Annual Plan 2020/21

COUNTIES MANUKAU HEALTH

2020/21 Annual Plan incorporating the 2019/20-2022/23 Statement of Intent and 2020/21 Statement of Performance Expectations

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

He Pou Koorero

(A Statement of Intention)

Ko te tumanako a tenei poaari he whakarato i teetahi o ngaa taupori Maaori nui, taupori Maaori matatini, puta noa i te motu. Ko te whakakikokiko i te mana-taurite hauora Maaori teetahi o aa maatou tino whaainga.

Ko too maatou hiahia ko te whakamana, ko te whakatinana hoki i te wairua me ngaa maataapono o Te Tiriti o Waitangi hei tuuaapapa i taa maatou e whai nei, me te whakapono nui - maa te aata whakapakari i te ara whakawaiora Maaori e taea ai te whakatutuki i te mana taurite hauora moo te katoa.

As a District Health Board we serve one of the largest and most diverse Maaori populations in the country. Achieving Maaori health equity is a key priority for us.

Our commitment to this is driven by our desire to acknowledge and respect the Treaty of Waitangi and our belief that if we are serious about achieving health equity for our total population, we must first strengthen our commitment and drive to accelerate Maaori health gain in our community.

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Minister's 2020/21 Letter of Expectations to Counties Manukau DHB

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Vui Mark Gosche
Chair
Counties Manukau District Health Board
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Tēnā koe Vui Mark

Letter of Expectations for district health boards and subsidiary entities for 2020/21

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2020/21.

DHBs make positive differences in the lives of New Zealanders and I look forward to working with you and your new Board to deliver the wider changes we need to improve outcomes. Strong and sustained leadership provides a foundation for high-performing DHBs and is critical to overall sector performance.

The Government intends to deliver long term, sustainable change to support improved wellbeing for New Zealanders. In the coming months we will receive the final report from the New Zealand Health and Disability System Review. Many of you have contributed to the review, and I thank you for that. The interim report aligned strongly with our Government's priorities and the changes we have underway to deliver better outcomes for Māori and improving equity and wellbeing. I expect you to be prepared and ready to implement Government decisions resulting from the review.

Wellbeing and equity underpin my priorities. Appendix one details expectations for the five system priorities:

- improving child wellbeing
- improving mental wellbeing
- improving wellbeing through prevention;
- better population outcomes supported by a strong and equitable public health and disability system
- better population health and outcomes supported by primary health care.

This letter will outline my expectations for a range of matters that contribute to performance across these priority outcomes.

Governance

The DHB Board sets the direction for the DHB and rigorously monitors the DHB's financial and non-financial performance and delivery on the Government's priorities.

I expect you to hold your Chief Executive (CE) and senior leadership team to account for their financial performance and on the delivery of equitable health outcomes for your population.

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As Chair, you will need to provide leadership and direction to the Board, providing guidance and support to members to ensure they effectively govern the DHB. Please ensure that you have a process in place to review the performance of the Board on a regular basis.

Sustainability

Every DHB must clearly demonstrate how strategic and service planning will support improved system sustainability, including models of care and the scope of practice of the workforce. You should address how your DHB will work with sector partners to deliver the Government's priorities and outcomes for the health and disability system while reducing cost increases and deficit levels.

Please ensure that your 2020/21 planning documents clearly identify your DHB's approach to financial and clinical sustainability at both a strategic level and operationally across each of my priority areas.

Service performance

I expect you to challenge and support your CE and senior leadership team to identify ways to respond to the challenges the DHB faces, including timely, high quality delivery of planned care, reducing the length of emergency department stays and increasing immunisation coverage. You will oversee progress on the plans they develop to address these issues.

You need to ensure that workforce and delivery plans support innovative models of care and don't merely add FTE to maintain existing approaches. I expect this to be supplemented with other activities, such as managing annual leave liabilities and maximising productivity in theatres and wards.

Achieving equity

Achieving equity in health outcomes and ensuring fairness in access to and experience of care is essential. I will always expect you to consider equity as you develop plans across priority areas and to prioritise resources to achieve equity across population groups. This will include improving health outcomes for Maori and Pasifika, and an explicit focus on addressing racism and discrimination in all of its forms across all aspects of your operations.

Embedding Te Tiriti o Waitangi and achieving pae ora (healthy futures) for Māori

Māori-Crown relations are a priority for this Government, and I expect your DHB to meet your Te Tiriti o Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I expect you to develop your plans in partnership with your iwi/Māori partnership boards and include a statement from the Chair of the partnership board in your annual plan alongside statements from yourself and your CE.

Achieving pae ora (healthy futures) for Māori is an important goal for the entire health and disability system. While this includes achieving equity in health outcomes for Māori, responding to our obligations under the Treaty of Waitangi goes beyond that. A critical aspect is enabling iwi, hapū, whānau and Māori communities to exercise their authority to improve their health and wellbeing. I expect your plan to specify how you will work with iwi and Māori communities in your district to achieve this goal.

Financial performance and responsibility

The 2018/19 and 2019/20 budgets have provided the largest increases in funding that DHBs have ever had. To improve service and financial performance, you must focus on good

decision-making within your sphere of control and influence. Most of the issues driving costs are within the control of the DHB, including the number and mix of full-time equivalent staff.

A central challenge in the public health system is to deliver a wide range of quality health services to New Zealanders while remaining within budget. You will be aware of your DHB's financial position and my expectation is that you and your Board will deliver improved financial management and performance; this is especially true for those DHBs that have struggled in recent years.

The In-Between Travel (IBT) appropriation will be devolved from 1 July 2020. I expect you to work with the Ministry of Health (the Ministry) to ensure a seamless transition of responsibilities. The Ministry has an ongoing stewardship responsibility to ensure that all IBT obligations are met.

Capital investment

Timely delivery of the business cases prioritised for investment from the Budget appropriation should be a strong focus. You must comply with financial performance expectations for capital investments requiring Crown equity. You will also be expected to deliver a business case within the budget parameters set, and ensure all investments are procured in a timely manner.

Business cases for high priority projects should continue to be developed irrespective of their immediate investment status and I will seek your assurance that this work is progressing.

I expect all DHBs to follow the guidelines for construction procurement developed by the Ministry of Business, Innovation and Employment. I also expect DHBs to support the initiatives being developed under the Construction Accord. Information on these initiatives will be provided as the work develops.

The Government is supporting a range of capital infrastructure initiatives. The wider public good from our capital projects must be realised, which requires adherence to certain principles. An example is the NZ Green Building Council (NZGBC) Green Star rating for new building developments. Capital builds ought to meet a 5-star standard in the absence of any other mature standard, and this aim should be written into design thinking from the outset. This should result in longer term efficiencies, both financial and environmental. During 2020/21, you will need to engage with the Ministry and other partners as we continue to evolve approaches to sustainable facility design.

National Asset Management Plan

I would like to thank your DHB for supporting the first iteration of the National Asset Management Plan (NAMP) and ask that you continue to engage with the NAMP work as we develop and implement the next phases. Please continue to strengthen your DHB's asset management approach, including focusing on critical service assets, embedding asset management practices and ensuring you appropriately govern service improvement and asset performance.

Service user councils

Service user/consumer councils are key mechanisms through which service users can give feedback on how health and disability services are delivered in different communities. The Health Quality and Safety Commission (the Commission) has provided guidance to support an effective approach – 'Engaging with consumers: A guide for district health boards' and 'Progressing consumer engagement in primary care'. I am aware that many DHBs already

have strong service user councils and I want to strengthen this across all districts and regions.

The Commission, in partnership with the sector, has developed quality and safety markers for service user engagement and I encourage your DHB to participate in this.

My priority areas

I have clearly communicated my priorities for the health system. I expect your annual plans to address these priorities to meet the needs of all population groups, especially those groups that experience the most significant inequities. The actions you commit to in your plan must contribute to lasting equity and outcome improvements for Māori and for your Pacific population, including a strong focus on prevention. Appendix one details expectations for the five system priorities, which will be further described in the planning guidance your DHB receives from the Ministry.

I look forward to engaging with you on your planning intentions, receiving your planning documents for 2020/21 and working with you as your DHB delivers on your commitments. I appreciate you are receiving this letter at a time when our system is facing emerging pressures from COVID-19. I am pleased to see the way the sector has worked together during the early response phase and I know DHBs will continue to support our collective system response.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Appendix one: Ministerial planning priority areas

Improving child wellbeing

The Child and Youth Wellbeing Strategy and Programme of Action (the Strategy) launched in August 2019 provides a clear pathway to ensuring New Zealand is the best place in the world for children and young people to live. I expect your annual plans to reflect how you are working to improve the health and wellbeing of infants, children, young people and their whanau. Your plans should focus on improving equity of outcomes (especially for Māori); on children and young people of interest to Oranga Tamariki; and children with greater need, including children and young people with disabilities.

I expect DHBs to increase childhood immunisation rates, especially for Māori. The recent measles outbreaks remind us of the impact of communicable diseases on our communities and the health sector and the importance of achieving full immunisation. I expect DHBs to work closely with their primary care providers to prioritise immunisation, including a renewed focus on robust pre-call and recall processes and immunisation outreach services.

I expect DHBs to focus on family and sexual violence screening, early intervention and prevention to ensure victims and families receive effective and timely health care and perpetrators are supported to break the cycle of family and sexual violence.

High quality maternity care is fundamental to ensure children get the best possible start in life. As part of their commitment to the Midwifery Accord signed in April 2019, I expect DHBs to implement a plan to improve recruitment and retention of midwives. You should use Care Capacity Demand Management (CCDM) work to ensure optimal staffing in maternity facilities.

Working with a full range of stakeholders, the Ministry has developed a comprehensive Maternity Action Plan to support a flexible, innovative and sustainable maternity system. I expect DHBs to work with all elements of the maternity system to ensure responsiveness to Māori and equitable access to quality maternity care, including maternal and infant mental health services.

Improving mental wellbeing

He Ara Oranga: Report on the Government Inquiry into Mental Health and Addiction and the Government's response, has set a clear direction for mental wellbeing in New Zealand. Supported by the investments announced in the 2019 Wellbeing Budget, we have a unique opportunity to improve the mental health and wellbeing of New Zealanders. Your leadership will drive system transformation in the mental health and addiction sector.

Collective action is needed to achieve equity of outcomes, in particular for Māori, as well as for other population groups who experience disproportionately poorer outcomes, including Pacific peoples, youth and Rainbow communities. You will work with the Ministry, the Initial Mental Health and Wellbeing Commission and the Suicide Prevention Office to support system transformation and the rollout of the Government's priority initiatives.

The mental health and addiction system must respond to people at different life stages and levels of need. I expect DHBs to work individually and collectively on mental health and addiction promotion, prevention and early intervention at the primary and community level. At the specialist end of the continuum you should ensure those with the most need have access to sustainable quality mental health and addiction services.

Improving New Zealanders' mental wellbeing will require collaboration with communities and non-government organisations (NGOs). I consider that DHBs have a social responsibility to

support the sustainability of NGOs and to empower communities to engage in the transformation of New Zealand's approach to mental health and addiction. This includes offering your expertise at no charge to NGOs and community organisations to support participation in new service delivery, particularly for communities who experience disproportionately poorer outcomes.

I expect you to contribute to the development of a sustainable and skilled workforce. You must invest to diversify, train and expand both the existing and new workforces. You should focus on training workforces to support the Government's primary mental health and addiction initiatives and communicate proactively with the Ministry about opportunities to expand coverage to reach underserved populations.

Improving wellbeing through prevention

Environmental sustainability

Ensure that you continue to contribute to our Government's priority of environmental sustainability, including green and sustainable facility design as noted above in the section on Capital Investment. I expect your annual plan to reflect your work to progress actions to mitigate and adapt to the impacts of climate change and enhance the co-benefits to health from these actions.

Antimicrobial resistance

I am concerned about the increasing threat of antimicrobial resistance (AMR) to our health security. DHBs have a key role in minimising this threat. The issues are systemic and require long-term planning and sustained actions.

I expect your annual plan to reflect actions that align with the objectives of the New Zealand Antimicrobial Resistance Action Plan and demonstrate you are working towards a sustainable approach to containing AMR.

Smokefree 2025

Smoking remains a major preventable cause of premature death, morbidity and health inequities. My expectation is that you work towards achieving Smokefree 2025. I expect to see effective community-based wrap-around interventions to support people who want to stop smoking, with a focus on Māori, Pacific people, pregnant women and those on a low income. The interventions should reflect your regional and programme provider collaborative efforts.

Bowel Screening

The National Bowel Screening Programme remains a priority for this Government. DHBs are expected to achieve national bowel screening targets (where applicable) and consistently meet diagnostic colonoscopy wait times. It is crucial that symptomatic patients are not negatively impacted by screening demand. DHBs must work individually and collectively to develop a sustainable endoscopy workforce, including support of training positions for nursing and medical trainees to meet growing demand in this area.

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

National Cancer Action Plan

On 1 September 2019 the Prime Minister, Rt Hon Jacinda Ardern and I launched the National Cancer Action Plan and its four key outcomes. DHBs have an important responsibility to drive the necessary changes and deliver of these outcomes.

I have established a National Cancer Control Agency, which will report to me on the implementation of the Cancer Action Plan. You will work with and take direction from the Agency to reach national standards of care and improve quality.

Disability

Disabled people experience significant health inequalities and they should be able to access the same range of health services as the general population. Your DHB should look for opportunities to increase its employment of disabled people to improve the competency and awareness of your workforce in matters regarding disabled people and to advance social inclusion more generally.

Accessibility means that your DHB provides a barrier-free environment, including information and communications for the independence, convenience and safety of a diverse range of people. This includes people who may have access needs, including disabled people, older people, parents and carers of young children and travellers.

Enabling disabled people to access health services includes ensuring that all key public health information and alerts are translated into New Zealand Sign Language. It means consulting disabled patients (including people with sensory, intellectual or physical impairments) on their preferred means of communication for appointment notifications and the like.

As with previous years, your DHB must make progress towards, or fully implement, the United Nations Convention on the Rights of Persons with Disabilities. DHBs also need to implement policies and procedures to collect information about disabled people within your patient population. DHBs should also ensure contracts with providers reflect the requirement to either ensure accessibility or put in place plans to transition to a more accessible service.

Healthy ageing

If our ageing population continues to grow as current trends suggest, the number of people with dementia, and the associated financial and social consequences, will grow commensurately. This Government is determined to make a positive difference in the lives of people with dementia, their families, whānau, friends and communities. I expect your DHB to work with your region to implement the regional dementia priorities.

Please ensure the DHB develops models of care to identify frail and vulnerable older people in community settings, in particular Māori and Pacific peoples, and provides supports to restore function and prevent the need for acute care.

Workforce

I expect DHBs to develop bargaining strategies that progress the Government Expectations on Employment Relations in the State Sector.

I expect bargaining strategies to progress consistent employment arrangements and support agile, innovative workforces to deliver services. Employment arrangements should encourage people to grow, develop and thrive in a work environment that supports transdisciplinary teams and innovative models of care. I expect commitments made in bargaining to be met, including working party commitments, Accords or programmes, such as the CCDM programme.

DHBs have an essential role in training our future workforce and providing learning and development opportunities for current workforces. I expect you to continue to utilise current workforces to support innovative and transdisciplinary practice across models of care and enable people to work to their full scope of practice.

DHBs must create environments in which all health and disability workforces thrive. DHBs should facilitate healthy and culturally reinforcing working environments that support health equity outcomes for all.

Workplace violence

I am concerned about what appears to be increased levels of violence in the health workplace. In accordance with the Health and Safety Act 2016, DHBs are responsible for the health and safety of their staff, patients and visitors. I expect DHBs to keep staff, patients and visitors safe by implementing appropriate policies, procedures and training to maintain public trust and confidence in the health and disability sector.

Health Research Strategy implementation

Research and innovation, analytics and technology are all crucial to achieving an equitable, sustainable health system and better patient outcomes.

The New Zealand Health Research Strategy (2017-2027) is the key platform for us all and it is important to implement the strategic priorities. In the next year, we should focus on developing a flourishing research and innovation culture in our DHBs in both primary and secondary care.

I have asked the Ministry to work with you and other stakeholders to build up DHB people and resources to support and enhance research, innovation and analytics so the system can make better use of the evidence and innovation and contribute to the Health Research Strategy objectives. Please work with the Ministry to design and invest in the programme of work with a focus on creating regional research and analytics networks that support staff engaged with research and innovation.

National Health Information Platform (nHIP/Hira)

Digital health services are important to me and to all New Zealanders and I expect DHBs to ensure the digital services you use are safe, secure, integrated, reliable and provide appropriate access to data and information.

I also expect you to support the Ministry in developing and designing nHIP/Hira services and to prioritise nHIP/Hira implementation activities in your annual plan.

Planned care

The refreshed approach to deliver elective and arranged services, under a broader planned care programme, will build on the development of the three-year plan you started in 2019/20. Timely access to planned care remains a priority. I urge you to take advantage of the increased flexibility in where and how you deliver these services; to ensure improved equity

of access and sustainability of service delivery; and to provide services that meet your population's health care needs, support timely care and make the best use or your workforce and resources.

I am particularly concerned, across many DHBs, about the number of people waiting beyond expectations for first specialist assessments, planned care interventions, ophthalmology follow-ups and diagnostic radiology services. Please ensure you have appropriate plans in place to support timely care.

Measuring Health System Performance

The System Level Measures (SLM) programme provides a framework for continuous quality improvement and integration across the health system. I intend to build upon the SLM framework by publicising local progress in responding to my national priorities from quarter one 2020/21. I expect DHBs to work with all health system partners to agree local actions and the contributory measures needed to make a tangible impact on health system performance. This will require broadening of alliances to include partners beyond the primary health organisations (PHOs). Equity gaps are evident in all SLMs and in nearly all districts. Where equity gaps exist, I expect local actions and contributory measures to focus on addressing these gaps.

Care Capacity Demand Management

I continue to expect significant progress on implementing all components of the CCDM programme this year, including detailed plans for full implementation in all units in nursing and midwifery by June 2021. Full implementation includes annual FTE calculations and agreed budgeted FTE in place. I expect timely reporting, including your assessment on progress towards meeting the June 2021 deadline for full implementation of CCDM. It is vital that nurses and midwives see the impact of CCDM FTE increases and effective variance response management on safe staffing levels and that the core data set drives quality improvement. It remains my expectation that CE performance expectations include delivering CCDM expectations within agreed timelines.

Better population health outcomes supported by primary health care

Primary care

Primary care makes a significant contribution to improving health outcomes and reducing demand on hospital services. Continuing to improve primary health care remains a priority for this Government.

DHBs must work with their primary care partners and lead their alliance(s) to develop and implement models of care that improve equity for Māori and other high needs populations through services that target the needs of these populations. I expect these new models of care to use broader multi-disciplinary teams, strengthened inter-professional collaboration and improved integration between secondary, primary and community care. I expect high-quality information and data to be shared through formal agreements and used to support decision-making, particularly in improving outcomes for Māori.

Long-term conditions

As I have previously advised, I expect DHBs to explicitly require improvements in performance and reporting on long-term conditions in their contracts with PHOs. DHBs should incentivise PHOs to improve equity, reduce the burden of long-term conditions, demonstrate improvements in primary care settings and increase accountability for effectively managing long-term conditions, especially diabetes.

Pharmacy

Progress has been made on the strategic vision of the Pharmacy Action Plan 2016. I expect this progress to accelerate as you work with the pharmacy sector to develop funding models and models of care that are equity focused and centred on service users. Please ensure your DHB enables pharmacist vaccinators to deliver a broader range of vaccinations to improve access.

Rural workforce

DHBs with rural communities should build on 2019/20 and improve access to services for rural people. I expect you and your rural alliance partners, including rural hospitals, to explore the opportunities to use the Ministry's rural workforce initiatives to strengthen your rural workforce and improve the sustainability of rural services.

Supporting delivery of the Māori health action plan

The sector has recently engaged in the development of a Māori Health Action Plan to further implement He Korowai Oranga: the Māori Health Strategy and improve Māori health outcomes. I expect all DHBs to demonstrate delivery and implementation of this plan in 2020/21 planning documents.

Improving wellbeing through public health service delivery

Public Health Units (PHUs) are key to protecting and improving health and you should ensure that your DHB has strong and sustainable public health capability and capacity. I expect to see PHU plans integrated with DHB Annual Plans where appropriate in 2020/21.

Over the next year, a programme is underway to develop criteria and to confirm the accountability arrangements for public health service delivery. I encourage your PHU and DHB to get involved in this process and support the programme.

Hon Chris Hipkins

MP for Remutaka

Minister of Education
Minister of Health
Minister of State Services

Leader of the House
Minister Responsible for Ministerial Services

Vui Mark Gosche
Chair
Counties Manukau District Health Board
m.gosche@outlook.com

20 October 2020

Dear Vui Mark

Counties Manukau District Health Board 2020/21 Annual Plan

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

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

We expect you to work with your fellow Chairs and continue discussions about how you can share skills and expertise in order to ensure that your financial performance is consistent with the agreed plan. We particularly encourage you ensure that your senior executives maintain the tight fiscal controls that will be necessary to sustain improvements in the out years. Your focus on strengthening financial management and performance, including through collaboration with your fellow Chairs, remains critical to creating a sustainable financial path. If financial performance deteriorates as has occurred in previous years, this deterioration limits our collective ability to invest more in new models of care and in primary care and population prevention approaches.

The Ministry will shortly engage with you on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. We encourage you to accept offers from the Ministry to utilise this funding.

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

We are aware that an extension was provided to the requirements for finalising DHB planning documents required by the Crown Entities Act 2004 due to the impacts of

COVID-19. If required, please update your published Statement of Performance expectations and Statement of Intent (if applicable) to align with your approved Plan.

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

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

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

Ngā mihi nui

Hon Chris Hipkins
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Margie Apa
Chief Exectuve

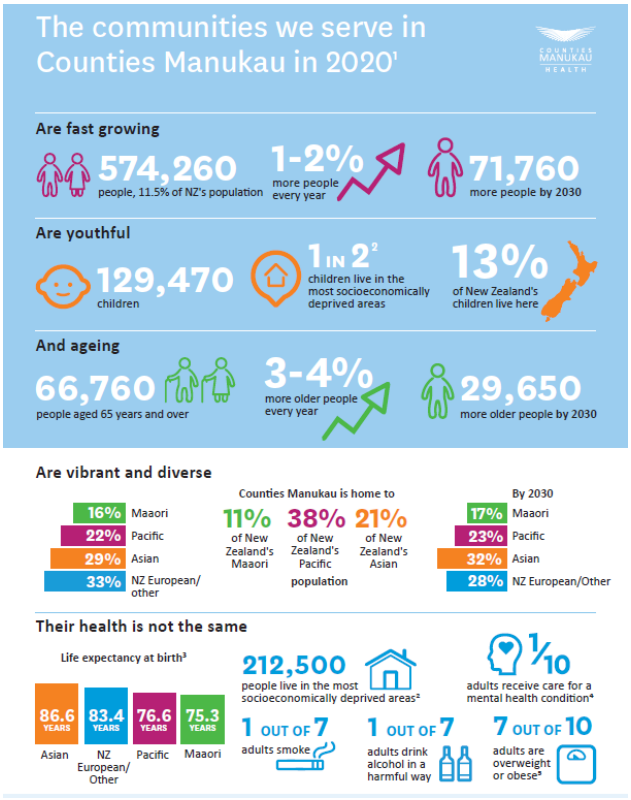
1. Overview of strategic priorities

1.1 Strategic intentions and priorities

The communities we serve

Counties Manukau District Health Board is one of twenty district health boards established under the New Zealand Health and Disability Act 2000 (NZPHD Act 2000) to plan and fund the provision of personal health, public health and disability support services for the improvement of the health of the population.

The Counties Manukau District Health Board provides and funds health and disability services to an estimated 574,260 [1] people in 2020 who reside in the local authorities of Auckland, Waikato and Hauraki Districts. We are one of the fastest growing district health board populations in New Zealand with a youthful and ageing population.



Our population is diverse and vibrant with strong cultural values. Counties Manukau is home to New Zealand's second largest Maaori population, largest population of Pacific peoples, as well as fast growing Asian communities.

Across our district, the health and circumstances of our communities are not the same. Thirty-seven percent of our population live in areas of high socioeconomic deprivation (NZDep2013 9&10[2]). Over 129,000 children live in Counties Manukau, with 1 in 2 living in areas of high socioeconomic deprivation. By 2030, our district is forecast to be 17 percent Maaori, 23 percent Pacific, 32 percent Asian and 28 percent European/Other ethnicity. There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau.[3]On the basis of the NZDep2018 measure, Otara, Mangere and Manurewa, home to many of our Maaori and Pacific communities, are the most socioeconomically deprived areas in our district.

Long-term mental and physical conditions do not affect all groups in our community equally[4]. Our population experiences relatively high rates of ill-health risk factors (such as smoking, obesity[5], hazardous alcohol use) that contribute to a 'package' of long term physical conditions which are responsible for the majority of potentially avoidable deaths. The rate of hospitalisation for circulatory diseases for our Maaori communities is estimated to be 88 percent higher than for non-Maaori.[6] Diabetes prevalence is higher amongst our Pacific (13.1 percent), Asian (7.3 percent) and Maaori (6.7 percent) communities compared to European/Other (5.3 percent).[7] Increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity and reducing obesity is key to improving the health of our population.

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[1] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2013-Census Base) – 2019 update.

[2] NZDep 2018 decile 9&10. New Zealand Index of Deprivation (NZDep) is an area-based measure of socioeconomic deprivation. It measures the level of deprivation for people in each small area. It is based on nine Census variables. NZDep can be displayed as deciles or quintiles. Quintile 5, or deciles 9 and 10, represents people living in the most deprived 20 percent of these areas.

[3] Chan WC, Papaconstantinou D, Winnard D (2019) life expectancy in Counties Manukau 2018 update.

[4] Winnard D, Papa D, Lee M, Boladuadua S et al (2013) populations who have received care for mental health disorders. CM Health, Auckland

[5] Based on unadjusted prevalence of overweight (BMI 25-25.9) and obese (BMI 30 or more) for CM Health adults aged over 15 years. Unadjusted prevalence for 2014-2017, New Zealand Health Survey. May 2018

[6] Source: Counties Manukau DHB Māori Health Profile 2015. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare. Based on hospitalisation data 2011-2013. http://www.countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/health-status/2015-counties-manukau-DHB-Maaori-health-profile.pdf

[7] Source: Health Quality and Safety Commission Atlas of Health Care Variation, Diabetes management (2018 data for CMDHB)

Our strategic direction and context

CM Health's Healthy Together strategy comprises three key objectives: Healthy Communities, Healthy Services and Healthy People, Whaanau and Families. These objectives are underpinned by a goal of achieving equity in key indicators for Maaori, Pacific and other communities with health disparities:

- achieve health improvement for all with targeted support for CM Health's most vulnerable people and communities,
- strengthen primary and community-based services to reduce the burden of disease and prevent ill health, and
- provide high-quality and high-performing modern specialist and hospital-based services.

The 2019/20 financial year was the last year of the 2015-2020 Healthy Together strategy. The CM Health Board has committed to refreshing our Healthy Together strategy for 2020/21 and beyond. This is currently in development and will be finalised by December 2020.

Long term conditions, growth and poverty may overwhelm our healthcare system

Our strategic goals are challenged by the social and economic demographic characteristics of the resident population CM Health provides healthcare for:

Obesity, long term conditions and mental health – Seven out of ten adults in Counties Manukau are obese or overweight and an estimated 36,000 people are morbidly obese (BMI 40+). There are approximately 8,000-9,000 more people with morbid obesity than expected given the age and ethnicity structure of our population. Obesity-related conditions such as diabetes and cardiovascular disease are a major contributor to our burden of long term conditions. Long term conditions such as coronary heart disease, diabetes, cerebrovascular diseases and obstructive pulmonary disease are the leading causes of potentially amenable mortality in Counties Manukau. In addition, nearly one in ten adults living in Counties Manukau received care for a mental health condition in 2011,[8] and in 2015 there were over 67,000 people in Counties Manukau living with one or more long term conditions.[9] The increasing prevalence of long term physical and mental health conditions is one of the major drivers of healthcare demand for our DHB.

Growing and ageing population - Counties Manukau is the third fastest growing DHB and our population is forecast to increase by 71,000 people by 2030. Our population is also ageing with 3 to 4 percent more people aged over 65 years in the Counties Manukau population every year. It is this group who will place the highest demands on health services in the years to come and is a challenge particularly significant for the Franklin and Eastern localities.

Large high-needs population - Socioeconomic deprivation is a key driver of health inequities. In 2020 we estimate that 212,500 people in Counties Manukau, over a third of all residents, are living in areas classified as being the most socioeconomically deprived in New Zealand. This is many more people living in these circumstances than any other DHB in New Zealand and this presents a challenge for health and social sector agencies to best support our people to flourish.

The burden of long term conditions, rapidly ageing and high proportion of people living in highly deprived households adds an additional cost to the healthcare system. This is because people living with obesity and long term conditions such as diabetes cost an additional $3,800 in healthcare costs compared to their equivalents without the condition. Overall Maaori and Pacific people in Counties Manukau receive one third more health services than predicted from their age structure.

[8] Winnard D, Papa D, Lee M, Boladuadua S, Russell S, Hallwright S, Watson P, Ahern T (2013) Populations who have received care for mental health disorders. Counties Manukau Health. Auckland: Counties Manukau Health.
[9] Chan WC, Winnard D, Papa D (2017) People identified with selected Long Term Conditions in CM Health in 2015. Counties Manukau Health. *Unpublished.*

Refreshing our strategic direction for 2020/21 and beyond

Counties Manukau Health (CM Health)[10] strategic intentions and priorities will be presented in our refreshed Healthy Together Strategy 2020-2025. This strategy is being developed within the local context described in the previous sections whilst also acknowledging, in particular, our commitment to:

- the Treaty of Waitangi (Te Tiriti o Waitangi)
- the New Zealand Health Strategy
- He Korowai Oranga (the Maaori Health Strategy)
- the Healthy Ageing Strategy
- the UN convention on the Rights of Persons with Disabilities
- Ola Manuia 2020-2025: Pacific Health and Well-being Action plan

The strategy is being developed in consultation with our consumers, staff, PHO and NGO representatives, and in partnership with Mana Whenua i Taamaki Makaurau. At the time of writing this Annual Plan, early signs from our stakeholders are that CM Health is heading in the right direction towards its strategic goal of

"achieve equity in key health indicators for Maaori, Pacific and communities with health disparities".

However, we acknowledge that we must try harder to achieve the changes we seek in as short a time as possible. We also acknowledge that the recommendations from the New Zealand Health and Disability System Review (Hauora Manaaki ki Aotearoa Whaanui) will have a bearing on plans which underpin the refreshed strategy, as has the recent Covid-19 pandemic response.

In conjunction with the Annual Plan, the plans underpinning the strategy will identify actions required to achieve the CM Health strategic goal over the next 5 years in a sustainable way and with the best health outcomes delivered within the current funding environment.

Sustaining future provision of healthcare in the current funding environment will require strategic choices about priorities

Since Healthy Together was published in 2015, in CM Health's view, funding and revenue growth have been outpaced by population growth and increasing demand for healthcare. CM Health has experienced a widening gap between revenue and the cost of meeting extra demand. Consequently, it has become increasingly difficult for CM Health to fiscally operate within its means.

The demand for healthcare associated with our growing, ageing and changing population is quickly outstripping the supply of workforce needed to deliver services using current models of care. Even if we did close our funding and revenue growth gaps, workforce development to deliver care in alternative ways would need to be accelerated to meet demand.

We are also faced with ageing facilities infrastructure. The average age of our buildings is 40 years and certain buildings are not suitable for future long-term use. National funding and affordability constraints over previous years has resulted in significant deferral of key hospital building maintenance resulting in a need to urgently remediate our facilities and seek significant investment in capacity expansion. Recent government investment in remediation and facilities expansion has been welcomed; however, continued investment is necessary to ensure our facilities remain fit for purpose into the future. CM Health's Statement of Performance Expectations outlines regionally prioritised major capital investments that will add critical service capacity, as well as remediation of health and safety and clinical service risks due to aging facilities infrastructure.

[10] To better reflect a health system approach for effective resource planning to meet our population needs and health sector priorities, this document will refer to the collective delivery of all health services and related infrastructure as Counties Manukau Health (CM Health). This reflects the combined Counties Manukau DHB, PHO and related non-government organisation (NGO) service delivery and support resources.

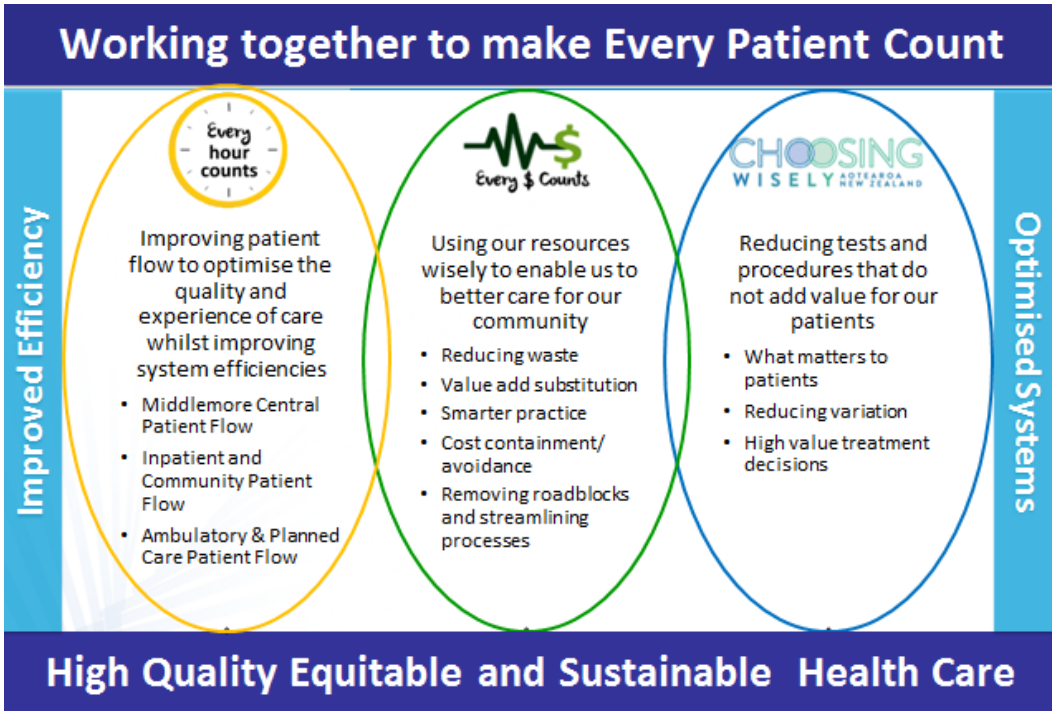
Through 2019/20 CM Health has responded to significant incidents and challenges; rapid mobilization of community and hospital response to measles in September 2019; diversion of hospital and in particular theatre resources to respond to White Island/Whakaari Island in December 2019, and ongoing responses to COVID19 from March 2020. Recovery of planned care and ensuring available capacity to meet acute demand growth will be an ongoing challenge for 20/21.

Within this context, our priorities for 2020/21 are to achieve a planned reduced deficit position of $29.9m by:

- constraining cost growth to do more with current resources enabled by rapid deployment of flow improvement initiatives (Every Hour Counts)
- enabling technologies to reduce time wasted and improve workflows and targeted investment within our funding constraints to high risk clinical services in both community and hospital services
- reinvigorating the Every Dollar Counts programme where the resources to implement savings initiatives were deployed to managing emergency incidents
- an expanded regional work programme with the Northern Region DHBs to seek further collaborative opportunities

Our Every Hour Counts, Every Dollar Counts and Choosing Wisely portfolios of work support CM Health's strategic aims of achieving high quality, equitable, sustainable healthcare for our patients, community and staff:

- ***Every Hours Counts*** will optimise patient flow by working smarter with the systems and resources we have e.g. linking testing and appointments on the same day to save patients' and staff time.
- ***Every Dollar Counts*** will reduce/avoid costs and protect revenue streams e.g. improving clinical documentation to optimise revenue for the care provided to patients.
- ***Choosing Wisely*** will reduce tests and procedures that do not add value to patients and staff.



These programmes of work will support CM Health staff to improve system performance by:

- working with teams to diagnose and design systems, services and processes that enable patients to receive the right care, in the right place, at the right time.
- reduce inequities in the system; privileging health equity for Maaori, Pasifika and those with health disparities.
- improving the experience for those delivering and receiving care.
- reducing harm, waste, duplication, fragmentation and inappropriate variation.
- developing a culture of continuous quality improvement and learning, at both a service and system level.

Clinical participation

Counties Manukau Health is committed to the national, regional and local strategies that guide the direction and delivery of care in New Zealand. Clinical and management leaders from within CM Health are active participants in national and regional forums focussed on meeting the health needs of New Zealanders as well as its local population. In 2019, senior clinical leadership was increased to better support improvements in delivering health outcomes, quality and safety of care and supporting our strategic direction. Service planning is undertaken in a partnership approach between managers and clinical staff, inclusive of development of this Annual Plan. CM Health clinical activities are overseen by the Clinical Governance Group, a team of senior clinical leaders. CM Health policy also requires Annual Plans to be endorsed by the Executive Leadership Team, for which membership includes the Chief Medical Officer, Chief Medical Advisor Primary Care, Chief of Allied Health, Scientific and Technical and Chief Nurse.

Te Tiriti o Waitangi

Counties Manukau DHB aims to fulfil our obligations as agent of the Crown under the Te Tiriti o Waitangi (Treaty of Waitangi). Our relationship with the tangata whenua of our district is expressed through a board-to-board relationship with Mana Whenua i Taamaki Makaurau.

Counties Manukau DHB has adopted a principles based approach to recognising the contribution that the Te Tiriti o Waitangi can make to better health outcomes for all, inclusive of Maaori.

The articles of Te Tiriti and the principles of partnership, protection and participation implicitly recognise the important role the health sector plays in recognising the indigenous rights of Maaori and therefore the status and rights of Maaori to achieve equitable health outcomes in comparison to the rest of the population.

Please see Section 2.7.1 for detail of planned activities from 2020/21 that demonstrate how we are committed to meeting our engagement and obligations as a Treaty Partner.

1.2 Message from the Chief Executive Officer of Counties Manukau Health

During the 2020/21 financial year CM Health is part way through a journey towards an underlying breakeven financial position. We are looking to significantly reduce our deficit year on year, with an aim to achieve breakeven by the end of the financial year 2021/22. This is a challenging but important undertaking, to ensure that we are not only clinically but financially sustainable in the coming years in order to meet our communities' needs and be in a position to attract further investment in the future.

The reality of this requirement to reduce our deficit is that we do not currently have the ability to increase spending in some areas that we would like to. While we are pleased to have received an additional $94m funding for the 2020/21 year, we are aware that our population remains undercounted for the purposes of the population based funding formula, impacting our revenue.

With this in mind, the next year will be focused on consolidating our current capacity and making sure that we are optimising the use of our resources and peoples' time. However, we will also be reviewing our position regularly throughout the year to ensure that we prioritise further investment opportunities when we are able to.

Despite the challenges we face, there is lots to look forward to in the coming year. I hope to build on our promising staff engagement results this year – 60% completion and 74% engagement score – and continue to prioritise health and safety in everything we do. We are also looking forward to having our detailed business case for the Manukau Health Park development signed off by the Ministry of Health so that we are able to commence work on the project. There are other exciting capital projects that we look forward to progressing and completing this year, including the second stage of the Tiaho Mai building which is due for completion in September 2020.

I look forward to continuing to work with our Board, Mana Whenua i Taamaki Makaurau and our communities during 2020/21 to build on our current position and progress our key areas of work.

