CAPITAL & COAST DISTRICT HEALTH BOARD

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# Annual Plan 2019/20

Incorporating the Statement of Intent and Statement of Performance Expectations

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

**Presented to the House of Representatives pursuant to sections 149 and 149 (L) of the Crown Entities Act 2004.**

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Annual Plan dated 17 October 2019

(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

# Hon Dr David Clark

**MP for Dunedin North**

Minister of Health

Associate Minister of Finance


19 DEC 2019

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

Dear David

**Capital & Coast District Health Board 2019/20 Annual Plan**

This letter is to advise you I have approved and signed Capital & Coast District Health Board's (DHB's) 2019/20 Annual Plan for one year together with the Minister of Finance, as submitted by the previous DHB governance.

I have made my expectations on improving financial performance very clear. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan on the expectation that you will continue to focus on opportunities for improving financial results for 2019/20 and into 2020/21 and beyond. The out-years have not been approved.

The Annual Plan indicates an improving out-years position. However, I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

It is expected that as Chair, along with your Board, you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast. Should the DHB experience liquidity issues, please keep the Ministry informed of the likely timing of the need for liquidity support. Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. The available equity is limited and applications for equity support will be subject to a rigorous prioritisation and approval process.

I am aware you are planning a number of service reviews in the 2019/20 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute


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approval of any capital business cases that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders that will deliver on our Government's Wellbeing priorities.

I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions identified in your annual plan.

I would like to thank you, your staff, and your Board for your commitment to delivering quality health care to your population and wish you every success with the implementation of your 2019/20 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr David Clark
**Minister of Health**

Hon Grant Robertson
**Minister of Finance**

cc Ms Fionnagh Dougan
Chief Executive
Capital & Coast District Health Board
Fionnagh.dougan@ccdhb.org.nz

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PART A

# Annual Plan 2019/20

# SECTION ONE: Overview of Strategic Priorities

## 1.1 Our Vision & Strategic Direction

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

*"Keeping our Community Healthy and Well."*

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

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

In setting the strategic priorities necessary to achieving our vision, CCDHB is guided by core legislative and governmental strategic directions including:

- the New Zealand Public Health & Disability Act 2000
- the Treaty of Waitangi
- the New Zealand Health Strategy
- He Korowai Oranga – the Māori Health Strategy
- 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018; and
- the Healthy Ageing Strategy.

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

## 1.2 Our Health System Plan

The CCDHB Health System Plan 2030 outlines our vision and strategy to transform the health system to support people to have better health and wellbeing throughout their lives and ensure equity amongst our populations.

The Health System Plan enables us to respond to the growing demand for healthcare, and increasing complexity of healthcare need with a system design that will improve outcomes and equity for the people of CCDHB and the communities we serve. The Health System Plan is supported by this whakatauki:

*Ma Tini, Ma Mano, Ka Rapa, Te Whai*

*By Joining Together We Will Succeed*

To achieve our obligations to the Minister and the communities we serve, we will:

**Deliver services that:**

- Promote health and wellbeing
- Prevent the onset and development of avoidable illness
- Improve health and wellbeing outcomes
- Support people to live better lives
- Support end of life with dignity.

**Deliver a health system that:**

- Achieve equitable health outcomes for all communities
- Strengthen our communities, families and whānau so they can be well
- Make it easier for people to manage their own health needs
- Delay the onset, and reduce the duration and complexity, of long-term health conditions
- Ensure expert specialist services are available to help improve people's health

**Strengthen our organisation to:**

- Ensure safety and quality of our services
- Create a sustainable and affordable healthcare system
- Deliver on the priorities of government
- Live within our means
- Be a good employer

## 1.3 Our Strategies

The Health System Plan is designed to support people and whānau-led wellbeing with the system organised around the two elements: 'People' and 'Place'.


### *People*

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

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

Recognising those who need more help including: Māori and Pacific Peoples in our district, people with disability, as well as the socially & economic vulnerable or an enduring mental illness and/or addiction and refugees.

### *Place*

Using 'place' as the basis for health and social supports creates immediate links to a community's strengths; it makes it easier to recognise and value community diversity, while organising a consistent system across many groups. Better information about the characteristics of the people being served, shared among those delivering services, is central to succeeding with this approach. It has the potential to reduce health care costs over time as communities increasingly support their own health and wellbeing.

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

The plan centres on the following three core care settings.

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

## 1.4 Our Priorities

As we implement our Health System Plan and long-term vision of how services will be delivered for our population, CCDHB is well positioned to successfully deliver against the New Zealand Health Strategy objectives. To do this we have a programme of work that builds on existing successes and finds new ways of using existing resources and choosing wisely.

CCDHB is committed to focus in key areas:

**Deliver and implement a health system that:**

- achieves equitable health outcomes
- Supports health and wellbeing through prevention and early intervention
- Alleviates pressure on our provider system
- Redirects the flow of people to the most appropriate setting of care with more people having their health needs met in the community
- Improves system performance to reduce duplication and waste
- Makes community health networks the central organising point for coordinating health care
- Hospital services retains and refines their focus on specialst care and services.

### *Achieving equitable health outcomes*

Overall, CCDHB's population is experiencing good health. Our residents are living longer and experiencing better health. However, inequities remain a significant challenge with Māori and Pacific, people with disability, as well as those who have low socio-economic status or an enduring mental illness and/or addiction experiencing the greatest burden of poor health. Inequity also drives avoidable utilisation of health services. Intensifying support to these populations improves health outcomes, and keeps people healthy and well in their community.

CCDHB is committed to achieving equity with a focus on Māori and Pacific people, people who are living with a disability, people who have enduring mental illness and those in our communities who have fewer resources available to them. We remain focused on achieving equity, and that it is sustainable over time. Our approach is to use a strategy of "simplify and intensify"; intensify resources and support for those who need us the most and simplify for those who need us the least. In this financial year, our efforts will be focused on our pro-equity approach supported through the the reallocation of effort and resources.

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

Specific equity initiatives in 2019/20 are outlined in the planning priority section.

### *Supporting health and wellbeing through prevention and early intervention*

Our Health System Plan makes Community Health Networks the central organising point responsible for meeting and coordinating health care. At CCDHB, we prioritise primary care development and the improvement of care. As we move to develop our Community Health Networks, the Healthcare Home is a key priority for CCDHB.

We have implemented Health Care Homes across CCDHB and have reached 80% coverage of our population across age and ethnicity. In year-three of Healthcare Home, the emphasis is on equity and ensuring models of service delivery are effective for all of our communities. Organising the delivery of health services in the community will support improved access to prevention and early intervention, including treatment and management.

As well as delivering an alternative model of care, Healthcare Home is having a positive and statistically significant impact on system level performance. Our local population's acute demand (ED presentations and acute admissions) is reducing. The collaborative relationship and network between CCDHB and our PHOs as health system partners is a key enabler for this system outcome.

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

stronger focus on integrating their work with our locality approaches.

## *Alleviating pressure on our provider system*

Our acute, planned, mental health and support services are experiencing demand that is becoming less seasonal and more long-term. In addition to the impacts of ageing, the combination of multiple co-morbidities and non-communicable diseases are driving increased patient complexity.

CCDHB has a focus on acute demand that manages the flow into the hospital and effectively manages flow within our hospitals. Pressure on key touch points of the hospital system such as the Emergency Department place enormous pressure on the system. We have a strong focus on facilitating improved patient flow, maximising the impact of existing resources and ways to manage people in the community before they require secondary care.

Our services providing planned care are reaching capacity. We are looking at alternative models of care in the most appropriate setting to help people stay well for longer without needing hospital care. These new approaches will enable more flexibility in service delivery options to meet the health needs of our population.

CCDHB is also facing a growing demand for mental health and addiction services across our specialist, primary care and community services. CCDHB has a comprehensive programme of work to improve mental health and wellbeing and ensure we effectively implement the recommendations of He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.

CCDHB continues on a pathway to improve system performance and outcomes for our communities. We are focused on providing effective and efficient services that meet the needs of our population and the populations we serve.

## *Our role as a regional care provider*

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

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

There is also a rapidly growing level of sub-regional collaboration. The appointment of a joint Chief Executive across Capital & Coast and Hutt Valley DHBs will accelerate the development of a population wide approach to healthcare across the sub-region.

We are working collaboratively with Hutt Valley DHB to deliver a joint Long Term Investment Plan (LTIP), including hospital network planning and the future configuration of services across our network facilities to support the health outcomes for our populations and communities.

The LTIP will demonstrate the expected benefits in terms of health outcomes, and improvement in access, equity and quality by investing appropriately in service development, workforce and facilities across the sub-region.

## *Patient safety and quality*

We are committed to fostering safe work environments that allow our staff to focus on patient care as their number one priority. We are focused on the capability of human resource, infrastructure and leadership to improve working conditions and patient safety. We are committed to delivering a system where gains in hospital efficiency relate to improvements in patient safety and quality. We are developing a quality framework that will ensure that safety, quality and equity are closely monitored as resources are limited.

Clinical Governance is the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents. All clinical and non-clinical staff at CCDHB are committed to providing high quality and safe patient care, with support from the Board and organisational management.

We have recently updated our Clinical Governance Framework and brought together individual elements to strengthen and sustain ongoing

improvement around the six dimensions of quality; safe, timely, equitable, effective, efficient and people centred (STEEEP).

## *Supporting our workforce*

CCDHB employs around 5,800 full time staff, making us a major employer in the Wellington region. CCDHB strives to be a good employer. We are aware that good employment practices are critical to attracting and retaining top health professionals and support staff who embody our values and culture in their practice and contribution to organisational life.

We recognise the aims, aspirations, cultural differences and employment requirements of Māori people, Pacific Peoples and people from other ethnic or minority groups. We are prioritising a range of strategies with a particular focus on the recruitment and retention of Māori and Pacific staff. These efforts will support the intention of having a workforce that is reflective of the populations we serve.

Our current focus is on getting the right mix of staff and skills in the places where they are needed most. We will provide opportunities for individual employee development and career advancement, including cultural competency training.

In 2018/19, all waged staff at CCDHB were moved to the living wage rate for 2018. A living wage is the hourly rate a staff member needs to pay for the necessities of life and participate as an active citizen in the community. It reflects the basic expenses of individuals and their families such as food, transportation, housing and childcare. Living wage investment is a significant achievement for CCDHB and will support our staff and their families to participate actively in society. CCDHB continues to implement to Government's MECA and pay equity settlements to eliminate pay inequities across the health sector.

## *Maximising digital solutions*

In order to meet some of the challenges of our future health system, we are continuing to prioritise digital solutions to shift our use of technology from an efficiency enabler to a system transformation tool.

Our Health System Plan outlines our vision for a system where:

- patient information is available to provide safe and effective care when and where it is needed;
- digitally-enabled models of care improve accessibility, equity, quality, safety, efficiency and service experience;
- digital solutions enable improved workflow, mobile workforce, care closer to home, care continuity and coordinated care planning, delivery and tracking.
- people and whānau to have the information and tools they need to stay well, and be involved in their care.
- clinicians and administrators using data to gain insights that drive people focused care and services as well as cross-sectoral service improvement.
- our staff confidently use digital health technologies; and,
- Our ICT systems, services and operating model enable adaptive and rapid cycle service improvement.

## *Our sustainability challenge*

CCDHB is committed to living within our means. Actions within this Annual Plan support a clinically and financially sustainable health system. Implementing the Health System Plan is a priority for CCDHB and is associated with a programme of work that transforms our health system.

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

Our Even Better Health Care (EBHC) programme of work is delivering system and model of care change to support clinical and financial sustainability. The support has been in five key areas:

- Acute and planned care flow through our secondary and tertiary hospital services;
- Integrated care;
- 3DHB mental health and addictions;
- People and culture; and,
- Analytics and ICT.

EBHC recognises our staff are our greatest asset and works with teams across the DHB to drive operational efficiency and effectiveness including new service delivery models. EBHC focuses on actions with benefits to system performance, quality and safety, hospital flow, patient outcomes and resource management and results in investment in capability, skills and tools that support good decision-making including analytics. In 2019/20, this programme of work will be focused on clinical and financial sustainability.

## *Managing capital investment*

Capital investment is under review as part of the Long Term Investment Planning process and we will ensure the Ministry is appraised of any significant requirements as they arise. The build of a new Children's Hospital is underway with the support of Treasury and the Ministry.

## *Building on our successes*

In 2018/19, we made some investment in low-cost sustainability initiatives. This investment in transformation has been small but has an impact. In 2019/20, we will continue to focus our service delivery and management of changed resources to deliver the Health System 2030. We have:

- a spotlight on equity and invested to achieve equity outcomes;
- Implemented community based acute response services to manage people in their community;
- Respond to critical clinical and support service need, including regional services;
- Support our workforce to ensure patient and staff safety, and adhere to MECA settlements;
- Respond to recommendations from the Clinical Governance Review to improve patient safety and quality;
- Worked with communities and localities in Porirua and Kāpiti to understand their health needs and expectations of the health system.

## *Responding to the Government's priorities*

In 2019/20, CCDHB will support the Ministers priorities, where resources allow:

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

The Wellbeing Budget 2019 has committed investment for healthcare in 2019/20. CCDHB will support the Ministry of Health to implement Budget 2019 appropriations across personal health and mental health.

## 1.5 Message from the Chair

I am delighted to present Capital & Coast District Health Board's Annual Plan, which sets out our strategic intentions for the 2019/20 financial year.

We have a strong focus on achieving equitable health outcomes for our communities, particularly for Māori, Pacific Peoples, people with disabilities and other communities experiencing inequities.

We expect the DHB to respond appropriately to safety, quality and performance issues for preventative, acute and planned care in a timely way. We have a strong focus on providing services in a timely manner.

As a Board we have refreshed our commitment to live sustainably within our means. We are deliberate in our investment choices to deliver better care and outcomes for our communities.

Knowing that the services we deliver are achieving equitable outcomes, a high performing health system, and financial sustainability are top priorities for me. Our need for financial sustainability will reduce the speed at which we will be able to invest in services to achieve equity and system transformation.

The appointment of a joint Chief Executive across Capital & Coast and Hutt Valley DHBs will assist both DHB Boards to drive a joint strategic vision and will result in improved services and health outcomes for both populations.

We continue to foster and expand strategic partnerships including with our Māori Partnership Board, community and primary care partners to improve health outcomes.

Oversight of the health system's performance is an integral role for the Board. As a Board, we have strong expectations that Capital & Coast DHB measures and reports on the right things, including equity, quality and financial sustainability.

To reach our medium term goals for a clinically and financially sustainable health system, we are building our capability to use data and evidence to support this focus. We are applying this capability in the delivery of our Long-Term Investment Plan, outlining how we respond to future challenges.

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

We are engaged in meeting the expectations of the Minister of Health, with which our Health System Plan is strongly aligned. We continue to emphasise action to improve child wellbeing, mental wellbeing, wellbeing through prevention, improve population health outcomes through primary care, and maintain strong and sustainable public health system.

**Andrew Blair**
**Board Chair**

## 1.6 Message from the Chief Executive

I am pleased to present Capital & Coast District Health Board's Annual Plan for the 2019/20 financial year. This plan outlines clear priorities for Capital & Coast DHB to meet the needs of our population, to achieve equitable health outcomes; focus our efforts on elevating performance; and allocate our resources to be an effective and sustainable health system, including financial sustainability.

It reflects a strong relationship between the wider factors influencing health and the leadership role we must take to build partnerships with other agencies, services and communities to build resilience and improve health and social wellbeing.

We are taking a life course approach to ensuring services are equipped to meet peoples' needs throughout every stage of life. This approach is critical for optimising health outcomes for our communities.

Our key actions across the life course focus on:

- Equitable outcomes, particularly for Māori, Pacific people, people with disabilities, those in with fewer resources available to them and those with enduring mental illness
- Mental health and addiction services
- Primary care services
- Child wellbeing
- The strength of our publically funded health system

We will continue to partner with Hutt Valley and Wairarapa DHBs to serve our communities and make the best use of resources. This work will be strengthened by my appointment as joint Chief Executive across Capital & Coast and Hutt Valley DHBs. In this role, I will accelerate the development of a population wide approach to healthcare across the sub-region. We will also continue to partner with the Central Region DHBs.

We have started to develop and apply new ways of working and have established some sound building blocks including the delivery of the Health System Plan 2030, integrated support services key projects and Even Better Health Care. In making a commitment to financial sustainability, we acknowledge this will constrain the pace of our investment in equity and the Health System Plan 2030.

We continue to strengthen our commitment to the safety and development of our workforce including implementing Care Capacity Demand Management (CCDM). Continuing to build our clinical governance will further strengthen our focus on the quality and safety of the services we deliver. With the strong support of our clinical leadership and dedicated staff, we are committed to working collaboratively and within available resources to deliver high quality health services for our people and communities.

Leveraging the existing strengths in our organisation including our strong relationships within and across our communities, a committed and involved clinical workforce, and our equity focus will be key to deliver on the ambitious targets we have set ourselves for 2019/20.

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

## 1.7 Signature Page

**Agreement for the Capital and Coast DHB 2019/20 Annual Plan between**

Hon. Dr. David Clark
Minister of Health
Date: 17/12/19

Hon. Grant Robertson
Minister of Finance
Date: 18/12/19

Andrew Blair
Chair
Date:

Dame Fran Wilde
Deputy Chair
Date:

Fionnagh Dougan
Chief Executive
Date: 3/12/19

# SECTION TWO: Delivering on Priorities

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

## 2.1 Health Equity

Achieving equity is a priority for CCDHB. We know that we do not do as well for Māori, Pacific people, people with disabilities, those who have fewer resources available to them and those with enduring mental illness. We can see this in our measurement of health system performance, impacts and outcomes. CCDHB is committed to improving health outcomes and achieving equity for our communities. Our focus is on improving performance ensuring we make best use of our available resources and ultimately achieving equity amongst our populations

We will continue to deliver:

- Taurite Ora: CCDHB's Māori Health Strategy 2019-2030
- Toe Timata Le Upega, the Pacific Action Plan 2017-2020
- the Sub-Regional Disability Strategy 2017-2022
- Living Life Well – A Strategy for mental health and addiction 2019-2025.

Our strategic priorities for addressing equity in 2019/20 include:

- the delivery of the Taurite Ora Action Plan; and,
- the CCDHB Pro-Equity Strategy 2019-2030

The development of the CCDHB Pro-Equity Strategy, along with the Taurite Ora Action Plan, outlines the work programme CCDHB has set for giving effect to Taurite Ora, achieving equity and becoming a pro-equity organisation for Māori and our communities. The refresh of the CCDHB Pacific Action Plan with Hutt Valley and Wairarapa DHBs will also adopt a pro-equity focus and outline our collective intention to achieve equity for our Pacific communities.

The Pro-Equity Strategy will lay the foundation for how CCDHB will operationalise our commitment to being a pro-equity organisation and will outline our approach to achieving equity, including how we will provide and commission services.

Delivery of the Pro-Equity Strategy will include an agreed set of equity principles, operational frameworks that translate principles into practice and a performance accountability framework to monitor and guide progress.

In particular, the Pro-Equity approach will embed equity in decision-making processes, commissioning frameworks and service delivery plans.

As a pro-equity organisation, we will develop models of care and commission services that achieve equity for our people and communities. This means optimising the configuration of existing investment and services, as well as prioritising new investment where we have available resources to services that have the greatest impact on health outcomes for Māori, Pacific people, people with disabilities, those who have fewer resources available to them and those with enduring mental illness.

As a pro-equity organisation, we support having a workforce that is reflective of the populations we serve and their needs. We are prioritising a range of strategies with a particular focus on the recruitment and retention of Māori and Pacific staff. We also want to ensure the right mix of staff and skills in the places where they are needed most to achieve equitable health outcomes.

CCDHB has a fundamental role in enabling and facilitating the health system to achieve equitable health outcomes. Partnership is key to success in achieving equitable health outcomes. We collaborate with our Māori Partnership Board, Sub-Regional Pacific Strategic Health Group and Sub-Regional Disability Advisory Group who provide advice on how we can achieve equitable health outcomes for the people and communities they represent.

In this Annual Plan, we outline our actions towards achieving equitable health outcomes particularly for Māori and Pacific people, people who are living with a disability, people who have enduring mental illness and those in our communities who have fewer resources available to them. CCDHB will contribute to equity priorities through the specific actions and milestones outlined in the section below.

## 2.2 Māori health

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

*Kua Takoto Te Rau Tapu*

*The challenge of health equity for Māori is laid down*

Taurite Ora guides DHB activity to achieve health equity and optimal health for Māori by 2030. Taurite Ora will be launched in 2019.

Our efforts to bring about changes in Māori health outcomes are part of a broader public health plan that is most cohesively described in the Ministry of Health's *He Korowai Oranga: Māori Health Strategy*. This overarching framework and its underlying themes of Pae Ora (healthy futures) founded on Whānau Ora (healthy families), Mauri Ora (Healthy individuals) and Wai Ora (healthy environments) guide our activity.

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

Taurite Ora is tailored to the identified health needs of Māori living in its district and describes the outcomes and impacts that will be measured against in achieving health equity for Māori. Taurite Ora highlights the most critical priorities to improve health outcomes for Māori. Success is dependent on working with our partners to improve Māori interactions with our services and address the poor experiences many Māori have told us about.

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

Taurite Ora has two outcomes:

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

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

## 2.3 Strategic discussions with the Ministry of Health

In 2019, CCDHB held strategic discussions with the Ministry of Health about the DHB's high-level planning intentions. These discussions are summarised below:

- Ensure the **safety and quality** of the services provided and commissioned through a Safety and Quality Framework to centralise the monitoring of patient safety, quality and equity of outcomes;
- Our sustainable approach to **achieving equitable health outcomes** is to use a strategy of "simplify and intensify"; intensify resources and support for those who need us the most and simplify for those who need us the least.
- Our Even Better Health Care programme of work will support **improved operational performance** to support clinical and financial system sustainability;
- **Reorganising our health system** to place Community Health Networks and Community Mental Health and Wellbeing Hubs at the centre of health care service delivery;
- Manage **clinical resource allocation** to ensure staffing resources and patient safety are strongly co-ordinated and can be monitored against the safety and quality framework;
- Support **safe staffing levels** to ensure the safety of our staff and their patients;
- Manage **acute and avoidable demand** in our hospitals and emergency department through patient flow projects and collaborative responses with the primary care and community sector;
- Ensure **safe environments** through high quality and safe patient care as well as a consistent focus on health and safety, staff wellbeing, clinical equipment and facility maintenance;
- Manage **service delivery** to both our local and regional population including bowel screening and planned care;
- Provide **regional tertiary care** services within our operational capacity that are appropriate for our role in the Central Region;
- Collaborate with Hutt Valley DHB on **joint clinical planning** to maximise future operational efficiencies across the three hospital sites; Wellington regional Hospital, Kenepuru Hospital and Hutt Valley Hospital.

## 2.3 Government Planning Priorities

### 2.3.1 Improving child wellbeing

**Child and youth wellbeing is a priority work programme for Government, the Ministry of Health and District Health Boards. This section identifies actions for children and young people that contributes to the development and delivery of New Zealand's first Child and Youth Wellbeing Strategy and preparing the Health and Disability sector for system transformation over time.**

**This Annual Plan reflects how CCDHB is actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.**

**CCDHB will contribute to a comprehensive approach to prevention and early intervention services (primary and community health) provided to women of child bearing age, infants, babies, pre-school and school-aged children and youth and their families/carers.**

| **Immunisation** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. Work with PHOs and iwi providers to complete a review of **newborn enrolment** for CCDHB, to increase the timeliness of enrolment for Māori and Pacific babies (EOA)<br>2. Review **immunisation precall-recall practices and protocols**, with a view to share example resources with primary care practices for implementation. The intention is to provide process support for smaller practices without the same capacity for process improvement and review (EOA)<br>3. Support the development of an **integrated maternal and child health service** in Porirua, to provide more proactive, responsive and comprehensive health care for Māori and Pacific children and families. This service will further enhance core health services including immunisation services and Tamariki Ora. (EOA)<br>4. Improve HPV and Boostrix immunisation coverage for Māori, Pacific and Asian children, via the Regional Public Health **school-based immunisation programme** (EOA):<br>• Focus activities in low decile schools at the beginning of the school year and high decile schools later in the school year<br>• Provide education sessions within the school prior to vaccination<br>• Maintain intensive phone follow up with parents/caregivers for vaccination consent including provision of information in other languages and digital information ( to enable immediate web-based translation into another language) and use of interpreters<br>• Refer students not vaccinated in the school based immunisation programme to primary care | **Milestone**<br>1. **Newborn enrolment:** Q1: Complete review; Q2-4: Implement interventions<br>2. **Immunisation practices and protocols:** Q2: Share resources with primary care practices<br>3. **Integrated maternal and child health service:** Q2: Commence implementation; Q4: Review first 6 months.<br>4. **School based immunisation:** Q3: initiate activities in low decile schools including education sessions; Q3: Monitor immunisation coverage | **Measure**<br>CW05<br>CW08<br>CW11 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved health equity<br>(healthy populations)<br>**Government priority outcome**<br>Make New Zealand the best place in the world to be a child<br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention)<br>**Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering | |

| **School-Based Health Services** | | | This is an equitable outcomes action (EOA) focus area |
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| **DHB activity**<br>1. The DHB will provide quantitative reports in quarter two and four on the implementation of **school based health services (SBHS)** in decile 1-4 secondary | **Milestone** | **Measure**<br>CW11 | **Government theme**<br>Improving the well-being of New Zealanders and their families |

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| schools, and decile 5 as applicable to the DHB; teen parent units and alternative education facilities as well as an additional six schools, Aotea College, Rongotai College, Tawa College, Wellington East Girls College, Kapiti College and Paraparaumu College (EOA)<br>2. In line with the **Youth Health Care in Secondary School Framework**, the DHB will engage with the providers of SBHS to ensure that there are strong linkages between school based providers and other community providers to support continuity of care when referring to another provider.<br>3. The DHB will support data matching between SBHS providers and PHOs to improve **youth enrolment in primary care**.<br>4. The DHB will co-design with young people an **integrated youth health services model** in Porirua. This will include youth friendly primary care services, a central hub with satellite services, and a shared vision to support youth health. This process will be implemented in phases, commencing in 2019/20 (EOA)<br>5. The DHB will provide quarterly narrative reports on the actions of the **Youth ICC** to improve the health of the DHB's youth population. | 1. **SBHS in decile 1-5 secondary schools:** Q2 and Q4: Quarterly Reporting<br>2. **Youth Health Care in Secondary School Framework:** Q1-4: Reporting<br>3. **Youth enrolment in primary care:** Q3: Complete data matching<br>4. **Integrated youth health services model:** Q1: Confirm the phased approach for implementation; Q2 – 4: Implementation plan confirmed.<br>5. **Youth ICC:** Q1 – 4: Quarterly Reporting Youth ICC | CW12 | **System outcome**<br>We have improved health equity<br>(healthy populations)<br><br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Make New Zealand the best place in the world to be a child<br><br>**Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

| **Midwifery workforce – hospital and LMC** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. Develop a **Midwifery Workforce Strategy**<br>2. Partner with Victoria University to support a new **midwifery training programme**, for potential commencement in 2019/20. The program is to be over four years and will provide more flexibility for students and make training accessible for more Māori and Pacific students (EOA)<br>3. Explore the potential to use a **Dedicated Education Unit model** to support student midwives and requesting specific support for Māori and Pacific learners from Tertiary Education Provider (EOA)<br>4. Re-establish and strengthen midwifery connection to **Kia Ora Hauora** to maximise recruitment of Māori and Pacific students (EOA)<br>5. Progress **CCDM for maternity** in line with the CCDM Annual Plan, including amendments as required. | **Milestone**<br>1. **Midwifery Workforce Strategy:** Q3: Strategy developed<br>2. **Midwifery training programme:** Q1: Victoria University decision on implementation, Q3. Commence implementation<br>3. **Dedicated Education Unit model:** Q3: Model Explored<br>4. **Kia Ora Hauora:** Q2: Connections Re-Established.<br>**5. CCDM for Maternity:** Q1-Q4: Report on progress | **Measure**<br>CW11 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br><br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

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| 6. Complete and review **timing studies** to enable FTE calculations. Await feedback from TrendCare regarding any potential maternity changes in future upgrades resulting from timing studies undertaken internationally. | 6. **Timing studies:** Q2: timing studies completed and reviewed | | | |

## First 1000 days (conception to around 2 years of age)

This is an equitable outcomes action (EOA) focus area

| DHB activity | Milestone | Measure | Government theme | |
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| 1. Support the development of an **integrated maternal and child health service** in Porirua, focusing on whānau-centric, community-led holistic support for Māori hāpu mama and their whānau and Pacific mothers, babies and families (EOA)<br>2. Interim evaluation of the first 6 months of the **integrated maternal and child health service.**<br>3. Coordinate up to three **Maternal and Child Wellbeing stakeholder group hui**, with a view to support better connection, information sharing and training between secondary, primary, community and NGO/charitable partners<br>4. As part of the CCDHB **SUDI Prevention Plan**, provide support and resource to improve Māori breastfeeding rates, including establishing wahakura wanānga programs in Porirua (EOA)<br>5. To ensure available funding is targeted appropriately, review investment in **childhood nutrition and physical activity**. | 1. **Integrated maternal and child health service:** Q2: Commence implementation<br>2. **Integrated maternal and child health service:** Q2: Review first 6 months.<br>3. **Maternal and Child Wellbeing stakeholder group hui:** Q4: Report on outcomes<br>4. **SUDI Prevention Plan:** Q1: Execute agreements for wahakura wanānga programs; Q4: Quarterly Reporting.<br>5. **Investment Plan:** Q3: Complete report | CW06<br>CW07<br>CW11 | Improving the well-being of New Zealanders and their families | |
| | | | **System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

