Annual Plan 2017/18

COUNTIES MANUKAU HEALTH

Incorporating the Statement of Performance Expectations 2017/18 and Statement of Intent 2017/18 – 2020/21

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.

Annual Plan dated XX 2017

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

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Minister's 2017/18 Letter of Expectations to Counties Manukau DHB

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

16 DEC 2016

Dr Lester Levy
Chairperson
Counties Manukau District Health Board
Private Bag 94 052
South Auckland Mail Centre
Auckland 2240

lester.levy@waitematadhb.govt.nz

Dear Dr Levy

Letter of Expectations for DHBs and Subsidiary Entities 2017/18
The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2016 Vote Health received an additional $568 million, the largest increase in seven years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy
The refreshed New Zealand Health Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to ensure that all New Zealanders live well, stay well and get well.

The DHB annual plans are the primary document for demonstrating DHB delivery of the Strategy, and your 2017/18 annual plan is expected to clearly demonstrate the linkages between the five themes of the Strategy and your DHB's performance story, activities and outcomes, while also maintaining a focus on Māori health outcomes and health equity.

In particular I want to see a strong focus on providing care in the community and for services to be provided closer to home, especially for the management of long-term conditions.

Finally, I want your Board to very carefully consider how any new local initiatives fit within the context of the Strategy.

Living Within our Means
While the global economic environment continues to be challenging, DHB funding has continued to be increased year on year. DHBs need to budget and operate within allocated funding and must have clear plans to improve year-on-year financial performance. Your DHB's financial performance is currently tracking to plan for 2016/17, and I trust that you will continue to consider where your DHB can make efficiency gains. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. In particular your Board must work closely with NZ Health Partnerships Ltd on ensuring the delivery of their current work programmes and services.

Working Across Government
I expect DHBs to continue supporting cross-agency work to support vulnerable families and progress outcomes for children and young people, including working with the new Ministry for Vulnerable Children, Oranga Tamariki once this has been established.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

All DHBs must continue to work closely with other social sector organisations to achieve cross-sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as the Prime Minister's Youth Mental Health Project, the Childhood Obesity Plan and the *Living Well with Diabetes* Plan.

Locally, I expect that Counties Manukau DHB will continue working with other agencies to reduce rheumatic fever through the delivery of its rheumatic fever prevention plan, deliver immunisation services that best meet local needs (particularly for Māori, Pacific and high-deprivation populations), and improve the rate of child and youth with transition plans from child and adolescent mental health and youth-focussed alcohol and other drug services.

National Health Targets

All of the national health targets are very important for driving overall performance, and have resulted in major improvements in the health outcomes of New Zealanders. I expect DHBs to remain focussed on achieving and improving performance against all six health targets. The *faster cancer treatment* target remains a top priority for service delivery for DHBs and further progress is expected during 2017/18.

The first national result for the *raising healthy kids* health target is 49 percent. I expect results for all DHBs to improve considerably each quarter as referral processes and clinical pathways are fully implemented.

Locally, Counties Manukau DHB has shown good performance in relation to the *shorter stays in emergency departments*, *increased immunisation* and *improved access to elective surgery* health targets. However, performance in relation to the other health targets can be improved. Please ensure delivery of these health targets is a priority for your DHB.

Streamlining of DHB Annual Planning

In order to ensure that the Health Strategy is informing DHB planning, DHB annual plans will be streamlined in 2017/18 so that they are focussed on my key expectations for your DHB. Your DHB should also be considering longer-term strategic planning (ten-year horizon) as a way to deliver on the vision of the Health Strategy, and I expect that in the future you will be able to demonstrate this planning.

Working regionally also continues to be important, and I expect that when you are considering your long-term strategic planning you are also considering this in a regional context.

There are a number of key planning priorities for 2017/18 that DHBs will need to clearly respond to in their annual plans. These planning priorities have been selected in order to progress the key Government expectations outlined above, and also to progress other key health initiatives, such as Bowel Screening, implementation of the Healthy Ageing Strategy and continued integration of health care in order to better prevent and manage long term conditions, and provide services and care in the best ways to meet local needs. This will require ongoing engagement with your primary and community partners, including implementation of the System Level Measures.

The full list of my planning priorities for 2017/18 is attached for your information. I have asked the Ministry to provide separate advice about how each of these should be reflected in your plan.

Concluding comments

In implementing your annual plan it is important that clinicians are engaged and involved throughout; clinical leadership is fundamental in delivering high-quality health services.

Please note that I am not requiring DHBs to refresh their statements of intent (SOIs) for tabling in 2017/18. However, please ensure you review your SOI produced in 2016/17 to confirm that there are no significant changes. The statements of performance expectations will still need to be produced and tabled.

Keep in mind that the Budget 2017 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available, including information on planning priorities.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2017/18.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

Minister's 2017/18 Letter of Approval 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
Private Bag 93311
Auckland 1640

07 MAY 2018

RECEIVED
14 MAY 2018
BY:

Dear Mr Gosche

Counties Manukau District Health Board 2017/18 Annual Plan

To formalise ongoing accountability and to provide surety, I have approved and signed the Counties Manukau District Health Board's (DHB) 2017/18 Annual Plan for one year together with the Minister of Finance.

I understand the DHB has planned deficits for 2017/18 and the out years, which represent a significant deterioration in its financial results from previous years. I am increasingly concerned about the deterioration in Counties Manukau DHB's financial performance, which has been exacerbated by the urgent requirement to remediate the DHB's deteriorating buildings.

I have been advised that a plan is being developed to return to financial sustainability and I consider that there is a need for additional assurance about the achievability of the DHB's plans to return to a sustainable position. Therefore, I am signing the plan in the expectation that you will work with the Ministry of Health to provide detail of how the DHB plans to improve its financial results.

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

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

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

I look forward to working with you in the future.

Yours sincerely

Hon Dr David Clark
Minister of Health

cc Dr Gloria Johnson, Acting Chief Executive, Counties Manukau District Health Board

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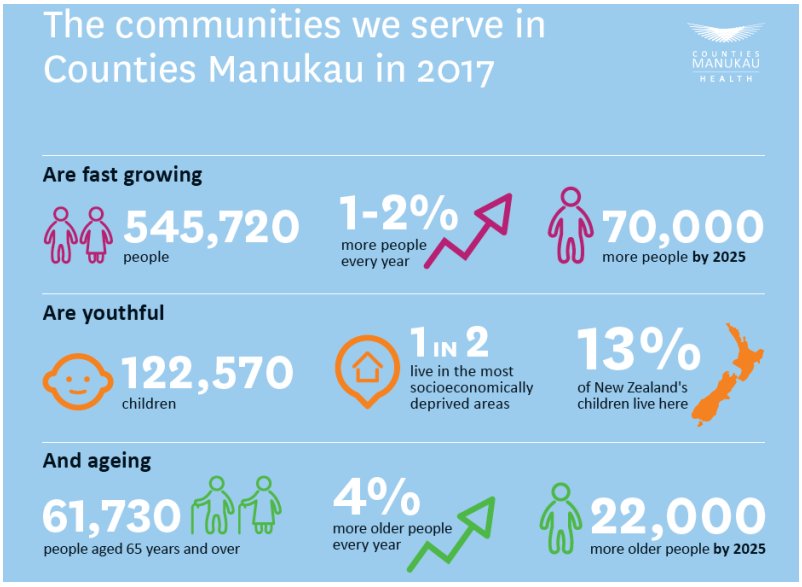
1.0 Overview of Strategic Priorities

1.1 Strategic Intentions/Priorities

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.

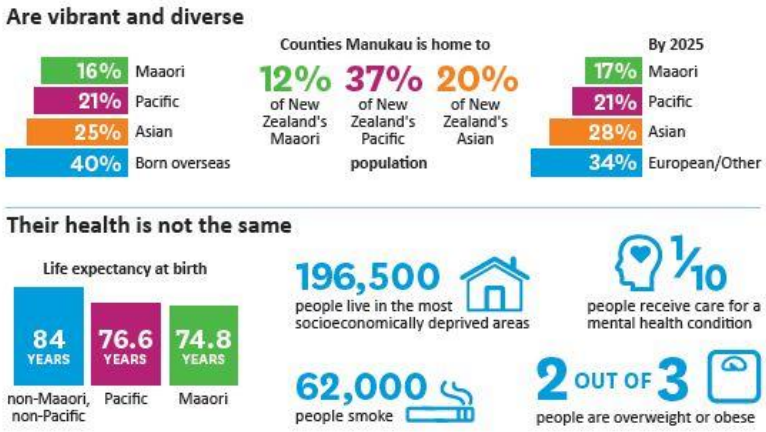
As a collective health system, Counties Manukau Health[1] provides and funds health and disability services to an estimated 545,720[2] people in 2017 who reside in the local authorities of Auckland, Waikato and Hauraki District. We are one of the fastest growing district health board populations in New Zealand with a youthful and ageing population.



Our population is diverse and vibrant with strong cultural values. Statistics New Zealand's first survey on Maaori well-being, Te Kupenga (2013), highlighted a number of strengths in our local Maaori. A high level of connectedness with whaanau was reported and 83 percent said it was 'easy' or 'very easy' to get support from their whaanau. 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. Over 122,000 children live in Counties Manukau, with almost 1 in 2 (approximately 45 percent) living in areas of high socioeconomic deprivation (NZDep2013 9&10[3]). There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau. [4] On the basis of the NZDep2013 measure, Otara, Mangere and Manurewa, home to many of our Maaori and Pacific communities, are the most socioeconomically deprived areas in our district.

Related to these inequities our population experiences relatively high rates of ill-health risk factors (such as smoking, obesity, hazardous alcohol use) for a 'package' of long term physical conditions which are responsible for the majority of potentially avoidable deaths. Increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity, and reducing obesity are key to improving the health of our population.



[1] 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.
[2] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2013-Census Base) – October 2016 update.
[3] 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.
[4] Chan WC, Winnard D, Papa D (2015). Life Expectancy, Leading Causes of Death and Amenable Mortality in Counties Manukau. 2015 update. Auckland: Counties Manukau Health.

CM Health Strategic Intentions and Priorities

CM Health's strategic intentions and priorities are presented in our Healthy Together 2020 Strategic Plan. This plan was developed in acknowledgement of our diverse and changing population and health needs, and communicates CM Health's strategic goal: "Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020."

Further information on CM Health's strategic intentions, and how we will measure our performance against these intentions, is included in our 2017 - 2021 Statement of Intent, at Appendix B.

National, regional and local strategic direction

Counties Manukau DHB operates collectively as part of a national health system. The overall direction is set by the Minister's expectations and the New Zealand Health Strategy. Counties Manukau DHB is committed to contributing to the Strategy's vision of 'All New Zealanders live well, stay well, get well' by providing more integrated care. The actions detailed in section 2 of this plan align to the Minister's Expectations and the Health Strategy themes.

Counties Manukau DHB is committed to the principles of the UN convention on the Rights of Persons with Disabilities and is guided by a range of national strategies including: the Healthy Ageing Strategy, Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-18 and the New Zealand Disability Strategy 2016-2026.

