goals of Living Well, Dying Well: A Strategy for a Palliative Care Approach 2017-2020.	Q2-Q3; Plan for implementation of strategic goals Q4; Implement strategic goals	
			5. Advance Care Planning (ACP): Increase awareness about and use of advance care planning across acute care services, government and community agencies, and older people and carers.	Q4; Achieve ACP monitoring outcomes	
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.	One team	**1.** In conjunction with providers and workers identify training needs of kaiāwhina workforce required to support a locality network model of service delivery for older people in communities.	Q1-Q2; Identify workforce needs Q3-Q4; Devise plan to address training needs	PP23: Improving Wrap Around Services – Health of Older People
			2. Identify existing workforce training opportunities and support worker participation	Q4; Training opportunities identified for the sector	
Living Well with Diabetes	Continue to implement the actions in Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020 in line with the Quality Standards for Diabetes Care.	Closer to home	**1. Psychological Support:** Assess existing service options for psychological support and align access to these services to address gaps in access or quantify the residual gap particularly for Māori, Pacific and high deprivation (Standard 4). (EOA)	Q1; Assess existing psychological support services Q2; Ensure psychological support services address gaps in access or equity	PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
			2. Diabetes Self-Management Education, Support Services and Resources: Improve coverage of diabetes self-management programmes through enhanced delivery (Standard 1).	Q1-Q4; ≥500 people in self-management programmes per quarter	
			3. Healthy Lifestyles: Monitor uptake of Green Prescriptions, Maternal Green Prescriptions and Pre-school Active Families, in relation to diabetes, including for Māori and Pacific (Standard 2). (EOA)	Q1-Q4; Monitor uptake Q4; Achieve agreed targets including equity.	
			4. Priority practices: Review the outcomes of current DCIP in priority practices and, if required, identify new priority practices. Note: Priority practices are identified based on highest volume of enrolled Māori, Pacific and total population with a diagnosis of diabetes. (EOA)	Q2 & Q4; Improvement of good or acceptable glycaemic control in Māori and Pacific (HbA1c indicator)	
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these link with the Reducing Childhood	Closer to home	**1. Childhood Obesity Plan:** Complete and begin implementation of a CCDHB Obesity Prevention Plan, including plans to achieve equitable outcomes for Māori and Pacific children. (EOA)	Q2; Complete CCDHB Obesity Prevention Plan Q3-4; Plan for implementation to begin 2018/19	PP38: Delivery of response actions agreed in annual plan (section 2)

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
	Obesity Plan (e.g. active families): - How these initiatives will specifically address equity - What milestones are expected by when in 2017/18, and how success will be measured against these		**2. Project Energise:** Apply recommendations of evaluation of Project Energise undertaken by Auckland University of Technology.	Q3; Apply recommendations	
			3. Healthy Conversation Skills: Complete a stocktake of the resources currently in use across the country to reduce childhood obesity and review outcomes of their implementation, including a review of resources effective at improving equitable outcomes for Māori and Pacific children. (EOA)	Q1; Stocktake and review Q2: Plan for implementation of resources Q3-Q4; Implementation of resources	
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance	**1. Service development:** Plan for and undertake a SWOT analysis of services provided for vulnerable children, their families, and pregnant women with complex needs, including current Child Protection Team capacity, to identify strengths of current services and areas for supported service development.	Q1-2; Plan for analysis Q3; Undertake analysis of services and identify areas for development Q4; Plan for implementation of actions in 2018/19 to address results of review	PP38: Delivery of response actions agreed in annual plan (section 2)
			2. Care Plans: Develop and coordinate care plans for children, young people and their families/whānau served by Oranga Tamariki by social workers in the Child Protection Team. (EOA)	Q3; Plan for and develop care plan response Q4; Implement care plan response	
			3. Data exchange: Identify data exchange capabilities of Oranga Tamariki with the DHB to identify the services provided to children in care, and identify opportunities for improved responses. (EOA)	Q1; Identify data exchange capability Q2; Identify opportunities for improved responses Q3; Plan for improved response implementation Q4; Implement responses	
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances).	One team	**1. Workforce Development- Disability Literacy Education**: Increase the disability education programme through the use of eLearning, toolkits and staff training on identification of Disability Support Needs and the impact on recovery from acute medical conditions. (EOA)	Q1-Q4; Increase disability education programme. Q3; Assess coverage. Q4; Respond to coverage gaps.	PP38: Delivery of response actions agreed in annual plan (section 2)
			2. Dashboard of Indicators: Investigate data underlying the Dashboard of Indicators, based on unique NHIs with a Disability Alert, to inform future activities for Disability Support Services. (EOA)	Q1; Plan for investigation. Q3; Undertake investigation. Q4; Develop approach to respond to outcomes.	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			3. Improve service access for people with a learning disability. Develop a resource targeted to staff working with people with learning disabilities in collaboration with quality team for explaining informed consent processes with the aim of following up with a kit for consumers. The latter will be completed with input from the Sub-regional Disability Advisory Group and People First. (EOA)	Q2; Investigate requirements of resource. Q3; Co-design resource. Q4; Implement resource.	
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector	Closer to home	**1. Health Care Home (HCH):** Progress roll-out of HCH model of care across primary care, targeting practices with high volumes of Māori and Pacific patients. Continue to integrate the District Nurses and Community Allied Health Teams. (EOA)	Q1-Q4; Launch two HCHs per quarter. Q4; Ensure ≥40% of enrolled Māori and Pacific populations are enrolled in the HCH model of care	PP22: Delivery of actions to improve system integration including SLMs
			2. Community Health Network: Establish a Community Health Network in Porirua, where 41% of the population is Māori or Pacific, using a locality approach to strengthen the HCH model. (EOA)	Q1-Q4; Implement processes to establish Community Health Network.	
			3. Health Pathway and Health Navigator: Increase the number and use of Health Pathway and Health Navigator tools to support clinicians and the community with best practice guidance/support.	Q4; >75 new Health Pathways localised and average number of users per month >1,000	
			4. ICT: Increase the utilisation of ICT enablers including the patient portal, shared electronic health record access, concerto access and shared care plan. (Refer to IT Planning Priority).	Q4; >20,000 people activated on the patient portal	
			5 Primary care packages: Increase the uptake and flexibility of existing primary care packages of care to deliver care closer to the patient.	Q4; >500 packages of care delivered in primary care	
	Refer to jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan attached as an Appendix.	Value and high performance	**1. Ambulatory sensitive hospitalisations:** Achieve within DHB equity for all population groups over 5 years (by 2021/22), and in 2017/18 achieve a 9% reduction in ASH rate for Pacific and maintain equity for Māori. (EOA)	Q1-Q4; Monitor and report against progress made each quarter to MOH	PP22: Delivery of actions to improve system integration including SLMs
			2. Patient Experience of Care: Ensure that 75% of primary care practices are participating in the patient experience survey and, in future years, achieve improvements in PES scores.	Q1-Q4; Monitor and report against progress made each quarter to MOH	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			3. Acute bed days: Achieve a 4% improvement in age-standardised acute bed day rates for Māori and Pacific, and over 5 years (by 2021/22) achieve equity for Māori and half the equity gap for Pacific.	Q1-Q4; Monitor and report against progress made each quarter to MOH	
			4. Amenable Mortality: Reduce amenable mortality rates for Māori and Pacific, and over 15 years (by 2026), half the equity gap.	Q1-Q4; Monitor and report against progress made each quarter to MOH	
			5. Proportion of babies who live in a smoke-free household at six weeks post natal: Achieve 50% of whānau who are asked about the smoking status of adults in the home and have this recorded at the 6 week WCTO check.	Q1-Q4; Monitor and report against progress made each quarter to MOH	
			6. Youth access to and utilisation of youth-appropriate health services: Achieve ≤15% of 10-24 year olds presenting to CCDHB hospitals whose answer to the alcohol screening question is Unknown.	Q1-Q4; Monitor and report against progress made each quarter to MOH	
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	**One team**	**1. Pharmacy Contracting:** Implement decisions made in relation to the pharmacy contracting arrangements.	Q1; Implement decisions from the pharmacy contracting arrangements	PP38: Delivery of response actions agreed in annual plan (section 2)
			2. Needs analysis: Contribute to the national needs assessment of DHBs' requirements for community pharmacy services.	Q1; Contribute to national needs assessment	
			3. Informed Community Services Use the information from the national needs assessments to inform community pharmacy services.	Q3; Use the information from the national needs assessments to inform community pharmacy services.	
			4. Review: Review stage 3 of community pharmacy new service model for long term conditions.	Q4; Review stage 3 of community pharmacy service model of long term conditions	
			5. Remedial action: Develop remedial action based on the CPAMS report.	Q4; Develop remedial action plan based on CPAMS report.	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	**Value and high performance**	**1. Consumer Engagement:** • Establish a Consumer Council. • Continue to participate in the National Patient Experience survey. (EOA)	Q4; Clinical Council established and activities focussed on improving communication & coordination of care established with measurable outcomes.	PP38: Delivery of response actions agreed in annual plan (section 2)
			2. Improve patient outcomes: Continue to apply CCDHB patient outcomes programmes including (EOA): • reducing medication errors • reducing hospital acquired pressure injuries • evaluate incident management processes • improving early detection of the deteriorating patient • improve the Communication and Coordination domains of the adult inpatient experience survey as identified in patient feedback. • supporting the national HQSC programmes, to identify areas for improvement • develop an integrated approach to the CCDHB Improvement Plan	Q4; Achieve targets set in Statement of Performance expectations related to: • medication errors. • hospital acquired pressure injuries. • Communication and Coordination domains of the adult inpatient experience survey. Q4; Achieve improvements in the early detection of the deteriorating patient. Q1-Q4; Support national HQSC programmes. Q1-Q4; develop an integrated approach to the CCDHB Improvement Plan.	
			3. Falls Management: Implement the Falls Prevention and Management Model in partnership with ACC (refer Health Ageing). (EOA)	Q1; Finalise business case Q1-Q4; Implement model and monitor outcomes	
			4. Leadership & capability: Implement capability and leadership programmes that support improvement science and increased clinical leadership to support sector capability and a culture of quality and safety improvement.	Q4; Strengthen clinical engagement through the Management Operating System (MOS), and the CCDHB Improvement Movement focussed on building improvement capability & capacity	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Living Within our Means	Commit to manage your finances prudently, and in line with the previous Minister's expectations and to ensure all planned financials align with previously agreed results.	**Value and high performance**	**1. CCDHB Sustainability Plan:** Implement year 1 of the CCDHB Sustainability Plan 2017-2021 within the context of the 2030 Health System Plan: • Commence roll out of 2030 Health Systems Plan recommendations • Apply the CCDHB Planning and Performance framework and tools • Undertake Service Reviews • Further develop long term investment and sector plans to include future forecasting of demand, funding and expenditure patterns • Data visualisation to support strategic prioritisation, procurement, contract management, compliance and reporting	Q1-Q4; Implement year 1 of the CCDHB Sustainability Plan 2017-2021. Q4; Complete year 1 deliverables of the CCDHB Sustainability Plan 2017-2021.	Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C.	NA.	**1. Cardiac services** <u>Cardiac System of Care Strategy</u> • Develop joint DHB oversight of shared echo waiting lists in the region to improve access to vulnerable echocardiography services. (EOA) <u>Timeliness of interventions</u> • Review and confirm the delivery of after hours on call rosters across the region. (EOA)	<u>Cardiac System of Care Strategy</u> Q4; Confirm partnerships and develop proposal for approval by COOs and GMs <u>Timeliness of interventions</u> Q4; Needs assessment tabled at COOs and GMs Forum	NA.
			2. Hepatitis C: Support the implementation and use of a clinical Healthcare Pathway, for identification, assessment and treatment of patients with Hepatitis C. (EOA)	Q1-Q4; Implement and monitor use of clinical Healthcare Pathway for Hepatitis C.	

Government Planning Priority	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
			3. Major Trauma: Lead the central region DHBs in implementing a regional major trauma system that will result in a reduction of preventable levels of mortality, complications and lifelong disability of clients who have sustained major trauma in the central region. (EOA) <u>National Major Trauma Minimum Dataset</u> • Report the elements of the National Major Trauma Minimum Dataset (NMTMDS) for major trauma patients to the New Zealand Major Trauma Registry. <u>Clinical Leadership</u> • Develop regional clinical guidelines and inter-hospital transfer processes to manage major trauma patients within the region.	<u>National Major Trauma Minimum Dataset</u> Q2 & Q4; Quarterly regional reporting of the New Zealand Major Trauma Minimum Dataset for major trauma patients to the National Major Trauma Registry no more than 30 days after patient discharge <u>Clinical leadership</u> Q2 & Q4; Biannual review of regional trauma processes developed	

Local and Regional Enablers

Local and Regional Enabler	Focus Expected for Capital & Coast DHB	Link to NZ Health Strategy	Capital & Coast DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	(i) Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. (ii) State when ePA, Nursing Documentation and CPOE will be implemented (not all expected in 2017/18). (iii) Complete ePharmacy and Nursing documentation implementations.	Smart system	**1. Regional Clinical Portal:** Implement Stage 1 of transition onto the Regional Clinical Portal; Data Migration to enable a single consolidated regional health record for patients in the region.	Q4; Completed	Quarterly reports from regional leads.
			2. ePharmacy: Replace current pharmacy system (Windose) with the regionally agreed common Pharmacy Information System (ePharmacy)	Q3; Completed	
			3. Regional Radiology Information System: Complete transition to the Regional Radiology Information System	Q2; Completed Q3-Q4; Respond to issues arising	
			4. Medicines reconciliation: Implement access to community dispensed medication for medicines reconciliation.	Q4; Completed (dependent on MOH)	
			5. ePrescribing: Begin analysis and planning for hospital ePrescribing & administration	Q4; Implementation plan completed	
			6. Discharges: Improve discharge prescription quality and discharge summary medications information to include a summary of medications on admissions, changes and medications on discharge	Q1-Q4; Begin Implementation in 2017/18	
			7. Electronic nursing documentation: Begin analysis and planning for electronic nursing documentation and observation	Q4; Implementation plan completed	
			8. Electronic Laboratory Orders: Implement Electronic Laboratory Orders	Q4; Complete Pilot Electronic Laboratory Orders	
			9. Capacity Planning: Progress implementation of a set of tools for the DHB's Integrated Operation Centre to undertake capacity planning to accurately forecast and manage hospital demand and capacity and plan for seasonal bed use.	Q1-Q2; Additional data integration and models developed.	
			9. WebPAS Theatre (Regional Configuration) Implementation: Complete the implementation of the regional configuration of WebPAS Theatre application to support maximising the utilisation of all operating theatres and staff.	Q2; Completed	
			10. Electronic Referrals: Develop a roadmap for eReferrals to better integrate primary, community and hospital services and support improved referral pathways.	Q4; Roadmap developed	
			11. GP Access to Hospital Records: Progress with the rollout of GPs access to their patients' hospital records (MAP)	Q4; Completed	
			12. Shared Care Plan: Implement a Shared Care Planning application to better integrate primary, community and hospital services	Q4; Completed	