Fepulea'i Margie Apa
Chief Executive

1.3 Message from the Chair of Counties Manukau District Health Board and Co-Chairs of Mana Whenua i Taamaki Makaurau

We are entering the 2020/21 financial year with a challenging task ahead of us. Outside of the existing pressures of achieving financial sustainability within the context of serving a quickly growing population with complex healthcare needs, COVID-19 recovery will be a key focus as we enter the year. Work is already well underway to catch-up on the activity that was lost during the lockdown period, and we anticipate that the effects of COVID-19 will be with us in some form throughout 2020/21 as New Zealand continues to adapt to the shifting global situation and we focus on protecting New Zealanders.

Our strong partnership is crucial as we face these challenges together and work to ensure that we are prioritising the needs of our population. The board to board collaboration between CM Health and Mana Whenua i Tamaaki Makaurau brings a Treaty Partnership perspective to the governance of the Health Board which we see as essential in understanding our Whaanau Maaori and communities in serving their unique healthcare needs. A large focus for us in the coming year will be leveraging this partnership to move forward with our goals on achieving health equity. We want to be clear on what health equity means for CM Health and our residents, and bring this to the fore of everything that we do.

Opportunity has already been seeded for the 20/21 year to further our equity agenda through some important initiatives; building closer working relationships with our southern neighbours Waikato DHB and Waikato Tainui to look at how we can best support our shared population through iwi collaboration and iwi-led provision, our work developing new models of care in the primary care setting through Te Ranga Ora and increasing Maaori and Pacific provision of community mental health services through the procurement process which is underway for those services.

Key to achieving these goals of continuing to meet growing demand and delivering on health equity is advancing our capital projects throughout the coming year. We want to continue developing our facilities through our 'Grow Middlemore', 'Grow Manukau' and 'Grow Community Hubs' portfolios of work, and make sure that these developments have our population's needs at the core of their design.

We look forward to continuing to work together in the coming year on our shared goals.

Vui Mark Gosche
Chair
Counties Manukau
District Health Board

Robert Clark and Barry Bublitz
Co-Chairs of Mana Whenua i Taamaki Makaurau

1.4 Signatories

Agreement for the Counties Manukau Health 2020/21 Annual Plan between

The Honourable Chris Hipkins
Minister of Health

The Honourable Grant Robertson
Minister of Finance

Vui Mark Gosche
Chair
Counties Manukau District Health Board

Tipa Mahuta
Deputy Chair
Counties Manukau District Health Board

Fepulea'i Margie Apa
Chief Executive
Counties Manukau District Health Board

2. Delivering on priorities

This section describes the actions that CM Health will undertake to deliver on the Government's priorities in the 2020/21 year. We have used the code **'EOA'** to identify equitable outcomes actions specifically designed to reduce health equity gaps for Maaori and Pacific populations. This Plan will also reflect the Metro Auckland 2020/21 System Level Measures Improvement Plan.

2.1 Minister of Health's Planning Priorities

The following sections identify CM Health's key response actions to deliver improved performance against the Government's 2020/21 Planning Priorities. A number of these actions are specifically targeted to accelerate health gain and to reduce inequities for Maaori, Pacific and more deprived populations.

The 2020/21 Planning Priorities are:

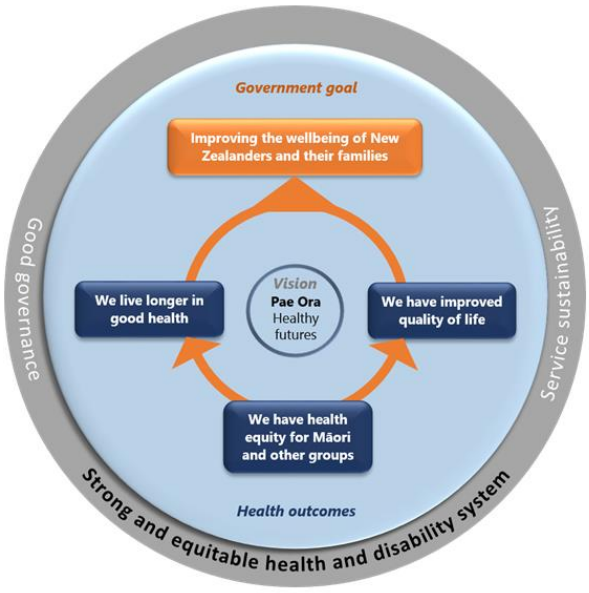
- Give practical effect to He Korowai Oranga – the Maaori Health Strategy
- Improving sustainability
- Improving child wellbeing – improving maternal, child and youth wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes supported by a strong and equitable public health and disability system
- Better population health outcomes supported by primary health care

Several of the priority areas benefit from or are directly influenced by the connections we share across the Northern Region. We will work closely with our regional partners to progress actions in a collaborative and consistent manner, rather than independently by each DHB.

2.2 Health and disability system outcomes framework

The health and disability system outcomes framework supports a stable system by clearly articulating what outcomes the system intends to achieve for New Zealanders, and the areas of focus through which to obtain those outcomes. Figure 1 shows the elements of health and disability system outcomes framework.

Figure 1 the health and disability system outcomes framework elements



2.3 Maaori Health Improvement

DHB obligations as a Treaty partner are specified in legislation. DHBs are to specify in their annual plans processes they use to meet these obligations. This includes, but is not limited to, information on:

- meeting the DHBs obligation to establish and maintain processes that enable Maaori to participate in, and contribute to, strategies for Maaori health improvement
- how the DHB will continue to foster the development of Maaori capacity for participating in the health and disability sector and for providing for the needs of Maaori.

Please see Section 2.7.1 for detail of planned activities for 2020/21 that demonstrate how CM Health is planning to deliver on He Korowai Oranga – the Maaori Health Strategy and continue to action our obligations as a Treaty Partner.

2.4 Health equity in DHB Annual Plans

Our Healthy Together Outcomes Framework describes the key outcomes and contributory measures that we will need to monitor and target to achieve our strategic health equity goal, as well as the key inputs and outputs required. The Framework identifies two long-term outcomes to monitor our progress: quantity of life in terms of mortality measured by 'life expectancy at birth' and quality of life. Please refer to our 2019 – 2023 Statement of Intent for further information and a detailed description of the Framework.

On a quarterly basis, CM Health monitors progress against our universal performance targets and our Statement of Performance Expectations (SPE) by ethnicity, to track our progress toward achieving equity across our performance measures and identify areas of focus for improvement and future planning.

CM Health recognises and respects Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. Te Tiriti o Waitangi establishes obligations for Maaori development, health and wellbeing by guaranteeing Maaori a leading role in health sector decision making in a national, regional, and whaanau/individual context. The New Zealand Public Health and Disability Act 2000establishes requirements of DHBs with respect to Crown treaty obligations. This furthers commitment to Maaori health gain by requiring DHBs to establish and maintain responsiveness to Maaori while developing, planning, managing and investing in services that do and could have a beneficial impact on Maaori communities.

Te Tiriti o Waitangi provides four domains under which Maaori health priorities for CM Health can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Maaori.

Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the CM Health's provision of structures and systems that are necessary to facilitate Maaori health gain and reduce inequities. It provides for active partnerships with mana whenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Maaori leadership, engagement, and participation in relation to CM Health's activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Maaori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, CM Health as a Te Tiriti obligation to honour the beliefs, values and aspirations of Maaori patients, staff and communities across all activities.

Te Tiriti provides an imperative for Crown entities to protect and promote the health of Maaori, respond to Maaori health aspirations and meet Maaori health need. It is recognised that there is an interrelationship between the DHBs Tiriti obligations and responsibility to achieve health equity for Maaori, it also acknowledged that these are distinct obligations (and separate requirements in the NZ Public Health and Disability Act). Maaori health equity is often seen as the area of commonality and overlap between these two priorities. In practice this means, that any equity plans developed by the DHB will need to

incorporate the specific right of Maaori to health equity and clearly affirm efforts to advance Maaori health as per our other accountabilities under te Tiriti.

Our priority groups for equity are our Maaori and Pacific communities. Our Asian communities represent over a quarter of our population and also require consideration where health disparities exist.

In Counties Manukau our Pacific and Asian communities constitute significant proportions of our non-Maaori group. This means if the total non-Maaori group are used as a comparator to consider Maaori inequities, the inequities of our Pacific population can obscure the extent of the inequities for our Maaori population. On the other hand, the healthy migrant effect for some of our Asian communities can also compound our equity comparisons.

Where possible, data for CM Health will therefore be presented as four ethnic groups for annual planning and reporting purposes – Maaori, Pacific, Asian, and NZ European/Other (non-Maaori, non-Pacific, non-Asian). Further disaggregation will take place at service planning level where appropriate.

2.5 Responding to the Guidance

The priority actions described in this document reflect the Ministry of Health's guidance and instructions for DHBs. The actions identified in CM Health's 2020/21 Annual Plan have been developed in consultation with key stakeholders across the organisation, including our PHO partners.

Public Health plans

Auckland Regional Public Health Service (ARPHS) is the regional provider of public health services and services the Counties Manukau District and the Metro Auckland region DHBs. ARPHS is one of New Zealand's 12 public health units (PHUs). ARPHS provides public health services through health protection and promotion, and disease prevention. ARPHS and DHB staff works closely together to improve population outcomes for the people of Taamaki Makaurau. A key role for ARPHS is provision of regulatory public health services.

ARPHS' vision is Te Ora ō Taamaki Makaurau. ARPHS' strategic long term outcomes are:

- People are protected from the harm of notifiable infectious diseases.
- People are protected from the impact of environmental hazards.
- People live free from the harms associated with harmful commodities.
- The environments in which people live, learn, work and play promote health and wellbeing.

ARPHS' work includes management of notifiable infectious and environmental diseases, including operational management of the regional tuberculosis control programme. ARPHS provides advice and support on actual/potential environmental hazards such as drinking and recreational water quality, air quality, border health protection, and hazardous substances. Much of ARPHS' work involves working with other agencies, including work on liquor licensing, smokefree, emergency response, physical activity and nutrition and obesity prevention activities. These other agencies include central government agencies, Auckland Council, non-government organisations and workplaces. ARPHS is also responsible for refugee health screening undertaken at the Maangere Refugee Resettlement Centre.

Key points of intersection for ARPHS with DHB activities are interfaces with primary and secondary services in managing communicable disease outbreaks, policy engagement and submissions and improving physical and social environments to support reduced harm from tobacco, alcohol and unhealthy food.

ARPHS is a contracted service to CM Health reporting through ADHB and contributing to services for the CM Health population. The services are described in the ADHB Plan and referenced in the relevant sections of this plan.

2.6 Regional Service Planning

The Northern Region Long Term Investment Plan (NRLTIP – January 2018), together with the Ministry of Health's priorities, continues to be the foundation that sets the long term direction of the Northern Region work plans involving all the Northern Region DHBs. The Northern Region 'whole of health system' response to COVID-19 has enabled rapid change and evolution in models of care across tier 1 and tier 2 services and has created an imperative to focus on faster, shorter, lifecycle projects and

initiatives that will deliver change. During the 2020/21 year our regional plan including our response to the COVID-19 pandemic recovery, to be delivered by the Northern Regional Alliance (NRA) working with DHBs, is focussed on actions to:

- Improve Equity
    - Achieving Health Equity for Maaori
    - Achieving Health Equity for Pacific Peoples
    - Equity Led Planned Care Recovery
- Improve Public & Population Health, Primary & Community Care
- Health Service Improvements and Model of Care Change:
    - Child Health
    - Frailty and Healthy Aging
    - Cancer Services
    - Mental Health & Addiction
    - Cardiovascular Services
    - Stroke
    - Major Trauma Services
    - Hepatitis C
- Improved Diagnostic Service Delivery
    - Laboratory
    - Radiology Services
- 'Enablers' of Health System Transformation and New Care models
    - Workforce
    - Data and Digital
    - Capital Programme
    - Collaborative Resourcing Framework.

2.7 Government planning priorities

The following sections identify CM Health's key response actions to deliver improved performance against the Government's 2020/21 Planning Priorities. A number of these actions are specifically targeted to accelerate health gain and to reduce inequities for our Maaori and Pacific populations.

The 2020/21 Planning Priorities are:

- Give practical effect to He Korowai Oranga – the Maaori Health Strategy
- Improving sustainability
- Improving child wellbeing – improving maternal, child and youth 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

Several of the priority areas benefit from or are directly influenced by the connections we share across the Northern Region. We will work closely with our regional partners to progress actions in a collaborative and consistent manner, rather than independently by each DHB.

2.7.1 Give practical effect to He Korowai Oranga – the Maaori Health Strategy

He Korowai Oranga, the Māori Health Strategy sets a vision of Pae ora – healthy futures – comprising three key elements:

- mauri ora – healthy individuals
- whānau ora – healthy families
- wai ora – healthy environments.

He Korowai Oranga continues to set a strong direction for Māori health. Importantly, the health and disability system is being challenged to do better and to go further. That includes continuing to meet our responsibilities under Te Tiriti o Waitangi (the Treaty of Waitangi), to address and improve substantial health inequities, and to ensure all services for Māori are appropriate and safe.

These challenges are substantial and require a strong plan to implement actions and meet expectations. As such, the development of a new Māori Health Action Plan is underway.

The first part of this section, Engagement and obligations as a Treaty partner, is based on current legislative responsibilities. The other sections are based on the Māori Health Action Plan discussions to date.

Engagement and obligations as Treaty partner					
DHB activity	**Milestone**	**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**		
			System outcome	**Government priority outcome**	
Treaty of Waitangi principles: The Waitangi Tribunal recommended that the following Treaty principles be adopted for the primary healthcare system:[11] **1.** The guarantee of tino rangatiratanga, which provides for Maaori self-determination and mana motuhake in the design, delivery and monitoring of primary health care; **2.** The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Maaori; **3.** The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Maaori. This includes ensuring that it, its agents and its Treaty partner are well informed on the extent, and nature of, both Maaori health outcomes and efforts to achieve Maaori health equity; **4.** The principle of options, which requires the Crown to provide for and properly resource kaupapa Maaori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Maaori models of care; **5.** The principle of partnership, which requires the Crown and Maaori to work in partnership on the governance, design, delivery and monitoring of primary health services. Maaori must be co-designers, with the Crown, of the primary health system for Maaori. Whilst WAI 2575 focused on primary health care, it is widely accepted that the recommendations can be considered applicable to the entire health system/all services					
1. Work with Mana Whenua i Taamaki Makaurau to identify partnering opportunities that focus on equity for Maaori and achieving mutual health outcomes that are specific to following key strategic documents: • CMH Health Strategy 2025 • Waikato Tainui Koiora Strategy 2050 **(EOA)**	**1a.** Review current MOU **1b.** Review recommendations considered by MWiTM and CMDHB Boards **1c.** MOU established outlining key areas of focus and actions e.g.: • Mana Motuhake • Leadership • Future design	**1a.** Q1 **1b.** Q2 **1c.** Q4	Review completed Report in Q2 with recommendations Revised MOU completed and Q4 report Progress report Q2	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child

[11] *Hauora Report*, page 163.

2. Work with Mana Whenua to co-design a framework to assess the impact of the CMH Treaty partnership approach to achieving an equity focus for Maaori and improving Maaori health outcomes **3.** Work with Mana whenua to co-design a research agenda that focuses on evidence-based approaches to accelerate the implementation of kaupapa Maaori models of care • Alignment with KA research programme • Comparative learning/engagement with indigenous models of care e.g. NUKA	**2a**. Develop tool that evaluates Treaty relationship in action based on agreed partnership agreement and actions **3a.** Research agenda developed in conjunction with Ko Awatea programmme **3b.** Kaupapa Maaori model of care developed in collaboration with Mana whenua	**2a.** Q2 **2b.** Q4 **3a. Q1** **3b. Q3**	Outcomes framework complete and Q4 report finalised Procure funding key Maaori research initiatives in Q1 Report on Progress Q2 Kaupapa Maaori service programme developed and prioritised for funding in Q3 Report on Progress Q2		

Maaori Health Action Plan – Accelerate the spread and delivery of Kaupapa Maaori Services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Provider Development **1.** Work with providers to co-design a five year provider investment plan targeting key areas: • Accelerating Kaupapa Maaori models of care • Governance and Leadership • Workforce Development • Information Technology • Service design and evaluation Outputs: • Complete "deep dive" analysis of all DHB and MoH contracts with Maaori providers to identify opportunities for service innovation and integration. • Complete "deep dive" analysis of cross sector contracts with Maaori providers to understand local investment and identify opportunities to form cross-sector collaboration. **(EOA)**	**1a.** Analysis of DHB and MoH contracts with Maaori providers complete and opportunities for innovation identified	Q1 and Q2	Report completed to inform DHB Funding Commissioning role	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
	1b. Analysis of cross sector contracts with Maaori providers complete and opportunities for collaboration identified	Q1 and Q2	Deep dive report completed end of Q2.		

Maaori Health Action Plan – Shifting cultural and social norms					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Provide leadership across the organisation to strategically lift responsiveness and performance of all services within CM Health to Maaori patients and their whaanau **(EOA)**	*To be developed by the Maaori Health Clinical Leadership Team and in consultation with mana whenua* **1a.** Scope leadership strategy **1b.** Complete leadership strategy and Q2 progress report. **1c.** Monitor progress **1d.** Q4 Report	Q1 Q2 Q3 Q4	. Milestones delivered	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
2. Develop organisational framework for CM Health staff cultural competence, and work with Organisational Development to implement framework **(EOA)**	*To be developed by the Maaori Health Clinical Leadership Team and in consultation with mana whenua* **2a.** Scope organisational framework. **2b.** Complete framework and progress report **2c.** Implement framework **2d.** Q4 progress report	Q1 Q2 Q3 Q4	Milestones delivered		
3. Deliver educational programme(s) to support cultural competence development **(EOA)**	*To be developed by the Maaori Health Clinical Leadership Team and in consultation with mana whenua*		Milestones delivered		

	3a. Develop a cultural competency work programme **3b.** Report progress **3c.** Implement programmes (s) **3d.** Report progress	Q1 Q2 Q3 Q4			

Maaori Health Action Plan – Reducing health inequities – the burden of disease for Maaori					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Deliver whaanau-centred integrated services to high needs, hard to reach Maaori and whaanau with complex needs with key CM Health priority health conditions. **(EOA)**	**1a.** Delivery of whaanau-centred outcomes-based packages of care.	Q1	Outcomes framework complete by Q1	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
	1b. FTE, CND Roles – Nursing and Allied Health	Q2			
	1c. Review current contracts and report progress in Q2	Q2			
	1d. Implement findings	Q3			
	1e. Report progress	Q4			
2. Refer to Provider Development section in Maaori Health Action Plan – Accelerate the spread and delivery of Kaupapa Maaori Services **(EOA)**					

Workforce Strategy Work alongside the wider CM Health Workforce strategy to ensure that the organisation is: **3.** Employing more Maaori at CM Health across all levels of the organisation **4.** Implementing strategies to improve retention of Maaori staff **5.** Supporting emerging Maaori leaders **6.** Developing Capacity and Capability within clinical leadership team to effectively represent Maaori Health at service, executive and governance forums **7.** Building and sustaining Maaori Leadership that is visible across the DHB, Regionally and Nationally **8.** Refer to the out-year planning section for other workforce activities **(EOA)**	Progress report Progress report Maaori Health Clinical Leadership Team is engaged in development and implementation of CM Health Workforce Strategy	Q2 Q4			

Maaori Health Action Plan – Strengthening system settings					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Refer to Provider Development section in Maaori Health Action Plan – Accelerate the spread and delivery of Kaupapa Maaori Services **(EOA)**				We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child

2.7.2 Improving sustainability

As New Zealand's population has continued to grow and age, with more complex health needs, the system has worked hard to keep up with demand, however the financial performance of DHBs is variable and has deteriorated in recent years. An enhanced focus on improving sustainability is required.

This plan demonstrates how strategic and service planning, both immediate and medium term supports improvements in system sustainability including significant consideration of models of care and the scope of practice of the workforce.

Consideration of sustainability objectives and actions includes how CM Health will work collectively with our sector partners to deliver the Government's priorities and outcomes for the health and disability system while also contributing to a reduction in cost growth paths and deficit levels.

Improved out year planning process					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Financial **1.** Refer to the next section on our commitment to sustainable savings				We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child
Workforce **1.** Development of 5-year workforce plan for CM Health inclusive of Maaori, Pacific and other ethnicities which will reflect the CM Health population **2.** Refer to the Maaori and Pacific Health action plans for specific workforce actions targeting Maaori and Pacific	**1a.** Finalise Workforce projections 2025 **1b.** Engage MSD for funding for recently COVID-19 displaced Maaori/Pacific to training programmes **1c.** Finalise yearly Action Plan 2021-2025 **1d.** Develop Manager Dashboard to measure ethnicity by Service	Q1 Q2 Q3 Q4	Workforce Projections presented to P Workforce Projections presented to People & Culture Sub-committee – Oct 2020 Plan presented to People & Culture Sub-committee – Jun 2021 Dashboard live in HR Reports		
	2a. Increase Pacific Health Science Academies (HSAs) by 50%	Q1	Number of HSAs (target 12)		

Our commitment to sustainable savings					
DHB activity	**Milestone**		**Measure**	**Government theme:** Improving sustainability	
				System outcome	**Government priority outcome**
Workforce Work continues across various strategies to optimise utilisation of our largest asset, our workforce. The predominant focus is use of data to inform/ optimise decision-making. Projects include; Bureau Efficiency, Rostering and Payroll Optimisation. Work to review models of care to optimise the use of our people resource and enable staff to work at top of their scope. Increased utilisation of Technology to enable alternative modes of delivering care e.g. telehealth	Scale of Bureau efficiency models to additional services On-going piloting of Care with Dignity project (allocation of patient watches) On-going model of care reviews Increasing utilisation of technology enablers e.g telehealth	Q2 Q2 Q1-4	Decrease in external bureau ordering in participating services compared to 12 months previous Decrease in care partner (watch) use in participating services compared to 12 months previous Service redesign. Increased number of remote consultations for follow –up appointments		Improving sustainability
System efficiencies To work with identified CMH services to increase system efficiency and reduce duplication and waste in system	Streamlined process for Outpatient eligibility Rollout of outsourced print/ post mail and increased use of email for patient correspondence.	Q1 and Q2 Q3	Reduction in patients declined for service due to clearance timeframe Increased volume of outsourced mail.		Improving sustainability
Contract redesign opportunities The DHB contract redesign allows an opportunity to redesign services with providers to ensure	Revision of contract deliverables aligned to	Q2	Contract reviews		

efficiencies and maximise value to patients and communities. An extensive co-design process is being undertaken with consumers, whaanau and primary care collectives, with a key focus on equity outcomes.	address equity and best value for population.				
Procurement and Supply chain This remains a significant focus for the DHB. Savings are being sought both in partnership with HealthSource, Pharmac and other central agencies and internally within the DHB to maximise the uptake of potential benefits. Continued rollout of oracle managed inventory and other supply chain optimisation strategies will assist visibility and management of stock and reduce staff time.	Implementation of oracle managed inventory across services and in community Reduced off-catalogue orders Benchmarking/ Investigation of high spend areas.	Q3 Q2 Q3	No. services using OMI Reduced number off catalogue orders Identification and review of high spend areas		Improving sustainability
Data capture and Revenue maximisation The DHB is undertaking a range of projects to ensure that we optimise capture of complexity. This benefits both clinical decision making and revenue capture. Inter District Flows are a key focus with audits to ensure accurate identification of IDFs.	Implementation of Clinical Documentation specialist roles enabling improved capture of care complexity. Implementation of coding software to optimise quality of coding within capacity available. Improved identification of IDF domicile opportunities	Q3 Q2 Q1-4	WIES impact in project areas Implementation date IDF cost avoidance.		Improving sustainability
Data for decision making	Rollout of Qlik to clinical services	Q1-4	Apps provided to all Clinical Divisions		Improving sustainability

Learning from insights from partner DHBs, CMH is rolling out analytics software to support and enable optimisation of clinical and managerial decision making due to availability of timely accurate and clinically appropriate information. Supporting key projects with relevant insightful information resources	Rollout of Qlik to enabling services		Apps provided to support major projects of Acute and Ambulatory flow		
Technology / Digital enablement The Healthy Together Technology programme focus for this year is on continuing our paper-lite strategy and fax-free initiatives, telehealth enablers and paperless outpatient clinics and remote working. These initiatives release time to care, remove over 1 million double-sided sheets of paper from the hospital and release pressure on facilities such as desk space and parking. Electronic Ward whiteboards and ongoing refinements to MedChart and eVitals support releasing time to care.	Implement electronic progress notes Electronic prescribing and lab ordering for outpatients eOutcome forms for outpatients Optimising Zoom, remote access and telehealth for remote working Implement eWard Whiteboards	Q2 Q1 Q4 Q1-4 Q3	Reduction in paper usage and printing costs Reduction in travel costs, parking costs Releasing time to care		Improving sustainability
Optimisation of capacity The Every Hour Counts programme of work is focused on maximising efficiency, realising capacity and managing demand in acute flow and ambulatory flow. This work also ties closely with the Manukau Health Park redesign and other enabling capital investments. Projects include; Inpatient flow, ED Flow, Proactive discharge, model of care redesign, service improvement and theatre Improvement.	On-going implementation of projects Scale up of projects where relevant to other areas		Improved flow performance metrics / KPI's Other project outcomes as listed.		Improving sustainability
Funding Our specialist population health team continue to work with Statistics NZ and central agencies to	The count of users of health care matches the	Q1-4	Comparing the Health Care User population		Improving sustainability

correct the undercount of the CM Health population. Enumeration issues in past Censuses have left the most vulnerable population in South Auckland undercounted, and thence underfunded. This correction is critical to the fairness and integrity of the population-based funding system. At stake is the future financial sustainability of the DHB and its ability to fully address observed inequity in health outcomes and care delivery.	Estimated Resident Population (ERP) counts across all DHBs		with the SNZ ERP population		

Working with sectors partners to support sustainable system improvements					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
• **South Auckland Social Wellbeing Board (SASWB)** Continue to engage with sector partners to improve social wellbeing across our community. Refer to the Cross Sectoral Collaboration including Health in All Policies section page 87 (**EOA)** • **Maaori Health** Please refer to the actions under the section Give Practical effect to He Korowai Oranga – the Maaori Health Strategy page 16 **(EOA)**				We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child

2.7.3 Improving child wellbeing

The Child and Youth Wellbeing Strategy (the Strategy) provides a framework to align the work of government and others to achieve the vision of 'Making New Zealand the best place in the world for children and young people'.

The nine principles promoting wellbeing and equity for all children and young people, operationalised for the Health and Disability system, are:

- Children and young people are taonga
- Māori are tangata whenua and the Māori-Crown relationship is foundational
- Children and young people's rights need to be respected and upheld
- All children and young people deserve to live a good life
- Wellbeing needs holistic and comprehensive approaches
- Children and young people's wellbeing are interwoven with family and whānau wellbeing
- Change requires action by all of us
- Actions must deliver better life outcomes
- Early support is needed - maintain contact across the early years and beyond and be alert and responsive to developing issues and opportunities.

Counties Manukau Health will actively work to improve the health and wellbeing of infants, children, young people and their whānau and carers with a particular focus on improving equity of outcomes.

Maternity and Midwifery workforce					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Develop and implement a CMH Women's Health recruitment & retention plan for 1-3 year period.	**1a.** Working group established and draft developed by end of Q 1 20/21	Q2	Plan developed by Oct 2020	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
2. Develop an equity plan for Maaori and Pacific women including a comprehensive approach to pregnant women, babies, children and their whaanau across CM Health. **(EOA)**	**2a.** Working group established and draft developed by end of Q3.	Q3	Plan developed and implemented by the end of Q3		
3. Continue to sponsor Maaori and Pacific students to attend AUT midwifery training in Manukau. **(EOA)**	**3a.** Programme reviewed Q2	Q2	Maaori and Pacific students enrolled at AUT for 2020 and 2021 year – target number tbc		
4. Develop and implement a plan to manage workload peaks particularly during the December/January holiday period.	**4a.** Draft plan developed by end of Sept 2020.	Q2	Plan in place by Nov 2020		
5. Develop a midwifery workforce strategy 2020-2025 reviewing models of care and the midwifery workforce needs to deliver these, prioritising workforce reflecting our community and focusing on equity around access to services and wrap around care for our most vulnerable women working with others carers and service providers. **(EOA)**	**5a.** Midwifery Workforce Strategy team in place by July 2020	Q1	Plan completed by end Sep 2020		

Maternity and early years					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Support the Well Child Tamariki Ora (WCTO) Review by undertaking a pilot in partnership with a Pacific WCTO provider in order to demonstrate improved outcomes for young parents through the delivery of an intensive model of support provided through a multidisciplinary team, beginning in Quarter One. **(EOA)**	**1a.** Pacific WCTO Pilot to begin in Q1	Q1	Number of Maaori and Pacific women engaged in the enhanced WCTO pilot Reporting against the 18 WCTO indicators and Start Well indicators to enable a comparison between the services Number and Percentage of Maaori and Pacific women engaged with Te Rito Ora c/w total number engaged with TRO	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
2. Continue to prototype an intensive home visiting support model alongside young parents in Mangere combined with psychological support in order to measure outcomes (including SUDI, breastfeeding, smoking cessation, drugs and alcohol and family violence and psychological distress). **(EOA)**	**2a.** Start Well prototype data will be collected and reported as a dashboard from Q1-Q4 including outcomes by ethnicity (EOA)	Q1-Q4			
3. Work with police and other agencies to identify a small number of young pregnant women identified as experiencing family violence and trauma and offer support by a social worker and clinical nurse specialist in order to test a new collaborative way of working. **(EOA)**	**3a**. Complete an Evidence and Insights learning package summarising learnings and recommendations by Q4	Q4			
4. Development and implementation of a co-ordinated community breastfeeding support strategy and service based on Te Rito Ora principles and involving NGOs and CM Health in partnership.**(EOA)**	Monitor and report equity of access to breastfeeding support for Maaori and Pacific women (EOA)	Q2 & Q4			

5. Targeting infant and maternity nutrition workshops to Maaori and Pacific women and engagement of local NGOs. **(EOA)**	Monitor and report equity of access to infant and maternal nutrition advice workshops for Maori and Pacific Women (EOA)	Q2 & Q4	Percentage of Maori Pacific women engaged with MKR workshops c/w total number		
6. Apply BFHI ten steps within maternity/neonatal facilities to ensure exclusive breastfeeding rates on discharge remain above 75%. **(EOA)**	Monitor exclusive breastfeeding rates on discharge for Maaori and Pacific babies (EOA)	Monthly	Percentage exclusive breastfeeding rate on discharge for Maori/Pacific women		
7. Develop and maintain Maaori and Pacific health workers specifically for maternal support with optimising infant nutrition up to six weeks of age. **(EOA)**			Percentage of total of Maori/Pacific health workers in infant nutrition (TRO) team		
8. Work with community partners to increase the capability of ECE teachers to address health and wellbeing issues (including child development, nutrition, adverse childhood experiences, and family violence) through development of a Community of Practice with education and community stakeholders. **(EOA)**	**8a.** CoP in place	Q1	Increased participation in early childhood education		
9. Work with intersectoral partners to iterate the ENGAGE self-regulation tool to maximise its effectiveness for Maaori and Pacific tamariki (through cultural adaptations) in South Auckland. **(EOA)**	**9a.** Redesign completed and tool launched in community settings	Q4	Increased self-regulation in participating populations		

10. Implement maternal oral health service for women with high oral health needs (including free access to dental services). **(EOA)**	**10a.** Service operational	Q1	Increased access to dental care Improved oral health		
11. Facilitate improvement project with Auckland DHB focused on improving secondary oral health services for CMH paediatric patients. **(EOA)**	**11a.** PDSA plans developed and implemented.	Q1	Number of CMH patients on the paediatric FSA waiting list – by month Waiting times for FSA (time from referral to FSA) – by month		
12. Undertake review of Adolescent Oral Health Coordination Service and implement changes to improve capacity and capability (with particular focus on rangatahi Maaori). **(EOA)**	**12a.** Changes implemented	Q2	Changes implemented		

SUDI				
DHB activity	**Milestone**	**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
			System outcome	**Government priority outcome**
The MoH goal is to reduce the SUDI rate to less than 0.1 per 1000 live births by 2025. In CM Health area there is a stark disproportionality for SUDI death for Maaori and Pacific infants. CYMRC: 14th data report 2013-17 reported a total of 49 babies died to SUDI in South Auckland The current SUDI rate for Maaori is 2.40 (26 deaths) and 1.77 for Pacific (21 deaths). 2 SUDI were non-Maaori non-Pacific. 2020/21 will be a challenging year for CM Health to improve the health outcomes of both Maaori & Pacific infants and whaanau/fanau being impacted by SUDI. **All of the below activities are EOAs for Maaori and Pacific**, the focus remains on our Maaori and Pacific Island populations, young mothers and those of our women and whaanau disadvantaged by living in low socio-economic areas.				

SUDI					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Survive & Thrive 2025 is the named approach encompassing universal SUDI risk assessment with referral to SUDI protection wrap-around-care for those babies identified at higher risk of SUDI. Implementation of this approach is a priority for CM Health across primary, secondary and community services.					
1. Risk Assessment Framework: Fully implement and monitor the SUDI risk assessment tool (an individualised, objective, evidence-based risk assessment for SUDI) to be completed for all mother-infant dyads in CM Health. **(EOA)**	**1a.** Integration of the SUDI risk assessment tool into Midwifery practice.	Q2	50% of infants born receive a SUDI risk assessment via the tool.	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
	1b. Ensuring infants most at SUDI risk are provided a SUDI risk assessment via the tool.	Q4	80% of infants (identified retrospectively) as being at greater risk of SUDI have received a SUDI risk assessment via the tool.		
2. SUDI protection wrap-around-care: Fully implement and monitor delivery of the Well Child Tamariki Ora (WTCO) providers delivering SUDI protection wrap around care to those infants referred at greater risk of SUDI. This service is inclusive of the delivery of culturally appropriate safe sleep beds & integration of weaving wahakura/haapu mama opportunities. This service will be in partnership with whaanau to facilitate and enable early health, wellbeing and social care. **(EOA)**	**2a.** Integration of SUDI protection wrap around care into the WCTO provider service model.	Q2	100% of infants referred to their preferred wrap-around-care service provider who has been identified via the SUDI tool as being of greater SUDI risk.		
	2b. Ensure access & distribution of safe sleep beds to those in need.	Q2	Monitor distribution of safe sleep beds as per MoH NSPP reporting.		

SUDI					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
3. Primary care: The Best Start Pregnancy Tool has been developed by CM Health & the Northern region PHO's. National Hauora Coalition is undertaking national implementation of Best Start Pregnancy tool for mothers of Maaori infants with the Generation 2040 project funding. This is currently being piloted in Auckland and Northland using a nurse led model supported by the GP. This tool will optimise primary care opportunities to advance early SUDI protection by identifying and mitigating the factors that impact on risk. The SUDI risk assessment will be incorporated into the six week check to further support infants & whaanau. **(EOA)**	**3a.** Build SUDI risk assessment into the six week assessment completed in Primary Care.	Q4	Assess baseline data (via health safe) to better inform future activities and goal setting.		
	3b. Consideration and provision of appropriate education/training needs to deliver a nurse led model within primary care	Q1-4	Assess & deliver agreed education/training requirements to sites integrating the Best Start Pregnancy tool.		
4. Post-SUDI Care: Continue to improve the post SUDI care pathway for whaanau and health/social care workforce around the following areas: **(EOA):** • Progress grief support and accessibility and required funding • Progress clinical support to ensure whaanau understanding of causes of SUDI and safe sleep practices for whaanau or in future pregnancies	**4a.** Collation of relevant counselling & grief support services within CM Health catchment area.	Q2	Provide recommendations as to progressing grief support and accessibility		
	4b. Establish a coordinated approach to provide whaanau Paediatric consults re PM findings.	Q1	Develop a pathway to ensure offer of consult to whaanau.		
	4c. Establish a coordinated approach for review of provisional SUDI	Q2	Develop a pathway to ensure oversight and rapid review of provisional SUDI		

SUDI					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
• Establish a process to have oversight and review of all provisional SUDI as and when required.			occurring for CM Health whaanau.		

Immunisation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Continue to Increase collaboration between Outreach Immunisation Services (OIS) and Well child providers (WCP)to support access and facilitate timely immunisation for infants under eight months not fully vaccinate, prioritising Maaori and Pacific babies **(EOA)**	**1a.** Quarterly monitoring of opportunities to improve immunisation coverage.	Q1	95% immunisation target reached for Maaori pepe and the total population Number of Maaori whaanau who take up the incentive scheme	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
2. Complete the evaluation of the year long Incentive programme to increase engagement of Maaori families with Outreach Immunisation Services. **(EOA).**	**2a.** Complete data analysis, interviews for participants and health providers	Q1	75% HPV dose 2, target reached		
3. Improve HPV and Boostrix immunisation coverage for Maaori and Pacific students via the Kidz First Public Health school-based immunisation team by strengthening the holiday home visiting immunisation initiative that supports	**3a.** Quarterly monitoring	Q1- Q4			

Immunisation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
students who have missed the school program to access vaccination **(EOA)**					

School-based health services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Implementing Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS: The DHB will continue to provide high quality, quantitative reports in quarters 2 and 4 for all schools that receive funding for SBHS. Each school nursing team will continue to provide an annual quality improvement plan, based on the 'Youth Health Care in Secondary Schools: A framework for continuous quality improvement' document. The DHB has two actions within SBHS for 2020/21 for improving the responsiveness of primary care to youth, as described below.					
1. In collaboration with identified partners, implement the Youth Primary Mental Health and Addictions plan **(EOA)**	**1a.** This is dependent on the outcome of the MoH RFP	Q4		We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
2. Increase the uptake of Long Acting Reversible Contraception (LARC) within SBHS schools, with a particular focus on Maaori and Pasifika students and those in Quintile 5 schools. **(EOA)**	**2a.** Roving LARC nurse to undertake LARC delivery and sexual health screening for Maaori and Pacific students and those in Quintile 5 schools.	Q1-Q4	Provide an accessible & responsive pathway to access LARCs/sexual health screening within a SBHS/AE setting. Monitor uptake of LARCs/ treatment provided inclusive of age/ethnicity which will provide a baseline for future years		
The youth service level alliance team (SLAT)			Ensure 95% of students eligible for a routine health assessment		

School-based health services				
DHB activity	**Milestone**	**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
			System outcome	**Government priority outcome**
The DHB commits to providing quarterly narrative reports on the actions of the SLAT and as outlined above, to improve health of the DHB's youth population. The DHB commits to ensuring the continued high performance of the SLAT through: • Reporting monthly to the Alliance Leadership Group, with a particular focus on delivery of the Rheumatic Fever Prevention Programme • Engaging with the Regional Youth Health Network bimonthly • Seeking to improve engagement with PHOs, with the goal of providing more youth-appropriate primary care		(including HEEADSSS assessment) receive one. Continue to upskill school nurses to work at the top of their scope via increase number of nurses trained as: - authorised vaccinators - nurse prescribers and provided comprehensive sexual health training.		