The Northern Region Health Plan (NRHP) demonstrates how the Government's objectives and the region's priorities will be met. The overall intent of the 2017/18 NRHP is to achieve gains across the Triple Aim Framework and the themes of the New Zealand Health Strategy, in addition to a strong focus on equity.

The three Metropolitan Auckland DHBs - Auckland, Waitemata and Counties Manukau - share a Board Chair. This allows for collaboration across the three DHBs and a more integrated and aligned approach to health services planning and delivery across Auckland. By working together the three DHBs will be able to significantly increase the focus on health outcomes as well as quality improvement, while providing greater value for money. We will be able to create capacity to further improve access to services, to better address health inequities and to ease our transition into the digital world. To ensure we take advantage of this new opportunity and extract the full potential from the positive elements we already have, we will need to collectively move away from siloed thinking and working. Instead we will adopt the best of each DHB and create the mindset, capacity and will for enduring change.

Counties Manukau DHB has an established district alliance with the five Primary Health Organisation (PHO) partners operating within the Counties Manukau district, reflecting shared system wide accountability and integration across community and hospital care providers. This includes Alliance Health Plus, East Health Trust, National Hauora Coalition, ProCare and Total Healthcare.

To better reflect a health system approach for effective resource planning to meet our population needs and health sector priorities, this Annual Plan 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.

Treaty of Waitangi

Counties Manukau DHB aims to fulfill our obligations as agent of the Crown under the Treaty of Waitangi. Our relationship with the tangata whenua of our district is expressed through a board-to-board relationship with Mana Whenua i Tamaki Makaurau. Counties Manukau DHB has adopted a principles based approach to recognising the contribution that the Treaty of Waitangi can make to better health outcomes for all, inclusive of Maaori.

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.

1.2 Message from the Chair and Chief Executive

Counties Manukau Health (CM Health) is delivering more care and a broader range of healthcare services than ever before and to a population that is growing rapidly.

To meet these challenges we have made strategic decisions to improve the health of people that live in Counties Manukau, supported by collaborative regional service and investment planning with the Auckland and Waitemata District Health Boards. Regional planning for prioritised long term investments will continue in 2017 as we work together to develop a collective view of future services needs and investments to 2025 and beyond. CM Health is in a strong position to contribute to regional planning with our system integration and quality improvement experience of the past nine years.

In 2016/17, we advanced our system integration commitment through working differently with social services using a Social Investment intersectoral approach for children aged up to 5 years of age living in Mangere. This work is complemented by development of social networks across each of our four localities to build service linkages that benefit patient, whaanau and family experience of care.

Our Healthy Together strategy continues our commitment to provide more care closer to home by growing the range of health services and integration of high quality services and workforces across primary health, community and hospital settings. Our strategic objectives and health equity goal have strong alignment with the April 2016 New Zealand Health Strategy to contribute to the national vision that "All New Zealanders live well, stay well, get well." The six national system level measures support a shared approach to improving health outcomes. In the Northern region, each of these measures is underpinned by an implementation plan led by our primary health organisations in partnership with district health board clinical and service leaders.

We look forward to nearing completion of our new Mental Health Inpatient Unit (Tiaho Mai) on the Middlemore site in 2018 and expansion of key specialty services experiencing high service demand growth. Regional commitment to information services investment continues to guide progress towards more reliable, connected technologies and systems.

We remain committed to improving our performance, meeting national targets, living within our means and most importantly, ensuring the ongoing delivery of efficient and effective, safe health services to our population.

This plan highlights how much achieving equitable outcomes matters and how we can only be successful by working together in a way that makes it easy for people to connect with services. We would like to thank our local community for their advice and contribution to services codesign to keep our focus on what matters to them. We are fortunate to have a very dedicated and skilled workforce in our hospitals and communities. We greatly appreciate the work they do and also the work of our community providers, NGOs, PHOs, volunteers and support groups. Only by all working together will we be successful in implementing the actions outlined in 2017/18 Annual Plan.

Dr Lester Levy
Chair

Dr Gloria Johnson
Acting Chief Executive

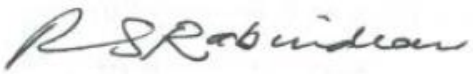
Signatories

Agreement for the Counties Manukau Health 2017/18 Annual Plan dated February 2018

Between

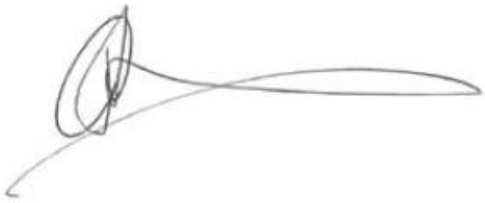
The Honourable Dr David Clark
Minister of Health

The Honourable Grant Robertson
Minister for Finance



Rabin Rabindran
Chair
Counties Manukau District Health Board

Mark Darrow
Chair, Audit Risk and Finance Committee
Counties Manukau District Health Board



Dr Gloria Johnson
Acting Chief Executive
Counties Manukau District Health Board

2.0 Delivering on Priorities and Targets

2.1 Government Planning Priorities

The tables below outline CM Health's key response actions to deliver improved performance against the Government's 2017/18 Planning Priorities. A number of these actions are specifically targeted to accelerate health gain and to reduce inequities for our Maaori and Pacific populations, as well as other population groups with health disparities. These targeted "equitable outcomes actions" can be identified in the table below by the code 'EOA'. Please refer to the CM Health 2017/18 Maaori, Pacific and Asian Health Plans for further detail on the targeted activities that support these equitable outcomes actions.

Several of the priority areas below benefit from or are directly influenced by the connections we share across the Northern Region. Many actions make sense to progress regionally, in a collaborative and consistent manner, rather than independently by each DHB. These have been developed with significant contributions from the Region's clinical networks, clinical governance groups and other regional workgroups and represent the thinking of clinicians and managers from both our hospital and community settings. Our Northern Region Health Plan provides more detail on this regional work.

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Prime Minister's Youth Mental Health Project	**Value and high performance**	1. Build relationships with Primary Care to deliver an enhanced School Based Health Services (SBHS) model across schools and kuras **(EOA)** 2. Improve access to primary mental health and alcohol brief intervention services in general practice, with a focus on 'youth friendly' primary care **(EOA)**	1. Monitor and review the enhanced SBHS model trialled in a low decile high school (Kootuitui Initiative/Papakura High School) by Q4 2. 95% of eligible students receive a HEADSSS assessment, with a focus on rangitahi Maaori by Q4 2. Work with the Regional Youth Health Network to implement the Youth Health System Level Measure (Q2 - Q4)	PP25: Prime Minister's Youth Mental Health Project

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		3. Upskill the primary care workforce to better engage with youth via the Youth Quality Improvement programme 4. Upskill the SBHS registered nurse workforce to provide timely treatment to their young people	3. Monitor and review the participating practices in the Youth Quality Improvement programme by Q2 4. Five school nurses to complete the Registered Nurse Prescribing in Community Health qualification by Q4	
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	People powered	1. Nurses to provide contraception choice e.g. discussion, referral, prescriptions or provision, and have sufficient access to contraceptive supplies (if agreed by the school Board) 2. Nurses to have Emergency Contraceptive Pill (ECP) endorsement or use standing orders (if agreed by the school Board) 3. Increasing workforce capabilities: i. Development of a project group with the aim of improving general practice and nursing capability in the prescribing provision and training of long acting contraception within localities ii. Commence the Registered Nurse Prescribing in Community Health qualification with the primary care and school nurse workforce iii. Opportunity for nurses who complete this training to also include a sexual health module if appropriate to their school 4. Build relationships with primary care to deliver an enhanced School Based Health Services (SBHS) model across high schools and kuras **(EOA)**	1. All funded high school nurses to have contraception discussions and access to contraceptives by Q2 (if consented by the school Board) 2. All funded high school nurses to have access to ECP by Q2 (if consented by the school Board) 3. Establishment of project group to develop a long acting contraception plan by Q2 3. Registered Nurse Prescribing in Community Health qualification commenced with primary care and school nurse workforce by Q1 3. To ensure nurses have access to complete the sexual health module by Q4 4. Ensure all funded schools have access to the enhanced SBHS model by Q4	PP38: Delivery of response actions agreed in annual plan

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Supporting Vulnerable Children BPS Target	One team	Continue actions to contribute to the reduction in assaults on children and to meet the requirements of the Vulnerable Children's Act including: 1. Continue to contribute to the governance, strategic planning and the implementation of Children's Teams Counties-wide 2. Continuing to screen for family violence and refer as appropriate 3. Maintain the National Child Protection Alert System that now includes high risk unborn women who meet section 18b of the Children Young Person's and their Families Act 1989 4. Continue to deliver the Violence Intervention Programme (VIP), including Power to Protect (formerly known as shaken baby education) for appropriate areas, and undertake regular audits 5. Contribute to Multi Agency Safety Plan (MASP) statutory agency (Ministry for Vulnerable Children Oranga Tamariki). This is developed after the 24 hour response meeting identifying each agency's responsibility	1. Ongoing contribution to establishment of Children's Teams over 2017/18 (Q1 – Q4) 2. Family violence screening ongoing over 2017/18 (Q1 – Q4) 3.National Child Protection Alert System maintained over 2017/18 (Q1- Q4) 4. VIP delivered over 2017/18 with regular audits conducted 5. Ongoing contribution to the MASP over 2017/18 (Q1- Q4)	PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	One Team	1. Work with other sectors e.g. Ministry of Social Development, Ministry of Education, to identify touch points where pregnant women engage and develop robust referral pathways to ensure registration with a Lead Maternity Carer (LMC) or notification to the DHB 2. Work in partnership with general practice to develop pathways which facilitate early registration for women who confirm their pregnancies with them	1.Undertake consultation with BPS partners to identify opportunities for collaboration by Q2 2. Scope up a centralised system to refer women who require support sourcing a midwife by Q1	PP38: Delivery of response actions agreed in annual plan (section 1)

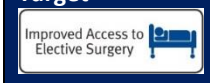
Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		3. Increase the number of Community LMC Midwives working within Counties Manukau 4. Build on the successes of the current smokefree pregnancy programme by further developing an integrated incentive scheme for high risk pregnant women 5. Work with the CM Health Maternity Consumer Group to develop a social marketing campaign targeting women who traditionally do not engage	3. Incentive scheme offered to new to area and new graduates who take up access holder agreements in Counties Manukau. Ongoing over Q1- Q4 4. Build a continuum of incentives which align with key milestones within the antenatal and postnatal period. Ongoing over Q1-Q4 5. Communication plan developed by Q2	
Keeping Kids Healthy BPS Target	**One Team**	1. Work with the Ministry of Education to develop and a joint plan to enable the implementation of a range of preventative health programmes within early childhood settings. The initiatives will focus on skin hygiene, good oral health, and healthy eating 2. Work with the relevant sectors to ensure that all eligible children and pregnant women are referred through to the Auckland Wide Healthy Homes Initiative (AWHI) for appropriate housing interventions 3. Scope the expansion of the Mana Kidz programme (sore throat management, skin and general health) to include preventative treatments such as fluoride application for children at high risk of dental caries Note that activity included in other priority areas of this Annual Plan and the CM Health Asian, Pacific and Maaori Health Plans will contribute to this target, for example: ▪ Childhood Obesity Plan ▪ Rheumatic fever prevention ▪ Oral health ▪ The 2017/18 Metro Auckland SLM Improvement Plan	1. Joint plan developed by Q2 2. Referral pathways to be developed from primary care, secondary care, school based health services and other sectors by Q4 3. Joint scoping exercise to be undertaken with Auckland Regional Dental Service , to be completed by Q2 (Term 4)	PP38: Delivery of response actions agreed in annual plan (section 1)