			13. Patient Portal: Increase the utilisation of patient portals to support greater patient involvement in their care planning and delivery.	Q4; Completed	
			14. Mental Health Shared Care Record & Plan: Implement tactical improvements and develop a long term roadmap for the tools used by the Mental Health, Addictions and Intellectual Disability Services to better coordinate care for their patients.	Q4; Tactical Improvements implemented and roadmap developed	
			15. IT support NBSP: Assess and plan for implementation of IT systems in support of National Bowel Screening Programme scheduled to start at CCDHB in 2018/19	Q1-Q4; Implementation plan completed (dependent on MOH)	
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	**One Team**	**1. Positive workplace:** Continue to deliver on the Positive workplace plan for the DHB; incorporating healthy workforce initiatives that support a positive and healthy environment: (i) review of the People Strategy occurs in July 2017 considering staff and union feedback and areas of focus; and (ii) launch early intervention processes	Q1; Analyse results of Staff engagement survey Q2; Review of the People Strategy complete Q2-Q3; Launch early intervention process	N/A
			2. Postgraduate Year 1 and 2: Continue to build capability through our commitment to workforce initiatives and high quality training for PGY 1s and 2s: develop and implement intern leave guidelines and increase PGY1 and PGY2 on the education committee	Q1; Intern leave guidelines developed and implemented Q4; Increased PGY1 and PGY2 on the education committee.	
			3. Capability and capacity development: build capability through workforce initiatives and high quality training for all health professionals: (i) Develop and implement Care, Capacity and Demand Management (CCDM) plan by CCDM Council; (ii) Align leadership development programmes with State Services Commission (SSC) framework and regional priorities; (iii) Develop a dedicated education unit for undergraduate nurses, first year or practice programmes and maximise postgraduate development maximised for Māori and Pacific. (EOA); and (iv) Calderdale Practitioners trained and commencing projects across the Central Region.	Q1; CCDJM plan developed and implemented. Q2; Leadership development programmes aligned with SSC framework and regional priorities. Q3; Dedicated unit for undergraduate nurses, first year or practice programmes developed Q4; 30 staff trained at foundation level for the Calderdale Foundation	
			4. Leadership: Develop a sustainable approach to leadership development with a strategy which incorporates the national priorities: Develop and implement an approach to talent management.	Q3; Talent management plan developed and implemented	

SECTION 3: Service Configuration

Service Coverage

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

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

CCDHB is not seeking any formal exemptions to the Service Coverage Schedule in 2017/18.

Active Service Changes

The table below describes all service changes that have been approved for implementation at CCDHB in 2017/18. Service changes that are sub-regional but do not affect the CCDHB domiciled population are excluded.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Community Pharmacy and Pharmacist Services	Implement the national pharmacy contracting arrangements and develop local services once agreed.	• More integration across the primary care team • Improved access to pharmacist services by consumers • Consumer empowerment • Safe supply of medicines to the consumer • Improved support for vulnerable populations • More use of pharmacists as a first point of contact within primary care.	National and Local
Bowel Cancer Screening Programme	Tranche 2 implementation of bowel cancer screening service in line with national programme.	• Improved detection and management of people with bowel cancer	National
Oral Maxillofacial	Develop a single acute service model for Lower North Island as part of the Central Region Service.	• Improve service sustainability	Regional
Mental Health: Community Youth Respite	Develop proposal around crisis respite and therapeutic recovery model to support children and young people and their families/whānau to live successfully as participating members of the community.	• More responsive services • Improved patient access • More efficient	3DHB Sub-regional
Mental Health: Community Based Acute and Crisis Respite	Implement agreed prioritised recommendations to reduce variation between the community-based acute crisis services in the service user groups targeted.	• More responsive services • Improved patient access • More efficient services • Improved patient outcomes	3DHB Sub-regional
Mental Health: ICAFS	Complete a review and implement an agreed and prioritised change programme within ICAFS.	• Improve waiting times • Improve integration of service with primary care partners • Improve patient outcomes • Improve patient experience	3DHB Sub-regional
Radiology	Evaluate clinical and financial viability of publicly-funded radiology services across the three DHBs, including services provided by both the DHBs and private providers. Develop proposed future options to improve radiology services across the system (community and hospital services).	• More responsive services • Improved patient access • More efficient services	3DHB Sub-regional
Needs Assessment and Service Coordination	Scope a whole of life approach to needs assessment and service coordination inclusive of DHB mental health and Ministry of Health funded NASC services.	• More responsive services • Improved patient access • Improved patient outcomes • Improved patient satisfaction • More efficient services	Local
Pacific Health Services	Implement agreed recommendations from the May 2015 service review of Pacific Health Inpatient Unit and the Pacific Navigation Service.	• More responsive services • Improved patient access • Improved patient outcomes • More efficient services	Local

The table below describes all service reviews that are anticipated at CCDHB in 2017/18.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Mental Health	Investigate options for implementation of proposed service model of care endorsed by the Mental Health and Addictions Network (MHAN).	• Improved waiting times • Improved integration of services with primary care partners • Improved outcomes for patients • Improved patient experience	Regional
Cancer Services	Develop options to strengthen ambulatory cancer care.	• More responsive services • Services Closer to home • Improved patient care	3DHB Sub-regional
Mental Health	Implement agreed prioritised improvement recommendations on Primary Care setting	• Improved waiting times • Improved integration of services with primary care partners • Improved outcomes for patients • Improved patient experience	3DHB Sub-regional
Facilities management	Review and align facilities management practices across CCDHB sites including approaches to car parking.	• Improved value for money and sustainability	Local
Kenepuru A&M Model Review	Review the current A&M model of service delivery and identify a locally sustainable and appropriate operating model.	• Improve waiting times, • Improve integration of service with primary care partners, • Improved outcomes for patients • Improved patient experience	Local
Maternity Services	Review DHB-run primary birthing centre services, to align with the Locality Network service model as set out in CCDHB's Health System Plan 2030.	• Increase efficiency of service • Improve resource utilisation	Local
Service Delivery Models for Support Services	Assess and review models for delivery of core non-clinical support services.	• Improved value for money and sustainability	Local
Travel Policy Changes	Review current practices to align with the National Travel Assistance policy.	• Improved value for money and sustainability • Reduced inequalities	Local

SECTION 4: Stewardship

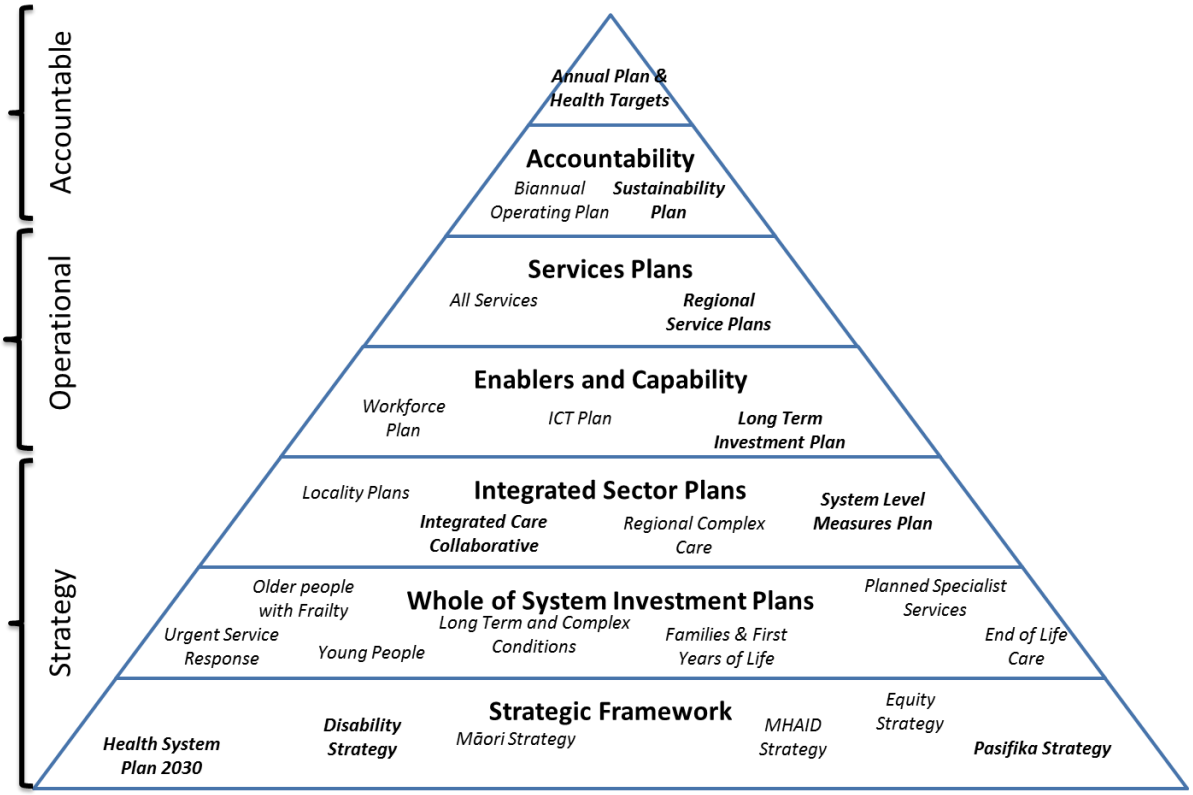
(Refer to Capital & Coast DHB's 2016/17 Statement of Intent for more information)

This section provides an outline of the arrangements and systems that CCDHB has in place to manage our core functions and to deliver planned services. Greater detail is included in CCDHB's three-yearly Statement of Intent, which was last produced for the 2016/17 year and is available on our website.

Managing our Business

In 2016/17 CCDHB redesigned its operational approach to deliver the core DHB planning and funding functions. The CCDHB Strategy, Innovation & Performance (SIP) Directorate is developing a comprehensive approach to planning and performance that is represented in the diagram below. This systematic and connected approach drives the translation of strategy into measurable actions.

This framework supports CCDHB to meet its obligations to the Minister of Health and be responsive to its environment through a clear and agreed process. It is specifically designed to apply whole of system commissioning as the key mechanism to inform integrated sector and service plans.



The framework ensures "joined – up" investment decision making across the whole of CCDHB activity, and will be used in partnership with leaders from our provider arms, our NGO and primary care sector as well as our regional and sub-regional partner DHBs.

Organisational performance management

CCDHB's performance is assessed on financial, quality, service delivery and system-level measures. , These measures are reported at Clinical Governance Groups, Executive Leadership Team and Board forums.

Funding and financial management

CCDHB's key financial indicators are spend against budget and budget against deficit. These are assessed against and reported through CCDHB's performance management process to the Executive Leadership Team, and the Finance and Risk Assessment Committee (FRAC). Further information about CCDHB's planned financial position for 2017/18 and out years is contained in Appendix B: Financial Performance.

Investment and asset management

CCDHB has made significant progress in improving its cost of service delivery and managing service change over the last three years. This progress forms the foundation for a three year sustainability pathway (CCDHB Sustainability Plan 2017-21) that emphasises cross-organisation and system governance of financial and service delivery performance. This pathway will be supported by specific and extensive activity and financial modelling and a defined programme of work that will deliver gains from year one and embedded system change by year three.

Part of the programme of work is the development of future capital investment, infrastructure development and service investment strategies which will be reflected in the final version of the Long Term Investment Plan submitted to Treasury in May 2017.

Shared service arrangements and ownership interests

CCDHB has a part ownership interest in Central Region Technical Advisory Service (CRTAS), the Regional Health Information Partnership (RHIP), Allied Linen Services Ltd. (ALSL) and New Zealand Health Partnerships. CCDHB is committed to its obligations and will contribute to strengthening these arrangements. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

CCDHB recognises that effective risk management is an integral component of good governance. The risk management framework (CCDHB Risk Management Framework) provides principles and process for guiding the delivery of risk management to ensure CCDHB is operating in accordance with the 2008 Health and Disability Service Standards and the AS/NZS ISO 31000:2009 standard for Risk Management, and the Health and Safety at Work Act 2015 and associated regulations. Health and Safety (H&S) is a particular focus across the DHB. Accountability for H&S is the responsibility of every manager and employee. Systems for reporting, investigating and managing H&S incidents and risk are deployed across the organisation.

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

The DHB also has established external and internal Audit functions which provide independent professional assessments as to key risks, the accuracy and integrity of CCDHB financial reports, and the adequacy of internal controls. The DHB is also undertaking the Treasury Investor Confidence Rating review this year.

Quality assurance and improvement

The core function of CCDHB is to maintain and improve the safety and quality of our health and disability services. We focus on patient safety and patient experience as the key indicators of our progress. Growing evidence indicates that better patient experience, developing partnerships with consumers, and patient and family-centred care are linked to improved health, clinical, financial, service, and patient satisfaction outcomes.

At CCDHB, quality of care is underpinned by the "Triple Aim", an international healthcare improvement policy (adopted in New Zealand by the Health Quality and Safety Commission) that outlines a plan for better healthcare systems.

Building Capability

Capital and infrastructure development

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

- The development of a Master Site Plan for all CCDHB facilities. This includes specific projects of the re-development of the regional children's hospital and an increase in ICU capacity.
- CCDHB has a number of older properties which are not suitable for on-going use. Options for these properties are being considered including demolition and sale. CCDHB has significant property assets with poor utilisation due to historical design. Options are being investigated to improve utilisation and reduce occupancy to create space for leasing. Opportunities exist to have medical research and other health agencies on the campus to create a medical research and health hub in the region.
- The Wellington Regional Hospital domestic hot and cold water systems are exhibiting signs of failure due to corrosion in the copper pipes, and this is causing leaks throughout the building. Plans are being developed to resolve this issue.