Family Violence and Sexual Violence				
DHB activity	**Milestone**	**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
			System outcome	**Government priority outcome**
Over the 2020/21 year CM Health will continue to implement the CM Health Violence Intervention Programme (VIP), which recognises the importance of improving equity for both Maaori and Pacific people. The 2016 VIP guidelines are aligned with both the He Korowai Oranga (Maaori Health Strategy 2014) and Nga Vaka o Kaiga Tapu (Ministry of Social Development Taskforce for Action on Violence within Families 2012). The guidelines encompass a framework based on leadership, knowledge and commitment to effective identification and response processes to intimate partner violence. CM Health will also implement the following activities in 2020/21:				

Family Violence and Sexual Violence					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Support recognition of family violence as a health issue with ELT oversight: • Embed routine enquiry into core health business • Review current SMO VIP training and develop and implement a training package that is tailored to the senior medical staff work and roster patterns. • ELT to actively encourage senior medical staff to complete this tailored training	**1a.** SMO workforce trained in VIP.	Q4	50% of SMO workforce trained in VIP across all 4 roll-out areas. • VIP Sponsor to agenda matter with ELT for support and direction • 20% of Paediatric SMO workforce trained by Q2	We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child
2. Formation of a Maternity Care, Child Wellbeing and Protection Multiagency Group (Refer to points 2. and 3. in the Maternity and Early Years section within this annual plan for detail on the intensive home visiting support models and collaboration with other agencies to provide support to young pregnant woman) which will focus on: • Work with an intersectoral framework to provide early intervention and attempt to reduce risk • Work collaboratively and information share to prevent siloed working • Greater support of Lead Maternity Carers (LMCs) with an allocated social worker to support early intervention with vulnerable pregnant mothers.	**2a.** Group to be formed. • Maternity Senior staff and Professional Lead for Social Work to form group	Q1-Q2	100% of LMC workforce to be supported by NGO Social Work provision. Chief Midwife and Professional Lead for Social Work supporting a forum for LMC's to access wider multi-disciplinary advice		

Family Violence and Sexual Violence					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
3. Safety Assessment Meeting (SAM) (Refer to the section on Cross-sectoral collaboration including Health in All policies for detail on the safety assessment meetings (SAM) as part of the South Auckland Social Wellbeing Board (SASWB). Prevention of, and response to, Family Violence and Harm is a key area of focus for SASWB, with specific work linked to the Joint Venture for Family Violence and Sexual Violence).: • Ensure the necessary resource and skill set of health professionals as active participants • Consider a Health Broker position to traverse across primary and secondary services to offer best health outcomes	**3a.** SAM Health representatives appointed/confirmed.	Q2	100% attendance by Health at North and South tables. 2 FTE Social Workers continue to be employed by the DHB's Pacific Health Service on fixed term funding from Mental Health services to increase capacity at SAM Tables daily		
4. Shaken Baby Prevention (SBP) Education • Offer education and training to all health professionals in the designated areas • Have clinical champions embed this as a core requirement of care • Audit outcome findings and track the trend as a KPI on scorecard data	**4a.** DHB endorsed Policy in place. All identified clinical areas have a designated Clinical Champion	Q1-Q4	100% education offered to parents/caregivers for ALL under 2 year olds in the following areas: • Maternity • Kidz First • Neonatal Care Monthly score card data reviewed and VIP Service offer on the floor support to all identified areas to maintain consistency		

Family Violence and Sexual Violence					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
			Clinical Champion Education Day arranged Q3		

2.7.4 Improving mental wellbeing

Together we must continue to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides holistic options for New Zealanders across the full continuum of need.

People with lived experience of accessing mental health or addiction services and their families must be central to this.

Counties Manukau Health will embed a focus on wellbeing and equity at all points of the system, while continuing to increase focus on mental health promotion, prevention, identification and early intervention.

Alongside building missing components of our continuum, the annual plans demonstrated how existing services can be strengthened to ensure that mental health and addiction services are cost effective, results focused and have regard to the service impacts on people who experience mental illness.

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

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Placing people at the centre of all service planning, implementation and monitoring programmes As a DHB, Counties Manukau Health has listened and heard from our communities - what is needed is a system of care clearly focused on people and their whaanau/families, more culturally-responsive and provided closer to where people live. He Ara Oranga, the Government inquiry into mental health and addictions echoes these messages and provides clear direction that further informs this new system of care that we have, and will continue to develop together. Similarly, each of our new initiatives continue to uphold leadership in promoting respect and observance of the Code of Health and Disability Services Consumers' Rights. This is also demonstrated in BAU within Mental Health Services by our designated Consumer and Family Whaanau leadership roles contributing at all levels of clinical governance. In front line services our Consumer Engagement Advisors ensure that Service Users and family whaanau are aware of the Code; and that copies of the Code are available at all of our sites. This is particularly evident in our Inpatient unit where our Consumer Engagement Advisors regularly assist Service Users and support them to access advocacy when required. We are able to demonstrate working with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities through our partnerships with local consumer networks, (including Te Kete Poumanu – Lived Experience Voice for Maaori), NGO, primary and community care agencies.					
1. Consumer and Whaanau Engagement - Demonstrate a commitment to lived experience and whaanau roles being supported and employed across policy, strategy and quality programmes. • Maaori and Pacific candidates will be prioritised in the recruitment process through engagement with our tangata whai ora / tangata ola and whaanau / fanau networks. **(EOA)** • Successful candidates will ensure that Service Users and family whaanau have access to information about their rights; have a voice within our community teams; and can speak with them, and on behalf of them, when required. • The new Consumer and Family Whaanau roles will ensure capacity to provide consistent and equitable support (according to the Code of Health and Disability Services Consumers' Rights) across all services	**1a.** Recruit 6.0 new FTE and complete orientation by end of Q2; including 3 FTE Consumer Engagement Advisors, 2 FTE Family Whaanau Engagement Advisors and 1 Youth Consumer Advisor .	Q2	1a. Record, analyse and prioritise service user and whaanau engagement activity and feedback (consumer voice) every month 1b. Implement a minimum of one high priority improvement initiative each quarter, with a focus on equitable outcomes for Maaori & Pacific	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
			1c. Communicate and update outcomes using visual management tools each quarter to service users and staff		
2. Maarama Real Time Feedback - Improve mechanisms that will enable real time feedback (RTF) from service users and their families into quality programmes. • New Consumer & Family Whaanau Experience Evaluator role is to enable roll-out of the Maarama survey across services. Maaori and Pacific candidates will be prioritised in the recruitment process through engagement with our tangata whai ora and whaanau networks. **(EOA)**	**2a.** Recruit Consumer & Family Whaanau Experience Evaluator by end of Q1.	Q1	2a. Review and prioritise actions from RTF Survey feedback quarterly		
	2b. Train staff in Experience-based design methodology to ensure a consistent co-design approach to quality improvement initiatives by Q3.	Q3	2b. Implement a minimum of one high priority improvement initiative each quarter, with a focus on equitable outcomes for Maaori & Pacific		
	2c. Implement the Maarama RTF survey to all teams by end of Q4. Develop the closing - the-loop feedback strategy	Q4	2c. Communicate and update outcomes using visual management tools each quarter to service users and staff		

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
3. Development & testing of Qliksense; this tool will enable MH&A to construct multiple dashboards of indicators from different clinical data sets Please refer to the MH&A Improvement Activities section for the HQS programmes of work	**3a.** 5 licenses & users operational by Q2	Q2 and Q4	x Dashboards created & used with x different views by Q4		
Embedding a wellbeing and equity focus					
1. Early Psychosis Intervention Team (EPIT) Service Users Improve employment, education and training options for people with low prevalence conditions.	**1a.** Base line audit to show number/% of EPIT clients in employment, training or education completed by end of Q1.	Q1	Report Targets agreed by end of Q1	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
	1b. Engage NGO Employment specialist or similar to work with Service Users by end of Q2.	Q2	% of Service Users working with NGO Employment specialist reported by end Q2		
	1c. Employment goals are included in Regional Collaborative Care Plan by end of Q3.	Q3-Q4	% of Service Users who have employment or education goals in the Regional		

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
			Collaborative Care Plan reported by end Q3. % EPIT Service Users in paid employment, training or education reported by end Q4.		

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. Improve the physical health outcomes for people with mental health and addiction conditions. There are large health inequities for people with mental health and addiction challenges. The aim as part of the equally well initiative is to enable supports for individuals within Mental health and addiction services to low cost / no cost community resources that will enhance physical wellbeing. **(EOA)**	**2a.** Complete Green prescription information sessions across NGO-funded community MH&A services by end of Q1	Q1	Number of MH&A service users accessing Green prescriptions increased from 2 to 100 by end of Q4	We live longer in good health	Support healthier, safer and more connected communities
	2b. Complete Green prescription information sessions across MH&A Provider Arm services by end of Q2	Q2			
	2c. Pilot of 12-week Green prescription health session will be completed within the Acute MH&A in-patient unit (for staff and service users) by end of Q4	Q4			
3. Improve responses to co-existing problems via stronger integration and collaboration between other health and social services. Develop AOD model of care for co-existing disorders as part of the wider AOD continuum for the Northern region which is integrated and evidence based within the health system and with other relevant agencies. **(EOA)**	**3a.** Services and Key stakeholders will be identified by end of Q1	Q1	A document will be produced which will inform, current status across all contracted provision (health and social services), gaps in	We live longer in good health	Support healthier, safer and more connected communities
	3b. Regional meetings established and commenced with key stakeholders by end of Q2	Q2			

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	3c. Gaps in service identified and strategies identified to enhance services and priority areas for future investment by end of Q4	Q4	service, evidence base and recommendations for future investment.		

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
4. Improve engagement strategies with Maaori, people with lived experience, and population groups who experience disproportionately poorer outcomes including Pacific peoples, youth and Rainbow communities. **(EOA)**	**4a.** Analyse Maaori & Pacific data engagement from Marama RTF Survey each quarter **4b.** Engagement Advisors actively engaging with Te Kete Pounamu (lived experience voice for Maaori) **4c.** Work with NGO service providers for the Rainbow community to ensure that services that we provide accurately reflect their voice and their needs **5d.**Review feedback that we receive and implement actions accordingly	Q1-Q4	Implement a minimum of one high priority improvement initiative each quarter, with a focus on equitable outcomes. Communicate and update outcomes using visual management tools each quarter to service users and staff	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
5. Continue to implement Supporting Parents, Healthy Children (COPMIA) to support early intervention in the life course by: • Improving liaison between CAMHS and Adult MH clinicians • Embedding processes to record children of Service Users	**5a.** Adult teams can demonstrate MDT routinely includes CAMHS clinician participation by end Q1. • MDT documentation demonstrates specific opportunities for consultation liaison with CAMHS clinician • All services have available resources for parents to talk to their children about mental health and addiction issues. • All services have resources available for children about mental health and addiction issues.	Q1-Q2	MDT minutes record consult liaison activity with CAMHS clinicians regarding the children of adult service users by end Q1. All services have a documented process for accessing and maintaining specific identified resources for parents & children by end of Q2	We have improved quality of life	Make New Zealand the best place in the world to be a child

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	5b. Utilise Audit recommendations to implement procedures to monitor HCC recording of parental status, and number, gender and age of children by end of Q2	Q2	80% of service users have parental status, and number, gender and age of children recorded by end of Q4		
6. Collaborate and work with the Ministry, the Mental Health and Wellbeing Commission, the Suicide Prevention Office and other leadership bodies and key partners to help drive transformation in line with He Ara Oranga. **(EOA)**	**6a.** Relationships are built with the Mental Health and Wellbeing Commission and the Suicide Prevention Office	Q2	Hui with Leaders from these groups hosted at Counties Manukau by end of Q2	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
Increasing access and choice of sustainable, quality, integrated services across the continuum					
1. A phased implementation of the new integrated primary MH&A model. The focus is on Maaori, Pacific and Youth. I.e. Practices with high Maaori, Pacific and Youth numbers will be prioritised for first implementations. **(EOA)**	**1a.** Collate baseline data on access to 4 components of the Model of Care (NGO, HIP, Health Coach, GP/Nurse)	Q1	Compare access data to the four components of the model (collected during 20-21 year) with baseline to ensure the model is increasing access for Maaori, PI and Youth.	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
2. Increase Maaori and Pacific access to social and cultural support through primary care **(EOA)**	**2a.** Commence implementation of Awhi Ora Model within General Practice	Q1	Awhi Ora Model implemented into 3 General Practices by end Q1	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
3. Work with the Ministry of Health and key stakeholders to plan evaluation of the model to understand equity of outcomes. **(EOA)**	**3a**. Evaluation framework defined by Q2	Q2	Maintain increased access across all General Practices during 20-21 year	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Continue working with General Practices to ensure that the Wellness Support model increase access and choice for Maaori, Pacific and Youth. (FA1) **(EOA)**	**4a.** Monitor access rates to Wellness Support by ethnicity and age	Q1-Q4	MH04 - Mental Health and Addiction Service Development (FA1 Primary Mental Health)	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
5. Update and implement the new model of care in Acute services	**5a.** Tiaho Mai staff complete Te Whare Tapa Wha Workbook training in preparation to introduce the workbooks to service user and integrate the workbooks into routine practice.	Q2	Pre/post data and service user feedback on groups and programme	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
6. Each service user will have a comprehensive treatment plan that reflects their stated goals	**6a.** The Te Whare Tapa Wha Workbook is routinely used to integrate service user goals into the treatment plan.	Q2	Audit of treatment plans shows that in 30% of cases service user goals have been integrated into the plan by Q2		
		Q3	Audit of treatment plans shows that in 70% of cases service user goals		

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
			have been integrated into the plan by Q3		
		Q4	Audit of treatment plans shows that in 80% of cases service user goals have been integrated into the plan by Q4		
7. Integrate new safety planning policy into routine clinical practice	**7a.**Tiaho Mai staff complete safety planning training, discharge planning training with emphasis on integrating safety plans into discharge plans	Q4	85% of all clinical staff working in Tiaho Mai have completed safety training by Q4		
	7b. Discharge plans show evidence of safety planning	Q3 and Q4	Audit of discharge plans shows that 60% have evidence of safety planning by Q3 70% by Q4		
8. Acute service users having co-occurring substance abuse disorders will have access to services that meet their needs: • Integration of drug/alcohol delirium screen within Intake and Acute Assessment	**8a.** Develop and obtain sign off of a screening tool that will be used by Intake and Acute Assessment	Q1	8a. Screening tool is signed off by clinical governance by Q1	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	8b. Intake staff are trained in use of screening tool	Q3	8b. 85% of staff trained by Q3 8c. Audit of use of screening tool shows: • 60% compliance by Q4 8d. 2 groups per month occurring by Q4 8e. 1 Dual Diagnosis Family/Whaanau support group occurring by Q4 8f. Design feedback questions and process by Q2 Implement feedback/liaison process by Q2		
	8c. Screening tool will be routinely used for new assessments where drugs and alcohol are a factor in the presentation	Q4			
	8d. Implement Dual Diagnosis Groups for service users as part of Tiaho Mai treatment programme as part of new model of care	Q4			
	8e. Implement Dual Diagnosis Family Whanaau support groups as part of Tiaho Mai treatment programme as part of new model of care	Q4			
	8f. Liaise with service users, staff, peer support to identify issues that interfere with referrals to specialist drug/alcohol services and design	Q3			

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	strategy to address these issues		Compile report of feedback by Q2 Develop strategy to overcome issues identified by Q3		
9. Redesign of NGO Provision The redesign of NGO provision is part of the development of a broader model of care designed to deliver an integrated DHB and NGO clinical and non-clinical response to population need across the continuum. Large-scale redesign of NGO provision requires a formal procurement process to contract providers to work differently, underpinned by new outcomes-based contracts. The new approach will enable providers to be leaders in the design and delivery of provision, with an intentional focus on the growth and development of the Maaori and Pasifika provider base. **(EOA)**	**9a.** Completion of RFP phase of procurement process and identification of preferred providers	Q1	Preferred providers identified in all five localities	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring or volunteering
	9b. Due diligence, contract negotiations	Q2	Contracts signed with provider partnerships in all five localities.		
	9c. Transition to new service provision.	Q3	Individual transition plans developed and implemented for 100% of service users receiving non-clinical supports from NGO providers.		
	9d. Increased capability in community mental health teams to do ILoC work.	Q2 and Q4	10% of total community FTE working in a primary-care facing way (Q2)		

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
			20% of total community FTE working in a primary-care facing way (Q4) 50% of general practices engaged with an ILoC team. (Q4)		
	9e. Partnership approach agreed for effective early intervention and meeting unmet need for Maaori.	Q4	Regular ILoC engagement in three marae-based clinics.		
Workforce					
1. Recruit Locum RN's from overseas to support MH&A workforce recruitment & retention	**1a.** Contracts in place by Q1	Q1 and Q2	10 contracts signed by Q1 & 15 Contracts signed by Q2	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
2. Strengthen lived experience leadership for the peer support workforce **(EOA)**	**2a.** Recruit new Associate Professional Leader role for Peer Support by end of Q1, to strengthen and develop Peer Support professional practice	Q1 and Q4	Implement Peer Potential Strategic Action Plan for the Peer Support workforce by end of Q4		
3. Employ family whaanau support. **(EOA)**	**3a.** Kai Manaki Family Whaanau in the role	Q1	20% increase in family whaanau included in		

Mental Health and Addiction System Transformation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	employed in the inpatient unit by Q1		treatment planning.		

Mental Health and Addiction Improvement Activities					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. MH02 - Improving mental wellbeing Improving mental health services using wellness and transition (discharge) planning • **HQSC Connecting Care Project –** Implement the Generic Discharge Pathway	Implement the new Generic Discharge Pathway into BAU at Pacific and Integrated Care Services North (currently under trial) by Q1	Q1	90% of service users discharged from Pacific and Integrated Care Services North to Primary Care are seen by their GP for review within 28 days 95% of service users with an open referral to Pacific and Integrated Care Services North are enrolled with a GP	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
	Implement the Generic Discharge Pathway at two additional	Q3	50% of service users in 2 new teams have an up-		

Mental Health and Addiction Improvement Activities					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	community mental health teams by Q3		to-date regional collaborative care plan		
	All Community MH teams & inpatient wards participating in quarterly transition plan quality audits by Q4	Q4	95% of MH&A clients discharged from inpatient wards and community MHS have a transition (discharge) plan 60% of MH&A clients discharged from inpatient wards and community MHS have a transition plan of acceptable standard		
MH05 - Reduce the rate of Maaori under the Mental Health Act: section 29 community treatment orders. **1.** Ensure clinical reviews are completed in a timely way. **(EOA)** **2.** Connect Service Users and whaanau to NGO for ongoing support. Increased involvement of Kaupapa Maaori services in the persons	**1a.** Audit of SMO consultation with whaanau for s.76 clinical reviews completed by end of Q2	Q2 and Q4	90% s.76 clinical reviews completed on time by Q4 50% of SMO consultation for s.76 clinical reviews include whaanau.	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities

Mental Health and Addiction Improvement Activities					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
care; in particular, at consultation before decision is made to put service user on a CTO. • Increased involvement of Kaupapa Maaori services in the persons care; in particular, at consultation before decision is made to put service user on a CTO • Explore whether funding of medication costs for people under a CTO is a factor in the decision to remain on a CTO, and therefore whether continuing funding once off a CTO might reduce CTO use. We will explore different options for funding, including whaanau ora Service users. ○ Connecting Service Users and whaanau to NGO for ongoing support	**2a.** Service users who are Maaori, for whom an application for CTO is made, will be referred to a consultation with Kaupapa Maaori services.	Q4	50% increase in consultation with Kaupapa Maaori services at the point of CTO application by end of Q4		
	2b. Ensure Service users coming off a CTO and receiving funded medication have ongoing support from an NGO by end of Q4 • Audit number of Service Users on a CTO who can come off the CTO if their medication costs are funded • Identify costs of medication • Identify funding availability • Develop funded medication pathway for	Q2 and Q4	Number of Service Users receiving funding to support medication after coming off CTO will be determined by end of Q4 • Funded medication pathway for Service Users coming off a CTO defined by end of Q2		

Mental Health and Addiction Improvement Activities					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	Service Users coming off a CTO • Ensure SU coming off a CTO and receiving funded medication have ongoing support from an NGO				
3. We are committed to participating in Zero seclusion (Safe for All) – **(EOA)**	Monitor and continually improve primary drivers associated with zero seclusion: • Resource & development • Safe care environments • Engaged workforce • Equitable data collection • Maaori and Pasifika cultural approach	Q4	50% reduction in seclusion for Maaori & Pacific males aged between 18-30 years, within the first 24-48 hours of admission by end of Q4	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
4. Increase service improvement that results from our adverse event reviews and improve the experience of service users, whaanau (in particular Maaori whaanau), and staff involved in adverse event reviews. Key outcomes - whaanau experience, staff experience, percent of recommendations actioned. **(EOA)**	**4a.** Gather data to understand barriers to regular follow-through on adverse event review recommendations.	Q2	100% agreed recommendations will be tied to an action plan or quality improvement plan at the appropriate-	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities

Mental Health and Addiction Improvement Activities					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	4b. Identify potential solutions.	Q2	level within three months of the recommendation being ratified by end of Q2		
	4c. Design processes for tracking, monitoring and supporting services with implementation of recommendations, including –	Q4	100% agreed recommendations will be monitored and reported at the appropriate-level clinical governance group by end of Q4		
	• A thematic review of the recommendations from serious incident review reports every six months to feed into directorate-wide quality improvement agenda.	Q4	100% of reviews will have a Family whaanau engagement plan within 3 months of the incident by Q4		

Suicide Prevention					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Renew CM Health strategic suicide prevention plan and link to the national plan **2.** Pilot and evaluate the Pisani Safeside Suicide Prevention training **3.** Development of digital innovations, sponsored by the Vodafone Innovation Fund **4.** Work with the national suicide prevention office regarding better postvention services especially for Maaori and Pacific Islanders **(EOA)** **5.** Continue to build and support primary care networks **(EOA)** • Build resilience in local communities especially Manurewa and Papakura • Expanding provision of marae-based traditional healing • Continue to collect and analyse data - both the provisional coroners' data and Middlemore ECC data	**1a.** Common linkages identified by end of Q2	Q2	Link CM Health strategic suicide prevention plan to the national plan by end of Q2	We live longer in good health	Support healthier, safer and more connected communities
	2a. 4 teams (75 staff) in secondary mental health services completed training by end of Q3	Q3 and Q4	Summary of Findings & Recommendations documented by end of Q4		
	3a. Develop suicide safety plan mobile phone application prototype by Q1	Q1 and Q4	Evaluation of feedback from 100 users who trialled prototype, completed by Q4.		
	4a. Counties Maaori prevention and postvention coordinator recruited by Q2	Q2			
	5a. Advocacy with Auckland council safer communities to safeguard suicide risk locations		Top 10 high risk suicide locations identified & Safer Communities Plans implemented in these areas		

Addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Specialist AOD Consult Liaison - Improve Mental Health Workforce capability to identify AOD co-existing problems and cultural equity. • Implement PDSA cycles of audit, improvement, re-audit to monitor progress. **2.** Review cultural validity/appropriateness of AOD screens for Maaori and Pacific in consultation with the Cultural Consult Liaison Teams. Agree on recommendations and improvement targets to improve cultural equity. **(EOA)**	**1a.** Retrospective file audit in selected target areas (TBA) and date range to determine current workforce use of screening tools and treatment planning for CEP issues.		By end of Q1, report on the number and percentage of: • Screens by ethnicity • Regional Collaborative Care Plans (RCCP) that include AOD treatment plans. • RCCP that include NGO addiction services involvement (CADs and NGOs). • RCCP that include Cultural Consult Liaison team.	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
	2a. Themed analysis of AOD/CCP Audit completed by end of Q2, with a focus on: • Screening • Included in RCCP	Q2	By end of Q2, report on improvement targets for: • Screening		

Addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	• Cultural consideration		• Screening included in RCCP • Cultural consideration included in screening and RCCP		
	2b. Implement improvement recommendations by end of Q3	Q3	Report progress against improvement targets by end of Q3.		
	2c. Repeat Audit and measure improvements against targets by end Q4.	Q4	Report improvement gains against targets by end Q4.		

Maternal Mental Health Services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Increase access for Maaori and Pacific mothers, Infants and Whaanau in the Perinatal Maternal & Infant Mental Health services, by developing an action plan with Raupua Whaiora (Maaori Consult Liaison team), Fale Toa (Pacific Consult Liaison team), & Women's Health (e.g. midwives) **(EOA)** 1b. Increase Consult Liaison with Primary Care, Oranga Tamaki and early parenting programmes; for example, Family Start & Start Well. Interface with Primary Care funding initiatives.	**1a.** Internal action plans agreed for Maaori and Pacific mothers by end of Q1	Q1	Baseline number of unique clients by ethnicity by end of Q1 10% increase in Maaori & Pacific unique clients by end of Q3	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
	1b. Develop survey to understand Maternal Mental Health learning requirements in the Primary sector by end of Q1 Develop & schedule primary care education sessions based on Survey feedback by end of Q2	Q1	Baseline number of consult liaisons by ethnicity by end of Q1 20% increase in Maaori & Pacific consult liaisons by end of Q3		
2. Ensure Maternal Mental Health services for Pacific women meet their cultural needs • Review Moana Research findings on Pacific women's experience on accessing Maternal Mental Health Services **(EOA)**	**2a.** Prioritise recommendations that are appropriate from Moana Research project by Q2	Q2	Phased implementation plan completed.		
3. Implement a PDSA cycle of continuous improvement to monitor and measure implemented recommendations and make further recommendations for continued improvement	**3a.** Commence phased implementation of recommendations by end of Q4	Q4	Report on targeted improvements against baseline		

Maternal Mental Health Services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	• Workforce cultural capability • Perinatal skills development				

2.7.5 Improving wellbeing through prevention

Preventing and reducing risk of 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 a public health and prevention focus. This focus, includes working with other agencies to address key determinants of health, creating supportive health enhancing environments, identifying and treating health concerns early and ensuring all people have the opportunity and support to live active and healthy lives.

PHUs have an important role to play to address key determinants of health, improve Māori health and achieve health equity and wellbeing by supporting greater integration of public health action and effort. DHBs and their PHU both have a role in contributing to improving the health and wellbeing of the population through prevention.

Auckland Regional Public Health Service (ARPHS, PHU for the metro Auckland region), provides public health services on behalf of CM Health. ARPHS is contracted and reports through ADHB and their contribution to services for the CM Health population for the Annual Plan is described in the ADHB Plan. This is referenced where appropriate in the sections below.

Environmental Sustainability					
DHB activity	**Milestone**		**Measure**	Government themes: **Improving the well-being of New Zealanders and their families** Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)	
				System outcome	**Government priority outcome**
Climate Change					
Energy and Water **1.** Continued work with the Energy Efficiency and Conservation Authority (EECA) meeting the Collaborative Agreement with targeted energy savings set at $100k per annum for FY20 compared to baseline FY16.	**1a.** Achievement of the savings target.	Q4	$100k saved per annum	We live longer in good health	Support healthier, safer and more connected communities
Carbon mitigation and adaptation **2.** Continuation with Toituu (Carbon Reduce) Certification and all carbon mitigation and adaptation activities. **3.** Review of future emission target to align the DHB with Science Based Targets (SBTs) i.e. carbon neutral by 2030. **4.** Implementation of sustainability action plan targeting the following focal areas: energy, transport, waste, green buildings, supply chain and reprocessing medical devices. **5.** Northern Region DHB and HealthSource environmental sustainability supply chain group. **6.** Development of a Regional Adaptation planning process and plan agreed.	**2a.** Maintenance of Toituu (Carbon Reduce) Certification.	Ongoing	Carbon reduction a minimum of 2% per annum	We have improved quality of life (lower pollution)	Make New Zealand the best place in the world to be a child
	3a. Target revision status	Q4	To be developed as Science Based Targets are developed nationally		
	4a. Implement 5 initiatives in 2020.	Q4			
	5a. Initiate 5 regional projects in 2020.	Q4			
	6a. Regional plan endorsed.	Q2	Published Adaptation Plan By end of Q2	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities

Environmental Sustainability					
DHB activity	**Milestone**		**Measure**	Government themes: **Improving the well-being of New Zealanders and their families** Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)	
				System outcome	**Government priority outcome**
Waste Disposal					
1. Recycling and waste reduction: CM Health will continue to recycle cardboard, soft plastic, mixed recycling, non-confidential paper, polystyrene and e-waste. CM Health will also undertake the following recycling and waste reduction activities: • Continue to improve waste segregation and recycling infrastructure. • Continue to deliver training to reduce preventable medical waste and general waste. • Further expansion of scissor and tweezer recycling. • Working with supply chain to reduce waste. • Implementation of third party medical instrument reprocessing project- pilot project – to assess safety, quality and benefit.	**1a.** Track impact of each project (CO2 and $)	Q4	Track all monthly waste weights, volumes and costs	We live longer in good health	Support healthier, safer and more connected communities

Antimicrobial resistance (AMR)					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. In 2020/21 CM Health will focus on those control methods identified by the World Health Organisation as the most important for control of antimicrobial resistance: antimicrobial stewardship, screening and environmental decontamination.	**1a.** Increase compliance from clinical areas for screening as per requests or admission criteria.	Q2	Measured % of eligible patients screened	We live longer in good health	Support healthier, safer and more connected communities
	1b. Consult on facilities development to increase ability to manage infectious diseases.	Q4	Increased isolation resources		
2. CM Health Antimicrobial Stewardship Committee continues to meet monthly to discuss issues and strategies relating to antimicrobial usage, infection prevention and control. The committee comprises members from infection control, clinical pharmacists, clinical microbiologists and the infectious diseases team, as well as a GP liaison member, community laboratory microbiologist, general nurse representation.	**2a.** Monthly meetings to discuss issues and strategies including liaison with CM Health laboratory services regarding updates on antimicrobial sensitivity patterns. **2b.** Recruitment of Acute Residential Care representative	Ongoing			
3. Continue and expand the CM Health internal surveillance processes for multidrug-resistant organisms (MDROs) in line with national Carbapenemase-producing Enterobacteriaceae (CPE) management guidelines. Activities include screening of patients who have spent time in overseas hospitals and patients who have recently travelled to certain countries.	**3a.** Expand surveillance processes to include screening of patients who have spent time in overseas hospitals and patients who have recently travelled to certain countries.	Q1	Documented processes are in place and audit tools developed		
4. Continue membership on National Technical Advisory Group for CPE management	**4a.** Provide advice and input as required to the development of national	Ongoing			

Antimicrobial resistance (AMR)					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	frontline policy and guideline development for CPE management.				
5. Establish an efficient MDRO screening system that is consistent with the New Zealand Antimicrobial Resistant Action Plan and other relevant documents such as the "IPC and management of CPE" (Guidelines for HCP in NZ acute and RCF) Ministry of Health 2018. This is also informed by local epidemiology: our DHB has one of the highest rates of CPE in NZ.	**5a.** Get adequate compliance from clinical areas (especially ED) for screening as per requests or admission criteria.	Q2	Measured % of eligible patients screened by questions and specimen testing.		
	5b. Refine screening protocols according to developing risk.	Q1 (with ongoing refinement based on developing risk)	Revised protocols available		
6. Increase isolation capacity.	**6.** Consult on facilities development to increase ability to manage infectious diseases.	Q4	Increased isolation resources		
7. Primary care and residential care settings will continue to work to ensure that front-line infection prevention and control practices are implemented continuously, effectively and consistently and in alignment with the New Zealand Antimicrobial Resistance Action Plan and other relevant documents such as the "IPC and management of CPE" (Guidelines for HCP in NZ acute and RCF) Ministry of Health 2018 (see activity 5).	**7.** Improved performance against infection control standards in the integrated ARC audits.	Q4	Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1) Adherence to local advice and guidelines in management of		

Antimicrobial resistance (AMR)					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
			suspected COVID cases in ARC		
8. CM Health Senior Infection Control Practitioner continues to provide support and advice to primary care (PHOs and general practices) on an ad hoc basis and as requested. Specific areas of focus include: • Sterilisation in office-based general practices • Hand hygiene – continue to provide information resources to primary care where requested and support with advice on how to best implement these practices in a primary care setting • COVID preparedness	**8.** Ad hoc advice and support provided to primary care providers.	Ongoing			
9. CM Health Senior Infection Control Practitioner to continue involvement as an invited participant at the South Auckland Aged Residential Care (ARC) forum and cluster groups. This involvement includes providing presentations on requested topics as well as advice and support on management of CPE in aged care settings.	**9.** Presentation on CPE cross-contamination in aged care provided by end of financial year.	Q4			
10. Audits antimicrobial prescribing in hospitals to identify opportunities to improve appropriate prescribing.	**10**. Annual data collection to establish usage data. Presentation on data to areas identified for improvement, as well as Antimicrobial Stewardship Committee	Q3	Increase in appropriate prescribing		
11. Audit current intravenous (IV) to oral antibiotic switch programme to reduce unnecessary exposure to invasive	**11.** Conduct audit using established methodology. Presentation on results to	Q2	Cost saving, Improved use of antibiotics, reduced		

Antimicrobial resistance (AMR)					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
devices such as IV cannulae and reduce costs associated with IV antimicrobials.	Antimicrobial stewardship committee.		patient harm and hospital-acquired infections.		
12. Audit current usage of surgical antibiotic prophylaxis to ensure compliance with guidelines and reducing unnecessary patient harm from over use of broader spectrum antibiotics	**12.** Audit surgical antibiotic prophylaxis using approved methodology. Presentation to Anaesthesia and Surgical Care. Further discussion on required changes in light of results.	Q2	Improved antibiotic usage, reduced patient harm.		
13. Continue antimicrobial stewardship ward rounds utilising a Pharmacist Prescriber in an innovative model of care.	**13.** Quantify interventions made by Pharmacist Prescriber using quality improvement methodology	Ongoing	Improved antibiotic usage, cost savings, reduced patient harm		
14. Develop Allergy service at CMH to assist with the accurate labelling of antibiotic-related allergies using a pharmacist prescriber	**14.** Establish a novel service for accurate labelling, oral challenges, desensitisations and education.	Q3	Improved patient safety, cost savings, improved patient care and antibiotic usage		
15. Develop and institute a process for facilitating in-patient vaccination for all funded vaccines	**15**. Use quality improvement methodology to improve access for inpatients who qualify for a funded vaccination.	Q3	Improved patient safety, cost savings, improved patient care and antibiotic usage. Improve equity of access to funded vaccinations.		

Antimicrobial resistance (AMR)					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
16. Work towards regional approach to antimicrobial stewardship – including hospital and community sectors.	**16**. Current regionalisation includes: standardised empiric treatment guidelines for hospital and community sector, management of beta-lactam allergy, training and education provided to community nurse prescribers, provision of integral pandemic responses; however, there is significant room for more activities.	Ongoing	Regionalisation of AMS activities		
17. Building on research on community antimicrobial use and infections: looking at discrepancies in ethnic groups in the CMH area.	**Completion of research** Retrospective review of Staphylococcus aureus bacteraemia and cellulitis. Community antibiotic usage amongst different ethnicities.	Ongoing	Analysis, presentation and dissemination of findings to improve management.		

Environmental and Border Health					
DHB activity ARPHS undertakes compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation	**Milestone**		**Measure**	Government theme: Improving the wellbeing of New Zealanders and their families	
				System outcome	**Government priority outcome**
1. Within the funding provided, the Auckland Regional Public Health Service (ARPHS) will work to deliver the activities contained in the Environmental and Border Health exemplar and report against the performance measures contained in the Vital Few Report across the region, ADHB, WDHB and CM.				We have improved quality of life	Support healthier, safer and more connected communities
2. In border health, ARPHS provides a timely response to interceptions of medical vectors such as exotic mosquitoes of human health significance.	Target 100%	As required	% of responses initiated within 2 hours of notification.		
3. ARPHS responds promptly to high risk enterics due to the risk of disease spread.	Target 95%	As required	% of high risk enteric disease cases for which the time of initial contact occurred during the same day of notification (Shigella and NZ acquired Typhoid and Paratyphoid).		
4. When issuing permissions for the use of Vertebrate Toxic Agents (VTAs) for pest control, ARPHS ensures that consultation with Maaori (iwi/hapu/whanau) has taken place and that the evidence provided by the applicant supports this consultation **(EOA).**	Target 100%	As required	% of approved applications with supporting evidence of consultation with Maori (iwi/hapu/whanau).		

Healthy food and drink					
DHB activity	**Milestone**		**Measure**	Government theme: Improving the wellbeing of New Zealanders and their families	
				System outcome	**Government priority outcome**
1. Healthy Food and Drink Policies **(EOA)** (a) CM Health has had a healthy food and drink policy for more than a decade. Since 2016 CM Health has been implementing a policy aligned with the National Healthy Food and Drink Policy. (b) CM Health has included a clause in 100% of funder arm contracts renewed in the 2017/18 year (from July 2017) outlining the expectation of implementation of a healthy food and drink policy (example clause below), except for those providers who sit under national contracts, i.e. Age Related Residential Care, Combined Dental Agreements and Community Pharmacy Services Agreements. In some instances, there are local schedules to national contracts in which the clause has been included (e.g. PHO agreements). *X.X. Healthy Food and Drink Policy* *X.X.1 DHBs expect you to have a role in promoting the health and wellbeing of your service users, staff and visitors to your service by supporting them to make healthy food and drink choices. From 1 July 2017, you will adopt a Healthy Food and Drink Policy covering all food and drinks sold on sites, and provided to service users, staff and visitors under your jurisdiction. At a minimum, your Policy is to be written and reflect the principles of the National District Health Boards and Ministry of Health Healthy Food and Drink Policy, which aligns with the Ministry of Health's Eating and Activity Guidelines. A template policy can be found at:* *https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations* . This clause is also part of our current Provider Specific Terms and Conditions template and as such will be included in any new funder	1a. Use most recent monitoring data to give detailed feedback to retailers and work with them to address barriers to increased compliance 1b. Healthy food and drink policy clause to be included in any new funder arm contracts, unless the Programme Managers have a clear rationale to specifically request that this clause is excluded.	Q2, Q4	Working with 50% of retail spaces to address compliance barriers with measured improvement in compliance by end of Q2 and 60-75% by Q4 Q2 and Q4 on the proportion of total contracts which have a healthy food and drink policy clause	We live longer in good health	Support healthier, safer and more connected communities

Healthy food and drink					
DHB activity	**Milestone**		**Measure**	Government theme: Improving the wellbeing of New Zealanders and their families	
				System outcome	**Government priority outcome**
arm contracts, unless the Programme Managers have a clear rationale to specifically request that this clause is excluded. **2.** Healthy Active Learning ARPHS will be managing the Healthy Active Learning initiative on behalf of CM Health and the other metro Auckland DHBs and their contribution for this section is described in, and will be reported through, the ADHB Annual Plan.					

Other CM Health activity to support improved outcomes for our population in relation to preventing and reducing obesity, improving nutrition and physical activity, and preventing diabetes and other long term conditions: (EOA)

Reducing obesity, and improving nutrition and physical activity are key to prevention of diabetes and other long-term conditions such as CVD, gout, osteoarthritis, some cancers, and preventing and improving many mental health disorders. Working in collaboration with those most affected by the inequities in long term conditions prevalence and severity (in particular Maaori and Pacific peoples) is key to developing strategies that make a difference.

Achieving the Smokefree Aotearoa 2025 goal and reducing alcohol related harm are also key to preventing many long term conditions; actions to address tobacco smoking and harmful alcohol use are described under other sections of this Plan.

In relation to nutrition, physical activity and obesity prevention:

CM Health is a member of the Healthy Auckland Together (HAT) collaborative, led by ARPHS, which focuses on improving environments across the metro Auckland rohe to support improved nutrition, physical activity and healthy weight, with a particular focus on children and young people and equity. This work includes addressing marketing to children and is described and reported through the ARPHS contribution to the ADHB Annual Plan.

CM Health has contributed resource to support the delivery of the Wai Auckland project, led by ARPHS under HAT, to decrease intake of sugary drinks and improve the accessibility of tap water in community settings across the metro Auckland with an equity focus.

Counties Manukau DHB has an estimated 87,000 adults with a BMI of 35 or greater – that is, in the bariatric range. The distribution is highly inequitable, with nearly half Pacific and a quarter Maaori. CM Health is developing a local plan to address unhealthy weight which has five components

- advocating for actions to address the obesogenic environment

Healthy food and drink				
DHB activity	**Milestone**	**Measure**	Government theme: Improving the wellbeing of New Zealanders and their families	
			System outcome	**Government priority outcome**
- weight management programmes, with a view to adding medical pathways to current surgical offerings - care of patients with high BMIs - addressing weight bias and stigmatisation and improving weight related health literacy - data coding and information about BMI in health systems Engagement of Maaori and Pacific communities is key to developing and implementing this Plan.				