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Reducing Rheumatic Fever	People powered	1. The National Hauora Coalition (NHC) is contracted directly by the Ministry of Health to provide the Auckland Wide Healthy Homes Initiative (AWHI) for children and whaanau living in Counties Manukau. In 2017/18 CM Health will support NHC with the provision of AWHI by: i. Establishing a role to support referrals to AWHI to ensure families who are eligible are referred to the housing programme (**EOA**) ii. Providing a senior CM Health management role to sit on the governance board of AWHI 2. Strengthen our local communications strategy to better reach our Maaori and Pacific youth regarding our rheumatic fever key messages. This will build on the Maaori and Pacific community engagement fund work and Health Promotion Agency (HPA) led communications and work **(EOA)** 3. Continue to support primary care to deliver rapid sore throat assessments by: i. Providing quarterly Continuing Nurse Education/Continuing Medical Education ii. Training for front line staff (including receptionists) iii. Ensuring access to amoxicillin for primary care clinics using rapid response model iv. Provide Health Promotion Agency resources to PHOs v. Make advanced form and training sessions available to all primary care clinics	1. Role established to support AWHI referrals by Q1 1. Senior CM Health management role to take position on governance board of AWHI by Q1 2. Hold a hui for key Maaori and Pacific stakeholders by Q1 3. Support provided to primary care to deliver rapid sore throat assessments (Q1-Q4)	PP28: Reducing Rheumatic Fever

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Increased Immunisation Health Target 	People powered	1. Develop and implement an immunisation communications plan to increase engagement of Maaori and high needs[5] whaanau with immunisation services **(EOA)** i. Develop targeted messages to educate and increase awareness of immunisation. Messaging to be appropriate and effective for Maaori and high needs whaanau ii. Distribution of communication plan resources including the Welcome to Child Health Services flyer and flu vaccination information iii. Communication of targeted messages to communities through local papers, radio talk-back interviews and community network 2. Engagement and liaison with early childhood education (ECE) and home-based childcare to promote 4 year immunisation in conjunction with B4 School Check 3. Proactive early identification and monitoring of Maaori babies to increase on time immunisation of Maaori babies **(EOA)** i. Maaori pepi and tamariki prioritised for immunisation and/or outreach services and 'milestone' immunisation alerts for immunisation used ii. Well Child Tamariki Ora (WCTO) nurses and school nurses provided with access to the National Immunisation Register (NIR) to allow immediate query of immunisation status 4. Immunisation Nurse Leader to work with all practices with low Maaori and high needs coverage rates and meet individually with each practice to improve performance measured by the DataMart report in the following month **(EOA)**	1. Communication plan and targeted messages developed, and materials distributed by end of Q1 1. Targeted messages communicated to communities by Q4 2. Engagement of Mangere and Otara ECEs and meeting held by end of Q1 2. Engagement of Manurewa and Papakura ECEs and meeting held by end of Q2 2. Engagement of Pukekohe and Franklin ECEs and meeting held by end of Q3 3. Monthly review of early identification and monitoring processes for Maaori babies and adjustment if necessary 3. WCTO nurses and school nurses to have access to NIR by end of Q1 4. Immunisation Nurse Leader to have identified and met with any relevant practices in Papakura or Franklin localities by end of Q2	Immunisation Health Target PP21: Immunisation Services

[5] For the purpose of the immunisation service, "high needs" is defined as families living in areas with NZDep2013 socioeconomic deprivation 9 and 10.

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		5. Implementation of targeted strategy Awhi Mai to educate and support mothers/caregivers on immunisations from 6 weeks to 4 years through WCTO; and to encourage engagement with primary care and a "health home". Strategy to be supported by referral into Whaanau Ora services **(EOA)**	5. Awhi Mai rolled out by end of Q2	
Shorter Stays in Emergency Departments Health Target 	Value and high performance	1. Reduce the time to analgesia for renal colic patients **(EOA)** 2. Reduce the time to antibiotic administration through the development of a new sepsis pathway 3. Continue regional work to reduce time to Percutaneous Coronary Intervention (PCI) for ST-Elevation Myocardial Infarction (STEMI) patients admitted afterhours 4. Implement a systematic way to identify alcohol harm related Emergency Department (ED) presentations and progress work to develop a care pathway for brief advice and referrals for hazardous and harmful alcohol use (**EOA**)	1. Undertake an equity assessment to investigate the causes of longer wait times experienced by Maaori and Pacific patients by Q4 1. Refine the processes for patient triage and the pain pathway by Q3 2. Trial transition from SIRS to quickSOFA by Q3 2. Develop a new sepsis pathway to improve timeliness and early goal directed therapy for patients with suspected sepsis by Q4 3. Identify issues that contribute to the longer average wait time to PCI for Maaori patients by Q4 4. Implement an agreed process for identifying alcohol harm related presentations by Q2 4. Develop a brief advice and referrals pathway for patients presenting with alcohol-related harm by Q4	Emergency Department Health Target 80 percent of patients requiring PCI have door to needle time of less than 90 minutes 80 percent of patients with analgesia within 30 minutes of arrival 80 percent of septic patients to have antibiotics within one hour of arrival 95 percent of patients presenting to ED are assessed for alcohol related harm by Q4

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Improved Access to Elective Surgery Health Target 	**Value and high performance**	1. Achieve the Improved Access to Elective Surgery Health Target by: i. Delivery against agreed volumes in Price Volume Schedule (PVS) ii. Using targeted initiative funding to increase access for First Specialist Appointments (FSA) and elective procedures iii. Review CM Health performance against regional and national performance 2. Increase clinical capacity to provide elective services i. Maximise theatre utilisation and productivity ii. Use alternative clinical staff to deliver a range of FSA, follow up and procedures appropriate to scope of practice iii. Continue to develop and support a wider range of service provision in locality hubs with greater linkages to primary care 3. Maintain timeliness of access to elective services i. Close monitoring of theatre activity through regular reporting and performance discussion ii. Ensure referral guidelines are available to streamline referral processes and to assist primary care to actively manage patients in the community iii. Improve capacity of outpatient clinics to manage volumes of patients seeking service 4. Improve health and equity of access for all populations **(EOA)** i. Provide timely and or early interventions with care closer to home to mitigate potential harm through delayed access to health assessments and treatment ii. Utilise recognised prioritisation tools to assess clinical need; support clinicians to undertake specialty based review of prioritisation practices to increase consistency of practice	1. Achievement of the Electives Health Target quarterly (Q1–Q4) 2. Meet other production and access targets (Q1 – Q4) 3. Maintain Elective Services Patient Flow Indicator (ESPI) compliance (Q1-Q4) 4. Specialty based review of prioritisation practices to increase consistency of practice by Q4	Electives Health Target of 20,535 elective surgical discharges in 2017/18. SI4: Standardised Intervention Rates OS3: Inpatient Length of Stay (Electives) Electives and Ambulatory Initiative Bariatric Initiative Additional Orthopaedic and General Surgery Initiative Elective Services Patient Flow Indicators

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		iii. Provide effective screening and patient centred preparation processes prior to treatment to minimise non-attendance and cancellations on the day		
Faster Cancer Treatment Health Target 	**One Team**	1. Prospective identification, monitoring and intervention throughout pathway to ensure patients receive timely diagnosis and treatment 2. Tumour-stream based pathway approach to standardise diagnostic and treatment access 3. Regional collaboration (formal and informal) and reporting to ensure cross-DHB pathways are timely and efficient, including: i. Regional Faster Cancer Treatment (FCT) Group ii. Regional FCT leads meeting iii. Regional Oncology Operations Group Tumour-stream regional development 4. Patient access and equity: Implement the findings from local research into patient-related factors leading to delay and the Cancer Nurse Coordinator Initiative evaluation **(EOA)**: i. Run patient/community workshops to inform pathway design aimed at improving access for Maaori, Pacific and other groups with health disparities ii. Targeted development of staff and patient resources and education	1.Cancer pathway facilitator to meet with cancer nurse coordinators for each tumour stream weekly from August 2.Analysis of current pathways and sustainable framework developed and implemented by end of Q1 3.Regional FCT Group to meet weekly 3. Regional FCT leads meeting to meet bi-monthly 3. Regional Oncology Operations Group to meet monthly 4. Patient/community workshop to be held by Q1 4. Actions resulting from workshop feedback to be implemented by end of Q2 4. Staff to be provided with resources to support better engagement of Maaori and Pacific cancer patients by Q3	Faster Cancer Treatment Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI Consistent pass rate across ethnic groups for the 62 and 31 day measures

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		5. Retrospective local and regional breach analysis of all aspects related to a patients diagnosis and treatment for on-going improvement	5. Cross-DHB breach analysis to be produced and analysed quarterly and identified improvements implemented where appropriate	
Better Help for Smokers to Quit Health Target 	**Smart System**	1. Refresh Master Record (Smokefree patient information system) to streamline referrals triage system and patient information 2. Develop an online self-referral system to be accessed via the CM Health website to enable easier access to the Smokefree service 3. Continue the sub segmentation, or 'Persona', work to more effectively target Smokefree services to specific population groups, particularly for Maaori and Pacific (**EOA**) 4. Increase understanding of opinions and reasons for low uptake of Nicotine Replacement Therapy (NRT) by some population groups, with a particular focus on Pacific people who smoke, and design a campaign or strategy to respond to findings (**EOA**)	1. Master Record (Smokefree patient information system) refreshed by Q1 2. Online self-referral system developed by Q1 3. 'Dorothy' (Maaori, female, grandmother, widowed, retired) persona tested and validated by Q1, and campaign using her opinion leaders and influence tested by Q2 3. 'Feta' (Pacific, male, family man) persona tested and validated by Q1 4. Hold a focus group of Pacific people who smoke to understand the experiences and opinions of Pacific people in relation to NRT by Q2 4. Design a campaign or strategy to respond to findings from focus group to encourage Pacific people to accept an offer of NRT or referral to cessation support by Q4	Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Raising Healthy Kids Health Target	**Closer to home**	Around 19% of children under the age of five in Counties Manukau are obese, with higher rates among Maaori (23.6%) and Pacific children (28.9%). Maaori and Pacific children and their families, and health professionals working with these families, are the priority population groups for the Raising Healthy Kids activity. 1. Ongoing monitoring of the systems and processes established to support and sustain achievement of the health target i. Weekly reporting to identify any issues ii. Bi-monthly Raising Healthy Kids Operational meetings with key stakeholders 2. On-going monitoring and addressing of declines i. Bi-monthly Raising Healthy Kids Operational meetings with key stakeholders ii. On-going dialogue with B4 School Check (B4SC) staff to elucidate the reasons that parents and caregivers decline referrals for on-going support iii. Focus groups with parents and caregivers who declined a referral for further support iv. Notification letter to GP when parents and caregivers decline a referral v. Six-monthly audit of declines 3. Develop culturally competent staff who are comfortable and able to engage families in conversation about achieving a healthy weight and ensure health services are culturally appropriate and accessible to families facing the complex realities of life where nutrition and physical activity may not be the highest priority **(EOA)** i. Delivery of training and mentoring to primary care, B4SC, WCTO and other key workforces to support health professionals to have conversations with families of overweight and obese children.[6]	1. 100% of issues with systems and processes identified and addressed each quarter 2. Focus groups and findings report completed by Q2 2. Decline notification letter sent to GP for all children who have a declined referral 2. Six monthly audit completed in Q2 and Q4 3. Training and mentoring completed by 80% of priority workforces by Q2 4. Quarterly service volumes achieved 5. Delivery of evaluation activities commence Q2	Raising Healthy Kids Health Target (target achieved by December 2017)