## Family Violence and Sexual Violence (FVSV)

This is an equitable outcomes action (EOA) focus area

| DHB activity | Milestone | Measure | Government theme | |
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| 1. Continue the roll out of **Violence Intervention Programme** (VIP) training to DHB clinicians (medical, nursing and allied health) in priority services (Emergency Department, Women's Health, Children's Health, Community Mental Health and Addictions Services)<br>2. Increase Routine Enquiry relating to **Intimate Partner Violence** (3IPV) for eligible patients presenting to priority services as outlined below:<br>a. 35% Emergency Department (ED)<br>b. 50% Children's Health | 1. **Violence Intervention Programme:** Q1-4: 60% of clinicians completed VIP training<br>2. **Intimate Partner Violence:** Q1-4: Eligible patients will be subject to Routine Enquiry | CW11 | Improving the well-being of New Zealanders and their families | |
| | | | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Support healthier, safer and more connected communities |

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| c. 80% Women's Health, Community Mental Health and Addictions Service<br>3. Increase **Disclosure Rates** (associated with Routine Enquiry) to at least 5% in priority services<br>4. Increase the use of the **Injury Flow Chart** relating to Child Abuse and Neglect for eligible patients (children <2 years old) presenting to ED to 85% | 3. **Disclosure Rates:** Q1-4: Increase Routine Enquiry Disclosure Rates to >5%<br>4. **Injury Flow Chart:** Q1-4: 85% of children <2 years presenting to ED will have a Chart completed | | | |

| **SUDI** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. Implement and monitor a **Safe Sleep Device Programme** across CCDHB. This programme will provide free safe sleep devices (including pepi pods and wahakura) to women with two or more of the following risk factors (EOA):<br>i. Pacific or Māori babies<br>ii. Smoke exposed baby (in pregnancy and/or in the home)<br>iii. Other biological or environmental concerns identified by clinical teams (e.g. prematurity, co-sleeping, etc.)<br>2. Implement **wahakura wānanga programmes** to hāpu mama and whānau, including focused messages around safe sleep, immunisation, breastfeeding and smoking cessation (EOA)<br>3. Support 100 Māori and Pacific mothers/primary caregivers of children aged 0-1 years living in Porirua, and others in their household, to quit smoking through CCDHB's **Hāpu Mama incentives programme** (EOA) | **Milestone**<br>1. **Safe Sleep Device Programme:** Q1 – Q4: Reporting<br>2. **Wahakura wānanga programmes:** Q3 – Q4: Reporting<br>3. **Hāpu Mama incentives programme:** Q1- Q4: Reporting | **Measure**<br>CW09<br>CW11 | **Government theme**<br>Improving the well-being of New Zealanders and their families | |
| | | | **System outcome**<br>We have improved health equity<br>(healthy populations) | **Government priority outcome**<br>Make New Zealand the best place in the world to be a child |

## 2.3.2 Improving mental wellbeing

**The Government has a vision of a mental health, addiction and wellbeing system without barriers, that is easy to navigate, where no door is the wrong door. DHBs have an important role to play in achieving this vision.**

**We must work together to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides options for New Zealanders across the full continuum of need.**

**This Annual Plan reflects how CCDHB will embed a focus on wellbeing and equity at all points of the system, alongside an increased focus on mental health promotion, prevention, identification and early intervention.**

**Alongside building missing components of our continuum, this Annual Plan demonstrates how we will strengthen existing services to ensure that mental health services are cost effective, results focused and have regard to the service impacts on people who experience mental illness.**

**CCDHB will provide a range of services that are of high quality, safe, evidence based and provided in the least restrictive environment.**

| **Inquiry into mental health and addiction** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br><br>The DHB will work with the Ministry of Health to implement the Government's agreed actions following **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction** and **Wellbeing Budget 2019** appropriations as advised by the Ministry. These actions relate to the *Living Life Well: Mental Health and Addiction Strategy Implementation Plan for 2019/20.*<br><br>**Embedding a wellbeing focus**<br><br>1. Complete a review of the **Triage and Urgent Response** and implement the findings to improve the response to acute referrals and triage for intervention. Improvements to the crisis and acute response services will be developed and co-designed with tāngata whaiora, general practice, NGOs, and the Emergency Department to ensure the person receives the most appropriate assessment and service response to meet their needs.<br>2. Work with PHOs to implement the 2018 Cardiovascular Disease Risk Assessment and Management for Primary Care guidelines and ensure we are providing **proactive CVD risk assessments** for people with severe mental illness from age 25 years (EOA)<br><br>**Building the continuum/increasing access and choice**<br><br>3. Explore options to inform the development of a prototype for locality based community **mental health and wellbeing hubs** to strengthen and increase focus on mental health promotion, prevention, identification and early intervention**.** Work in partnership with the Ministry, Māori, Pacific people, young people, people with lived experience, NGOs, primary and community organisations, and other stakeholders to plan an integrated approach to mental health, addiction and wellbeing.<br>4. Continue existing initiatives that contribute to **primary mental health and addiction outcomes**, and align with the future direction set by He Ara Oranga, including strengthening delivery of psychological therapies.<br>5. Recommendations from the recently completed review of **Te Ara Pai** service (Stepping Stones to wellness) will be implemented to ensure that the service is meeting the needs of tāngata whaiora and that services that support wellbeing are appropriate, effective and accessible for tāngata whaiora | **Milestone**<br><br>1. **Triage and Urgent Response Review:** Q1-Q4: Quarterly reporting<br>2. **Proactive CVD risk assessments**: Q2-Q4: Quarterly reporting<br>3. **Mental health and wellbeing hubs:** Q4: Model developed for Porirua<br>4. **Primary mental health and addiction outcomes:** Q1: Framework developed<br>5. **Te Ara Pai**: Q4: Recommendations implemented<br>6. **Suicide Prevention Strategy:** Q1: Feedback on *Every Life Matters;* Q2-Q4: Update, consult on and implement 3DHB Action Plan<br>7. **Suicide prevention and postvention:** Q1: Centralise functions<br>8. **Suicide prevention and postvention:** Q1-Q4: Continue efforts targeting priority populations | **Measure**<br><br>MH06 | **Government theme**<br><br>Improving the well-being of New Zealanders and their families<br><br>**System outcome**<br><br>We have improved quality of life<br><br>(health maintenance and independence) | **Government priority outcome**<br><br>Support healthier, safer and more connected communities |

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| **Suicide Prevention**<br>6. Contribute to the implementation of the **Suicide Prevention Strategy**, *Every Life Matters,* and any associated plans. Update the 3DHB Suicide Prevention and Postvention Action Plan in line with *Every Life Matters.*<br>7. Increase capacity and improve responsiveness to **suicide prevention and postvention** across the 3DHBs. This will include the centralisation of prevention and postvention functions from external providers back into CCDHB to enable a more integrated, joined up approach across NGOs, primary, secondary care providers and intersectoral partners.<br>8. Continue **suicide prevention and postvention** efforts to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives and integration of mental health and addiction services. Strengthen the response and support to specific population groups who are disproportionately affected by suicide (eg, Maori, Pacific, LGTBQI and youth). Improve the responsiveness of the various touchpoints in the health system (e.g. Emergency Departments) by implementing recommendations in the health system review report commissioned in 2019/19 (EOA) (This is also a Population Mental Health activity)<br>**Crisis Response**<br>9. Complete a review of the **Triage and Urgent Response Service** and implement the findings to improve the response to acute referrals and triage for interventions<br>***Workforce***<br>10. Implement the **workforce improvement activities** in the 2019/20 implementation plan, including:<br>a. Implement approaches to actively recruit and retain our Māori and Pacific mental health workforce;<br>b. look at the mental health workforce pipeline and work with education providers to grow the Māori and Pacific workforces;<br>c. consider the skills and lived experience needed in our workforce to challenge stigma and discrimination of people with enduring mental health conditions;<br>d. scope a workforce improvement plan that includes identification of gaps and plans to grow the workforce;<br>e. improve our approach to workforce management through the review of patient acuity and service need (roster review). | 9. **Triage and Urgent Response Service:** Q1-Q4: Quarterly reporting<br>10. **Workforce improvement activities:** Q1-Q4: Quarterly reporting<br>11. **Mental Health and Wellbeing Commission:** Q4: Support established Commssion<br>12. **Forensic workforce development:** Q1: Summary of workforce development plans to Ministry of Health<br>13. **Forensic workforce Budget 2019:** Q1-Q4: Ministry and budget dependent<br>14. **Forensic Framework:** Q1-Q2: Engage in stakeholder consultation; Q3-Q4: Feedback on draft framework | | | |

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| **Mental Health and Wellbeing Commission**<br>11. The DHB will work collaboratively with any new **Mental Health and Wellbeing Commission** established by Government.<br>**Forensics**<br>12. The DHB will provide the Ministry with a summary of existing **workforce development** plans/programmes within MHAIDS for youth and adult forensic mental health.<br>13. The DHB will confirm the establishment of any new roles established as part of the Forensic Mental Health Services **initiatives in Budget 2019**.<br>14. The DHB will engage in the development of the **Forensic Framework** project run by the Ministry of Health by supporting MHAIDS to participate in Ministry-led stakeholder workshops and provide feedback on the draft framework in 2020 when the Ministry makes this available. | | | | |

| **Population mental health** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. Development of the **3DHB Community Mental Health and Wellbeing Integration** model of care to implement the 3DHB Mental Health and Addictions Strategy – *Living Life Well 2019-2025* (EOA)<br>2. Increase capacity and improve responsiveness to **suicide prevention and postvention** across the 3DHBs. This will include the centralisation of prevention and postvention functions from external providers back into CCDHB to enable a more integrated, joined up approach across NGOs, primary and secondary care providers. Strengthen the response to specific populations who are disproportionately affected by suicide (eg. Maori, Pacific, LGTBQI, youth). We will also have a focus on improving the responsiveness of the various touchpoints in the health system (e.g. Emergency Departments) by implementing recommendations following a system review report commissioned in 2018/19 (EOA)<br>3. Continue to implement the requirements of the **Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SACAT)**.<br>4. **Increase primary care access** for clients with severe and enduring mental illness and substance use disorders by expanding existing contracts to provide free GP visits for opioid substitution clients (OST) and increased access to a primary mental health nurse (EOA) | **Milestone**<br>1. **3DHB Community Mental Health Integration:** Q1&2: Develop action plan; Q3&4: Implement action plan.<br>2. **Suicide prevention and postvention:** Q1: Increase capacity; Q2: Develop action plan; Q3&4: Implement action plan.<br>3. **SACAT:** Q1-Q4: Implementation<br>4. **Increase primary care access:** Q1-Q4: Implement and monitor.<br>5. **Alcohol and Other Drugs (AOD)**: Q1: Introduce new role; Q1-Q4: Monitor<br>6. **Te Ara Pai review:** Q1: Complete review; Q2: Review recommendations and develop | **Measure**<br>MH01<br>MH03<br>MH06 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Support healthier, safer and more connected communities |

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| 5. Monitor provision of support to complex **Alcohol and Other Drugs (AOD)** clients with severe/enduring addiction issues post Substance Addiction Compulsory Assessment and Treatment (SACAT); introduce a specialist addiction social worker role into a community provider to work with these complex AOD clients post SACAT (EOA)<br>6. Review the **Te Ara Pai NGO wrap around support services** (housing, employment, home based support, navigation, family support) for moderate to severe clients to ensure services are responsive, culturally appropriate and relevant to current needs (EOA)<br>7. Establish a **collaborative MDT forum** between NGO providers and MHAIDS to support the transition of MH&A service users back into the community<br>8. Transition the specialist **Pasifika community mental health team** from MHAIDS to a Pacific community provider/setting and co design a pacific model of care that will effectively support pacific people to stay well in the community<br>9. Complete a review of the **Triage and Urgent Response Service** and implement the findings to improve the response to acute referrals and triage for interventions.<br>10. In partnership with the Police and Wellington Free Ambulance**,** develop and implement a pilot programme that provides a front line **collaborative response to 111 calls** from people experiencing mental health distress.<br><br>In addition to the above, the DHB is working closely with **Piki**, a 3DHB primary mental health pilot initiative, delivered by Tū Ora Compass Health PHO and Te Awakairangi Health, providing free mental health / alcohol or drug problem **support to young people** (18-25 years old). | action plan; Q3&4: Implement proposed changes<br>7.**Collaborative MDT forum:** Q1: Establish forum; Q2-4: continue to facilitate forums and review effectiveness<br>8. **Pasifika community mental health team:** Q1: develop project plan; Q2: co-design model of care and recruit staff; Q3-4, implement and review.<br>9. **Triage and Urgent Response Service :** Q1-4; undertake review, implement recommendations and review effectiveness of changes.<br>10. **Collaborative response to 111 calls:** Q1-4: Develop scope, project plan, implementation, review effectiveness. | | | |

| **Mental health and addictions improvement activities** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. Continue to monitor use of seclusion through the **Restraint and Seclusion Elimination Monitoring and Advisory Group** and reduce seclusion rates for Māori.<br>2. **Co-design seclusion reduction activities** with consumers, tāngata whaiora, family and whānau who use acute units, followed by testing of selected activities to reduce seclusion rates for Māori (EOA)<br>3. Develop a programme of work for **Learning from Serious Adverse Events**. | **Milestone**<br>1. **Restraint and Seclusion monitoring:** Q1-Q4: Quarterly reporting<br>2. **Co-design Seclusion reduction activities** Q1: Co-design completed; Q2: Test selected improvement ideas. | **Measure**<br>MH02<br>MH03<br>MH05<br>MH06 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life | **Government priority outcome**<br>Support healthier, safer and more |

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| 4. Complete a review of the **Triage and Urgent Response service**[1] and implement the findings to improve the response to acute referrals and triage for interventions.<br>5. Implement the **3DHB 'Acute Continuum of Care'** to better match need to service provision, enhance coordinated service provision across a range of providers, and improve integration and patient flow through the system. This will include supporting prioritised pathways with a focus on responding to Māori mental health needs (EOA)<br>6. The Client Pathway project group is focusing on a range of initiatives to improve overall clinical practice, including improving percentage of clients discharged with a **quality transition or wellness plan**.<br>7. MHAIDS will implement a revised **mental health clinical governance** structure to enhance its patient safety culture and encourage ongoing service improvement activity and review. | 3. **Serious Adverse Events:** Q1-4: Quarterly reporting<br>4. **Triage and Urgent Response service:** Q1-Q4: Quarterly reporting<br>5. **3DHB 'Acute Continuum of Care':** Q1-4: Quarterly reporting<br>6. **Transition Planning:** Q1-Q4: Quarterly reporting<br>7. **Mental health clinical governance:** Q4: revised structure implemented | | (health maintenance and independence) | connected communities |

| **Addiction** | | | This is an equitable outcomes action (EOA) focus area | |
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| MHAIDS provides community alcohol and drug assessment and treatment for adults living in the CCDHB region who have or are concerned they may have moderate to severe mental health and substance use disorders. The MHAIDS Opioid Treatment Service is based in Wellington and provides satellite clinics in Porirua, Kāpiti, Lower Hutt and Upper Hutt.<br>**DHB activity**<br>1. Review current AOD NGO services followed by the development and co-design with key stakeholders of a **3DHB AOD model of care** and practice pathway, with particular focus on priority populations including Māori, Pacific and youth (EOA)<br>2. Provide the Ministry of Health with a list of all **existing and planned AOD services** in the Capital & Coast district (including DHB contracted NGO services) by 30 September 2019.<br>3. The 3DHBs will implement the final decisions on the proposal to move to a **lead DHB model** with one management structure for all secondary and tertiary mental health and AOD services across the 3DHBs to improve access (EOA) | **Milestone**<br>1. **3DHB AOD model of care:** Q4 complete model of care<br>2. **Existing and planned AOD services:** Q1: list provided<br>3. **Lead DHB model:** Q3-Q4: Implement final decisions of a lead DHB model<br>4. **Triage and Urgent Response Service:** Q1-Q4: Quarterly reporting | **Measure**<br>MH06 | **Government theme**<br>Improving the well-being of New Zealanders and their families | |
| | | | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Support healthier, safer and more connected communities |

[1] The Triage and Urgent Response Service is part of the 3DHB Mental Health, Addiction and Intellectual Disability Service (MHAIDS)

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| 4. Complete a review of the **Triage and Urgent Response service** and implement the findings to improve the response to acute referrals and triage for interventions. | | | | |

| **Maternal mental health services** | | | This is an equitable outcomes action (EOA) focus area | |
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| The stocktake undertaken in 2018/19 showed that CCDHB does not fund primary/ community maternal mental health services (apart from a specialist maternal mental health service).<br>**DHB activity**<br>1. Consider options to enhance the **integrated maternal and child health service** in Porirua, to provide timely, continuity of support for Māori and Pacific women through the first 1000 days (EOA)<br>2. Develop and commence implementation of a 3DHB Mental Health and Addiction **Population Outcomes Framework**, which links the activities across the three DHBs with the desired outcomes and provides a means of tracking and reporting progress. | **Milestone**<br>1. **Integrated maternal and child health service:** Q4: review model and consider maternal mental health enhancements<br>2. **Population Outcomes Framework:** Q2: Framework developed and implementation initiated | **Measure**<br>MH06 | **Government theme**<br>Improving the well-being of New Zealanders and their families | |
| | | | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Support healthier, safer and more connected communities |

## 2.3.3 Improving wellbeing through prevention

**Preventing ill health and promoting wellness is vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards prevention. This preventive focus includes supporting people to live active and health lives, working with other agencies to address key determinants of health, and to identify and treat health concerns early in the life course and in the life of progress of the disease.**

## Cross-sectoral collaboration

| DHB activity | Milestone | Measure | Government themes | |
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| This activity is an important part of locality planning focusing on the needs of our communities by working in collective partnership models:<br>1. **Housing:** Cross-sectoral collaboration with Wellington City Council, Housing New Zealand and Ministry of Housing and Development to develop a coordinated plan in line with the Housing First principles to respond to homelessness in Wellington City (EOA)<br>2. Partnering with health social care providers to implement an **Integrated Youth Service** in Porirua (EOA)<br>3. Partner with Victoria University to support a new **midwifery training programme**, for potential commencement in 2019/20<br>4. Partnering with key social agencies as part of the Wellington Regional Strategic Governance Group – **Mental Health Working Group**. This group has been established to improve outcomes for people who experience mental distress, ensuring the right services are delivered at the right time to the right people for better outcomes.<br>Ngati Toa Rangatira is collaborating with the Government to establish the iwi (Ngati Toa) as a community housing provider (Te Āhuru Mōwai). Once established, Te Āhuru Mōwai will upgrade and manage 900 Housing New Zealand properties in Tawa, Elsdon, Takapūwāhia, Titahi Bay and Mana. The opportunity to provide warm and safe homes compliments the health services provided by Ora Toa PHO in improving health outcomes in the Porirua area. | 1. **Housing:** Q1 – Q4; Quarterly Reporting<br>2. **Integrated youth health services model:** Q1: Confirm the phased approach for implementation; Q2 – 4: Implementation plan confirmed<br>3. **Midwifery Training Programme:** Q1: Victoria University decision on implementation, Q3. Commence implementation<br>4. **Mental Health Working Group:** Q1 – Q4; Quarterly Reporting | *Annual plan actions – status update reports* | Improving the well-being of New Zealanders and their families<br>Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand) | |
| | | | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Transition to a clean, green carbon neutral new Zealand |

## Waste disposal

| DHB activity | Milestone | Measure | Government themes |
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| 1. Continue to raise **public awareness** of their ability to return unused medicines to community pharmacies so that disposal of them can be performed in a safe | | *Annual plan* | Improving the well-being of New Zealanders and their families |

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| manner. Posters will be published in Community Pharmacies encouraging clients to return waste medicine. | **Public Awareness**: Q2: Posters sent to pharmacies and other points to display | *actions – status update reports* | Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)<br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence)<br>**Government priority outcome**<br>Transition to a clean, green carbon neutral new Zealand |

| **Climate change** | | | |
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| **DHB activity**<br>1. CCDHB will undergo the second independently audited **carbon footprint measure** (as identified in the 2018/19 stocktake). A benchmark was completed for 2017/18 and has been audited in Q3 of 2018/19. | **Milestone**<br>**Carbon footprint measure:** Q3: audit completed (% reduction in $CO_2$ emissions per overnight event count from 2017/18 benchmark) | **Measure**<br>*Annual plan actions – status update reports* | **Government themes**<br>Improving the well-being of New Zealanders and their families<br>Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)<br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence)<br>**Government priority outcome**<br>Transition to a clean, green carbon neutral new Zealand |

| **Drinking water** | | | This is an equitable outcomes action (EOA) focus area |
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| **DHB activity**<br>1. CCDHB will **support Regional Public Health drinking water activities** with an initial focus on the annual drinking water survey and compliance report. | **Milestone**<br>1. **Support drinking water activities:** Q1-Q4: Review | **Measure**<br>*Annual plan* | **Government theme**<br>Improving the well-being of New Zealanders and their families |

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| 2. CCDHB will support Regional Public Health to identify and investigate incidents, complaints and notifications of adverse **drinking water quality** (or adequacy) of networked, tankered and temporary drinking water supplies (EOA)<br>3. Regional Public Health will promote **compliance with the drinking-water requirements** of the Health Act 1956 and achievement of the Drinking-Water Standards for New Zealand to drinking-water suppliers and water carriers, and undertake compliance and enforcement action as required (EOA)<br>4. CCDHB will support Regional Public Health to work with local councils as per the MOU for the **Wellington Region Drinking Water Joint Working Group** to monitor and assess drinking water issues collectively, including advocating for input and/or representation from mana whenua (EOA) | compliance report and support RPH to respond to outcomes<br>2. **Drinking water quality:** Q4: report on the number of investigations completed<br>3. **Compliance with the drinking-water requirements:** Q4: percentage of networked water suppliers serving more than 100 people with approved water safety plans<br>4. **Wellington Region Drinking Water Joint Working Group:** Q1-Q4: Report on Māori input and/or representation from mana whenua | *actions – status update reports* | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence)<br><br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Grow and share New Zealand's prosperity more fairly |

| **Healthy food and drink** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. Align the **3DHB Food and Beverage Guidelines** with the national policy (exception of drinks which will remain stricter than the national policy); and finalise the implementation of the guidelines (one phase outstanding)<br>2. **Compliance:** Continue to monitor all foodservice providers on site<br>3. 3DHB food and beverage guidelines and policies included in **tender documents**:<br>• Tender documents for all outsourced café and coffee services<br>• General services tender (includes patient meals and staff cafeteria)<br>Compliance with the guidelines and policy are included in the evaluation criteria and dietetic personnel utilised in the evaluation process.<br>4. A **Healthy Food and Drink Policy Clause** will be included in relevant contracts with community providers, excluding residential care facilities.<br>5. CCDHB will support Regional Public Health to develop processes, in partnership with other relevant agencies, for reporting the number of Early Learning Settings, primary, intermediate and secondary schools that have current **water-only** | **Milestone**<br>1. **3DHB Food and Beverage Guidelines:** Q4: Guideline implemented<br>2. **Compliance:** Q2: Providers audited; Q4: Plan developed to correct any non-compliant areas<br>3. **Tender documents:** Q4: Food and beverage clauses included in all tender documents<br>4. **Healthy Food and Drink Policy Clause:** Q2 and Q4: Report on number of community contracts with a Healthy Food and Drink Policy<br>5. **Water-only and healthy food policies:** Q2 and Q4: Report | **Measure**<br>*Annual plan actions – status update reports* | **Government theme**<br>Improving the well-being of New Zealanders and their families<br><br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence)<br><br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Support healthier, safer and more connected communities<br><br>**Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

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| (including plain milk) **policies and healthy food policies** consistent with the Ministry of Health's Eating and Activity Guidelines | progress or the number of schools with current water-only and healthy food policies | | | |

| **Smokefree 2025** | | | This is an equitable outcomes action (EOA) focus area | |
|---|---|---|---|---|
| **DHB activity**<br>1. Refresh and implement the **DHB Tobacco Control Plan** for 2019-2021 focusing on integration of services and support for hāpu wāhine, Māori, and Pacific peoples (EOA)<br>2. Support 100 Māori and Pacific mothers/primary caregivers of children aged 0-1 years living in Porirua to quit smoking through CCDHB's **Hāpu Mama incentives programme** (EOA)<br>3. Ongoing monitoring and support for Well Child Tamariki Ora providers to embed data recording and collection to support the **babies living in smokefree homes** SLM (EOA)<br>4. Maintain a programme of continuous quality improvement initiatives to support achievement of the **Better Help for Smokers to Quit** targets, including equity for Māori and Pacific peoples (EOA)<br>5. The DHB will support improved performance in the **Better Help for Smokers to Quit** hospital target with a focus on addressing barriers to performance, including equity for Māori and Pacific peoples (EOA) | **Milestone**<br>1. **DHB Tobacco Control Plan:** Q1: Plan approved<br>2. **Hāpu Mama incentives programme:** Q4: Support 100 mothers/primary caregivers in 2019/20<br>3. **Babies living in smokefree homes:** SLM Reporting<br>4. **Better Help for Smokers to Quit:** Q1-4: Quarterly reporting<br>5. **Better Help for Smokers to Quit:** Q1-Q4: Quarterly reporting | **Measure**<br>PH04<br>SS06 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence)<br>**System outcome**<br>We live longer in good health (prevention and early intervention) | **Government priority outcome**<br>Grow and share New Zealand's prosperity more fairly |

| **Breast Screening** | | | This is an equitable outcomes action (EOA) focus area | |
|---|---|---|---|---|
| **DHB activity**<br>CCDHB aims to achieve participation of at least 70 percent of women aged 45-69 years in the most recent 24 month period, and eliminate equity gaps for priority women, including Māori and Pacific women.<br>1. Regional Screening Services will provide 6 **weekend breast screening clinics** and aim to screen a target of 40 women at each clinic (dependent on MRT resource) | **Milestone**<br>1. **Weekend clinics:** Q2 & Q4: Quarterly reporting<br>2. **Evening clincs:** Q2-Q4: Quarterly reporting | **Measure**<br>PV01 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life | **Government priority outcome** |

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| 2. Regional Screening Service will implement a monthly **evening breast screening clinic** during the working week and aim to screen a target of 15 women at each clinic.<br>3. To support the BSA two-year pathway to achieve the 70% screening target for Māori and Pacific women, Regional Screening Services' recruitment and retention team will aim to support an additional 50 Māori and 15 Pacific women who are **overdue or unscreened** to attend a breast screening clinic<br>4. Regional Screening Services will use the results of a recent survey to plan for the most effective and efficient way of **increasing access to breast screening services** with a particular focus on improving access for Māori and Pacific women (EOA)<br>5. Regional Screening Services will trial **same day biopsies and first specialist appointments** at the breast symptomatic clinic to facilitate access and faster cancer treatments. | 3. **Overdue or unscreened women**: Q2-Q4: Quarterly reporting<br>4. **Increasing access to breast screening services:** Q2-Q4: Quarterly reporting<br>5. **Same day biopsies and first specialist appointments:** Q2-Q4: Quarterly reporting | | (health maintenance and independence) | Grow and share New Zealand's prosperity more fairly |
| | | | **System outcome**<br>We live longer in good health (prevention and early intervention) | |

| **Cervical Screening** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>CCDHB aims to achieve at least 80 percent participation of women aged 25-69 years in the most recent 36 month period, and eliminate equity gaps for priority group women, including Māori, Pacific and Asian women.<br>1. Regional Screening Services will provide 4 **weekend cervical screening clinics** at Kenepuru and aim to screen a target of 35 women at each clinic.<br>2. Regional Screening Services will provide 10 **evening cervical screening clinics** at screening sites across CCDHB and aim to screen a target of 12 women at each clinic<br>3. Regional Screening Services will partner with general practices with a high proportion of **overdue or unscreened women** and report the number of women who attend the 4 combined cervical and breast screening clinics for priority women<br>4. Regional Screening Services will use the results of a recent survey to plan for the most effective and efficient way of **increasing access to cervical screening** | **Milestone**<br>1. **Weekend clinics**: Q2-Q4: Quarterly reporting<br>2. **Evening clinics**: Q2-Q4: Quarterly reporting<br>3. **Overdue or unscreened women**: Q2-Q4: Quarterly reporting<br>4. **Increasing access to cervical screening services**: Q2-Q4: Quarterly reporting<br>5. **Community-based cervical screening clinics**: Q2-Q4: Quarterly reporting | **Measure**<br>PV02 | **Government theme**<br>Improving the well-being of New Zealanders and their families | |
| | | | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Grow and share New Zealand's prosperity more fairly |
| | | | **System outcome**<br>We live longer in good health (prevention and early intervention) | |

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| **services** with a particular focus on improving access for Māori and Pacific women. (EOA)<br>5. Provide 16 free **community-based cervical screening clinics** per annum in high-needs communities, targeting Māori, Pacific, and Asian women. (EOA) (Also a Cancer Services activity)<br>6. Regional Screening Services will work with Tū Ora Compass Health to identity general practices with high volumes of **Asian women overdue or underscreened**. We will collaborate with two general practices with high Asian patient populations to increase access to screening for Asian women.<br>7. Regional Screening Services will collaborate with 14 general practices in CCDHB to use data matching reports to identify and offer **support to priority group** Māori, Pacific, and Asian women who are unscreened and under screened.<br>8. Regional Screening Services will **promote key messages** around the importance and benefits of cervical screening and supporting women into the screening pathway on their new Facebook page, sponsorship and attendance at Piniklicious, ATAMU Waitangirua, Creekfest, Maraeroa Marae Health Clinic and other community events where priority populations gather, linking with NCSP Māori and Pacific Support to Service Providers to follow-up DNA referrals, advertising on community social media pages | 6. **Overdue or underscreened Asian women**: Q2-Q4: Quarterly reporting<br>7. **Support for priority women**: Q2-Q4: Quarterly reporting<br>8. **Promote key messages**: Q2-Q4: Quarterly reporting | | | |