Smokefree 2025					
DHB activity Actions to advance progress towards the smokefree 2025 goal and support our Public Health Unit to undertake compliance activities as per the Smoke-free Environments Act 1990	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. With a particular focus on hapuu waahine Maaori and Pacific, outcomes related to harm from smoking will be improved by: - Continuing to focus on smokefree ABC in primary, secondary, maternity, mental health and community health settings. - An increase in referrals to cessation support. - Support for the delivery of Stop smoking medicines. **(EOA)**	**1a.** An increase in primary care referrals to Living Smokefree Service by 15%.	Q4	PH04: Better help for smokers to quit (primary care) CW09: Better help for smokers to quit (maternity)	We have health equity for Maaori and other groups	Make New Zealand the best place in the world to be a child
	1b. 45% of those supported to stop smoking are Maaori.	Q4			
	1c. 25% of those supported to stop smoking are Pacific.	Q4			
	1d. An increase people dispensed stop smoking medications in primary care by 12%.	Q4			

Smokefree 2025					
DHB activity Actions to advance progress towards the smokefree 2025 goal and support our Public Health Unit to undertake compliance activities as per the Smoke-free Environments Act 1990	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Implement "Tobacco Free Generation (TFG) approach" projects in Counties Manukau, which will involve **(EOA)**: - Smokefree pregnancies and babies live in smokefree homes/whaanau through Smokefree Pregnancy and whaanau Incentives Programme - Young people are supported to be smokefree (i.e. to never start smoking) through youth-led projects - Young people who smoke are supported to quit with a particular focus on young waahine Maaori	**2a**. An increase in participation in pregnancy and whaanau incentives programme by 10%. **2b.** 60% of those supported to stop smoking are hapuu waahine Maaori. **2c.** Engage with 10 schools in priority localities on TFG activities **2d.** An increase in stop smoking outcomes for young waahine Maaori by 25%	Q1-Q4			
2. Provide support to patients/ clients who smoke, who choose to vape to stop smoking including accurate information about vaping so that they can make an informed choice about the benefits and risks of vaping.	**3a.** Develop monitoring systems to capture data on vaping use by patients/clients	Ongoing			
3. ARPHS leads and supports collaborative actions with key stakeholders to make progress towards Smokefree 2025.		Q4	Narrative on outcomes		

Smokefree 2025					
DHB activity Actions to advance progress towards the smokefree 2025 goal and support our Public Health Unit to undertake compliance activities as per the Smoke-free Environments Act 1990	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
4. ARPHS undertakes compliance activities as per the Smoke-free Environments Act 1990 and reports against the performance measures contained in the Vital Few Report.		Q4			
5. Controlled Purchase Operations (CPO) designed to monitor and enforce provisions related to the Smokefree Environments Act 2003 focus on high deprivation areas (NZDep 7-10)		Q4	% of tobacco retailers visited during CPOs in NZDep areas 7-10. Target: 70% Baseline: 18/19: 77.1%		
Please refer to the 2020/21 Metro Auckland SLM Improvement Plan for a number of additional activities					

Breast Screening					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
CM Health is committed to achieving equity in screening coverage. Coverage as at Dec 2019 by DHB for women aged 50-69 years was: Maaori **65.3%**, Pacific **83.7%, other 70.2%.** Total coverage **71.5%.** Coverage targets for Pacific and the total population have been met. BreastScreen Counties Manukau and the CM Health Screening Support Services work together on strategies in the Counties Manukau area to increase coverage in priority groups. Activities to improve breast screening coverage for Maaori women specifically include:					
1. Improved data follow up from data matching to identify Maaori women who are not enrolled and to find new contact details for women who may have moved **(EOA)**: • Regular data matching with all primary care practices in the DHB • Data match with DHB patient management system • 100% of Maaori women identified through data matching are followed up by telephone.	**1a.** DHB data match completed by December 2020.	Q2	70% coverage target achieved for Maaori women by June 2020	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
	1b. Outcomes from primary care data matches analysed to ensure equitable outcomes from this activity.	Q4			
2. Tailoring and orienting services to support access and engagement, Mana Wahine days are run monthly on Saturdays for Maaori women, where both breast and cervical screening is offered **(EOA)**.	**2a.** 12 Mana Wahine days held in 2020/21 year.	Q4	Report number of Maaori women screened at Mana Waahine days June 2021		

Cervical Screening					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
CM Health is committed to improving cervical screening coverage and achieving equity in screening coverage. Cervical screening coverage is lowest for Maaori and Asian women. CM Health is focused on improving coverage rates for both population groups via primary care and our Support to Screening Service. CHM co-ordinates the Metro Auckland Cervical Screening Programme meetings to discuss strategies, the group includes the metro Auckland DHBs, PHOs, and Screening Support Services and NCSP register.					
1. With a specific focus on priority populations, the actions to be implemented by the DHB Screening Support Service and Cervical Screening co-ordinator are **(EOA)**: • Support for PHOs to prioritise women by clinical risk and ethnicity who have a history of high grade cytology and a year or more overdue for follow up. • Provision of smear taker support for PHOs with high numbers of priority women • Continue with monthly Mauri Ora Mana Wahine days; • Provide community smear-taking clinics in a number of locations, including at local marae and at the Manukau SuperClinic. At the Manukau SuperClinic this includes the provision of evening and weekend clinics to reduce access barriers.	**1a.** 75% of High Priority Women in the high grade cytology project contacted	Q4	Strong system SS08: Improving Cervical Screening coverage	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
	1b. Each PHO increases number and percentage of enrolled high needs women screened by June 2021 in comparison to July 2020.	Q4			
	1c. 12 Mana Wahine clinics held by June 2021. **1d**. 12 evening/weekend community clinics held by June 2020.	Q4			

Reducing alcohol related harm					
DHB activity Actions to support our Public Health Unit to advance activities relating to reducing alcohol related harm and to undertake enforcement of the Sale and Supply of Alcohol Act 2012	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Commit to undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012. This must include delivering and reporting on the activities relating to the nine public health regulatory performance measures contained in the previous Vital Few report **(EOA)**				We have improved quality of life	Support healthier, safer and more connected communities
1a. ARPHS inquiries into on-, off-, club and special licence applications in line with regulatory plan.		As required	Number of license applications and renewals (on, off club and special) received and processed		
1b. ARPHS provides reports to the District Licensing Committee (DLC) where there are matters in opposition related to liquor licence applications.	Target 100%	As required	% reports (for premises where matters in opposition were identified) provided to the licensing committee within 15 days.		
1c. ARPHS re-designs its compliance processes to give greater consideration and stronger voice to Maori needs when assessing liquor licence applications (EOA).	Target 100%	Q4	% of new bottle shop license applications consulted with Ngaati Whaatua and Tainui (Te Runanga O Ngaati Whaatua and Raukura Hauora O Tainui)		

Reducing alcohol related harm					
DHB activity Actions to support our Public Health Unit to advance activities relating to reducing alcohol related harm and to undertake enforcement of the Sale and Supply of Alcohol Act 2012	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. CMDHB have an Alcohol Harm Minimisation Programme of work underway, two key focus areas being **(EOA)**: • Pursuing equity in access to high quality and culturally-appropriate healthcare services, particularly: Screening for hazardous alcohol use, brief intervention, and referral to treatment when indicated (SBIRT; also known as the Alcohol ABC Approach), • Working with communities and intersectoral partners to influence the social determinants of hazardous drinking and alcohol-related harm.	**2a.** Alcohol Harm Minimisation Action Plan refreshed (2020-2025) **2b.** Alcohol Harm Minimisation Programme Evaluation completed.	Q2 Q2	• CMDHB Alcohol Harm Minimisation Programme refresh of Action Plan completed by end of Q2 • Evaluation of the first phase of the Alcohol Harm Minimisation Programme completed by Q2 • Please also refer to the System Level Measures (SLM) Plan for work in General Practice	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities

Sexual Health					
DHB activity	Milestone		Measure	Government theme: Improving the wellbeing of New Zealanders and their families	
				System outcome	**Government priority outcome**
Sexual health service provision is led by ADHB for the metro Auckland region, through Auckland Regional Sexual Health Service. Activities for this section are described below and within the ADHB Annual Plan					
1. Support the completion of a Metro-Auckland communications plan alongside NGOs to maximise the impact of multiple organisations' communications, this will be co-designed with Māori and Pacific organisations **(EOA)**	**1a.** Plan Completed Q1 2020/21	Q1	Metro Auckland Communications Plan in place	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
2. Participate in the control the syphilis outbreaks in Metro Auckland, through: • Strengthen contract tracing • Start Syphilis Point of Care (PoC) testing in outreach clinics to improve access • Implement proactive testing aimed at male sex with male, Maaori and Pacific, as the most at-risk groups **(EOA)**	**2a.** Ongoing **2b.** Syphilis Point of Care Testing starts Q2 2020/21 **2c.** Proactive testing implemented March 2021	Ongoing Q1 Q3	Point of care testing available for syphilis		
	3a. Reporting implemented within a quarter of plan being implemented	Q4	Regular and reliable reporting in place		
3. Develop metrics for each service that help us understand our health outcome gaps particularly for our Maaori and Pacific patients	**4a.** Metrics developed	Q4			
Health Promotion Activities that DHBs agreed to carry out at the 10 June 2019 meeting of GMs Planning and Funding to support their PHU's contribution to sexual health include: • Encouraging collaboration and ensuring roles are clearly agreed between the PHU and relevant DHB business units to undertake: o Communications to community, media and health providers regarding sexually transmitted infections (STI) outbreaks o Support for the National Syphilis Action Plan o Contract tracing/partner notification o Support for STI management in primary care including training as required.					

Communicable Diseases					
DHB activity Actions to advance communicable diseases control work by our Public Health Unit	Milestone		Measure	Government theme: Improving the wellbeing of New Zealanders and their families	
				System outcome	Government priority outcome
1. ARPHS maintains an appropriate and efficient system for receiving, considering and responding to: • notifications of suspected and confirmed cases of communicable diseases • public health management of cases of communicable diseases and their contacts • enquiries from medical practitioners, the public and others about suspected communicable diseases of public health concern		As required	Number of disease notifications received	We have improved quality of life	Support healthier, safer and more connected communities
1. Conduct surveillance in which data is systematically collected, analysed, interpreted and acted upon for the purpose of preventing, identifying and responding to communicable disease issues.		Q4	Summary of surveillance activities		
2. ARPHS receives Tuberculosis disease case notifications and oversees case and contacts management in partnership with relevant clinical services.	Target 90%	As required	% of smear positive pulmonary TB cases contacted by the Public Health Nurse within three days of clinical notification		
3. Contact tracing protocols ensure a proactive engagement with Maori and Pacific population groups. **(EOA)**		Q4	Narrative on outcomes		

Cross-sectoral collaboration including Health in All Policies				
DHB activity	Milestone	Measure	Government theme: Improving the wellbeing of New Zealanders and their families	
			System outcome	Government priority outcome

As described in the Improving Wellbeing through Prevention section of this Plan, Auckland Regional Public Health Service (ARPHS) provide core public health functions on behalf of the three metro-Auckland DHBs, and the detail of their contributions for the Counties Manukau population are described in, and will be reported through, the ADHB Annual Plan.

Importantly, in relation to the Health in All Policies approach, ARPHS provide policy advice and submissions on public health and social service relevant issues (e.g. the Healthy Homes Standards consultation) on behalf of metro-Auckland DHBs, working closely with DHBs to gain DHB CEOs' signoff where that is deemed particularly useful. CM Health also elects to submit directly as a DHB to some policy consultation processes, usually led through the Population Health Directorate.
ARPHS also provide the backbone function for the Healthy Auckland Together (HAT) collaboration, of which CM Health is a part of alongside both health and non-health sector partners. HAT is working to improve environments to support healthy nutrition, physical activity and obesity prevention, and includes Auckland Council, Auckland Transport, and University of Auckland, along with a variety of health sector partners.

South Auckland Social Wellbeing Board
CM Health is a key partner in the South Auckland Social Wellbeing Board (SASWB), originally one of three Cabinet mandated Place-Based Initiatives (PBIs). The SASWB partners, local and national decision-makers from 11 government agencies within and outside the health sector plus Auckland Council, who jointly fund many of the services and support whaanau receive, are working together to improve health and social outcomes for children and their whaanau in South Auckland. There is a focus on Maaori and Pacific whaanau. CM Health is also the organisational host for the SASWB staff who support the work of the SASWB (e.g. leadership, programme management, and evidence and insights).

The SASWB work has evolved to focus on a 'test and learn' improvement approach to inform local decision-making, identifying system-level change and commissioning opportunities that will improve universal and targeted services within and across agencies' core business to better provide meaningful support for whaanau and children in the early years. It recognises a holistic, coordinated whaanau approach is needed.

Prevention of, and response to, Family Violence and Harm is a key area of focus, with specific work linked to the Joint Venture for Family Violence and Sexual Violence.

SASWB learnings are being fed into the Ministry of Health's review of the WCTO. Start Well Māngere, an initiative of SASWB, is an intensive home-visiting programme for young mothers offering support from pregnancy to when their child is aged five. Start Well Māngere tests the benefits of a long-term trusted, responsive relationship beginning in the antenatal period, between health and social worker professionals and young mothers. Start Well includes elements of both WCTO's universal checks and services and the social support aspects of Family Start as well as additional sick child expertise and navigation support.

Early Childhood Education is recognised by SASWB as a key setting for engagement with children and whaanau, building parental networks and support (peer support) and potentially a hub for social and health support. An initial focus has been on emotional development and improving executive functioning.

Cross-sectoral collaboration including Health in All Policies					
DHB activity	Milestone		Measure	Government theme: Improving the wellbeing of New Zealanders and their families	
				System outcome	Government priority outcome
1. CM Health continues to support a move towards a 'self-sustaining' model for SASWB backbone function based on resource contributions from the SASWB member agencies. **(EOA)**	**1a**. Sustainable SASWB model in operation	Q2, Q4	Q2 Model in operation Q4 Report on progress	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
2. Ensure that there is an appropriate, sustainable health contribution to the 'One-system Response to Family Harm', led operationally by Police. This includes participation in the daily, cross sector Safety Assessment Meeting (SAM) after acute family harm incidents, and embedded pathways to respond to referrals from the SAM to health services. Maaori and Pacific peoples are disproportionately impacted by family harm; improving social sector responses to family harm is an **EOA.**	**2a.** Sustainable SAM health response.	Q4			
3. Ensure there are embedded pathways to respond to referrals from the SAM to health services, and for appropriate information sharing under the Family Violence Act and revised Oranga Tamariki Act.	**3a.** Documentation of embedded pathways **3b.** Staff training rolled out re appropriate information sharing under the Family Violence Act and revised Oranga Tamariki Act	Q4	Pathways documented Staff training completed		
Other CM Health cross-sectoral activity *Referral support to AWHI (Housing Support Service):* As part of the DHB Rheumatic Fever Prevention programme, the DHB employs referral support to ensure families who are eligible, receive referral to AWHI – the housing support service contracted directly by the Ministry of Health with the provider (National Hauora Coalition). *Integration of Social Work Support in pregnancy/early years:* The DHB has an initiative linking midwives with social work support available through Family Start.					

Cross-sectoral collaboration including Health in All Policies				
DHB activity	Milestone	Measure	Government theme: Improving the wellbeing of New Zealanders and their families	
			System outcome	Government priority outcome
Providing coordinated local responses to emerging drug threats such as synthetic cannabinoids: In the event of sudden and serious increases in acute harms associated with synthetic drug use, such as deaths and overdose incidents, CM Health will work with ARPHS, other Auckland region DHBs, and cross sectoral partners in a coordinated way to address the emerging issues.				

2.7.6 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 and living with more disability.

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; to improve system sustainability, to improve health and to reduce differences in health outcomes.

Delivery of Whaanau Ora					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Refer Section on Maaori Health Action Plan – Accelerate the spread and delivery of Kaupapa Maaori services	**1a.** Evaluate implementation of Integrated Service Agreements targeting high needs, hard to reach Maaori and whaanau with complex needs with key CM Health priority health conditions. **1b.** Complete "deep dive" analysis of all DHB and MoH contracts with Maaori providers to identify opportunities for service innovation and integration. **1c.** Complete "deep dive" analysis of cross sector contracts with Maaori providers to understand local investment and identify opportunities to form cross-sector collaboration **1d.** Develop a preferred provider network	Q1- Q4		We have health equity for Maaori and other groups	Support healthier, safer and more connected communities

Pacific Health Action Plan					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Commitment to Ola Manuia 2020-2025 Improving Health Equity is a whole of CM Health DHB commitment. Over the 2020/21 year, CM Health is committed to implementing activities that will improve health equity for Pacific people. These activities are highlighted throughout this plan. CM Health will also support the new Ministry of Health, Ola Manuia 2020-2025 Pacific Health and Wellbeing Action Plan. This section highlights the contribution to improve health equity for Pacific people by the small Pacific Health Development team at CM Health in the Fanau Ola and Workforce services. **Fanau Ola Services** Fanau Ola Service aims to achieve health equity for the Pacific community at Counties Manukau Health by supporting patients and their fanau that are referred to the Fanau Ola Service. Fanau Ola Service is committed to achieving better health and well-being for Pacific people. Fanau Ola Service plans to engage effectively with patients and their fanau at Middlemore as well as in their home environment to improve their healthcare experience.					
1. Provide integrated support for Pacific clients and their fanau that are referred to Fanau Ola Service. **(EOA)** **2.** Implement a common definition of what a 'Complex Case' is with key referrers e.g. ED (incl. Kidz First and other business units within CM Health), PHOs/Primary Health Care and other organisations (MSD, Work and Income, Police, Kaainga Ora). **(EOA)** **3.** Increase Pacific Cultural Competency in CM Health services to improve engagement and experience with Pacific patients and their fanau. **(EOA)**	**1a.** All referrals and their fanau's 'Health Plans' are completed	Q1-Q4	Number of referrals and extra fanau members supported	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
		Q1-Q4	Number of Safety Assessment Meetings (SAM) including both cases and those that were impacted		
		Q1-Q4	All referrals and their fanau were supported and are now Better Off (self-reported) compared to when they were referred to FOS, before they are discharged from FOS care		
	2a. All referrers to FOS agree on the definition of *Complex Case*.	Q1	100% of all referrers adopt the definition		

	3a. All departments make it compulsory for new staff to do the Pacific Cultural Competency Training	Q1-Q4	Number of staff at CM Health who participate in the Pacific Cultural Competency Training course.		
Pacific Work Force Increasing the Pacific workforce at the DHB to reflect the population it serves					
1. Work with MoH to identify six additional schools that would successfully support Pacific Health Science Academies (HSA) **(EOA)** **2**. Work with HSAs to adopt a data reporting template. **3.** Strengthen the relationship with our key tertiary partners by signing MoUs to enable the sharing of data of students that have graduated from our programmes	**1a.** Contact potential schools to determine whether there is interest in establishing a Pacific HSA in their schools.	Q1	Increase the number of current HSAs by 100% (12 schools in total – approx. 25 students per school)	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
	2a. All HSAs adopt the data reporting template.	Q1-Q4	80% of HSA cohorts are retained from year to year. 80% of each cohort achieves their NCEA level.		
	3a. Meet key tertiary Institution officials that are able to sign, agree and sign the MoUs.	Q1	All key tertiary partners sign the MoU and are able to start sharing data		

Care Capacity Demand Management					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Fully implement the Safe Staffing Care Capacity Demand Management (CCDM) programme. • CCDM will provide the tools to create equitable workloads across CCDM inclusive areas. This will ensure the right number and type of staff are working in the right place at the right time to match the care needs of our patients. (**EOA)**	**1a.** TrendCare data complete and accurate across all acute inpatient areas by December 2020**.**	Q2	100% patient acuity actualisation rate is maintained. >90% inter-rater reliability (IRR) score. 100% patient types within benchmark. 100% accurate staff allocate screen. Quality Patient Care – incidents, experience, care rationing episodes, staff mix, acuity, bed utilisation, care hours variance, shifts below target, acute staffing shortage incidents. Quality work environment – variance indicator	We have improved quality of life We have health equity for Maaori and other groups	Ensure everyone who is able to, is earning, learning, caring or volunteering
	1b. Core Data Set operational in all CCDM inclusive areas by 30 June 2021.	Q4			
	1c. Variance response management tools and processes operational in all CCDM inclusive areas by 30 June 2021.	Q4			
	1d. Readiness for FTE calculations scoped for all CCDM inclusive areas by 30 June 2021 with 50% of FTE calculations completed by end of Q4.	Q4			
2. Establish TrendCare Governance to oversee the implementation and on-going utilisation of the TrendCare System to maximise use of available functions, data quality and organisational return on investment.	**2a.** Seamless connection between TrendCare and other relevant information systems (PMI, rostering, HRM, payroll, patient menu etc) by 30 June 2021.	Q4			

Care Capacity Demand Management					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	2b. Evidence of data quality ensuring confidence in the use of TrendCare data for resource planning – on-going milestone measured daily, weekly, monthly, quarterly.	Q1-Q4	score, roster gaps, overtime, extra shifts, staff incidents, unplanned leave, staff satisfaction survey, professional development. Best use of health resources – casual use, total staff hours, excess accrued leave, late discharges, ED length of stay, personnel costs.		
3. Develop business as usual plan and processes for monitoring Safe Staffing CCDM efficacy.	**3a.** CCDM business rules inform operational processes and monitoring of efficacy by 30 June 2021.	Q4			
	3b. CCDM and TrendCare KPIs included in appraisals and performance reviews by 30 June 2021**.**	Q4			
	3c. Evidence of data quality and improvement plans across all CCDM inclusive areas by 30 June 2021.	Q4			
	3d. Operational local data councils in all	Q4			

Care Capacity Demand Management					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	CCDM inclusive areas by 30 June 2021.				
	3e. Completion of annual IRR testing for all TrendCare users by 30 April 2021.	Q3			

Disability Action Plan					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. The Metro Auckland Region DHBs have collectively developed a regional Disability Strategy Implementation Plan. This plan informs the areas of focus where work will be progressed for DHBs to improve accessibility and health outcomes for disabled people. CM Health has developed a draft 3-year action plan which has several key deliverables: • Finalise and implement the action plan • Increase awareness and engagement of the action plan - develop a Disability Webpage and publish action plan on the webpage • Publish progress on this action plan on webpage	**1a.** Continue to implement the CM Health Disability Action Plan	Q1 – 4	Report on progress against the deliverables in the Action Plan	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities

Disability					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. CM Health has introduced a disability responsive training course for all staff. We will continue to increase the percentage of staff undertaking training in disability awareness, by improving uptake of mandatory e-Learning on disability responsiveness and cultural competency training with a focus on disability. **(EOA)**	**2a.** Promote disability training and development activities. **2b.** Measure uptake of training activity.	Q1 – Q4	Increase in number of staff who have undertaken mandatory training and cultural competency training	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
3. Provide training to managers and staff involved in recruitment to enable employment of more disabled people	**3a.** Training offered to managers and recruitment staff	Q2	Number of managers completed training		

Planned Care					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Background: Planned Care is a broader concept than medical and surgical services traditionally known as Electives or Arranged services. Planned Care is patient-centred and includes a range of treatments funded by DHBs delivered in inpatient, outpatient, primary and community settings. It also includes selected early intervention programmes that can prevent or delay the need for more complex healthcare interventions. Over 2020/21 CM Health will continue efforts to achieve Planned Care intervention targets, increase clinical capacity and maintain timeliness and equity of access to Planned Care services (including diagnostics and radiology) in line with the National Planned Care Vision and key principles. In Q3, 20/21 CM Health will begin implementation of its Healthy Together strategy for the 2020 - 2025 years. This will include a Clinical Services and Population Health Improvement Plan which will take account of the Planned Care principles: • Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed. • Balance national consistency and the local context • Support consumers to navigate their health journeys • Optimises sector capacity and capability • Ensures the Planned Care systems and supports are designed to be fit for the future					
The following activities will fulfil the five key principles of Planned Care related to Equity, Access, Quality, Timeliness and Experience. **1.** We will achieve SS07 Planned Care Measures Services by: • Delivery against agreed volumes in Price Volume Schedule (PVS). • Using targeted initiative funding to increase access for Planned Care Initiative Discharges and procedures • Review CM Health performance against regional and national performance.	**1a.** Achieve SS07 Planned Care Measures.	Q1- Q4	SS07: Planned Care Interventions [12] 20,185 Inpatient Surgical Discharges 10,611 Minor Procedures 326 Non-Surgical Interventions	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities

[12] The targets have not been updated for 20/21 as this information is taken from the funding envelope and price volume schedule. There are negotiations underway with the Ministry of Health.

Planned Care					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. Increase clinical capacity to provide Planned Care services: • Optimise theatre utilisation and productivity. • Use alternative groups of clinical staff to deliver a range of ambulatory interventions appropriate to scope of practice.	**2a.** Meet production and access targets. **2b.** Monitor the outcome of Theatre productivity following agreed actions for the Theatre Optimisation Group **2c.** Expansion and further development of Nurse led clinics. Joint Follow up clinics	Q2- Q4	Elective Services Patient Flow Indicator results Monitor alternative models of care expansion (e.g. % patients seen by alternative clinical staff, No's of advanced practitioners) Diagnostic waiting times for Angiography, Computerised Tomography(CT), and Magnetic Resonance Imaging (MRI) Ophthalmology – outsourcing surgery Monitor the Health Pathways portal guidelines and impact on referrals	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities
3. Maintain timeliness and equity of access to Planned Care services: • 3a. Improve timely and equitable access for new patients referred for specialist services by ensuring management and referral guidelines are available to assist primary care to actively manage appropriate patients in the community • 3b. Support services to regain compliant ESPI status through review of performance, models of care and access thresholds and regular monitoring against ESPI recovery plan.	**3a**. Referral guidelines available for primary care via Health Pathways portal - some will require review 2020/21 **3b.** Regain Elective Services Patient Flow Indicators compliance (ESPI 2 and 5). Production planning for each service **3c.** Implemented within MoH required timelines **3d.** 75% of local anaesthetic skin	Q1-Q4 Q1-Q4			

Planned Care					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
• 3c. Implement national electronic clinical prioritisation tools into services as released for use to increase equity of prioritisation. • 3d. Deliver minor procedures in procedural clinics and community settings allowing theatre rooms to be utilised for elective surgical activity. • 3e. Prioritise high risk cancer patients and high clinical priority patients for treatment within 4 months or sooner if clinically indicated with other patients being treated in turn. • 3f. Ensure equity of access to Cancer services and timely FCT access for Maori patients by utilising input from Cancer Nurse Coordinators (CNC) and Maori Health team to navigate care pathways **(EOA)** • 3g. Ensure equity of access to Cancer services and timely FCT access for Pacifica patients by utilising input from Cancer Nurse Coordinators and Pacific Health team to navigate care pathways (EOA)	procedures delivered in procedure unit **3e-g.** Monthly reporting from population CNCs. Reports to include contact volumes, ethnicity, FCT target compliance and qualitative narrative completed by the CNC in conjunction with the Maaori and Pacific Health Gains teams.	Q1-Q4 On-going already in place	Monitor ESPI compliance Compliance with MoH clinical prioritisation tools Monitor the use of procedure units		
4. Begin implementation of Clinical Services Plan	Dependent upon outcomes of Clinical Services Plan	Q3-Q4		We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities

Acute Demand					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Acute data capturing: Refer to the Data and Digital section for the SNOMED implementation.					
Improving Patient Flow: CM Health's Every Hour Counts portfolio aims to improve patient flow to optimise the quality of care, the experience of care and the experience of caring whilst improving the efficiency of the system. Please see below for some of the key secondary care-focused activities planned for 2020/21 as part of Every Hour Counts and on-going improvement activities.					
In the year 2020/21 CM Health will actively manage growth in acute inpatient admissions through: **5.** Increasingly efficient utilization of existing bed capacity through initiatives to maintain efficient and effective care: - Extended hours of GP access to specialist medical phone advice regarding admission decisions, - Improved capacity and capability of Acute Medicine Rapid Access Clinic (AMRAC) to provide alternatives to admission - Expansion of non-hospital related capacity and capability to provide alternative options to acute hospital based admission, e.g.; admission to Hospital in the Home (HiTH) direct from Medical Assessment (MAU), to prevent acute hospital admission. - Maintaining optimal hospital length of stay for patient complexity. - Ensure the period of time between the decision to admit and the decision to medically clear for discharge is as efficient and streamlined as possible to prevent prolonged hospital stay, keep patients well, avoid hospital acquired harm and prevent/reduce risk of unnecessary readmission. - Minimizing unnecessary and avoidable delays to discharge - Anticipating socially complex discharge barriers early, i.e. at point of admission and planning appropriate non-medical interventions in parallel with medical care: e.g.; initiating PPPR requirements	To maintain medical occupancy at <100% at all times	Q3 and Q4	Days with medical occupancy >100%	We have improved quality of life (health maintenance and independence) We have Health Equity for Maori and other groups.	Support healthier, safer and more connected communities

Acute Demand					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
early, confirming EPOA on admission, utilizing POAC options/Taikura Trust Service Providers for residential placement to support earlier family decisions where possible. - Navigate available care pathways with support of the Maaori and Pacifica Health Units to ensure timely and equitable access to and discharge from acute services. **(EOA)**					
Improving Patient Flow					
6. Manukau Health Park Redesign	Model of care redesign	Q1-Q4	Measures to be agreed with the incoming Head of Manukau Health Park Taskforce		
	Workforce redesign	Q1-Q4			
	Digital enablers	Q1-Q4			
7. Optimising GP Referrals	Eligibility	Q1-Q2			
	Two way communication and advice	Q1-Q4			
	Diagnostic funding	Q1-Q4			
	Unmet need	Q1-Q4			
	Visibility of referral	Q1-Q4			
8. Theatre Optimisation	Improve access for acute and elective surgeries The model of care for staffing will be reviewed for the Acute and Elective procedures as part of the theatre optimisation review	Q1-Q3	Measure: % theatre utilisation (both MMH and MSC) and % decrease in cancellations		

Acute Demand					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
9. Individual Service Improvements • **Orthopaedics** Use of both sites MMH & MSC when required for acute surgery. Close Monitoring of out of region referrals. • **Diabetes in Pregnancy service improvement** • **Cardiac Investigation Unit service improvement** • **Paediatric Medicine waiting list**	• Milestones and measures determined by each service improvement team	Q1-Q4	• TAT for acute hands through ED and improved patient experience. • Number of acute surgical performed at MSC • Number of out of region referrals		
Primary Care Initiatives **1.** Implement and operationalize identified work streams from Patient After Hours Urgent Access (PAUA) working group **2.** Improve continuity of care across primary and secondary providers through changes to discharge summary process.	**1a.** Work streams implemented by end of Q2 **1b.** Emergency department demand managed through	Q2	Framework for work streams completed Discharge summary process change completed.		

Acute Demand					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
3. Increase access to timely, acute care options within communities, this will have the benefit of easing demand on emergency department resources by diverting patients to urgent care clinics with focus on priority populations	ambulance diversion work by Q3 **2a.** Changes to discharge summary process between ED, Urgent Care, and General Practice completed by beginning of Q4 **3a.** Transition Emergency Q from pilot to on-going Programme (subject to board approval)	Q3	Emergency Department treatment of non-emergency acute care (triage 4 and 5) are reduced		
		Q4	Programme transition completed		

Rural Health					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Co-design a new model of care for people in Franklin living with multiple long term conditions employing virtual/telecare services as one of the five Te Ranga Ora Prototype Collectives	**1a.** Rural model of care implemented by Q4	Q4	People receiving services virtually	We have equity for Maaori and other groups	Support healthier, safer and more connected communities
2. Utilise the Rural Service Level Alliance Team (SLAT) to review rural primary care services in Franklin to support equity of access (enrolment and utilisation) for Maaori and commission new services with the DHBs rural funding allowance. This will build on one of the Te Ranga Ora Prototype Collectives co-design work findings and is likely to include better ways to support patient/whaanau choice or provider and virtual care options	**2a.** Stocktake completed by end of the year, December 2020	Q2	More to be added		

Healthy Ageing					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Report on the number of patients who are seen by the Fracture Liaison Service, including those under 65 years due to the demographic profile of CM Health. This data will be used to identify the patients that require further investigation and need to be managed, both for osteoporosis and falls prevention. As	**1a.** Quarterly reports on volumes and progress.	Q1-Q4	1. Number of patients seen by the FLS, target = 1200. 2. Report on the number of patients enrolled in a Strength	We have equity for Maaori and other groups	Support healthier, safer and more connected communities
	1b. By Q4 we will achieve our annual target	Q4			

necessary, referrals are sent to Dexa, falls prevention clinic or to home/ community strength and balance programme. **2.** Collaborate with primary healthcare providers to increase uptake in the falls prevention screening programme with referral to the programme as appropriate. Undertake an awareness raising programme of the falls prevention programme within the DHB, targeting allied health, outpatient, acute and community services. Identify older people aged 75 years and over at risk of falls through primary care screening, with referral as appropriate to promote enrolment to Strength and Balance programme. CM Health will continue to screen Maaori with a fall in the previous 12 months at an earlier age of 65 years. **(EOA)** **3.** Increase the number of patients seen by our ED Geriatric service to assist in identifying Frail Elderly patients and connecting them with appropriate services, including avoiding unnecessary hospitalisation. **4.** The HCSS review and transition plan will include a work stream with an equity focus and CMDHB intends to work closely with our Pacific providers to identify HCSS equity issues for older Pacific people. Northern Region HOP PMs are planning a meeting/s in the near future with all contracted HCSS providers across the region to discuss equity issues. **5.** Dementia priorities for CMH for 20/21	**2a.** Quarterly reports on volumes and progress.	Q1-Q4	and Balance programme 3. Number of patients seen by ED Geriatric service & proportion who are not admitted 4. Reported via SS13 5. Number of referral received from Franklin area 6. Number of patients seen in Franklin for cognitive impairment assessment and diagnosis.		
	2b. By Q4 we will achieve our annual target	Q4			
	3a. Quarterly updates on number of patients seen and not admitted.	Q1-Q4			
	4a. Quarterly updates on progress to implement	Q1-Q4			

By working more closely with the Community Geriatric team, The Memory Team will extend their service delivery to include Franklin which had previously been excluded due to resources and distance. **6.** As part of the regional Frailty Steering group CMH will contribute towards the roll out of the Mini-ACE (MoCA replacement tool) and continue to support primary care use of the cognitive impairment pathway to promote early diagnosis of dementia. **7.** CMH is actively developing an updated delirium and dementia pathway. This will utilise the 4AT assessment to replace the CAM and include a routine cognitive screen – AQ test on admission. The pathway once accepted, will be introduced across the Middlemore Hospital. Base line compliance auditing has been completed. This can be repeated once implemented.-	**5a.** Quarterly updates on progress to implement **6a.** Quarterly updates on progress to implement **7a.** Quarterly updates on progress to implement, measures to be developed to be included for year 21/22				

Improving Quality					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Improving Equity Te Ranga Ora is to develop new integrated primary and community co-designed LTC models of care. These models of care will further involve Service Users and their whaanau in decisions about their care and treatment as much as they want to be. 15.6% of Service Users with Diabetes said they were not involved in decisions about their care and treatment (National primary care patient experience survey (2018 data). For further information, please refer to the section on Te Ranga Ora within Primary Healthcare Integration and Long Term Conditions including Diabetes (pages 122 and 126) Please refer to the 2020/21 Metro Auckland SLM plan	**1a.** To see a reduction in the % reported by Service Users as not being involved in decisions made about their care and treatment.	Q4	National Primary Care Patient Experience Survey. Question 5: Have you been involved in decisions about your care and treatment as much as you wanted to be?	We have equity for Maaori and other groups	Support healthier, safer and more connected communities
2. Improving Consumer Engagement • CM Health is a pilot site for the Consumer Engagement QSM. The Patient and Whaanau Cantered Care Board (comprising of patients and staff) has been providing governance during the pilot phase and will be confirmed as the governance group for the QSM implementation, and its Terms of Reference modified, in June 2020.	**2a.** Governance Group confirmed	Q2			
	2b. QSM submission template reflects SURE framework	Q2			

• The QSM submission template will reflect the SURE framework. • The first upload will be on 1 June and 1 December 2020 and twice yearly after that.	**2c.** First upload of framework report	Q2			

New Zealand Cancer Action Plan 2019-2029					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Part one: Current Performance actions					
1. Using a MOS Board approach, develop KPIs for cancer service delivery that are clearly visible to the organisation and align with 3 year planning. **2.** Investigate available systems and implement a cancer dashboard to capture a wider range of data than is currently available. This will be used to drive improvement activity and service change and provide transparency of process steps across cancer pathways **3.** Use the recommendations from the HQSC Partners in Care project to inform and action improvements in care of Pacific women with endometrial cancer and Maaori men with lung cancer. **(EOA)**	**1a.** System will be in place with measurable KPIs	Q1	SS11: Faster cancer treatment	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
	2a. Dashboard will be in place	Q3			
	3a. Project report completed and action plan developed	Q1			
Provide people who have completed cancer treatment with services to improve quality of life and to live well beyond cancer					
CM Health also commits to contributing to the Ministry of Health's development of a national Cancer Plan and working with the Ministry of Health and the Northern Region Cancer Network to implement and deliver local actions from within the Cancer Plan.					