Future development of hospital infrastructure requires significant investment. Options to partner with other parties including private investors, private hospitals, research organisations and Iwi will be considered.

Information technology and communications systems

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

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

In addition to maintaining and improving critical ICT systems and services, future investment will align to the following areas to support DHB goals:

- **Digitising patient/consumer interaction** to support the move to care in the home and self-care.
- **Digitising end-to-end processes** by implementing systems that enable electronic referrals, workflow, shared care and service coordination across and within care settings.

- **Digitally and data enabled decisions** by improving the availability and quality of data for decision making, Population Health and System Performance analysis, and the use of electronic decision support at point of care.
- **Mobility and Unified Communications** to enable new models of care, improved safety and greater efficiency.
- **Regional systems** programmes to support regional sharing of information, optimal use of scares clinical resources and new models and processes for care.
- **Sustainable** clinical / business applications and systems, infrastructure and ICT operations.

Further detail about CCDHB's current IT initiatives is contained in the 2017/18 Central Region's Regional Service Plan, and in the section on local and regional enablers within this document on page 27.

Workforce

CCDHB has a clearly defined programme to build the necessary organisational culture, leadership and workforce, including equal employment opportunities, needed to deliver on its strategic objectives. These programmes are detailed in the 2017/18 Central TAS Regional Service Plan; which builds off the 3DHB Human Resources Plan 2014-2016. Internally, CCDHB is developing a People Strategy that will set out our specific actions to meet the objectives set out in the two plans above.

To ensure a consistent approach to leadership and workforce planning, CCDHB works collaboratively with the national DHB General Managers Human Resources group, DHB Shared Services (through the Regional Director – Workforce), Health Workforce New Zealand and the State Services Commission in using national frames works to achieve agreed regionally-based workforce solutions.

CCDHB will meet the Government's 'Expectations for Pay and Employment Conditions in the State Sector' both within the bargaining strategies and parameters agreed with DHB Shared Services, and within our own strategies. We also continue to practice pro-active national and international recruitment strategy implementation to support in areas of higher recruitment and retention needs.

Consumer and Community Engagement

In 2017/18, CCDHB will establish a formal consumer engagement mechanism such as a Consumer Council to strengthen consumer engagement and input in the co-design of service changes and improvements. The Consumer Council will advise the Board and will be developed building on the community knowledge and linkages of our Māori, Pacific, Disability and Mental Health networks. The Council will foster local linkages across each area and work to engage people on community health issues as well as other ways to involve people who use services

Existing consumer and community engagement in CCDHB include:

- Sub-regional Disability Advisory Group (SRDAG): SRDAG works alongside the DHB to ensure the needs of people with disability across ages and localities are integrated into all programmes of work. SRDAG has led the creation of the new Sub-regional Disability Strategy 2017-2022.
- Child to Adult Transition Project: This project aims to re-evaluate how young people leaving secondary services transition back into Primary Care as their main service provider. The project uses a co-design methodology. It is led by young people and their family/whānau members to ensure the new model suits their needs and as well as the needs of clinicians.
- New Zealand Sign Language in Health: This project aims to research the needs of NZSL users in health within the sub region and use the outcomes to inform a 5 year work plan. The research component was led by a NZSL user steering group.

- The Sub-regional Mental Health Consumer Leadership Group has been in existence for one year and advises on the 3DHB Mental Health Strategy.

Clinical Governance, Engagement and Leadership

Clinical governance is the organisational mechanism used to set goals, monitor and drive improvement and accountability for clinical quality and safety. Clinical leadership is the operational system that supports health professionals to perform appropriately and achieve the goals set by clinical governance groups. Clinical engagement is the formal and informal mechanisms whereby clinicians are involved in organisational decision-making at all levels, including clinical governance and leadership. Clinical engagement is essential for effective service improvement, financial stewardship and governance.

CCDHB supports its clinicians to participate in and lead the comprehensive interconnected local, sub regional and regional clinical governance, leadership and engagement systems in place. These networks, pathways and shared clinical arrangements secure specialised capability with our regional and sub-regional DHB partners, as well as supporting service integration with primary and community providers.

Strengthening local leadership is assisted by the sub-regional Alliance Leadership Teams, the Strategic Clinical Governance Group and involvement of clinicians in the development of collaborative service models at various levels. The Strategic Clinical Governance Group is responsible for providing clinical leadership; leading the development of clinical governance across all of the services provided by the DHB; overseeing the quality and safety of services delivered by DHB providers and the clinical quality programme; and providing advice and recommendations to the DHB Board, Chief Executive and management**.**

Co-operative developments

Improving health and wellbeing requires CCDHB to work with partners to deliver health services, develop integrated health and social service responses and benefit from shared infrastructure costs. In the delivery of hospital and health services CCDHB is developing a work plan with its nationwide tertiary care partners, in the region as a complex care provider, and in partnership with Hutt Valley DHB in particular.

In the delivery of Mental Health, Addiction and Intellectual Disability services CCDHB is a nationwide provider of complex services, a regional provider and the sub-regional provider across CCDHB, Hutt Valley DHB and Wairarapa DHB.

CCDHB has strong working relationships with its three PHOs and the NGO sector. These partners are integrated through alliance leadership teams, integrated care collaboratives and in whole of system commissioning approaches.

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

SECTION 5: Performance Measures

2017/18 Performance Measures

The DHB non-financial monitoring framework aims to provide a rounded view of performance in key areas using a range of performance markers. The measures are intended to cover a specific set of markers of DHB performance in key areas, rather than all health services or DHB activity. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

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

Each performance measure has a nomenclature to assist with classification as follows:

Code	Dimension
HS	Health Strategy
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – Establishment of baseline (no target/performance expectation is set)

Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2017/18.

Interpreting our Performance:

- Performance indicated by '---' is suppressed due to low numbers.
- N/A - DHBs are not required to report at this time and national targets are not applicable.
- TBC/TBA – CCDHB is waiting on advice from Ministry of Health.

Performance Measure	Performance Expectation	Target Groups		2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
HS: Supporting delivery of the New Zealand Health Strategy	One brief example (single dot point) per strategy theme each quarter, to highlight an action, initiative or activity delivered in the quarter. These highlights will be included on the DHB quarterly dashboards for sharing with the Minister (no performance assessment will be made).											Quarterly	N/A
PP6: Improving the health status of people with severe mental illness through improved access	% of the population accessing specialist mental health service	Age 0-19	Māori	N/A	N/A	4.77%	N/A	5.08%	N/A	3.77%	N/A	Quarter 2 & Quarter 4	Youth Mental Health Mental Health
			Other	N/A	N/A	3.45%	N/A	3.49%	N/A	3.77%			
			Total	N/A	N/A	3.68%	N/A	3.77%	N/A	3.77%			
		Age 20-64	Māori	N/A	N/A	7.07%	N/A	7.02%	N/A	3.60%			
			Other	N/A	N/A	3.15%	N/A	3.20%	N/A	3.60%			
			Total	N/A	N/A	3.55%	N/A	3.60%	N/A	3.60%			
		Age 65+	Māori	N/A	N/A	1.65%	N/A	1.49%	N/A	1.20%			
			Other	N/A	N/A	1.15%	N/A	1.19%	N/A	1.20%			
			Total	N/A	N/A	1.17%	N/A	1.20%	N/A	1.20%			
PP7: Improving mental health services using wellness and transition (discharge) planning	% of clients discharged will have a quality transition or wellness plan		Total	N/A	N/A	N/A	N/A	N/A	N/A	≥95%	≥95%	Quarterly	Youth Mental Health Mental Health
	% of audited files meet accepted good practice		Total	N/A	N/A	N/A	N/A	N/A	N/A	≥95%	≥95%		
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	% of people seen by Mental Health Provider Arm within 3 weeks		Age 0-19	N/A	55.6%	61.4%	61.0%	63.8%	57.7%	≥80%	≥80%	Quarterly	Youth Mental Health Mental Health
	% of people seen by Mental Health Provider Arm within 8 weeks		Age 0-19	N/A	90.2%	90.6%	89.4%	84.7%	85.9%	≥95%	≥95%		
	% of people seen by Addictions Services (Provider Arm and NGO) within 3 weeks		Age 0-19	N/A	73.7%	73.7%	68.25	65.4%	62.9%	≥80%	≥80%		
	% of people seen by Addictions Services (Provider Arm and NGO) within 8 weeks		Age 0-19	N/A	97.4%	100%	90.9%	92.3%	85.7%	≥95%	≥95%		
PP10: Oral health – Mean DMFT score at year 8	Mean DMFT for children examined in the Year 8 group	Age 12-13	Māori	0.80	N/A	N/A	N/A	N/A	N/A	2017: ≤0.56 2018: ≤0.56	N/A	Quarter 3	Child Health
			Pacific	1.07	N/A	N/A	N/A	N/A	N/A				
			Other	0.46	N/A	N/A	N/A	N/A	N/A				
			Total	0.56	N/A	N/A	N/A	N/A	N/A				

Performance Measure	Performance Expectation	Target Groups		2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
PP11: Children caries-free at 5 years of age	% caries-free in the children examined at 5 years old	Age 5	Māori	50%	N/A	N/A	N/A	N/A	N/A	2017: ≥72% 2018: ≥72%	N/A	Quarter 3	Child Health
			Pacific	39%	N/A	N/A	N/A	N/A	N/A				
			Other	73%	N/A	N/A	N/A	N/A	N/A				
			Total	66%	N/A	N/A	N/A	N/A	N/A				
PP12: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years	% access to DHB-funded adolescent dental services	Year 9 up to age 17 years	Māori	*N/A*	N/A	N/A	N/A	N/A	N/A	2017: ≥85% 2018: ≥85%	N/A	Quarter 4	Child Health
			Pacific	*N/A*	N/A	N/A	N/A	N/A	N/A				
			Other	*N/A*	N/A	N/A	N/A	N/A	N/A				
			Total	*76.7%*	N/A	N/A	N/A	N/A	N/A				
PP13: Improving the number of children enrolled in DHB funded dental services	% of pre-school children enrolled in DHB-funded oral health services	Age 0-4	Māori	70.2%	N/A	N/A	N/A	N/A	N/A	2017: ≥95% 2018: ≥95%	N/A	Quarter 3	Child Health
			Pacific	85.7%	N/A	N/A	N/A	N/A	N/A				
			Other	106.9%	N/A	N/A	N/A	N/A	N/A				
			Total	97.3%	N/A	N/A	N/A	N/A	N/A				
	% of enrolled pre-school and primary school children overdue for their scheduled examinations	Age 0 to Year 8 inclusive	Māori	9%	N/A	N/A	N/A	N/A	N/A	2017: ≤10% 2018: ≥10%	N/A		
			Pacific	12%	N/A	N/A	N/A	N/A	N/A				
			Other	16%	N/A	N/A	N/A	N/A	N/A				
			Total	15%	N/A	N/A	N/A	N/A	N/A				
PP20: Improved management for long term conditions	Focus Area 1: Long Term Conditions: narrative report											Quarterly	Living Well with Diabetes
PP20: Diabetes Services	Focus Area 2: Diabetes Services: Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*												
	Focus Area 2a: % of people enrolled in a PHO with diabetes with managed HbA1c levels (≤64 mmol/mol)	Age 15-74	Māori	N/A	N/A	60%	N/A	59%	N/A	≥64%	≥64%		Living Well with Diabetes
			Pacific	N/A	N/A	55%	N/A	57%	N/A				
			Indian	N/A	N/A	68%	N/A	67%	N/A				
			Other	N/A	N/A	71%	N/A	69%	N/A				
			Total	N/A	N/A	66%	N/A	66%	N/A				

Performance Measure	Performance Expectation	Target Groups		2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
	Focus Area 2b: % with HbA1C levels ≤80 mmol/mol	Age 15-74	Total	N/A	N/A	90%	N/A	65%	N/A	≥90%	≥90%		
	Focus Area 2c: % with HbA1C levels ≤100 mmol/mol	Age 15-74	Total	N/A	N/A	99%	N/A	72%	N/A	≥98%	≥98%		
	Focus Area 2d: % with HbA1C levels >100 mmol/mol	Age 15-74	Total	N/A	N/A	2%	N/A	1%	N/A	≤2%	≤2%		
PP20: Cardiovascular Disease	Focus Area 3: Cardiovascular health narrative report												
	Focus Area 3a: % of the eligible population who have had their CV risk assessed in the last five years	Māori		N/A	87%	87%	87%	87%	87%	≥90%	≥90%		Childhood Obesity
		Pacific		N/A	89%	89%	88%	88%	88%				
		Other		N/A	91%	91%	91%	91%	90%				
		Total		N/A	91%	91%	91%	90%	90%				
		Māori men age 35-44		N/A	70%	69%	69%	69%	68%	≥90%	≥90%		
PP20: Acute Heart Service	Focus Area 4: Acute Heart Services narrative report												
	Focus Area 4a: % of high-risk patients receiving an angiogram within 3 days of admission			N/A	N/A	90.8%	N/A	89.3%	N/A	≥70%	≥70%		Primary Care Integration
	Focus Area 4b: % of ACS patients undergoing coronary angiography having registry data completion within 30 days			N/A	N/A	99%	N/A	98.3%	N/A	≥95%	≥95%		
	Focus Area 4c: % of cardiac surgery patients having registry data completion within 30 days of discharge			N/A	N/A	99%	N/A	98.3%	N/A	≥95%	≥95%		
PP20: Stroke Service	Focus Area 5: Stroke Services: Narrative report												
	Focus Area 5a: % of potentially eligible stroke patients thrombolysed			N/A	N/A	N/A	N/A	19%	24%	≥8%	≥8%		Primary Care Integration
	Focus Area 5b: % of stroke patients admitted to a stroke unit or service with demonstrated stroke pathway			N/A	N/A	N/A	N/A	78%	75%	≥80%	≥80%		
	Focus Area 5c: % of patients admitted with acute stroke transferred to inpatient rehabilitation services within 7 days			N/A	N/A	N/A	N/A	74%	81%	≥80%	≥80%		