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

**New Zealanders are living longer, but also spending more time in poor health.**

**This means we can expect strong demand for health services in the community, our hospitals, and other care settings.**

**Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development, and joined-up service planning to maximise system resources and to improve health and increase equity.**

| **Engagement and obligations as a Treaty partner** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>These activities are underpinned by CCDHB's Māori Health Strategy – Taurite Ora:<br>1. Complete, publish and launch **Taurite Ora**: CCDHB's Māori Health Strategy and Action Plan 2019-2030 (EOA)<br>2. Continue to support the **Māori Partnership Board** (MPB) function as an overseer, contributor, and monitor of Māori health within CCDHB (EOA)<br>3. Develop a pathway for increasing the number of **Māori workforce** across all areas of the organisation (EOA)<br>4. Provide **cultural competency** training opportunities for all staff including Tikanga training, Te Tohu Whakawaiora and Te Reo classes (EOA)<br>5. **Taurite Ora – Māori health providers**: Complete year 1 activities related to the strategic priority 'Māori health providers are thriving', including a review of the CCDHB Māori Health funding portfolio. | **Milestone**<br>1. **Taurite Ora:** Q1: Taurite Ora published<br>2. **Māori Partnership Board:** Q1-Q4: Bi-monthly meetings<br>3. **Māori workforce:** Q4: pathway developed<br>4. **Cultural competency:** Q4: report against outcome<br>5. **Taurite Ora – Māori health providers:** Q4: year 1 activities complete. | **Measure**<br>SS12 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved health equity<br>(healthy populations) | **Government priority outcome**<br>Make New Zealand the best place in the world to be a child |

| **Delivery of Whānau Ora** | | | This is an equitable outcomes action (EOA) focus area |
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| **DHB activity**<br>1. Commit to a **pro-equity programme of work** that delivers: | **Milestone**<br>1. **Pro-equity work programme:** Q4: pro-equity work programme | **Measure**<br>SS17 | **Government theme**<br>Improving the well-being of New Zealanders and their families |

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| a. a clear CCDHB equity goal and direction<br>b. an agreed set of equity principles<br>c. an operational framework that translates principles into policies and practices<br>d. a performance framework to monitor and guide progress<br>e. an agreed target-staged implementation (EOA)<br>2. Support the development of an **integrated maternal and child health service** in Porirua, focusing on whānau-centric, community-led holistic support for Māori hāpu mama and their whānau and Pacific mothers, babies and families (EOA)<br>3. Develop and implement a plan focused on how to achieve the target of **zero seclusion and compulsory treatment**, including:<br>a. Undertaking a case review of every episode of seclusion or compulsory treatment order to identify how these might have been avoided and opportunities for improvement. (EOA)<br>4. Support and collaborate with CCDHB **Māori health providers** and Te Pou Matakana to identify opportunities for alignment (EOA)<br>5. Work with Wairarapa and Hutt Valley DHBs to develop a **3DHB Pacific Health Plan** focused on achieving equity and improved health outcomes for Pacific people.<br>6. Strengthen working relationships with **Pasifika Futures** core partners, Taeaomanino Trust and He Whānau Manaaki o Tararua Free Kindergarten to support achievement of the Outcomes Framework for Prosperous Pacific Families. | established & all ELT members have Māori health equity KPIs<br>2. **Integrated maternal and child health service**: Q2: Commence implementation; Q4: Review first 6 months<br>3. **Zero seclusion and compulsory treatment:** Q1-Q4: Quarterly reporting<br>4. **Māori health providers:** Q1-Q4: Increase collaboration<br>3. **3DHB Pacific Health Plan:** Q2: First draft; Q4: Final draft approved<br>4. **Pasifika Futures:** Q1-Q4: Strengthen working relationships; Q4: review performance and identify opportunities to maximise resource | | **System outcome**<br>We have improved health equity<br>(healthy populations) | **Government priority outcome**<br>Make New Zealand the best place in the world to be a child |

| **Care Capacity Demand Management** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity** | **Milestone** | **Measure** | **Government theme** | |
| 1. **Progress CCDM** for nursing in line with CCDM Annual Plan, including amendments as required. All reporting to the Ministry of Health and the CCDM Governance Group on schedule<br>2. **Expansion of TrendCare** into new areas such as mental health and forensic (MHAIDS) and day wards. | 1. **Progress CCDM:** Q4; work plans on schedule and scheduled reporting complete<br>2. **Expansion of TrendCare:** Q1: MHAIDS and day wards implemented | *Annual plan actions – status update reports* | Improving the well-being of New Zealanders and their families | |
| | | | **System outcome**<br>We have improved quality of life | **Government priority outcome**<br>Support healthier, safer and more |

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| 3. **Local Data Councils** focused on quality improvement through the core data set in place in all areas using TrendCare. Enhance the dataset and its utility by undertaking heat mapping to identify challenges and opportunities for quality improvement, as well as measurement of progress.<br>4. **TrendCare accuracy and quality checks** undertaken monthly in line with the staffing methodology checks required.<br>5. **Staffing methodology:** Progress FTE calculations in all areas which meet the requirements and fulfil the quality checking process.<br>6. Progress **variance response management** including: essential cares, specific escalation plans for ED and maternity, standard operating procedures and Capacity at a Glance (CaaG) screens incorporating TrendCare acuity, capacity and variance indicator scoring with full reporting capabilities to meet Ministry of Health reporting requirements. | **3. Local Data Councils:** Q4: 100% coverage of Local Data Councils in areas using TrendCare; Q4: report on evidence of the core data set being used for quality improvement and measurement of success<br>4. **TrendCare accuracy and quality checks:** Q1-Q4; satisfactory standards met<br>5. **Staffing methodology:**<br>Q1-Q4: FTE calculations continue as planned<br>**6. Variance response management:** Q4; New CaaG screens (as per CCDM standards and specifications) and variance indicator scoring system fully implemented | | (health maintenance and independence)<br>**System outcome**<br>We have improved health equity<br>(healthy populations)<br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | connected communities<br>**Government priority outcome**<br>Make New Zealand the best place in the world to be a child<br>**Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

| **Disability** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>This activity is underpinned by the 3DHB Sub-Regional Disability Strategy 2017 – 2022 (Wairarapa, Hutt Valley and Capital & Coast District Health Boards): <u>Enabling Partnerships: Collaboration for effective access to health services</u><br>1. Work with Māori and Pacific people with disabilities to determine the key goals and priorities for **improving access to services**. (EOA) (This is also a Workforce / Health literacy activity)<br>2. Develop and implement a **Disability Education Plan** that incorporates a rights based approach to reduce inequitable health outcomes across the disabled, Māori and Pacific communities (EOA)<br>3. Develop and complete a **Disability Survey** with our workforce to better understand the areas where capability development is required. The survey will | **Milestone**<br>1. **Improving access:** Q1-Q2: review barriers; Q3-Q4: Develop a plan to support uptake<br>2. **Disability Education Plan:** Q1: Review education material; Q2: Develop plan<br>3. **Disability survey:** Q1-2: Develop survey; Q3: Release survey; Q4: Analyse results<br>4. **Disability Responsiveness eLearning Module:** Q4: Report on % staff completed module | **Measure**<br>*Annual plan actions – status update reports* | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence)<br>**System outcome**<br>We have improved health equity | **Government priority outcome**<br>Support healthier, safer and more connected communities<br>**Government priority outcome** |

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| be endorsed by the Sub Regional-Disability Advisory Group which will include Māori and Pacific input.<br>4. Continue quality improvement processes on the **Disability Responsiveness eLearning Module** to all staff and report on the percentage of staff that have completed the training.<br>5. Improve patient experiences by including information about a patient's sensory, physical, intellectual disabilities on **Disability Alerts**[1], and put in place a quality standard which is measured. | 5. **Disability Alerts:** Q1: develop quality standard; Q3/4: Review attainment against standard every 6 months | | (healthy populations) | Make New Zealand the best place in the world to be a child |

| **Planned Care** | | | This is an equitable outcomes action (EOA) focus area | |
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| **Part One:**<br>1. Achieve the **Planned Care target** through patient focused projects to reduce the DNA rate, including re-designing letters to patients regarding their appointments and involving patients in the scheduling process. These projects will be tested in services with high DNA rates for Maori and Pacific before wider implementation.<br>2. Improve waiting times for planned care by achieving over 90% of services **prioritising referrals** within the required timeframe<br>3. Improve waiting times for planned care by **working with primary care** to ensure triaging clinical staff have sufficient information to manage referrals.<br>4. Work with Hutt Valley DHB to progress the programme of work to jointly plan and coordinate the delivery of **planned care services** across our network of hospitals (Wellington, Kenepuru, and Hutt Hospital) to ensure access to timely and high-quality secondary services that are both clinically and financially sustainable.<br>5. Develop a community focused early intervention **musculoskeletal service** aimed at Maori and Pacific people in Porirua. | **Milestone**<br>1. **Planned Care target:** Q1-Q4: On track to achieve Planned Care Target; Q4: Target achieved (15,111)<br>2. **Prioritisation of referrals:** Q1-Q4: Services achieving meet prioritising objective.<br>3. **Working with primary care:** Q1-Q4: Services achieving meet prioritising objective.<br>4. **Planned care services**: Q1-Q4: Progress report on joint hospital network planning<br>5. **Musculoskeletal service:** Q4: Service ready for implementation | **Measure**<br>SS7<br>SS8 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Support healthier, safer and more connected communities |

[1] Disability Alerts contain specific information provided by the patient on how best to meet their support needs.

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| **Part Two:**<br>1. The DHB will provide the Ministry of Health with an outline of our planned engagement, analysis and development activities for developing the Three Year Plan. | **Quarter 1**<br>DHBs will provide an outline of their engagement, analysis and development activities for developing the Three Year Plan**.** | A plan is submitted that outlines the proposed approach to develop the Three Year Plan**.** | | |
| 2. The DHB will undertake analysis of changes that can be made to Planned Care Services including consultation with DHB Consumer Councils and other key stakeholders. | **Quarter 2**<br>DHBs will undertake analysis of changes that can be made to their Planned Care Services including consultation with DHB Consumer Councils and other key stakeholders. | A summary report outlining the outcomes of the analysis and consultation processes to understand local health needs, priorities and preferences. | **System outcome**<br>We have improved health equity<br>(healthy populations) | **Government priority outcome**<br>Make New Zealand the best place in the world to be a child |
| 3. The DHB will DHBs will submit a Three Year Plan to improve Planned Care Services to the Ministry of Health | **Quarter 3**<br>DHBs will submit their Three Year Plan to improve Planned Care Services | Submission of the Three Year Plan to improve Planned Care Services. | | |
| 4. The DHB will provide the first update on actions taken to improve equitable and timely access to Planned Care services (EOA) | **Quarter 4**<br>DHBs provide the first update on actions taken to improved Planned Care | An update is provided on actions outlined in the Three Year Plan to improve Planned Care Services. | | |

<table>
<tr><td colspan="3">Acute Demand</td><td colspan="3">This is an equitable outcomes action (EOA) focus area</td></tr>
<tr><td rowspan="2">DHB activity<br><br>CCDHB has a focus on acute demand that both manages the flow into the hospital and effectively manages flow within our hospitals.<br>1. Discuss with the Ministry the resourcing requirements and constraints for CCDHB to implement SNOMED coding in the Emergency Department by 2021.<br>2. Improve patient flow for admitted patients: Roll out daily discharge planning board rounds across selected services.<br>3. Improve management of patients with long-term conditions in the community and frailty in ED:<br>• Collaborate with Healthcare Homes to support patients with long-term conditions to stay well in the community.<br>• Support a rapid assessment of frail elderly patients presenting to ED to enable improved access to specialist advice (EOA)<br>4. Equity for Māori in Wellington Emergency Department Project: a collaborative project between Wellington Regional Hospital ED and Māori Health Development Group to support a goal of being a pro-equity service that will meet the needs of Māori patients, whānau and staff (EOA)<br>5. Pilot Mental Health staff based in ED between 7am and 3.30pm, 7 days a week, to improve wait time for patients requiring mental health and addiction services who have present to the ED, and consider extending this service to 11pm based on outcomes of the pilot (EOA)</td><td rowspan="2">Milestone<br><br>1. SNOMED coding in Emergency Departments: Q2-Q4: Discuss with MOH<br>2. Patient flow: Q1-2: Roll out of daily discharge planning board rounds for selected services.<br>3. Patient Management to ED: Q2: CareFUL team reoriented to ED; Q4: Practices meet Year of Care Plans target<br>4. Equity for Māori in Wellington Emergency Department: Q1: Data analysis; Q1: Embed Tikanga practices; Q2: Develop new policies; Q3: Decrease in the number of Māori who leave after being triaged and before being seen by a doctor.<br>5. Improve wait times for mental health and addiction patients: Q1: Recruit to positions; Q3: analyse the impact on wait times and consider extending service</td><td rowspan="2">Measure<br><br>SS10</td><td colspan="2">Government theme<br><br>Improving the well-being of New Zealanders and their families</td></tr>
<tr><td>System outcome<br><br>We have improved quality of life<br><br>(health maintenance and independence)</td><td>Government priority outcome<br><br>Support healthier, safer and more connected communities</td></tr>
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| **Healthy Ageing** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. Continue to work with ACC, HQSC and the Ministry of Health to promote and increase enrolment in **strength and balance programmes** and improvement of osteoporosis management; Implementation and monitoring of the 3DHB Community Falls Management Programme<br>2. Ensure that local Service Specifications align to the vision, principles, core components, measures and outcomes of the national framework for **Home and Community Support Services (HCSS)**: CCDHBs service specifications and model of funding aligns with the National framework. CCDHB is in the process to transition to two providers of HCSS in 2019<br>3. Address the **drivers of acute demand** for people 75 plus presenting at ED: support early intervention and management of frail and pre-frail older people to stay well in the community (EOA)<br>4. **Pacific Neighbourhood Nurse Led Service** in Porirua to support Pacific individuals, families, and communities to manage their health needs in the context of complex life situations and circumstances (EOA)<br>5. Define and implement an integrated **Palliative care** model of care.<br>6. **Advance Care Planning** is trialled with Māori, Pacific Peoples and dementia groups to understand cultural influences, barriers and information implementing ACP with these groups (EOA) | **Milestone**<br>1. **Strength and Balance programmes:** Q1-Q4: Quarterly Reporting<br>2. **Home and Community Support Services:** Q1: Service Specs aligned<br>3. **Drivers of acute:** Q2: Service defined, Q4: Staff recruited<br>4. **Pacific Neighbourhood Nurse Led Service**: Q1-4: Quarterly Reporting<br>5. **Palliative care:** Q2: Model of care designed, Q3: Consultation<br>6. **Advance Care Planning**: Q4: Trials with Māori, Pacific Peoples and Dementia groups completed | **Measure**<br>SS04 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence)<br>**Government priority outcome**<br>Support healthier, safer and more connected communities<br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention)<br>**Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering | |

| **Improving Quality** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. **Atlas of Healthcare Variation – Gout**: Development and implementation of a project with community pharmacies in Porirua to measure urate levels and adjust medication dosage where appropriate to prevent Gout, with a focus on Māori and Pacific (EOA)<br>2. Improve **Patient Experience**: Support patient safety culture by improving the serious adverse events process, strengthen the Speaking Up for Safety programme, introduce restorative practice, update the open communication training, implementing the | **Milestone**<br>1. **Atlas of Healthcare Variation:** Q1: project initiated; Q2 initial assessment<br>2. **Patient Experience**: SLM reporting | **Measure**<br>SS05 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life<br>**Government priority outcome**<br>Support healthier, safer and more | |

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| Korero Mai - Whānau led escalation of deteriorating patient (see SLM Improvement Plan)<br>3. **System Level Measures**: please see SLM Improvement Plan<br>4. **Antimicrobial resistance - hospital**: Continue to comply with the New Zealand Antimicrobial Resistance Actions Plan. Activities for 2019/20 include:<br>(a) Continuous surveillance of both multidrug resistant organisms (MDRO) and hospital-associated cases of CDI,<br>(b) Update the policies for 'active screening for MDRO' and 'transmission based precautions'<br>(c) Hand hygiene (HH) auditing across all inpatient areas<br>(d) Antimicrobial stewardship (AMS) rounds, and<br>(e) Anti-infective use point prevalence surveys<br>5. **Antimicrobial resistance – residential care**: CCDHB will continue to support residential care providers to meet the Infection Control Standard (HDS (IPC) S.2008:3.1) through a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This will be through the implementation of an appropriate infection prevention and control (IPC) programme<br>6. **Antimicrobial resistance – primary care:** CCDHB will collaborate with PHOs regarding the support they provide to general practices to meet the Infection Control Standard (HDS (IPC) S.2008:3.1) through a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. | 3. **System Level Measures**: SLM reporting<br>4. **Antimicrobial resistance - hospital**: Q1-Q4: Continuous surveillance; Q1: Policies updated; Q2: HH auditing to include all inpatient areas; Q1: AMS rounds commenced; Q2 and Q4: surveys completed<br>5. **Antimicrobial resistance – residential care**: Q4: Audited facilities to comply with standards<br>6. **Antimicrobial resistance – primary care**: Q4: Audited facilities to comply with standards | | (health maintenance and independence)<br><br>**System outcome**<br>We have improved health equity<br>(healthy populations)<br><br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | connected communities<br><br>**Government priority outcome**<br>Make New Zealand the best place in the world to be a child<br><br>**Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

| **Cancer Services** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>CCDHB has a whole of service cancer improvement programme.<br>1. Achieve **Faster Cancer Treatment** target for all population groups (see Statement of Performance Expectations) (EOA)<br>2. Support **Regional Coordination** and improved access to cancer treatment by working with Wairarapa and Hutt Valley DHBs to review options for extended outreach services and services closer to home | **Milestone**<br>1. **Faster Cancer Treatment:** Q1-Q4: Targets achieved<br>2. **Regional Coordination**: Q2: Working with Wairarapa and Hutt Valley DHBs; Q4: Increase outreach treatment delivery to have services provided closer to home | **Measure**<br>SS01<br>SS11 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br><br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Support healthier, safer and more connected communities |

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| 3. Implement recommendations from **Cancer Model of Care Review** and establish work programme to support increased access to care, while reducing health disparities, integrating health care across our health system (EOA)<br>4. Progress further implementation of the **MOSAIQ oncology management system** at CCDHB, to provide improved patient safety with the utilisation of standardised prescribing protocols, quality checklists, etc. enhancing scheduling opportunities for outreach treatment delivery.<br>5. Work with the Ministry of Health to develop their **Cancer Plan,** and commence local actions from the Cancer Plan.<br>6. **Bowel Cancer Quality Improvement Report:** Maintain the current symptomatic colonoscopy performance ahead of the bowel screening (Care pathway recommendation) | 3. **Cancer Model of Care Review:** Q4: Enhance a tumour stream model of care<br>4. **MOSAIQ oncology management system**: Q1: Development of clinical protocols and business change; Q2: Commence rollout<br>5. **Cancer Plan**: Q4: Ministry Plan developed and actions commenced<br>6. **Bowel Cancer Quality Improvement Report:** Q1-Q4; maintain performance – quarterly reporting | | **System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

| **Bowel Screening** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>This section is contingent on CCDHB being formally advised of an implementation date in 2019/20:<br>1. CCDHB will continue to endeavour to ensure **colonoscopy wait time** indicators are consistently met; an increase in funding is proposed for 2019/20.<br>2. CCDHB will continue to endeavour to ensure **equitable access** throughout the screening pathway: investigate the provision of colonoscopy services at Kenepuru Community Hospital (to promote Māori and Pacific attendance). This facility will also enable CCDHB to reduce waiting lists and support screening once the National bowel screening programme commences - | **Milestone**<br>1. **Colonoscopy wait time:** Q1-4: Quarterly reporting<br>2. **Equitable access:** Q1-2: investigate service proposal Kenepuru | **Measure**<br>SS15 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

| **Workforce** | | | This is an equitable outcomes action (EOA) focus area |
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| **DHB activity** | **Milestone**<br>1. **DHB workforce priorities:** Q1-4: Quarterly reporting | **Measure**<br>*Annual plan* | **Government theme**<br>Improving the well-being of New Zealanders and their families |

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| Our professional heads collectively agree to the broader principles of the Annual Plan and are fully committed to achieving what is reasonably possible within current resources.<br>1. **DHB workforce priorities:** Workforce actions for 2019/20 include:<br>• Child Health: Develop a Midwifery Workforce Strategy (*see section 'Midwifery Workforce')*<br>• Mental Health: Implement the workforce improvement activities in the 2019/20 implementation plan for Living Life Well (see Inquiry into Mental Health and Addiction)<br>• Develop a pathway for increasing the number of Māori workforce across all areas of the organisation (EOA) (*see section 'Engagement and obligations as a Treaty partner'*)<br>• Develop a Pacific Workforce Development Plan to increase the capacity and capability of the Pacific health and disability workforce.<br>• In Quarter 1, report to the Ministry funding for professional development for nurse practitioners and an outline of the professional development package. If national benchmarking indicates an increase is required, the Office of the Chief Nursing Officer will facilitate the DHBs response.<br>• In Quarter 4, complete a stocktake of professional development packages for nurse practitioners with non-DHB employers.<br>• Promote the professional development package for DHB-employed nurse practitioners as a benchmark to support the development of the nurse practitioner workforce in the community (Q1-Q4)<br>2. **Taurite Ora – Māori workforce:** Develop an action plan to respond to workforce outcomes of Taurite Ora including; increase the proportion of Māori staff employed at CCDHB and increase the number of staff attending cultural competency training (EOA)<br>3. **Workforce diversity:** CCDHB will continue to work with DHB Shared Services to (EOA):<br>• identify and understand workforce data and intelligence to inform workforce planning<br>• upskill, provide education and train health workforces<br>• provide training placements and support transition to practice for eligible health workforce graduates and employees (including PGY1, PGY2 and CBA placements)<br>• form alliances with training bodies (educational institutes, professional colleges, responsible authorities, and other professional societies) | 2. **Taurite Ora – Māori workforce**: Q4: report the proportion of Māori staff employed at CCDHB and the number of staff attending cultural competency training<br>3. **Workforce diversity:** Q1-Q4: Work with DHB Shared Services<br>4. **Health literacy:** Q4: Health Literacy Plan developed<br>5. **Strengthen clinical leadership:** Q1-Q4: Programmes to improve clinical leadership implemented<br>6. **Inter-professional Workforce Plan:** Q4: Plan developed<br>7. **Cultural competence:** Q4: Report number of staff who have undertaken cultural competency training<br>8. **Values:** Q1: Values workshops completed; Q2: Values identified; Q3-Q4: Implement values<br>9. **Strategy for diversity:** Q4: Strategy developed<br>10. **Supporting Safety Culture:** Q1-Q4: implement outstanding actions and review programme and identify priorities for year 3 | *actions – status update reports* | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence)<br><br>**System outcome**<br>We have improved health equity<br>(healthy populations)<br><br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Support healthier, safer and more connected communities<br><br>**Government priority outcome**<br>Make New Zealand the best place in the world to be a child<br><br>**Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

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| 4. **Health literacy:** workforce actions for 2019/20 include:<br>• Develop a Health Literacy Plan focused on supporting our workforce to develop effective health literacy practices and our workforces' development and capacity needs<br>5. **Strengthen clinical leadership,** actions for 2019/20 include:<br>• Develop a Leadership Series for Allied Health, Scientific and Technical and Nursing leadership to support the development plans for these workforces.<br>• Develop a Leaders as Coaches programme with relevant courses, online learning and simulation exercises.<br>• Complement our existing Frontline Leadership, Emerging Leaders and Manage Well programmes with a Clinical Leadership programme and refreshed Orientation.<br>6. Develop an **Inter-professional Workforce Plan**, which includes addressing vulnerable workforces and future workforce needs<br>7. Build **cultural competence** across health workforce<br>• Provide cultural competency training opportunities for all staff including Tikanga training, Te Tohu Whakawaiora and Te Reo classes (EOA) (*see section 'Engagement and obligations as a Treaty partner'*)<br>8. Confirm and launch the organisation's revised **values** based behaviours and support application of the new values across teams. Embed values in CCDHB's systems, processes, policies and activities.<br>9. Development a **strategy for diversity** and inclusion, identity and belonging.<br>10. **Supporting Safety Culture:**<br>• Introduce and develop restorative ways of working to respond to harm to patients or staff<br>• Connect Speaking up for Safety with the DHB's Values work programme to embed both across the organisation<br>• Conduct a follow Safety Attitudes questionnaire to assess the effectiveness of the Supporting Safety Culture programme<br>• Review the Supporting Safety Culture programme and identify priorities for the third year of the programme in 2020/21. | | | | |

| **Data and Digital** | | | This is an equitable outcomes action (EOA) focus area |
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| **DHB activity** | **Milestone** | **Measure** | **Government theme** |

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| 1. Improving **equity** through digital systems/investments (EOA):<br>a. Complete business case for multilingual versions of an electronic Patient Experience Survey<br>b. Progress work to set up a Pacific Health Cultural Assessment tool on MAP and the ability to share with clinicians involve in the care of Pacific patients<br>c. Pilot electronic referrals from hospital services (including Emergency Department) to community providers.<br>d. Make the Māori keyboard (including ability to add macrons) the standard profile<br>e. Extending free patient Wi-Fi to the outpatients<br>f. Improving access to data and analytical report for Māori & Pacific services<br>g. Implement electronic Health Passport for Disabilities | 1. **Equity:**<br>(a) Q3: Business case implemented;<br>(b) Q2: Implemented<br>(c) Q4: Pilot for referrals to asthma educators implemented<br>(d) Q1: Implemented<br>(e) Q2: Implemented<br>(f) Q4: Implemented<br>(g) Q3: Implemented | *Annual plan actions – status update reports* | Improving the well-being of New Zealanders and their families | |
| 2. Leveraging approved **standards and architecture**<br>a. Complete a Security Improvement Work Plan for 2019-21 based on the findings of the independent review against the Health Information Security Framework<br>b. Complete the Allied Health Activity Capture project to improve the Allied Health service's ability to meet data standards.<br>c. Discuss with the Ministry the resourcing requirements and constraints for CCDHB to implement SNOMED coding in the Emergency Department by 2021.<br>d. Implement a FHIR (Fast Health Interoperability Resources Standard). | 2. **Standards and Architecture:**<br>(a) Q1: Plan completed<br>(b) Q1: Implemented<br>(c) Q2-Q4: Discuss with MOH<br>(d) Q1: Implemented | | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Support healthier, safer and more connected communities |
| 3. Supporting **new models of health care delivery** through technology<br>a. Implement a Shared Care Plan function in Indici.<br>b. Extend use of Zoom to other services to support new models of care including telehealth and multi-disciplinary meetings | 3. **New Models of Health Care Delivery:**<br>(a) Q1: Implemented<br>(b) Q4: Progressed | | | |
| 4. Leveraging **Regional and National Initiatives**<br>a. Complete transition to the Regional Radiology Information System<br>b. Regional Clinical Portal – Complete the replication of data from local Clinical Data Repositories into the Regional Clinical Data Repository<br>c. National Bowel Screening – Transition onto the National Bowel Screening Platform | 4. **Regional and National Initiatives:**<br>(a) Q2: Implemented<br>(b) Q2: Completed<br>(c) Q2: Transitioned | | | |

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| 5. Implementing **Application Portfolio Management**<br>a. Long Term Investment Plan – complete an Asset Management Plan for information, communications and technology assets | 5. **Application Portfolio Management:**<br>Q2: Completed | | | |
| 6. **Mobile ePatient Observations (MEPO)**:<br>a. Complete implementation business case for Mobile ePatient Observations | 6. **MEPO:** Q1: Implementation business case completed | | | |
| 7. **eMedication** Management<br>a. Link NZePS data to discharge documentation and improve discharge information to include medication on admission, on discharge and record changes with reasons<br>b. Implement a new ePrescribing solution for Addiction Services with connection to NZePS<br>c. Complete a Request for Proposals (RFP) of a hospital ePrescribing and administration system<br>d. Complete implementation business case for a hospital ePrescribing and administration system | 7. **eMedication:**<br>(a) Q4: Implementation<br>(b) Q4: Implementation<br>(c) Q2: RFP completed<br>(d) Q4: Implementation business case completed | | | |
| 8. **Cath Lab System**: Complete implementation of a replacement Cath Lab system | 8. **Cath Lab System:**<br>Q2: Implementation completed | | | |
| 9. **Medical Oncology System**: Complete implementation of a replacement Medical Oncology system | 9. **Medical Oncology System:**<br>Q2: Implementation completed | | | |

## Collective Improvement Programme

This is an equitable outcomes action (EOA) focus area

| **DHB activity** | **Milestone** | **Measure** | **Government theme** | |
|---|---|---|---|---|
| 1. The DHB will engage in **collective improvement work** as this develops. | **1. Collective improvement work:**<br>Q1-Q4: Engagement as required | SS02 | Improving the well-being of New Zealanders and their families | |
| | | | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Support healthier, safer and more connected communities |

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| | | | **System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

| **Delivery of Regional Service Plan (RSP) priorities** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>CCDHB will support the region to deliver the RSP:<br>1. Support work in our region's identified **priority areas** (Cancer, Cardiac, Radiology, and Regional Care Arrangements)<br>2. CCDHB will support work in the region to implement the New Zealand Framework for **Dementia Care**. We will provide input into the regional stocktake by:<br>- reviewing and commenting on draft questions;<br>- connecting stakeholders/providers into the regional stocktake; and,<br>- work with our regional partners to identify priority areas to progress implementation of the Framework within the Central Region.<br>3. **Hepatitis C**:<br>• Work in collaboration with other DHBs to implement the Hepatitis C clinical pathway<br>• Work in an integrated way to increase access to care and promote primary care to manage patients prescribing of the new pangenotypic Hepatitis C treatments. Encourage primary care to manage the patients with Hepatitis C particularly with respect to the use of the new pangenotypic hepatitis C medications<br>• Support primary care to identify patients with one or more Hepatitis C risk factors and to test them for the presence of hepatitis C antibodies<br>• support providers to actively work with services, such as needle exchange clinics and other acute setting, to educate and if necessary test at-risk clients | **Milestone**<br>1. **Priority areas:** Q1-Q4: Quarterly report on milestones<br>2. **Dementia care**: Q1-Q4: Quarterly report on milestones<br>3. **Hepatitis C**: Q1-Q4: Quarterly report on milestones | **Measure**<br>SS02 | **Government theme**<br>Improving the well-being of New Zealanders and their families | |
| | | | **System outcome**<br>We have improved quality of life<br>(health maintenance and independence) | **Government priority outcome**<br>Support healthier, safer and more connected communities |
| | | | **System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