Bowel Screening and colonoscopy wait times					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Work with the Ministry of Health, the Bowel Screening Programme (BSP) National Coordination Centre and primary care toward ensuring equitable participation in the National Bowel Screening Programme					
1. Promote the programme to priority populations, Maaori, Pacific and participants living in high socioeconomic deprivation **(EOA)**: • Review the programme Communication Plan with a view to ensuring bowel screening media promotional activities reach priority populations. • Promotional activities targeting priority groups including Pacific churches, Marae, Pacifica, Polyfest and Poukai. • Work with the National Coordination Centre and MoH to improve participation through an active follow-up process. • Carry out outreach activities as resources permit, including text and phone follow-up to encourage participation amongst priority groups.	**1a.** Implement the Communication Plan.	Q2 and Q4	60% participation achieved for eligible Maaori and Pacific in the BSP programme. 95% of BSP patients with a positive faecal immunochemical test (FIT) are offered a colonoscopy or CT colonography within 45 working days of a result on the BSP IT system in Q2, Q3 and Q4 Urgent, non-urgent and surveillance colonoscopy wait times	We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering
	1b. Analysis of outcomes from outreach activities	Q3			
	1c. Outcomes for GP facilitated group sessions Q4.	Q4			

• Work with primary care to encourage opportunistic requests for a test kit for Maaori and Pacific participants and to facilitate GP letters and arrange group presentations to participants who have not returned a kit. • Provide transport and support for BSP participants as required to ensure equitable access to colonoscopy services. **2.** Develop a production plan with the aim to catch up on the waitlists from ceasing colonoscopies during COVID 19 to ensure on-going colonoscopy wait times are met.	**2a.** Production plan developed, implemented and regularly monitored**.**		are consistently met in Q2, Q3 and Q4. 70% of P2 diagnostic patients have a colonoscopy within 42 days		

Workforce					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Workforce Diversity					
1. Match the Maaori workforce to the population **(EOA)** • Increase the number of Maaori Midwifes by supporting Maaori midwifery students to complete the programme and transition into work • Increase the number of Maaori nurses through partnerships with tertiary providers to support Maaori nursing	**1a.** Quarterly dashboard measuring number of participants	Q4	Number graduates from Maaori midwifery programme 50% Dashboard of Maaori nurse graduates from MIT	We have improved health equity	Support healthier, safer and more connected communities

students and transition them into employment					
2. Match the Pacifica workforce to the population **(EOA)** • Increase the number of Pacific Midwifes by supporting pacific midwifery students to complete the programme and transition into work • Increase the number of Pacific nurses through partnerships with tertiary providers to support Pacific nursing students and transition them into employment	**2a.** Quarterly dashboard measuring number of participants	Q4	Number graduates from Pacific midwifery programme 50% Dashboard of Pacific nurse graduates from MIT DHB has Tertiary support programme		
3. Develop actions to support of Te Tumu Whakarae's position statement on increasing Maaori participation in health and disability work forces **4.** Deliver the workforce sections of the Disability Strategy **5.** Provide training placements and support transition to practice for eligible health work force graduates and employees.	**3a.** Recruitment Policy Review **3b.** Develop manager dashboard to measure ethnicity by service **4a.** Quarterly Report to ELT and People and Culture Sub-committee **5a.** Nursing graduate programme offers employment to Maaori and Pacific nursing graduates	Q2 Q4 Q4 Q2	Policy consultation Mana Whenua Board Policy presented Q3 at ELT Dashboard live in HR Reports		
Health Literacy					
6. In 2020/21 we aim to establish a Health Literacy Advisory Committee that will oversee a comprehensive programme of work (a Health Literacy Action Plan) that will embed health literacy within 'the system'. The Committee will report to the Patient	**6a.** A Health Literacy Committee will be formed, reporting to the Patient and Whaanau Centred Care Board, with membership representative of the DHB	Q1			

and Whaanau Centred Care Board and will comprise of membership from across the organisation and system including primary, community and secondary care. The programme of work will go beyond training, and will include a suite of approaches targeting communication and cultural competency for all staff including non-clinical. Customer service models, navigation needs, patient education and activation (PAM) will be investigated as we endeavour to make our system more health literate for patients, family and whaanau. Our approach will include short term, medium term and longer term objectives for sustainable progress.	**6b.** A Health Literacy Action Plan (developed by the Health Literacy Committee) will be commenced by June 2021	Q4			
	6c. The revised Procedure for the Development and Management of Patient Health Education Resources will be embedded Dec 2020	Q2			
Cultural Safety					
7. Improve the Cultural Competency of the workforce	**7a.** Office of the Chief Nurse and People & Professional Development Team to design and implement Cultural Competency Guidelines	Q4			
Leadership					
8. Growing leaders • Leadership Roadmap to develop leaders at all levels	**8a.** Develop leadership Roadmap **8b.** Publish Roadmap and fund programmes on Roadmap	Q2 Q3	Presented to Chief Executive Presented to Chief Executive		
9. Supporting new managers into management roles	**9a.** Publish new Manager Guide and Process	Q3			
10. Succession planning for executive leadership roles					

• Development of talent management identification process and populate with 2020 to 2025 • Development of key roles identification process and populate with 2020 to 2025		Q2 Q4	Presented to People and Culture Sub-committee Presented to People and Culture Sub-committee		
COVID-19					
11. Cross sector approach in response to a public health need Counties Manukau Health has an Emergency Plan '2018-2021 CM Health Emergency Plan' which illustrates the emergency management arrangements in place at national, regional and local levels to maintain a resilient and sustainable health sector during any potential or significant public health emergency[13]. In the instance of a public health need, Counties Manukau Health will work as part of a northern region incident management team – Northern Region Health Coordination Centre (NRHCC) for example, for both COVID-19 and the measles outbreak recently. The following actions would be undertaken in response to the public health need: • Northern Region Incident Management team is initiated • An Incident Controller is appointed for Counties Manukau Health who would report into the Northern Region Incident Management team • Each DHB will create a CIMS framework (Coordinated Incident Management System) according to the specific public health need • An all of sector Primary Care response including Maaori and Pacific providers would also work with and report to the regional team The regional and local CIMS teams would be responsible for collaborating with the Ministry of Health and wider community providers to respond to the public health need					

[13] Counties Manukau Health Emergency Plan can be found on the CM Health website: https://countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/199a3fec9c/2018-2021-CM-Health-Health-Emergency-Plan.pdf

Data and Digital					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Actions to improve our information technology systems to better support healthcare delivery to our population					
1. Participate in national initiatives a. National Health Plan b. National Health Information Exchange c. #FaxFree	**1a**. Ongoing	Q1-Q4		We have improved quality of life	Support healthier, safer and more connected communities
	1b. Ongoing	Q1-Q4			
	1c. Dec 2020	Q2			
2. Contribute to developing and implementing the Regional Information Systems Strategic Plan (ISSP) with focus on the following programmes: • Telehealth: Continue implementation of patient management system integration to zoom • Workspace: Implement Windows 2010, Office 365 • Identity Access Management: Implement tap-on-tap-off, single sign-on for clinicians • Cyber-security capability: Continue to improve IT security maturity and strengthen disciplines associated with cyber security • Regional Collaborative Community Care (RCCC): Participate in the implementation of a new community focused clinical care system • Infrastructure as a Service (IAAS): Initiate move of appropriate infrastructure to cloud, and develop our hybrid cloud approach.	**2a.** Continue implementation of patient management system integration to zoom by Feb 2021	Q3			
	2b. Implement Windows 2010, Office 365 by June 2021	Q4			
	2c. Implement tap-on-tap-off, single sign-on for clinicians by June 2021	Q4			
	2d. Continue to improve IT security maturity and strengthen disciplines associated with cyber security by June 2021	Q4			
	2e. Initiate move of appropriate infrastructure to cloud, and develop our hybrid cloud approach by June 2021	Q4			

3. Core Clinicals: continue to develop electronic systems to support clinical workflow	**3a.** Implement eClinical Notes for our clinical staff by June 2021	Q4			
4. Implement Smart Systems • Laboratory eOrders (bloods) • Smartpage for orderlies and transit nurses	**4a.** Implement Laboratory eOrders by Oct 2020	Q2			
	4b. Implement Smartpage for orderlies and transit nurses by December 2020	Q2			
5. Use Robotics Processing Technology for automated transfer of data between systems (e.g. eReferral System to patient administration system)	**5a.** Robotics Processing Technology implemented by December 2020	Q2			
6. Enhance existing clinical systems: • eReferral optimisation: Improve communication between GPs, NGOs and hospitals • Regional Operating Model (ROM): embed the successful regional model for continuous, incremental improvements to the Clinical Portal	**6a.** e-referral optimised by March 2021	Q3			
	6b. ROM embedded to the Clinical Portal	Ongoing			
7. Implementation of SNOMED Coding in Emergency Care Pending funding approval and project development in 2019/20 to clarify ED Clinician workflow and interactions with clinical systems and develop and enhance ED Workflow user experience tools to better support the data capture	**7a.** Initiate project by July 2020	Q1			
	7b. Development and delivery by December 2020	Q2			
	7c. Optimisation by June 2021	Q4			
8. Preparation for 9 Digit NHI numbers 2022 Pending funding approval and project development in 2019/20 to clarify affected systems and links with iPM Upgrade project.	**8a.** Initiate project by June 2021	Q4			

9. Data Visualisation – develop Qlik dashboards specific to the needs of various departments, with a focus on Maaori and Pacifika data to help inform strategy and monitor progress against initiatives.	**9a.** Qlik dashboards developed by June 2021	Q4			

Further information is provided in Section 4, Building capability, Information technology and communications systems

During the COVID-19 pandemic response, Telehealth (telephone and video) appointments enabled us to deliver over 25,000 appointments that may otherwise have been cancelled. Patient feedback has been positive and tells us we should continue to offer telehealth appointment options. Work to sustain and implement telehealth includes building patient choice into our booking processes, integration of the video platform with our booking system, and development of electronic tools such as patient information, patient questionnaires, eLabs, ePrescribing, eOutcome and eSurgical waitlist.

Implementing the New Zealand Health Research Strategy					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Development of a Research Strategy (in addition to existing research policies and procedures) to provide a roadmap for the continued development of a research culture across the DHB. The strategic goals of our Research Strategy align with the Health Research Council New Zealand Health Prioritisation Framework (NZHPF) and NZ Health Research Strategy. Issues of equity and regional collaboration will be a particular focus.	**1a.** DHB Research strategy to be finalised by end of Q2	Q2	CM Health Research Strategy Document finalised	Health equity for Maaori and other groups	Support healthier, safer and more connected communities

2. By end of 2020, baseline data for the following key performance indicators, as defined in the research strategy, will be established. This will enable evaluation of success in these areas after as the research strategy is rolled out over the next three years: - Number of projects with a focus on metabolic issues - Number of projects with a focus on early intervention - Numbers of Maaori, Pacific and Asian researchers in CMDHB - Numbers of Maaori and Pacific nurses leading research projects - Numbers of research proposals with a Maaori, Pacific or Asian focus - Numbers of services and professions with an individual research strategy - Numbers of internally funded research projects - Numbers of staff employed by divisions/departments to support research activity - Numbers of academic health professionals employed at CMDHB - Number of staff positions with time specifically allocated for research - Number of staff in CMDHB undertaking research degrees - Number of nurses leading research projects	**2a.** Report detailing measurement of these variables by end of Q4	Q4	Measurement of variables described		

- Number of staff attending research workshops - Number of CMDHB research reports received in research office - Number of research publications with CM Health identified on them - Number of collaborations with organisations outside the boundaries of health					
3. Delivery of 'Research Week' in 2020 which provides a forum for DHB researchers to present their work to others	**3a.** Research Week delivered by end of Q4 2020	Q1	Number of presentations and research workshops taking place in Research Week 2020		
4. Delivery of a wide range of Research Workshops in 2020/2021 to contribute to capability building for Researchers across CMDHB	**4a.** Research Workshops delivered by end of Q4 2021	Q4	Numbers of workshops and attendees in 2020		

Delivery of Regional Service Plan (RSP) priorities and relevant national service plans					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Hepatitis C: Activities related to the 2020/21 RSP will be compiled and submitted by The Northern Regional Alliance (NRA).					
1. Hepatitis C Collaborate with regional DHB partners to implement the clinical pathway and key priorities in the National Hepatitis C Action Plan (once the plan is published) by: • providing targeted testing of patients most at risk for HCV exposure (EOA) through point-of-	Dec 2020	Q2	Number of newly diagnosed HCV RNAs for the Northern Region	We live longer in good health (prevention and early intervention)	Support healthier, safer and more connected communities

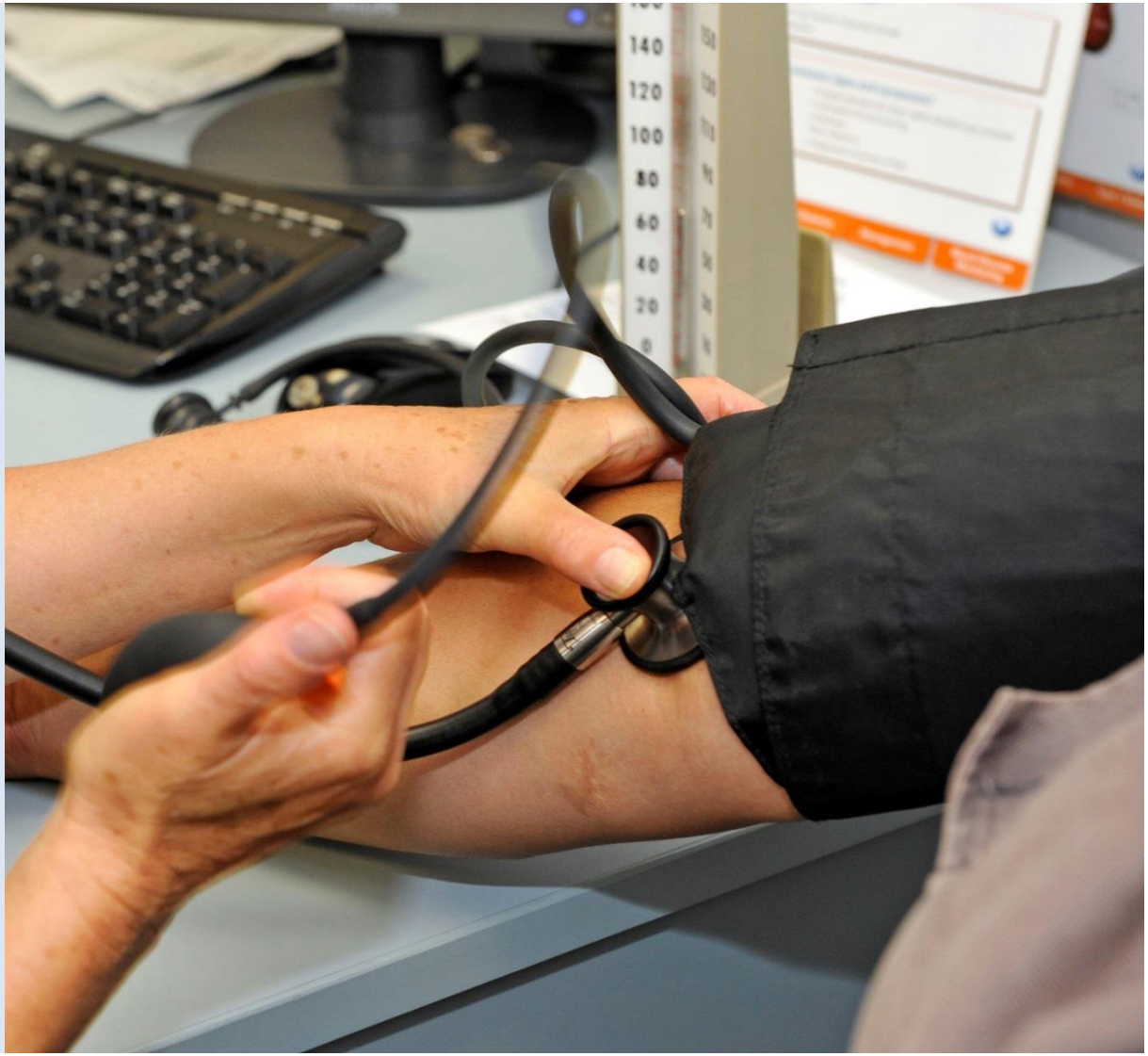
Delivery of Regional Service Plan (RSP) priorities and relevant national service plans					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
care and/or community-based laboratory services • collaborating across primary and secondary care to support people with allied services (e.g. community alcohol and drug services, needle exchange, and other social agencies) best placed to support HCV treatment and ongoing management Collaborate with regional partners to increase access to primary care and promote primary care prescribing of the new pangenotypic hepatitis C treatments by: • raising awareness and providing education on HCV, risk factors and management/treatment options to primary care teams, specifically NGOs and service providers with known at-risk patient populations • enhancing the delivery of an integrated hepatitis C service through community-based HCV testing and care	Sep 2020 Mar 2021 Jun 2021	Q1 Q3 Q4			

2.7.7 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.



Primary health care integration					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Te Ranga Ora Te Ranga Ora will see the development of comprehensive, culturally-capable services and models of care for Maaori, Pacific People and people living in quintile 5 with two or more long term conditions. Models will be co-designed and delivered in partnership with local communities and delivered across the Counties Manukau rohe in a phased approach. Supported by CM Health collaboration with MSD and Kaainga Ora. The aim is to establish five prototype systems of care that bring together multiple organisations (general practice, pharmacy, telehealth providers, social care providers, and NGO) who will work in partnership to enable people in our communities to access a responsive, integrated range of wellness, health and social services close to their homes and their whaanau. People will see their culture and what matters to them reflected in the care and support that they receive.					
1. Develop and implement five place based models of care with 'Te Ranga Ora' Prototype Collectives that enable local community leadership and determination over the co-design and implementation process, foster collaborative relationships and take strengths based approach. **(EOA)**	**1a.** Five Prototype Collectives established by Q1. **1b.** Collective governance and leadership structures established by Q1 **1c.** Identify baseline measures to understand who the target population is and the current service provision delivered by the Prototype Collective members to this population by Q2. **1d.** New integrated primary and community co-designed LTC models of care developed by Q4	Q1 Q1 Q2 Q4	PH03: Improving Maaori enrolment in PHOs to meet the national average of 90% PH01: Improving system integration and SLMs PH02: Improving the quality of data collection in PHO and NHI registers SS13: Improved management for long term conditions	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities

Primary health care integration					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. Implementation of a Metro Auckland Regional Flexible Funding Pool (FFP) Application and Governance Framework is ongoing, this work includes the development of an Outcomes Framework which will increase transparency and align resources and activities around priority areas agreed by the Service Level Alliance Team (SLAT). Improving Equity is one of the 9 identified priorities and will be a key consideration for the Outcomes Framework. This work is also meant to align with National Health Targets and System Level Measures. **(EOA)**	**2a**. Development of an Outcomes Framework by end of Q2 **2b**. Implementation and Outcomes monitoring of the Framework by the end of Q4.	Q2 Q4	Completion of activity		
Please refer to the 2020/21 Metro Auckland SLM Improvement Plan for a number of additional activities, in particular on enablers, respiratory admissions in 0-4 year olds, complex conditions, primary options for acute care and e-portals.					

Emergency Ambulance Services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
The DHB remains committed to the 10 year plan to achieve a high functioning and integrated National Air Ambulance service and will participate through the National Ambulance Collaborative to achieve this. The DHB will support the implementation of					

Emergency Ambulance Services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
changed Governance arrangements to include DHBs to effect improved partnership with MOH and ACC in all elements of leadership of the NASO work programme, and supports the development of a robust national process to scope the requirements of a national tasking service					

Pharmacy					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
To support the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA), we will:			PH01: Improving system integration and SLMs SS13: Improved management for long term conditions	We have health equity for Maaori, and other groups	Support healthier, safer and more connected communities
1. Along with Auckland and Waitemata DHBs, develop the service model for Enhanced Residential Care Pharmacy services as part of the Pharmacy Service Level Alliance (Pharmacy SLA) to achieve equitable access to the medication optimisation expertise of pharmacists for people living in aged residential care facilities.	Activity completed	June 2021 (Q4)			
2. Expand 'Owning My Gout' pharmacy service, widen access to more pharmacies in high Pasifika areas,	Ten pharmacies in areas with high priority patients	June 2021 (Q4)			

Pharmacy					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
increase GP buy-in and increase uptake by people with gout.	(Maaori, Pacific, quintile 5) provide care to at least 140 patients in total.		SS04: Delivery of actions to improve Wrap Around Services for Older People		
3. Implement the recommendations that arise from the ICPSA Schedule 1 review (medicine and supply chain).	Activity completed	Ongoing			
4. Implement key local strategies to improve access and vaccination rates by raising awareness and promote pharmacy and other immunisation providers to improve influenza and measles vaccination with a focus on high priority populations e.g. Maaori, Pacific people who are eligible for funded vaccination (over 65s, pregnant and those with a listed Long Term Condition as per the Pharmac schedule) **(EOA)**	The number of pharmacies providing vaccinations will be increased from 30 in 2019-2020 to 45 in 2020-2021 with at least 8 of these in areas servicing high priority populations (e.g. Mangere, Otara, Manurewa, Clendon, Flatbush). Report vaccination number by ethnicity.	June 2021 (Q4)			
5. Along with Auckland and Waitemata DHBs, develop an equity plan for community pharmacies **(EOA)**	Activity completed	June 2021 (Q4)			

Long Term Conditions including Diabetes					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Green Prescription. Implementation and continued service improvement of new and enhanced Green Prescription services through a Counties Manukau Green Prescription Steering Group.	**1a.** Complete service implemented by Q1	Q1	Number of engaged adults in Green Prescription programme	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
	1b. Governance established by Q1	Q1	Proportion of engaged adults in target population (Maaori, Pacific, Q5, pregnant women and people with mental health condition)		
2. Data driven quality improvement through the LTC Clinical Governance Group. Quarterly data and performance discussions with the Long Term Conditions Clinical Governance Group to measure and monitor progress of the 10 practices who are furthest from meeting the agreed diabetes and cardiovascular disease (CVD) targets. *Please refer to Te Ranga Ora under Primary Health Care Integration section on Page 122 of this Annual Plan for activities targeted towards models of care to engage and support people and whaanau living with Long-Term Conditions (LTCs), including Diabetes.* *Please refer to Healthy Food and Drink Section on Page 75 of this Annual Plan for activities*	**2a.** Improved performance against the five Metro Auckland Diabetes Indicators for the 10 practices requiring additional support by Q4	Q4	TBC on PHO discussion		

targeted towards health protection and promotion. *Please refer to the 2020/21 SLM Plan for activities targeted toward early risk assessment and risk factor management efforts for people with high and moderate cardiovascular disease risk by supporting the spread of best practice from those producing the best and most equitable health outcomes.*					
Diabetes • Counties Manukau Health has implemented a new contract to fund key components of pathway care for high needs people with long-term conditions from 1 July 2019 • The contract covers services such as podiatry, insulin initiation, dietetics, phlebotomy, palliative care and group self-management education. • This targeted funding for high needs populations will support patients who have costs as a barrier when getting their blood tests for HbA1c.					
1. Collaboration with primary healthcare providers and diabetes services to promote and support diabetes management. CM Health will progress regular data matches with primary care and enable bulk referrals to retinal screening. Screenings will be prioritised based on ethnicity and HbA1c. This will ensure all patients with diabetes are receiving a referral to retinal screening services and support the screening and specialist services to ensure services are accessible with clear referral pathways	**1a.** Conduct quarterly data match for retinal screening services **1b.** Implement monitoring and reporting framework for retinal screening by Q1	Q1	Percentage of people with diabetes with regular retinal screen by ethnicity SS13 FA2 Diabetes	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
2. Collaboration with primary healthcare providers and specialist secondary care services to deliver group diabetes self-management education (SME) which is culturally sensitive and where possible, delivered by peer facilitators and health coaches. CM Health will continue to use the Health Education and Impact Questionnaire (hei-Q) to evaluate SME impact. This is a user-friendly, relevant, and psychometrically sound instrument which has been translated into several	**2a**. Provision of culturally appropriate group diabetes SME programmes for people with diabetes	Q4	Number of people referred to Diabetes SME Programme SS13 FA1 Diabetes		

languages and enables comprehensive evaluation of patient education programs, which can be applied across a broad range of chronic conditions. **(EOA)**					

2.8 Financial performance summary

CM Health remains fully committed to achieving the Government's priorities, despite the increasing fiscal constraints the health sector is facing. Capacity pressures associated with unprecedented growth in the demand for clinical services have placed significant strain on current budgets and staff across the system. Even when allowing for implementation of change and innovations to increase efficiency, projected increases in demand across the health system in the coming years will be difficult to accommodate whilst maintaining fiscal sustainability. We also continue to accommodate cost pressures with respect to Multi Employer Collective Agreements (MECA) and related wage and salary increases.

While we are pleased to have received an additional $94m funding for the 2020/21 year, we are aware that our population remains undercounted for the purposes of the population based funding formula, impacting our revenue. In the 20/21 year, of the $107.2m million of additional funding received (PBFF and other funding streams i.e. ACC, MoH MECA and CFA agreements outside PBFF) $75.8m of new funding is committed to price increases, $25.2m committed to volume or demand driven growth in mental health, primary and community services and $14.89m is committed to hospital capacity. Much of this cost growth will not be funded by new revenue and will need to be met by savings within the core base.

Despite these circumstances, CM Health acknowledges the expectation from its Board and the MoH to work towards an underlying breakeven over 2 financial years. The current 2020/21 position is a deficit of $29.9m, reducing to breakeven by the end of 2022/23.

To reach our goals of deficit reduction, the approach to the 2020/21 budget has required considered trade-offs in what we choose to prioritise within the budget; at this point in the business cycle we have been unable to commit to additional spending in some areas which we would have liked to. Throughout 2020/21 we intend to regularly review our financial position and maintain a visible list of opportunities for further re-investment through savings elsewhere.

The following tables should be viewed with reference to the financial narrative in section 2.0 of the Statement of Performance Expectations.

Statement of comprehensive income

Net Result	2018/19 Audited Actual $000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Revenue						
Ministry of Health	1,588,449	1,713,095	1,780,012	1,908,005	2,017,778	2,125,554
Other Government	37,081	48,666	37,625	38,694	39,793	40,923
Other	43,524	44,811	44,753	45,845	46,968	48,123
Inter DHB and Internal	76,863	94,453	85,358	88,428	91,659	95,057
Total Revenue	**1,745,917**	**1,901,025**	**1,947,748**	**2,080,972**	**2,196,198**	**2,309,657**
Expenses						
Personnel	778,616	742,051	763,591	807,325	845,524	884,667
Outsourced	96,118	107,647	97,477	108,619	113,018	113,964
Clinical Support	124,202	131,630	133,615	138,013	140,756	145,175
Infrastructure	81,675	86,640	88,131	92,150	93,226	94,056
Personal Health	523,101	565,627	570,756	596,808	628,579	661,761
Mental Health	63,709	68,928	78,778	82,311	86,594	91,065
Disability Support	148,553	152,546	161,083	170,410	181,834	194,133
Public Health	8,783	25,915	7,871	8,186	8,591	9,012
Maaori	2,776	2,826	2,880	8,030	10,275	10,566
Operating Costs	**1,827,533**	**1,883,810**	**1,904,182**	**2,011,852**	**2,108,397**	**2,204,399**
Operating Surplus / (Deficit)	**(81,616)**	**17,215**	**43,566**	**69,120**	**87,801**	**105,258**
Depreciation	34,779	40,136	40,861	45,828	50,423	60,678
Capital Charge	36,424	33,625	32,512	33,185	37,302	44,502
Interest	-	25	72	74	76	78
Net Deficit	**(152,819)**	**(56,571)**	**(29,879)**	**(9,967)**	**-**	**-**
Other Comprehensive Income	101,984	-	-	-	-	-
Deficit	**(50,835)**	**(56,571)**	**(29,879)**	**(9,967)**	**-**	**-**

Note: *Included in the 2018/19 audited result and 2019/20 unaudited result are additional provisions for the remediation of the areas of non-compliance in terms of the Holiday's Act.*

Note: *A funding increase assumption of $94m has been top sliced for Mental Health Ring fence and Inter District Flows. The residual balance will be allocated to the Provider based on volumes, with the remainder allocated to Governance and Funder based on proportionate net surplus (deficit).*

Output classes

The following tables provide a prospective summary of revenue and expenses by Output Class.

Prevention

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**47,332**	**48,582**	**49,989**	**50,117**
Personnel costs	25,174	25,677	26,191	25,677
Outsourced Services	1,035	1,056	1,077	1,056
Clinical Supplies	4,326	4,413	4,501	4,413
Infrastructure & Non-Clinical Supplies	1,526	1,557	1,588	1,557
Other	15,271	15,879	16,632	17,414
Total Expenditures	**47,332**	**48,582**	**49,989**	**50,117**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Early detection and management

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**278,591**	**289,723**	**301,519**	**313,233**
Personnel costs	967	986	1,006	986
Outsourced Services	40	41	41	41
Clinical Supplies	166	169	173	169
Infrastructure & Non-Clinical Supplies	59	60	61	60
Other	277,359	288,467	300,238	311,977
Total Expenditures	**278,591**	**289,723**	**301,519**	**313,233**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Intensive assessment and treatment

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**1,423,520**	**1,519,336**	**1,608,197**	**1,696,447**
Personnel costs	723,314	771,242	803,619	843,584
Outsourced Services	95,821	106,929	111,295	112,275
Clinical Supplies	135,467	140,586	143,940	151,469
Infrastructure & Non-Clinical Supplies	150,362	159,113	168,100	183,468
Other	348,435	370,693	395,503	419,911
Total Expenditures	**1,453,399**	**1,548,563**	**1,622,457**	**1,710,707**
Net Deficit	**(29,879)**	**(29,227)**	**(14,260)**	**(14,260)**

Rehabilitation and support

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**198,305**	**209,021**	**222,120**	**235,422**
Personnel costs	14,138	14,420	14,709	14,420
Outsourced Services	581	593	605	593
Clinical Supplies	2,430	2,478	2,528	2,478
Infrastructure & Non-Clinical Supplies	857	874	892	874
Other	180,299	190,656	203,386	217,057
Total Expenditures	**198,305**	**209,021**	**222,120**	**235,422**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Total

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**1,947,748**	**2,080,973**	**2,196,198**	**2,309,657**
Personnel costs	763,593	807,325	845,525	884,667
Outsourced Services	97,477	108,619	113,018	113,965
Clinical Supplies	142,389	147,646	151,142	158,529
Infrastructure & Non-Clinical Supplies	152,804	161,604	170,641	185,959
Other	821,366	865,746	915,872	966,537
Total Expenditures	**1,977,629**	**2,090,940**	**2,196,198**	**2,309,657**
Net Deficit	**(29,879)**	**(9,967)**	**-**	**-**

3. Service Configuration

3.1 Service Coverage

All DHBs are required to deliver a minimum of services, as defined in The Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually. Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Maaori, Pacific and high-needs groups. Counties Manukau DHB 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.
Counties Manukau DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2020/21.

3.2 Service Change

The table below describes all service reviews and service changes that have been approved for implementation in 2020/21. This also includes service changes as a result of COVID-19.

Table 1

Service Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Additional 15 Maternity beds	Additional maternity beds were opened on the Middlemore Hospital site and these required resourcing at 16.9 FTE.	The additional resourced beds will ensure that women in child birth can access a bed when required.	Local
Additional Medical beds	Ward 17 has added an additional 30 beds for use by General Medical patients. The beds are resourced at an additional 42.1 FTE.	The additional beds have improved the availability of in-patient beds to: • Reduce waiting times in the Emergency Department • Improve the patient, family and whaanau experience • Improve the effectiveness and efficiency of medical care teams • Improve the capacity of the hospital to meet peaks in acute patient demand • Improve regional capacity of available beds as the population grows	Local and Regional
Additional clinical staff	Additional 24.2 FTE clinical staff to address growth in demand, including annualised from previous years.	The additional clinical staff are appointed across many services to keep pace with growth in patient numbers. This will help improve responsiveness and patient experience.	Local
Insourcing of renal dialysis	30.8 FTE staff are being transferred from an outsourced provider to the DHB.	The outsourcing contract is no longer possible as the supplier has withdrawn from providing renal care.	Local
Insourcing of security staff	13.6 FTE security staff are being hired in place of the outsourced contract and security across sites is being improved.	Insourcing more of the security function will: • Improve consistency and competency of approach to providing site security services • Improve responsiveness in dealing with violence against staff • Improve safety of staff, patients and property	Local

Te Ranga Ora – co-design and deliver innovative Primary and Community services to support people and whaanau living with Long-Term Conditions	Te Ranga Ora will see the development of comprehensive, culturally-capable services and models of care for Māori, Pacific People and people living in quintile 5 with two or more long term conditions. Models will be co-designed and delivered in partnership with local communities and delivered across the Counties Manukau rohe in a phased approach. Supported by CM Health collaboration with MSD and Kāinga Ora.	This will establish five prototype systems of care that bring together multiple organisations (general practice, pharmacy, telehealth providers, social care providers, and NGO) who will work in partnership to enable people in our communities to access a responsive, integrated range of wellness, health and social services close to their homes and their whaanau. People will see their culture and what matters to them reflected in the care and support that they receive.	Local
Ngaa Kaimanaaki – Supporting whaanau wellbeing via deployment of community leaders	The first phase of the Ngaa Kaimanaaki approach utilises three Maaori Providers in the Counties Manukau rohe to provide support to whaanau in underserved areas and address the spectrum of needs for whaanau members. The service involves the deployment of Kaimanaaki (25 FTE for 3 months), coordinators and clinical leads total of (2 FTE across the three providers). Each Maaori provider has developed their own local community response teams to undertake holistic assessments of whaanau and develop wellbeing plans. The Kaimanaaki service also includes provision of whaanau financial support for immediate health and wellbeing needs during COVID-19	There are numerous benefits to this service including provision of formal support for community leaders and volunteers with key skills and networks responding to vulnerable and high-needs whaanau members. These Kaimanaaki work alongside existing health and social support staff to ensure that services are responsive to the spectrum of whaanau needs (identifying pressing needs and the best solutions). This approach also provides a central and coordinated response for whaanau during the different alert levels of the COVID-19 pandemic. The service also ensures connection of whaanau to health care providers in their local community and establishes clinical oversight for Kaimanaaki. Additionally, the services leverages key data for whaanau as Kaimanaaki act as conduits for information identifying the needs of each whaanau member and communicating this to Maaori providers and Counties Manukau DHB.	Local
Ngaa Kaimanaaki – Iwi expansion	Phase two of this approach supports a partnership between Iwi (Waikato-Tainui as well as Mana Whenua i Tamaki Makaurau) and the DHB by deploying additional Kaimanaaki (up to 25 FTE) via a Maaori hauora provider network.	Leverage local marae, hapuu and Iwi capacity to strengthen Kaimanaaki response to vulnerable and high needs whaanau members. Develop and build Iwi and DHB data capability to better inform commissioning planning.	Local
Maaori Influenza vaccination programme	The service will co-ordinate the implementation of five mobile teams that will employ a variety of techniques to promote and deliver vaccination to vulnerable populations, including Kaumaatua in their home or providing access to alternate clinic sites such as Marae.	To provide services that increase access to the influenza vaccine for Maaori who meet eligibly conditions for free vaccination, particularly Kuia and Koroua over 65 years.	Local
Community Testing Stations	Community Based Assessement Centres (CBACs) set up in Counties Manukau Region to provide ongoing testing for COVID-19	The CBACs allow for continuous monitoring of the spread of COVID-19 in the community	Regional

Managed Isolation & Quarantine facility support	Joint Northern region DHB development of a health support model for the Managed Isolation & Quarantine facilities	For people in isolation: • Standardised and consistent approach to Covid-19 testing • Provision of appropriate and timely health care support for people in isolation For the NZ population: • Keeping Covid-19 out of the community	Regional & National

4. Stewardship

This section will outline the DHB's stewardship of its assets, workforce, Information Technology/Information Systems (IT/IS) and other infrastructure needed to deliver planned services.

CM Health commits to working with its Alliance partners and Auckland Regional Public Health Services, within its fiscal and resource capabilities, to promote and deliver services that enhance the effectiveness of prevention activities, and to undertake its functions within regulatory parameters.

4.4 Managing our business

Organisational performance management

In our role as provider of hospital and specialist services, we have an agreed set of financial and non-financial performance indicators with an established structure for reporting and review. Productivity and quality indicators are reported at operational and clinical management forums and to the Board and related Board committees, i.e. the Hospital Advisory Committee (HAC) and Community and Public Health Advisory Committee (CPHAC) and others.

In 2020/21 we continue to work regionally to support further improvement against the national System Level Measures and other priorities as described previously in this annual plan.

Funding and financial management

CM Health utilises business and public sector standard practices that ensure best practice financial management at both the macro and micro level. At a macro level there are robust budget, forecasting and reporting processes that link in all levels of management in a structured framework accountable through the Chief Financial Officer to the Chief Executive and Board. Additional financial savings and improvement plans including Every $ Counts and Every Hour Counts and monitoring controls are in place to support the DHB to recover its financial deficit position. At a micro level, procuring and funding of non-government organisation (NGO) provider services requires a commercial approach, including meeting "Government Rules of Sourcing" requirements, to ensure value for money services and financially sustainable NGO providers.

Please refer to the Financial Performance Summary in Section 2.0 of the Statement of Performance Expectations 2020/21 for further information about Counties Manukau DHB's planned financial position for 2020/21 and out years.

Local and regional investment and asset management

In 2016 all DHBs completed a 10-year Long Term Investment Plan (LTIP) as part of the new Treasury Investment Management and Asset Management Performance (IMAP) system for monitoring investments across government. The Northern Region DHBs chose to collaborate and align investment plans and collective priorities.

The first Northern Region Long Term Investment Plan (NRLTIP) was completed and approved by each DHB Board in 2018. The plan details regionally prioritised investments over a 10 to 15 year timeframe within the context of a 25 year horizon. The NRLTIP sets the Northern Region strategic investment path, and supports the Region to deliver optimal health gain for the Northern Region's population within available resources.

The NRLTIP identifies three investment themes for the Northern Region:

- Fixing our current facilities to ensure they are fit for purpose. This includes the concepts of asset resilience, renewal and refurbishment
- Future proofing our capacity for expected demand. This recognises that there are lead times of 5 to 10 years for some asset developments and that these cannot be developed in crisis
- Accelerating model of care change programmes. This includes enhancing levels of service and transformative change.

The NRLTIP signalled an immediate requirement for a significant lift in our Region's capital expenditure; particularly to address the issues identified against the NRLTIP 'Fix' and 'Future-proof' themes. Significant and urgent investment is needed in the Northern Region to ensure population health needs are met and to ensure the sustainability of existing health services.

The plan was developed under our regional governance structure with contribution from the Region's clinical networks, clinical governance groups and other region-wide work groups; these workgroups included representation from across the continuum of care and from within different health care settings. The NRLTIP Programme Steering Group ensured a collaborative approach to the planning work and, in addition to regional health sector representatives, included local representation from Auckland Council as well as national representation from the Ministry of Health and Treasury.

The NRLTIP investment logic directly reflects the Northern Regional Intervention Logic and Regional Business Objectives to ensure that the investment plans, that shape the capital works to be progressed across our Region, are based on a shared view of the priorities for our Region.

Shared service arrangements and ownership interests

Counties Manukau DHB has a part ownership interest in the Northern Regional Alliance Ltd, healthSource NZ Ltd (formerly healthAlliance NZ Ltd) and NZ Health Innovation Hub Limited Partnership. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

Counties Manukau DHB has a formal risk management and reporting system. CM Health is currently reviewing and refining its risk management system, including the internal risk register. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement

Counties Manukau DHB's approach to improvement science is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

4.5 Building capability

The following sections outline key capabilities and initiatives to support improved capability in 2020/21, across capital and infrastructure investment, information technology and communication systems, workforce and co-operative developments.

4.5.1 Capital and infrastructure development

Regional population health priorities

As part of the work for the NRLTIP, the Northern DHBs established a Regional Public and Population Health Deep Dive Steering Group to clarify the service delivery intentions and the short, medium and long term investment implications

for Public and Population Health in the Northern Region, with a particular focus on addressing inequities in access and outcomes.

CM Health will continue to engage with this work to progress population health priorities for the Region.

Regional capital and infrastructure development – Regional Capital Investment Programme[14]

Health Services in the Northern Region are dealing with existing assets (facilities, infrastructure and clinical equipment) in variable condition, considerable growth in demand and a need to develop capability for different care models to improve health equity and outcomes for our population. The 2018 Northern Region Long Term Investment Plan (NRLTIP) and subsequent studies describe the size and nature of the demand for health services and the Region's intended response to ensure future capability to deal with these demands.

The Regional Capital Investment Group (RCIG) is accountable for overseeing a programme to ensure that the planning, delivery and the on-going management of our capital investments will meet the future needs of our population.

Long term objectives

The Regional Capital Investment Group and its three RCIG working sub-groups were established to address the long term goals of a Capital Investment Programme i.e. to deliver and maintain a future investment path for significant health capital investments that:

- Is consistent with the Northern Region long term health planning strategic direction
- Gives effect to national and regional policy
- Adheres to best practices, including business cases, asset management and capital delivery activities supported by processes aligned to good practice investment planning principles

2020/21 Annual Objectives

The objectives for the Regional Capital Investment Programme during 2020/21 are to:

- Oversee work to develop a prioritised capital investment programme that aligns with regional direction and national priorities
- Support capital business case development (including quality assurance and Regional endorsements)
- Progress the capital planning and investment process improvements
- Provide oversight and coordination of delivery of the investment programme at a regional level
- Consider any changes to investment strategy following the Region's Covid-19 response

CM Health capital and infrastructure development

In 2017/18 CM Health aligned its long-term district investment plan with the agreed NRLTIP priorities. This requires a balanced district investment portfolio which aligns with regional priorities to manage capacity growth and support whole of system solutions. The pipeline of investment priorities will progress through to business case development.

The 2020/21 fiscal year will include completion and progression of major capital projects already underway (as per Table 2 below) and significant development of business cases to address critical facilities infrastructure risks and service capacity challenges.

Table 2

Capital Project (funded and underway)	Category of project	Planned completion date
Acute Mental Health unit	Replacement	September 2020
Scott Building reclad	Remediation	August 2021
Gastroenterology Procedure room	Expansion	September 2021

[14] Source: Capital Section Northern Region Service Plan

Renal dialysis unit	Expansion	September 2022
Second Cardiac Cath Lab	Expansion	September 2022
Radiology department	Relocation	December 2022
Neonate unit	Expansion	To be confirmed
Manukau Health Park (incl. outpatient clinics, Radiology, Renal, Theatres, Breast)	Expansion	To be confirmed

A review of primary and community services and future investment requirements is progressing with the aim to develop a plan in response to inter-sectorial developments and local population health priorities. This is integral to CM Health being able to deliver its refreshed strategy.