Performance Measure	Performance Expectation	Target Groups		2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
PP21: Immunisation coverage	Focus Area 1a: % of children fully immunised at age 24 months	At 2 years	Māori	N/A	94.4%	92.1%	95.5%	95.2%	91.8%	≥95%	≥95%	Quarterly	Supporting Vulnerable Children Increased Immunisation
			Pacific	N/A	95.1%	94.7%	94.7%	94.7%	94.3%				
			Total	N/A	94.7%	94.1%	94.9%	94.5%	94.7%				
	Focus Area 1b: % of children fully immunised at age 5	At 5 years	Māori	N/A	91.8%	87.9%	87.2%	90.0%	89.6%	≥95%	≥95%		
			Pacific	N/A	90.8%	93.9%	93.9%	95.8%	93.5%				
			Total	N/A	90.5%	91.2%	92.0%	92.4%	91.6%				
	Focus Area 2: % of eligible girls fully immunised against HPV	Eligible girls	Māori	N/A	N/A	82.5%	N/A	N/A	N/A	≥75%	≥75%	Quarter 4	
			Pacific	N/A	N/A	68.4%	N/A	N/A	N/A				
			Total	N/A	N/A	69.1%	N/A	N/A	N/A				
	Focus Area 3: % of population 65+ immunised against influenza	Age 65+	Total	N/A	N/A	N/A	59.7%	N/A	N/A	≥75%	≥75%	Quarter 1	Healthy Ageing
PP22: Improving system integration (SLM)	Report on delivery of actions and milestones to improve system integration and introduction of System Level Measures. Jointly agreed Alliance/DHB Improvement Plan to be provided at the end of Q1 to support achievement of this.											Quarterly	Primary Care Integration Improving Quality
PP23: Implementing the Healthy Ageing Strategy	1.a Future Models of Care	DHBs are to report progress during the quarter (in brief) to deliver on agreed action(s) and milestones.										Quarterly	Healthy Ageing
	1.b Integrated Falls and Fracture Prevention and Rehabilitation Services	DHBs are to report progress during the quarter (in brief) to deliver on agreed action(s) and milestones.											
		Report on practical (and concrete) steps taken to improve coding of falls at the point of entry to hospital with the aim of accurately capturing fall related injuries.											
		Report the number of older people (65 and over, or younger if identified as a falls risk) that have: received in-home strength and balance retraining services; received community/group strength and balance retraining services; been seen by the fracture liaison service or similar fracture prevention service; been prescribed bisphosphonates, including 5mg/100ml zoledronic acid infusions, for treatment of osteoporosis.											
	1.c Actions to improve equity	DHBs are to report progress during the quarter (in brief) to deliver on agreed action(s) and milestones.											

Performance Measure	Performance Expectation	Target Groups	2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
	1.d Workforce regularisation	DHBs are to report progress during the quarter (in brief) to deliver on agreed action(s) and milestones.										
	1.e Locally prioritised action(s)	DHBs are to report progress during the quarter to deliver on one (or more) DHB-identified action (not included above that may or may not be included in the DHB's Annual Plan) that the DHB has prioritised locally to highlight implementation of the Healthy Ageing Strategy and that it expects to have the greatest impact on outcomes for older people locally.										
	2.a DHBs are expected to report by exception, volumes and measures associated with the InterRAI.											Healthy Ageing
	2.b % of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan		N/A	N/A	N/A	N/A	N/A	N/A	≥95%	≥95%		
PP25: Prime Minister's youth mental health project	Reports on progress and delivery of the Prime Minister's youth mental health initiatives 1, 3 & 5:										Quarterly	Youth Mental Health Mental Health
	Initiative 1.a: School Based Health Services quantitative report											
	Initiative 3: Youth Primary Mental Health											
	Initiative 5: Improving the responsiveness of primary care to youth											
PP26: Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Focus Area 1: Primary Mental Health: Template and narrative report on services delivered										Quarterly	Mental Health Youth Mental Health
	Focus Area 2: District Suicide Prevention and Postvention: Report on highlights, exceptions, who and # trained											
	Focus Area 3: Improving Crisis response services: Report on actions undertaken to reduce the rate of known clients being referred to by police to crisis teams, and outcomes											
	Focus Area 4: Improve outcomes for children: Exceptions report where actions identified in the Annual Plan for improving outcomes for children are not on track											
	Focus Area 5: Improving employment and physical health needs of people with low prevalence conditions: Exceptions report where actions identified in the Annual Plan are not on track											
PP27: Supporting Vulnerable Children	Checklist report and progress update against actions and milestones agreed in the Annual Plan										Quarterly	Supporting Vulnerable Children
PP28: Reducing Rheumatic Fever	Reducing the Incidence of First Episode Rheumatic Fever: Initial hospitalisation rate per 100,000 total population	Māori	N/A	N/A	N/A	N/A	N/A	N/A	≤1.0	≤1.4	Quarterly	Rheumatic Fever
		Pacific	N/A	N/A	N/A	N/A	N/A	N/A				

Performance Measure	Performance Expectation	Target Groups	2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
		Total	N/A	N/A	2.0	N/A	2.3	N/A				
PP29: Improving waiting times for diagnostic services	Elective Coronary Angiography: % of accepted referrals receiving angiography within 90 days		N/A	99.0%	99.4%	99.7%	99.4%	97.8%	≥95%	≥95%	Quarterly	Improved Access to Elective Surgery Faster Cancer Treatment Bowel Screening
	Computed Tomography : % of accepted referrals receiving scan within 42 days		N/A	87.0%	85.2%	85.5%	83.3%	75.2%	≥95%	≥95%		
	Magnetic Resonance Imaging: % of accepted referrals receiving scan within 42 days		N/A	56.0%	61.1%	59.1%	49.3%	42.2%	≥90%	≥90%		
	Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 14 days		N/A	90.5%	100%	97.4%	97.2%	85.2%	≥90%	≥90%		
	Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 30 days		N/A						100%	100%		
	Non-Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 42 days		N/A	83.1%	86.0%	88.8%	72.6%	58.2%	≥70%	≥70%		
	Non-Urgent Diagnostic Colonoscopy: % of accepted referrals receiving procedure within 90 days		N/A						100%	100%		
	Surveillance Colonoscopy: % of people receiving procedure within 84 days		N/A	86.6%	76.7%	73.4%	61.2%	47.5%	≥70%	≥70%		
	Surveillance Colonoscopy: % of people receiving procedure within 120 days		N/A						100%	100%		
PP30: Faster Cancer Treatment	Part A: 31 Day Indicator: % of patients receiving their first cancer treatment (or other management) within 31 days from date of decision-to-treat		N/A	85.1%	87.6%	89.7%	90.6%	88.3%	≥85%	≥85%	Quarterly	Faster Cancer Treatment
PP31: Better help for smokers to quit in public hospitals	% of adults admitted to hospital as inpatients who identify as a current smoker receiving brief advice and support to quit smoking		N/A	93.1%	92.2%	92.3%	88.7%	92%	≥95%	≥95%	Quarterly	Better Help for Smokers to Quit
PP32: Improving the quality of ethnicity data collection in PHO and NHI registers	Report on delivery of actions and milestones to improve quality of ethnicity data collection										Quarter 2 & Quarter 4	Primary Care Integration Improving Quality

Performance Measure	Performance Expectation	Target Groups		2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
PP33: Improving Māori enrolment in PHOs	% of Māori enrolled with a PHO			N/A	86.3%	86.3%	83.9%	84.4%	84.6%	≥90%	≥90%	Quarter 2 & Quarter 4	Primary Care Integration
PP34: Improving the percentage of households who are smoke free at six weeks postnatal	Report on actions taken to reach target of all adults in household are completely smoke free											Quarter 1 & Quarter 3	Better Help for Smokers to Quit Child Health
	% of households who are smoke free at six weeks postnatal			N/A	N/A	N/A	N/A	N/A	N/A	See SLM Plan	N/A		
PP36: Reducing the rate of Māori under the Mental Health Act: section 29 community treatment orders	% of Māori under community treatment orders of the Mental Health Act: S29			N/A	N/A	N/A	N/A	N/A	N/A	-10%	N/A	Quarterly	Mental Health
PP37: Improving breastfeeding rates	% of infants exclusively or fully breastfed at 3 months	Māori		N/A	N/A	N/A	N/A	N/A	N/A	≥60%	≥60%	Quarter 1 & Quarter 3	Child Health Childhood Obesity
		Pacific		N/A	N/A	N/A	N/A	N/A	N/A				
		Total		N/A	N/A	N/A	N/A	N/A	N/A				
PP38: Delivery of response actions and milestones agreed in the annual plan for each Government planning priority	Report on the delivery of all actions and milestones agreed to during the reporting period			Actions and milestones supporting the health-led BPS targets: Healthy Mums and Babies, and Keeping Kids Healthy								Quarterly	All priorities
				Actions and milestones supporting all priorities (including BPS targets)								Quarter 2 & Quarter 4	
SI1: Ambulatory Sensitive Hospitalisations (ASH, a SLM) Note: 0-4 target advised as part of jointly agreed (by district alliances) System Level Measure Improvement Plan in Q1 PP22 reporting	Non-standardised ASH rate per 100,000 population	Age 0-4	Other	N/A	4,867	5,329	5,184	5,376	5,536	Link to SLM	N/A	Quarter 2 & Quarter 4	Child Health Primary Care Integration
			Māori	N/A	7,047	7,444	6,750	6,474	6,415				
			Pacific	N/A	12,878	13,186	12,059	12,146	12,079				
			Total	N/A	6,035	6,594	6,235	6,330	6,436				
	Standardised ASH rate per 100,000 population	Age 45-64	Other	N/A	2,246	2,601	2,725	2,744	2,714	≤3,214	N/A		
			Māori	N/A	5,343	6,094	6,206	5,457	5,423				
			Pacific	N/A	7,085	7,909	7,793	7,688	7,131				
			Total	N/A	2,779	3,181	3,288	3,238	3,177				

Performance Measure	Performance Expectation	Target Groups	2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
SI2: Delivery of Regional Service Plans (RSP)	Part 1: Progress report on implementation of RSP priorities, including related actions supporting implementation of the Healthy Ageing Strategy (Dementia and interRAI)										Quarterly	All Regional Priorities
SI2: Implementation of integrated hepatitis C assessment and treatment services	Part 2a: Number of people diagnosed with hepatitis C, by age and genotype										Quarter 2 & Quarter 4	
	Part 2b: Number of HCV patients who have had a Liver Elastography Scan in the last year	New patients, by age and ethnicity										
		Follow-up patients, by age and ethnicity										
	Part 2c: Number of people receiving PHARMAC funded antiviral treatment per annum, by age and ethnicity											
	Part 3: National Sudden Unexpected Death in Infancy (SUDI) Prevention Programme (NSPP)										Quarterly	
SI3: Ensuring delivery of Service Coverage	Report on progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage identified										Quarter 2 & Quarter 4	All Priorities
SI4: Standardised Intervention Rates (SIRs)	Major Joint Replacement procedures SIR per 10,000 population		N/A	22.36	24.13	25.68	27.78	27.42	21	21	Quarter 1	Improved Access to Elective Surgery
	Cataract procedures SIR per 10,000 population		N/A	38.97	40.61	40.34	47.10	39.30	27	27		
	Cardiac Surgery SIR per 10,000 population		N/A	4.69	5.34	6.54	5.21	4.78	6.5	6.5	Quarterly	
	Percutaneous Revascularisation SIR per 10,000 population		N/A	10.90	12.50	10.25	12.83	12.50	12.5	12.5		
	Coronary Angiography SIR per 10,000 population		N/A	24.30	27.19	37.86	28.34	34.70	34.7	34.7		
SI5: Delivery of Whānau Ora	Mental Health: Report on progress of Whānau Ora in the district										Quarter 2 & Quarter 4	Better help for smokers to quit Mental Health Child Health
	Asthma: Report on progress of Whānau Ora in the district											
	Oral Health: Report on progress of Whānau Ora in the district											
	Obesity: Report on progress of Whānau Ora in the district											
	Tobacco: Report on progress of Whānau Ora in the district											
	Commissioning Agencies: Report on engagement and collaboration with Whānau Ora Commissioning Agencies											
SI7: Total Acute Hospital Bed Days per capita (SLM)	Total acute hospital bed days per capita is a System Level Measure											
SI8: Patient Experience of Care (SLM)	Focus Area 1a: National inpatient survey - Patient experience survey data supplied according to HQSC requirements										Quarterly	Primary Care Integration Improving Quality
	Focus Area 1b: Report on delivery of actions and milestones to improve patient experiences											
	Focus Area 2: The primary care survey is a System Level Measure											

Performance Measure	Performance Expectation	Target Groups		2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
SI9: Amenable Mortality Rate (SLM)	Amenable mortality is a System Level Measure												
SI10: Improving Cervical screening coverage	% of eligible women who have had a cervical sample taken in the last 3 years	Women aged 25-69	Māori	N/A	N/A	64%	N/A	63%	N/A	≥80%	≥80%	Quarter 2 & Quarter 4	Primary Care Integration
			Pacific	N/A	N/A	67%	N/A	68%	N/A				
			Asian	N/A	N/A	67%	N/A	64%	N/A				
			Other	N/A	N/A	86%	N/A	85%	N/A				
			Total	N/A	N/A	80%	N/A	78%	N/A				
SI11: Improving breast screening rates	% of eligible women have had a screening mammogram in the last two years	Women age 50-69	Māori	N/A	N/A	67%	N/A	67%	N/A	≥70%	≥70%	Quarter 2 & Quarter 4	Primary Care Integration
			Pacific	N/A	N/A	68%	N/A	69%	N/A				
			Other	N/A	N/A	72%	N/A	74%	N/A				
			Total	N/A	N/A	72%	N/A	73%	N/A				
OS3: Inpatient Average Length of Stay (ALOS), standardised	Part 1: Elective Surgical Inpatient standardised ALOS (ratio of actual to predicted, multiplied by the nationwide inpatient ALOS)			N/A	1.59	1.58	1.55	1.55	1.57	≤1.47	≤1.47	Quarterly	Improving Quality
	Part 2: Acute Inpatient standardised ALOS (ratio of actual to predicted, multiplied by the nationwide inpatient ALOS)			N/A	2.41	2.36	2.32	2.29	2.28	≤2.3	2.3		Improving Quality
OS8: Reducing Acute Readmissions to Hospital	Acute readmission rates to hospital within 28 days		Total	N/A	7.7%	7.7%	7.7%	7.7%	7.7%	≤7.7%	N/A	Quarterly	Improving Quality Primary Care Integration
			Age 75+	N/A	10.5%	10.5%	10.7%	10.6%	10.7%	≤10.6 %	N/A		
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1a: % of new NHI registrations in error (causing duplication)			N/A	3.19%	2.22%	2.17%	3.17%	2.55%	>2% & ≤4%	N/A	Quarterly	Improving Quality Living within our Means
	Focus Area 1b: % of non-specific ethnicity in new NHI registrations			N/A	3.65%	4.23%	1.63%	2.96%	2.75%	>0.5% & ≤2%	N/A		
	Focus Area 1c: % of updates to ethnicity in existing NHI records with a non-specific value			N/A	1.16%	0.71%	0.89%	0.89%	0.44%	>0.5% & ≤2%	N/A		
	Focus Area 1d: % of validated addresses			N/A	N/A	N/A	N/A	N/A	N/A	≥76% & ≤85%	N/A		
	Focus Area 1e. Invalid NHI data updates			N/A	N/A	N/A	N/A	N/A	N/A	TBC	TBA		