## 2.3.4 Better population health outcomes supported by primary health care

**Primary health care is a priority work programme for Government, the Ministry of Health and District Health Boards.**

**An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase use of illness-preventing behaviours and treatments, and thereby increase people's ability to participate in work and education.**

**Primary health care is earlier, safer, cheaper, and better connected to people's daily routines. However, the primary health care system does not serve all people equitably. Some people are avoiding or delaying engaging with primary care services because of cost. There is also the potential for a different primary care model to better suit people's lives and better integrate across health disciplines and facilities, thereby improving health outcomes.**

<table>
<tr><td colspan="3">Primary health care integration</td><td colspan="2">This is an equitable outcomes action (EOA) focus area</td></tr>
<tr><td rowspan="4">DHB activity<br><br>CCDHB's Alliance Leadership Team is known as the Integrated Care Collaborative (ICC). The ICC is a board of decision makers from a range of organisations across the health system who, through their own organisations, give effect to the decisions made by the Alliance and achieve the ICC's purpose as outlined in the Alliance Charter. Linkages are maintained with the DHB's Health System Committee, PHO Clinical Quality Board and Primary/Secondary Clinical Governance Group. Service Level Alliance Teams carry out the ICC's work programme and report to the Alliance on a bi-monthly basis. A dedicated Integrated Care team in the Planning & Funding Directorate supports the ICC and Service Level Alliance Teams work programmes.<br><br>1. CCDHB will continue to strengthen the Alliance relationships, broaden membership and develop services based on robust data and analytics (EOA)<br>2. Implement the CCDHB Māori enrolment in primary care action plan (EOA)<br>3. CCDHB is focused on improving Māori enrolment in primary care, particularly young people in Porirua where the most significant gap is identified (EOA)<br>4. The SLM Improvement Plan has a strong equity focus – the plan will identify equity targets and actions to improve health outcomes for those populations (EOA)<br>5. Primary health care workforce: Expanding the skills and workforce participating in proactive and acute care in partnership with Health Care Homes.<br>6. Give effect to the System Level Measures Improvement Plan, which has a focus on improving access to primary care services for high needs patients (EOA).</td><td rowspan="4">Milestone<br><br>1. Strengthen alliance relationships: Q1-4: SLM Reporting<br>2. Māori enrolment in primary care: Q2: Action plan implemented<br>3. Māori enrolment in primary care: Q2 and Q4: 90% target<br>4. Equity focus: Q2: Action Plan Developed<br>5. Primary health care workforce: Q1-Q4: Monitor skills mix in Health Care Homes.<br>6. SLM Plan: Q1-Q4: Monitor actions from the SLM Plan</td><td rowspan="4">Measure<br><br>PH01<br>PH03</td><td colspan="2">Government theme<br><br>Improving the well-being of New Zealanders and their families</td></tr>
<tr><td>System outcome<br><br>We have improved quality of life<br><br>(health maintenance and independence)</td><td>Government priority outcome<br><br>Support healthier, safer and more connected communities</td></tr>
<tr><td>System outcome<br><br>We have improved health equity<br><br>(healthy populations)</td><td>Government priority outcome<br><br>Make New Zealand the best place in the world to be a child</td></tr>
<tr><td>System outcome<br><br>We live longer in good health<br><br>(prevention and early intervention)</td><td>Government priority outcome<br><br>Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
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| **Pharmacy** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. Continue to support the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA) and prioritise local need and support **equitable health outcomes**: the major focus of new Pharmacy investment within CCDHB through Community Pharmacies, and of Pharmacy Facilitation services, will be activities in areas of both high deprivation and high Māori and Pacifica populations. Specifically:<br>a. Community Pharmacy based Gout management services in selected Porirua Pharmacies. We will invest in community pharmacies with high Māori and Pacifica populations to support the population with high number of Gout sufferers (Māori and Pacific) (EOA)<br>b. Community Pharmacy ECP service with funding to be based on pharmacies whose clients have high rates of teenage pregnancies: review current Pharmacy Facilitation Service<br>2. Continue to support Pharmacies to deliver **immunisation**. Use web based publicity and signage within the community to inform the public about subsidised immunisation.<br>3. Review **CPAMS service**: Develop and use new criteria focusing on equity to select pharmacies to provide this service (funding will be within baseline pharmacy budget). Equity for Māori and Pacific Peoples will be a consideration when contracting these services (EOA)<br>4. Support the work to enable the separation of dispensing into separate **ICPSA** schedules (medicine and supply and clinical advice) by June 2020 | **Milestone**<br>1. **Equitable health outcomes:**<br>(a) Q2: service established;<br>(b) Q1: service reviewed<br>2. **Immunisation:** Q1: Publicity material released<br>3. **CPAMS service:** Q2: Review performance; Q3: New contracts issued<br>4. **ICPSA:** Q4: Separate ICPSA schedules | **Measure**<br>*Annual plan actions – status update reports* | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life<br>(health maintenance and independence)<br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | **Government priority outcome**<br>Support healthier, safer and more connected communities<br>**Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

| **Diabetes and other long-term conditions** | | | This is an equitable outcomes action (EOA) focus area | |
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| **DHB activity**<br>1. The DHB and Primary Care will support the development of an integrated programme of support for people to **live healthy lifestyles** through behavioural change support, health coaches and health improvement practitioners. (EOA)<br>2. The DHB will assess equitable access to and outcomes from culturally appropriate **self-management education and support services** as part of the Q2 2019/20 self- | **Milestone**<br>1. **Live healthy lifestyles:** Q2 & Q4 report on implementation status and people served.<br>2. **Self-management education and support services:** Q2: self- | **Measure**<br>SS13 | **Government theme**<br>Improving the well-being of New Zealanders and their families<br>**System outcome**<br>We have improved quality of life | **Government priority outcome** |

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| assessment against the Quality Standards for Diabetes Care. Identified gaps will be remedied in Q4 in partnership with our PHOs who deliver the self-management education (EOA)<br>3. Our Diabetes Clinical Network will use **practice level data** to identify inequitable service provision and inform quality improvement initiatives (EOA)<br>4. The DHB will support improved outcomes for people diagnosed with **type 2 diabetes** at a young age (with a focus on Māori and Pacific Peoples aged 25-39 years) by tailoring interventions for young people and their families. Report on the success of targeted initiatives (EOA)<br>5. The DHB will work with PHOs to ensure that best practice is shared across general practices from those producing the best and most equitable health outcomes from early risk assessment and risk factor management efforts for people with high and moderate **cardiovascular risk** (EOA) | assessment; Q4: plan developed to address gaps identified from self-assessment<br>3. **Practice level data:** Q2 & Q4: Report on initiatives and how these are being implemented<br>4. **Type 2 diabetes:** Q4: Reduce the number of Māori and Pacific young people with an HBA1C greater than 64mmol/mol by 4%<br>5. **Cardiovascular risk:** Q4: Increase the number of people with high cardiovascular risk who have had an annual review. | | (health maintenance and independence)<br><br>**System outcome**<br>We live longer in good health<br>(prevention and early intervention) | Support healthier, safer and more connected communities<br><br>**Government priority outcome**<br>Ensure everyone who is able to, is earning, learning, caring or volunteering |

## 2.4 Financial performance summary

The prospective planned result for Capital and Coast DHB 2019/20 annual plan is a deficit of $15.9 million. The actual result for 2018/19 is a deficit of $96.4m. This includes a provision for a Holiday Act pay-out of $67m plus a write-off of $6m for impairment of investment in the National Oracle System.

**CCDHB Summary Financial Table**

| Capital & Coast DHB<br>Annual Plan Budget for the Four Years ending 30 June 2023 | 2017/18<br>$'M | 2018/19<br>$'M | 2019/20<br>$'M | 2020/21<br>$'M | 2021/22<br>$'M | 2022/23<br>$'M |
|---|---|---|---|---|---|---|
| Funding (excluding IDF inflows below) | 873.3 | 934.3 | 967.6 | 1,054.6 | 1,040.0 | 1,076.7 |
| Services provided for Other DHBs (IDF Inflows) | 218.2 | 227.3 | 242.2 | 251.9 | 262.0 | 272.5 |
| **Total Funding** | **1,091.4** | **1,161.6** | **1,209.8** | **1,306.5** | **1,301.9** | **1,349.2** |
| DHB Provider Arm | 736.9 | 860.2 | 806.5 | 833.3 | 857.9 | 891.9 |
| Funder Arm | 266.7 | 288.6 | 304.1 | 313.3 | 322.7 | 332.3 |
| Governance Arm | 9.6 | 11.0 | 12.0 | 11.7 | 12.0 | 12.3 |
| Services Purchased from Other DHBs (IDF Outflows) | 96.4 | 98.1 | 103.1 | 106.2 | 109.3 | 112.6 |
| **Total Allocated** | **1,109.7** | **1,258.0** | **1,225.7** | **1,264.5** | **1,302.0** | **1,349.2** |
| **Surplus / (Deficit)** | **(18.2)** | **(96.4)** | **(15.9)** | **42.0** | **(0.0)** | **0.0** |

| Capital & Coast DHB<br>Statement of Comprehensive Income & Expenditure Budget for the Four Years ending 30 June 2023 | Actual 2017/18 (000s) | Actual 2018/19 * (000s) | Plan 2019/20 ** (000s) | Plan 2020/21** (000s) | Plan 2021/22 (000s) | Plan 2022/23 (000s) |
|---|---|---|---|---|---|---|
| **REVENUE** | | | | | | |
| Government and Crown Agency Sourced | 1,059,652 | 1,124,508 | 1,176,971 | 1,222,401 | 1,266,591 | 1,312,461 |
| Patient / Consumer Sourced | 5,245 | 5,238 | 4,966 | 5,165 | 5,372 | 5,586 |
| Other Income | 26,529 | 31,874 | 27,861 | 78,904 | 29,987 | 31,111 |
| **TOTAL REVENUE** | **1,091,425** | **1,161,621** | **1,209,799** | **1,306,471** | **1,301,950** | **1,349,159** |
| **OPERATING COSTS** | | | | | | |
| *Personnel Costs* | | | | | | |
| Medical Staff | 150,607 | 187,670 | 170,050 | 175,151 | 178,406 | 182,432 |
| Nursing Staff | 193,129 | 238,301 | 217,226 | 223,796 | 227,856 | 231,230 |
| Allied Health Staff | 55,602 | 63,990 | 62,609 | 64,371 | 66,302 | 68,291 |
| Support Staff | 7,903 | 10,930 | 10,145 | 10,434 | 10,747 | 11,070 |
| Management / Administration Staff | 60,531 | 72,008 | 78,165 | 79,548 | 81,873 | 84,265 |
| **Total Personnel Costs** | **467,771** | **572,898** | **538,194** | **553,301** | **565,184** | **577,288** |
| *Clinical Costs* | | | | | | |
| Outsourced Services | 25,808 | 24,601 | 22,493 | 23,808 | 24,586 | 25,389 |
| Clinical Supplies | 123,130 | 130,291 | 129,210 | 133,070 | 137,063 | 141,174 |
| **Total Clinical Costs** | **148,938** | **154,891** | **151,702** | **156,878** | **161,649** | **166,563** |
| *Other Operating Costs* | | | | | | |
| Hotel Services, Laundry & Cleaning | 19,171 | 23,809 | 23,160 | 23,854 | 24,570 | 25,307 |
| Facilities | 40,597 | 43,401 | 43,731 | 45,043 | 46,394 | 47,786 |
| Transport | 2,995 | 3,157 | 3,055 | 3,147 | 3,241 | 3,338 |
| IT Systems & Telecommunications | 12,435 | 13,454 | 13,797 | 14,211 | 14,638 | 15,077 |
| Interest & Financing Charges | 24,414 | 29,850 | 26,332 | 27,121 | 27,935 | 28,773 |
| Professional Fees & Expenses | 7,897 | 7,258 | 7,159 | 2,663 | 2,742 | 2,825 |
| Other Operating Expenses | 11,308 | 10,886 | (1,169) | 7,152 | 11,629 | 24,980 |
| Democracy | 397 | 432 | 1,038 | 480 | 493 | 505 |
| Provider Payments | 363,159 | 386,765 | 407,202 | 419,418 | 432,001 | 444,961 |
| Recharges | 10,578 | 11,193 | 11,498 | 11,202 | 11,474 | 11,753 |
| **Total Other Operating Costs** | **492,951** | **530,204** | **535,803** | **554,291** | **575,117** | **605,307** |
| **TOTAL COSTS** | **1,109,661** | **1,257,994** | **1,225,699** | **1,264,471** | **1,301,950** | **1,349,159** |
| **NET SURPLUS / (DEFICIT)** | **(18,236)** | **(96,373)** | **(15,900)** | **42,000** | **0** | **0** |
| ***Asset Revaluation (Equity movement - IRFS requirement) | 113,105 | (5,350) | - | - | - | - |
| **TOTAL COMPREHENSIVE INCOME SURPLUS/(DEFICIT)** | **94,869** | **(101,723)** | **(15,900)** | **42,000** | **0** | **0** |

* Please note that the 2018/19 Actual includes adjustments for year end provisions i.e. Holidays Act and write offs.

** Please note that final agreement of the 2019/20 Plan is pending. Plan for 2020/21 includes a donation of $50m from benefactor towards the Children's Hospital

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

## Capital & Coast DHB
### Statement of Financial Position
### Budget for the Four Years ending 30 June 2023

| | Actual 2017/18 (000s) | Actual 2018/19 (000s) | Plan 2019/20 (000s) | Plan 2020/21 (000s) | Plan 2021/22 (000s) | Plan 2022/23 (000s) |
|---|---|---|---|---|---|---|
| **Non Current Assets** | | | | | | |
| Land | 41,165 | 41,165 | 41,165 | 41,165 | 41,165 | 41,165 |
| Buildings | 474,112 | 447,637 | 451,729 | 477,006 | 462,895 | 448,008 |
| Clinical Equipment | 26,550 | 33,611 | 50,184 | 68,477 | 86,565 | 104,440 |
| Information Technology | 11,208 | 14,921 | 18,879 | 22,881 | 26,795 | 30,617 |
| Work in Progress | 30,092 | 42,115 | 42,145 | 44,198 | 44,198 | 44,198 |
| Other Fixed Assets | 9,333 | 4,374 | 5,385 | 6,572 | 7,701 | 8,771 |
| Total Non Current Assets | 592,460 | 583,823 | 609,486 | 660,299 | 669,319 | 677,199 |
| Current Assets | | | | | | |
| Cash | 17,602 | 33 | 33 | 33 | 33 | 33 |
| Trust/Investments | 9,693 | 10,754 | 10,754 | 10,754 | 10,754 | 10,754 |
| Prepayments | 3,075 | 4,197 | 4,197 | 4,197 | 4,197 | 4,197 |
| Accounts Receivable | 43,580 | 58,394 | 51,217 | 51,217 | 51,217 | 51,217 |
| Inventories | 8,067 | 9,046 | 9,046 | 9,046 | 9,046 | 9,046 |
| Other Current Assets | 5,610 | (6,528) | - | 2 | 2 | 2 |
| Total Current Assets | 87,628 | 75,896 | 75,247 | 75,249 | 75,249 | 75,249 |
| Current Liabilities | | | | | | |
| Bank overdraft | - | 2,704 | 17,188 | 45,118 | 57,413 | 68,560 |
| Payables & Accruals | 148,505 | 215,766 | 219,093 | 195,461 | 195,670 | 195,889 |
| GST & Tax Provisions | 9,351 | 9,642 | 9,642 | 9,642 | 9,642 | 9,642 |
| Current Private Sector Debt | 247 | 55 | 55 | 55 | 55 | 55 |
| Total Current Liabilities | 158,104 | 228,167 | 245,978 | 250,276 | 262,779 | 274,145 |
| Net Current Assets | (70,476) | (152,271) | (170,731) | (175,027) | (187,530) | (198,896) |
| **NET FUNDS EMPLOYED** | **521,984** | **431,552** | **438,756** | **485,272** | **481,788** | **478,303** |
| Term Liabilities | | | | | | |
| Non Current Crown Debt - CHFA | 55 | - | - | - | - | - |
| Restricted & Trust Funds Liability | 9,746 | 72 | 10,760 | 10,760 | 10,760 | 10,760 |
| Non Current Provisions & Payables Personnel | 6,247 | 6,958 | 6,958 | 6,958 | 6,958 | 6,958 |
| Total Term Liabilities | 16,048 | 7,029 | 17,717 | 17,717 | 17,717 | 17,717 |
| **Net Assets** | **505,936** | **424,522** | **421,038** | **467,555** | **464,072** | **460,586** |
| **General Funds** | | | | | | |
| Crown Equity | 765,362 | 774,716 | 797,780 | 802,296 | 788,124 | 784,640 |
| Revaluation Reserve | 136,711 | 131,361 | 131,361 | 131,361 | 131,361 | 131,361 |
| Trust & special funds no restriction | (307) | 10,648 | - | - | - | - |
| *Retained Earnings* | | | | | | |
| Retained Earnings - DHB | (395,830) | (492,203) | (508,103) | (466,101) | (455,413) | (455,414) |
| Total Retained earnings | (395,830) | (492,203) | (508,103) | (466,101) | (455,413) | (455,414) |
| Total General Funds | 505,936 | 424,522 | 421,038 | 467,555 | 464,072 | 460,586 |
| **NET FUNDS EMPLOYED** | **521,984** | **431,552** | **438,756** | **485,272** | **481,788** | **478,303** |

## Prospective Cash Flow

| **Capital & Coast DHB**<br>**Statement of Cashflows**<br>**Budget for the Four Years ending 30 June 2023** | **Actual 2017/18 (000s)** | **Actual 2018/19 (000s)** | **Plan 2019/20 (000s)** | **Plan 2020/21 (000s)** | **Plan 2021/22 (000s)** | **Plan 2022/23 (000s)** |
|---|---|---|---|---|---|---|
| **Operating Activities** | | | | | | |
| Government & Crown Agency Revenue Receiv | 1,066,677 | 1,139,635 | 1,239,635 | 1,286,635 | 1,335,635 | 1,386,635 |
| All Other Revenue Received | 15,512 | 19,299 | 19,989 | 19,989 | 19,989 | 19,989 |
| **Total Receipts** | **1,082,189** | **1,158,934** | **1,259,623** | **1,306,623** | **1,355,623** | **1,406,623** |
| Payments for Personnel | (453,548) | (501,958) | (545,758) | (562,758) | (579,758) | (596,758) |
| Payments for Supplies | (195,516) | (200,849) | (227,511) | (250,357) | (244,922) | (263,973) |
| Capital Charge | (24,373) | (29,805) | (29,805) | (30,505) | (31,305) | (32,105) |
| GST (net) | (1,535) | (2,244) | (2,244) | (2,244) | (2,244) | (2,244) |
| Other Payments | (378,368) | (415,453) | (435,453) | (447,453) | (460,453) | (473,453) |
| **Total Payments** | **(1,053,340)** | **(1,150,309)** | **(1,240,771)** | **(1,293,317)** | **(1,318,682)** | **(1,368,533)** |
| **Net Cashflow from Operating** | **28,849** | **8,625** | **18,852** | **13,306** | **36,941** | **38,090** |
| **Investing Activities** | | | | | | |
| Interest Receipts from 3rd Party | 1,557 | 1,204 | 1,248 | 1,248 | 1,248 | 1,248 |
| | **1,557** | **1,204** | **1,248** | **1,248** | **1,248** | **1,248** |
| **Capital Expenditure** | | | | | | |
| Land, Buildings & Plant | (11,436) | (18,139) | (11,777) | (11,777) | (11,777) | (11,777) |
| Clinical Equipment | (7,122) | (13,152) | (25,159) | (25,159) | (25,159) | (25,159) |
| Other Equipment | (3,191) | (3,979) | (3,103) | (3,103) | (3,103) | (3,103) |
| Informations Technology | (4,778) | (4,142) | (6,961) | (6,961) | (6,961) | (6,961) |
| **Total Capital Expenditure** | **(26,528)** | **(39,412)** | **(47,000)** | **(47,000)** | **(47,000)** | **(47,000)** |
| **Increase in other Investments** | (1,584) | - | - | - | - | - |
| **Net Cashflow from Investing** | **(26,555)** | **(38,208)** | **(45,752)** | **(45,752)** | **(45,752)** | **(45,752)** |
| **Financing Activities** | | | | | | |
| Deficit Support | - | 14,100 | 15,900 | 8,000 | - | - |
| Other Financing Activities | (3,810) | (3,730) | (3,484) | (3,484) | (3,484) | (3,485) |
| **Total Financing Activities** | **(3,810)** | **10,370** | **12,416** | **4,516** | **(3,484)** | **(3,485)** |
| Net Cashflow | (1,516) | (19,214) | (14,484) | (27,931) | (12,294) | (11,147) |
| Plus: Opening Cash | 28,812 | 27,296 | 8,083 | (6,401) | (34,332) | (46,626) |
| **Closing Cash** | **27,296** | **8,083** | **(6,401)** | **(34,332)** | **(46,626)** | **(57,773)** |
| Closing Cash comprises: | | | | | | |
| Balance Sheet Cash | 27,296 | 10,787 | 10,787 | 10,787 | 10,787 | 10,787 |
| Balance Sheet Operating Overdraft | - | (2,704) | (17,188) | (45,118) | (57,413) | (68,560) |
| **Total Cashflow Cash (Closing)** | **27,296** | **8,083** | **(6,401)** | **(34,332)** | **(46,626)** | **(57,773)** |

## Prospective Output Class Financials

| Capital & Coast DHB<br>Statement of Objectives and service performance<br>Budget for the Year Ending 30 June 2020<br>Statement of revenue and expenses by output class | Prevention<br>(000s) | Early Detection and Management<br>(000s) | Intensive Assessment and Treatment<br>(000s) | Rehabilitation and Support<br>(000s) | Total DHB<br>(000s) |
|---|---|---|---|---|---|
| **REVENUE** | | | | | |
| Crown | 12,754 | 265,031 | 770,775 | 128,411 | **1,176,971** |
| Other | - | - | 32,828 | | **32,828** |
| **Total Revenue** | **12,754** | **265,031** | **803,603** | **128,411** | **1,209,799** |
| **EXPENDITURE** | | | | | |
| Personnel | 200 | 3,769 | 532,209 | 2,017 | **538,194** |
| Depreciation | | | 36,000 | | **36,000** |
| Capital charge | | | 26,281 | | **26,281** |
| Provider Payments | 11,103 | 218,965 | 96,405 | 105,714 | **432,187** |
| Other | 1,452 | 42,297 | 128,608 | 20,680 | **193,037** |
| **Total Expenditure** | **12,754** | **265,031** | **819,503** | **128,411** | **1,225,699** |
| **Net Surplus/(Deficit)** | **-** | **-** | **(15,900)** | **-** | **(15,900)** |

| Capital & Coast DHB<br>Statement of Objectives and service performance<br>Budget for the Year Ending 30 June 2021<br>Statement of revenue and expenses by output class | Prevention<br>(000s) | Early Detection and Management<br>(000s) | Intensive Assessment and Treatment<br>(000s) | Rehabilitation and Support<br>(000s) | Total DHB<br>(000s) |
|---|---|---|---|---|---|
| **REVENUE** | | | | | |
| Crown | 13,011 | 270,776 | 807,410 | 131,204 | **1,222,401** |
| Other | - | - | 84,069 | - | **84,069** |
| **Total Revenue** | **13,011** | **270,776** | **891,480** | **131,204** | **1,306,471** |
| **EXPENDITURE** | | | | | |
| Personnel | 177 | 3,343 | 547,992 | 1,789 | **553,301** |
| Depreciation | | | 37,080 | | **37,080** |
| Capital charge | | | 27,069 | | **27,069** |
| Provider Payments | 11,403 | 224,882 | 96,967 | 108,571 | **441,823** |
| Other | 1,625 | 46,253 | 134,716 | 22,605 | **205,199** |
| **Total Expenditure** | **13,206** | **274,477** | **843,824** | **132,964** | **1,264,471** |
| **Net Surplus/(Deficit)** | **(195)** | **(3,702)** | **47,656** | **(1,760)** | **42,000** |

| Capital & Coast DHB<br>Statement of Objectives and service performance<br>Budget for the Year Ending 30 June 2022<br>Statement of revenue and expenses by output class | Prevention<br>(000s) | Early Detection and Management<br>(000s) | Intensive Assessment and Treatment<br>(000s) | Rehabilitation and Support<br>(000s) | Total DHB<br>(000s) |
|---|---|---|---|---|---|
| **REVENUE** | | | | | |
| Crown | 13,481 | 280,565 | 836,598 | 135,947 | **1,266,591** |
| Other | - | - | 35,359 | - | **35,359** |
| **Total Revenue** | **13,481** | **280,565** | **871,957** | **135,947** | **1,301,950** |
| **EXPENDITURE** | | | | | |
| Personnel | 181 | 3,410 | 559,769 | 1,825 | **565,183** |
| Depreciation | | | 38,193 | | **38,193** |
| Capital charge | | | 27,881 | | **27,881** |
| Provider Payments | 11,896 | 234,891 | 94,753 | 113,412 | **454,952** |
| Other | 1,658 | 47,178 | 143,849 | 23,057 | **215,741** |
| **Total Expenditure** | **13,734** | **285,478** | **864,444** | **138,294** | **1,301,950** |
| **Net Surplus/(Deficit)** | **(253)** | **(4,914)** | **7,513** | **(2,346)** | **(0)** |

# 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 $42 million per annum is planned for 2019/20

## 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 2019/20 is $42 million. CAPEX is required to be funded internally.

## Equity Drawing

Additional deficit support may be requested for the 2019/20 financial year.

## Working Capital

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

## Gearing and Financial Covenants

No gearing or financial covenants are in place.

## Asset Revaluation

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

## Strategy for disposing of assets

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

## Disposal of Land

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

# SECTION THREE: Service Configuration

## 3.1 Service Coverage

All DHBs are required to deliver a minimum of services, as defined in the Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually. Responsibility for service coverage is shared between DHBs and the Ministry.

DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific Peoples and high-needs groups.

CCDHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services. CCDHB is not seeking any formal exemptions to the Service Coverage Schedule in 2019/20.

## 3.2 Service Change

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

### Summary of Service Changes for 2019/20

| Change | Description of Change | Benefits of Change | Change for local, regional or national reasons |
|---|---|---|---|
| **He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction** | In 2018, the He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction and also a local Wairarapa Mental Health and Addictions Service Review were completed. In light of these two reports, the DHB will plan for service development which aligns with the reports in partnership with our stakeholders and service providers. This may result in commissioning a different range of services to that which is currently funded. It may also result in the termination of some current agreements to allow the commissioning of best practice model-of-care services that support optimal population health outcomes. | Improved health outcomes<br>Improved patient experience<br>Improved responsiveness to Māori health<br>Strengthened clinical and operational partnership<br>Value for money | National |
| **Vascular Service** | We will be implementing non-contact First Specialist Assessment and Follow Up outpatient clinics | Easier access for patients particularly from outside Wellington. Less travel, expense of travel. | Regional |
| **Ophthalmology service** | Implementation of national age-related macular degeneration (AMD) and glaucoma referral guidelines | Nationally consistent acceptance criteria, consistent timeframes for review and follow up | Sub-regional |
| **Renal Services** | We will explore how CCDHB might better meet the needs of the Hutt Valley DHB community by exploring a dialysis unit in Hutt Valley DHB. | Improved access, reduced cost, improvement of patients on long term dialysis. | Sub-regional |

| Change | Description of Change | Benefits of Change | Change for local, regional or national reasons |
|---|---|---|---|
| **Community Pharmacist Services** | Implement Hutt Valley DHB's Pharmacists Services Strategy, which includes reviewing the Long Term Condition service provided by pharmacists, and the commissioning of pharmacist services to aged residential care. | More integration across the primary care team<br>Improved access to pharmacist services<br>Consumer empowerment<br>Safe supply of medicines to the consumer<br>Improved support for at-risk populations<br>More use of pharmacists as a first point of contact within primary care. | Sub-regional |
| **Inpatient mental health services models of care** | Following significant issues with the physical space of our Te Whare Ahuru mental health inpatient unit, Hutt Valley has embarked on a strategic assessment and single stage business case to consider facility options. | Improved health outcomes<br>Improved patient experience<br>Improved responsiveness to Māori health | Sub-regional |
| **Acute mental health services and alcohol and other drug treatment services** | Wairarapa, Hutt Valley and Capital & Coast are undertaking a review of their mental health acute services and alcohol and other drug treatment services. This may result in commissioning a different range of services that what is currently funded. It may also result in the termination of some current agreements to allow the commissioning of best practice model-of-care services that support optimal population health outcomes. | Improved health outcomes<br>Improved patient experience<br>Improved responsiveness to Māori health<br>Value for money | Sub-regional |
| **Acute Care Continuum** | A project to develop an acute care services has commenced. The aim of the project is to develop an improved model of integrated service delivery, focusing on a defined range of services which will together deliver an 'Acute Care Continuum'. The system design approach taken with this project aims to deliver best practice improvements to better meet the acute needs of services users including improved support for family / whanau. The outcome of this project will determine the investment approach for a range of linked acute services, including inpatient and NGO provided services. This may result in commissioning a different range of services than currently funded, with potential review and updating or termination of some existing contracts. | Integration between providers of acute care services<br>Improved access and responsive support for at risk service users and family / whanau<br>Address health inequities<br>Value for money | Sub-regional |
| **MHAIDS Structural Review** | Two consultation processes will take place in relation to the 3DHB Mental Health, Addiction and Intellectual Disability Service (MHAIDS). The first will propose to staff that MHAIDS is led on behalf of Wairarapa, Hutt Valley and Capital & Coast DHBs by CCDHB. This proposal would see all MHAIDS | Improved governance structures<br>Strengthened clinical and operational partnership<br>Stronger locality leadership presence<br>Value for money | Sub-regional |

| Change | Description of Change | Benefits of Change | Change for local, regional or national reasons |
|---|---|---|---|
| | staff being employed by CCDHB. The second consultation process will cover a fundamental review of the leadership structures and clinical governance of MHAIDS. Both consultation processes are expected to be completed by early 2019/20 with any resulting implementation complete by the end of this calendar year. | Improved health outcomes | |
| **Sub-regional clinical services planning** | As part of the sub-regional hospital network programme, CCDHB and Hutt Valley DHB will be reviewing the delivery of the following services: Breast Services, Oncology services, Renal Dialysis Services, Gastroenterology/ Colonoscopy, Ear, Nose and Throat, Cardiology, and Ophthalmology services. | Improved population health outcomes<br>Maintain the financial sustainability of the services<br>Value for money | CCDHB and Hutt Valley DHB |
| **Pain Services** | Hutt Valley DHB and CCDHB are considering options to develop a community-based pain service for patients that are not funded by ACC (i.e. non-injury related). | Improved access to services, closer to home<br>Address health inequities<br>Improved health outcomes<br>Early intervention and self-management support. | CCDHB and Hutt Valley DHB |
| **Bowel Screening** | CCDHB is planning to implement the National bowel screening programme in March 2020 | Bowel Screening aims to reduce the mortality rate from bowel cancer by diagnosing and treating bowel cancer at an early curable stage, as well as identifying and removing pre-cancerous adenomas from the bowel before they become cancerous. | Local |

# SECTION FOUR: Stewardship

## 4.1 Managing our Business

### *Organisational performance management*

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

### *Funding and financial management*

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

### *Investment and asset management*

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

CCDHB and Hutt Valley DHB have entered into a joint sub-regional clinical planning process. CCDHB will deliver an LTIP by July 2019 to meet Treasury requirements, with a joint LTIP (CCDHB and Hutt Valley DHB) to be delivered by July 2020. The joint hospital network planning work programme is an input into CCDHB's LTIP for 2019, and will inform the joint LTIP in 2020. The LTIP will inform 'what' investments are needed to implement the strategic vision and associated strategies of CCDHB and Hutt Valley DHB. These investments have to deliver on ensuring the safety and quality of our services, the impact on equity and outcomes amongst our populations and the sustainability of our health system.