Counties Manukau Health adopted an Environment Sustainability Strategy in 2012 and our new facilities are designed based on Green Star principles. For each major facilities development, the early concept design processes that inform business case development includes cost benefit assessment of sustainability options.

Final design is subject to affordability, however the new Acute Mental Health Unit, Tiaho Mai demonstrates some of these features.

4.5.2 Information technology (IT) and communications systems

Information systems are fundamental to our ability to meet the organisation's purpose and priorities. Our goal is for information to be easily accessible to those who need it including patients, to support the best decisions, improve the quality and safety of care provided, and improve patient experience across the care continuum.

The Northern Region has developed its Long Term Investment Plan (LTIP) to provide an investment path for the region to address its key healthcare delivery issues around capacity and capability. A key element of the LTIP is the Information Systems Strategic Plan (ISSP), including the roadmaps that support its delivery. The Northern Region ISSP is fully aligned with the National Health Strategy and the Ministry of Health's Digital Strategy, and this alignment has been detailed in the ISSP which has been reviewed by the Ministry of Health. The four key investment objectives in the ISSP are to strengthen our ICT foundations, simplify our layers of applications, become experts at interoperability, and become a capable region.

Strengthening our ICT foundations. The scope of this includes moving our infrastructure to the all-of-government private cloud datacentres, developing a robust telecommunications capability, identity and access management, moving to Windows 10 / Office 365, and developing our hybrid cloud approach and capability.

Simplify our layers of applications. Within this investment stream, the implementation of an Application Portfolio Management (APM) tool is complete. The results from this implementation are being used to support a number of initiatives focused on application stabilisation, as well as the replacement of ageing systems. It is expected that these initiatives will support the ISSP strategy in its objectives to rationalise, standardise, and simplify the number and diversity of applications wherever possible. It is expected that this process will extend to 2024, to accommodate the larger investments in transforming major application sets, such as those involved in the key workstreams of:

- HARP – the ADHB Patient Administration System replacement programme
- RCCC – Regional Collaborative Community Care
- HIP – Health Information Platform

Interoperability. We will grow our capability through embedding the MuleSoft Application programme interface (API) capability, and beginning the design of our regional data sharing and health information platform.

Become a capable region. Our focus in growing our regional capabilities includes further developing our P3M3 (Programme and Project Management) and business case capabilities as well as continuing to invest in innovation and digital acceleration.

Implementation of the regional community care system, RCCC, is planned to commence in 2020/21. While Counties Manukau Health plans to join in later years, our contribution to design and implementation will be crucial. This project is a major enabler of better collaboration and information exchange between community, primary and secondary care.

The RCCC solution is designed to support most community facing services owned by the Northern Region DHBs who provide care to consumers and their whanau living in the community.

Examples of services using RCCC include:

- Mental Health (inpatient and ambulatory)
- Health of Older People (including Needs Assessment services)
- Community Nursing
- Long Term Conditions services
- Community base rehabilitation
- Diabetes services
- For these services, RCCC is a complete record of clinical activities.

RCCC will provide simple integration with other key information such as inpatient care (via Concerto/Clinical Portal) and primary care information systems.

For the consumer and whaanau*:* RCCC will give access to information that is created during their interactions with a wide range of DHB based community providers. The will be able to interact with this information including care planning, being able to add and edit this data. This will give ownership and control to the consumer and their whaanau.

For DHB based community service provider*:* RCCC will act as the complete patient record with no need to use paper records. It will give simple access to other DHB information sources such as Clinical Portal and éclair. It will provide views of information from primary care providers.

For other DHB clinical staff*:* RCCC will be easily accessible from other DHB based systems such Clinical Portal.

Counties Manukau Health has already taken part in the HIMSS digital maturity assessment. We are now using the results of this process to identify gaps in our digital footprint and ensure we have plans in place to address these through our capital planning process. Our plans to implement new smart systems for eOrdering, storage of clinical images (photography) and the introduction of eClinical Notes for our health professionals demonstrate our commitment to increasing our digital maturity.

Our local programme of work is derived directly from the Regional Information Systems Strategic Plan (ISSP) or it aligns with the ISSP in principle. All new projects are overseen by the new regional governance structure established in 2019. Our goal is for information to be easily accessible to those who need it, including patients and whanaau, to support the best decisions, improve the quality and safety of care provided, and improve patient experience across the care continuum. Together with our regional partners we will:

- continue to strengthen our shared information service, with a focus on responsiveness and value
- continue to improve access to our health data through Qlik Sense data visualisations
- participate in the Regional ISSP governance forums
- continue to contribute to development and implementation of the Regional Information Services Strategic Plan (ISSP)
- continue to invest regionally in a reliable and sustainable technology infrastructure
- participate in national initiatives, e.g. the National Health Plan and National Health Information Exchange
- continue to improve the maturity of our regional cyber-security capability
- continue investments in electronic support of clinically-led service initiatives

Our IT security has matured greatly in the past two years through a significant investment in cyber-security and. It is important to continually maintain and strengthen our digital security in our increasingly interconnected world. The plans for cyber security investment in 20-21 are being finalised. Subject to funding, the aim will be to build on investment to date – such as foundational security incident event management (SIEM) tools and resources – to further embed a cyber-security controls framework which complies with HISF / NZISM and Ministry of Health digital service requirements.

During the COVID-19 pandemic response, Telehealth (telephone and video) appointments enabled us to deliver over 25,000 appointments that may otherwise have been cancelled. Patient feedback has been positive and tells us we should continue to offer telehealth appointment options. Work to sustain and implement telehealth includes building patient choice into our booking processes, integration of the video platform with our booking system, and development of electronic tools such as patient information, patient questionnaires, eLabs, ePrescribing, eOutcome and eSurgical waitlist.

Please refer to the Data and Digital section in Section 2.7.6 for further information about our IT and communication commitments for 2020/21.

4.5.3 Workforce

Provide training placements and support transition to practice for eligible health workforce graduates and employees

The strong relationships with our strategic tertiary partners will continue in 2020/21 through regular liaison and forums and expansion to additional tertiary partners. As with 2019/20 focus remains on increasing the number of student placements CM Health is able to offer our tertiary providers, through exploring different models of placements and developing inter-professional education opportunities. There is intent to accommodate student placements for students who live in the local area and Maaori and Pasifika students.

Nurse Entry to Practice (NETP) graduates within the Counties Manukau region are supported with the CM Health NETP programme, with intake numbers anticipated to increase in 2020/21. Nursing, occupational therapy and social work graduates are supported through the New Entry to Specialist Practice (NESP) (Mental Health) programme, with an increase likely in graduate numbers. Scoping the capacity of the NETP and NESP programmes to support additional students will continue in 2020/21.

An allied health new graduate supervision group will continue to be offered throughout 2020/21, this is an inter-professional group open to physiotherapy, occupational therapy, social work, dietetic and speech and language therapy graduates in their first year of employment.

CM Health continues to offer trainee places to the following allied health, scientific and technical professions; anaesthetic technicians, cardiopulmonary technicians, physiology technicians, ultrasonographers, and clinical psychology internships through funding from the Health Workforce Directorate, Ministry of Health. There is continued liaison with the Northern Regional Alliance on regional workforce strategies.

CM Health is working with Manukau Institute of Technology to investigate the provision of health care assistant student placements earlier in their training programme.

Form alliances with training bodies to ensure that we have a well trained workforce

CM Health is represented on several professional programmes advisory boards with tertiary education institutes, e.g. physiotherapy at Auckland University of Technology, and nursing at Manukau Institute of Technology, Auckland University of Technology and the University of Auckland. These offer an opportunity to influence the content and delivery of these programmes with the intention of training programmes producing health graduates who are fit for purpose. There is also representation on professional boards including Occupational Therapy New Zealand Aotearoa, Nursing Council of New Zealand, and the Medical Sciences Council of New Zealand.

An intrinsic part of CM Health is the Ko Awatea Education Centre. It is purpose-built to provide an open, social learning space, with lecture theatres, breakout rooms, and a variety of teaching spaces. The Centre was built in 2011 as a joint venture project with the Auckland University of Technology, Manukau Institute of Technology and the University of Auckland, and is a contemporary building with modern capabilities to match. The Centre has a Customer Support and Technology Help office providing service and support to the Centre and its users. In addition to providing a training venue for our future allied health, medical, and nursing workforce, the centre also hosts a large number of CM Health staff forums and events and local, national and international visitors.

4.5.4 Co-operative developments

There is a need to continue to build on the strong relationships with our strategic tertiary partners, and to expand our linkages with additional tertiary providers. As with 2019/20 focus remains on increasing the number of student placements we are able to offer our tertiary providers, through exploring the expansion of the Dedicated Education Unit (DEU). This scoping is being undertaken with involvement from Manukau Institute of Technology, the University of Auckland and Auckland University of Technology.

There has been development in the graduate entry nursing Masters programmes at both Auckland University of Technology and the University of Auckland. CM Health has been linked in with the development of these innovative programmes, with the first students from both programmes undertaking student placements at CM Health in 2019/20. We continue to collaborate with the University of Auckland in relation to postgraduate research supporting Bachelor of Nursing (Honours) and PhD intern programmes.

As with 2019/20, discussions will continue in 2020/21 with the Tertiary Education Commission around further development programmes for the Kaiawhina/unregulated workforce to build on the numeracy and literacy training delivered in 2018/19.

4.6 Workforce

Please refer to the Workforce priority in Section 2.7.6 for details of our planned workforce activities for 2020/21.

4.7 Information technology

Please refer to the IT priority in Section 2.7.6 for details of our planned workforce activities for 2020/21.

5. Performance measures

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

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

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

5.4 2020/21 Performance Measures

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Year 1	49%	
		Year 2	49%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	<0.74	
		Year 2	<0.74	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled (≥ 95 percent of pre-school children (aged 0-4 years of age) will be enrolled in the COHS)	Year 1	>=95%
			Year 2	>=95%
		Children (0-12) not examined according to planned recall (≤ 10 percent of pre-school and primary school children enrolled with the COHS will be overdue for their scheduled examinations with the COHS.)	Year 1	<=10%
			Year 2	<=10%
CW04	Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	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 fully immunised.		
		95% of five year olds fully immunised.		
		75% of boys and girls fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the		

Performance measure		Expectation		
		Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two years	95% of two year olds have completed age-appropriate immunisations due between birth and two years.		
CW09	Better help for smokers to quit (maternity)	90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to four (and decile five after January 2020) secondary schools, teen parent units and alternative education facilities and actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.		
		Initiative 3: Youth Primary Mental Health.		
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Maaori, other & total	Total	3.9%
			Maaori	5.8%
			Other	3.4%
		Age (20-64) Maaori, other & total	Total	3.9%
			Maaori	9.0%
			Other	3.1%
		Age (65+) Maaori, other &total	Total	2.2%
			Maaori	3.0%
			Other	2.1%
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.	

Performance measure		Expectation	
			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 Maaori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Maaori 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.	
MH0	Improving mental health services by improving inpatient post discharge follow-up rates	Developmental measure with data shared in 2020/21 to inform developmental of baselines and performance expectations for 2021/22	
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.	
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.	
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified.	
SS03	Ensuring delivery of Service Coverage	Provide reports as specified.	
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified.	
SS05	Ambulatory sensitive hospitalisations (ASH adult)	Total 45-64 years	4,651/100,000 population

Performance measure		Expectation		
SS07	Planned Care Measures	Planned Care Measure 1: Planned Care Interventions		XXXX inpatient surgical discharges XXXX minor procedures XXXX non-surgical interventions (TBC on price volume schedule negotiations)
SS07	Planned Care Measures	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 priority tool.
		Planned Care Measure 3: Diagnostics waiting time	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

Performance measure		Expectation		
				results are reported, within 6 weeks (42 days).
		Planned Care Measure 4: Ophthalmology Follow-up Waiting Times	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 6: Acute Readmissions	0-28 days	< or equal to 10.7% (TBC on price volume schedule negotiations)
		Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.	
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	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	To be confirmed by MOH
			New NHI registration in error (duplication)	Group A >2% to < or equal to 4%
		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	Greater than or equal to 90% and less than 95%
			National Collections completeness	Greater than or

Performance measure		Expectation		
				equal to 94.5% and less than 97.5 %
			Assessment of data reported to the NMDS	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions, milestones and measures to: Support people with LTC to self-manage and build health literacy.	
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*	
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity	
			Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months.	
		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	

Performance measure		Expectation	
			Cath/PCI registry data collection within 30 days of discharge and Indicator 2b: ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. 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 - Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes) - ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), - Beta-blocker if LVEF<40% (5-classes). - *An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5: Device Registry Completion - ≥99% of patients who have a pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of this procedure. Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
		Focus Area 5: Stroke services	Indicator 1 ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital"
			Indicator 2 Reperfusion Thrombolysis/ Stroke Clot Retrieval: 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission

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

Appendix 1: 2020/21 Statement of Performance Expectations

Statement of Performance Expectations 2020-21

COUNTIES MANUKAU HEALTH

He Pou Koorero

(A Statement of Intention)

Ko te tumanako a tenei poaari he whakarato i teetahi o ngaa taupori Maaori nui, taupori Maaori matatini, puta noa i te motu. Ko te whakakikokiko i te mana-taurite hauora Maaori teetahi o aa maatou tino whaainga.

Ko too maatou hiahia ko te whakamana, ko te whakatinana hoki i te wairua me ngaa maataapono o Te Tiriti o Waitangi hei tuuaapapa i taa maatou e whai nei, me te whakapono nui - maa te aata whakapakari i te ara whakawaiora Maaori e taea ai te whakatutuki i te mana taurite hauora moo te katoa.

As a District Health Board we serve one of the largest and most diverse Maaori populations in the country. Achieving Maaori health equity is a key priority for us.

Our commitment to this is driven by our desire to acknowledge and respect the Treaty of Waitangi and our belief that if we are serious about achieving health equity for our total population, we must first strengthen our commitment and drive to accelerate Maaori health gain in our community.

Signed on behalf of the Counties Manukau District Health Board

Vui Mark Gosche
Chair
Counties Manukau District Health Board

Tipa Mahuta
Deputy Chair
Counties Manukau District Health Board

Fepulea'i Margie Apa
Chief Executive
Counties Manukau District Health Board

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Statement of Performance Expectations including Financial Performance (for tabling as SPE)

1.1 Statement of Performance Expectations

Four 'output classes' are used by all District Health Boards (DHBs) to reflect the nature of services they fund and provide. These output classes reflect the continuum of care and are: prevention services, early detection and management services, intensive assessment and treatment services and rehabilitation and support services.

This SPE is organised by output class and describes the services CM Health plans, funds, provides and promotes within each output class. Each output class includes a number of key measures of output and impact that are significant to CM Health's achievement of key strategic objectives, and that provide a fair representation of our DHB's performance. Note that these measures are not intended to be a comprehensive outline of all performance measurement activity within the organisation.

In presenting CM Health's performance story, it is important to present a mix of measures that indicate performance in a range of different ways. For example, for some services the most important measure of performance will be how much of it is delivered (volume), whereas for other services the best measure of performance may be how quickly that service was provided (timeliness).

This SPE therefore includes a spread of indicators that cover the following areas of performance: Volume (V), Timeliness (T), Quality (Q) and Coverage (C). Each of the performance measures has a reference classification to assist with quick categorisation.

Reference Key			
SLM	System Level Measure	**V**	Volume
SLMc	System Level Measure Regional Contributory Measure as included in the 2020/21 Auckland, Waitemata & Counties Manukau Health Alliances System Level Measures Improvement Plan (the 2020/21 Metro Auckland SLM Improvement Plan)	**T**	Timeliness
		Q	Quality
		C	Coverage

1.2 Note on the baselines and targets contained in the Statement of Performance Expectations

Unless otherwise indicated, CM Health's actual performance as at Quarter 4 2018/19 year has been used as the baseline measurement for CM Health's Statement of Performance Expectations. CM Health is unable to use Quarter 4 2019/20 performance as the baseline as this data will only be available after the SPE publication date (15 August 2020).

Footnotes have been used throughout the document to identify those measures for which a different baseline has been used. This includes those measures reported only in Quarters 1 and 3 only in which case the Quarter 3 2018/19 performance has been used as the baseline, and for Metro Auckland System Level Measures Improvement (SLM) Plan baselines.

Many of CM Health's performance targets are set by the Ministry of Health or through the Metro Auckland SLM Improvement Plan and represent the minimum level of performance that CM Health is aiming to achieve. In some cases, CM Health may have achieved results in Quarter 4 2018/19 that are higher than the stated target

for 2020/21. This does not indicate that CM Health intends to reduce the level of performance in 2020/21 but does show that CM Health exceeded the minimum level of performance in 2018/19.

1.3 Prevention Services

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.

Preventative services are aligned with our **Healthy Communities** strategic objective that is focused on primary (ill-health) prevention across the life course.

Performance Measure		Baseline 2018/19	Target 2020/21	Notes
Health Promotion and Education Services				
Percentage of PHO enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months	Total	91%	90%	C
	Maaori	89%		
	Pacific	91%		
	Asian	91%		
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer who are offered brief advice and support to quit smoking	Total	95%	90%	C
	Maaori	94%		
Percentage of babies living in smokefree homes at six weeks postnatal	Total	45%[1]	53.9%[2]	SLMc
Percentage of babies fully or exclusively breastfed at 3 months	Total	49%[3]	70%	Q
	Maaori	42%		
	Pacific	44%		
Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Total	100%	95%	Q
	Maaori	100%		
	Pacific	100%		
	Other	100%		

[1] Baseline is for the period January 2019 to June 2019, to align with the 2020/21 Metro Auckland SLM Improvement Plan
[2] The target represents a 2% relative increase from baseline as per the 2020/21 Metro Auckland SLM Improvement Plan.
[3] Baseline data is as at Q3 2018/19.

Performance Measure		Baseline 2018/19	Target 2020/21	Notes
Number of eligible adult service users engaged in the Green Prescription programme each year	Total	5,869[4]	4,000	V
Immunisation Services				
Proportion of 8 month olds who have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Total	93%	95%	C
	Maaori	84%		
	Pacific	95%		
	Asian	98%		
Proportion of eligible boys and girls fully immunised with HPV vaccine	Total	62%	75%	C
	Maaori	54%		
	Pacific	72%		
	Asian	60%		
Percentage of people aged over 65 years who have had their flu vaccinations	Total	53%[5]	75%	C
	Maaori	43%		
	Pacific	65%		
	Asian	54%		
Health Screening				
Proportion of women aged 50-69 years who have had a breast screen in the last 24 months	Total	72%	70%	C
	Maaori	65%		
	Pacific	83%		
	Other	70%		
Proportion of women aged 25-69 years who have had a cervical smear in the last three years	Total	66%	80%	C
	Maaori	62%		
	Pacific	68%		
	Asian	66%		
	Other	67%		

[4] The 2018/19 baseline is based on the definition "Number of adult referrals to Green Prescription services" however the target is based on the new definition "Number of eligible adult service users engaged in the Green Prescription programme each year".
[5] Results are reported annually in Q1 of each year, covering a six month period of 1 March to 30 September. Baseline data is for the period 1 March 2019 to 30 September 2019.

Performance Measure		Baseline 2018/19	Target 2020/21	Notes
Percentage of four year olds receiving a B4 School Check	Total	90%	90%	C
	Maaori	91%		
	Pacific	92%		
	Other	89%		
Percentage of year 9 students in decile 1-4 high schools alternative education and teen parent unit facilities provided with a HEADSSS[6] assessment	Total	93%[7]	95%	C
	Maaori	96%		
	Pacific	95%		
	Asian	82%		

1.4 Early Detection and Management Services

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Maaori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals. Early detection and management services are aligned with our **Healthy Services** and **Healthy People, Whaanau and Families** strategic objectives which focus on making services more responsive and easier to access and providing support for people to self-manage at home.

[6] This is an interview based assessment tool for adolescents about Home Education/Employment Activities Drugs Sexuality Suicide
[7] Baseline data is at December 2019 as data is reported to the end of the calendar year.

Performance Measure		Baseline 2018/19	Target 2020/21	Notes
Primary Health Care Services				
Percentage of population enrolled in a PHO	Total	96%	90%	C
	Maaori	91%		
	Pacific	114%[8]		
	Asian	90%		
Percentage of newborns enrolled in general practice by 3 months	Total	89%	85%	C
	Maaori	70%		
	Pacific	86%		
	Other	101%		
Amenable mortality rate per 100,000 population[9]	Total	101.2[10]	98.1[11]	SLM
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	90%	90%	C
	Maaori	87%		
	Pacific	90%		
	Other	91%		
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)[12] and no inequity	Total	52%	60%	Q
	Maaori	45%		
	Pacific	44%		
	Other	63%		
Percentage of patients with CVD risk >20% on dual therapy (dispensed)	Total	52%	70%[13]	Q
	Maaori	49%	70%	
	Pacific	59%	70%	

[8] As the 2018 Census results have yet to be released, calculation of the 2018/19 results for PHO enrolment used the 2013 Census data for population denominators. As the Census historically has underestimated the Pacific population, the 2018/19 result for Pacific is greater than 100%.
[9] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30 2016.
[10] Baseline data is for the 12 months ended 30 June 2013. This baseline period has been used in order to align with the 2018/19 Metro Auckland SLM Improvement Plan. Updated baseline data will rely on the 2018 Census information, which is not yet available.
[11] For the total population this measure targets a 6% relative reduction from the 2013 baseline by 30 June 2021, as per the 2020/21 Metro Auckland SLM Improvement Plan. The 2020/21 Metro Auckland SLM Improvement Plan also includes a separate target for Maaori and Pacific of a 2% relative reduction by 30 June 2021.
[12] Note that CM Health currently uses the PHO DCIP cohort based on the population aged 15-74 years enrolled with Counties Manukau practices as the denominator for this measure. Work is currently underway to mature and refine HbA1c reporting in CM Health.
[13] The 2017/18 SLM Improvement Plan targeted a 5% relative increase from baseline for this measure, however due to the persistent inequities in CVD management for Māori, CM Health has chosen to adopt the Metro Auckland Clinical Governance Forum target of 70% for all ethnic groups.

Performance Measure		Baseline 2018/19	Target 2020/21	Notes
	Asian	49%	70%	
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)	Total	58%[14]	70%	SLMc Q
	Maaori	58%	70%	
	Pacific	64%	70%	
	Asian	61%	70%	
Oral Health Services[15]				
Proportion of children under 5 years enrolled in DHB-funded community oral health services	Total	79%	≥95%	SLMc C
	Maaori	68%		
	Pacific	82%		
	Asian	77%[16]		
	Other	84%		
Percentage of enrolled children caries free at age 5 years	Total	46%	49%[17]	Q
	Maaori	32%		
	Pacific	31%		
	Other	63%		
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children (12/13 years)	Total	0.83	0.74[18]	Q
	Maaori	1.03		
	Pacific	1.17		
	Other	0.57		
Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Total	73%	≥85%	C
Diagnostics				

[14] Baseline data is as at Quarter 3 2018/19.
[15] Baseline data is based on the calendar year (to 31 December 2018), except for adolescent measure which is Q4 2018/19.
[16] Baseline data for Asian children is at 2015/2016 as updated baseline data is not yet available.
[17] The 2020/21 Ministry of Health target for the percentage of children caries free at age 5 (49%) is the lower than the 2019/20 target (51%).
[18] The 2020/21 Ministry of Health target for mean DMFT score for Year 8 children (0.74) is lower than the 19/20 target (0.75).

Performance Measure		Baseline 2018/19	Target 2020/21	Notes
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	96%	95%	T
	MRI	50%	90%	T
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	100%	90%	T
Proportion of patients accepted as non-urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	75%	70%	T
Ambulatory Sensitive Hospitalisations				
Ambulatory sensitive hospitalisation (ASH) rate in children aged 0-4 years per 100,000 population	Total	6,249[19]	6,062[20]	SLM
	Maaori	5,589	5,421	Q
	Pacific	10,763	10,440	
Sudden Unexpected Death of an Infant (SUDI)				
SUDI deaths per 1,000 live births	Total	1.18[21]	<0.1[22]	Q
	Maaori	2.40		
Pharmacy				
Number of prescription items subsidised	Total	8,067,467[23]	N/A[24]	V

1.5 Intensive Assessment and Treatment Services

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a hospital. These services are generally complex and are provided by health care professionals that work closely together.

They include:

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

[19] Baseline data is at December 2019 to align with the 2020/21 Metro Auckland SLM Improvement Plan.
[20] This measure targets a 3% relative reduction from baseline.
[21] Baseline data Q3 2017/18.
[22] The Ministry of Health expects DHBs to work toward achieving the target of <0.1 per live births by 2025.
[23] Baseline data is at December 2019. This is a 12-month running total.
[24] Measure is demand driven – not appropriate to set target.

On a continuum of care these services are at the complex end of treatment services and focussed on individuals. Intensive assessment and treatment services are aligned with our **Healthy Services** strategic objective that is focused on excellent, collaborative, high quality and safe health services.

Performance Measure			Baseline 2018/19	Target 2020/21	Notes
Mental Health					
Percentage of population who access mental health services[25]	Age 0-19 years	Total	3.9%	3.9%[26]	C
		Maaori	5.9%	5.8%[27]	
		Other	N/A	3.4%[28]	
	Age 20-64 years	Total	3.9%	3.9%[29]	
		Maaori	9.3%	9.0%[30]	
		Other	N/A	3.1%[31]	
	Age 65+ years	Total	2.0%	2.2%	
		Maaori	2.7%	3.0%	
		Other	N/A	2.1%[32]	
Proportion of people referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks for 0-19 years	Mental Health (Hospital	3 weeks	70%	80%	T
		8 weeks	89%	95%	
	Addictions (Hospital Care Arm	3 weeks	99%	80%	
		8 weeks	100%	95%	
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[33]		Total	72%	95%	T
Reduce the rate of Maaori per 100,000 population under the Mental Health Act: section 29 community treatment orders		Total	94	N/A	T
		Maaori	334	301[34]	
Elective Services					
	Inpatient treatments		5,088	20,185	

[25] The 2020/21 access targets for 0-19 year olds and 20-64 year olds are higher than the 2019/20 access targets as we have exceeded our targets for each group except age 65+.
[26] In 2019/20 this target was 3.10%.
[27] In 2019/20 this target was 4.25%.
[28] Other category is new for 2020/21 annual plan
[29] In 2019/20 this target was 3.10%.
[30] In 2019/20 this target was 7.50%.
[31] Other category is new for 2020/21 annual plan
[32] Other category is new for 2020/21 annual plan
[33] Source: www.mhakpi.health.nz. CM Health is in the process of developing a suite of mental health and wellbeing measures. As these measures are being developed, the timeliness of post-acute discharge community care contact being made provides a reasonable indication of how our MHA inpatient and community services are performing.
[34] The 2020/21 target represents a 10% decrease from baseline by Q4 2020/21.

Performance Measure			Baseline 2018/19	Target 2020/21	Notes
Planned Care Measure 1: Planned Care Interventions[35]	Minor interventions		3,743	10,611	V
	Non-surgical alternatives		0	326	
Acute Services					
Readmissions – acute readmissions to hospital		0-3 days	2.3%[36]	≤2.3%	V
		0-28 days	10.4%	≤10.7%	
Inpatient average length of stay		Acute LOS	2.75 days	2.3 days	Q
		Elective LOS	1.59 days	1.50 days	
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours			80%	95%	T
Cancer Services					
Proportion of patients who receive their first 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		Total	83%	90%	T
Cardiac Services					
Percentage of high-risk patients who receive an angiogram within 3 days of admission		Total	60%	>70%	T
		Maaori	46%		
		Pacific	60%		
		Other	59%		
Stroke Services					
Percentage of potentially eligible stroke patients thrombolysed			13.3%	10%	C
Quality and patient safety					
Percentage of admissions with hospital acquired complication			1.9%[37]	<2.3%	Q
Rate of falls with major harm per 1000 bed days			0.04[38]	<0.04	Q
Percentage of inpatients (aged 75+) assessed for risk of falling			95%[39]	90%	Q

[35] This was a new measure for 2019/20. Baseline data is from Q1 2019/20. The targets have not been updated for 20/21 as this information is taken from the funding envelope and price volume schedule. There are negotiations underway with the Ministry of Health.
[36] Baseline data for this measure is year to June 2019.
[37] Baseline as at Quarter 3 2018/19..
[38] Baseline is year to June 2019.
[39] Result is as at Quarter 3 2018/19.

Performance Measure		Baseline 2018/19	Target 2020/21	Notes
Rate of S. aureus bacteraemia (SAB) per 1000 bed days		0.09[40]	<0.09	Q
Compliance with good hand hygiene practice		88%	80%[41]	Q
System Level Measures				
Acute hospital bed days per capita (standardised) [42]	Maaori	707.5[43]	686.3[44]	SLM
	Pacific	740	717.8	Q

1.6 Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for a range of services including day care, home-based support services and residential care services. Rehabilitation services are provided by specialised multidisciplinary teams overseen by a Geriatrician and/or Rehabilitation Medicine Specialist Medical Officer. On a continuum of care these services will provide support for individuals. Rehabilitation and support services are aligned to our **Healthy People, Whaanau and Families** strategic objective which is focused on supporting people, whaanau and families to stay well and live independently in the community

Performance Measure		Baseline 2018/19	Target 2020/21	Notes
Age Related Residential Care (ARRC)				
Percentage of people in ARRC who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of previous assessment		92%	95%	T
Percentage of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI Home Care assessment tool in the six (6) months prior to that first LTCF assessment		88%	90%	T
Home Based and Community Support				
Percentage of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan.		97%	95%	Q
Assessment, Treatment and Rehabilitation Services				
Number of older people that have received in-home strength and balance retraining services	Aged 65+	588	1,118	V

[40] Baseline is year to June 2019.
[41] Currently, the national hand hygiene compliance target for DHBs is set at 80 percent by HQSC. CM Health achieved the target as at June 2019 with 88% compliance.
[42] In line with the equity focus of the 2018/19 planning guidance, the targets for reducing bed days in the 2018/19 SLM Plan are for Māori and Pacific populations specifically.
[43] Baseline data is at December 2019 to align with the 2020/21 Metro Auckland SLM Improvement Plan.
[44] This measure targets a 3% relative reduction from baseline.

Performance Measure		Baseline 2018/19	Target 2020/21	Notes
Number of older people that have received community / group strength and balance retraining services	Aged 65+	1530	1,400	V
Total number of offerings per class for community group strength and balance retraining services	Aged 65+	1,723	2,325 places	
Number of older people that have been seen by the Fracture Liaison Service (FLS) or similar fracture prevention service	Aged 50-74	639	600	V
	Aged 75-84	424	300	
	Aged 85+	361	300	
Palliative care[45]				
Number of Palliative Pathway Activations (PPAs) in Counties Manukau		123	552[46]	V
Number of Hospice Proactive Advisory conversations between the hospice service, primary care and ARRC health professionals		113	552[47]	V

[45] The following measures are part of the regional Better Palliative Care Outcomes Service which has been implemented and delivered in the Auckland Region from 2017/18. This service implements a system-based approach to enable six hospices across the Auckland region to work together with the Metro Auckland DHBs, Age Related Residential Care (ARRC) and primary care stakeholders to achieve better palliative care outcomes for those with a terminal illness and their families regardless of where in the system palliative care is provided.
[46] The target for 2019/20 was 866. Targets for both PPAs and conversations were agreed as part of innovation funding with MoH for palliative care in 2018/19. Contract targets have subsequently been revised (lowered) as better data has been provided to estimate the need of palliative care in primary care.
[47] The target for2019/20 was 866. Targets for both PPAs and conversations were agreed as part of innovation funding with MoH for palliative care in 2018/19. Contract targets have subsequently been revised (lowered) as better data has been provided to estimate the need of palliative care in primary care.

1.7 Output classes

The following tables provide a prospective summary of revenue and expenses by Output Class and should be viewed with reference to the financial narrative in section 2.0.

Prevention

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**47,332**	**48,582**	**49,989**	**50,117**
Personnel costs	25,174	25,677	26,191	25,677
Outsourced Services	1,035	1,056	1,077	1,056
Clinical Supplies	4,326	4,413	4,501	4,413
Infrastructure & Non-Clinical Supplies	1,526	1,557	1,588	1,557
Other	15,271	15,879	16,632	17,414
Total Expenditures	**47,332**	**48,582**	**49,989**	**50,117**
Net Surplus (Deficit)	-	-	-	-

Early detection and management

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**278,591**	**289,723**	**301,519**	**313,233**
Personnel costs	967	986	1,006	986
Outsourced Services	40	41	41	41
Clinical Supplies	166	169	173	169
Infrastructure & Non-Clinical Supplies	59	60	61	60
Other	277,359	288,467	300,238	311,977
Total Expenditures	**278,591**	**289,723**	**301,519**	**313,233**
Net Surplus (Deficit)	-	-	-	-

Intensive assessment and treatment

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**1,423,520**	**1,519,336**	**1,608,197**	**1,696,447**
Personnel costs	723,314	771,242	803,619	843,584
Outsourced Services	95,821	106,929	111,295	112,275
Clinical Supplies	135,467	140,586	143,940	151,469
Infrastructure & Non-Clinical Supplies	150,362	159,113	168,100	183,468
Other	348,435	370,693	395,503	419,911
Total Expenditures	**1,453,399**	**1,548,563**	**1,622,457**	**1,710,707**
Net Deficit	**(29,879)**	**(29,227)**	**(14,260)**	**(14,260)**

Rehabilitation and support

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**198,305**	**209,021**	**222,120**	**235,422**
Personnel costs	14,138	14,420	14,709	14,420
Outsourced Services	581	593	605	593
Clinical Supplies	2,430	2,478	2,528	2,478
Infrastructure & Non-Clinical Supplies	857	874	892	874
Other	180,299	190,656	203,386	217,057
Total Expenditures	**198,305**	**209,021**	**222,120**	**235,422**
Net Surplus (Deficit)	-	-	-	-

Total

	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Total Revenue	**1,947,748**	**2,080,973**	**2,196,198**	**2,309,657**
Personnel costs	763,593	807,325	845,525	884,667
Outsourced Services	97,477	108,619	113,018	113,965
Clinical Supplies	142,389	147,646	151,142	158,529
Infrastructure & Non-Clinical Supplies	152,804	161,604	170,641	185,959
Other	821,366	865,746	915,872	966,537
Total Expenditures	**1,977,629**	**2,090,940**	**2,196,198**	**2,309,657**
Net Deficit	**(29,879)**	**(9,967)**	-	-

2. Financial performance

2.1 Introduction

CM Health remains fully committed to achieving the Government's priorities, despite the increasing fiscal constraints the health sector is facing. Capacity pressures associated with unprecedented growth in the demand for clinical services have placed significant strain on current budgets and staff across the system. Even when allowing for implementation of change and innovations to increase efficiency, projected increases in demand across the health system in the coming years will be difficult to accommodate whilst maintaining fiscal sustainability. We also continue to accommodate cost pressures with respect to Multi Employer Collective Agreements (MECA) and related wage and salary increases.

While we are pleased to have received an additional $94m funding for the 2020/21 year, we are aware that our population remains undercounted for the purposes of the population based funding formula, impacting our revenue. In the 20/21 year, of the $107.2m million of additional funding received (PBFF and other funding streams i.e. ACC, MoH MECA and CFA agreements outside PBFF) $75.8m of new funding is committed to price increases, $25.2m committed to volume or demand driven growth in mental health, primary and community services and $14.89m is committed to hospital capacity. Much of this cost growth will not be funded by new revenue and will need to be met by savings within the core base.

Despite these circumstances, CM Health acknowledges the expectation from its Board and the MoH to work towards an underlying breakeven over 2 financial years. The current 2020/21 position is a deficit of $29.9m, reducing to breakeven by the end of 2022/23.

To reach our goals of deficit reduction, the approach to the 2020/21 budget has required considered trade-offs in what we choose to prioritise within the budget; at this point in the business cycle we have been unable to commit to additional spending in some areas which we would have liked to. Throughout 2020/21 we intend to regularly review our financial position and maintain a visible list of opportunities for further re-investment through savings elsewhere.

2.2 Forecast financial statements

2.2.1 Summary by funding arm

Net Result	2018/19 Audited Actual $ 000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Provider	(137,941)	(87,803)	(111,440)	(135,621)	(159,220)	(190,820)
Governance	1,361	(2,064)	(5,724)	(5,249)	(5,387)	(4,339)
Funder	(16,239)	33,296	87,285	130,903	164,607	195,159
Eliminations	-	-	-	-	-	-
Operating Deficit	**(152,819)**	**(56,571)**	**(29,879)**	**(9,967)**	**-**	**-**
Other Comprehensive Income	101,984	-	-	-	-	-
Deficit	**(50,835)**	**(56,571)**	**(29,879)**	**(9,967)**	**-**	**-**

Note: A funding increase assumption of $94m has been top sliced for Mental Health Ring fence and Inter District Flows. The residual balance will be allocated to the Provider based on volumes, with the remainder allocated to Governance and Funder based on proportionate net surplus (deficit).