Performance Measure	Performance Expectation	Target Groups	2016 (*2015*)	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	C&C Target	NZ Target	Reporting Freq	Reference to Government Planning Priority
	Focus Area 2a: % of NBRS records that have accurate dates and link to NNPAC and NMDS		N/A	99.8%	98.9%	97.0%	97.0%	98.7%	≥97% & <99.5 %	≥97% & <99.5%		
	Focus Area 2b: % of National Collection records successfully loaded	PRIMHD	N/A	99.7%	99.7%	99.6%	99.3%	97.0%	≥98% & <99.5 %	≥98% & <99.5%		
		NMDS	N/A	99.3%	99.3%	98.8%	98.7%	99.2%				
		NNPAC	N/A	99.9%	99.9%	99.9%	99.7%	99.6%				
		NBRS	N/A	98.8%	98.7%	99.0%	98.6%	98.6%				
	Focus Area 2c: % of diagnosis code descriptors submitted to the NMDS edited from standard descriptions		N/A	92.0%	94.4%	N/A	A	A	≥75%	≥75%		
	Focus Area 2d: % of NNPAC events loaded more than 21 days post month of discharge		N/A	94.5%	94.8%	66.3%	92.5%	P	≥95% & <98%	≥95% & <98%		
	Focus Area 3: Report on PRIMHD data quality audits and corrective actions		N/A	99.7%	99.7%	N/A	99.4%	A	N/A	N/A		
Output 1: Mental Health Output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: A) five percent variance (+/-) of planned volumes for services measured by FTE, B) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and C) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		N/A						+/- 5% of plan	+/- 5% of plan	Quarterly	
DV4: Improving patient experience									Link to SLM	N/A	Quarterly	
DV6: Youth access to and utilisation of youth appropriate health services (SLM developmental measure)									Link to SLM	N/A	Quarterly	
DV7: Number of babies who live in a smoke-free household at six weeks post-natal (SLM developmental measure)									Link to SLM	N/A	Quarterly	

APPENDIX A:
Statement of Performance Expectations

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

Interpreting Our Baseline and Target Performance

Types of measures

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

Standardisation

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

Targets and estimates

Some of our performance measures are demand-based and are included to show a picture of the services that the DHB funds and provides. For these measures, there are no assumptions about whether an increase or decrease is desirable. For performance measures that are demand-based, we have provided an estimate of our 2017/18 performance (indicated with 'Est.'), based on historical and population trends.

Baselines marked with (*) are from January to December 2015 and those marked with (**) are a snapshot of June 2016, and are the most recent data available.

Output Class – Prevention

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

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

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

Measure	Class / Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The number of disease notifications investigated	Prevention / Quantity	Total	986	986	986
		Māori	66	66	66
		Pacific	57	57	57
The number of environmental health investigations	Prevention / Quantity		677	677	677
The number of premises visited for alcohol controlled purchase operations	Prevention / Quantity		107	107	107
The number of premises visited for tobacco controlled purchase operations	Prevention / Quantity		96	96	96

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

***Output Area Description*:** Health promotion service: inform people about health matters and health risks, and support people to be healthy. Success begins with awareness and engagement, reinforced by community health programmes that support people to maintain wellness or assist them to make healthier choices.
***What we want to achieve*:** People are healthier and better supported to manage their own health. Children have a healthy start in life. Lifestyle factors that affect health are well-managed. Equitable health outcomes.

Measure	Class / Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	Prevention / Quantity		30	30	30
The percentage of infants fully or exclusively breastfed at 3 months	Prevention / Coverage	Total	51.2%	62.2%	≥60%
		Māori	41.2%	42.6%	
		Pacific	62.5%	62.5%	
Number of new referrals to Public Health Nurses in primary/intermediate schools	Prevention / Quantity	Total	1,222*	1,222	1,222
		Māori	479*	479	479
		Pacific	535*	535	535

Measure	Class / Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The number of adult referrals to the Green Prescription programme and the Green Prescription Plus programme	Prevention / Quantity	Total	N/A	1,200	1,200
The number of pregnant women referred to the Maternal Green Prescription programme	Prevention / Quantity	Māori & Pacific	N/A	73	73
		Other	N/A	73	73
		Total	N/A	145	145
The number children (3 – 5 yrs) referred to the Pre-School Active Families programme	Prevention / Quantity	Māori & Pacific	N/A	104	104
		Other	N/A	44	44
		Total	N/A	148	148
The number of children (5 -18 yrs) referred to the Active Families programme (CCDHB component)	Prevention / Quantity	Total	N/A	120	120
The number of primary schools enrolled in the Project Energize Programme	Prevention / Quantity	Total	9	15	25

***Output Area*: Immunisation Services**

***Output Area Description*:** Immunisation services: work to prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The work spans primary and community care and allied health services to optimise provision of immunisations across all age groups, both routinely and in response to specific risk.
***What we want to achieve*:** Fewer people experience vaccine preventable diseases. A high coverage rate. Equitable health outcomes.

Measure	Class / Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The percentage of two year olds fully immunised	Prevention / Coverage	Total	95%	95%	≥95%
		Māori	95%	95%	
		Pacific	94%	95%	
The percentage of eight month olds fully vaccinated	Prevention / Coverage	Total	93%	95%	≥95%
		Māori	91%	96%	
		Pacific	93%	96%	
The percentage of Year 7 children provided Boostrix vaccination in schools in the DHB	Prevention / Coverage	Total	72%	72%	≥70%
		Māori	88%	93%	
		Pacific	82%	93%	
The percentage of Year 8 girls vaccinated against HPV (final dose) in schools in the DHB	Prevention / Coverage	Total	69%	69%	≥75%
		Māori	78%	78%	
		Pacific	85%	85%	

Output Area: **Smoking Cessation Services**

***Output Area Description*:** Smoking cessation services: are provided by clinical staff to smokers to help smokers quit. Clinicians follow the ABC process: **A**sk all patients whether they smoke and document their response; if the patient smokes, provide **B**rief advice to quit smoking; and if patient agrees, provide **C**essation support (e.g. a prescription for nicotine gum or a referral to a provider like Quitline)
***What we want to achieve*:** Fewer people take up smoking tobacco and quit attempts are made by more current smokers. Equitable health outcomes.

Measure	Class / Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The percentage of PHO enrolled patients who smoke have been offered help to quit	Prevention / Coverage	Total	83%	85%	≥ 90%
		Māori	80%	85%	

Measure	Class / Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
smoking by a health care practitioner in the last 15 months		Pacific	83%	84%	
The percentage of hospitalised smokers receiving advice and help to quit	Prevention / Coverage	Total	92%	92%	≥ 95%
		Māori	92%	92%	
		Pacific	92%	92%	
The percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer being offered brief advice and support to quit smoking	Prevention / Coverage	Māori	100%	100%	≥ 90%
		Total	97%	98%	

***Output Area*: Screening Services**

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

Measure	Class/Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The percentage of eligible children receiving a B4 School Check	Prevention / Coverage	High need	91%	91%	≥90%
		Total	90%	90%	
The percentage of eligible women (25-69 years old) having cervical screening in the last 3 years	Early Detection & Management / Coverage	Total	64%	78%	≥80%
		Māori	67%	67%	
		Pacific	80%	80%	
The percentage of eligible women (50-69 years old) having breast screening in the last 2 years	Early Detection & Management / Coverage	Total	64%	73%	≥70%
		Māori	64%	67%	
		Pacific	68%	69%	

Output Class – Early Detection and Management

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

***Output Area*: Primary Care Services**

***Output Area Description*:** Primary care services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners, and other primary health care professionals; aimed at improving, maintaining, or restoring health. These services keep people well by: intervening early to detect, manage, and treat health conditions (e.g. health checks); providing education and advice so people can manage their own health; and, reaching those at risk of developing long-term or acute conditions.
***What we want to achieve*:** Accessible, affordable and connected primary care services. Long-term conditions are well-managed. Increased availability of urgent and acute primary health care services. Fewer people are admitted to hospital for avoidable conditions. Equitable health outcomes.

Measure	Class / Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The percentage of the DHB-domiciled population that is enrolled in a PHO	Early Detection & Management / Coverage	Total	93%	94%	≥94%
The percentage of the eligible population assessed for CVD risk in the last five years	Early Detection & Management / Coverage	Total	91%	90%	≥90%
		Māori	89%	90%	
		Pacific	87%	88%	
The number of new and localised Health Pathways in the sub-region	Early Detection & Management / Quality		172	250	375
The number of visits to the Health Pathways website in the last month of the financial year	Early Detection & Management / Quantity		1,375	1,703	2,000

***Output Area*: Oral Health Services**

***Output Area Description*:** Dental services are provided to children (pre-schooler, primary school & intermediate school children) and adolescents (year 8 up to their 18th birthday) by registered oral health professionals to assist people in maintaining healthy teeth and gums.
***What we want to achieve*:** Sustained level of utilisation of dental services by children and adolescents. Better teeth and gum health in children with reduced numbers of caries, decayed, missing and filled teeth. Equitable health outcomes. A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is also indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health.

Measure	Class / Type	Group	Baseline 2015	Forecast 2016	Target/Est. 17/18-18/19
The percentage of children under 5 years enrolled in DHB-funded dental services	Early Detection & Management / Coverage	Total	95%	95%	≥95%
		Māori	68%	68%	
		Pacific	87%	87%	
The percentage of adolescents accessing DHB-funded dental services	Early Detection & Management / Coverage	Total	77%	77%	≥85%

Output Area: **Pharmacy**

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

Measure	Class / Type	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The number of initial prescription items dispensed	Early Detection & Management / Quantity	2,432,210	2,349,154	2,350,000
The percentage of the DHB-domiciled population that were dispensed at least one prescription item	Early Detection & Management / Coverage	78%	78%	78%
The number of people registered with a Long Term Conditions programme in a pharmacy	Early Detection & Management / Coverage	6,092	5,976	6,000
The number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	Early Detection & Management / Quantity	224	219	220

Output Class – Intensive Assessment and Treatment

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

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

***Output Area*: Medical and Surgical Services**

***Output Area Description*:** Unplanned hospital services (Acute services) are for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need of care. Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Planned Services (Elective surgery) are services for people who do not need immediate hospital treatment and are 'booked' services. This also includes non-medical interventions (coronary angioplasty) and specialist assessments (first assessments, follow-ups, or preadmission assessments).
***What we want to achieve*:** Reduced acute/unplanned hospital admissions. People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.

Measure	Class / Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The percentage of patients admitted, discharged or transferred from Emergency Department within six hours	Intensive Assessment & Treatment / Timeliness		91%	91%	≥95%
The number of surgical elective discharges	Intensive Assessment & Treatment / Quantity		10,864	10,864	10,852
The standardised inpatient average length of stay (ALOS) in days, Acute	Intensive Assessment & Treatment / Timeliness		2.36	2.29	≤2.3
The standardised inpatient average length of stay (ALOS) in days, Elective	Intensive Assessment & Treatment / Timeliness		1.58	1.55	≤1.47
The rate of inpatient falls causing harm, per 1,000 bed days	Intensive Assessment & Treatment / Quality		1.3	0.4	≤1.0
The rate of Hospital Acquired Pressure Injuries, per 1,000 bed days	Intensive Assessment & Treatment / Quality		0.9	0.8	≤0.8
The rate of identified medication errors causing harm, per 1,000 bed days	Intensive Assessment & Treatment / Quality		0.1	0.05	≤0.1
The weighted average score in the Patient Experience Survey by domain	Intensive Assessment & Treatment / Quality	Communication	8.4	8.3	≥8.4
		Coordination	8.4	8.3	≥8.4
		Partnership	8.7	8.5	≥8.6
		Physical & Emotional Needs	8.6	8.3	≥8.5
The percentage of "DNA" (did not attend) appointments for outpatient specialist appointments	Intensive Assessment & Treatment / Quality	Total	7%	7%	≤6%
		Māori	15%	15%	≤15%
		Pacific	17%	16%	≤16%

Output Area: **Cancer Services**

***Output Area Description*:** Cancer services include diagnosis and treatment services. Cancer treatment in the sub-region is delivered by the Wellington Blood and Cancer Centre.
***What we want to achieve*:** People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.

Measure	Class / Type	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The percentage of patients, ready for treatment, who waited less than four weeks for radiotherapy or chemotherapy	Intensive Assessment & Treatment / Timeliness	100%	100%	100%
The percentage of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred	Intensive Assessment & Treatment / Timeliness	83%	85%	≥85%

Output Area: **Mental Health and Addictions Services**

***Output Area Description*:** Specialist Mental Health Services are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population.
***What we want to achieve*:** People have shorter waits for specialist assessment and treatment. Patients have a positive experience of care. Services provided are safe and effective. Equitable health outcomes.