[6] Priority workforces for the training and mentoring are B4SC and WCTO staff, in addition to primary care practices with high estimated numbers of overweight and obese children

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		4. Deliver targeted family-based nutrition, activity, lifestyle and parenting skills programmes to support families to make and sustain a range of positive lifestyle changes with a focus on Maaori and Pacific children and their families and those living in quintile 5 **(EOA)** i. Delivery of Active Futures programme ii. Delivery of Plunket Community Health Worker Home Visiting Service 5. Scope and progress evaluation activities along the referral pathway from B4SC through to primary care and family based lifestyle programmes		
Bowel Screening	**Value and high performance**	During 2017/18 CM Health is committed to the implementation of the National Bowel Screening Programme (NBSP) in Counties Manukau including the following activities: 1. Include information technology to support the NBSP on the CM Health IT work plan and continue to work with the Ministry of Health regarding the integration of IT to support the NBSP 2. Include an equity focus, including the identification of priority populations, when planning for the NBSP roll out 3. Identify and implement improvements to colonoscopy services in a sustainable way by: i. Continued recruitment of endoscopists ii. Training Nurse Endoscopists iii. Building more endoscopy facilities iv. Standardising and streamlining triage and management for all referrals v. Forecasting & planning production vi. Outsourcing to private providers when necessary	1 and 2. National Bowel Screening Programme operational in Counties Manukau by July 2018 3. Ongoing sustainable improvements to colonoscopy services including recruitment and training of endoscopists and development of endoscopy facilities according to MOH agreed timeframes in Counties Manukau NBSP business case	PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Mental Health	People powered	1. Improve the percentage of transition plans completed for young people discharged from the Child and Adolescent Mental Health Services (CAMHS) and youth Alcohol and Other Drug (AOD) Services	1. Develop new report on discharge/transition plans to be available to all Mental Health and Addictions (MHA) teams to inform approximation to target by Q1 2. 95% of young people discharged from CAMHS and AOD will have a Transition Plan by Q2	PP7: Improving mental health services using transition (discharge) planning
	Value and high performance	1. Establish Integrated Care Locality Teams (ICLT): i. Establish initial ICLT presence in each CM Health locality ii. Integrate child & youth and adult cultural specialist teams to take a life-course approach for Maaori & Pacific whaanau/fanau (**EOA**) iii. Realign specialist community teams to reflect local population need and support the locality approach (**EOA**) 2. Enhance access to MHA support at primary level: i. Implement MHA new after-hours Triage service ii. Implement MHA new after-hours Warm Line service	1. Minimum of 3 MHA clinicians and 3 consultant psychiatrists (one each for CAMHS, adult and Mental Health Services for Older People (MHSOP)) dedicated resource working in each locality ICLT by end of Q1 1. Maaori and Pacific Adult and Child and Youth teams co-located by end of Q2 1. Specialist community Full Time Equivalent reflects the population need of each locality within the existing resources by end of Q4 2. After-hours Triage service implemented by end of Q1 2. After-hours Warm Line service implemented by end of Q2	PP38: Delivery of response actions agreed in annual plan

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Healthy Ageing	**Closer to home**	1. Work with ACC, Health Quality & Safety Commission (HQSC) and the Ministry of Health to develop a Falls and Fracture Prevention System as outlined in the Healthy Ageing Strategy and the HQSC Reducing Harm from Falls Programme 2. Work regionally to further understand national and local variances across dementia pathways and to facilitate a co-operative national approach to strengthening dementia pathways and approaches for people with dementia and their carers 3. Work regionally and in collaboration with DHB Shared Services and the Ministry of Health particularly, during the development and implementation of the national Home and Community Support Sector (HCSS) regularisation and model of care and the Age-related Residential Care (ARRC) funding review **(EOA)** 4. Work regionally to improve the (proactive) use of InterRAI data across the continuum (i.e. community services through primary and secondary care) to identify equity, population and service trends, and improve outcomes for older people **(EOA)** 5. Continue through local and regional network to focus on improving stroke outcomes for Maaori and Pacific patients including promotion of the FAST campaign and access to hyperacute stroke services including thrombolysis **(EOA)** 6. Implement relevant actions to deliver on the Regional Service Plan objectives (some detailed above) to: i. Strengthen dementia care pathways ii. Proactively use InterRAI data to drive service improvement iii. Work collaboratively to implement workforce activities in the Healthy Ageing Strategy 2016	1. Establish a Whole-of-System Falls and Fracture Steering Group by Q1 1. Quarterly reporting against agreed system-wide objectives (incident targets) for falls, falls-related fractures, and falls-related hip fractures 2. Implementation of the Eastern Locality Primary cognitive impairment pathway by Q4, and quarterly reporting of progress 2. Report on the number of people being managed via a primary care pathway in the Eastern Locality by Q4 3. Quarterly narrative reports detailing progress 4. Northern regional HOP Planning and Funding group will work with Clinical Network to identify quality indicator benchmarks from the InterRAI data and report on quality improvement initiatives ongoing over 2017/18 5. Report progress quarterly via the PP20 stroke reporting 6. Quarterly reporting of progress against Regional Service Plan objectives via SI2 quarterly reports	PP23: Improving Wrap Around Services – Health of Older People

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		7. Work regionally with Hospices of Auckland to support implementation of the Better Palliative Care Outcomes for Auckland regional service integration proposal 8. Work with the CM Health Palliative Care Clinical Working Group to complete a review of palliative care services in Counties Manukau including: i. Co-design sessions with stakeholders to develop a model for integrated palliative care services that incorporates the hospice-led regional services ii. Development of a whole of system implementation plan for integrated palliative care services that improves access for patients, whaanau and carers and addresses current and future population need	7. Regional 'Better Palliative Care Outcomes for Auckland' Advisory Group established and operational by end of Q1 7. 'Better Palliative Care Outcomes for Auckland' initiatives are operational in the Counties Manukau district by end of Q2 8. Review of palliative care services completed by end of Q1 8. Whole of System implementation plan for integrated palliative care services in Counties Manukau is approved for delivery by end of Q2	
Living Well with Diabetes	**Closer to home**	Of the people in the Counties Manukau district with poorly controlled diabetes, approximately 18% are Maaori, 49% are Pacific and 10% are Indian. The following activities therefore aim to improve glycaemic control and disease management for this target population by providing culturally appropriate and accessible treatment and self-management support. 1. Continue to target those patients who have poor glycaemic control through the implementation of a Planned Proactive Care approach including: i. the roll out of self-management services including Health Coaches that provide individually tailored self-management plans with Maaori and Pacific patients with poor control being prioritised**(EOA)** ii. Evaluation of the current virtual review model between primary and secondary care and development of the model based on findings	1. Implementation of Self Management Services and Health Coaches rolled out to all localities by end of Q1 1. Evaluation of current benefits of virtual review model and recommendations for any amendments by end of Q1	PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		2. Improve patient engagement and access to allied health services in community settings (including podiatry, dietetics, retinal screening and health psychology services) for Maaori and Pacific patients including establishment of the Manukau community-based retinal screening service and marae based clinics (EOA) 3. Diabetes Nurse Specialists and Senior Medical Officers will be supporting primary care through multi-disciplinary team meetings, virtual reviews, physical reviews with patients and structured education at the practice in order to better plan the treatment and management of individuals with complex needs **(EOA)**	2. Manukau community-based retinal screening service established by end of Q2 2. Report on assess progress and access rates to allied health services in Q2 3. On-going multi-disciplinary team meetings throughout year	
Childhood Obesity Plan	**Closer to home**	CMDHB is committed to progressing DHB-led initiatives from the Ministry of Health Childhood Obesity Plan and from the Metro-Auckland Healthy Weight Action Plan. We place particular importance on ensuring the actions of this plan are focused on and meet the needs of our Maaori and Pacific populations who are disproportionately affected by overweight and obesity. 1. Support women of childbearing age to be a healthy weight i. Promote Green Prescription to primary care and identify and address barriers to primary care referrals ii. Implement the National Healthy Food and Drink Policy and ensure compliance iii. Work with primary care to increase routine monitoring of weight in primary care 2. Support and promote healthy weight gain in pregnancy and healthy infant nutrition i. Work with Lead Maternity Carers (LMCs) to improve accuracy of recording of height and weight on booking form ii. Work with LMCs to ensure women receive personalised information about weight gain in pregnancy	1. Increased number of Maaori and Pacific women of child bearing age enrolled in Green Prescription 1. 100% compliance to National Healthy Food and Drink Policy by June 2018 2. Increased number of Maaori and Pacific pregnant women enrolled in Green Prescription 2. 100% of pregnant women screened for gestational diabetes mellitus (GDM) by Q2 2. Target service volumes for Maaori and Pacific achieved for Te Rito Ora and B4Baby breastfeeding services each quarter 2. Increased breastfeeding rates for Maaori and Pacific by Q4	PP38: Delivery of response actions agreed in annual plan

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	**Milestones**	
		iii. Optimise the screening of diabetes in pregnancy and ensure national guidelines are adhered to; assess compliance with HbA1c and that the appropriate referral pathway is followed iv. Collaborate with primary care, Green Prescription providers, LMCs and DHB maternity services to identify and address barriers, and enhance referrals to Green Prescription with a focus on Maaori and Pacific women **(EOA)** v. Undertake quality research an support the following: the TARGET study, the Gestational Diabetes Mellitus Study of diagnostic thresholds (GEMS) and the Healthy Mums and Babies Study (HUMBA) vi. Ensure antenatal education available to promote and support breastfeeding vii. Ensure culturally appropriate support available to promote and support breastfeeding with focus on Maaori and Pacific women and their whaanau **(EOA)** viii. Deliver community cooking courses to support pregnant woman and parents and whaanau of 0-2 year olds to make healthy, affordable and culturally appropriate meals. Priority populations for the course are Maaori, Pacific and South Asian. **(EOA)** 3. Influence healthy nutrition and healthy movement alongside individual level approaches to enable behaviour change for children, young people, caregivers and families. i. Strengthen support for schools to prioritise healthy nutrition and support the implementation of healthy food and beverage policies ii. Utilise INFORMAS survey results to engage with ECEs and schools to support development and implementation of food policies and healthy food environments	2. Target service volumes achieved for Maaori and Pacific women enrolled in antenatal education 3. Delivery of 8 community cooking courses by Q4 3. Quarterly service volumes achieved family-based nutrition, activity, lifestyle and parenting skills programmes 3. By December 2017, 95% of obese children identified in the B4SC programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions 3. Message alignment complete with 5 key messages agreed upon by Q3 3. Feasibility of pilot scoped by Q3	