### *Shared service arrangements and ownership interests*

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

### *Risk management*

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

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

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

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

### *Quality assurance and improvement*

Clinical Governance is the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.[2] A shared

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

commitment is required from all clinical and non-clinical staff to provide high quality and safe care, and organisational support from board to the ward.

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

CCDHB's clinical governance framework has four components[3]. These are:

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

They provide a structure to implement strategies to improve and enhance the quality of care.

## 4.2 Building Capability

### *Capital and infrastructure development*

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

- The development of Asset Management Plans including clinical equipment and facilities, and a Master Site Plan for all CCDHB facilities. Deferred maintenance of facilities and equipment is a key component of these planning processes.
- CCDHB has a number of older properties which are not suitable for use. Options for these properties are being considered. CCDHB has significant property assets with poor utilisation due to historical design. Options are being investigated to improve utilisation.
- The Wellington Regional Hospital domestic hot and cold water systems are exhibiting signs of failure. Remediation plans are being developed to support a business case resolve this issue.
- A project to build a new Children's Hospital is in progress due to the generosity of a benefactor who has offered a $50 million contribution including design and construction management. Total project budget of $105 million includes relocation of existing services, the replacement of sewage and storm water pipes and demolition of old buildings.
- Development of a six bed facility/extension to Haumietiketike, the National Intellectual Disability Inpatient Unit, has been approved by the Minister. The projected capital cost of the six bed unit is $8.4m. This includes all costs of construction for the Individualised Specialised Units extension to Haumietiketike.
- Maturity of asset management planning is improving following a review, which was an element of the Treasury ICR review in 2017. Three separate streams of work are in progress for each: ICT, clinical equipment and facilities. Another ICR review is planned for 2019.

### *Information technology and communications systems*

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

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

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

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

In addition to the key investments we are making in line with the focus areas (detailed in the Data &

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

Digital section of the Annual Plan), ICT are also undertaking key initiatives to improve its capacity and capability to deliver including:

- Completing its Future State Enterprise Architecture and key systems roadmaps including Infrastructure, Digital Imaging, Office 365, Electronic Health Record and Patient Administration System;
- Automating a number of routine, manually intensive tasks including testing and account creation to release additional capacity to meet increased demand;
- Establishing customer engagement pathways that are visible to provide our stakeholders with clear points of entry and service level expectations;
- Implementing Application Portfolio Management for our top 10 systems;
- Establishing more agile, product based teams to improve the effectiveness of our delivery to key priorities; and
- Establishing a dedicated security team to improve the IT security of our key systems and information assets.

## *Workforce*

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

CCDHB employs around 5,800 full time staff, making us a major employer in the Wellington region In 2018/19, all waged staff at CCDHB were moved to the living wage rate for 2018. . A living wage is the hourly rate a staff member needs to pay for the necessities of life and participate as an active citizen in the community. It reflects the basic expenses of individuals and their families such as food, transportation, housing and childcare. Living wage investment is a significant achievement for CCDHB and will support our staff and their families to participate actively in society. CCDHB also continues to implement to Government's pay equity settlements to eliminate pay inequities across the health sector.

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

CCDHB's People Strategy has the following principles and strategic intent:

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

Our professional heads collectively agree to the broader principles of the Annual Plan and are fully committed to achieving what is reasonably possible within current resources.

## *Equity*

Finalisation of Taurite Ora, the Māori Health Strategy and the development of the Māori Action Plan in 2019 signals CCDHB's intention to make significant progress towards becoming a pro-equity organisation. Workforce initiatives are, and will remain, central to these initiatives.

Developing and implementing a Pro-Equity strategy that integrates our equity approach, including how we operate as an organisation, how we commission services, and how we monitor performance, improve outcomes and achieve equity for all of our communities.

Developing models of care and commissioning services that improve equity will include services within our communities, building on our locality based planning; services in our community health networks and our specialty services.

Measuring the system performance of all services is a priority to identify who you are, and where you live has an impact on your potential health and wellbeing. This includes analysing how people access

services, whether they remain in appropriate care pathways, and whether they achieve the expected health outcomes.

Improving CCDHB's systems to allow for the collation of accurate data about the ethnic backgrounds of all employees, and particularly Māori people, and Pacific People will be a priority in 2019/20. This work will address long-run workforce system challenges and see the collection of ethnicity, and other, employee-related data standardised and rationalised across CCDHB's workforce systems. The ongoing implementation of the business information tool Qlik will allow for improved and wider access to, and use of, this data.

Workforce priorities will focus on improving the effectiveness and appropriateness of CCDHB's attraction, recruitment and retention of employees from different ethnic groups, with a particular focus on Māori people, and Pacific People. These efforts will support the intention of having a workforce that is more reflective of the populations we serve.

Recognising that all employees have a role to play in providing a safe and supportive health care environment to our priority populations, there will be an increased focus on providing staff from across CCDHB with development and support in growing their understanding and improving their application of the principles of Te Tiriti o Waitangi; improving their Te Reo; and growing their cultural competence.

### *Staff Wellbeing*

With the focus in 2018/19 on the development of CCDHB's Wellbeing Framework and Programme, the focus in 2019/20 will shift towards identifying and developing a sustainable wellbeing programme.

The year will begin with completion of strategy development for specific wellbeing priority areas e.g. fatigue relating to shift work and rostering, staff experiencing domestic violence, staff experiencing trauma potential incidents at work, low paid workforces.

It will progress to focus on mental health, with the aim of strengthening the 2018 campaign of utilising the Mental Health Foundation's 5 Ways to Wellbeing as a basis. The year will conclude with development of a strategy regarding diversity, inclusion, identity and belonging.

The particular needs of Māori and Pacific staff are a high priority within this work.

### *Diversity*

The diversity of our workforce needs to reflect the communities we serve. Specific strategies to attract, recruit and retain our Māori, Pacific and disability workforce are present in all of these strategies.

We will continue to build our understanding of our workforce through better use of workforce data, and ongoing use of survey tools. We will continue to develop our ability to integrate workforce intelligence and utilise forecasting tools.

We will also continue to build the capability of our new graduates through our commitment to workforce initiatives and high quality training for groups such as RMO Postgraduate Year 1 and 2 (PGY 1s and 2s); our New Entry to Specialist Practice programme for nursing; and the development of a programme to improve the support for allied health, technical and scientific graduates and trainees.

### *Health Literacy and Communication*

In developing a programme focused on building effective healthcare worker communication, the following questions, which are taken from the 6 Dimensions of a Health Literate Organisation (Ministry of Health) will be considered

1. How will we encourage and support our workforce to develop effective health literacy practices?
2. How will we continue to identify our workforces' development and capacity needs?

In 2019, a plan based on the principles of health literacy will be developed, specifically answering the two questions above. We have identified the communication capabilities for our workforce and audited our current learning offerings. The implementation of the plan will follow throughout the year.

### *DHB Workforce Priorities*

CCDHB will focus on the following workforce priorities during the 2019/20 year:

**Values:** We will launch and embed organisational values resulting from co-design work undertaken in early 2019/20. In the first half of the year, this will involve the confirmation and launch of the organisation's revised values, which will be followed by confirmation of values based behaviours and communicate to support application of the new values at both individual and team levels. In the second half of the year the new values will be embedded in CCDHB's systems, processes, policies and activities. Connections will also be made with

the development of strategy for diversity and inclusion, identity and belonging.

**Leadership**: We will continue with our existing offerings of the Frontline Leadership Programme, Emerging Leaders and Manage Well. In 2019/20, these offerings will be complemented with a Clinical Leadership Programme and refreshed Orientation.

Leaders as Coaches will be our main focus of development to support our organisation culture work. It will have two threads - leader to team member coaching and peer to peer coaching. It will consist of course participation, online learning, and simulation exercises.

A leadership series will be developed for Allied Health, Scientific & Technical and Nursing leadership to support the development plans for these workforces. The leadership series will be comprised of short workshops where the priorities of the organisation, including dialogue about equity, will be discussed and made real.

**Supporting Safety Culture:** 2019/20 is the second year of our three year Supporting Safety Culture Programme, and will build on the significant progress made throughout 2018/19.

In the first half of 2019/20, CCDHB will introduce restorative ways of working to respond to harm to patients or staff.

Following on from the 2018 implementation of the Safety Attitudes Questionnaire (SAQ), a further SAQ survey will take place to assess the effectiveness of the Supporting Safety Culture programme in building a strong safety culture.

2019/20 will conclude with a review of the Supporting Safety Culture programme to ensure appropriate priorities are identified for the third year of the programme in the 2020/21 year.

## *Co-operative developments*

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

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

The two DHBs are developing a two DHB 'hospital network'. A joint planning process will support the development of a hospital network that serves the Wellington, Kāpiti, Porirua and Hutt Valley communities. Identifying services that would benefit clinically, and financially, from joint provision across the network could significantly improve the ability of both DHBs to improve health outcomes with our available resources.

In the delivery of hospital and health services CCDHB is developing a work plan with its nationwide tertiary care partners and in the region as a complex care provider. This includes developing a clinical services planning approach in partnership with Hutt Valley DHB for services that may be shared.

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

CCDHB has strong relationships with its two PHOs and the NGO sector. The partners work together for system improvement through the local Alliance Leadership Team, the Integrated Care Collaborative (ICC).

## *Regional Public Health*

Regional Public Health (RPH) is the public health unit for the 3DHB sub-region (Wairarapa, Hutt Valley and Capital & Coast DHBs). Organisationally, RPH is part of Hutt Valley DHB. The three DHBs work in partnership with RPH in their work on health promotion/improvement, enhancing the effectiveness of prevention activities in other parts of the health system, and regulatory services.

The integration of Regional Public Health activity into locality and Community Health Network activity has commenced to ensure our efforts to improve health outcomes in our communities are aligned. The details about the activities of RPH are contained in the Regional Public Health 2019/20 Annual Plan.

# SECTION FIVE: Performance Measures

## 5.1 Performance Measures

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

- Child wellbeing
- Mental wellbeing
- Strong and equitable health and disability system
- Primary care and prevention.

The DHB monitoring framework and accountability measures have been updated for 2019/20 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governan

| Performance measure | | Expectation | | |
|---|---|---|---|---|
| **Improving child wellbeing (CW)** | | | | |
| CW01 | Children caries free at 5 years of age | Year 1 | 71% | |
| | | Year 2 | 71% | |
| CW02 | Oral health: Mean DMFT score at school year 8 | Year 1 | 0.49 | |
| | | Year 2 | 0.49 | |
| CW03 | Improving the number of children enrolled and accessing the Community Oral Health Service | Children (0-4) enrolled | Year 1 | ≥95% |
| | | | Year 2 | ≥95% |
| | | Children (0-12) not examined according to planned recall | Year 1 | ≤10% |
| | | | Year 2 | ≤10% |
| CW04 | Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years | Year 1 | ≥85% | |
| | | Year 2 | ≥85% | |
| CW05 | Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over | 95% of eight month olds are fully immunised | | |
| | | 95% of five year-olds have completed all age-appropriate immunisations due between birth and five year of age. | | |
| | | 75% of girls and boys fully immunised – HPV vaccine. | | |
| | | 75% of 65+ year olds immunised – flu vaccine. | | |
| CW06 | Child Health (Breastfeeding) | 70% of infants are exclusively or fully breastfed at three months. | | |
| CW07 | Newborn enrolment with General Practice | 55% of new-borns enrolled in General Practice by 6 weeks of age. | | |
| | | 85% of new-borns enrolled in General Practice by 3 months of age. | | |
| CW08 | Increased immunisation at two years | 95% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years | | |
| CW09 | Better help for smokers to quit (maternity) | 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking. | | |
| CW10 | Raising healthy kids | 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. | | |
| CW11 | Supporting child wellbeing | Provide report as per measure definition | | |
| CW12 | Youth mental health initiatives | Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS. | | |
| | | Initiative 3: Youth Primary Mental Health. | | |
| | | Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population. | | |
| CW13 | Reducing rheumatic fever | Reducing the Incidence of First Episode Rheumatic Fever to 1.0 per 100,000. | | |
| **Improving mental wellbeing (MH)** | | | | |

| | | | | |
|---|---|---|---|---|
| MH01 | Improving the health status of people with severe mental illness through improved access | 0-19 year olds | Māori | 6.3% |
| | | | Other | 3.7% |
| | | | Total | 4.1% |
| | | 20-64 year olds | Māori | 8.0% |
| | | | Other | 3.3% |
| | | | Total | 3.8% |
| | | 65+ year olds | Māori | 1.8% |
| | | | Other | 1.3% |
| | | | Total | 1.3% |
| MH02 | Improving mental health services using wellness and transition (discharge) planning | 95% of clients discharged will have a quality transition or wellness plan. | | |
| | | 95% of audited files meet accepted good practice. | | |
| MH03 | Shorter waits for non-urgent mental health and addiction services | Mental health provider arm | 80% of people seen within 3 weeks | |
| | | | 95% of people seen within 8 weeks | |
| | | Addictions (Provider Arm and NGO) | 80% of people seen within 3 weeks | |
| | | | 95% of people seen within 8 weeks | |
| MH04 | Rising to the Challenge: The Mental Health and Addiction Service Development Plan | Provide reports as specified | | |
| MH05 | Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders | Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year. | | |
| MH06 | Output delivery against plan | Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan. | | |
| **Improving wellbeing through prevention (PV)** | | | | |
| PV01 | Improving breast screening coverage and rescreening | 70% coverage for all ethnic groups and overall. | | |
| PV02 | Improving cervical screening coverage | 80% coverage for all ethnic groups and overall. | | |
| **Better population health outcomes supported by strong and equitable public health services (SS)** | | | | |
| SS01 | Faster cancer treatment – 31 day indicator | 85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat. | | |
| SS02 | Delivery of Regional Service Plans | Provide reports as specified. | | |
| SS03 | Ensuring delivery of Service Coverage | Provide reports as specified. | | |
| SS04 | Delivery of actions to improve Wrap Around Services for Older People | Provide reports as specified. | | |
| SS05 | Ambulatory sensitive hospitalisations (ASH adult) | Māori | 6,070 | |
| | | Pacific | 7,893 | |
| | | Other | 2,573 | |
| | | Total | 3,140 | |
| SS06 | Better help for smokers to quit in public hospitals | 95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking. | 95% | |
| SS07 | Planned Care Measures | Planned Care Measure 1: Planned Care Interventions | 15,111 | |
| | | Planned Care Measure 2: Elective Service Patient Flow Indicators | ESPI 1 | 100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less) |
| | | | ESPI 2 | 0% – no patients are waiting over four months for FSA |
| | | | ESPI 3 | 0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT) |
| | | | ESPI 5 | 0% - zero patients are waiting over 120 days for treatment |

| | | | | |
|---|---|---|---|---|
| | | | ESPI 8 | 100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool |
| | | Planned Care Measure 3:<br>Diagnostics waiting times | Coronary Angiography | 95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) |
| | | | Computed Tomography (CT) | 95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days). |
| | | | Magnetic Resonance Imaging (MRI) | 90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days). |
| | | Planned Care Measure 4:<br>*Ophthalmology Follow-up Waiting Times* | No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service. | |
| | | Planned Care Measure 5:<br>*Cardiac Urgency Waiting Times* | All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency. | |
| | | Planned Care Measure 6:<br>*Acute Readmissions* | 12.4% (Acute readmissions for all index stay types) | |
| SS08 | Planned care three year plan | Provide reports as specified | | |
| SS09 | Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections | Focus Area 1: Improving the quality of data within the NHI | New NHI registration in error (causing duplication) | >2% and < or equal to 4% |
| | | | Recording of non-specific ethnicity in new NHI registration | >0.5% and < or equal to 2% |
| | | | Update of specific ethnicity value in existing NHI record with a non-specific value | >0.5% and < or equal to 2% |
| | | | Validated addresses excluding overseas, unknown and dot (.) in line 1 | >76% and < or equal to 85% |
| | | | Invalid NHI data updates | MoH to confirm |
| | | Focus Area 2: Improving the quality of data submitted to National Collections | NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures. | ≥90% and <95% |
| | | | National Collections completeness | Greater than or equal to 94.5% and less than 97.5 % |
| | | | Assessment of data reported to the NMDS | Greater than or equal to 75% |
| | | Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD) | | Provide reports as specified |
| SS10 | Shorter stays in Emergency Departments | 95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours. | | |
| SS11 | Faster Cancer Treatment (62 days) | 90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. | | |
| SS12 | Engagement and obligations as a Treaty partner | Reports provided and obligations met as specified | | |
| SS13 | Improved management for long term conditions | Focus Area 1: Long term conditions | Report on actions to:<br>Support people with LTC to self-manage and build health literacy. | |

| | | | |
|---|---|---|---|
| | | Focus Area 2: Diabetes services | Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.* |
| | | | Ascertainment: target 95-105% and no inequity<br>HbA1c<64mmols: target 60% and no inequity<br>No HbA1c result: target 7-8% and no inequity |
| | | Focus Area 3: Cardiovascular health | Provide reports as specified |
| | | Focus Area 4: Acute heart service | Indicator 1: Door to cath - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram. |
| | | | Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and<br>Indicator 2b: ≥ 99% within 3 months. |
| | | | Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram). |
| | | | Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge -<br>- Aspirin*, a 2nd anti-platelet agent*, statin and an ACEI/ARB (4 classes), and<br>- LVEF<40% should also be on a beta-blocker (5-classes).<br>An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents. |
| | | | Indicator 5: Device registry completion - ≥99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of the procedure. |
| | | Focus Area 5: Stroke services | Indicator 1 ASU:<br>80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway |
| | | | Indicator 2 Thrombolysis:<br>10% of potentially eligible stroke patients thrombolysed 24/7 |
| | | | Indicator 3: In-patient rehabilitation:<br>80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission |
| | | | Indicator 4: Community rehabilitation:<br>60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge. |
| SS15 | Improving waiting times for Colonoscopy | Urgent diagnostic colonoscopy - 90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less. | |
| | | Non-urgent diagnostic colonoscopy - 70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less. | |
| | | Surveillance colonoscopy - 70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less. | |
| | | Screening colonoscopy - 95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system. | |
| SS16 | Delivery of collective improvement plan | Deliverable to be confirmed | |
| SS17 | Delivery of Whānau ora | Provide reports as specified. | |
| **Better population health outcomes supported by primary health care** | | | |
| PH01 | Delivery of actions to improve system integration and SLMs | Provide reports as specified. | |
| PH02 | Improving the quality of ethnicity data collection in PHO and NHI registers | Provide reports as specified. | |
| PH03 | Access to Care (PHO Enrolments) | Meet and/or maintain the national average enrolment rate of 90%. | |
| PH04 | Primary health care: Better help for smokers to quit (primary care) | 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months | |
| **Annual Plan reporting** | | | |
| Annual plan actions – status update reports | | Provide reports as specified | |

PART B

# Statement of Intent 2019/20 - 2021/20

Incorporating the
Statement of Performance Expectations
including Financial Performance

# Foreword from Chair and Chief Executive

I am delighted to present Capital & Coast District Health Board's Statement of Intent, which sets out our strategic intentions for the next three years.

We have a strong focus on achieving equitable health outcomes for our communities, particularly for Māori, Pacific Peoples, people with disabilities and other communities experiencing inequities.

We expect the DHB to respond appropriately to safety, quality and performance issues for preventative, acute and planned care in a timely way. We have a strong focus on providing services in a timely manner.

As a Board we have refreshed our commitment to live sustainably within our means. We are deliberate in our investment choices to deliver better care and outcomes for our communities.

Knowing that the services we deliver are achieving equitable outcomes, a high performing health system, and financial sustainability are top priorities for me.

The appointment of a joint Chief Executive across Capital & Coast and Hutt Valley DHBs will assist the Boards to drive a joint strategic vision and will result in improved services and health outcomes for both populations.

We continue to foster and expand strategic partnerships including with our Māori Partnership Board, community and primary care partners to improve health outcomes.

Oversight of the health system's performance is an integral role for the Board. As a Board, we have strong expectations that Capital & Coast DHB measures and reports on the right things, including equity, quality.

To reach our medium term goals for a clinically and financially sustainable health system, we are building our capability to use data and evidence to support this focus. We are applying this capability in the delivery of our Long-Term Investment Plan, outlining how we respond to future challenges.

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

We are engaged in meeting the expectations of the Minister of Health, which aligns with our Health System Plan. We continue to emphasise action to improve child wellbeing, mental wellbeing, wellbeing through prevention, improve population health outcomes through primary care, and maintain strong and sustainable public health system.

**Andrew Blair**
**Board Chair**

I am pleased to present Capital & Coast District Health Board's Statement of Intent. This document outlines clear priorities for Capital & Coast DHB to meet the needs of our population, to achieve equitable health outcomes; focus our efforts on elevating performance; and allocate our resources to be an effective and sustainable health system.

It reflects a strong relationship between the wider factors influencing health and the leadership role we must take to build partnerships with other agencies, services and communities to build resilience and improve health and social wellbeing.

We are taking a life course approach to ensuring services are equipped to meet peoples' needs throughout every stage of life. This approach is critical for optimising health outcomes for our communities.

Our key actions across the life course focus on:

- Equitable outcomes, particularly for Māori, Pacific peoples, those with socio-economic deprivation, and those experiencing disabilities
- Mental Health and Addictions services
- Primary Care services
- Child Wellbeing
- The strength of our publically funded health system.

We will continue to partner with Hutt Valley DHB and Wairarapa DHB to serve our communities and make the best use of resources. This work will be strengthened by the appointment of a joint Chief Executive across Capital & Coast and Hutt Valley DHBs which will accelerate the development of a population wide approach to healthcare across the sub-region. We will also continue to partner with the Central Region DHBs.

We have started to develop and apply new ways of working and have established some sound building blocks including the delivery of the Health System Plan 2030, integrated support services key projects and Even Better Health Care.

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

Leveraging the existing strengths in our organisation including our strong relationships within and across our communities, a committed and involved clinical workforce, and our equity focus will be key to deliver on the ambitious targets we have set ourselves for the next three years.

**Julie Patterson**
**Interim Chief Executive**

# Signature Page

Agreement for the Capital and Coast DHB Statement of Intent 2019/20 – 2021/22, incorporating the Statement of Performance Expectations including Financial Performance

Andrew Blair
Chair
Date: 26/06/2019

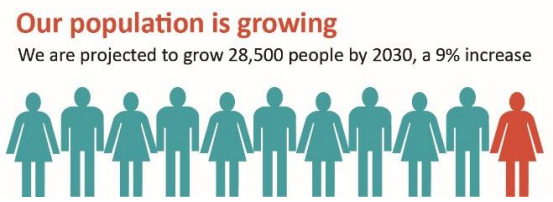
Dame Fran Wilde
Deputy Chair
Date: 26/06/2019

# PART 1: Who we are and what we do

Capital & Coast DHB (CCDHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act (2000). We are the Government's funder and provider of health services to the residents living in the Kāpiti Coast District, Porirua City and Wellington City.

## Who we are

The CCDHB region is diverse. Our communities reflect many cultures, ethnicities and abilities as well as geographic settings. In 2018, an estimated 318,000 people called the region home. This is projected to grow by 28,500 people by 2030; a 9% increase.



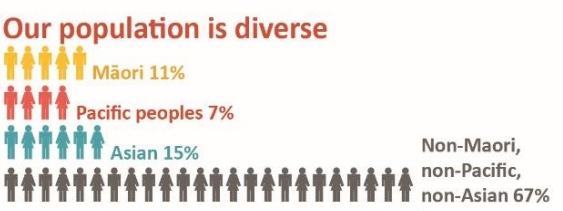

In 2018, 106,400 people under 25 years of age made up 33% of the region's population. Most people (58%) were aged 25-69 years (183,000). The remaining 9% were people over 70 years; 29,000 people.

In 2018, Wellington had a large proportion of people in the younger working age group of 20–44 years (90,500 people), while nearly one-quarter (23%) of the Porirua population were aged under 15 years (13,000 people). Just over one-quarter (26%) of the Kāpiti Coast population were aged over 65 years; 11,500 people.


The region is ethnically diverse. In 2018, 28,500 people identified as Māori (11% of the population), 21,000 identified as Pacific peoples (7%) and 35,500 identified as Asian (15%); 67 percent of the population identified as Non-Māori, Non-Pacific, Non-Asian (i.e. Other) category (228,000).

Porirua had a larger proportion of Māori (16% or 9,000 people) and Pacific peoples (21% or 12,000 people), while 89 percent of the Kāpiti Coast population identified as 'Other' ethnicities (70,800 people).

Our Māori and Pacific populations tend to be younger, with 29% of the region's Māori (10,600) and 27% of the region's Pacific people (6,000) aged under 15 years in 2018..




There are 72,200 people with a disability living in the CCDHB region. This is expected to increase to 84,500 by 2030; this partially reflects our ageing population.


### *A changing population*

The CCDHB population is changing: the population is growing, ageing and becoming more diverse.

The majority of the population increase is predicted to be in our Māori and Asian communities. For Māori, we expect growth of 20% or 7,300 people. Our Asian population is predicted to grow by 43% or 20,300 people. Pacific peoples and 'Other' populations are expected to grow much more slowly and even decline in some younger age groups.

There will be significant growth in the number of older people in the region, as our large baby boomer generation shifts into older age brackets. The largest growth is expected be in the 70-79 and 80+ age groups; as our population is living to reach much older ages.

### *The health of our population*

Compared to New Zealand as a whole, we are relatively 'healthy and wealthy'. We have a high life expectancy at 82 years, rates of premature deaths from conditions amenable to healthcare have declined by 45% between 2000 and 2015, and the majority of our population (62%) live in areas of low deprivation.

However, we also have groups who experience inequitable health outcomes; in particular, Māori, Pacific peoples, those experiencing disabilities and those who live in highly deprived areas, concentrated in Porirua.

## What we do

CCDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities in our region. These expectations are reflected in our vision:

*"Keeping our Community Healthy and Well."*

The objectives of DHBs are outlined within the Health and Disability Act (2000). These objectives include:

- Improve, promote, and protect the health of communities;
- Reduce inequalities in health status;
- Integrate health services, especially primary and hospital services; and,
- Promote effective care or support of people needing personal health services or disability support.

DHBs act as 'planners', 'funders' and 'providers' of health services as well as owners of Crown assets.

### *Local Services*

CCDHB provides community and hospital services throughout the region.

CCDHB has a range of contract with community providers, such as primary health organisations, pharmacies, laboratory, and community NGOs.

CCDHB operates two hospitals: Wellington Regional Hospital in Newtown and Kenepuru Community Hospital in Porirua. We also operate the Kapiti Health Centre in Paraparaumu, and Rātonga-Rua-O-Porirua, a large mental health campus based in Porirua.

We provide a range of specialist services in the community including district nursing, rehabilitation services, social work, alcohol and drug services, and home support services. CCDHB also provides sub-regional, regional and tertiary services for other DHBs.

CCDHB employs around 5,700 staff and has an annual budget of $1.2 billion in 2019/20.

### *Sub-Regional Services*

CCDHB provides services to the people of Hutt Valley DHB and Wairarapa DHB under 2DHB (CCDHB and Hutt Valley DHB) and 3DHB models.

CCDHB and Hutt Valley DHB serve populations that are geographically co-located. CCDHB provides more services to the Hutt Valley DHB population than any other DHB. There are also DHB services provided to both populations, either at CCDHB or at Hutt Valley DHB.