Measure	Class / Type	Group	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The number of people accessing secondary mental health services	Intensive Assessment & Treatment / Quantity	Total	9,950	10,181	10,000
		Māori	2,039	2,091	2,120
		Pacific	707	690	730
The percentage of patients 0-19 referred to non-urgent child & adolescent mental health services that were seen within eight weeks	Intensive Assessment & Treatment / Timeliness	Total	61%	85%	95%
The percentage of patients 0-19 referred to non-urgent child & adolescent addictions services that were seen within eight weeks	Intensive Assessment & Treatment / Timeliness	Total	91%	92%	95%
The percentage of people admitted to an acute mental health inpatient service that were seen by mental health community team in the 7 days prior to the day of admission	Intensive Assessment & Treatment / Quality	Total	61%	61%	75%
The percentage of people discharged from an acute mental health inpatient service that were seen by mental health community team in the 7 days following the day of discharge	Intensive Assessment & Treatment / Quality	Total	91%	91%	90%

Output Class – Rehabilitation and Support

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

Output Area: Disability Services
***Output Area Description*:** Many disability services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the DSS, which work with disabled people to help identify their needs and to outline what disability support services are available. They allocate Ministry-funded support services and assist with accessing other supports. ***What we want to achieve*:** Responsive health services for people with disabilities. Enhanced quality of life for people with disabilities.

Measure	Class / Type	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The number of sub-regional and CCDHB Disability Forums	Rehabilitation and Support / Quantity	CCDHB: 2 3DHB: 1	CCDHB: 3 3DHB: 0	≥1
The number of sub-regional Disability Newsletters	Rehabilitation and Support / Quantity	8	6	≥3
The total number of hospital staff that have completed the Disability Responsiveness eLearning Module	Rehabilitation and Support / Quality	547	623	≥1,000
The total number of people with a Disability Alert	Rehabilitation and Support / Quality	5,530	5,915	≥6,550

Output Area: Health of Older People Services
***Output Area Description*:** These are services provided to enable people to live as independently as possible and to restore functional ability. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups. ***What we want to achieve*:** Improve the health, well-being, and independence of our older people. Reduced acute/unplanned hospital admissions. Older people with complex health needs are supported to live in the community. Services provided are safe and effective.

Measure	Class / Type	Baseline 2015/16	Forecast 2016/17	Target/Est. 17/18-18/19
The percentage of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical (interRAI) assessment and a completed care plan	Rehabilitation and Support / Coverage	100%	100%	100%
The percentage of people 65+ receiving DHB-funded HOP support who are being supported to live at home	Rehabilitation and Support / Coverage	58%	59%	≥60%
The percentage of the population aged 75+ who are in Aged Residential Care (including private payers)	Rehabilitation and Support / Coverage	11%**	11%	≤11.8%
The percentage of residential care providers meeting three or more year certification standards	Rehabilitation and Support / Quality	97%	100%	100%
The percentage of residential care providers meeting four year certification standards	Rehabilitation and Support / Quality	N/A	42%	≥45%

Output Class – Financials

Capital & Coast DHB **Statement of Objectives and service performance** **Budget for the Year Ending 30 June 2018** **Statement of revenue and expenses by output class**	**Prevention (000s)**	**Early Detection and Management (000s)**	**Intensive Assessment and Treatment (000s)**	**Rehabilitation and Support (000s)**	**Total DHB (000s)**
REVENUE					
Crown	11,166	241,274	680,443	122,120	**1,055,003**
Other	-	-	21,511		**21,511**
Total Revenue	**11,166**	**241,274**	**701,954**	**122,120**	**1,076,514**
EXPENDITURE					
Personnel	113	2,172	460,173	1,162	**463,620**
Depreciation			35,771		**35,771**
Capital charge			24,450		**24,450**
Provider Payments	9,744	201,011	58,117	101,281	**370,153**
Other	1,309	38,091	144,442	19,678	**203,520**
Total Expenditure	**11,166**	**241,274**	**722,954**	**122,120**	**1,097,515**
Net Surplus/(Deficit)	**-**	**-**	**(21,000)**	**-**	**(21,000)**

Capital & Coast DHB **Statement of Objectives and service performance** **Budget for the Year Ending 30 June 2019** **Statement of revenue and expenses by output class**	**Prevention (000s)**	**Early Detection and Management (000s)**	**Intensive Assessment and Treatment (000s)**	**Rehabilitation and Support (000s)**	**Total DHB (000s)**
REVENUE					
Crown	11,360	245,463	692,256	124,240	**1,073,320**
Other	-	-	21,835	-	**21,835**
Total Revenue	**11,360**	**245,463**	**714,091**	**124,240**	**1,095,154**
EXPENDITURE					
Personnel	116	2,216	469,355	1,185	**472,872**
Depreciation			35,771		**35,771**
Capital charge			24,450		**24,450**
Provider Payments	9,935	205,156	55,385	103,378	**373,854**
Other	1,309	38,091	145,129	19,678	**204,207**
Total Expenditure	**11,360**	**245,463**	**730,091**	**124,240**	**1,111,154**
Net Surplus/(Deficit)	**0**	**0**	**(16,000)**	**(0)**	**(16,000)**

Capital & Coast DHB **Statement of Objectives and service performance** **Budget for the Year Ending 30 June 2020** **Statement of revenue and expenses by output class**	**Prevention (000s)**	**Early Detection and Management (000s)**	**Intensive Assessment and Treatment (000s)**	**Rehabilitation and Support (000s)**	**Total DHB (000s)**
REVENUE					
Crown	11,558	249,725	704,275	126,397	**1,091,954**
Other	-	-	22,163	-	**22,163**
Total Revenue	**11,558**	**249,725**	**726,438**	**126,397**	**1,114,117**
EXPENDITURE					
Personnel	118	2,260	476,379	1,209	**479,965**
Depreciation			35,771		**35,771**
Capital charge			24,450		**24,450**
Provider Payments	10,118	208,993	53,167	105,314	**377,592**
Other	1,322	38,472	144,670	19,874	**204,338**
Total Expenditure	**11,558**	**249,724**	**734,437**	**126,398**	**1,122,117**
Net Surplus/(Deficit)	**(0)**	**0**	**(8,000)**	**(0)**	**(8,000)**

APPENDIX B:
Financial Performance

Financial Performance

The prospective planned result for Capital and Coast DHB 2017/18 annual plan is a deficit of $21 million. The final result for 2016/17 was a deficit of $25.1 million.

CCDHB Summary Financial Table

Capital & Coast DHB Budget for the Four Years Ending 30 June 2021	2015/16 $'M	2016/17 $'M	2017/18 $'M	2018/19 $'M	2019/20 $'M	2020/21 $'M
Funding (excluding IDF inflows below)	809.4	823.9	858.5	873.3	888.4	903.7
Services provided for Other DHBs (IDF Inflows)	212.2	215.4	218.0	221.9	225.7	229.7
Total Funding	**1,021.6**	**1,039.2**	**1,076.5**	**1,095.2**	**1,114.1**	**1,133.4**
DHB Provider Arm	683.9	698.8	716.3	729.0	736.1	743.5
Funder Arm	257.8	264.0	274.2	277.0	279.7	282.5
Governance Arm	10.3	8.8	11.1	8.3	8.4	8.6
Services Purchased from Other DHBs (IDF Outflows)	81.5	92.7	95.9	96.9	97.9	98.9
Total Allocated	**1,033.5**	**1,064.4**	**1,097.5**	**1,111.2**	**1,122.1**	**1,133.4**
Surplus / (Deficit)	**(11.9)**	**(25.1)**	**(21.0)**	**(16.0)**	**(8.0)**	**(0.0)**

CCDHB Prospective Financial Performance

Capital & Coast DHB Statement of Comprehensive Income & Expenditure Budget for the Four Years Ending 30 June 2021	Actual 2015/16 (000s)	Actual 2016/17 (000s)	Plan 2017/18 (000s)	Plan 2018/19 (000s)	Plan 2019/20 (000s)	Plan 2020/21 (000s)
REVENUE						
Government and Crown Agency Sourced	991,390	1,009,013	1,050,481	1,068,718	1,087,272	1,106,149
Patient / Consumer Sourced	4,397	4,452	4,253	4,317	4,382	4,448
Funder Arm Sourced	6,673	5,292	4,523	4,602	4,682	4,764
Other Income	19,117	20,484	17,258	17,517	17,781	18,048
TOTAL REVENUE	**1,021,576**	**1,039,241**	**1,076,515**	**1,095,154**	**1,114,117**	**1,133,409**
OPERATING COSTS						
Personnel Costs						
Medical Staff	141,921	148,155	150,307	153,312	155,612	157,948
Nursing Staff	172,765	181,535	186,831	190,567	193,425	196,327
Allied Health Staff	53,988	54,326	56,722	57,856	58,724	59,605
Support Staff	8,035	7,436	7,820	7,977	8,096	8,218
Management / Administration Staff	57,178	59,578	61,941	63,160	64,108	65,069
Total Personnel Costs	**433,887**	**451,030**	**463,620**	**472,872**	**479,965**	**487,166**
Clinical Costs						
Outsourced Services	37,545	32,233	31,936	32,415	32,198	32,151
Clinical Supplies	117,128	118,191	118,545	120,324	120,324	120,324
Total Clinical Costs	**154,673**	**150,425**	**150,481**	**152,738**	**152,521**	**152,475**
Other Operating Costs						
Hotel Services, Laundry & Cleaning	16,465	18,510	18,644	18,924	18,924	18,924
Facilities	40,939	41,042	40,610	41,011	41,360	41,706
Transport	2,734	2,834	2,760	2,801	2,801	2,802
IT Systems & Telecommunications	10,511	13,068	12,960	12,961	12,961	12,961
Interest & Financing Charges	22,291	14,109	24,598	24,598	24,598	24,598
Professional Fees & Expenses	5,226	7,738	5,328	5,910	5,910	5,923
Other Operating Expenses	6,993	8,026	7,840	4,958	4,958	4,959
Democracy	508	860	519	527	527	528
Provider Payments	339,270	356,741	370,153	373,853	377,592	381,369
Total Other Operating Costs	**444,934**	**462,929**	**483,413**	**485,543**	**489,630**	**493,769**
TOTAL COSTS	**1,033,495**	**1,064,383**	**1,097,515**	**1,111,153**	**1,122,117**	**1,133,410**
NET SURPLUS / (DEFICIT)	**(11,918)**	**(25,143)**	**(21,000)**	**(16,000)**	**(8,000)**	**(0)**

Capital & Coast DHB **Statement of Financial Position** **Budget for the Four Years Ending 30 June 2021**	**Actual 2015/16 (000s)**	**Actual 2016/17 (000s)**	**Plan 2017/18 (000s)**	**Plan 2018/19 (000s)**	**Plan 2019/20 (000s)**	**Plan 2020/21 (000s)**
Non Current Assets						
Land	25,705	25,705	25,705	25,705	25,705	25,705
Buildings	410,286	396,986	387,782	378,182	368,582	358,582
Clinical Equipment	31,182	29,049	28,749	28,449	28,149	27,849
Information Technology	12,764	11,938	11,578	10,894	10,210	9,526
Work in Progress	24,863	15,472	17,697	17,697	17,697	17,697
Other Fixed Assets	2,891	10,218	14,298	19,098	23,898	28,698
Total Non Current Assets	507,691	489,368	485,809	480,025	474,241	468,057
Current Assets						
Cash	12,868	20,403	20,202	21,001	21,801	23,500
Trust/Investments	7,232	8,409	8,409	8,409	8,409	8,409
Prepayments	4,017	5,632	5,632	5,632	5,632	5,632
Accounts Receivable	44,284	43,962	46,190	46,190	46,690	46,690
Inventories	7,345	8,602	8,602	8,602	8,602	8,602
Total Current Assets	75,746	87,009	89,036	89,835	91,135	92,834
Current Liabilities						
Bank overdraft	-	-	-	-	-	-
Payables & Accruals	123,435	136,710	138,663	137,163	136,165	135,165
GST & Tax Provisions	10,383	8,618	8,618	8,618	8,618	8,618
Current Crown Debt - CHFA	34,326	326	326	326	326	326
Total Current Liabilities	168,144	145,654	147,607	146,107	145,109	144,109
Net Current Assets	(92,398)	(58,645)	(58,571)	(56,272)	(53,974)	(51,275)
NET FUNDS EMPLOYED	**415,294**	**430,723**	**427,238**	**423,754**	**420,268**	**416,784**
Term Liabilities						
Non Current Crown Debt - CHFA	305,628	302	302	302	302	302
Restricted & Trust Funds Liability	7,407	8,488	8,488	8,488	8,488	8,488
Non Current Provisions & Payables Personnel	5,994	6,473	6,473	6,473	6,473	6,473
Total Term Liabilities	319,029	15,263	15,263	15,263	15,263	15,263
Net Assets	**96,264**	**415,460**	**411,975**	**408,490**	**405,004**	**401,519**
General Funds						
Crown Equity	424,818	769,751	787,266	799,852	804,367	800,882
Revaluation Reserve	23,606	23,606	23,606	23,606	23,606	23,606
Trust & special funds no restriction	665	71	71	-	-	-
Retained Earnings						
Retained Earnings - DHB	(352,825)	(377,968)	(398,968)	(414,968)	(422,968)	(422,968)
Total Retained earnings	(352,825)	(377,968)	(398,968)	(414,968)	(422,968)	(422,968)
Total General Funds	96,264	415,460	411,975	408,490	405,005	401,521
NET FUNDS EMPLOYED	**415,294**	**430,723**	**427,238**	**423,754**	**420,268**	**416,784**