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		iii. Deliver targeted family-based nutrition, activity, lifestyle and parenting skills programmes to support families to make and sustain a range of positive lifestyle changes with a focus on Maaori and Pacific children and their families and those living in quintile 5 **(EOA)** iv. Ensure childhood obesity health target is met through a suite of initiatives – refer Raising Healthy Kids section v. Support the implementation of the regional growth chart solution for use in secondary care in metro Auckland DHBs vi. Work with ARDS and the Northern Region DHBs to develop consistent health promotion messages using the common risk factor approach for obesity and oral health vii. Scope the feasibility for a pilot to assess measuring weight and height at the year eight dental check		
Child Health	**Value and high performance**	1. Work with Oranga Tamariki to transition the current Gateway contract from an outputs to outcomes based framework	1. Gateway contract updated with outcomes based framework: (a) Current contract service specifications and reporting reviewed by Q2; and (b) Changes to be made recommended to Oranga Tamariki by Q3	PP38: Delivery of response actions agreed in annual plan

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		2. Work with multi agency partners to review care pathways for children under care 3. Implement recommendations to improve timeliness and access to services for children under care	2. Work with multi agency partners to review care pathways for children under care: (a) Review to better understand the issues causing substantive delays for tamariki referred through to Gateway services conducted by Q2 (b) Initiatives across all sectors which could be piloted to improve timeliness identified by Q3 (c) PDSA cycles for agreed actions established (pending resourcing) in Q3 and Q4 3. Actions to improve timeliness and access to services implemented (subject to funding and outcomes of 2 above)	
Disability Support Services	**One team**	1. Clinical and management leadership team participation in knowledge development and patient/consumer co-design for quality model of care development, service and facility design of our new Living Well Centre for Specialised Rehabilitation 2. Clinical and management leadership team participation in knowledge development and patient/consumer co-design for new integrated inpatient stroke services model development and implementation	1. Narration of activities and outcomes of co-design Q1- Q4 2. Narration of activities and outcomes of co-design Q1 – Q4	PP38: Delivery of response actions agreed in annual plan

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Primary Care Integration	**Closer to home**	1. Phase 1 of the Enhanced Primary Care (EPC) Programme: Continue collaborative partnership between CM Health and Primary Health Organisations (PHOs) to co-design and deliver a more sustainable model of general practice – with the objective to release capacity in general practice teams to enable more integrated and co-ordinated support for complex patients 2. Completion of the modules three and four of the EPC programme in which a co-design process will promote population health management by general practices and community health services to identify their most vulnerable groups, e.g. Maaori and Pacific, and target interventions tailored to the individual/locality/community needs **(EOA)** 3. Phase 2 of the EPC: Use of technology enablers to create opportunities for patients to better engage with general practice and to support self- management e.g. patient portals and shared care plans 4. Planned Proactive Care (PPC) Programme: Implementation of the PPC Contract for 2017-2020 with an emphasis on funding for primary care to move away from the 15 minute consultation to 60 minute sessions for patients identified as being at risk of poor health outcomes including Maaori and Pacific living in areas of high socioeconomic deprivation. This will ensure a 'whole of person' approach, including goal setting and agreed actions for change, as well as support practitioners to participate in MDT sessions to deliver locality based care. A district wide systematic approach to risk stratification will support identification of high needs patients. Outcome measures to include five key clinical indicators, System Level Measures, patient experience and continuation of the quality improvement framework	1.EPC Phase 1: Enhance the Model - Pilot phase completed by Q2 2. Vulnerable/high needs population groups identified by general practices and supporting community health teams and integrated models of care designed for these cohorts by end of Q2 3. EPC Phase 2: Large Scale roll out of EPC including technology enablers to CM Health practices. To commence in Q1 2017 and roll out over a period of 24 months 4. Planned Proactive Care contract commencement Q1	PP22: Delivery of actions to improve system integration including SLMs

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
		5. Continue implementation of the PPC for children model in collaboration with PHOs, general practice, nurses and Senior Medical Officers (SMOs) across the sector to address in the first instance, respiratory, skin conditions, and constipation. Phase 2 will incorporate obesity 6. Align service development activities under each of the primary care integration initiatives (EPC and PPC) to ensure data collection is linked to outcomes and a robust evaluation framework 7. Continue locality based integration, aligning community care teams with primary care, and further developing reablement and rapid response services.	5.Planned proactive care for children model implemented by Q1 6. Combined DHB/PHO working group to define PPC outcomes measures/method of collection and identify feedback mechanisms to key stakeholders by Q1 7. Continue development of locality based care systems to address local population needs	
	Value and high performance	The Counties Manukau Health and Auckland Waitemata Alliance Leadership Teams (the Alliances) have jointly developed a 2017/18 Metro Auckland System Level Measures Improvement Plan. Many of the priorities and activities included within this plan contribute to the *value and high performance theme* in the New Zealand Health Strategy. The joint approach to development of the single improvement plan will ensure streamlined activity and reporting, and the best use of resources within the health system. The 2017/18 System Level Measures Improvement Plan is at Appendix C.	As included in the 2017/18 System Level Measures Improvement Plan attached at Appendix C	As included in the 2017/18 System Level Measures Improvement Plan attached at Appendix C

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Pharmacy Action Plan	One Team	The following actions are in draft pending approval from the DHB Shared Services Agency (DHBSS). 1. Implement the national pharmacy contracting arrangements 2. Develop local pharmacist services strategies which align with the Pharmacy Action Plan and the Integrated Pharmacist Services in the Community vision 3. Continue to develop and implement consumer focused services and better integration with wider community based interdisciplinary teams **(EOA)**	1. Local DHB commissioning for integrated pharmacist services that meet population needs. 2. Further expand pharmacy gout medication optimisation service. Collect 12 months of data to inform the development of a business case to support roll out of the service.	PP38: Delivery of response actions agreed in annual plan
Improving Quality	Value and high performance	1. Improve 'Partnership' section of the National Patient Experience Survey by implementing Patient and Whaanau Centred Care Standards 2. Improve response rates for the National Patient Experience Survey each quarter 3. Establish a Patient Experience Team to support co-ordination and delivery of the Patient and Whaanau Centred Care programme and Consumer Council 4. Review the complaints and compliments process	1. Q2 implementation with improvement in the Survey by Q4 2. Ongoing improvement to response rates over Q1-Q4 3. Patient Experience Team established by June 2018 4. Complaints and compliments process reviewed by Q1	PP38: Delivery of response actions agreed in annual plan

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Living Within our Means	**Value and high performance**	CM Health's financial management strategy is focused on employing a mix of strategic projects and divisionally driven efficiencies to ensure adequacy of funding, value creation, quality and safety, and productivity enhancement. Actions planned to ensure value and high performance in 2017/18 include: 1. Deploy local strategies to increase completeness of 2018 census, informing a fairer distribution of MOH funding 2. Enhancing operational efficiency, improving patient flow and increased care coordination e.g. reducing acute admissions and outsourcing where efficient 3. Reducing clinical and non-clinical variation across the system 4. Advancing enhanced primary care and proactive care in the community 5. Investment in Healthy Together technology enablers	Planned financials align with previously agreed results.	Agreed financial templates.
Delivery of Regional Service Plan	**NA**	**Cardiac Services** 1. CM Health will continue work via the Regional Cardiac Network to support implementation of improved models of care to meet demand and enhance quality of care across the continuum. In 2017/18 CM Health will have a particular focus on: i. Cardiac catheter and EP lab services: Continue local and regional review of capacity and demand for cardiac catheter lab and EP services to inform future planning and capacity building ii. Heart Failure: A collaborative approach between Cardiology, General Medicine, Primary Care and patients is planned to review heart failure management within the primary and secondary care environment iii. Cardiac Rehabilitation: Align current Cardiac Rehab programme with core components agreed regionally with focus on integration with Locality Hubs (where relevant facilities available)	1. Ongoing over 2017/18	NA

Government Planning Priority	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
	NA	**Stroke Services** 2. CM Health will continue participation as part of the Northern Regional Stroke Service Project Group and continue work to align our local service delivery model development to the regional plan with an emphasis on optimising quality, patient experience and clinical outcomes. In 2017/18 CM Health will focus on continuing work to set regional stroke objectives by 1 July 2018. Regional objectives for 2017/18 are: ▪ Improve timely access for patients presenting within the hyper-acute stage of stroke (<12 hours of onset) ▪ Maintain timely access to acute inpatient stroke services ▪ Improve timely access to rehabilitation services ▪ Improve health information to support clinical practice, measure KPIs & other reporting/analysis ▪ Further develop stroke leadership and collaboration **Hepatitis C Services** 3. Support the roll-out of an integrated Hepatitis C service across the region including support for primary care, raising awareness, extending services and monitoring progress 4. Continue roll out of community based screening and treatment through Counties Manukau localities **Major Trauma** 5. CM Health will continue to participate in the Regional Trauma Network to support the following regional focus areas: ▪ Use data from the New Zealand Major trauma Registry to identify where we perform well and where we perform poorly, and work to address these issues; ▪ Develop regional clinical guidelines applicable for small to large hospitals; and ▪ Implement the per-hospital destination policies.	2. Ongoing over 2017/18 3. Ongoing over 2017/18 4. Ongoing over 2017/18 5. Ongoing over 2017/18	

2.2 Financial Performance Summary

The following tables provide our statement of comprehensive income and a prospective summary of revenue and expenses by output class. Note that we are working on a three year recovery plan that will return our organisation to a breakeven position. Accordingly outer year plans for 2018/19 to 2020/21 should be read as indicative and will be updated once the three year recovery plan has been agreed by the Executive Leadership Team and endorsed by the CM Health Board.

Refer to Appendix A for further detail.