In 2018, an estimated 150,000 people lived in Hutt Valley DHB. Hutt Valley's population has greater ethnic diversity and is slightly younger compared to CCDHB. Hutt Valley DHB's population is predicted to grow by 4% or 6,500 people by 2030.

A further 45,500 people live in Wairarapa DHB. The population of Wairarapa DHB is projected to grow by 2,600 people (6%) by 2030.

### *Tertiary Services*

CCDHB is the complex care provider for the Central Region. The Central Region includes Hawkes Bay, MidCentral, Whanganui, Wairarapa, Hutt Valley and Capital & Coast DHBs.

In 2018, the Central Region population was 922,855 people. This represents 19% of the total New Zealand population and is projected to grow by 6 percent by 2030 to just under one million people (978,900).

***Map of Central Region DHBs***

CCDHB is also a provider of some tertiary services outside the Central Region (for example Taranaki DHB and Nelson Marlborough DHB) as well as some national services.

## Achieving health equity in CCDHB

Improving equity performance is a priority for CCDHB. This focus is on ultimately achieving equity amongst our populations. We know that we don't do as well for Māori and Pacific Peoples in our district, people with disability, as well as those who have low socio-economic status or an enduring mental illness and/or addiction. CCDHB is committed to improving health outcomes and achieving equity for our communities.

CCDHB's strategic direction, to reduce and ultimately eliminate inequities, is driven by:

- Taurite Ora, Māori Health Strategy 2018-2030
- CCDHB Pro-Equity Implementation Plan
- Toe Timata Le Upega, Pacific Action Plan 2017-2020
- Sub-Regional Disability Strategy 2017-2022

This document reflects our commitment improving health outcomes and promoting human rights-based health care that is equitable, inclusive and accessible.

## The key challenges we are facing

Our health system is generally performing well: New Zealanders are living longer and experiencing better health. From 2000 to 2012, New Zealand's amenable mortality rate decreased across all age groups, though ethnic and gender disparities persist.

Even though New Zealanders are living longer in better health, there are a number of challenges as a provider and funder of health services:

**Health Inequities** - The inequity present in some communities is fuelling health needs. As in most other countries, there are poorer health outcomes across the socioeconomic hierarchy. Inequalities in health begin to appear very early in life, accumulate over the life course, and are reflected in most common causes of death, injury or hospitalisation. Inequitable health outcomes are present for Māori and Pacific Peoples in our district, people with disability, as well as those who have low socio-economic status or an enduring mental illness and/or addiction.

**Child Wellbeing** - Giving every child the best start in life is crucial to reducing health inequities across the life course. The Children's Commissioner identified that children who experience poverty will have both a forward liability for the health sector and a cross-sector liability, representing a productivity cost to individuals, businesses, and the nation.

**Long-Term Conditions** - The impact of long-term conditions is growing. Although we are living longer, and living longer in good health, some people are living longer in poor health. The New Zealand Burden of Disease study found that 88% of health loss in New Zealand is caused by long-term mental and physical conditions. Alongside this, disability now accounts for over half of the total health loss experienced by the population as a whole.

**Mental Health and Addictions** - CCDHB is facing a growing need for mental health and addiction services. There are about 40,000 people with mental health needs currently living in the CCDHB region. This figure is expected to rise to 44,000 people by 2030. Not all these people will require the support of mental health services, but some people, particularly those with moderate or severe mental health needs, are likely to require additional support to manage and maintain their health and wellbeing.

**Aging Population -** The demand on our healthcare system continues to increase as the population is growing and ageing. Improvements in health will not necessarily reduce spending on healthcare. The number of people aged over 70 years is expected to increase significantly. Forecasts suggest that by 2030 at least one in six people will be aged 70 years or over, and the population aged over 80 will increase by over 80%.

**Sustainability of Specialised Services -** We see growing complexity in the people we do care for. The purpose of Wellington and Kenepuru Community hospitals is to provide acute care and to ensure access to planned (non-acute) services, birthing services, and a comprehensive range of subspecialties. Wellington Hospital is a tertiary service centre that serves the people of the Central Region, with the greatest level of support being provided to Hutt Valley DHB.

**Financial sustainable -** The demand trends for health services, together with projected expenditure trends, mean that the cost of the current model of healthcare is unaffordable and unsustainable.

The CCDHB Health System Plan (HSP) outlines the strategic direction that will allow CCDHB's health system to respond more effectively to the growing and changing needs of its people and populations, reduce inequalities and enable communities to better sustain their own health and well-being over time.

# Part 2: What are we trying to achieve?

## Our Strategic Direction

To deliver on our vision ***"Keeping our Community Healthy and Well"***, CCDHB is implementing a health system that organises service delivery in the most appropriate setting, for our people and communities that makes the best use of resources to achieve positive health outcomes and equity amongst our population.

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

The Health System Plan (HSP) outlines CCDHB's strategy to improve the performance of our healthcare system to support people to have better health and wellbeing throughout their lives and ensure equity amongst our communities.

The HSP will enable us to respond to the growing demand for healthcare, and increasing complexity with a system design that will improve outcomes and equity for the people of the CCDHB region, and the wider Central Region. The HSP is supported by this whakataukī:

> "Ma Tini, Ma Mano, Ka Rapa, Te Whai
>
> By Joining Together We Will Succeed"

Good health and wellbeing are central to every person's ability to live a satisfying life and contribute both socially and economically to the community they live in.

Our health system will keep our community healthy by:

- Promoting health and wellbeing
- Preventing the onset and development of avoidable illness
- Improving health outcomes
- Supporting people to live better lives
- Supporting the end of life with dignity

Improving the health and wellbeing of communities requires an approach broader than the traditional boundaries of health and social services.

Partnership with local councils, government agencies, NGOs and community organisations from other sectors is required to better respond to the social determinants of health. These partnerships are being developed through locality based approaches working in partnership with our communities of Kāpiti, Porirua and Wellington.

The HSP is designed to support people and whānau-led wellbeing with the system organised around the two elements: 'People' and 'Place'.

## *People*

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

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

Recognising those who need more help include: Māori and Pacific Peoples in our district, people with disability, as well as the socially & economic vulnerable or an enduring mental illness and/or addiction and refugees.

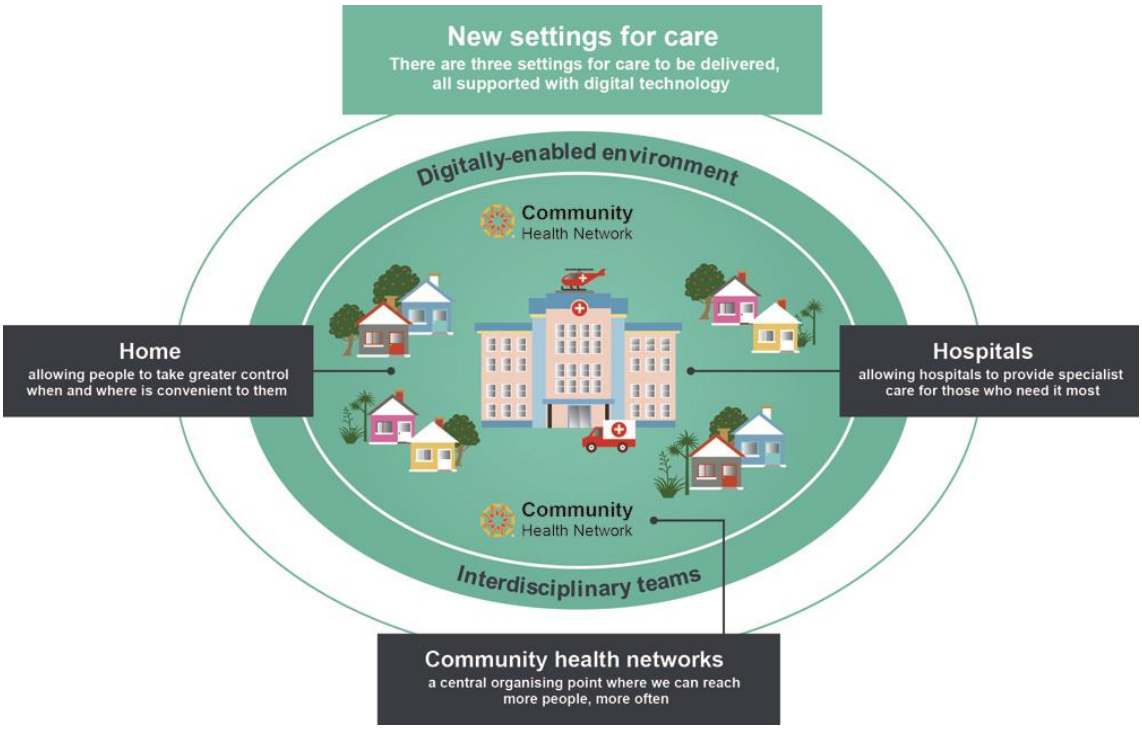
## *Place*

Using 'place' as the basis for health and social supports creates immediate links to a community's strengths; it makes it easier to recognise and value community diversity, while organising a consistent system across many groups. Better information about the characteristics of the people being served, shared among those delivering services, is central to succeeding with this approach. It has the potential to reduce health care costs over time as communities increasingly support their own health and wellbeing.

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

The plan centres on the following three core care settings.

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



## National, Regional and Sub-Regional Strategic Direction

### *National*

The Minister's Letter of Expectations sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities.

The priorities for 2019/20 include:

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

### *Regional*

CCDHB is a complex tertiary provider for the Central Region, as well as a specialist provider for its own communities. CCDHB is committed to improving regional care arrangements with our partner DHBs in the Central Region.

The central region's priorities and activities are outlined in the Regional Services Plan. An implementation programme has been developed focussed on the key regional strategic priorities:

- Equity
- Tertiary Services Strategy
- Radiology
- Cardiology
- Cancer

### *Sub-Regional*

CCDHB and Hutt Valley DHB share a Chief Executive and a Board Chair. Our Boards hold joint quarterly meetings which allows further collaboration and a more integrated and aligned approach to planning and delivery of health services across the two DHBs.

**Hospital Network Planning –** In 2018, CCDHB and Hutt Valley DHB entered into a joint sub-regional clinical planning process. A joined up approach offers the opportunity for joint provision of key services and to strengthen the network of hospitals in the greater Wellington region.

CCDHB and Hutt Valley DHB serve populations that are geographically co-located. A greater proportion of the Hutt Valley DHB population receive services at CCDHB, than any other population. There are a large number of services that are provided by CCDHB for the Hutt Valley DHB population as well as services where there is collaboration across the two DHBs.

There are few services that are jointly provided. They include advanced care planning and the disability strategy. The most significant clinical service is Mental Health and Addiction Services (MHAIDS) which is provided across the three DHBs (including Wairarapa DHB).

CCDHB has strong relationships with its PHO partners and the NGO sector. We work together for system improvement through the local Alliance Leadership Team, the Integrated Care Collaborative (ICC).

## Focus for 2019/20

Our focus is on delivering on the HSP. The HSP is underpinned by knowing the major drivers of demand for health care, and the potential opportunities offered by increasingly affordable, reliable, and sophisticated technologies.

The HSP presents three key strategies for developing our approach to 'people' as an organising system for health care:

- **Simplifying care** for those who have good health literacy and resources
- **Intensifying care** for those who have less resources and experience greater levels of avoidable poor health
- Strengthening investment in **acting early to prevent avoidable costs** around health care over a lifetime.

The HSP also outlines four key strategies for developing our approach to 'place' as an organising system for health care:

- **Working with and in communities** to develop location-specific approaches to health care for local populations
- Using health resources effectively by **organising their use around settings of care**
- Developing **interdisciplinary health teams** who work together to support safe and effective health care Strengthening **innovation, using technologies** to improve knowledge, choice, and access to care.

### *Key programmes and initiatives in 2019/20*

**Equity** - CCDHB is investing to sustainably achieve equity, with a focus on those where inequitable outcomes have the greatest negative impact. The development of the CCDHB **Pro-Equity Strategy** puts in place the building blocks for CCDHB to advance as a pro-equity organisation.

**Taurite Ora -** CCDHB has developed a new Māori health strategy, Taurite Ora: CCDHB Māori Health Strategy and Action Plan 2019-2030. This strategy will guide activity to achieve equitable Māori health outcomes in the CCDHB district by 2025 with a broader goal of 'pae ora', (healthy futures for Māori) by 2030.

**Hospital Network Planning -** CCDHB and Hutt Valley DHB have entered into a joint sub-regional clinical planning process. The joint hospital network planning work programme is an input into CCDHB's Long Term Investment Plan for 2019, and will inform the joint Long Term Investment Plan in 2020.

**Children's Hospital** - The construction of a new Children's Hospital is underway with the support of Treasury and the Ministry of Health.

**Primary Care** - The Health Care Home is a key priority for CCDHB, as we move to develop our Community Health Networks. The emphasis in year-three of this programme is on equity and ensuring models of service delivery are effective for all of our communities.

**Tertiary Services Strategy** - Delivering quality and clinically sustainable specialised care at Wellington Hospital requires building on existing clinical care arrangements. CCDHB is committed to improving regional care arrangements with our partner DHBs in the Central Region. A separate tertiary services strategy will be developed in 2019/20.

**Mental Health and Addictions** - CCDHB has a comprehensive programme of work to improve mental health and wellbeing and ensure we effectively implement the recommendations of the Mental Health Inquiry.

## Health and safety

At CCDHB the health and safety of all workers, patients and all others utilising our facilities and services is paramount.

CCDHB is committed to the development and maintenance of a positive health and safety culture, providing safe and secure facilities, having well trained, instructed and supervised workers, to ensure their and others safety.

## Workforce

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

We recognise the aims, aspirations, cultural differences and employment requirements of Māori, Pacific Peoples, people from other ethnic or minority groups and those experiencing disabilities. We will prioritise a range of strategies with a particular focus on the recruitment and retention of Māori and Pacific staff. We will provide opportunities for individual employee development and career advancement, including cultural competency training.

CCDHB's People Strategy has the following principles:

# PART 3: How we manage our business

## Organisational performance management

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

## Funding and financial management

CCDHB's key financial indicators are spend against budget and budget against deficit. These are assessed against and reported through CCDHB's performance management process to the Executive Leadership Team and the Finance and Risk Assessment Committee.

## Investment and asset management

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

CCDHB and Hutt Valley DHB have entered into a joint sub-regional clinical planning process. CCDHB will deliver a Long Term Investment Plan (LTIP) by July 2019 to meet Treasury requirements, with a joint LTIP between CCDHB and Hutt Valley DHB to be delivered by July 2020. The joint hospital network planning work programme is an input into CCDHB's LTIP for 2019, and will inform the joint LTIP in 2020. Our LTIP will inform 'what' investments are needed to implement the strategic vision and associated strategies of CCDHB and Hutt Valley DHB. These investments have to deliver on ensuring the safety and quality of our services, the impact on equity and outcomes amongst our populations and the sustainability of our health system.

## Shared service arrangements and ownership interests

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

## Risk management

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

Health and Safety is a particular focus across the DHB. Accountability for health and safety is the responsibility of every manager and employee. Systems for managing health and safety risk are deployed across the organisation.

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

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

## Quality assurance and improvement

Clinical Governance is the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.[4] A shared commitment is required from all clinical and non-clinical staff to provide high quality and safe care, and organisational support from board to the ward.

The CCDHB Clinical Governance Framework has recently been updated. This framework aims to bring individual elements together to strengthen and sustain ongoing

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

improvement around the six dimensions of quality; safe, timely, equitable, effective, efficient and people centred (STEEEP).

CCDHB's clinical governance framework has four components[5]. These are:

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

They provide a structure to implement strategies to improve and enhance the quality of care.

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

# PART 4: How we measure our performance
# Statement of Performance Expectations including Financial Performance

This section must be tabled in Parliament. All components of this section are mandatory (section 149C of the Crown Entities Act 2004)

As both the major funder and provider of health services in the CCDHB region, the decisions we make and the way in which we deliver services have a significant impact on the health and wellbeing our population and communities.

Having a limited resource pool and growing demand for health services, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The results are then presented in our Annual Report at year end.

The following section presents CCDHB's Statement of Performance Expectations for 2019/20.

**Interpreting Our Performance**

As it would be overwhelming to measure every service delivered, the services we deliver have been grouped into four services classes. These are common to all DHBs and reflect the types of services provided across the full health and wellbeing continuum:

- Prevention services
- Early detection and management services
- Intensive assessment and treatment services
- Rehabilitation and support services

Under each service class, we have identified a mix of measures that we believe are important to our community and stakeholders, and provide a fair indication of how well the DHB is performing.

**Setting Standards**

In setting performance standards, we consider the changing demography of our population, areas of increasing demand and the assumption that resources and funding growth will be limited.

Our performance standards reflect the outcomes the DHB is wanting to achieve:

- Strengthen our communities and families so they can be well;
- It is easier for people to manage their own health needs;
- We have equal health outcomes for all communities;
- Long term health conditions and complexity occur later in life and for shorter duration; and,
- Expert specialist services are available to improve health gain.

We also seek to improve the experience of people in our care and public confidence in our health system.
While targeted intervention can reduce service demand in some areas, there will always be some demand the DHB cannot influence, such as demand for maternity services and palliative care services. It is not appropriate to set targets for these services, however they are an important part of the picture of health need and service delivery in our region.

In health, the number of people who receive a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time. To ensure a balanced, well rounded picture, the mix of measures identified in our Statement of Performance Expectations address four key aspects of service performance:

| | |
|---|---|
| Access | How well are people accessing services, is access equitable, are we engaging with all of our population? |
| Timeliness | How long are people waiting to be seen or treated, are we meeting expectations? |
| Quality | How effective is the service, are we delivering the desired health outcomes? |
| Experience | How satisfied are people with the service they receive, do they have confidence in us? |

With a growing diversity and persistent inequities across our population, achieving equity of outcomes is an overarching priority for the DHB. All of our targets are universal, with the aim of reducing disparities between population groups.

**Where does the money go?**

In 2019/20, the DHB will receive approximately $1.2 billion dollars with which to purchase and provide the services required to meet the needs of our population.

The table below represents a summary of our anticipated financial split for 2019/20 by service class.

| | 2019/20 |
|---|---|
| **Revenue** | **Total $'000** |
| **Prevention** | 12,437 |
| **Early detection & management** | 268,810 |
| **Intensive assessment & treatment** | 792,513 |
| **Rehabilitation & support** | 136,039 |
| **Total Revenue - $'000** | **1,209,799** |
| | |
| **Expenditure** | |
| **Prevention** | 12,437 |
| **Early detection & management** | 268,810 |
| **Intensive assessment & treatment** | 808,413 |
| **Rehabilitation & support** | 136,039 |
| **Total Expenditure - $'000** | **1,225,699** |
| | |
| **Surplus/(Deficit) - $'000** | **(15,900)** |

## Prevention Services

**Why are these services significant?**

Prevention services are publically funded services that promote and protect the health of the whole population or targeted populations. These services seek to address individual behaviours by targeting physical and social environments and norms that can influence and support people to make healthier choices and are, in this way, distinct from treatment services.

The four leading long-term conditions; cancer, cardiovascular disease, diabetes, and respiratory disease—make up 80% of the disease burden for our population. By supporting people to make healthier choices we can reduce the risk factors that contribute to these conditions. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore be a very cost-effective health intervention.

**How will we demonstrate our success?**

| **Immunisation Services** | | | | |
|---|---|---|---|---|
| These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| % of eight month olds fully vaccinated | Māori | 96% | 86% | ≥95% |
| | Pacific | 90% | 94% | |
| | Non-Māori, Non-Pacific | 95% | 96% | |
| | Total | 93% | 94% | |
| % of two year olds fully immunised | Māori | 93% | 90% | ≥95% |
| | Pacific | 98% | 94% | |
| | Non-Māori, Non-Pacific | 96% | 94% | |
| | Total | 96% | 94% | |
| % of five year olds fully immunised | Māori | 88% | 84% | ≥95% |
| | Pacific | 96% | 91% | |
| | Non-Māori, Non-Pacific | 92% | 91% | |
| | Total | 92% | 89% | |
| % of children aged 11 years provided Boostrix vaccination | Māori | 73% | 73% | ≥70% |
| | Pacific | 75% | 75% | |
| | Non-Māori, Non-Pacific | 74% | 74% | |
| | Total | 74% | 74% | |
| % of children (girls and boys aged 12 years) provided HPV vaccination | Māori | 46% | 46% | ≥75% |
| | Pacific | 47% | 47% | |
| | Non-Māori, Non-Pacific | 65% | 65% | |
| | Total | 59% | 59% | |

| **Health Promotion Services** | | | | |
|---|---|---|---|---|
| These services inform people about risk, and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| % of infants fully or exclusively breastfed at 3 months | Māori | 52% | 50% | ≥60% |
| | Pacific | 44% | 54% | |
| | Non-Māori, Non-Pacific | 68% | 69% | |
| | Total | 63% | 65% | |
| % of four year olds identified as obese at their B4 School Check referred for family based nutrition, activity and lifestyle intervention | Māori | 96% | 97% | ≥95% |
| | Pacific | 97% | 90% | |
| | Non-Māori, Non-Pacific | 91% | 100% | |
| | Total | 95% | 96% | |
| % of PHO-enrolled patients who have quit smoking in the last 12 months | Māori | 9% | 8% | 12% |
| | Pacific | 9% | 8% | |
| | Non-Māori, Non-Pacific | 15% | 14% | |
| | Total | 13% | 12% | |

| Population-based Screening Services | | | | |
|---|---|---|---|---|
| These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| % of eligible children receiving a B4 School Check | Māori | 82% | 84% | ≥90% |
| | Pacific | 81% | 90% | |
| | Non-Māori, Non-Pacific | 94% | 92% | |
| | Total | 90% | 90% | |
| % of eligible women (25-69 years old) having cervical screening in the last 3 years | Māori | 61% | 63% | ≥80% |
| | Pacific | 68% | 66% | |
| | Non-Māori, Non-Pacific | 79% | 79% | |
| | Total | 77% | 77% | |
| % of eligible women (50-69 years old) having breast cancer screening in the last 2 years | Māori | 67% | 68% | ≥70% |
| | Pacific | 70% | 69% | |
| | Non-Māori, Non-Pacific | 73% | 72% | |
| | Total | 73% | 72% | |

| Public Health Services | | | | |
|---|---|---|---|---|
| These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| Number of disease notifications investigated | Māori | 109 | 109 | 109 |
| | Pacific | 92 | 92 | 92 |
| | Non-Māori, Non-Pacific | 1090 | 1090 | 1090 |
| | Total | 109 | 109 | 109 |
| Number of new referrals to Public Health Nurses in primary/intermediate schools | Māori | 756 | 756 | 756 |
| | Pacific | 707 | 707 | 707 |
| | Non-Māori, Non-Pacific | 424 | 424 | 424 |
| | Total | 1,887 | 1,887 | 1887 |
| Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region | Total | 20 | 20 | 20 |
| Number of environmental health investigations | Total | 727 | 727 | 727 |
| Number of premises visited for alcohol controlled purchase operations | Total | 70 | 70 | 70 |
| Number of premises visited for tobacco controlled purchase operations | Total | 17 | 17 | 17 |
| Number of investigations related to requirements of the Drinking-Water Standards | Total | 9 | 9 | 9 |

## Early Detection and Management Services

**Why are these services significant?**

The New Zealand health system is experiencing an increasing prevalence of long-term conditions; so-called because once diagnosed, people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others and prevalence increases with age.

Our Health System Plan is designed to support people and whānau-led wellbeing with the system organised around two elements: People and Place. For most people, their general practice team is their first point of contact with health services and is vital as a point of continuity in improving the management of care for people with long-term conditions. By promoting regular engagement with primary and community services we are better able to support people to stay well, identify issues earlier, and reduce complications, acute illness and unnecessary hospital admissions. Our approach will be particularly effective where people have multiple conditions requiring ongoing intervention or support.

**How will we demonstrate our success?**

| Oral Health Services | | | | |
|---|---|---|---|---|
| These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| % of children under 5 years enrolled in DHB-funded dental services | Māori | 67% | 68% | ≥95% |
| | Pacific | 80% | 76% | |
| | Non-Māori, Non-Pacific | 103% | 98% | |
| | Total | 94% | 90% | |
| % of children caries free at 5 years | Māori | 51% | 53% | ≥69% (2018) |
| | Pacific | 39% | 44% | |
| | Non-Māori, Non-Pacific | 77% | 78% | |
| | Total | 70% | 72% | |
| Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 | Māori | 0.79 | 0.80 | ≤0.49 (2018) |
| | Pacific | 0.97 | 0.92 | |
| | Non-Māori, Non-Pacific | 0.41 | 0.42 | |
| | Total | 0.51 | 0.52 | |
| % of children (0-12) enrolled in DHB oral health services examined according to planned recall | Māori | 14% | 13% | ≤10% |
| | Pacific | 14% | 13% | |
| | Non-Māori, Non-Pacific | 12% | 8% | |
| | Total | 12% | 9% | |
| % of adolescents accessing DHB-funded dental services | Māori | 55% | 55% | ≥85% |
| | Pacific | 78% | 75% | |
| | Non-Māori, Non-Pacific | 82% | 81% | |
| | Total | 80% | 77% | |

| Primary Care Services | | | | |
|---|---|---|---|---|
| These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive service. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| % of the DHB-domiciled population that is enrolled in a PHO | Māori | 86% | 86% | ≥94% |
| | Pacific | 102% | 99% | |
| | Non-Māori, Non-Pacific | 95% | 94% | |
| | Total | 94% | 93% | |
| % of the eligible population assessed for CVD risk in the last five (ten) years | Māori | 83% | 82% | ≥90% |
| | Pacific | 85% | 83% | |
| | Non-Māori, Non-Pacific | 83% | 82% | |
| | Total | 83% | 82% | |
| % of people with diabetes aged 15-74 years enrolled with a PHO who latest HbA1c in the last 12 months was <=64 mmol/mol | Māori | 61% | 61% | ≥70% |
| | Pacific | 51% | 56% | |
| | Non-Māori, Non-Pacific | 70% | 69% | |
| | Total | 66% | 66% | |
| Avoidable hospital admission rate for children aged 0-4 (per 100,000 people) | Māori | 7,330 | 8,143 | 5,700 |
| | Pacific | 10,100 | 10,297 | |
| | Non-Māori, Non-Pacific | 5,039 | 5,700 | |

| | | | | |
|---|---|---|---|---|
| | Total | 6,038 | 6,685 | |
| Avoidable hospital admission rate for adults aged 45-64 (per 100,000 people) | Māori | 6,163 | 6,070 | 2,537 |
| | Pacific | 6,636 | 7,893 | |
| | Non-Māori, Non-Pacific | 2,387 | 2,537 | |
| | Total | 2,943 | 3,140 | |
| Primary Care Patient Experience scores | Communication | 8.5 | 8.4 | 8.0 |
| | Partnership | 7.6 | 7.5 | |
| | Physical & Emotional Needs | 7.8 | 7.8 | |
| | Coordination | 8.4 | 8.5 | |

| **Pharmacy Services** | | | | |
|---|---|---|---|---|
| These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment, and is therefore indicative of a successful service. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| % of the DHB-domiciled population that were dispensed at least one prescription item | Māori | 66% | 66% | 78% |
| | Pacific | 81% | 78% | |
| | Non-Māori, Non-Pacific | 81% | 79% | |
| | Total | 78% | 77% | |
| % of people aged 65+ years receiving five or more long-term medications | Māori | 30% | 30% | 25% |
| | Pacific | 39% | 39% | |
| | Non-Māori, Non-Pacific | 27% | 27% | |
| | Total | 28% | 28% | |
| Number of people registered with a Long Term Conditions programme in a pharmacy | Total | 6,823 | 6,668 | 6,604 |
| Number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy | Total | 225 | 210 | 250 |

## Intensive Assessment and Treatment Services

***Why are these services significant?***

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually provided in hospital settings, which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events; others are planned, and access is determined by clinical triage, capacity, treatment thresholds and national service coverage agreements.

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and is crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enable people to establish more stable lives, and result in improved confidence in the health system.

As a provider of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs. Improved processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes for our population.