2.2.2 Statement of comprehensive income

Net Result	2018/19 Audited Actual $000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Revenue						
Ministry of Health	1,588,449	1,713,095	1,780,012	1,908,005	2,017,778	2,125,554
Other Government	37,081	48,666	37,625	38,694	39,793	40,923
Other	43,524	44,811	44,753	45,845	46,968	48,123
Inter DHB and Internal	76,863	94,453	85,358	88,428	91,659	95,057
Total Revenue	**1,745,917**	**1,901,025**	**1,947,748**	**2,080,972**	**2,196,198**	**2,309,657**
Expenses						
Personnel	778,616	742,051	763,591	807,325	845,524	884,667
Outsourced	96,118	107,647	97,477	108,619	113,018	113,964
Clinical Support	124,202	131,630	133,615	138,013	140,756	145,175
Infrastructure	81,675	86,640	88,131	92,150	93,226	94,056
Personal Health	523,101	565,627	570,756	596,808	628,579	661,761
Mental Health	63,709	68,928	78,778	82,311	86,594	91,065
Disability Support	148,553	152,546	161,083	170,410	181,834	194,133
Public Health	8,783	25,915	7,871	8,186	8,591	9,012
Maaori	2,776	2,826	2,880	8,030	10,275	10,566
Operating Costs	**1,827,533**	**1,883,810**	**1,904,182**	**2,011,852**	**2,108,397**	**2,204,399**
Operating Surplus / (Deficit)	**(81,616)**	**17,215**	**43,566**	**69,120**	**87,801**	**105,258**
Depreciation	34,779	40,136	40,861	45,828	50,423	60,678
Capital Charge	36,424	33,625	32,512	33,185	37,302	44,502
Interest	-	25	72	74	76	78
Net Deficit	**(152,819)**	**(56,571)**	**(29,879)**	**(9,967)**	**-**	**-**
Other Comprehensive Income	101,984	-	-	-	-	-
Deficit	**(50,835)**	**(56,571)**	**(29,879)**	**(9,967)**	**-**	**-**

***Note**: Included in the 2018/19 audited result and 2019/20 unaudited result are additional provisions for the remediation of the areas of non-compliance in terms of the Holiday's Act.*

2.2.3 Funder

Revenue	2018/19 Audited Actual $000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Ministry of Health	1,539,361	1,660,554	1,729,703	1,854,653	1,961,382	2,066,115
Other Government	183	133	176	181	186	192
Other	779	779	779	779	779	779
Inter DHB and Internal	90,275	108,019	99,697	103,685	107,833	112,146
Total	**1,630,598**	**1,769,485**	**1,830,356**	**1,959,298**	**2,070,180**	**2,179,231**
Personal Health	1,283,084	1,339,555	1,345,966	1,408,294	1,462,338	1,518,470
Mental Health	156,429	167,732	177,273	183,603	190,763	198,192
Disability Support	180,637	184,632	193,167	203,406	215,767	229,029
Public Health	8,783	25,915	7,871	8,186	8,591	9,012
Maaori	2,776	2,826	2,880	8,030	10,275	10,566
Governance	15,128	15,529	15,914	16,876	17,839	18,802
Total Expenditure	**1,646,837**	**1,736,189**	**1,743,071**	**1,828,395**	**1,905,573**	**1,984,072**
Net Surplus / (Deficit)	**(16,239)**	**33,296**	**87,285**	**130,903**	**164,607**	**195,159**

2.2.4 Eliminations

Revenue	2018/19 Audited Actual $000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Ministry of Health	-	-	-	-	-	-
Other Government	-	-	-	-	-	-
Other	-	-	-	-	-	-
Inter DHB and Internal	899,915	920,348	921,703	962,650	989,700	1,017,535
Total	**899,915**	**920,348**	**921,703**	**962,650**	**989,700**	**1,017,535**
Personal Health	759,983	773,928	775,210	811,486	833,759	856,709
Mental Health	92,720	98,804	98,495	101,292	104,169	107,127
Disability Support	32,084	32,086	32,085	32,996	33,933	34,897
Public Health	-	-	-	-	-	-
Maaori	-	-	-	-	-	-
Governance	15,128	15,530	15,914	16,876	17,839	18,802
Total Expenditure	**899,915**	**920,348**	**921,703**	**962,650**	**989,700**	**1,017,535**
Net Surplus	**-**	**-**	**-**	**-**	**-**	**-**

2.2.5 Provider

Revenue	2018/19 Audited Actual $000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Ministry of Health	33,960	37,013	34,395	36,476	38,557	40,638
Other Government	35,950	48,533	37,449	38,513	39,606	40,731
Other	42,309	43,697	43,974	45,066	46,189	47,344
Inter DHB and Internal	886,503	906,781	907,364	947,393	973,526	1,000,445
Total	**998,722**	**1,036,024**	**1,023,183**	**1,067,448**	**1,097,878**	**1,129,159**
Personnel	767,951	730,941	750,386	793,825	831,721	870,552
Outsourced	95,094	106,051	94,103	105,149	109,449	110,293
Clinical Support	124,142	131,507	133,615	138,013	140,756	145,175
Infrastructure	78,273	81,542	83,074	86,995	87,371	88,701
Operating Costs	**1,065,460**	**1,050,041**	**1,061,177**	**1,123,982**	**1,169,297**	**1,214,721**
Operating Surplus	**(66,738)**	**(14,017)**	**(37,995)**	**(56,534)**	**(71,419)**	**(85,562)**
Depreciation	34,779	40,136	40,861	45,828	50,423	60,678

Capital Charge	36,424	33,625	32,512	33,185	37,302	44,502
Interest	-	25	72	74	76	78
Net Deficit	**(137,941)**	**(87,803)**	**(111,440)**	**(135,621)**	**(159,220)**	**(190,820)**
Other Comprehensive Income	101,984	-	-	-	-	-
Total Comprehensive Income	**(35,957)**	**(87,803)**	**(111,440)**	**(135,621)**	**(159,220)**	**(190,820)**

2.2.6 Governance

Revenue	**2018/19 Audited Actual $000**	**2019/20 Unaudited Actual $ 000**	**2020/21 Plan $ 000**	**2021/22 Plan $ 000**	**2022/23 Plan $ 000**	**2023/24 Plan $ 000**
Ministry of Health	15,128	15,528	15,914	16,876	17,839	18,802
Other Government	948	-	-	-	-	-
Other	436	335	-	-	-	-
Inter DHB and Internal	-	-	-	-	-	-
Total	**16,512**	**15,863**	**15,914**	**16,876**	**17,839**	**18,802**
Personnel	10,665	11,110	13,205	13,500	13,804	14,115
Outsourced	1,024	1,596	3,374	3,470	3,569	3,670
Clinical Support	60	123	-	-	-	-
Infrastructure	3,402	5,098	5,059	5,155	5,854	5,355
Total Expenditure	**15,151**	**17,927**	**21,638**	**22,125**	**23,227**	**23,141**
Net Surplus / (Deficit)	**1,361**	**(2,064)**	**(5,724)**	**(5,249)**	**(5,387)**	**(4,339)**

2.2.7 Balance Sheet

	2018/19 Audited Actual $000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Current Assets						
Cash and Bank	14,437	26,328	(1,016)	(9,751)	2,538	22,862
Trust Funds	843	837	837	837	837	837
Debtors	53,679	63,991	63,991	63,991	63,991	63,991
Inventory	8,868	11,305	11,305	11,305	11,305	11,305
Assets Held for Sale	5,320	5,320	5,320	5,320	5,320	5,320
Current Assets Total	**83,147**	**107,781**	**80,437**	**71,702**	**83,991**	**104,315**
Non-Current Assets	**881,179**	**919,622**	**948,641**	**1,020,381**	**1,142,720**	**1,229,759**
Total Assets	**964,326**	**1,027,403**	**1,029,078**	**1,092,083**	**1,226,711**	**1,334,074**
Current Liabilities						
Creditors	107,340	152,459	152,460	152,460	152,460	152,460
Loans	-	-	-	-	-	-
Employee Provisions	254,438	296,044	304,044	312,044	320,044	328,044
Total Current Liabilities	**361,778**	**448,503**	**456,504**	**464,504**	**472,504**	**480,504**
Working Capital	**(278,631)**	**(340,722)**	**(376,067)**	**(392,802)**	**(388,513)**	**(376,189)**
Net Funds Employed	**602,548**	**578,900**	**572,574**	**627,579**	**754,207**	**853,570**
Non-Current Liabilities						
Employee Provision	35,353	35,214	35,214	35,214	35,214	35,214
Term Loans	-	-	-	-	-	-
Restricted funds	836	837	837	837	837	837
Other	1,035	1,190	1,190	1,190	1,190	1,190
Total Non-Current Liabilities	**37,224**	**37,241**	**37,241**	**37,241**	**37,241**	**37,241**
Crown Equity	**565,324**	**541,659**	**535,333**	**590,338**	**716,966**	**816,329**
Net Funds Employed	**602,548**	**578,900**	**572,574**	**627,579**	**754,207**	**853,570**

2.2.8 Movement of equity

	2018/19 Audited Actual $000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Total Equity at beginning of Period	**614,804**	**565,324**	**541,659**	**535,333**	**590,338**	**716,966**
Deficit for period	(152,819)	(56,571)	(29,879)	(9,967)	-	-
Crown Equity injection	1,774	33,325	23,963	65,394	127,038	99,779
Crown Equity withdrawal	(419)	(419)	(419)	(419)	(419)	(419)
Revaluation Reserve	101,984	-	-	-	-	-
Movement in restricted funds	-	-	-	-	-	-
Other movements	-	-	9	(3)	9	3
Total Equity at end of Period	**565,324**	**541,659**	**535,333**	**590,338**	**716,966**	**816,329**

2.2.9 Cashflow

	2018/19 Audited Actual $000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Operating Activities						
Crown Revenue	1,574,724	1,705,071	1,764,757	1,891,785	2,000,594	2,107,404
Other	170,027	199,280	181,982	188,187	194,604	201,253
Interest rec.	1,725	1,007	1,000	1,000	1,000	1,000
Suppliers	(1,047,790)	(1,131,897)	(1,140,665)	(1,204,607)	(1,262,947)	(1,319,807)
Employees	(651,668)	(701,537)	(755,591)	(799,325)	(837,524)	(876,667)
Interest paid	-	-	-	-	-	-
Capital charge	(36,424)	(33,462)	(32,512)	(33,185)	(37,302)	(44,502)
GST (Net)	383	901	-	-	-	-
Net cash from Operations	**10,977**	**39,363**	**18,972**	**43,855**	**58,425**	**68,681**
Investing activities						
Sale of Fixed assets	433	62	10	-	-	-
Total Fixed Assets	(29,210)	(59,856)	(69,258)	(117,564)	(172,755)	(147,717)
Investments and Restricted Trust Funds	(2,377)	(588)	(612)	-	-	-
Net cash from Investing	**(31,154)**	**(60,382)**	**(69,860)**	**(117,564)**	**(172,755)**	**(147,717)**
Financing						
Crown Debt	-	-	-	-	-	-

Equity – Capital	1,355	32,906	23,544	64,975	126,619	99,360
Net appropriation to/from Trust funds	-	(2)	-	-	-	-
Net cash from Financing	**1,355**	**32,904**	**23,544**	**64,975**	**126,619**	**99,360**
Net increase / (decrease)	(18,822)	11,885	(27,344)	(8,734)	12,289	20,324
Opening cash	**34,102**	**15,280**	**27,165**	**(179)**	**(8,914)**	**3,375**
Closing cash	**15,280**	**27,165**	**(179)**	**(8,914)**	**3,375**	**23,699**

2.2.10 Capital expenditure

	2018/19 Audited Actual $000	2019/20 Unaudited Actual $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000	2023/24 Plan $ 000
Baseline Capital	24,604	18,099	49,187	38,982	41,455	42,117
Strategic Capital	4,606	41,757	20,071	78,582	131,300	105,600
Total	**29,210**	**59,856**	**69,258**	**117,564**	**172,755**	**147,717**

2.3 Accounting policies

The forecast financial statements have been prepared on the basis of the significant accounting policies, which are expected to be used in the future for reporting historical financial statements. The significant accounting policies used in the preparation of these forecast financial statements included in this Annual Plan are summarised below. A full description of accounting policies used by CM Health for financial reporting is provided in the Annual Reports that are published on the CM Health website: https://countiesmanukau.health.nz

2.3.1 Reporting entity

CM Health is a Crown entity as defined by the Crown Entities Act (2004) and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown. CM Health has designated itself and the group as a public benefit entity (PBE) for financial reporting purposes. CM Health's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions e.g. laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services for the district.

The forecast consolidated financial statements of CM Health comprise our interest in associates and jointly controlled entities. The CM Health group consists of the parent, CM Health and its Joint ventures healthAlliance N.Z. Limited (25 percent); HealthSource New Zealand Limited (25 percent) and NZ Health Partnerships Limited (5 percent). It has an Associate investment in Northern Regional Alliance Limited (33.3 percent). The DHB's associates and joint venture are incorporated and domiciled in New Zealand.

2.3.2 Basis of preparation

The forecast financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

2.3.3 Statement of compliance

The forecast financial statements of the DHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act (2000) and the Crown Entities Act (2004), which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). These forecast financial statements have been prepared in accordance with *PBE-FRS 42: Prospective Financial Statements*. These forecast financial statements comply with Public Sector PBE accounting standards. The forecast financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

2.3.4 Presentation currency and rounding

The consolidated forecast financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

2.3.5 Forecast information

In preparation of the forecast financial statements, the DHB has made estimates and assumptions concerning future events. The assumptions and estimates are based on historical factors and other factors including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions may differ from subsequent actual results.

The financial statements for the year ended 30 June 2020 are the unaudited actual result at the time of publishing.

The accounting policies applied in the projected financial statements are set out in section 2.6

2.4 Significant assumptions

2.4.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2020/21 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing un-utilised/approved debt facilities.

Where previously there appeared to be significant opportunity to continue to improve efficiencies and limit the cost impact of growth, the current outlook provides much more limited opportunities in these historical areas.

In response, CM Health has taken a whole of system approach to value creation, quality and safety, productivity enhancement and efficiency. This approach includes consistent focus on clinical leadership, process realignment, integration and new models of care.

2.4.2 Personnel costs

Despite the international economic position, the anticipated level of clinical wage settlements will continue to be an on-going challenge in relation to the mismatch of health worker wage/salary expectations and affordability. The annualised on-going cost of settlement is 1.9 percent – 5 percent due to automatic on-going step functions, on-cost implications and increasing entitlements. Combined, these costs are greater than the Crown Funding growth and need to be absorbed by internal efficiencies and other initiative savings. Acknowledging the State Service Commission advice following COVID, assumptions for 2020/21 have been applied at 1.9%.

We continue to manage management and administration FTEs. Despite this, we have prioritised personnel costs to support acceleration of essential health system integration, whole of system programmes and related activities. This requires commitment to project, programme, analytical and change management resource to be successful.

2.4.3 Third party and shared services provision

Our focus for 2020/21 continues to be alignment of localities development and related primary care/community services. The form that investment will take is still evolving and there is an expectation of increased third party participation and provision of public services integrated with core/essential CM Health services. Regional service planning and the Northern Region Long Term Investment Plan priorities will inform this.

Capital investment constraints and increasing health target expectations are likely to require a closer look at third party and shared regional capacity expansion. This will include a strong direction regarding increased provision of shared services, through HealthSource New Zealand Limited (HealthSource) with heightened reliance around realisation of tangible savings.

2.4.4 Supplies

CM Health is working very closely with and contributing to, the national procurement and supply chain efficiency objectives. Regional efficiencies through shared services provided by HealthSource will be included in our living with our means projects.

2.4.5 Services by other DHBs and regional providers

There is a significant commitment to regional cooperation and alignment of service provision to reduce wastage from unnecessary variation and better leverage our collective expertise. CM Health contributes to the regional Service Review Group, Clinical Networks and range of other forums to support effective service delivery across the metropolitan Auckland region.

The continuing commitment (albeit constrained) to investment in priority initiatives aligned with the Northern Region Health Plan and Long Term Investment Plan; including those focused on slowing the growth of hospital services and the improving quality and consistency of care.

2.4.6 Other primary and community care contracts

Historically there has been Mental Health under-spends which are essentially timing issues rather than permanent under-spends. These benefits have been approved to fund urgently needed mental health facilities planned for 2018/19 to 2020/21.

Publicly ACC has indicated a tighter fiscal affordability envelope and as well, a tightening of their payment parameters. While this is difficult to quantify currently, CM Health expects to offset any downside by further opportunities or enhancement of existing contracts.

2.4.7 Enabling technology infrastructure

Prioritised Information System (IS) infrastructure (technology) investment has been agreed regionally and funded by healthAlliance and is essential for health system business continuity and effective implementation of integration models of care between secondary and primary/community care settings. The capital commitment for the regional DHBs collectively is significant. This investment will target IS infrastructure resilience that will provide a sound foundation for shared clinical and business information systems. Refer to the Data and Digital Priority in Section 2.7.6 and Section 4.5.2 of the Annual Plan for an outline of regional IS investments and local innovations. The net financial impacts will include both capital and operational costs.

2.4.8 Capital investment

CM Health's Long Term Investment Plan supports the strategic priority to move away from reliance on physical brick and mortar solutions to manage capacity growth and adopt whole of system solutions with a focus on community based service expansion. The realities of high hospital service demand now mean we need to augment this strategic priority with a regional approach to investments to address urgent inpatient bed capacity and related hospital services and site investments. Development of the Northern Regional Long Term Investment Plan (NRLTIP) is evaluating where and when potential new hospital sites will be required to manage the region's significant future growth. Regional service planning continues to seek opportunities to leverage regional capacity as a means of meeting short to medium term demand for health services.

CM Health's changing financial position has required a reassessment of local capital investment prioritisation. Figure 1 below illustrates the likely cash-flow profile for major capital projects approved or currently within the pathway for approval. This includes:

- a new 76-bed acute mental health facility approved in the 2015/16 year with construction and commissioning continuing through to 2020/21 for Stage 2 (due for completion in September 2020) (Stage 1 was commissioned November 2018).
- a business case for increased capacity at Manukau Health Park incorporating additional Theatres, Outpatients, Radiology and the enabling infrastructure costs.

Figure 2 below outlines likely major capital (projects greater than $5m) investment projects, which are dependent on confirmation of Northern Region Long Term Investment Plan priorities, related service change reviews in progress and confirmation of affordability. These investments reflect a mix of repair for existing facilities, expansion to meet service capacity demands and model of care changes for future sustainability.

Once the abovementioned evaluation is complete Counties Manukau District Health Board will submit the detailed business cases to the Northern Region governance groups, then onto the MOH and Treasury. Many capital investments require regional service review processes to ensure the most effective allocation of resources and quality of service. Local and regional Information and Communication Technology investments are planned regionally through the Regional Information Services Strategic Plan.

Figure 1: Approved Major Facilities Capital Projects >$5m as presented in the 2020/21 – 2023/24 Annual Plan

Major Facilities Project	Planned Funding Source	Unaudited actual 2019/20 $000	2020/21 $000	Year 2-5 $000	Year 6-10 $000	Outer years > 10 years	Total $000
Acute Mental Health Unit	Crown	27,169	-	-	-	-	27,169
Scott Building Recladding	Crown + CM Health	14,544	9,674	3,282	-	-	27,500
Scott Dialysis & Cath Lab	CM Health	550	1,139	14,418	-	-	16,107
Gastroenterology Expansion	CM Health	363	5,529	981	-	-	6,873
Harley Gray Radiology Relocation	Crown	200	918	20,882	-		22,000
Manukau Health Park - Phase 1	Crown + CM Health	3,400	5,140	215,890	4,590	2,000	231,020
Building recladding - Kidz First, McIndoe and Manukau Elective Surgical Hospital	Crown	250	1,450	53,300	-	-	55,000
Neonates (additional cots)	Crown	-	4,929	71	-	-	5,000
Core Infrastructure (Galbraith - phase 1)	Crown	250	1,750	16,000	2,000	-	20,000
Sub Totals		**46,726**	**30,529**	**324,824**	**6,590**	**2,000**	**410,669**

Figure 2: Unapproved Major Facilities Capital Projects >$5m

Major Facilities Project	Planned Funding Source	Unaudited actual 2019/20 $000	2020/21 $000	Year 2-5 $000	Year 6-10 $000	Outer years > 10 years	Total $000
Grow Manukau							
Phase 2							
Infrastructure	Crown	-	-	-	88,868	27,470	116,338
Support Services	Crown	-	-	-	63,000	-	63,000
Outpatients	Crown	-	-	-	127,550	31,330	158,880
Radiology Hub	Crown	-	-	-	24,000	-	24,000
Community Incentre Dialysis	Crown	-	-	6,827	-	-	6,827
Elective Surgery Centre	Crown	-	-	-	156,000	132,000	288,000
Immediate Remediation							
Otara Spinal Unit and Adult Rehabilitation Replacement	Crown + CM Health	1,000	250	48,950	41,100	-	91,300
Grow Middlemore							
Replace Galbraith & growth							
Maternity & Gynaecology (100 beds)	Crown	-	250	32,700	77,050	-	110,000
Inpatient Ward block (6 wards)	Crown	-	-	-	176,000	-	176,000
Critical Infrastructure (MMH - phase 2)	Crown	-	-	15,000	55,000	-	70,000
Expand Infusion and oncology (18 chairs)	Crown	-	-	-	12,400	-	12,400
Colvin Replacement (scope to be confirmed)	Crown	-	-	-	-	-	-
Theatres & radiology expansion (Harley Gray - Stage 2)	Crown	-	-	30,400	65,600	-	96,000
ED and Critical Care refurbishment and expansion	Crown	-	-	48,000	96,000	-	144,000
Helipad	Crown	-	-	-	10,000	-	10,000
Cath lab (additional capacity)	Crown	-	-	-	40,000	-	40,000
Gastro procedure theatres (additional capacity)	Crown	-	-	-	10,000	-	10,000
Middlemore Carparking	Crown	-	-	14,350	10,250	-	24,600
Whanau support / accomodation (10 suites)	Crown + Donations	-	-	-	5,000	-	5,000
Grow community hubs							
Franklin Hub	Crown	-	-	4,363	4,363	-	8,726

Botany Hub and replace Primary Maternity unit	Crown	-	-	-	43,449	-	43,449
Otara Hub and replace Tamaki Oranga (Adult Mental Health)	Crown	-	-	-	37,542	-	37,542
Manukau Hub	Crown	-	-	5,567	-	-	5,567
Papakura Hub and replace Primary Maternity unit	Crown	-	-	19,353	25,000	-	44,353
New Acute Hospital							
Southern site land acquisition	Crown	-	-	48,000	-	-	48,000
New Southern Hospital Stage 1	Crown	-	-	-	240,000	720,000	960,000
New Southern Hospital Stage 2	Crown	-	-	-	-	246,000	246,000
Sub Totals		**1,000**	**500**	**273,510**	**1,408,172**	**1,156,800**	**2,839,982**

2.4.9 Capital investment funding

Capital investment will be funded from a number of sources including working capital, crown funding and operating surpluses.

2.4.10 Banking

CM Health operates under no banking covenant; all previous crown debt has now been converted to Equity. The Counties Manukau District Health Board maintains a working capital facility with New Zealand Health Partnerships via the Bank of New Zealand, together with lease/finance facilities with both Commonwealth Bank and Westpac.

Figure 1: Banking facilities

Facilities	Available Facility at 1 July 2020 $000,000
NZ Health Partnerships (working capital)	$75.5
Lease facilities	$15.0

2.4.11 Property, plant and equipment

CM Health revalues property, plant and equipment in accordance with the Public Benefit Entity International Public Sector Accounting Standard 17: Property, Plant and Equipment. CM Health land and buildings are revalued every five years or where there is a material change. The last revaluation occurred in 30 June 2019 on an 'Optimised Depreciated Replacement Costs' basis.

There is recognition of the rising burden of clinical equipment replacement and this has accelerated CM Health's commitment to an Enterprise Asset Management System, with continued roll out in 2020/21.

2.5 Additional Information and Explanations

2.5.1 Disposal of land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, CM Health will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. CM Health will comply with the relevant protection mechanism that addresses the Crown's obligations under the Treaty of Waitangi and any processes related to the Crown's good governance obligations in relation to Maaori sites of significance.

2.6 Significant Accounting Policies

Subsidiaries

Subsidiaries are entities controlled by Counties Manukau DHB. Counties Manukau DHB does not have any subsidiaries to consolidate.

Investments in Associates and Jointly Ventures

Associates are those entities in which Counties Manukau DHB has significant influence, but not control, over the financial and operating policies. Significant influence is presumed to exist when Counties Manukau DHB holds between 5-33 percent of the voting power of another entity. Joint ventures are those entities over whose activities Counties Manukau DHB has joint control, established by contractual agreement and requiring unanimous consent for strategic financial and operating decisions. Associates and Joint Ventures are not accounted for using the equity method or proportionate method, as they are not material.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

MOH Revenue

Funding is provided by the MOH through a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the Appropriation equally throughout the year.

The revenue recognition approach for MOH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantially linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as Counties Manukau DHB provides the service.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied.

ACC Contract Revenues

ACC contract revenue is recognised as revenue when eligible services are provided and contract conditions have been fulfilled.

Rental revenue

Rental revenue is recognised as revenue on a straight-line basis over the term of the lease.

Revenue relating to service contracts

Revenue from services rendered is recognised in profit or loss in proportion to the stage of completion of the transaction at the reporting date. The stage of completion is assessed by reference to surveys of work performed.

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Counties Manukau DHB region is domiciled outside of Counties Manukau. The MOH credits Counties Manukau DHB with a monthly amount based on estimated patient treatment for non-Counties Manukau residents within Counties Manukau. An annual wash-up occurs at year end to reflect the actual number of non-Counties Manukau patients treated at Counties Manukau DHB.

Interest revenue

Interest revenue is recognised using the effective interest method.

Donations and bequests

Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/(deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit prior to other comprehensive income and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Interest expense

Borrowing costs are recognised as an expense in the financial year in which they are.

Leases

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit prior to other comprehensive income over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty that the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit prior to other comprehensive income over the lease term as an integral part of the total lease expense.

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.

Bank overdrafts are shown as borrowings in current liabilities in the statement of financial position.

Debtors and other receivables

Debtors and other receivables are recorded at their face value, less provision for impairment.

A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired.

The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

A bank deposit is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the bank, probability that the bank will enter into receivership or liquidation, and default in payments are considered indicators that the deposit is impaired.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. The loss of service potential of inventories held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the lower of cost or replacement cost at the date of acquisition.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit prior to other comprehensive income in the period of the write-down.

Non-Current assets held for sale

Non-Current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-Current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of Non-Current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-Current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

Property, plant, and equipment consist of the following asset classes:

- land;
- buildings, plant and infrastructure;
- clinical equipment, IT and motor vehicles;
- other equipment; and
- work in progress.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years.

The carrying values of land and buildings are assessed annually by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive income and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit prior to other comprehensive income will be recognised first in the surplus or deficit prior to other comprehensive income up to the amount previously expensed, and then recognised in other comprehensive income.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The cost of self-constructed assets includes the cost of materials, direct labour, the costs of dismantling and removing the items and restoring the site on which they are located if relevant, an appropriate proportion of direct overheads and capitalised borrowing costs.

Work in progress is recognised at cost, less impairment, and is not depreciated.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit prior to other comprehensive income as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Figure 2: Depreciation rates of assets

Class of Asset	Estimated Life	Depreciation Rate
Buildings		
Structure/Envelope	5 - 100 years	1% - 20%
Electrical Services	5 - 15 years	6% - 20%
Other Services	5 - 25 years	4% - 20%
Fit out	5 - 10 years	10% - 20%
Infrastructure	2 - 100 years	1% - 50%
Plant and equipment	5 - 10 years	10% - 20%
Clinical Equipment	1 - 15 years	6% - 100%
Information Technology	1 - 8 years	12.5% - 100%
Vehicles	1 – 12.5 years	8% -100%
Other Equipment	1 - 14 years	7% - 100%

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Finance Procurement and Information Management System (FPIM)

The Finance Procurement and Information Management System (FPIM) is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. CMDHB holds an asset at cost of capital invested by CMDHB in the FPIM Programme. This investment represents the right to access the FPIM assets and are considered to have an indefinite life. DHBs have the ability and intention to

review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows: Acquired computer software 2-5 years (20 percent – 50 percent)

Impairment of Property, Plant & Equipment and Intangible Assets

Counties Manukau DHB does not hold any cash generating assets. Assets are considered cash generating where their primary objective is to generate a commercial return.

Property, Plant & Equipment and Intangible Assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the service potential of the asset is not primarily dependent on the asset's ability to generate net cash inflows and where the DHB would, if deprived of the asset, replace its remaining service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

For assets not carried at re valued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Creditors and other payables

Creditors and other payables are generally settled within 30 days so are recorded at their face value.

Borrowings

Borrowings are initially recognised at their fair value. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past, practice that has created a constructive "obligation".

Long-term entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as sick leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- Likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- The present value of the estimated future cash flows.

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows for entitlements. The inflation factor is based on the expected long-term increase in remuneration for employees.

Presentation of employee entitlements

Continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, retirement gratuities and sick leave expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

Employer contributions to Kiwi Saver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit prior to other comprehensive income as incurred.

Defined benefit scheme

Counties Manukau DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit in the plan will affect future contributions by individual employers, because there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditure will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are not recognised for future operating losses.

Restructuring

A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Partnership Programme

The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of four years up to a specified maximum amount. At the end of the four-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date.

Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Revaluation reserves

These reserves are related to the revaluation of land and buildings to fair value.

Trust funds

This reserve records the unspent amount of donations and bequests provided to the DHB.

Goods and services tax

All items in the forecast financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense. The GST (net) component of cash flows from operating activities reflects the net GST paid to and received from the IRD. The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for the forecast financial statement purposes and to be consistent with the presentation basis of the other primary forecast financial statements.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

The DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

Cost Allocation

Counties Manukau DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

- Direct costs are those costs directly attributable to an output class.
- Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.
- Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.
- The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these forecast financial statements, the Board has made estimates and assumptions concerning the future.

These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Land and buildings revaluations

The significant assumptions applied in determining the fair value of land and buildings.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed.

Assessing the appropriateness of useful life and residual value estimates requires the DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the DHB, and expected disposal proceeds (if any) from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit prior to other comprehensive income and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets
- Asset replacement programs

- Review of second-hand market prices for similar assets; and
- Analysis of prior asset sales

The DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Retirement and long service leave

Retirement and long service leave provisions are subject to a number of estimates and uncertainties surrounding the timing of retirement and the uptake.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

The DHB has exercised its judgement on the appropriate classification of leases, and has recognised no leases as finance leases.

Agency relationship

Determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sale of goods or the rendering of services. This judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.

For a number of contracts Counties Manukau DHB makes payments to the service providers on behalf of the DHBs receiving services. These DHBs will then reimburse Counties Manukau DHB for the costs of the services provided in their districts. Where Counties Manukau DHB has assessed that it has acted as an agent for the other DHBs, payments and receipts in relation to the other DHBs are not recognised in the Counties Manukau DHB forecast financial statements.

Appendix 2: System Level Measures Improvement Plan

System Level Measures Improvement Plan

Auckland, Waitemata &
Counties Manukau Health Alliances

2020
2021

FINANCIAL YEAR

***Tawhiti rawa tō tātou haerenga te kore haere tonu, maha rawa wā tātou mahi te kore mahi tonu*.**

We have come too far to not go further and we have done too much to not do more.

– Sir James Henare

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CONTENTS

1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (the Alliances) have jointly developed a 2020/21 System Level Measures Improvement Plan.

Continuing with the *one team* theme in the New Zealand Health Strategy, the joint approach to development of the single improvement plan will ensure streamlined activity and reporting, and best use of resources within the health system.

Extensive consultation was carried out across the sector in the development of the 2018/19 System Level Measures Improvement Plan. This year's plan is a further consolidation of the 2018/19 plan. The Covid-19 pandemic has had a significant impact on the delivery of the SLM programme. Primary care capacity to engage with a broad plan has been reduced. The 2020/21 plan has been through a prioritisation process to focus on post-pandemic priorities. Some activities have been removed from the current plan and will be reintroduced in subsequent plans.

Some activities have been removed as they have been successfully achieved. Some have been found to be impractical or not easily measurable. These too have been removed. Activities have been included where they can be expected to contribute to milestone measures over a three year time frame. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement.

New contributory measures have been added where data collection processes have been developed in response to identified clinical priorities. Examples of this include alcohol harm reduction and smoking cessation rates. An extensive stocktake of activity against the 2018/19 plan, across primary and secondary care allowed stakeholders to contribute to the prioritisation of activities in the current plan.

The Alliances are firmly committed to including additional well-aligned contributory measures over a three year timeframe, as the structures, systems and relationships to support improvement activities are further embedded. This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples.

The district health boards (DHBs) included in this improvement plan are:

- Auckland DHB;
- Waitematā DHB, and
- Counties Manukau DHB.

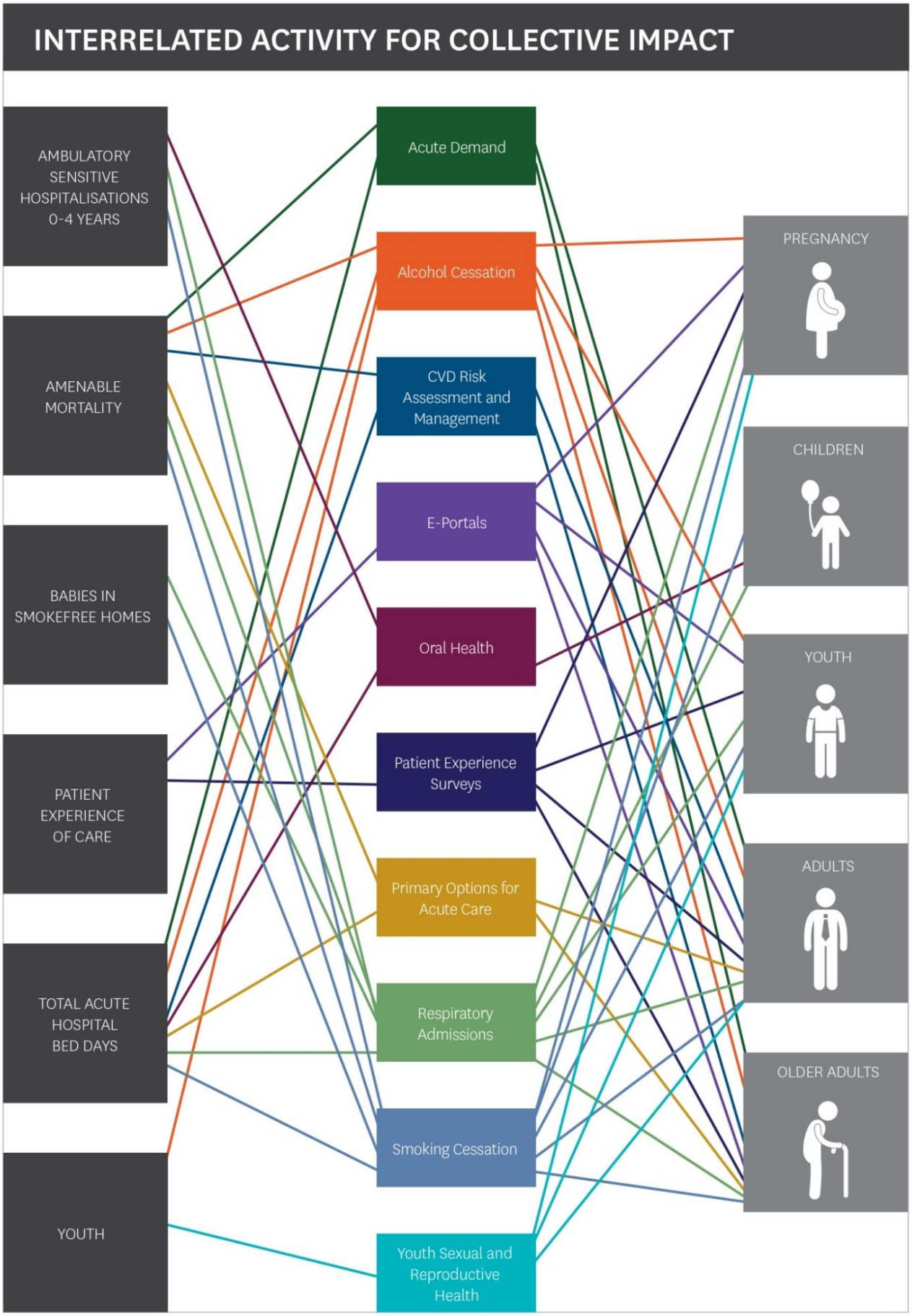
The primary health organisations (PHOs) included in this improvement plan are:

- Alliance Health Plus Trust;
- Auckland PHO;
- East Health Trust;
- National Hauora Coalition;
- ProCare Health (PHO) Limited;
- Total Healthcare PHO, and
- Comprehensive Care.

The diagram below shows an overview of the relationship between milestones and key activities chosen for the Metro Auckland System Level Measures, and the stage of life they represent. The current plan will maintain this approach of supporting activities and contributory measures that will have impact on multiple milestones.

The plan continues to promote a prevention approach and a strong focus on improving equity of outcome for Māori and other populations with high health need across the greater Auckland region.

2. INTERRELATED ACTIVITY FOR COLLECTIVE IMPACT



3. PURPOSE

This document outlines how the 2020/21 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the activities that will be fundamental to this improvement. Please note that, as further discussed in section 4, implementation planning is developed annually to sit under this document to provide a higher level of detail.

4. BACKGROUND

The New Zealand Health Strategy outlines a high-level direction for New Zealand's health system over 10 years to 2026, to ensure that all New Zealanders live well, stay well and get well. One of the five themes in the strategy is 'value and high performance' 'te whāinga hua me te tika o ngā mahi'. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health has worked with the sector to develop a suite of SLMs that provide a system-wide view of performance. The Alliances are required to develop an improvement plan for each financial year in accordance with Ministry of Health expectations. The improvement plan must include the following six SLMs:

- ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds
- total acute hospital bed days per capita
- patient experience of care
- amenable mortality rates
- youth access to and utilisation of youth-appropriate health services, and
- babies living in smokefree homes.

Each SLM, has an improvement milestone to be achieved in 2020/21. The milestone must be a number that shows improvement (either for Māori, total population, or a specifically identified population to address equity gaps) for each of the six SLMs.
A brief description of activities to be undertaken by all alliancing partners (primary, secondary and community) to achieve the SLM milestones.
Contributory measures for each of the six SLMs that is chosen by the district alliance based on local needs, demographics and service configurations that enable the alliance to measure local progress against the SLM activities.
Signatures of all district alliance partners to demonstrate an integrated and partnership approach to the development and implementation of the improvement plan.
In 2016, the Counties Manukau Health and Auckland Waitemata Alliances agreed to a joint approach to the development of the SLM Improvement Plan. This included the establishment of a Metro Auckland Steering Group and working groups for each SLM. Steering Group membership includes senior clinicians and leaders from the seven PHOs and three DHBs. The Steering Group is accountable to the Alliances and provides oversight of the overall process.

In 2020/21, SLMs continue to be business-as-usual. There is a focus on risk factors for respiratory infections including smoking, vaccination for influenza and pertussis. There is also priority given to effective use of Primary options for Acute Care (POAC) to prevent unnecessary use of hospitals and greater use of primary care patient portals to improve efficiency of contactless primary care where appropriate. The governance structure of Alliance Leadership and Steering Group continue to guide improvement processes. The responsibility for implementation sits primarily with the Implementation Group. This group has primary care representation and flexible subject matter expertise dependant on topic and requirements. The Implementation Groups stopped meeting during the pandemic but will again meet regularly during 2020/21 to further develop key actions (particularly at a local level) and inform implementation planning, monitor data, facilitate systems partnerships, and collaboratively guide the ongoing development of the SLMs with the Steering Group and Alliance Leadership Teams.
The work of the Implementation Group is guided by an Implementation Plan which sits under this plan and contains considerably more detail on activities and timeframes, and how a quality improvement approach will be taken for each area. The distinction between this high level plan and an implementation plan is necessary in a relatively complex environment of seven PHOs spanning three DHBs.

We continue to benefit from PHO leadership. The role of PHO lead has been retained from the original working group structure, and leads now have responsibility for diffused matrix management of SLM planning and implementation in their key activity areas. They continue to engage with other systems partners.

Data sharing between primary and secondary care is developing under the Metro Auckland Data Sharing Framework. This allows data matching with primary care and non-primary care data sources, more consistent reporting, establishment of baseline performance across DHBs and PHOs and drives quality improvement facilitated by the Implementation Group.

Reporting processes, both at a local and regional level have been embedded and DHBs and PHOs have access to both static and dynamic reporting in order to monitor progress and identify opportunities for improvement and individual performance is routinely discussed supportively in the Implementation Group.

4.1 Equity Approach, Consultation and Partnership

This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples. In planning, each contributor has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those with the poorest health outcomes.

Consultation prior to and during planning for 2018/19 was more extensive than previous years. This process was extended to better address the expectations of mana whenua, and to discuss decision-making proactively. In addition, the Māori health gain teams across the region were invited to workshop the concepts and various drafts of the plan and provided valuable input. Feedback received from the engagement sessions with stakeholders was incorporated into development of the improvement plan. This included a sector-wide pre-planning workshop, cultural consultation workshops, consumer meetings, and a presentation of draft measures, milestones and interventions to stakeholders, the Steering Group and Alliances. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

The 2018/19 Improvement Plan was shared with the DHB Māori, Pacific and Asian health gain teams and their feedback was incorporated. Consultation with other relevant cultural groups and equity partners has been an essential part of this process. The 2018/19 SLM Improvement Plan was designed to align with DHB Māori Health Plans.

The 2020/21 plan is a consolidation of the 2018/19 plan and therefore continues with a strong focus on equity.

4.2 Regional Working

As in previous years, a single improvement plan has been developed in 2019/20 for the Alliances and three Metro Auckland DHBs. As a number of PHOs cross the Metro Auckland DHB boundaries and are members of both Alliances this is considered the most practical and achievable approach given limited resources. Improvement milestones and contributory measures have been carefully selected to take into account the context, population and current performance of each DHB in the wider Auckland region. One regional plan also promotes closer regional collaboration between stakeholders, and ensures that patient outcomes are promoted in a consistent way.

4.3 2020/21 Priorities for System Level Measures

The 2020/21 plan continues to focus on cross–system activities which have application to multiple milestones as demonstrated in the ‘interrelated activity for collective impact’ diagram in Section 2. An extensive stocktake was conducted with both primary and secondary care stakeholders to establish the uptake of the SLM activities, identify barriers and focus on the areas for prioritisation for the 2019/20 plan. The results of the stocktake were discussed with the Implementation Group and clinical leaders before being considered by the Steering Group. The aim was to consolidate the plan.