2.2.1 Statement of comprehensive income

Prospective statement of financial performance for the four years ended 30 June 2018, 2019, 2020 and 2021

Net Result	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Revenue						
Crown	1,496,414	1,538,144	1,593,800	1,645,078	1,697,920	1,752,046
Other	43,049	39,027	37,748	38,677	39,714	41,191
Total Revenue	**1,539,463**	**1,577,171**	**1,631,548**	**1,683,755**	**1,737,634**	**1,793,237**
Expenses						
Personnel	564,665	592,388	621,253	638,399	657,461	677,175
Outsourced	72,651	87,899	79,707	81,906	84,356	86,883
Clinical Supplies	113,865	110,384	117,481	120,898	124,684	128,601
Infrastructure	65,203	73,807	75,068	68,107	70,292	72,582
Personal Health	483,756	482,167	498,787	509,350	522,981	537,138
Mental Health	60,209	61,585	65,464	76,518	78,967	81,495
Disability Support	111,598	117,984	122,976	126,223	129,920	133,747
Public Health	2,577	3,200	1,140	1,151	1,206	1,243
Maaori	452	2,748	1,824	1,874	1,930	1,987
Operating Costs	**1,474,976**	**1,532,162**	**1,583,700**	**1,624,426**	**1,671,797**	**1,720,851**
Operating Surplus	**64,487**	**45,009**	**47,848**	**59,329**	**65,837**	**72,386**
Depreciation	30,637	31,889	31,932	32,251	32,573	32,898
Capital Charge	18,510	18,200	35,928	37,078	38,264	39,488
Interest	12,470	7,860	-	-	-	-
Net Surplus	**2,870**	**(12,940)**	**(20,012)**	**(10,000)**	**(5,000)**	**-**
Other Comprehensive Income	45,400	(64,423)	-	-	-	-
Surplus (Deficit)	**48,270**	**(51,483)**	**(20,012)**	**(10,000)**	**(5,000)**	**-**

2.2.2 Prospective summary of revenues and expenses by output class

Prospective financial performance by output class for the four years ended 30 June 2018, 2019, 2020 and 2021

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Prevention				
Total Revenue	4,656	10,960	11,311	11,673
Personnel	-	-	-	-
Outsourced	-	-	-	-
Clinical Supplies	-	-	-	-
Infrastructure	-	-	-	-
Other	4,656	10,960	11,311	11,673
Total Expenditure	4,656	10,960	11,311	11,673
Net Surplus / (Deficit)	**-**	**-**	**-**	**-**
Early Detection and Management				
Total Revenue	231,300	242,145	249,893	257,888
Personnel	-	-	-	-
Outsourced	-	-	-	-
Clinical Supplies	-	-	-	-
Infrastructure	-	-	-	-
Other	231,300	242,145	249,893	257,888
Total Expenditure	231,300	242,145	249,893	257,888
Net Surplus / (Deficit)	**-**	**-**	**-**	**-**
Intensive Assessment and Treatment				
Total Revenue	1,267,652	1,297,585	1,339,106	1,381,956
Personnel	621,253	638,399	657,461	677,175
Outsourced	79,707	81,906	84,356	86,883
Clinical Supplies	125,408	128,909	132,775	136,773
Infrastructure	135,001	129,425	133,038	136,796
Other	325,295	328,946	336,476	344,329
Total Expenditure	1,286,664	1,307,585	1,344,106	1,381,956
Net Surplus / (Deficit)	**(20,012)**	**(10,000)**	**(5,000)**	**-**
Rehabilitation and Support				
Total Revenue	128,940	133,065	137,324	141,720
Personnel	-	-	-	-
Outsourced	-	-	-	-
Clinical Supplies	-	-	-	-
Infrastructure	-	-	-	-
Other	128,940	133,065	137,324	141,720
Total Expenditure	128,940	133,065	137,324	141,720
Net Surplus / (Deficit)	**-**	**-**	**-**	**-**
Total				
Total Revenue	1,631,548	1,683,755	1,737,634	1,793,237
Personnel	621,253	638,399	657,461	677,175
Outsourced	79,707	81,906	84,356	86,883
Clinical Supplies	125,408	128,909	132,775	136,773
Infrastructure	135,001	129,425	133,038	136,796
Other	690,191	715,116	735,004	755,610
Total Expenditure	1,651,560	1,693,755	1,742,634	1,793,237
Net Surplus/ (Deficit)	**(20,012)**	**(10,000)**	**(5,000)**	**-**

2.3 Local and Regional Enablers

Local and Regional Enablers	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
IT	**Smart System**	1. Work collaboratively with regional colleagues to develop a Northern Region Information Systems Strategic plan (RISSP) to achieve the Northern Regions objective to increase the value provided by the healthcare system 2. Implement eVital to collect patient observations and nursing assessments, leveraging earlier implementations at Waitemata, Canterbury and West Coast DHBs 3. Implement regional e-Orders for laboratory & radiology within CM Health and implement Medchart pilot for electronic prescribing and administration leveraging developments and learnings within the region 4.Programme of work to enable community teams to be more mobile, effective, efficient and integrated across disciplines and with primary care with the aim to remove duplication, increase capacity, improved patient access, enable coordinated care	1.RISSP approval June 2017, implementation commences Q1 2.eVitals implemented in two wards by Q2 2017 3. Radiology orders implemented in early adopter wards in Q1, rollout to commence Q2 3.Laboratory Orders implemented Q1, rollout to commence Q2 3.Medchart Pilot commenced by Q4 (dependent on regional ePharmacy upgrade) 4.Rollout of community central platform and workforce mobilisation commences by Q2 4.Increased uptake and functionality of patient portals throughout the year 4.Increased number of providers and patients using shared care for coordination of care and updating care plans 4.Introduction of telehealth tools in primary care by Q2 with increased utilisation over the year 4.Complete regional eReferral inter and intra hospital referrals implementation by Q4	Quarterly reports from regional leads.

Local and Regional Enablers	Link to NZ Health Strategy	Counties Manukau Health Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
Workforce	**One Team**	Continue to work regionally to reshape and grow workforce capacity and capability. 1. Build workforce capability in the following priority areas: i. Leadership ii. Patient experience and co-design iii. Improvement and safety iv. Change 2. Implement the State Services Commission Leadership and Talent Framework to support workforce development 3. Implement initiatives to increase and support diversity and inclusion across the system, with a particular focus on growing our Maaori and Pacific workforce (EOA) 4. Advance the Whakamana Takuta Maaori Health Equity Campaign project to grow the Maaori medical workforce in Counties Manukau (EOA) 5. Develop a more agile, responsive and flexible workforce to support the delivery of whole of system care 6. Build workforce capability to apply a health equity approach in their work 7. Support the intent and undertake actions with key partners and associated Kaiawhina workforces as outlined in the Healthy Ageing Strategy. Key partners are the Ministry of Health, Waitemata DHB and aged residential care, home and community support services	1. Agree and implement the development plan for 2017/18 to align to the needs of the CM Health operating model 2. All key and critical positions are identified and development/ succession plans initiated 3. Complete a stocktake of existing activity and effectiveness to guide the development of the diversity and inclusion plan for the 2017/18 year 4. Increase Maaori PGY1 junior doctor intake by Q2 5. Review and identify gaps against the requirements of the CM Health operating model and develop a framework to support the transformation	NA

3.0 Service Configuration

Service Coverage

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

Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific and high-needs groups. 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 2017/18.

Service Change

The table below describes all service reviews and service changes that have been approved or proposed for implementation in 2017/18.

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
After Hours Network Contracts	It is anticipated that new after-hours service arrangements will be in place by 1 November 2017. Providers will deliver Urgent Care Services after hours and overnight, with a focus on meeting population needs in each of the localities.	There will be improved access to affordable, subsidised after hours care for high needs populations closer to where people live.	Regional
Community Health Services	CM Health is planning for investment in Community Health Hubs to support and enable more integrated services closer to where people live. This will include reconsideration of our current community service configuration.	An expanded range of integrated community services will be available to people in a more accessible way. The services will be more closely aligned with and support local general practice.	Local
Community Pharmacist Services Agreement	Implement the national pharmacy contracting arrangements and develop local services once agreed.	The new contracting arrangements will enable more integration across the primary care team; improved access to pharmacist services by consumers; consumer empowerment; the safe supply of medicines to the consumer; improved support for vulnerable populations and more use of pharmacists as a first point of contact within primary care.	National
Gastroenterology	Introduction of National Bowel Screening Program tentatively scheduled for July 2018 (subject to further discussion with MOH)	Reduced mortality from bowel cancer	National
Mental Health and Addictions Services in the Community	A substantive amount of NGO mental health and addictions services will be reorganised to develop a more comprehensive suite of services that is locality specific.	This will better support integration and team work across the service user journey. This will enable earlier access to services and interventions in primary care and the community. Services will be more focused around the service user and their whaanau.	Local

Palliative Care Service Contracts	The Palliative Outcomes Initiatives are a metro Auckland systems based approach to deliver improved outcomes for people with palliative care needs, better integrated services and improved capacity across the system. In addition, over 2017/18 CM Health will develop a whole of system implementation plan for palliative care services. This will be aligned with the Palliative Outcomes Initiatives and may result in changes to hospice service specifications.	Service users will experience a more comprehensive suite of coordinated services across providers.	Local/Regional
Rehabilitation Services	CM Health's long term investment plan includes development of a new model of rehabilitation services enabled by a new Living Well Centre.	The new model will be more service user focused supported by a combined centre of excellence with prevention, rehabilitation and health maintenance service delivery which acts as a centre of gravity for specialised rehabilitation services and wellbeing within a high needs community.	Regional & National
Self-Management Support Service Contracts	Currently CM Health contracts Primary Health Organisations to deliver self-management support services to their enrolled population. A procurement process was initiated in 2016 that will significantly change where and how services are provided. This new approach requires a much more integrated way of working with general practice teams in each locality.	Services will more collaborative and locality-based to deliver a more comprehensive range of support solutions. The focus will be on Maaori, Pacific and high needs populations and will be important for reducing health inequities in our district.	Local
Regional Planning	CM Health will continue to operate by the agreed regional service change process to promote rational regional service distribution to strengthen the region overall, create opportunity for certain services to be delivered locally and not destabilise any particular DHB. In 2017/18 the focus will be on local medical oncology and urology service delivery where we will investigate the options for transitioning some high volume medical oncology and urology service elements away from the Northern Region Tertiary centre (Auckland DHB), and into regional secondary and community based delivery. Other regional reviews in progress that will continue over 2017/18 include cardiology, oral health, head and neck services.	Intended service change will have the benefit of improving local access for Counties Manukau residents.	Local/Regional

4.0 Stewardship

Refer to Counties Manukau DHB's 2016/17 Annual Plan that incorporates the Statement of Intent for more detailed information.

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

4.1 Managing our Business

4.1.1 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 2017/18 we will continue regional work to develop and mature the national System Level Measures reporting processes to reflect greater sharing of accountability for population health outcomes with our primary care alliances.

4.1.2 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 Finance Director to the Chief Executive and Board. 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.

Further information about Counties Manukau DHB's planned financial position for 2017/18 and out years is contained in the Financial Performance Summary section and in Appendix A: Statement of Performance Expectations.

4.1.3 Investment and asset management

The most recent Investor Confidence Rating (ICR) assessment led by the Treasury gave Counties Manukau DHB an 'A' rating, which exceeds the 'C' rating expected of a Tranche 2 organisation. Counties Manukau DHB's asset management maturity was rated as Middle Intermediate (62/100) against a long term target of lower advanced (82/100).

All DHBs are required to complete a stand-alone Long Term Investment Plan (LTIP) covering at least 10 years. LTIPs are part of the new Treasury system for monitoring investments across government, the Investment Management and Asset Management Performance (IMAP) system.

The Northern Region DHBs are working together to develop a Northern Region Long Term Investment Plan (NRLTIP). The NRLTIP will deliver a high level, integrated strategic plan to guide medium to long term regional investment decisions related to Physical Infrastructure, Clinical Equipment and Information and Communication Technology (ICT). The NRLTIP work plan focuses the most effort on 'Physical Infrastructure' investment requirements facing our region. The 'Clinical Equipment' and 'ICT' portfolio investment plans will draw from relevant work currently taking pace in parallel investment planning work streams (for example the Information Systems Strategic Plan (ISSP)) and other investment planning work which has already been completed in the Northern Region.