**How will we demonstrate our success?**

| Maternity Services | | | | |
|---|---|---|---|---|
| These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| % of maternity deliveries made in Primary Birthing Units | Māori | 21% | 21% | ≥9% |
| | Pacific | 22% | 22% | |
| | Non-Māori, Non-Pacific | 8% | 8% | |
| | Total | 11% | 11% | |

| Acute and Urgent Services | | | | |
|---|---|---|---|---|
| These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| Number of Community Acute Response packages of care provided in community settings | Total | 620 | 729 | ≥729 |
| Number of zero-fee consultations at after-hours services by children under 13 years | Māori | 2,862 | 2,622 | ≥2,622 |
| | Pacific | 4,053 | 3,716 | ≥3,716 |
| | Non-Māori, Non-Pacific | 14,831 | 12,154 | ≥12,154 |
| | Total | 21,746 | 18,492 | ≥18,492 |
| Age-standardised ED presentation rate per 1,000 population in sub-regional hospitals | Māori | 196 | 198 | ≤158 |
| | Pacific | 250 | 243 | |
| | Non-Māori, Non-Pacific | 158 | 152 | |
| | Total | 166 | 161 | |
| % of patients admitted, discharged or transferred from ED within 6 hours | Māori | 89% | 86% | ≥95% |
| | Pacific | 90% | 85% | |
| | Non-Māori, Non-Pacific | 90% | 87% | |
| | Total | 90% | 87% | |
| Standardised acute readmission rate within 28 days | Total | 12.1% | 12.4% | 12.4% |

| Elective & Arranged Services | | | | |
|---|---|---|---|---|
| These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| Number of surgical elective discharges | Total | 11,341 | 11,205 | 11,205 |
| % of patients given a commitment to treatment but not treated within four months | Total | <5% | <5% | <5% |
| % of "DNA" (did not attend) appointments for outpatient appointments | Māori | 15% | 15% | 14% |
| | Pacific | 17% | 17% | 16% |
| | Non-Māori, Non-Pacific | 6% | 5% | 5% |
| | Total | 8% | 7% | 7% |
| % of patients waiting longer than four months for their first specialist assessment | Total | <0.4% | <0.4% | <0.4% |
| | Māori | 92% | 93% | ≥90% |
| | Pacific | 86% | 92% | |

| | | | | |
|---|---|---|---|---|
| % 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 | Non-Māori, Non-Pacific | 92% | 93% | |
| | Total | 90% | 88% | |

| Mental health, addictions and wellbeing services | | | | | |
|---|---|---|---|---|---|
| These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of a responsive and efficient service. | | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| % of population accessing community mental health services | Mental health services | Māori | 1.2% | 1.2% | 1.2% |
| | | Pacific | 0.8% | 0.8% | 0.8% |
| | | Non-Māori, Non-Pacific | 0.4% | 0.4% | 0.4% |
| | | Total | 0.6% | 0.6% | 0.6% |
| | Addiction services | Māori | 2.1% | 1.9% | 1.9% |
| | | Pacific | 1.2% | 1.0% | 1.0% |
| | | Non-Māori, Non-Pacific | 0.4% | 0.4% | 0.4% |
| | | Total | 0.7% | 0.6% | 0.6% |
| % of population accessing secondary: | Mental health services | Māori | 7.0% | 6.9% | 6.9% |
| | | Pacific | 3.5% | 3.5% | 3.5% |
| | | Non-Māori, Non-Pacific | 3.1% | 3.1% | 3.1% |
| | | Total | 3.5% | 3.5% | 3.5% |
| | Addiction services | Māori | 2.0% | 1.9% | 1.9% |
| | | Pacific | 1.0% | 0.9% | 0.9% |
| | | Non-Māori, Non-Pacific | 0.6% | 0.6% | 0.6% |
| | | Total | 0.8% | 0.8% | 0.8% |
| % of patients 0-19 referred to non-urgent child & adolescent services that were seen within eight weeks: | Mental health services | Māori | 79% | 93% | ≥95% |
| | | Pacific | 93% | 89% | |
| | | Non-Māori, Non-Pacific | 93% | 91% | |
| | | Total | 90% | 91% | |
| | Addiction services | Māori | 91% | 97% | |
| | | Pacific | 100% | 100% | |
| | | Non-Māori, Non-Pacific | 100% | 96% | |
| | | Total | 96% | 97% | |
| % of people admitted to an acute mental health inpatient service that were seen by mental health community team: | 7 days prior to the day of admission | Māori | 70% | 70% | ≥75% |
| | | Pacific | 80% | 67% | |
| | | Non-Māori, Non-Pacific | 74% | 77% | |
| | | Total | 73% | 74% | |
| | 7 days following the day of discharge | Māori | 70% | 79% | ≥90% |
| | | Pacific | 78% | 92% | |
| | | Non-Māori, Non-Pacific | 73% | 83% | |
| | | Total | 73% | 83% | |
| Rate of Māori under the Mental Health Act: Section 29 community treatment orders | | Māori | 520 | 482 | 434 |
| | | Non- Māori | 139 | 139 | 125 |

| Quality, safety and patient experience | | | | |
|---|---|---|---|---|
| These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate quality processes and strong clinical engagement. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| Rate of In-hospital falls with fractured neck of femur, per 100,000 admissions by month | Total | 11.1 | 14.5 | 14 |
| Rate of staphylococcus aureus bacteraemia, per 1,000 bed days | Total | 0.2 | 0.2 | |
| Rate of surgical site infections for hip and knee operations, per 100 procedures | Total | 0.70 | 0.41 | 0.41 |
| Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, per 1,000 admissions | Total | Not Available | 1.7 | 1.7 |
| Rate of rapid response escalations, per 1000 admissions | Total | Not Available | 40.4 | 40.4 |
| Rates of deep vein thrombosis/pulmonary embolus | Total | 0.91 | 1.05 | 1.05 |
| The weighted average score in the Inpatient Experience Survey by domain | Communication | 8.5 | 8.5 | 8.5 |
| | Partnership | 8.7 | 8.5 | 8.7 |
| | Physical & Emotional Needs | 8.7 | 8.6 | 8.7 |
| | Coordination | 8.4 | 8.1 | 8.5 |

## Rehabilitation and Support Services

**Why are these services significant?**

Rehabilitation and support services provide people with the assistance they need to live safely and independently in their own homes or regain functional ability after a health related event. These services are considered to provide people with a much higher quality of life as a result of people being able to stay active and positively connected to their communities. This is evidenced by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admission or readmission into our hospitals.

Even when returning to full health is not possible, timely access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness or crisis, these services have a major impact on the sustainability of our health system by reducing acute demand, unnecessary ED presentations and the need for more complex interventions. These services also support patient flow by enabling people to go home from hospital earlier.

Support services also include palliative care for people who have end-of-life conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably and have their needs met in a holistic and respectful way, without undue pain and suffering.

**How will we demonstrate our success?**

| Disability Support Services | | | | |
|---|---|---|---|---|
| These services support people with disabilities to find solutions to support their engagement in health services. Success is measured by responsive services that support people with disabilities and consumer-clinician partnership. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| Number of CCDHB Disability Forums | Total | 0 | 1 | 3 |
| Number of sub-regional Disability Forums | Total | 0 | 1 | 1 |
| % of hospital staff that have completed the Disability Responsiveness eLearning Module | Total | 18% | 18% | 33% |
| Number of people with a Disability Alert | Total | 8,357 | 8,800 | 9,000 |
| % of the CCDHB domiciled population with a Disability Alert who are Māori or Pacific | Māori | 10% | 10% | 11% |
| | Pacific | 6% | 6% | 7% |

| Home-based and Community Support Services | | | | |
|---|---|---|---|---|
| These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| % of people 65+ receiving DHB-funded HOP support who are being supported to live at home | Māori | 67% | 63% | ≥60% |
| | Pacific | 63% | 64% | |
| | Non-Māori, Non-Pacific | 60% | 60% | |
| | Total | 60% | 60% | |
| % 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 | Māori | 100% | 100% | ≥98% |
| | Pacific | 100% | 100% | |
| | Non-Māori, Non-Pacific | 100% | 100% | |
| | Total | 100% | 100% | |
| % of people who have had an interRAI assessment with an Advance Care Plan | Total | 4.1% | 4.2% | ≥4.2 |
| Rate of hip (neck of femur) fractures due to a fall per 1,000 people 50+ | Total | 2.6 | 2.5 | ≤2.5 |
| Number of older people accessing respite services | Total | 455 | 506 | ≥506 |

| Aged Residential Care Services | | | | |
|---|---|---|---|---|
| With an ageing population, demand for aged related care (ARC) is expected to increase, but a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care. | Target Group | Baseline 2017/18 | Forecast 2018/19 | Target 2019/20 |
| Rate of ED presentations from aged residential care facilities that are not admitted per 1,000 population in aged residential care | Total | 5.69 | 5.53 | ≤5.53 |
| % of residential care providers meeting four year certification standards | Total | 53% | 61% | ≥53% |

# Financial Performance

The prospective planned result for Capital and Coast DHB 2019/20 annual plan is a deficit of $15.9 million. The actual result for 2018/19 is a deficit of $96.4m. This includes a provision for a Holiday Act pay-out of $67m plus a write-off of $6m for impairment of investment in the National Oracle System.

**CCDHB Summary Financial Table**

| Capital & Coast DHB<br>Annual Plan Budget for the Four Years ending 30 June 2023 | 2017/18<br>$'M | 2018/19<br>$'M | 2019/20<br>$'M | 2020/21<br>$'M | 2021/22<br>$'M | 2022/23<br>$'M |
|---|---|---|---|---|---|---|
| Funding (excluding IDF inflows below) | 873.3 | 934.3 | 967.6 | 1,054.6 | 1,040.0 | 1,076.7 |
| Services provided for Other DHBs (IDF Inflows) | 218.2 | 227.3 | 242.2 | 251.9 | 262.0 | 272.5 |
| **Total Funding** | **1,091.4** | **1,161.6** | **1,209.8** | **1,306.5** | **1,301.9** | **1,349.2** |
| DHB Provider Arm | 736.9 | 860.2 | 806.5 | 833.3 | 857.9 | 891.9 |
| Funder Arm | 266.7 | 288.6 | 304.1 | 313.3 | 322.7 | 332.3 |
| Governance Arm | 9.6 | 11.0 | 12.0 | 11.7 | 12.0 | 12.3 |
| Services Purchased from Other DHBs (IDF Outflows) | 96.4 | 98.1 | 103.1 | 106.2 | 109.3 | 112.6 |
| **Total Allocated** | **1,109.7** | **1,258.0** | **1,225.7** | **1,264.5** | **1,302.0** | **1,349.2** |
| **Surplus / (Deficit)** | **(18.2)** | **(96.4)** | **(15.9)** | **42.0** | **(0.0)** | **0.0** |

| Capital & Coast DHB<br>Statement of Comprehensive Income & Expenditure Budget for the Four Years ending 30 June 2023 | Actual 2017/18 (000s) | Actual 2018/19 * (000s) | Plan 2019/20 ** (000s) | Plan 2020/21** (000s) | Plan 2021/22 (000s) | Plan 2022/23 (000s) |
|---|---|---|---|---|---|---|
| **REVENUE** | | | | | | |
| Government and Crown Agency Sourced | 1,059,652 | 1,124,508 | 1,176,971 | 1,222,401 | 1,266,591 | 1,312,461 |
| Patient / Consumer Sourced | 5,245 | 5,238 | 4,966 | 5,165 | 5,372 | 5,586 |
| Other Income | 26,529 | 31,874 | 27,861 | 78,904 | 29,987 | 31,111 |
| **TOTAL REVENUE** | **1,091,425** | **1,161,621** | **1,209,799** | **1,306,471** | **1,301,950** | **1,349,159** |
| **OPERATING COSTS** | | | | | | |
| *Personnel Costs* | | | | | | |
| Medical Staff | 150,607 | 187,670 | 170,050 | 175,151 | 178,406 | 182,432 |
| Nursing Staff | 193,129 | 238,301 | 217,226 | 223,796 | 227,856 | 231,230 |
| Allied Health Staff | 55,602 | 63,990 | 62,609 | 64,371 | 66,302 | 68,291 |
| Support Staff | 7,903 | 10,930 | 10,145 | 10,434 | 10,747 | 11,070 |
| Management / Administration Staff | 60,531 | 72,008 | 78,165 | 79,548 | 81,873 | 84,265 |
| **Total Personnel Costs** | **467,771** | **572,898** | **538,194** | **553,301** | **565,184** | **577,288** |
| *Clinical Costs* | | | | | | |
| Outsourced Services | 25,808 | 24,601 | 22,493 | 23,808 | 24,586 | 25,389 |
| Clinical Supplies | 123,130 | 130,291 | 129,210 | 133,070 | 137,063 | 141,174 |
| **Total Clinical Costs** | **148,938** | **154,891** | **151,702** | **156,878** | **161,649** | **166,563** |
| *Other Operating Costs* | | | | | | |
| Hotel Services, Laundry & Cleaning | 19,171 | 23,809 | 23,160 | 23,854 | 24,570 | 25,307 |
| Facilities | 40,597 | 43,401 | 43,731 | 45,043 | 46,394 | 47,786 |
| Transport | 2,995 | 3,157 | 3,055 | 3,147 | 3,241 | 3,338 |
| IT Systems & Telecommunications | 12,435 | 13,454 | 13,797 | 14,211 | 14,638 | 15,077 |
| Interest & Financing Charges | 24,414 | 29,850 | 26,332 | 27,121 | 27,935 | 28,773 |
| Professional Fees & Expenses | 7,897 | 7,258 | 7,159 | 2,663 | 2,742 | 2,825 |
| Other Operating Expenses | 11,308 | 10,886 | (1,169) | 7,152 | 11,629 | 24,980 |
| Democracy | 397 | 432 | 1,038 | 480 | 493 | 505 |
| Provider Payments | 363,159 | 386,765 | 407,202 | 419,418 | 432,001 | 444,961 |
| Recharges | 10,578 | 11,193 | 11,498 | 11,202 | 11,474 | 11,753 |
| **Total Other Operating Costs** | **492,951** | **530,204** | **535,803** | **554,291** | **575,117** | **605,307** |
| **TOTAL COSTS** | **1,109,661** | **1,257,994** | **1,225,699** | **1,264,471** | **1,301,950** | **1,349,159** |
| **NET SURPLUS / (DEFICIT)** | **(18,236)** | **(96,373)** | **(15,900)** | **42,000** | **0** | **0** |
| ***Asset Revaluation (Equity movement - IRFS requirement) | 113,105 | (5,350) | - | - | - | - |
| **TOTAL COMPREHENSIVE INCOME SURPLUS/(DEFICIT)** | **94,869** | **(101,723)** | **(15,900)** | **42,000** | **0** | **0** |

* Please note that the 2018/19 Actual includes adjustments for year end provisions i.e. Holidays Act and write offs.

** Please note that final agreement of the 2019/20 Plan is pending. Plan for 2020/21 includes a donation of $50m from benefactor towards the Children's Hospital

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

| Capital & Coast DHB<br>Statement of Financial Position<br>Budget for the Four Years ending 30 June 2023 | Actual 2017/18 (000s) | Actual 2018/19 (000s) | Plan 2019/20 (000s) | Plan 2020/21 (000s) | Plan 2021/22 (000s) | Plan 2022/23 (000s) |
|---|---|---|---|---|---|---|
| **Non Current Assets** | | | | | | |
| Land | 41,165 | 41,165 | 41,165 | 41,165 | 41,165 | 41,165 |
| Buildings | 474,112 | 447,637 | 451,729 | 477,006 | 462,895 | 448,008 |
| Clinical Equipment | 26,550 | 33,611 | 50,184 | 68,477 | 86,565 | 104,440 |
| Information Technology | 11,208 | 14,921 | 18,879 | 22,881 | 26,795 | 30,617 |
| Work in Progress | 30,092 | 42,115 | 42,145 | 44,198 | 44,198 | 44,198 |
| Other Fixed Assets | 9,333 | 4,374 | 5,385 | 6,572 | 7,701 | 8,771 |
| Total Non Current Assets | 592,460 | 583,823 | 609,486 | 660,299 | 669,319 | 677,199 |
| Current Assets | | | | | | |
| Cash | 17,602 | 33 | 33 | 33 | 33 | 33 |
| Trust/Investments | 9,693 | 10,754 | 10,754 | 10,754 | 10,754 | 10,754 |
| Prepayments | 3,075 | 4,197 | 4,197 | 4,197 | 4,197 | 4,197 |
| Accounts Receivable | 43,580 | 58,394 | 51,217 | 51,217 | 51,217 | 51,217 |
| Inventories | 8,067 | 9,046 | 9,046 | 9,046 | 9,046 | 9,046 |
| Other Current Assets | 5,610 | (6,528) | - | 2 | 2 | 2 |
| Total Current Assets | 87,628 | 75,896 | 75,247 | 75,249 | 75,249 | 75,249 |
| Current Liabilities | | | | | | |
| Bank overdraft | - | 2,704 | 17,188 | 45,118 | 57,413 | 68,560 |
| Payables & Accruals | 148,505 | 215,766 | 219,093 | 195,461 | 195,670 | 195,889 |
| GST & Tax Provisions | 9,351 | 9,642 | 9,642 | 9,642 | 9,642 | 9,642 |
| Current Private Sector Debt | 247 | 55 | 55 | 55 | 55 | 55 |
| Total Current Liabilities | 158,104 | 228,167 | 245,978 | 250,276 | 262,779 | 274,145 |
| Net Current Assets | (70,476) | (152,271) | (170,731) | (175,027) | (187,530) | (198,896) |
| **NET FUNDS EMPLOYED** | **521,984** | **431,552** | **438,756** | **485,272** | **481,788** | **478,303** |
| Term Liabilities | | | | | | |
| Non Current Crown Debt - CHFA | 55 | - | - | - | - | - |
| Restricted & Trust Funds Liability | 9,746 | 72 | 10,760 | 10,760 | 10,760 | 10,760 |
| Non Current Provisions & Payables Personnel | 6,247 | 6,958 | 6,958 | 6,958 | 6,958 | 6,958 |
| Total Term Liabilities | 16,048 | 7,029 | 17,717 | 17,717 | 17,717 | 17,717 |
| **Net Assets** | **505,936** | **424,522** | **421,038** | **467,555** | **464,072** | **460,586** |
| **General Funds** | | | | | | |
| Crown Equity | 765,362 | 774,716 | 797,780 | 802,296 | 788,124 | 784,640 |
| Revaluation Reserve | 136,711 | 131,361 | 131,361 | 131,361 | 131,361 | 131,361 |
| Trust & special funds no restriction | (307) | 10,648 | - | - | - | - |
| *Retained Earnings* | | | | | | |
| Retained Earnings - DHB | (395,830) | (492,203) | (508,103) | (466,101) | (455,413) | (455,414) |
| Total Retained earnings | (395,830) | (492,203) | (508,103) | (466,101) | (455,413) | (455,414) |
| Total General Funds | 505,936 | 424,522 | 421,038 | 467,555 | 464,072 | 460,586 |
| **NET FUNDS EMPLOYED** | **521,984** | **431,552** | **438,756** | **485,272** | **481,788** | **478,303** |

## Prospective Cash Flow

| Capital & Coast DHB<br>Statement of Cashflows<br>Budget for the Four Years ending 30 June 2023 | Actual 2017/18 (000s) | Actual 2018/19 (000s) | Plan 2019/20 (000s) | Plan 2020/21 (000s) | Plan 2021/22 (000s) | Plan 2022/23 (000s) |
|---|---|---|---|---|---|---|
| **Operating Activities** | | | | | | |
| Government & Crown Agency Revenue Receiv | 1,066,677 | 1,139,635 | 1,239,635 | 1,286,635 | 1,335,635 | 1,386,635 |
| All Other Revenue Received | 15,512 | 19,299 | 19,989 | 19,989 | 19,989 | 19,989 |
| **Total Receipts** | **1,082,189** | **1,158,934** | **1,259,623** | **1,306,623** | **1,355,623** | **1,406,623** |
| Payments for Personnel | (453,548) | (501,958) | (545,758) | (562,758) | (579,758) | (596,758) |
| Payments for Supplies | (195,516) | (200,849) | (227,511) | (250,357) | (244,922) | (263,973) |
| Capital Charge | (24,373) | (29,805) | (29,805) | (30,505) | (31,305) | (32,105) |
| GST (net) | (1,535) | (2,244) | (2,244) | (2,244) | (2,244) | (2,244) |
| Other Payments | (378,368) | (415,453) | (435,453) | (447,453) | (460,453) | (473,453) |
| **Total Payments** | **(1,053,340)** | **(1,150,309)** | **(1,240,771)** | **(1,293,317)** | **(1,318,682)** | **(1,368,533)** |
| **Net Cashflow from Operating** | **28,849** | **8,625** | **18,852** | **13,306** | **36,941** | **38,090** |
| **Investing Activities** | | | | | | |
| Interest Receipts from 3rd Party | 1,557 | 1,204 | 1,248 | 1,248 | 1,248 | 1,248 |
| | **1,557** | **1,204** | **1,248** | **1,248** | **1,248** | **1,248** |
| **Capital Expenditure** | | | | | | |
| Land, Buildings & Plant | (11,436) | (18,139) | (11,777) | (11,777) | (11,777) | (11,777) |
| Clinical Equipment | (7,122) | (13,152) | (25,159) | (25,159) | (25,159) | (25,159) |
| Other Equipment | (3,191) | (3,979) | (3,103) | (3,103) | (3,103) | (3,103) |
| Informations Technology | (4,778) | (4,142) | (6,961) | (6,961) | (6,961) | (6,961) |
| **Total Capital Expenditure** | **(26,528)** | **(39,412)** | **(47,000)** | **(47,000)** | **(47,000)** | **(47,000)** |
| **Increase in other Investments** | (1,584) | - | - | - | - | - |
| **Net Cashflow from Investing** | **(26,555)** | **(38,208)** | **(45,752)** | **(45,752)** | **(45,752)** | **(45,752)** |
| **Financing Activities** | | | | | | |
| Deficit Support | - | 14,100 | 15,900 | 8,000 | - | - |
| Other Financing Activities | (3,810) | (3,730) | (3,484) | (3,484) | (3,484) | (3,485) |
| **Total Financing Activities** | **(3,810)** | **10,370** | **12,416** | **4,516** | **(3,484)** | **(3,485)** |
| Net Cashflow | (1,516) | (19,214) | (14,484) | (27,931) | (12,294) | (11,147) |
| Plus: Opening Cash | 28,812 | 27,296 | 8,083 | (6,401) | (34,332) | (46,626) |
| **Closing Cash** | **27,296** | **8,083** | **(6,401)** | **(34,332)** | **(46,626)** | **(57,773)** |
| Closing Cash comprises: | | | | | | |
| Balance Sheet Cash | 27,296 | 10,787 | 10,787 | 10,787 | 10,787 | 10,787 |
| Balance Sheet Operating Overdraft | - | (2,704) | (17,188) | (45,118) | (57,413) | (68,560) |
| **Total Cashflow Cash (Closing)** | **27,296** | **8,083** | **(6,401)** | **(34,332)** | **(46,626)** | **(57,773)** |

| Capital & Coast DHB<br>Statement of Objectives and service performance<br>Budget for the Year Ending 30 June 2020<br>Statement of revenue and expenses by output class | Prevention<br>(000s) | Early Detection and Management<br>(000s) | Intensive Assessment and Treatment<br>(000s) | Rehabilitation and Support<br>(000s) | Total DHB<br>(000s) |
|---|---|---|---|---|---|
| **REVENUE** | | | | | |
| Crown | 12,754 | 265,031 | 770,775 | 128,411 | **1,176,971** |
| Other | - | - | 32,828 | | **32,828** |
| **Total Revenue** | **12,754** | **265,031** | **803,603** | **128,411** | **1,209,799** |
| **EXPENDITURE** | | | | | |
| Personnel | 200 | 3,769 | 532,209 | 2,017 | **538,194** |
| Depreciation | | | 36,000 | | **36,000** |
| Capital charge | | | 26,281 | | **26,281** |
| Provider Payments | 11,103 | 218,965 | 96,405 | 105,714 | **432,187** |
| Other | 1,452 | 42,297 | 128,608 | 20,680 | **193,037** |
| **Total Expenditure** | **12,754** | **265,031** | **819,503** | **128,411** | **1,225,699** |
| **Net Surplus/(Deficit)** | **-** | **-** | **(15,900)** | **-** | **(15,900)** |

| Capital & Coast DHB<br>Statement of Objectives and service performance<br>Budget for the Year Ending 30 June 2021<br>Statement of revenue and expenses by output class | Prevention<br>(000s) | Early Detection and Management<br>(000s) | Intensive Assessment and Treatment<br>(000s) | Rehabilitation and Support<br>(000s) | Total DHB<br>(000s) |
|---|---|---|---|---|---|
| **REVENUE** | | | | | |
| Crown | 13,011 | 270,776 | 807,410 | 131,204 | **1,222,401** |
| Other | - | - | 84,069 | - | **84,069** |
| **Total Revenue** | **13,011** | **270,776** | **891,480** | **131,204** | **1,306,471** |
| **EXPENDITURE** | | | | | |
| Personnel | 177 | 3,343 | 547,992 | 1,789 | **553,301** |
| Depreciation | | | 37,080 | | **37,080** |
| Capital charge | | | 27,069 | | **27,069** |
| Provider Payments | 11,403 | 224,882 | 96,967 | 108,571 | **441,823** |
| Other | 1,625 | 46,253 | 134,716 | 22,605 | **205,199** |
| **Total Expenditure** | **13,206** | **274,477** | **843,824** | **132,964** | **1,264,471** |
| **Net Surplus/(Deficit)** | **(195)** | **(3,702)** | **47,656** | **(1,760)** | **42,000** |

| Capital & Coast DHB<br>Statement of Objectives and service performance<br>Budget for the Year Ending 30 June 2022<br>Statement of revenue and expenses by output class | Prevention<br>(000s) | Early Detection and Management<br>(000s) | Intensive Assessment and Treatment<br>(000s) | Rehabilitation and Support<br>(000s) | Total DHB<br>(000s) |
|---|---|---|---|---|---|
| **REVENUE** | | | | | |
| Crown | 13,481 | 280,565 | 836,598 | 135,947 | **1,266,591** |
| Other | - | - | 35,359 | - | **35,359** |
| **Total Revenue** | **13,481** | **280,565** | **871,957** | **135,947** | **1,301,950** |
| **EXPENDITURE** | | | | | |
| Personnel | 181 | 3,410 | 559,769 | 1,825 | **565,183** |
| Depreciation | | | 38,193 | | **38,193** |
| Capital charge | | | 27,881 | | **27,881** |
| Provider Payments | 11,896 | 234,891 | 94,753 | 113,412 | **454,952** |
| Other | 1,658 | 47,178 | 143,849 | 23,057 | **215,741** |
| **Total Expenditure** | **13,734** | **285,478** | **864,444** | **138,294** | **1,301,950** |
| **Net Surplus/(Deficit)** | **(253)** | **(4,914)** | **7,513** | **(2,346)** | **(0)** |

## 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 $47 million per annum is planned for 2019/20

### 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 Planned Care 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 2019/20 is $47 million. CAPEX is required to be funded internally.

## Equity

**Equity Drawing**

Additional deficit support may be requested for the 2019/20 financial year.

## Working Capital

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

## Gearing and Financial Covenants

No gearing or financial covenants are in place.

## Asset Revaluation

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

## Strategy for disposing of assets

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

## Disposal of Land

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

PART C

# System Level Measures Improvement Plan 2019/20

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Ora Toa PHO

Cosine Primary Care Network

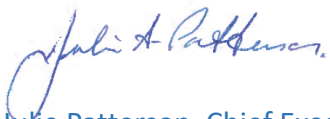
Tū Ora COMPASS HEALTH

# System Level Measures Improvement Plan 2019/20

HCC

Submission 1 July 2019

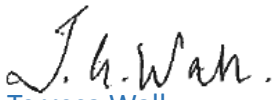
**Signatories for the 2019/20 CCDHB SLM Plan**



Julie Patterson, Chief Executive (Interim),
Capital & Coast DHB

Dr Bryan Betty
Chair, Integrated Care Collaborative

Jeff Lowe
Cosine Primary Care Network Trust



Terresa Wall
Chair, Ora Toa PHO

Martin Hefford
CE, Tū Ora Compass Health

Rachel Haggerty
Director, Strategy Innovation & Performance. CCDHB

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

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

The Integrated Care Collaborative (ICC) Alliance is a key mechanism through which the CCDHB HSP will be realised. The ICC alliance includes primary care, hospital services, planning and funding, ICT leads, pharmacy, ambulance, consumers and other key partners. The associated programme of work has included the implementation of the Health Care Home model and the integration of community services. The ICC has also introduced acute care services, diabetes consultant's collaborative case conferencing and new primary care packages of care. Enablers such as Health Pathways, patient portal, access to patient records across the sector have also been part of the ICC focus. The benefits of these developments are monitored through a number of process, quality and impact measures that include some of the national System Level Measures (SLMs).

The SLMs Framework is another lever to support improvements aligned with the CCDHB Health System Plan. The ICC ALT agreed that the milestones for the SLMs should take into consideration the strategic priorities across the sector and focus on equity. All measures within the plan are stratified for Māori, Pacific and non-Māori/Pacific. This is in line with the ICC focus on progressing the pro-equity approach.

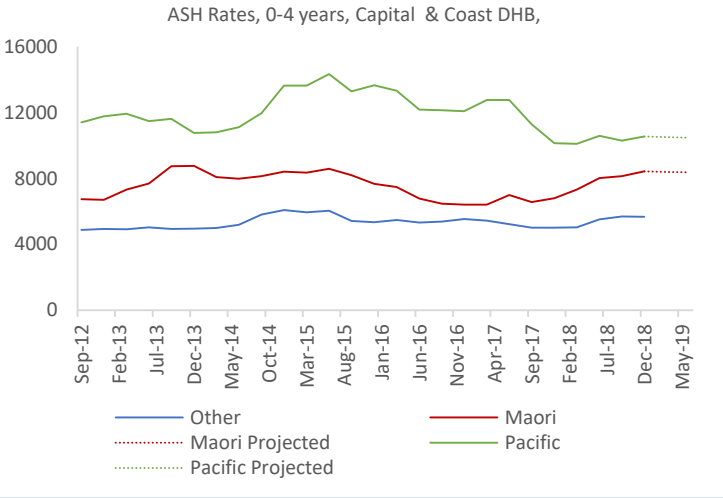
The CCDHB SLM Plan has been developed with the following principles:

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

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

# Ambulatory Sensitive Hospitalisations 0-4 Years

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

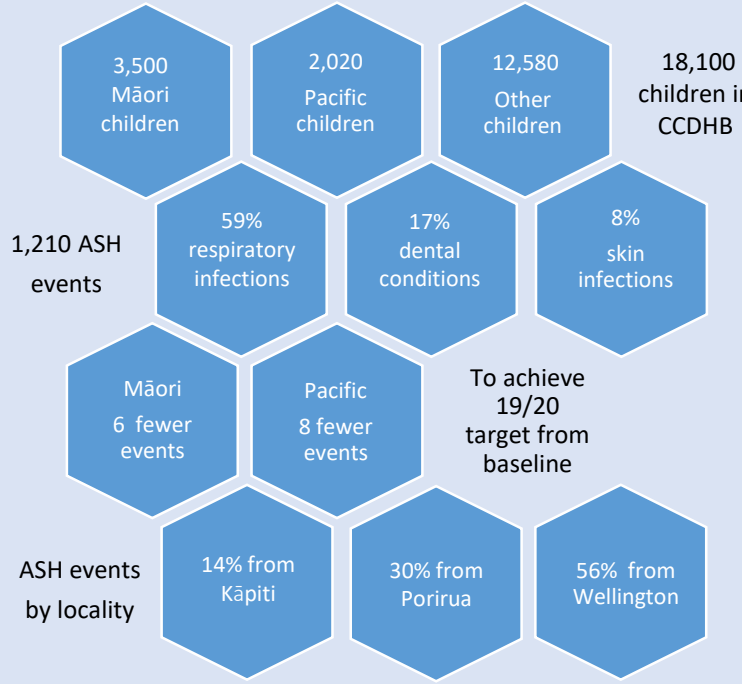



Ambulatory Sensitive Hospitalisation (ASH) 0-4yo 2019/20 milestone: 2% reduction in ASH events for Māori and Pacific.