Prospective Cash Flow

Capital & Coast DHB **Statement of Cashflows** **Budget for the Four Years Ending 30 June 2021**	**Actual 2015/16 (000s)**	**Actual 2016/17 (000s)**	**Plan 2017/18 (000s)**	**Plan 2018/19 (000s)**	**Plan 2019/20 (000s)**	**Plan 2020/21 (000s)**
Operating Activities						
Government & Crown Agency Revenue Received	1,022,392	1,038,337	1,060,814	1,075,701	1,095,395	1,113,894
All Other Revenue Received	19,273	21,301	21,301	21,621	21,945	22,274
Total Receipts	**1,041,665**	**1,059,638**	**1,082,115**	**1,097,322**	**1,117,340**	**1,136,169**
Payments for Personnel	(428,737)	(436,835)	(448,835)	(455,567)	(462,401)	(469,337)
Payments for Supplies	(206,770)	(206,053)	(211,971)	(211,971)	(213,790)	(213,369)
Capital Charge	(8,086)	(5,662)	(24,450)	(24,450)	(24,450)	(24,450)
GST (net)	(929)	(3,099)	(3,099)	(3,099)	(3,099)	(3,099)
Other Payments	(363,934)	(379,649)	(381,649)	(384,963)	(388,328)	(391,742)
Total Payments	**(1,008,456)**	**(1,031,298)**	**(1,070,004)**	**(1,080,050)**	**(1,092,068)**	**(1,101,996)**
Net Cashflow from Operating	**33,209**	**28,340**	**12,111**	**17,272**	**25,273**	**34,172**
Investing Activities						
Interest Receipts from 3rd Party	1,786	1,436	1,436	1,436	1,436	1,436
	1,786	**1,436**	**1,436**	**1,436**	**1,436**	**1,436**
Capital Expenditure						
Land, Buildings & Plant	(15,455)	(8,997)	(14,400)	(14,400)	(14,400)	(14,400)
Clinical Equipment	(7,707)	(3,198)	(7,200)	(7,200)	(7,200)	(7,200)
Other Equipment	(735)	(941)	(3,600)	(3,600)	(3,600)	(3,600)
Informations Technology	(1,801)	(1,955)	(4,800)	(4,800)	(4,800)	(4,800)
Total Capital Expenditure	**(25,698)**	**(15,091)**	**(30,000)**	**(30,000)**	**(30,000)**	**(30,000)**
Increase in other Investments	(3,499)	(840)	(840)	-	-	-
Net Cashflow from Investing	**(27,411)**	**(14,495)**	**(29,404)**	**(28,564)**	**(28,564)**	**(28,564)**
Financing Activities						
Equity Injections	5,600	-	-	-	-	-
Deficit Support	-	10,000	21,000	16,000	8,000	-
Interest Paid	(14,210)	(11,324)	(100)	(100)	(100)	(100)
Other Financing Activities	(3,808)	(3,809)	(3,809)	(3,809)	(3,809)	(3,809)
Total Financing Activities	**(12,418)**	**(5,133)**	**17,091**	**12,091**	**4,091**	**(3,909)**
Net Cashflow	(6,621)	8,713	(202)	799	800	1,699
Plus: Opening Cash	26,720	20,100	28,812	28,611	29,410	30,210
Closing Cash	**20,100**	**28,812**	**28,611**	**29,410**	**30,210**	**31,909**
Closing Cash comprises:						
Balance Sheet Cash	20,100	28,812 -	28,611	29,410	30,210	31,909
Total Cashflow Cash (Closing)	**20,100**	**28,812**	**28,611**	**29,410**	**30,210**	**31,909**

Financial Assumptions

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

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

Revenue

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

Expenditure

- Personnel expenditure increase in line with wage cost of settlement expectations

- Trendcare model for nursing staff rosters across all Directorates
- Supplies and expenses based on current contract prices where applicable
- Depreciation to include base, plus work in progress, plus new purchases
- Capital Charge at 6% payable half yearly
- Total Capital Expenditure of up to $30 million per annum is planned from 2017/18

Financial Risks

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

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

Capital Plan

The operational capital funding requirements for the Provider Arm will be met from cash flow from depreciation expense, and they are prioritised with the clinical leaders and managers both within the Directorates and across the Provider Arm. Items with compliance, health & safety and a risk to patient care elements, or essential to support the District Annual and Strategic Plans, or yielding a fast payback have been included to be funded from the internal cash flow. The baseline CAPEX for 2017/18 is $30 million. CAPEX is required to be funded internally.

Equity

Equity Drawing
Additional deficit support may be requested for the 2017/18 financial year.

Working Capital

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

Gearing and Financial Covenants

No gearing or financial covenants are in place.

Asset Revaluation

Land and buildings are valued to fair value as determined by an independent registered valuer with sufficient regularity. This is to ensure the carrying amount is not materially different to fair value and the valuation is done at least every five years. The previous revaluation was carried out in June 2013.

Strategy for disposing of assets

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

Disposal of Land

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

APPENDIX C:
System Level Measures Improvement Plan

Capital & Coast DHB

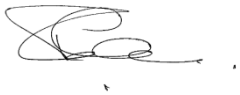
System Level Measures Improvement Plan 2017/18

Written by: Astuti Balram, ICC Programme Manager,

on behalf of the CCDHB Integrated Care Collaborative (ICC) Alliance

V2 Final for Submission to MOH 24th July 2017

Signatories

Capital & Coast DHB	Debbie Chin, Chief Executive
	
Integrated Care Collaborative	Dr Bryan Betty, Chair
	
Compass Health	Martin Hefford, Chief Executive
	
Cosine Primary Care Network Trust	Dr Peter Moodie, Director
	
Ora Toa PHO	Teiringa Davies, Manager
	

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Introduction

Background

The national System Level Measures Framework has been developed with a system-wide view of performance, building on the previous Integrated Performance Incentives Framework (IPIF). This was in response to a desire to lift performance measurement from a transactional approach to one based on outcomes, and aligns with the refreshed New Zealand Health Strategy. The Ministry of Health has worked with the sector to co-develop a suite of System Level Measures (SLMs) to support this whole-of-system view of performance.

CCDHB committed to work in partnership to jointly develop and agree the 2017/18 Improvement Plan with the Integrated Care Collaborative Alliance Leadership Team (ALT). The CCDHB SLM plan includes the following:

- an improvement milestone for the SLM (either for total population, Maori or other population where equity gaps exist) from the district baseline provided by the Ministry
- brief description of activities to be undertaken by primary, secondary and community providers to achieve the SLM milestone
- suite of contributory measures for the SLM and
- district alliance stakeholder agreement with the plan

In addition the DHB has local Implementation Plan to support the SLM Improvement Plan that includes:

- Activities to meet the Improvement Milestones for SLMs and the quantitative goals for selected contributory measures
- An investment logic, including the above activities and key stakeholder contributions
- A local reporting and accountability dashboard and framework.

2017/18 System Level Measures

The six System Level Measures (SLMs) being implemented for 2017/18 are:

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

The following three SLMs and two primary care Health Targets will be incentivised through the Primary Health Organisation (PHO) Services Agreement in 2016/17:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Better help for smokers to quit (90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months & 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
- Increased immunisation for eight month olds (95 percent of eight months olds will have their primary course of immunisation - six weeks, three months and five months immunisation events - on time)

CCDHB SLM Plan Development 2017/18

Collaborative Development Team

The ICC ALT and Programme Board provided direction for the development processes undertaken. In addition to members of these leadership group, the CCDHB SLM development has included discussion with the following:

- PHO CE and/or Clinical Quality Leads
- Hospital Services Quality Team
- Director of Nursing, Primary & Integrated Care
- CCDHB GP Clinical Advisor
- ICC ALT Programme Manager & Co-ordinator
- Māori Health Director and Māori Health Development Group, CCDHB
- Pacific Health Director and Pacific Directorate Team, CCDHB
- Child & Youth Health Team, Strategy, Innovation & Performance Directorate
- Child ICC Steering Group, as well as expanded stakeholder group at workshop
- 3DHB Youth Service Level Alliance, as well as expanded stakeholder group at workshop
- GM, Mental Health & Addictions, Strategy, Innovation & Performance Directorate

Principles for Improvement 2017/18

The ICC ALT and the SLM Development Group agreed that the milestones for the SLMs should take into consideration the strategic priorities across the sector, focus on achieving equity and be attainable while supporting the current good performance of CCDHB.

To support the focus on equity in the SLM Plan the following are underway:

- Develop and implement of a CCDHB Equity Strategy
- Data for the SLMs and CMs will be monitored and reported by ethnicity, where possible
- Implementation plan that will focus on accelerating improved outcome for Māori, Pacific and populations with high need
- Advice and oversight by Māori will be sought and provided to support accelerated improved outcome for Māori
- A Pacific Alliance is in development and this group will maintain a focus and work together to achieve outcomes for target populations, including children.

In selecting the contributory measures (CM) and the domains within the Youth SLM the following principles were applied:

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

Where an improvement initiative and CM is included in the DHB Annual Plan 2017/18, this has been referenced with "(AP 17/18)".

Improvement Initiative – Health Care Home

While improvements in SLMs will require the partners in the CCDHB system to deliver a number of initiatives, one of the key developments is the CCDHB Health Care Home (HCH) model. The CCDHB HCH initiative is a team-based health care delivery model, led by primary health clinicians, providing comprehensive and continuous health and social care with the goal of supporting individuals to obtain the best possible health outcomes. To deliver on this in CCDHB the HCH practices are required to deliver the following service elements: GP triage and on the day telephone consults; on the day appointment for triaged patients; call management arrangements; extended hours availability; patient portal uptake and increased use; delivery of packages of care (POAC); Person Centric Appointments; Year of Care planning for at risk; clinical and administrative pre-work; enhanced layout of facilities; workforce development; lean process and community Service Integration. CCDHB is working to achieve more than 40% coverage of its population by the end of 2017/18.

SLM Plan 2017/18 Governance

The CCDHB SLM Performance Dashboard has been developed to provide performance data for each SLM, a description summary of progress and trend data on each CM. The dashboard is utilised by the ICC ALT to enable governance of the overall SLM Plan, and will be shared with each PHOs Clinical Governance Group, the Māori Health Development Group and Pacific Health Team to support the drive for improvement. Specific SLM dashboards will also be utilised by respective ICC ALT Steering Groups to drive service improvement initiatives and provide oversight for their area of focus.

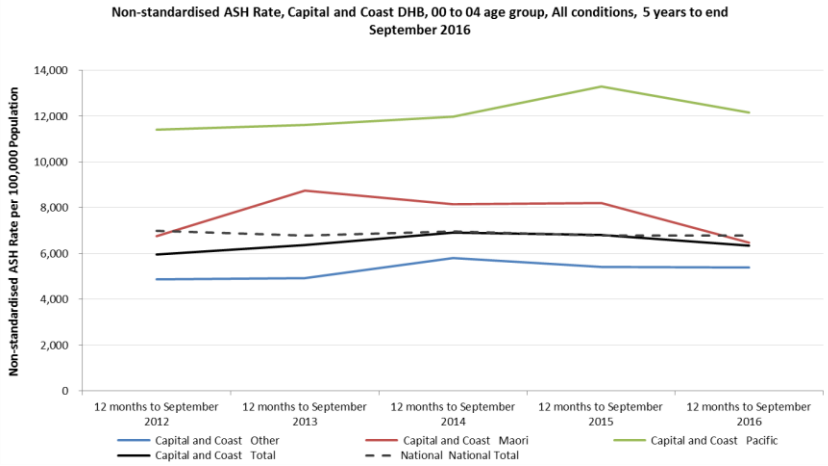
Ambulatory Sensitive Hospitalisations 0-4yo

We want all of our children to have a healthy start in life

One of the CCDHBs strategic goals is to improve child health and child health services in the CCDHB. Our system will empower all families to maximise their children's health and potential. In doing so CCDHB milestone will be to achieve equity for all population groups over 5years (by 2021/22), and for 2017/18 a 9% reduction in ASH rate for Pacific and maintenance of equity for the Māori population with total population.

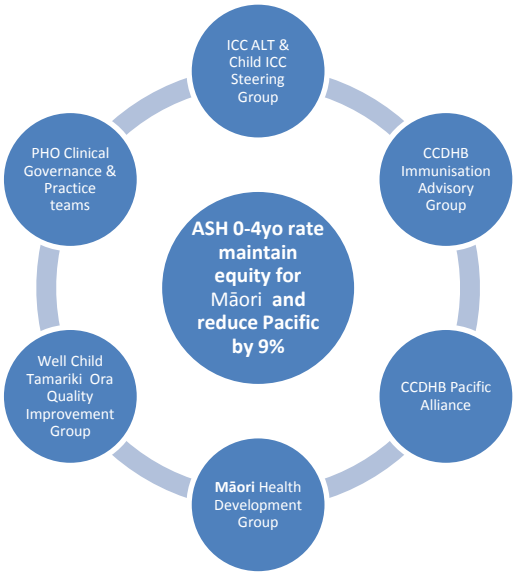
Where we are now?

- Most years CCDHB rates are lower than national rates
- The Top 10 includes conditions related to respiratory, skin and dental
- Inequities are evident with Pacific children whose rates are about double that of total population.
- Equity for Māori children, in comparison to the Total population, has been achieved however there is still a gap between Māori and Other
- It is also noted that while the rates for Pacific children are relatively higher, the actual volumes of ASH related presentations are considerably lower than for the total. (Yr to Sept 2016 by volume Pacific 249, Māori 235, Other 701)



How will we get there?

Key partners in the CCDHB System who will work together to improve this SLM:



Initiatives led by these groups will focus on improvements preventative, proactive & acute care for babies, children and their whanau

Improvement initiatives	Contributory Measures
Review Core 1 check and develop an improvement action plan focused on immunisation rates of Māori, Pacific and new migrant babies. (AP 17/18)	Immunisation Health Target
Assess the pathway, uptake and follow through of referrals to Pre-school Active Families for Māori and Pacific children. (AP 17/18)	Healthy Kids Health target
Improve dental enrollment through data sharing mechanisms (AP 17/18)	Dental enrollment and carries free rates
Health Care Home enrollment to include populations with high numbers of Māori & Pacific children	Child coverage numbers in HCH
Implement improvements to referral processes for the Pacific Navigation Service	Referrals volumes of children to Pacific Navigation

Patient Experience of Care

We want to encourage patient involvement and feedback

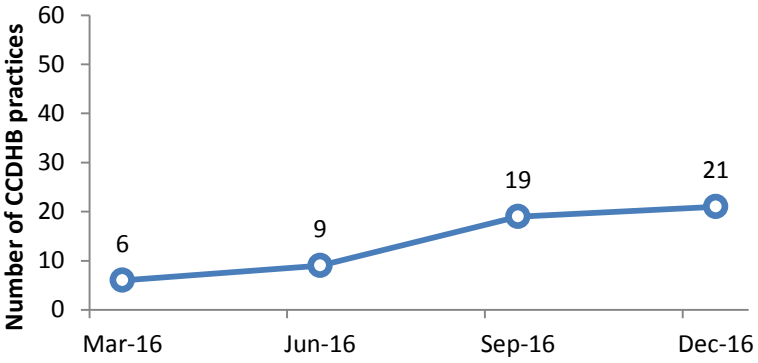
This will support improvement initiatives that will lead to improved health service design and patient experience of care. One of the DHBs local priorities is to monitor patient experience to ensure better health outcomes are achieved. In 2017/18 CCDHB will ensure that 75% of primary care practices are participating in the patient experience survey (PES) and in future years achieve improvements in PES scores. The 2017/18 AP includes the establishment of a Consumer Council (AP 17/18).