The Covid-19 pandemic has put the health system and particularly primary care under pressure. This year’s plan has been influenced by this event and has a focus on preventing respiratory illness by concentrating on smoking

cessation and vaccination for respiratory conditions, and referral to healthy housing. Other priorities include effective use of POAC and greater use of patient portals to improve efficiency of delivery of care. Management of cardiovascular risk factors for both primary and secondary prevention is also a priority.

The plan has been developed using a medium term approach. It includes immediate activity that will contribute to goals to be achieved within three years. This year we continue to support the essential work that is the foundation for quality improvement activities, including enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

Overarching priorities for 2020/21 continue to adopt a prevention approach, and focus on improvements in equity of outcome or access. These activities support intervention in high risk populations, and collective impact. They were developed and planned with a population focus that included specific consultation with patients, family and whānau, and community. Some contributory measures aim for improvement in specific populations such as Māori and Pacific, particularly where significant inequity exists. It is expected that activity to improve these measures will also improve results for the total population as the processes are universal with a focus on high risk groups.

5. ENABLERS TO CAPACITY AND CAPABILITY

ENABLERS TO CAPACITY AND CAPABILITY	
TRAINING AND EDUCATION	▪ SLM related Continuing Medical Education/ Continuing Nursing Education is filmed and shared regionally ▪ Health literacy improvement ▪ Auckland Regional HealthPathways ▪ Resources and key messages on various SLM work streams ▪ Planned communications of key messages at regular intervals.
DATA AND INFORMATION MANAGEMENT	▪ SLM data definitions, sourcing, analysis and reporting ▪ Ongoing use of the Metro Auckland Data Sharing Framework ▪ Increased use of data to inform implementation and improvement activities ▪ National Child Health Information Platform being rolled out in A/WDHB and Northland. Offers similar functionality to Kidzlink in CMH ▪ Advanced forms for improved data collection ▪ Commitment to equity view in data analysis and reporting, identifying areas for Māori and Pacific health gain.
SYSTEMS PARTNERSHIP	▪ Lead Maternity Carer (LMC) ▪ Well Child Tamariki Ora (WCTO) ▪ Auckland Regional Dental Services (ARDS) ▪ Immunisation Advisory Center (IMAC) ▪ Association with Auckland Regional Public Health Service (ARPHS) ▪ Pharmacy support ▪ Community laboratories ▪ Primary Care teams ▪ Secondary Care services ▪ Māori and Pacific providers ▪ Health navigators and health coaches ▪ School based health services.
QI SUPPORT	▪ Use of improvement methodologies underlying improvement activities ▪ Supported integration of cross-sectorial improvement activities.
CLINICAL LEADERSHIP	▪ Liaison with Metro Auckland Clinical Governance Forum ▪ Population health clinical leadership in planning and implementation.
CULTURAL LEADERSHIP	▪ Stepwise consultation and feedback huis with Māori and Pacific providers ▪ Support from Mana Whenua.

6. SYSTEM LEVEL MEASURES 2020/21 MILESTONES

Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2021.** **3% reduction for Māori populations by 30 June 2021.** **3% reduction for Pacific populations by 30 June 2021.**

Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori populations by 30 June 2021.** **3% reduction for Pacific populations by 30 June 2021.**

Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 5% relative improvement on Inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with in a way you could understand?' by 30 June 2021.** **Primary care survey: 5% relative improvement on PES question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?' by 30 June 2021.**

Amenable Mortality	
System level outcome	Preventing and detecting disease early
Improvement milestone	**6% reduction for each DHB (on 2013 baseline) by 30 June 2021.*** **2% reduction for Māori and Pacific by 30 June 2021.** *** Five year target set in 2016 to be achieved by 30 June 2021**

Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care
Improvement milestone	**Increase coverage of chlamydia testing for males to 6% by 30 June 2021.**

Babies in Smokefree Homes	
System level outcome	Healthy start
Improvement milestone	**2% relative increase in the proportion of babies living in smoke free homes by 30 June 2021.**

7. IMPROVEMENT ACTIVITIES AND CONTRIBUTORY MEASURES

The following section outlines the specific improvement activity plan and contributory measures for the six SLMs for 2020/21. Improvement activities create change, improvement in contributory measures and contribute to improved outcomes in the various SLM milestones. For 2020/21, Auckland Metro region are focused on choosing activities which relate to multiple milestones where possible for best collective impact.

7.1 Ambulatory Sensitive Admissions in 0-4 year olds

Activities	Contributory Measure
Increase uptake of children's influenza vaccination to prevent respiratory admissions by: • Improving vaccination rates in primary care of children aged 0-4 years with previous respiratory admissions through the provision of data, practice-level improvement activities, and following up reporting of vaccination uptake provided throughout the season. • Prioritised vaccination of eligible Māori and Pacific children.	Influenza vaccination rates for eligible Māori children. Target 30%. Influenza vaccination rates for eligible Pacific children. Target 30%.
Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness leading to hospital admission by: • Develop a process to include primary care consultation in the data set to better understand where missed opportunities exist. • Implementing the Best Start Pregnancy Tool so it can function as a pregnancy register in primary care. • Set primary care recalls for pregnant women to ensure they have developed a relationship with a midwife. • Improve the flow of health information by increasing usage of the Best Start Pregnancy tool by midwives. • Develop a process for making pertussis vaccination more readily available in primary care.	Influenza vaccine coverage rates for pregnant Māori. Target 50%. Influenza vaccine coverage rates for pregnant Pacific. Target 50%. Pertussis vaccine coverage rates for pregnant Māori. Target 50%. Pertussis vaccine coverage rates for pregnant Pacific. Target 50%.
Support a decrease in respiratory admissions with social determinants by: • Develop a baseline measurement of referrals to healthy housing with the aim of increasing referrals rates from primary care. • Prompt e-referral to Healthy Housing using Best Start Pregnancy, with a focus on pregnant low income Māori and Pacific women. • Increase referral of pregnant women who smoke for support to stop smoking when they visit general practice to confirm their pregnancy.	Percentage of practices that have Best Start Pregnancy tool installed. Target 30%. Referrals to maternal incentives smoking cessation programmes, for pregnant women. Target each quarter: 27 for ADHB; 58 for WDHB, and 180 for CMH.

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.2 Youth Sexual and Reproductive Health

Activities	Contributory Measure
Improve chlamydia testing in young people 15-24 years old in particular, and in sexual and reproductive health of youth in general by: • Increasing engagement with young people by working with general practices to encourage participation in the RNZCGP MOPS Youth Service audit. • Increased sexual health screening and funded sexual health consults for enrolled young people 15-24 years old (including screening for pregnant woman). • Develop a process to include primary care consultation in the data set to better understand where missed opportunities exist.	Percentage of practices with at least one GP who has completed an RNZCGP approved youth audit. Target 50%

Milestones: The Youth milestone will be improved by these activities.

7.3 Alcohol Harm Reduction

Activities	Contributory Measures
Improve data collection and reporting on alcohol harm reduction interventions in Counties Manukau Health through: • Establishment of an alcohol ABC baseline in primary care for reporting indicators. • Provide general practices with localised resources, training and effective tools to support the systematic and equitable delivery of alcohol ABC to their enrolled population. • Improve data collection capability to multiple practice management systems.	Percentage of the enrolled population aged 15 years and over with alcohol status documented. Target 55%.

Milestones: The Amenable Mortality, Total Acute Hospital Bed Days and Youth milestones will be improved by these activities.

7.4 Smoking Cessation for Māori and Pacific

Activities	Contributory Measure
Patient outcomes related to harm from smoking will be improved by: • Regularly reporting rates of referrals received by cessation support providers and rates of cessation medication therapy prescribed in primary care. • Audit a selection of practices to ensure referral data is accurate • Develop a surveillance report to monitor smoking prevalence by ethnicity and age. • Develop a report to monitor cessation rates by practice. • Query build lists of pregnant women coded as smoking to update smoking brief advice and direct them into cessation support programmes. • Assuring those who have been prescribed cessation medications are followed up by the local smokefree team for support with medication adherence & quitting. • Identify role of RN in Quit Smoking and upskill by completing a fast-track version of the National Training Standards Programme for smoking cessation. Ensure at least one person is trained per practice.	Rate of referral to smoking cessation providers by PHO. Target 6%. Rate of prescribing of smoking cessation medications by PHO. Target 12%.

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.5 Cardiovascular Disease (CVD) Risk Assessment and Management

Activities	Contributory Measure
Primary care and systems partners work together to support equitable CVD Risk Assessment (RA) for Māori by: • Provision of prioritised lists of eligible patients for risk assessment to practices, with Māori and Pacific first. Practices will set recalls and screen patients.	CVDRA rates for Māori. Target 90%.
Improved outcomes for patients with a high risk of CVD event are sought by: • Patients who have previously had a CVD event and who are eligible, receive the funded influenza vaccination. Monitored by DHB and ethnicity. • Implement a regionally agreed process to identify at practice level, high risk patients who are not taking recommended medications and record where medications are not tolerated or patients have declined treatment.	Percentage of Māori with a previous CVD event who are prescribed triple therapy. Target 70%. Percentage of Māori with a CVD risk over 20% who are prescribed dual therapy. Target 60%.
Reporting and improvement of clinical management through prescribing is facilitated through: • Comparing dispensing data to prescribing data and identifying any opportunities for improvements. • Specific actions will be developed after the analysis is complete.	
Opportunities to improve data collection and quality are advanced through: • Continue with a pilot focused on coding specified conditions (e.g. IHD, AF, CKD, diabetes). The results, expected in the next six months will inform further activities.	

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.6 Complex Conditions and Frail Elderly

Activities	Contributory Measures
Māori and Pacific patients with ASH conditions (e.g. CHF, CVD, COPD, AF/Stroke and Cellulitis) receive appropriate clinical support: • Māori and Pacific patients aged 45-64 with ASH conditions who are eligible receive the funded influenza vaccination.	
Improve coding in primary care for specified long term and complex conditions (e.g. COPD and CHF) by matching ICD10 codes from secondary care with PHO registers and developing a process to supplement coding as clinically appropriate.	
Increase referral of patients at high risk of falls to an appropriate Strength and Balance Falls Prevention Programme by: • PHOs to promote the uptake of falls prevention screening templates in all primary care patient management systems. • Development of an updated Goodfellow Unit falls prevention webinar. • DHBs to support contracted programme providers to engage directly at a general practice level to increase the profile of the falls prevention programme, prioritising practices with a high proportion of older people in their enrolled population.	Percentage of patients aged 75 years and over (65 years for Māori and Pacific) who have been screened for falls risk. Target 50%.

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.7 Primary Options for Acute Care (POAC)

Activities	Contributory Measure
Primary and secondary care will work together with the POAC team to increase utilisation of POAC for high needs populations, particularly Māori and Pacific people aged 45-64 by: • Promotion of POAC and referral pathways within general practice. • Focusing on increasing utilisation of POAC for ASH conditions, particularly, CHF, COPD and cellulitis. • Develop regular reports for PHOs on POAC usage	POAC initiation rate in primary care. Target 3 per 100 for each PHO. Report by ethnicity

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.8 E-portals

Activities	Contributory Measure
Continued support for patient enrolment (logon) to e-portals by practices (given that unique email addresses are a critical dependency) by carrying out the following activities: • Receptionist training and socialisation. • Linking with practice accreditation processes.	Percentage of each PHO's enrolled population with login access to a portal. Target 30%.

Milestones: The Patient Experience of Care milestone will be improved by these activities.

7.9 Patient Experience Surveys in Primary and Secondary Care

Activities	Contributory Measure
Primary care will improve patient experience by: • Working with early adopter practices to champion engagement. • Prioritising feedback from Māori and Pacific patients. • Participating in CQI activity via 'PES to PDSA' or 'You said – We did activity/Kōrero mai'. • Developing a PDSA activity focussed on Māori and Pacific. • PHO to practice support continues in monitoring and managing reports post survey week. • Practices utilise feedback from patients and whānau when making changes in the practice. • Develop processes for collection and monitoring of email addresses for Māori and Pacific patients.	Percentage of Maori and Pacific patients eligible for the primary care patient experience survey who have valid email addresses. Target 40%.
Secondary care will improve patient experience by: • Focusing on the medication safety question in the National Inpatient Survey with a multidisciplinary approach. • Create training package in conjunction with a Health Psychologist for all hospital pharmacists and student pharmacists with links to patient experience, multidisciplinary team relationships, framing and communication approaches. • Development of Health Navigator resources and online resources. • Development of an acute pain management discharge checklist. • Testing of electronic solutions via Medchart to prompt patient conversations. • Co-design of patient experience initiatives with a focus on Māori and Pacific people (CMDHB). • Sharing learnings with primary care through established networks and forums. Improving visibility of reporting of Māori and Pacific response rates, with a view to encouraging awareness via activities as noted above. Primary and secondary care will work together to explore the underlying data for Māori and Pacific patients enrolled in primary care to identify barriers to participations in the PHC PES.	ADHB/WDHB Percentage of hospital pharmacists will have completed the medication safety training package. Target 50%

Milestones: The Patient Experience of Care milestone will be improved by these activities.

8. SYSTEM LEVEL MEASURE MILESTONES IN DETAIL

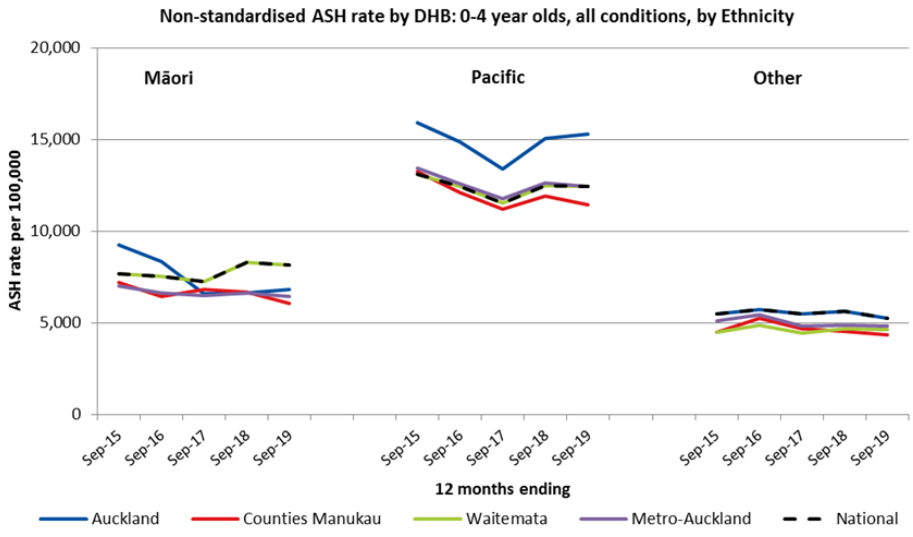
8.1 Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds

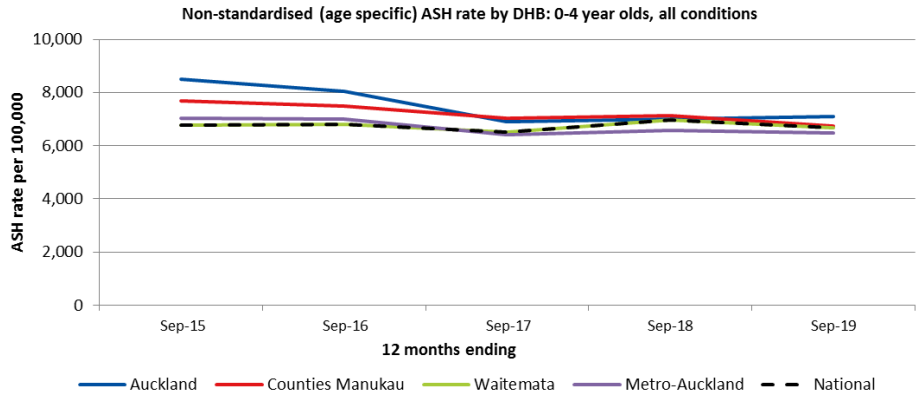
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2021.** **3% reduction for Māori populations by 30 June 2021.** **3% reduction for Pacific populations by 30 June 2021.**

Ambulatory sensitive hospitalisations are admissions considered potentially preventable through pre-emptive or therapeutic interventions in primary care. The admissions included are made up of a specified set of discharge codes considered to be ambulatory sensitive, and are assigned based on the primary diagnosis. This is a challenging indicator as social determinants of health are a significant contributor. The amount realistically amenable to timely access to quality primary care has not been quantified and there is little evidence about what works outside of immunisation for vaccine preventable diseases. Despite these challenges there are many promising approaches.

In addition to paediatric and maternal immunisation, smoking cessation and improving the housing environment are important for improving this milestone. This year we have chosen to focus on these aspects of the Child and Adolescent Asthma Guidelines, fitting with a broader focus on respiratory admissions, which is the largest contributor to Ambulatory Sensitive Hospitalisations in 0-4 across the three DHBs.

We plan to build on improvements in immunisation rates and spread the methodology to other high risk cohorts which will improve outcomes in acute hospital bed days.





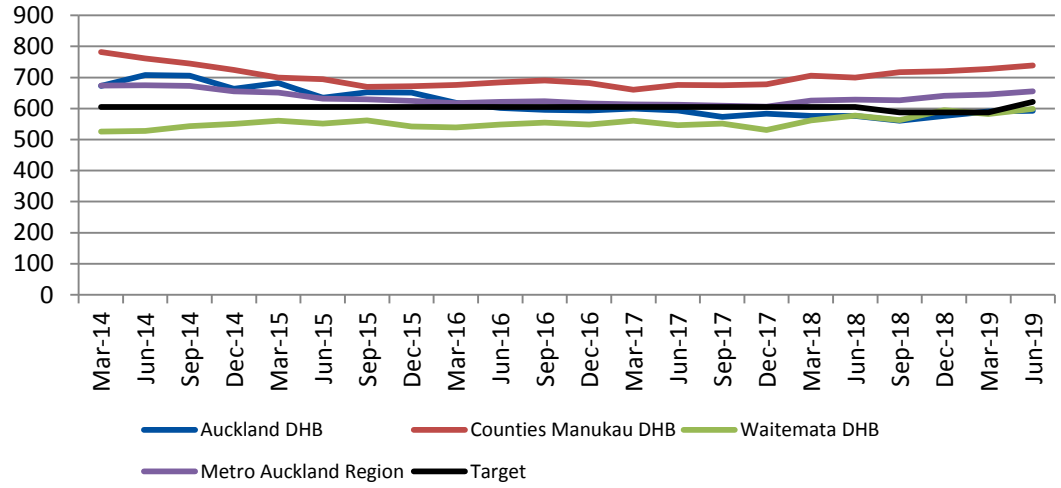
This year we aim to continue our focus on equity with an improvement for Māori and Pacific rates.

8.2 Total Acute Hospital Bed Days

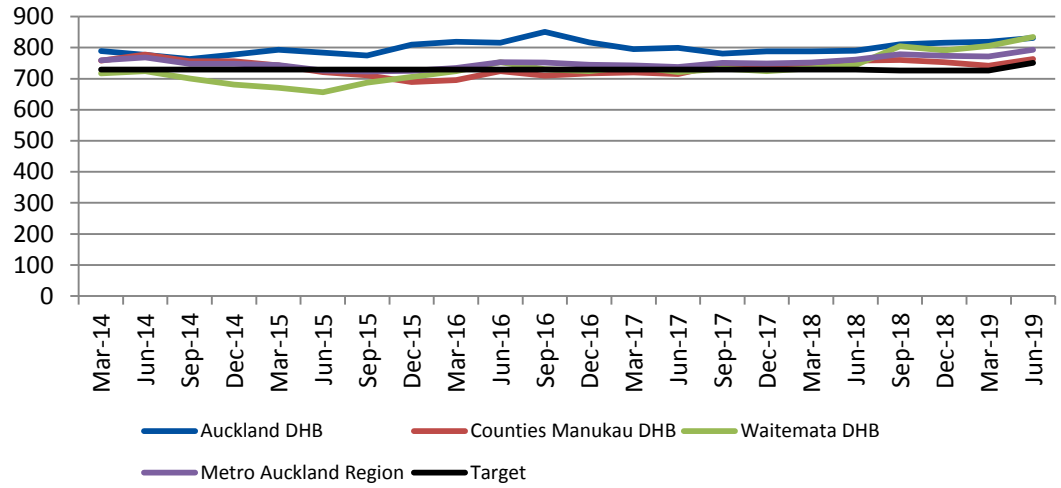
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori population by 30 June 2020.** **3% reduction for Pacific population by 30 June 2020.**

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. The intent of the measure is to reflect integration between community, primary and secondary care, and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. We will achieve a greater reduction in acute bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific targets for these populations are higher due to the inequity when compared to the total population.
We plan to target populations most likely to be admitted or readmitted to hospital, and focus on prevention and treatment of conditions that contribute the most to acute hospital bed days. Priority areas include alcohol harm reduction, CVD management, influenza vaccination for high risk groups and effective use of POAC. Conditions identified as highest priority include congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Coding for these conditions in primary care will be improved so effective interventions can be targeted.
Total acute hospital bed days for 2019/20 for Māori and Pacific identify marked inequities when compared to non-Māori, non-Pacific rates, so we will continue to focus on patients from this population in addition to the prioritised conditions.

Standardised Acute Bed Days per 1,000 Maori Population: 12 months ending



Standardised Acute Bed Days per 1,000 Pacific Population: 12 months ending



8.3 Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 5% relative improvement on Inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with in a way you could understand?' by 30 June 2021.** **Primary care survey: 5% relative improvement on PES question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?' by 30 June 2021.**

Patient experience is a good indicator of the quality of health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes. The Health Quality and Safety Commission (HQSC) patient experience survey (PES) domains cover key aspects of a patient's experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs.
The 2020/21 plan continues to look at performance of individual questions rather than response rates to the survey.
The patient experience surveys have been significantly disrupted during 2019/20 with:

- A refresh of the survey precluding direct comparison of questions between the old and new surveys
- A change in provider contributing to a pause in delivery of the survey and discontinuous data flow
- The Covid-19 crisis which further contributed to pausing the survey and also resulted in a significant changes in the way patients accessed primary care

Hospital Inpatient PES: The medication side effect question has been modified for the recent inpatient survey. At the time of submission of this plan data was not available for the modified question. It is highly likely that the communication of medication information will continue to be an area for improvement for the total population and also for Māori.
The milestone for 2020/21 will continue to focus on the knowledge patients have about possible medication side effects when they are discharged from hospital. This will be achieved by education of multidisciplinary teams focusing on patient empowerment, health literacy, and equity. A baseline will be established and improved upon when the first survey is conducted using the new survey.

Primary Health Care PES: The PHC PES is also well established in primary care. In keeping with the aim of reducing inequality the question about individual or cultural needs was chosen. This question has been introduced in the new survey and again a baseline will be established with the first round of the survey. Patient feedback and PDSA improvement cycles will lead to changes in practices that are important to patients and will promote cultural awareness.

8.4 Amenable Mortality

System level outcome	Preventing and detecting disease early
Improvement milestone	**6% reduction for each DHB (on 2013 baseline) by 30 June 2021.** **2% reduction for Māori and Pacific by 30 June 2020.**

Two contributory measures have been consistent in amenable mortality improvement planning to date, those that have the greatest evidence-based impact – cardiovascular disease (CVD) management and smoking cessation.

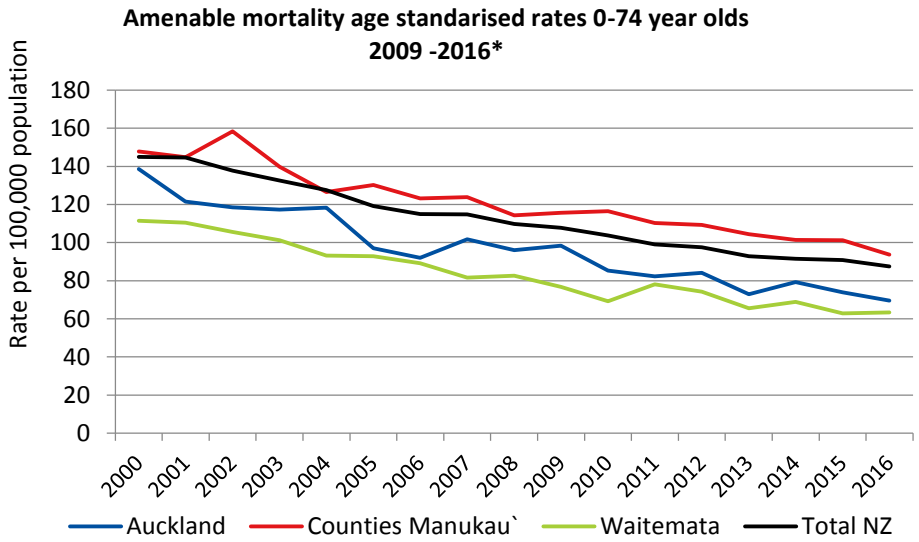
CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Patients with established CVD (and those assessed to be at high CVD risk) are at very high risk of coronary, cerebral and peripheral vascular events and death, and should be the top priority for prevention efforts in clinical practice.

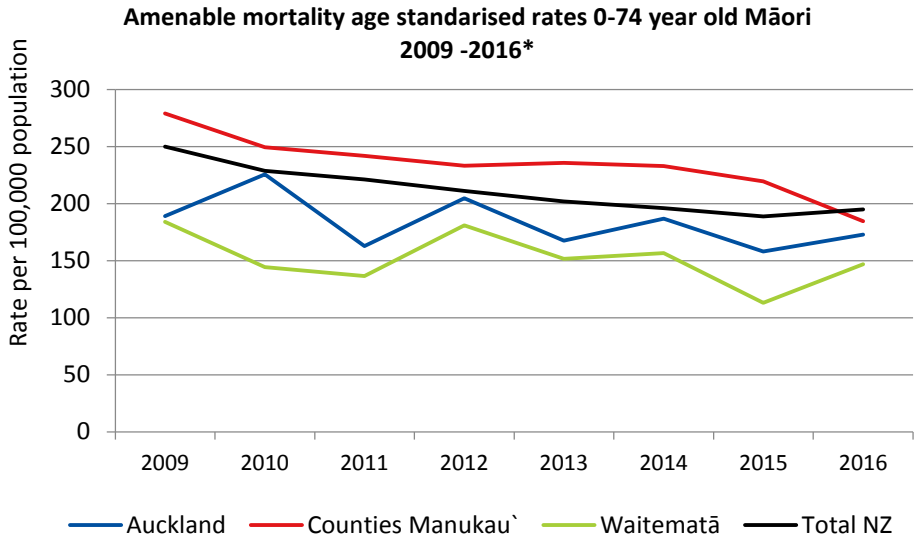
In 2020/21 we aim to build on the work done in implementation of the new Consensus Statement for Assessment and Management of CVD. With the risk assessment algorithms available to primary care there will be a stronger emphasis on risk assessment for Māori and primary prevention for those at greatest risk. We continue to focus on secondary prevention for this population.

Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. In 2013, 15% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (33%) and Pacific people (23%). Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

Through the use of data sharing we can focus on referrals to smoking cessation services by practitioners in different parts of the health system.

The 2020/21 plan will build on the successful implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption.




Amenable mortality age standarised rates 0-74 year old Māori
2009 -2016*
Rate per 100,000 population
300
250
200
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2009
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Auckland
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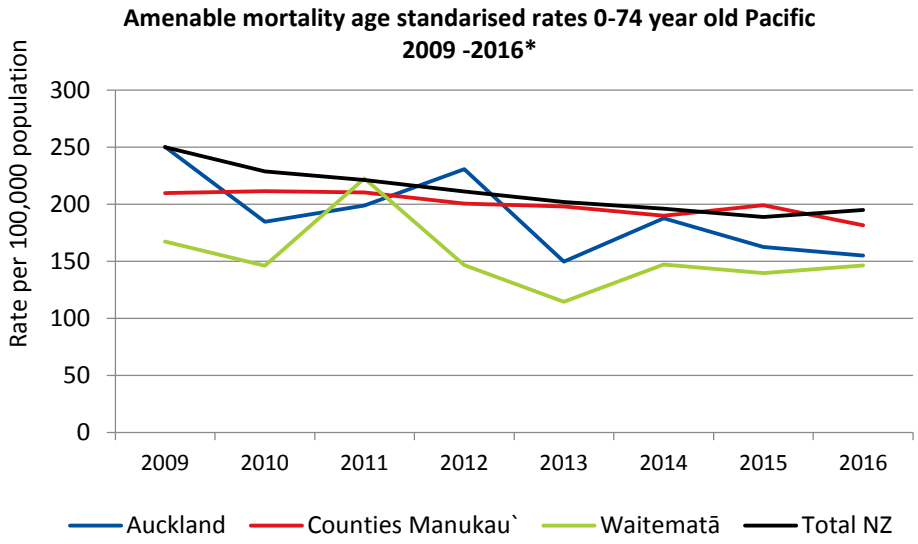
Waitematā
Total NZ


Amenable mortality age standarised rates 0-74 year old Pacific
2009 -2016*
Rate per 100,000 population
300
250
200
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2009
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2016
Auckland
Counties Manukau`
Waitematā
Total NZ

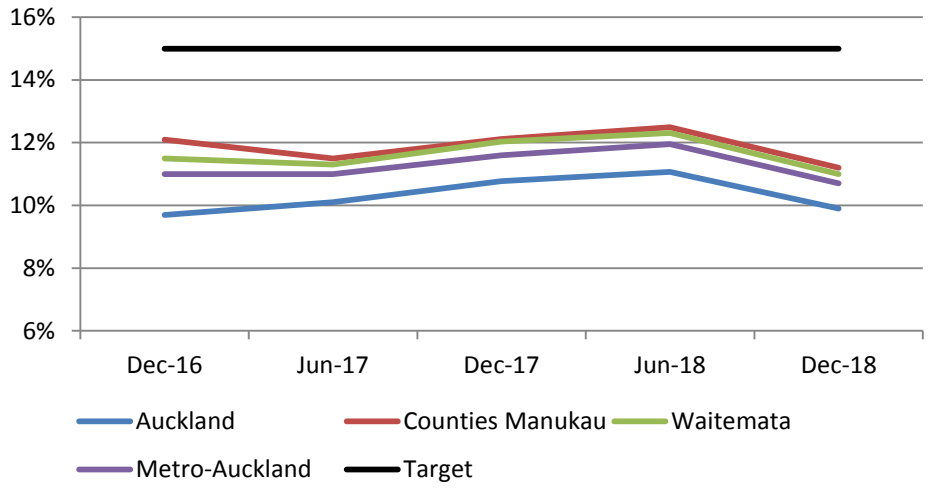
8.5 Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care
Improvement milestone	**Increase coverage of chlamydia testing for males to 6% by 30 June 2021.**

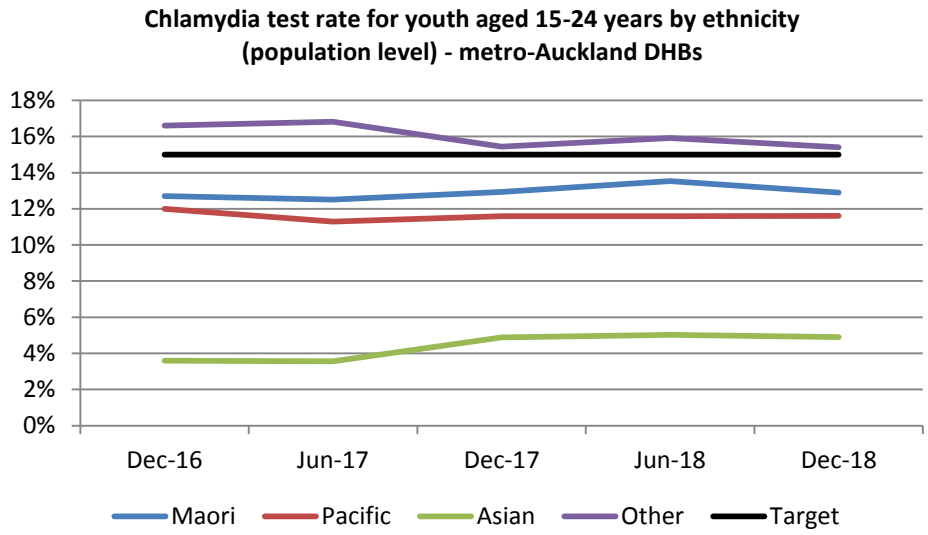
Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet may progress to adults with an increased risk for poor health and overall poor life outcomes through disengagement and isolation from society and riskier behaviors, in terms of drug and alcohol abuse and criminal activities.

Chlamydia testing coverage: This is an indicator of young people's access to confidential youth appropriate comprehensive healthcare. For those young people 15 years and older who have been, or are sexually active, access to chlamydia testing is an indicator of access to condoms, contraceptives, and to a discussion with a clinician about consent, sexuality and other harm minimisation. For some young people this may mean addressing their safety, unmet mental health needs, or alcohol and drug problem.

Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most often diagnosed in females aged 15-19 years and in males aged 20–24 years. Māori and Pacific young people have substantially higher rates of chlamydia than non-Māori non Pacific youth. In addition, when tested, males are more likely to test positive, although this may be because they are only presenting when they have symptoms. In the UK, data from the youth screening programme shows that more than 50% of 16–24 years olds with chlamydia have no or non-specific symptoms. For testing coverage to be effective in reducing the prevalence of chlamydia it needs to target those who have the highest risk of infection, namely males, and Māori and Pacific youth of either gender. While we aim to increase screening rates for all youth there is a focus on improving rates for males.

Chlamydia test rate for youth aged 15-24 years (population level)

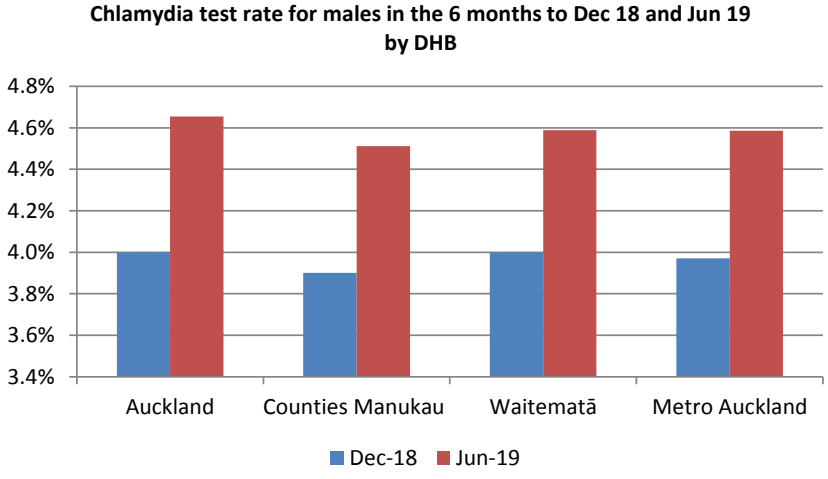




Chlamydia testing coverage in 15-24 year old males

Results for the 6 month period to June 2019: males only.

DHB	Ethnicity	No of people having chlamydia tests	Population	Chlamydia test rate (%)
Auckland	Māori	184	4,230	4.3
	Pacific	244	5,480	4.5
	Asian	256	16,480	1.6
	Other	1,344	17,380	7.7
Counties Manukau	Māori	454	8,700	5.2
	Pacific	553	11,500	4.8
	Asian	261	9,880	2.6
	Other	663	12,720	5.2
Waitematā	Māori	263	6,110	4.3
	Pacific	190	4,170	4.6
	Asian	161	9,270	1.7
	Other	1,387	24,060	5.8
Metro-Auckland	Māori	901	19,040	4.7
	Pacific	987	21,150	4.7
	Asian	678	35,630	1.9
	Other	3,394	54,160	6.3



8.6 Babies in Smokefree Homes

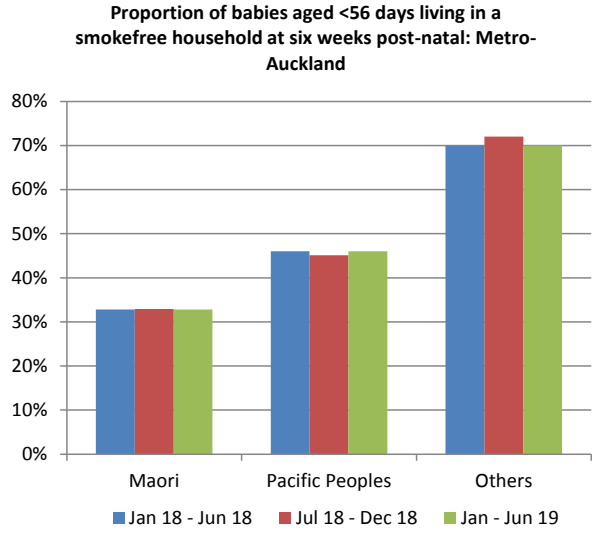
System level outcome	Healthy start
Improvement milestone	**Increase the proportion of babies living in smokefree homes by 2%**

The definition of a smoke-free household is one where no person ordinarily resident in the home is a current smoker. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy, to birth, to the home environment within which they will initially be raised. Of note, smoking during pregnancy and exposure to tobacco smoke in infancy is highest for Māori and Pacific.

Babies living in smokefree homes at 6 weeks postnatal

Reporting period		DHB of domicile		
	Metro-Auckland	**Auckland**	**Counties Manukau**	**Waitematā**
Jan 18 - Jun 18	59.5%	66.8%	52.8%	61.9%
Jul 18 – Dec 18	60.9%	68.3%	54.7%	62.2%
Jan 19 - Jun 19	54.6%	66.2%	44.7%	57.5%
2019/20 Targets	**60.7%**	**68.2%**	**53.9%**	**63.2%**

There is still some work to be done, as data does not reflect live births. This may be improved by an increase in the proportion of births enrolled with WCTO providers. This work should support both smoking intervention in pregnancy and the post-natal period, and continued quality data collection in the Well Child Tamariki Ora space.



Fewer Māori babies live in smokefree homes. Rates for Pacific are also lower than other ethnicities. This correlates with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations.

Our work will be supported by earlier identification of smoking in pregnancy and referral to services for pregnant women and their whānau.

9. GLOSSARY

ABC	Assessment, Brief Advice, and Cessation Support
ADHB	Auckland District Health Board
AF	Atrial Fibrillation
ARDS	Auckland Regional Dental Service
ARPHS	Auckland Regional Public Health Service
ASH	Ambulatory Sensitive Hospitalisations
A/WDHB	Auckland Waitematā District Health Boards
CHF	Coronary Heart Failure
CKD	Chronic Kidney Disease
CME/CNE	Continuing Medical Education/Continuing Nursing Education
CMH	Counties Manukau Health (referring to Counties Manukau District Health Board)
COPD	Chronic Obstructive Pulmonary Disorder
CVD	Cardiovascular Disease
CVD RA	Cardiovascular Disease Risk Assessment
DHB	District Health Board
ED	Emergency Department
GP	General Practice/General Practitioner
HQSC	Health Quality Safety Commission
IHD	Ischaemic Heart Disease
IMAC	Immunisation Advisory Centre
LMC	Lead Maternity Carer
MACGF	Metro Auckland Clinical Governance Forum
MADSF	Metro Auckland Data Sharing Framework
PDSA	Plan, Do, Study, Act
PES	Patient Experience Survey
PHC PES	Primary Healthcare Patient Experience Survey
PHO	Primary Healthcare Organisation
PMS	Practice Management Systems
POAC	Primary Options for Acute Care
SLM	System Level Measure
SMI	Serious Mental Illness (refers to schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder as per the National Consensus Statement for Risk Assessment and Management of CVD in Primary Care)
STI	Sexually Transmitted Infection
UK	United Kingdom
WDHB	Waitemata District Health Board
WCTO	Well Child Tamariki Ora