The NRLTIP will outline the region's strategic directions, investigate a number of investment scenarios and provide an approach to assess and prioritise future investments, supporting the region to deliver the optimal health gain for the northern region's population within the available resources. The NRLTIP will build on the work done by each DHB in developing their individual long term investment plans.

The project is being undertaken using a three phase approach as follows:

- Phase 1 – Preliminary Analysis – understanding the baseline and drivers for change
- Phase 2 – Understanding and agreeing the counterfactuals
- Phase 3 – Agreeing and informed Long Term Investment Plans

The outputs from all three phases will be reported to the Regional Governance Group. The project has completed Phase 1 with Phase 2 now underway and will provide a Draft NRLTIP for regional Review and agreement during July 2017.

4.1.4 Shared service arrangements and ownership interests

Counties Manukau DHB has a part ownership interest in the Northern Regional Alliance Ltd, 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.

4.1.5 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).

4.1.6 Quality assurance and improvement

Counties Manukau DHB's approach to quality assurance and improvement 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.

4.2 Building Capability

4.2.1 Capital and infrastructure development

In 2017/18 CM Health will align its long term district investment plan with the agreed NRLTIP. It is expected that this will require a balanced district investment portfolio which aligns with regional priorities to manage capacity growth and support whole of system solutions including community based service developments.

In 2017/18, major investment projects in progress include:

- Acute Mental Health Inpatient Unit construction completion and commissioning on the Middlemore Hospital site
- Subject to approval of the Indicative Business Case, development of the detailed business case for the Living Well Centre, including specialised rehabilitation and associated approvals
- Community Health Services development of locality based community hubs included as part of Programme and Business Case approvals
- Regional agreed Information and Communications Technology developments (see below)

4.2.2 Information technology and communications systems

Counties Manukau DHB's information technology and communication systems goals align with the national and regional strategic direction for information technology (IT). Further detail about Counties Manukau DHB's current IT initiatives is contained in the 2017/18 Northern Regional Service Plan, and in the section on local and regional enablers within this document.

4.2.3 Workforce

Below is a short summary of CM Health's organisational culture, leadership and workforce development initiatives. Further detail about the regional approach to workforce is contained in the 2017/18 Northern Regional Service Plan.

The People Strategy for CM Health has been developed to support our Healthy Together Strategic Plan. This focuses on transformation and system integration to better meet the needs of the community we serve. It aims to establish CM Health as a high performing organisation and an employer of choice, by being a great and safe place to work. It will guide the development of people and shape the culture in ways that will accelerate transformation and progress integration at pace.

Key pieces of work for 2017/18 include:

- Building workforce capability in the following priority areas:
    - Leadership
    - Patient Experience and co-design
    - Improvement and safety
    - Change
- Implementing the State Services Commission Leadership and Talent Framework to support workforce development, and developing and implementing the College of Leadership, Innovation, Management and Beliefs (CLIMB) Leadership Programme
- Implementing initiatives to increase and support diversity and inclusion across the system, with a particular focus on growing our Maaori and Pacific workforce
- Developing capability of community teams to deliver inter professional care closer to home, including increasing undergraduate training and new graduate employment placements into primary and community care providers

4.2.4 Co-operative developments

Counties Manukau DHB works and collaborates with a number of external organisations and entities. Below are some examples of the broad range of collaborations (but not limited to):

- Our regional partners at Auckland and Waitemata DHBs. CM Health together with Auckland and Waitemata DHBs and the Ministry of Health are collaborating to deliver Programme W&AT! to supports Pacific students from Year 13 through their tertiary studies.
- The South Auckland Social Investment Board (SIB). Counties Manukau DHB is a member agency of SIB, and hosts the SIB Programme Office
- A broad range of social sector agencies including the Ministry of Social Development, Ministry of Education, New Zealand Police, Te Puni Kōkiri, Ministry for Pacific Peoples, Department of Corrections, Ministry of Justice, Housing New Zealand Corporation and Tamaki Oranga
- Turuki Health in Mangere and other Maaori health providers working with CM Health to deliver Whaanau Ora integrated services to high need Maaori and hard to reach whaanau populations
- Local government and council via CM Health's locality-based work
- Early childhood education centers, primary and secondary schools
- Ko Awatea's education partnerships with tertiary education providers including the University of Auckland, Auckland University of Technology Auckland, Manukau Institute of Technology
- The Middlemore Foundation, a charitable trust supporting the health services provided by CM Health
- Strategic collaboration with the Accident Compensation Corporation.

5.0 Performance Measures

2017/18 Performance Measures

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

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

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

Code Dimension

HS Health Strategy

PP Policy Priorities

SI System Integration

OP Outputs

OS Ownership

DV Developmental – Establishment of baseline (no target/performance expectation is set)

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

Performance Measure		2017/18 National Performance Expectation
HS: Supporting delivery of the New Zealand Health Strategy		Quarterly highlight report against the Strategy themes
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	To be agreed as part of reporting for Q1 2017/18.
	Age 20-64	
	Age 65+	
PP7: 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
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm	80% of people seen within 3 weeks.
		95% of people seen within 8 weeks.
	Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.
		95% of people seen within 8 weeks.
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1	0.81
	Ratio year 2	0.81
PP11: Children caries-free at	Ratio year 1	60%

Performance Measure		2017/18 National Performance Expectation
five years of age	Ratio year 2	60%
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1	85%
	% year 2	85%
PP13: Improving the number of children enrolled in DHB funded dental services		
Measure 1: Number of Pre-School Children Enrolled in DHB-funded Oral Health Services	% year 1	95%
	% year 2	95%
Measure 2: Number of Enrolled Pre-School and Primary School Children Overdue for their Scheduled Examinations	% year 1	<=10%
	% year 2	<=10%
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)		
Focus area 1: Long-term conditions	Report on activities in the Annual Plan	
Focus area 2: Diabetes services	Implement actions from Living Well with Diabetes	
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator)	
Focus area 3: Cardiovascular (CVD) health	Indicator 1: 90% of the eligible population will have had their cardiovascular risk assessed in the last five years	90%
	Indicator 2:% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years	90%
Focus area 4: Acute heart service	70% of high risk patients will receive an angiogram within 3 days of admission	70%
	Over 95% of patients with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days	95%
Focus area 5: Stroke Services	8% of potentially eligible stroke patients thrombolysed 24/7	8%
	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%
PP21: Immunisation coverage	% of two year olds fully immunised	95%
	% of five year olds fully immunised	95%
	% of eligible girls fully immunised - HPV vaccine	75%
	% of the population aged 65 years and over who are immunised against influenza annually (measured at 30 September)	75%
PP22: Delivery of actions to improve system integration including SLMs	Report on activities in the Annual Plan.	
PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan.	
	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	95%

Performance Measure		2017/18 National Performance Expectation
	completed care plan.	
PP25: Prime Minister's youth mental health initiative	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.	
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).	
	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.	
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for each focus area: ▪ Primary Mental Health ▪ District Suicide Prevention and Postvention ▪ Improving Crisis Response Services ▪ Improving outcomes for children ▪ Improving employment and physical health needs of people with low prevalence conditions	
PP27: Supporting vulnerable children	Report on delivery of the actions and milestones identified in the Annual Plan	
PP28: Reducing Rheumatic Fever	Reducing the Incidence of First Episode Rheumatic Fever	4.5 per 100,000 total population
PP29: Improving waiting times for diagnostic services	Coronary angiography: 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	95%
	CT and MRI –95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days)	95% for CT scans
		90% for MRI scans
	Diagnostic colonoscopy: ▪ 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days, inclusive), 100% within 30 days ▪ 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days	90% within 14 days 100% within 30 days 70% within 42 days 100% within 90 days
	Surveillance colonoscopy: ▪ 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days	70% within 84 days 100% within 120 days
PP30: Faster cancer treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat	85%
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	95%
PP32:Improving the accuracy of ethnicity reporting in PHO registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).	
PP33: Improving Māori enrolment in PHOs	% of Māori population enrolled with a PHO	90%
	Report on delivery of the actions and milestones to improve the Māori enrolment rates with PHOs.	
PP34: Improving the percentage	% of babies (up to 50 days of age) who live with a	TBC by MOH

Performance Measure		2017/18 National Performance Expectation
of women who are smoke free at two weeks postnatal	recorded household smoker	
PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.	% of the Māori population under community treatment orders s29 of the Mental Health Act	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.
PP37: Improving breastfeeding rates	% of infants exclusively or fully breastfed at three months (Total and Māori)	60%
PP38:Delivery of response actions agreed in annual plan	Report on activities in the Annual Plan.	
SI1: Ambulatory sensitive hospitalisations	Age group 0-4 years (SLM measure)	See System Level Measures Improvement Plan included at Appendix C
	Age group 45-64 years	4,334/100,000
SI2: Delivery of Regional Service Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region	
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of any exceptions to service coverage identified in the Annual Plan, and not approved as long-term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry)	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement	21.0 per 10,000
	Cataract procedures	27.0 per 10,000
	Cardiac surgery	6.5 per 10,000
	Percutaneous revascularisation	12.5 per 10,000
	Coronary angiography services	34.7 per 10,000
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.	
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.	
SI10: Improving cervical screening coverage	% of women aged 25 – 69 years (by ethnicity) who have had a cervical sample taken in the last 3 years (adjusted for hysterectomy)	80% coverage for all ethnic groups and overall.
SI11: Improving breast screening rates	% of women aged 50 -69 years (by ethnicity) who have had a screening mammogram in the last two years. This includes women who may have turned 70 or 71 during the monitoring period.	70% coverage for all ethnic groups and overall.
OS3: Inpatient Length of Stay	Elective LOS	1.52 days
	Acute LOS	2.50 days
OS8: Reducing Acute Readmissions to Hospital	To be confirmed – indicator definition under review by Ministry of Health	Ministry of Health to confirm over 2017/18 year
OS10: 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 identity data	New NHI registration in error A. Greater than 2% and less than or equal to 4% B. Greater than 1% and less than or equal to 3% C. Greater than 1.5% and less than or equal to 6%	 >2% and ≤4% >1% and ≤3% >1.5% and ≤6%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% and ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and ≤2%
	Validated addresses unknown	>76% and ≤85%

Performance Measure		2017/18 National Performance Expectation
	Invalid NHI data updates	Ministry of Health to confirm over 2017/18 year
Focus area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	>= 97% and <99.5%
	National Collections File load Success	>= 98% and <99.5%
	Assessment of data reported to NMDS	>= 75%
	Timeliness of NNPAC data	>= 95% and <98%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified about data quality audits.	
Output 1: Mental health 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, and actual expenditure on the delivery of programmes or places is within 5% (+/−) of the year-to-date plan	
DV4: Improving patient experience	No performance expectation/target set.	
DV6: SLM youth access to and utilisation of youth appropriate health services	No performance expectation/target set.	
DV7: SLM number of babies who live in a smoke-free household at six weeks post natal	No performance expectation/target set.	