Where we are now?

- The uptake of the PES in primary care is increasing
- CCDHB is on national average for 4 core elements: communication, coordination, partnership, physical & emotional needs for most quarters as per the primary care PES
- CCDHB maintains good return rates for the hospital PES

In future there is a strong motivation for CCDHB to move to focusing on the results of the PES results across primary and secondary care and consideration of an equity focus.

Practice uptake of patient experience survey



How will we get there?

Key partners in the CCDHB System who will work together to improve this SLM

Improvement initiatives	Contributory Measures
PHO facilitation teams support uptake of the National Enrollment Service (NES) in practice, which is required to run the PES across some practices	NES uptake by practices
Hospital experience survey is a focus of the Hospital Quality team, as well as related improvement initiatives eg. Reducing medicine errors (AP 17/18)	Return rate of hospital patient experience survey
Promote the use of the patient portal in primary care through the Health Care Home programme	Patient portal uptake and activation

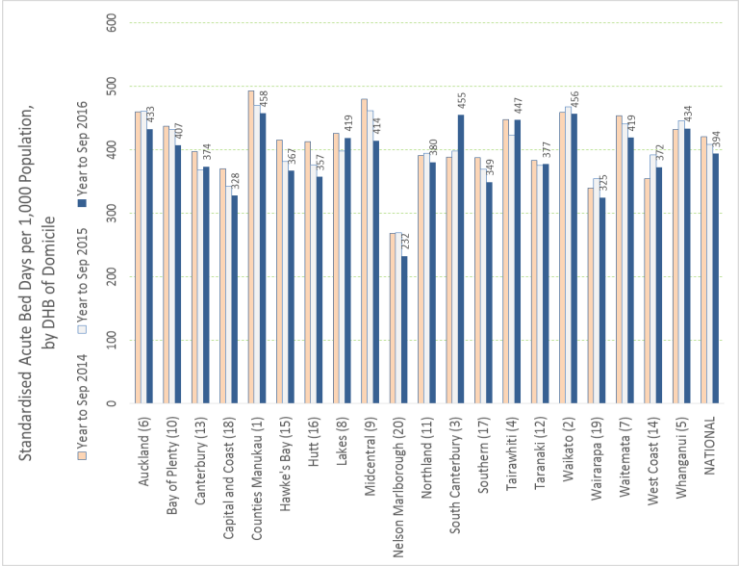
Acute Bed Days

We want our population to be well in the community and be supported to receive appropriate care when they are not well.

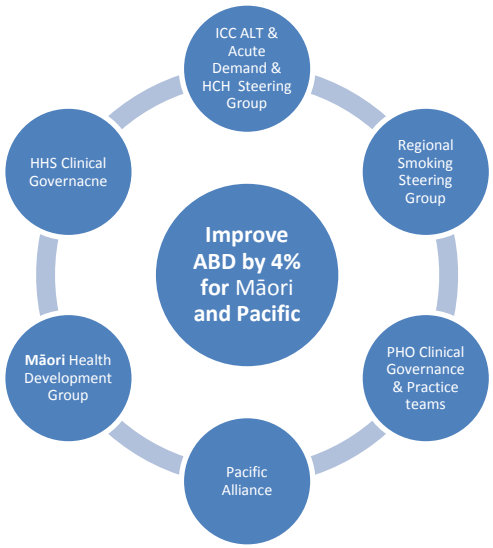
Better health and independence for people, families and communities is the CCDHB vision with a focus on equity. In doing so over 5years (by 2021/22) CCDHBs milestones will be to achieve equity for Māori and half the equity gap for Pacific. For 2017/18 this will require an improvement of 4% ABD, age standardised rates for both Māori and Pacific populations in 2017/18 to be on track for the 5yr target.

Where we are now?

- CCDHB has the 2nd lowest ABD in NZ, with continued improvement over the last few years
- Compared to other age bands, >85yo have the highest bed day per 1000
- Equity is yet to be achieved for Māori and Pacific populations compared to total utilizing age standardized rates
- Stroke, respiratory infection and heart failure are the Top 3 diagnosis (DRG) for acute bed days per 1000
- Acute length of stay and elective length of stay in CCDHB continue to reduce over recent quarters
- ED attendance rate had been increasing more quickly than the national rate however has slowed in the last two years



How will we get there?



Initiatives led by these groups will focus on improvements preventative, proactive, acute care as well as patient flow through the hospital.

Improvement initiatives	Contributory Measures
Progress roll-out of HCH model across primary care, targeting practices with high volumes of Māori and Pacific. (AP 17/18)	HCH Enrollment
Improve flow in ED and specialty response to ED (AP 17/18)	Length of Stay
PHO facilitation teams drive process improvements in practices to achieve smoking Health Target and increase referrals for cessation support (AP 17/18)	Smokers Quit Rate
PHO facilitation teams support practices with opportunistic and recall processes to achieve flu vaccination targets (AP 17/18)	Vaccination rates in >65yo
Increase the uptake and flexibility of existing primary care packages of care (AP 17/18	Uptake of primary care packages of care

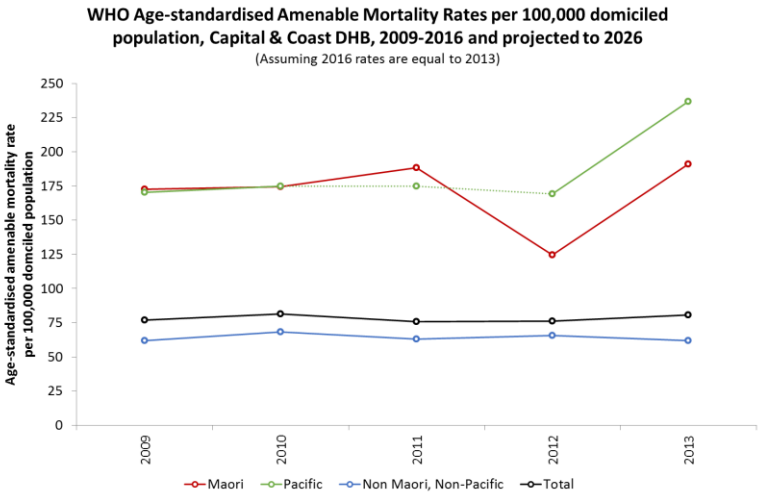
Amenable Mortality

We want to have an effective CCDHB health system, for the individual and population.

As per the DHBs strategic goals and local priorities CCDHB will look to reduce amenable mortality rates for Māori and Pacific, with a focus to half the equity gap 10yrs from now- 2027. (Note baseline data is from 2013)

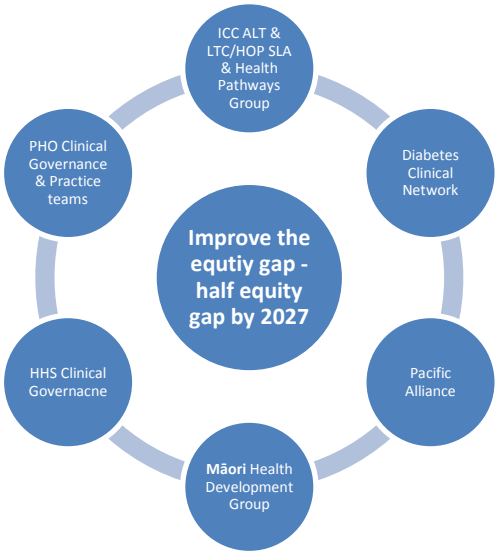
Where we are now?

- 5th lowest in the NZ, with small fluctuations
- Inequities evident with the Pacific population having the highest mortality rates, followed by Māori and then the other population
- Ischaemic Heart Disease (IHD), diabetes and suicide and are ranked the Top 3 conditions for CCDHB



How will we get there?

Key partners in the CCDHB System who will work together to improve this SLM



Initiatives led by these groups will focus on improvements preventative, proactive and enabling equitable access for all population groups.

Improvement initiatives	Contributory Measures
Complete and begin implementation of a CCDHB Obesity Prevention Plan, including plans to achieve equitable outcomes for Māori and Pacific children. (AP 17/18)	Uptake of Green Prescription Plus
PHO facilitation teams support practices to achieve cervical screening targets through provision of regular data feedback between PHOs and practices (AP 17/18)	Cervical screening rates
Deliver the Diabetes Care Improvement Plan (AP 17/18) and cardiovascular management in primary care	HbA1C>64mmol/mol and not on insulin Microalbuminuira & not on ACEI High (>20%) CVD risk and on statin
Primary care access supported in primary care as ongoing focus in PHOs and through the HCH model	Access ratio
Continue to progress localization of Health Pathways (AP 17/18)	Number of pathways & utilisation

Babies living in Smokefree Homes

We want all our babies to have the best start in life in a safe and healthy environment

In CCDHB we want our babies to thrive and go on to become adults that self determine their own health outcomes The aim of our CCDHB system is to encourage, inform and support our population to enjoy excellent health and wellbeing for themselves and their families. In doing so, CCDHB will focus on increasing the proportion of whānau who are asked about the smoking status in the home and have this recorded at the 6week Well Child Tamariki Ora check to at least 50%.

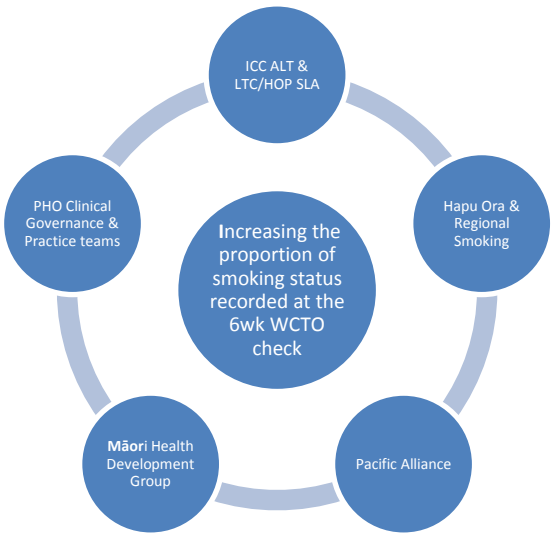
Where we are now?

New babies with no record ie unknown for household smoker at a WCTO Core Contact before 50 days of age		
Was the smoking status checked at 6wk check? 1 Jul-16 to 31 Dec-16	**Total**	**Percentage**
Yes	204	14%
No, Not Asked, Unknown, (blank)	1233	86%
Total	1437	100%

14% of whanau are asked about the smoking status in the home at the 6week Well Child Tamariki Ora check in CCDHB.

How will we get there?

Key partners in the CCDHB System who will work together to improve this SLM



Initiatives led by these groups will initially focus on improvements in data collection, and in the future population, antenatal and postnatal smoking cessation support for whānau and babies.

Improvement initiatives	Contributory Measures
Work with WCTO Improvement Group to assess and improve the processes for the WCTO data collection at the 6wk check	Smoking status recorded at 6wk check
Encourage referral of young Māori females and whānau to Regional Smoking Service	Service utilization
Improve registration of pregnant women with LMC though the Maternity Quality & Safety programme	Percentage of women registered with LMC
Monitor and assess the Hapū Ora service for young pregnant women to ensure responsiveness and outcomes aligned with expectations. (AP 17/18)	Uptake of Hapū Ora service
Maintain a programme of ABC training for health care professionals to support achievement of the health target in primary care and the KPI for hospital maternity services. (AP 17/18)	ABC training delivery

Youth access to & utilisation of youth appropriate services

We want our youth to be healthy, safe and supported.

In 2017/18 CCDHB will focus on the Alcohol and Other Drugs domain of the developmental Youth SLM. The long-term aim is that young people experience less alcohol & drug related harm and receive appropriate support. In 2017/18, CCDHB will primarily aim to improve data quality around alcohol-related Emergency Department (ED) presentations for 10 – 24 year olds and aim to have ≤15% of 10-24yo presenting to CCDHB hospital whose answer to the question "is alcohol associated with this event?" is "Unknown .

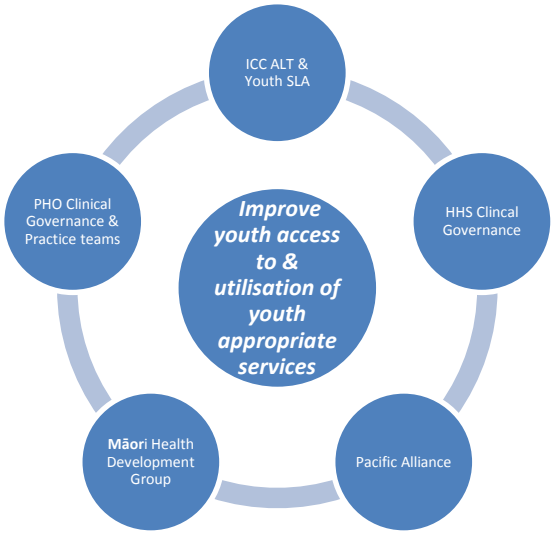
Where we are now?

For the Youth SLM target setting CCDHB will utilise the following two domains

% of 10-24yo presenting to CCDHB hospital whose answer to the question "is alcohol associated with this event?" is "Unknown"			
	2015/16	**2016/17 year to date**	**Target**
Maori	65%	17%	≤15%
Pacific	64%	15%	≤15%
Other	61%	15%	≤15%
Total	62%	15%	≤15%

How will we get there?

Key partners in the CCDHB System who will work together to improve this SLM



Initiatives led by these groups will initially focus on improvements in data collection

Improvement initiatives	Contributory Measures
Work with ED to improve screening and data collection processes on alcohol related presentation.	Alcohol related presentations
Implement a 3DHB Youth Alcohol & Other Drug / Co-existing Problems specialist liaison service	Referral volumes to service
Primary care teams encouraged to implement processes to complete alcohol screening	Numbers of youth with alcohol screening completed in primary care