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

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

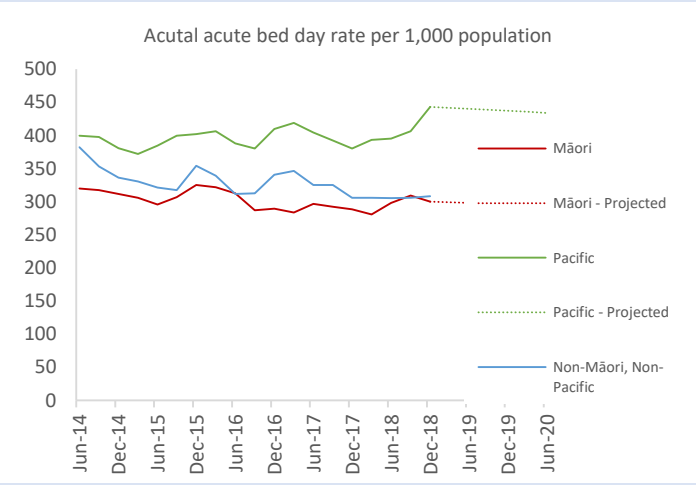
The longer term aim is to ensure that ASH rates for these populations reduce to at least the rates of the non-Maori & non-Pacific population group.




| Opportunity | Actions | Contributory Measures |
|---|---|---|
| Whanau enrolled in VLCA practices are more likely to experience ASH events and/or present to ED and A&M. Improved access to primary care, particularly for Māori and Pacific children and families, is central to achieving equity in childhood ASH. | • Implement an integrated Mātua, Pepi, Tamariki service for Porirua mothers, babies, children and families, to provide culturally responsive primary care for Māori and Pacific families in Porirua.<br>• DHB, PHOs and LMCs will identify barriers for newborn enrolment via questionnaire targeted to key stakeholders and implement improvement processes accordingly.<br>• Facilitating enrolment for Māori people who are not enrolled and present to Kenepuru A&M. They will be provided with enrolment information and asked for consent to allow PHOs to proactively follow them up. | Newborn enrolment rate |
| Respiratory conditions contribute the majority of ASH conditions in CCDHB, particularly repeat ASH events. Prevention, effective treatment plans and support during acute episodes will support these children in the community. | • Increase the uptake of influenza vaccination of 0-4 year olds in practices. PHO will generate eligible lists for all practices prioritised by ethnicity and provide regular feedback on immunisation performance to practices.<br>• ICC Flu Group review the 2019 influenza immunisation campaign and impact, and develop the 2020 approach.<br>• Review immunisation precall, recall and decline practices and protocols, with a focus on improving process and access for Māori and Pacific through the Immunisation Network.<br>• Improve asthma management for Māori and Pacific families through an initiative that includes training for staff, ECE based initiatives, and referral pathways through the Child ICC Network. | ASH rate for asthma & wheeze 0-4 year olds<br>Childhood influenza rate<br>Immunisation rates (8 months, 2 years) |
| Partnering with ECEs presents an opportunity to provide practical support for children who would otherwise not seek treatment/prevention on a range of conditions or behaviours. | • Working with Regional Public Health and East Porirua Pacific ECEs and Kohangas, to identify opportunities to 'intensify' health promotion in East Porirua, with a focus on skin care, asthma and general child wellbeing.<br>• Continue the skin packs in Porirua schools initiative through the Child ICC Network. | ASH rate for skin infections 0-4 year olds |

# Acute Bed Days

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



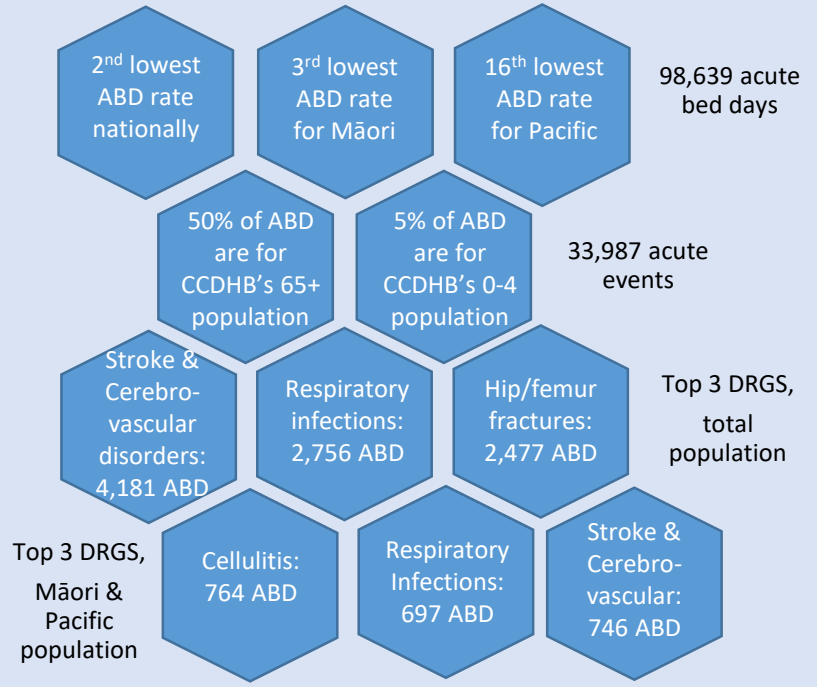

Note the age standardised rate for Māori is higher than Other ethnicities. We use the actual rate per 1,000 to model actual reductions in events and bed days. A reduction in actual acute bed days will also result in a reduction in the standardised rate for Māori.

Acute Bed Day (ABD) 2019/20 milestone: 2% reduction in actual acute bed day rate for Māori and Pacific. This equates to a reduction of 407 acute bed days or 156 fewer acute events.

The number of acute bed days is complex and attributable to many factors. Improvements to acute demand and patient flow will enable services to be smarter about acute responses and improve patient flow in hospital. Access to and timely diagnostics, comprehensive patient care coordination and logistics with a well equipped workforce will enable people to receive acute care in primary and community settings.

An Acute Demand and Bed Capacity Steering Group is providing oversight of a range of initiatives to improve bed occupancy across the system. The focus is to focus on winter peaks and ongoing pressures.

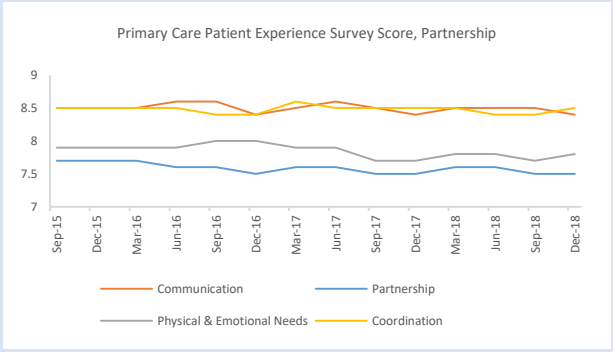
The long-term aim is to ensure that ABD rates for Māori and Pacific populations reduce to at least the same rates of the non-Maori & non-Pacific population groups.

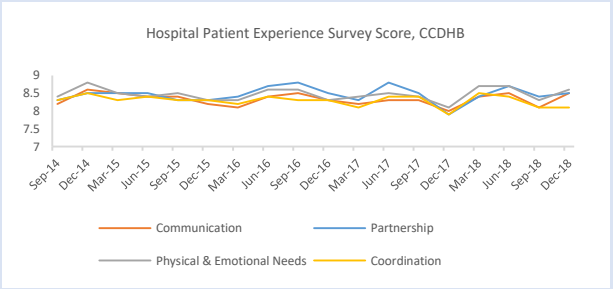



| Opportunity | Actions | Contributory measure |
|---|---|---|
| There is increased demand on bed capacity. Similar to 2018, an increase in demand is being experienced prior to winter. Current standardised acute bed days per 1,000 population are 433.3 for Māori, 615.5 for Pacific, and 289.6 for other ethnicities. | • Implement new Patient Care Coordinators and allied health roles on the medical and rehabilitation wards to intervene early in the admission in order to support early discharge for complex patients.<br>• Improve discharge processes for long-stay patients in general medical wards and introduce improved acute flow tools across selected wards<br>• Introduction of Influenza POCT to influence bed management in Influenza season | Acute ALOS for CCDHB-domiciled population |
| Growth in ED presentation numbers continue and have exceeded capacity. Enhancing the management of people in primary care via community based acute response services will support people to receive care in the community. Current age-standardised ED presentation rates to sub-regional hospitals are 198 for Māori, 243 for Pacific and 152 for other ethnicities. | • Increased investment in packages of care and increase the range of care packages available to Health Care Homes and VCLA practices. The focus will be initially in Kapiti where a higher proportion of older people reside.<br>• Introduce packages of care to enable ambulance diversion back to primary care in partnership with the local ambulance service<br>• Introduce packages of care to support ED and assessment units to discharge people back to primary care early. This will be supported with warm handovers to support people returning safely to primary care. | Age-standardised ED presentation rates in sub-regional hospitals for CCDHB-domiciled population |
| Frail older people contribute to a significant volume of bed occupancy due to their complex health and social circumstances. Current age-standardised acute events in sub-regional hospitals for CCDHB-domiciled people aged >65 years are 309 Māori, 392 Pacific and 203 for other ethnicities. | • Implement the Community Health of Older People Initiative that will provide acute and proactive care support for people. This involves a Geriatrician and Nurse Practitioners who will partner with Health Care Homes and Allied Health teams to support care in the community. The service will participate in multidisciplinary proactive care planning, take acute calls from the community and complete comprehensive older people assessments.<br>• Implement additional pharmacist facilitation roles in Health Care Homes practices where there are larger numbers of older people. The pharmacists will focus on polypharmacy and participate in the year of care planning multidisciplinary meetings. | Age-standardised acute admission rates in sub-regional hospitals for CCDHB-domiciled people aged >65 years |

# Patient Experience of Care

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




Patient Experience of Care – 2019/20 milestone: Improve lowest scoring domains Primary Care PES Partnership domain ≥ 7 for Pacific and Māori. Improve inpatient PES scores to: coordination ≥ 8.2, communication ≥ 8.6, Physical & emotional needs ≥ 8.7, and partnership ≥ 8.6.

The number of respondents to the Primary Care survey has increased over time, while the number of respondents to the Hospital survey has fluctuated in the recent data. The response rates for Māori and Pacific in both surveys remain lower than for the 'Other' population. Feedback from CCDHB partners identify that the length and complexity of the survey limits responses, particularly from Māori and Pacific people. This remains a challenge in making improvements from an equity perspective.

CCDHB's scores in the Primary Care survey for the total population are at or above the national average for the 4 domains: Communication, Coordination, Partnership, Physical & Emotional needs. CCDHB is below the national average for 3 domains for Māori, and all domains for Pacific. The hospital survey scores for the total population are at or above the national average for the 4 domains: Communication, Coordination, Partnership, Physical & Emotional needs. There is an insufficient sample for analysis by ethnicity.

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

28,979 people invited to Primary Care Survey

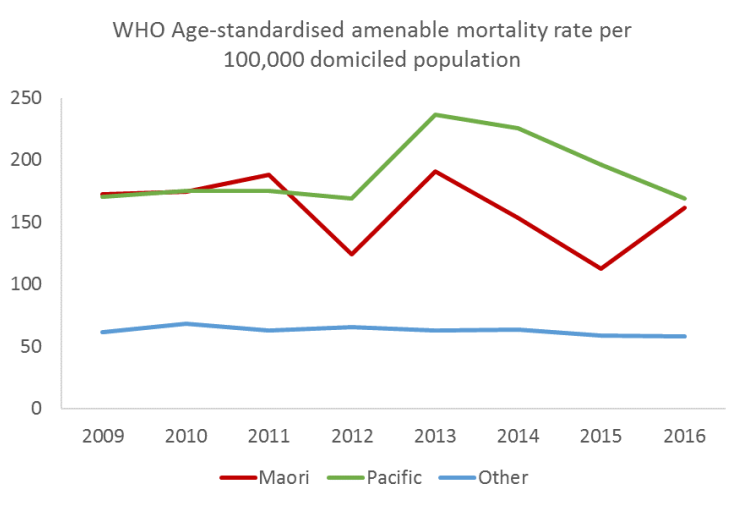
- 25% response rate; 7,093 respondents
- 24% response rate; 402 Māori respondents
- 22% response rate; 129 Pacific respondents
- 66% of respondents are female
- 10% of respondents are 15-24 years
- 32% of respondents are 65+ years
- 24% of people invited via email complete the survey
- 0.6% of people invited via SMS complete the survey

| | | Communication | Partner-ship | Physical & Emotional Needs | Coordination |
|---|---|---|---|---|---|
| Primary Care | Māori | 8.4 ▬ | 7.3 ▼ | 7.5 ▼ | 7.9 ▼ |
| | Pacific | 8.3 ▼ | 7.0 ▼ | 7.5 ▼ | 8.3 ▼ |
| | Other | 8.5 ▲ | 7.6 ▬ | 7.8 ▲ | 8.5 ▬ |
| Inpatient | Total | 8.5 ▲ | 8.5 ▼ | 8.6 ▼ | 8.1 ▼ |

| Opportunity | Actions | Contributory measure |
|---|---|---|
| Primary care will focus on the partnership domain, with a focus on improving the quality and patient focused approach to long term conditions planning. | • Patient centred care plan training will be rolled out across the Health Care Homes teams including the primary care teams, District Nurses and Community Allied Health teams.<br>• Health Care Homes will introduce shared medical appointments with groups of people with particular long term conditions.<br>• Expansion of the Health Care Home multidisciplinary care planning across the final tranche of practices | Number of cases discussed at HCH multidisciplinary team meetings. |
| There is an opportunity to increase scores across all domains in the hospital patient experience survey by improving the patient safety culture. This will improve our response to patients and families especially when things don't go as planned. | • Implement planned activities to support patient safety culture. These include improving the serious adverse events process, strengthen the speaking up for safety programme , introduce restorative practice, updating the open communication training, implementing the Korero Mai - Whānau led escalation of deteriorating patient.<br>• Work with Māori and Pacific Health teams to initiate an improvement project to improve the response rate for Māori and Pacific. Initial activity to include understanding what is driving the current response rate. Solutions may include alternative feedback methods. | Hospital PES - All domains |
| Simplifying access to health care options for people with technology solutions, where appropriate, is a key strategy for Health Care Homes. The increased use of the patient portal and accessibility of patient notes via the portal; supports patient care and creates efficiencies within practices. | • Patient portal activation in Health Care Homes and VCLA practices will be increased in line with annual improvement goals agreed to through the Health Care Home change programme.<br>• All Health Care Homes in their second year in the programme are incentivised to open their clinical notes to patients via the portal<br>• Obtain patient portal activation data by ethnicity through ongoing negotiation with the portal vendor | Percentage patient portal activation |

# Amenable Mortality

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

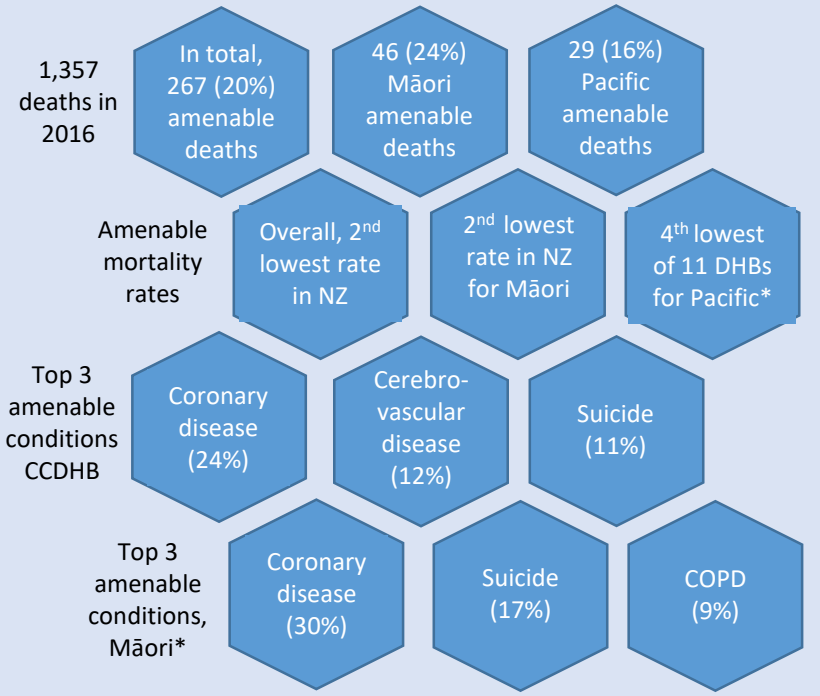



*Draft* Amenable Mortality (AM) 2019/20 milestone: At the end of 2026 Amendable Mortality for all ethnicities will be equivalent. 2016 target yet to be updated.

In 2014 and 2015, AM rates for Māori and Pacific tracking downwards. For 2015 and 2016 downwards trend has continued for Pacific and risen for Māori.

A reduction in Amenable Mortality (AM) rates requires across sector preventative and pro active care approach so long term conditions are managed well and people have the care they need in their community. The CCDHB has taken a long term approach to reduce AM rates. This reflects that changes today will impact on the rates of AM in the future.

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

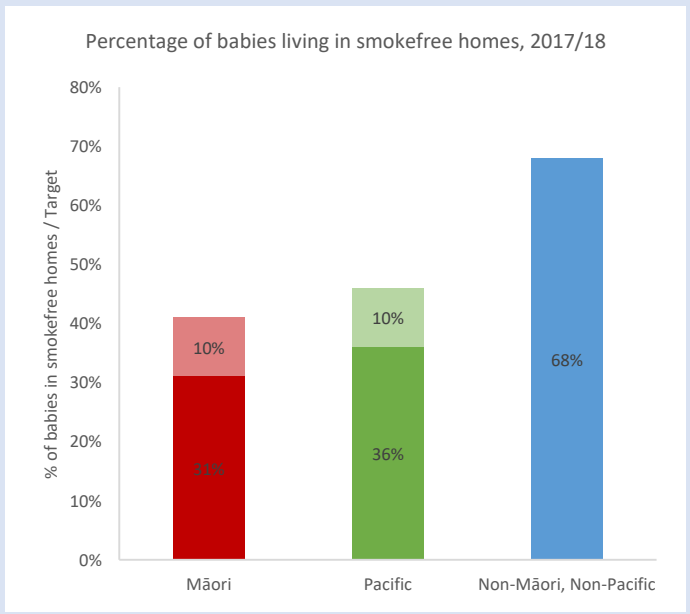



*Rates suppressed due to low numbers; Conditions for Pacific population not published by MOH

| Opportunity | Actions | Contributory measure |
|---|---|---|
| Effective long term condition management requires a wide range of approaches and increasingly requires an approach that supports a range of co-existing long term conditions. Through the Health Care Home model a number of interventions to support long term conditions that are linked to higher rates of amenable mortality will be implemented. | • Health Care Homes will pilot Health Coaches as part of their teams to work with people with long term conditions to improve outcomes that are important to their health.<br>• Health Care Homes will work towards agreed targets in Year of Care Planning for those people identified as higher risk as per the risk stratification tools.<br>• The ICC Diabetes Clinical Network will apply its maturity matrix tool to priority practices and redirect specialist support across the community to broaden their reach and impact<br>• Pilot role of the health Improvement Practitioner and health coach roles in four health centres | Percentage of year of care plans completed of those identified as high risk admission in Health Care Homes<br><br>Percentage HbA1c<64 mmol/L |
| Improving CCDHB smoking quit rates will significantly reduce the risk related to a number of long term conditions, the related morbidity and future mortality. Supporting smokers and their families to quit continues to be a focus across the CCDHB system. Smoking quit rates are 8% for Māori, 8% for Pacific and 14% for other ethnicities. | • Refresh and implement the DHB Tobacco Control Plan for 2019-2021 focusing on integration of services and support for hāpu wāhine, Māori, and Pacific peoples.<br>• Expand the Hāpu Mama incentives programme to support 100 Māori and Pacific mothers of children aged 0-4 years to quit smoking. | Smoking quit rate |
| Cardiovascular disorders and diabetes continue to be the largest causes of amenable mortality for the total population and Māori. Implementing the new screening guidelines that recommend expanded target age bands will activate earlier care for people at higher risk of these conditions. | • PHOs will work with practices with large volumes of people who require screening with a range of activities such as establishing targeted clinics, funding Māori and Pacific men's breakfast event and facilitating men's health groups<br>• Cardiovascular screening practice level data to be included in the Diabetes Clinical Network. The Network will drive cyclical improvement activities to improve screening, including the identification of three key healthy heart messages that can be promoted across the DHB. | Percentage of PHO enrolled population identified as high risk of CVD and not on statin |

# Babies Living in Smokefree Homes

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

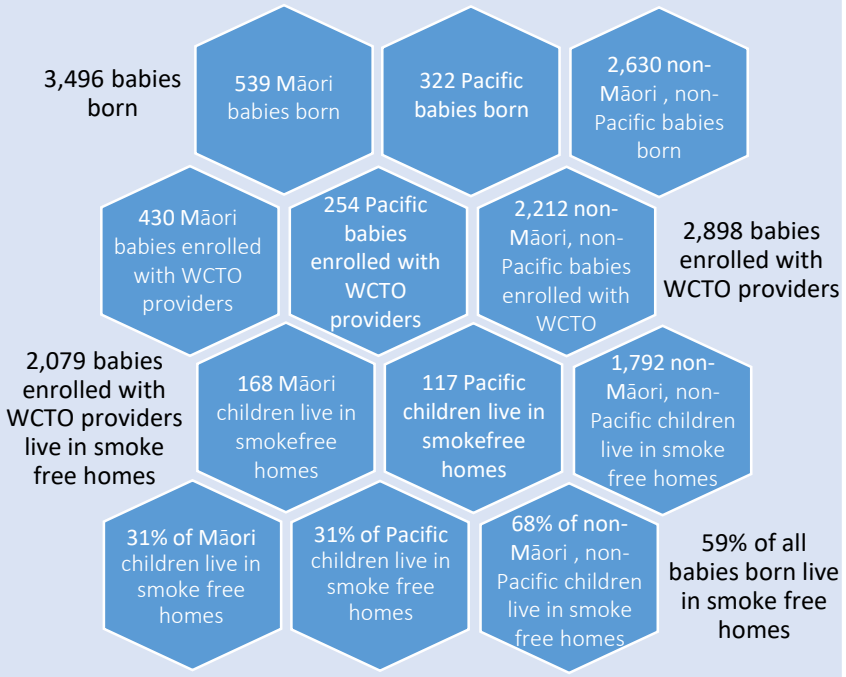



Babies Living in a Smokefree Home 2019/20 milestone: 10% improvement in percentage of Māori and Pacific babies live in smokefree homes. This will result in an additional 53 Māori babies and 31 Pacific babies living in smokefree homes.

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

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

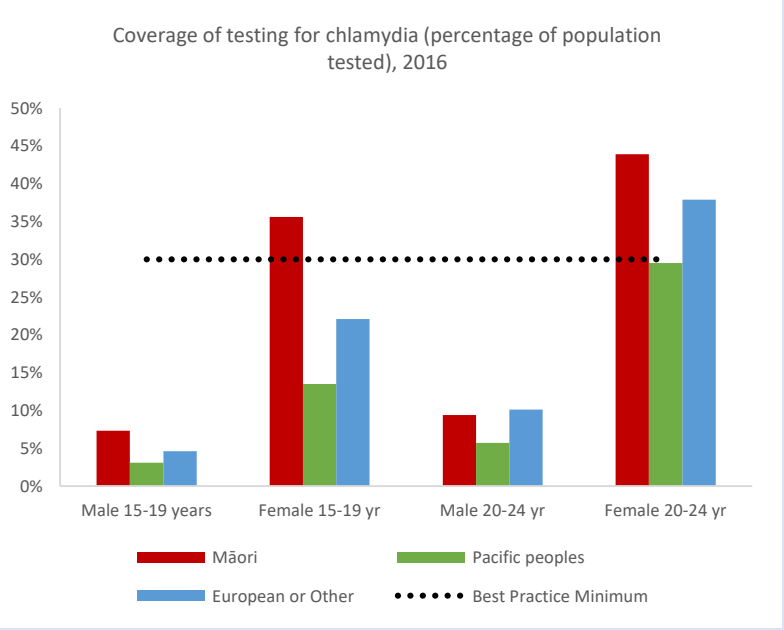
Through National SUDI prevention programme, CCDHB will focus on smoking cessation during the antenatal and postnatal periods. Primary care and the hospital are key vehicles for the implementation of the programme to support vulnerable babies in this early stages and as they grow.




| Opportunity | Actions | Contributory measure |
|---|---|---|
| Whānau focused stop smoking support and resources will provide a healthy start for babies life and has the potential to impact on more than the individual. | • Implement wahakura wānanga programmes to vulnerable hāpu mama and whānau, including focused messages around safe sleep, immunisation, breastfeeding and smoking cessation. | Mothers who are smokefree at two weeks post-natal |
| Primary health care providers have an opportunity to support whanau in their smoking cessation journey as part of their overall health care needs. | • PHOs will initiate quarterly data matching processes within practices to identify new born babies and cross reference with those who identify as smokers who live in the same household. This will be the first step to identify at a practice and PHO level the rate of babies in a household with/without smokers. | PHO rate of babies in households with smokers |
| Porirua has the highest number and percentage of smokers compared to Wellington and Kāpiti. In 2017, 23% of women from Porirua who gave birth identified as a smoker. | • Implement and monitor a smoking cessation incentives program in Porirua, focused on hāpu mama and their whanau. This may include petrol or supermarket vouchers provided by the Hāpu mama smoking cessation service. | Uptake of cessation service by hapu mama and their whanau |

# Youth access to & utilisation of youth appropriate services

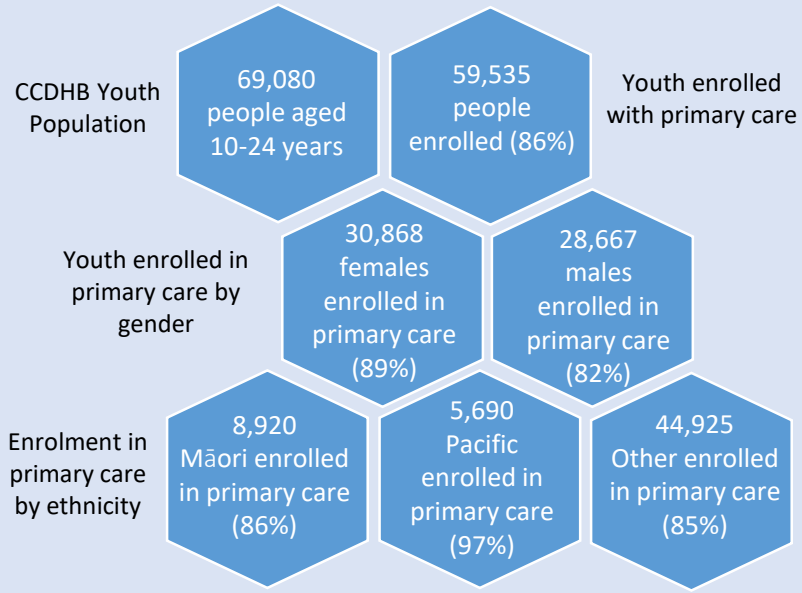
Supporting our youth to build healthy and safe lives is a focus in the CCDHB HSP. Young people are not high users of the health system, but the choices they make now impact on their future health needs.




In 2019/20, CCDHB will focus on the sexual health domain of the Youth SLM and aim to support young people to manage their sexual and reproductive health safely and receive youth friendly care. The 2019 milestone is to improve male coverage of testing to 15%, across all ethnic groups and maintain 30% coverage of testing for females. This will result in an estimated 2,200 males and 10,300 females tested for chlamydia.

Chlamydia is the most commonly reported STI and coverage screening rates vary considerably between gender and ethnicity. Through increasing coverage of chlamydia testing we aim to improve youth primary care enrolment and utilisation and also positively impact on risk of associated health conditions such as pregnancy rates and mental health conditions. Improvement projects are underway focused on youth in high needs areas to ensure youth health needs are met.

Connecting youth with health providers and strengthening links with primary care; youth can access what they need, when and where they need it.




| Opportunity | Actions | Contributory measure |
|---|---|---|
| Youth engage with a variety of health services, outside of primary care. To ensure youth receive access and care into adulthood, enrolment with a primary provider is beneficial. Through better integration between all youth providers, youth will have a continuation of health service access. . | • Increase Sexual and Reproductive Health Education in low decile schools through MOH funded services<br>• To complete data matching with YOSS and School Based Health Services to improve youth enrolments in Primary Care<br>• Connect with sports clubs and PHOs to discuss and implement ways of encouraging young Māori men to enrol in primary care through the ICC Youth Steering Group. | Youth enrolment in primary care by ethnicity |
| Youth utilisation of health services will provide youth with access to community services, supporting positive health care decisions. There is greater risk for youth living in low social economic areas and addressing factors . | • Activate primary care recall process to recall young males who have not been vaccinated for HPV<br>• Implement standardised process with primary care practices to enable nurses to order blood tests that accompany swap to complete the full STI screen. | Utilisation of Primary Health Services by Youth |