Appendices

APPENDIX A: 2017/18 Statement of Performance Expectations

CM Health's Statement of Intent 2017-2021 sets out our strategic Healthy Together goal and objectives, in terms of improving the health of our population and ensuring the sustainability of the Counties Manukau health system, for the years 2017 to 2021.[1] To monitor progress towards Healthy Together over this period we use the Healthy Together Outcomes Measurement Framework which is included in our Statement of Intent.

We also monitor and evaluate our performance towards our Healthy Together goal and objectives on an annual basis in our Statement of Performance Expectations (SPE). This SPE includes a number of important strategic outcomes and contributory measures from our Healthy Together Outcomes Measurement Framework alongside a range of other indicators which we believe are significant to our community and stakeholders, and provide a fair representation of our DHB's performance.

The SPE is a requirement of the Crown Entities Act 2013 and sets the annual performance expectations of the DHB. Recent actual performance data are used as the baseline for targets.[2] Actual results of service performance against what was forecast here will be published in our 2017/18 Annual Report.[3] The following SPE presents Counties Manukau DHB's planned performance for 2017/18.

Note that the Healthy Together Outcomes Measurement Framework includes a number of measures that are being developed over the 2017/18 year. Where these measures are not currently measurable they have not been included in the 2017/18 SPE but will be included in future SPEs.

Health Equity

Not everyone living in Counties Manukau experiences the same health outcomes and we care about achieving health equity for our community. All targets in this SPE are universal with the aim of reducing equity gaps that exist in health outcomes for some population groups in Counties Manukau. To further support this, wherever possible, performance data in this SPE will be provided by ethnicity.

CM Health has published separate 2017/18 Maaori, Pacific and Asian health plans. A number of the performance indicators from these plans have been included in this SPE to highlight areas of particular significance and priority in terms of improving health outcomes for our Maaori, Pacific and Asian peoples living in Counties Manukau.

Crown Entities Amendment Act 2013

The 2013 amendments to the Crown Entities Act 2004 provide for DHBs to have a Statement of Intent with a four year focus, and to be updated every three years instead of annually. The current Counties Manukau DHB Statement of Intent can be accessed here: http://countiesmanukau.health.nz

The requirement under Sections 142 and 143 of the Crown Entities Act 2004 to provide an annual Statement of Forecast Service Performance within the Statement of Intent has now been replaced with the requirement to have a SPE.

This SPE has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, and Public Finance Act and the expectations of the Minister of Health. The annual forecast financial statements will be provided as part of the SPE in accordance with the Crown Entities Amendment Act 2013.

[1] CM Health's Statement of Intent is tabled in Parliament and is available on the DHB's website: www.countiesmanukau.health.nz
[2] For 2017/18 in order to align baseline data across the three Auckland metropolitan DHBs, 2015/16 baseline data is included in the 2017/18 Statement of Performance Expectations.
[3] CM Health's Annual Report is tabled in Parliament and is available on the DHB's website: www.countiesmanukau.health.nz.

1.0 Input levels against Output Classes

The following tables provide a prospective summary of revenue and expenses by Output Class. Note that we are working on a three year recovery plan that will return our organisation to a breakeven position. Accordingly outer year plans for 2018/19 to 2020/21 should be read as indicative and will be updated once the three year recovery plan has been agreed by the Executive Leadership Team and endorsed by the CM Health Board.

Prevention

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	4,656	10,960	11,311	11,673
Personnel	-	-	-	-
Outsourced	-	-	-	-
Clinical Supplies	-	-	-	-
Infrastructure	-	-	-	-
Other	4,656	10,960	11,311	11,673
Total Expenditure	4,656	10,960	11,311	11,673
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**

Early detection and management

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	231,300	242,145	249,893	257,888
Personnel	-	-	-	-
Outsourced	-	-	-	-
Clinical Supplies	-	-	-	-
Infrastructure	-	-	-	-
Other	231,300	242,145	249,893	257,888
Total Expenditure	231,300	242,145	249,893	257,888
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**

Intensive assessment and treatment

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	1,267,652	1,297,585	1,339,106	1,381,956
Personnel	621,253	638,399	657,461	677,175
Outsourced	79,707	81,906	84,356	86,883
Clinical Supplies	125,408	128,909	132,775	136,773
Infrastructure	135,001	129,425	133,038	136,796
Other	325,295	328,946	336,476	344,329
Total Expenditure	1,286,664	1,307,585	1,344,106	1,381,956
Net Surplus/(Deficit)	**(20,012)**	**(10,000)**	**(5,000)**	**-**

Rehabilitation and support

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	128,940	133,065	137,324	141,720
Personnel	-	-	-	-
Outsourced	-	-	-	-
Clinical Supplies	-	-	-	-
Infrastructure	-	-	-	-
Other	128,940	133,065	137,324	141,720
Total Expenditure	128,940	133,065	137,324	141,720
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**

Total

	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Revenue	1,631,548	1,683,755	1,737,634	1,793,237
Personnel Costs	621,253	638,399	657,461	677,175
Outsourced	79,707	81,906	84,356	86,883
Clinical Supplies	125,408	128,909	132,775	136,773
Infrastructure	135,001	129,425	133,038	136,796
Other	690,191	715,116	735,004	755,610
Total Expenditure	1,651,560	1,693,755	1,742,634	1,793,237
Net Surplus / (Deficit)	**(20,012)**	**(10,000)**	**(5,000)**	**-**

2.0 Output Classes

Four "output classes" are used by all 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), Coverage (C) and Quality (Q).

Each of the performance measures has a reference classification to assist with quick categorisation.

Reference Key			
NHT	National Health Target	**V**	Volume
SLM	System Level Measure	**T**	Timeliness
SLMc	System Level Measure Regional Contributory Measure as included in the 2017/18 Auckland, Waitemata & Counties Manukau Health Alliances System Level Measures Improvement Plan (the 2017/18 Metro Auckland SLM Improvement Plan)	**Q**	Quality
		C	Coverage

2.1 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 2015/16	Target 2017/18	Notes
Health Promotion and Education Services				
Proportion of enrolled patients who smoke and are seen in General Practice are offered brief advice and support to quit	Total	92%	90%	NHT C
	Maaori	91%		
	Pacific	92%		
	Asian	93%		
Proportion of hospitalised patients who smoke that are offered brief advice and support to quit smoking	Total	96%	95%	C
	Maaori	96%		
	Pacific	96%		
	Asian	94%		
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer who are offered brief advice and support to quit smoking	Total	100%	90%	NHT C
	Maaori	97%		

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
Percentage of PHO-enrolled patients who smoke who accepted smoking cessation support	Total	24.4%[4]	26.8%[5]	SLMc Q
Percentage of houses that are smokefree at two weeks postnatal[6]	Total	91%	95%	Q
	Maaori	72%		
Percentage of babies fully or exclusively breastfed at 3 months	Total	46%	60%	Q
	Maaori	37%		
	Pacific	39%		
Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Total	29%[7]	95%	NHT Q
	Maaori	29%		
	Pacific	28%		
	Other	49%		
Number of children aged <5 years referred to Active Futures	Total	N/A[8]	350 (75% to be Maaori, Pacific or quintile 5)	V
Number of children aged 5-18 years referred to Green Prescription Active Families	Total	125	171 (75% to be Maaori, Pacific or quintile 5)	V
Number of adult referrals to Green Prescription services	Total	5,896[9]	7,300	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	95%	95%	NHT SLMc C
	Maaori	90%		
	Pacific	97%		
	Asian	99%		
Proportion of eligible girls fully immunised with HPV vaccine	Total	62%	75%	C
	Maaori	63%		
	Pacific	68%		
	Asian	61%		
Percentage of people aged over 65 years who have had their flu vaccinations	Total	47%	75%	C
	Maaori	44%		
	Pacific	64%		
	Asian	47%		
Health Screening				
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Total	69%	70%	C
	Maaori	65%		
	Pacific	76%		
	Other	68%		
Proportion of women aged 20 – 69 years who have had a cervical smear	Total	75%	80%	C

[4] Baseline data is as at 30 September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[5] 2017/18 targets represent a 10% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[6] 2015/16 Baseline data as at March 2016. Note that from 2017/18 there is a developmental national System Level Measure focused on the proportion of babies living in smokefree households at six weeks of age. As baseline data and targets are still in development, in 2017/18 CM Health will continue to report on the 2 week post-natal measure.
[7] Baseline data for six months ending August 2016 (Q1) (new Health Target)
[8] New service (commenced March 2017) therefore baseline data not available.
[9] Total number of adult referrals received between 1 July 2015 and 30 June 2016 including repeat referrals.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
in the last three years	Maaori	69%		
	Pacific	82%		
	Asian	67%		
	Other	79%		
Percentage of four year olds receiving a B4 School Check	Total	101%	90%	C
	Maaori	100%		
	Pacific	90%		
	Other	109%		
Percentage of year 9 students in decile 1-4 high schools, alternative education and teen parent unit facilities provided with a HEADSSS assessment[10]	Total	91%	95%[11]	C
	Maaori	87%		
	Pacific	94%		
	Asian	N/A[12]		

2.2 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.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
Primary Health Care Services				
Percentage of population enrolled in a PHO	Total	98%	95%	C
	Maaori	93%		
	Pacific	117%		
	Asian	83%		
Amenable mortality rate per 100,000 population[13]	Total	104.4[14]	102.3[15]	SLM Q
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	92%	90%	C
	Maaori	89%		
	Pacific	92%		
	Other	93%		
Percentage of eligible Maaori men aged 35-44 who have had their cardiovascular risk assessed in the last 5 years	Maaori	73%	90%	C
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c < 64 mmol/mol)[16]	Total	65%	69%	Q
	Maaori	61%		
	Pacific	58%		

[10] Performance is measured using school/calendar year. Baseline data as at 31 December 2016.
[11] Performance against target to be measured at 31 December 2017.
[12] Asian data is being developed over the 2017/18 year. Baseline data is therefore not available for this population group.
[13] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30.
[14] Baseline data is for the 12 months ended 30 June 2013. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[15] 2017/18 targets represent a 2% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[16] Note that CM Health currently uses the PHO CDIP 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.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
	Other	73%		
Percentage of patients with CVD risk >20% on dual therapy (dispensed)	Total	49%[17]	52%[18]	Q
	Maaori	48%	51%	
	Pacific	49%	52%	
	Asian	43%	46%	
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)	Total	58%[19]	61%[20]	Q
	Maaori	55%	58%	
	Pacific	62%	65%	
	Asian	51%	53%	
% of each PHO's practices registered with an e-portal[21]	Total	52%	55%	SLMcV
Oral Health Services[22]				
Proportion of children under 5 years enrolled in DHB-funded community oral health services	Total	84%	95%	SLMcC
	Maaori	74%		
	Pacific	85%		
	Asian	87%		
	Other	90%		
Percentage of enrolled children Caries free at age 5 years	Total	48%	60%	Q
	Maaori	38%		
	Pacific	30%		
	Asian	56%		
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children (12/13 years)	Total	0.96	0.81	Q
	Maaori	1.29		
	Pacific	1.42		
	Asian	0.72		
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services	Total	73.3%	85%	C
Diagnostics				
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	92%	95%	T
	MRI	62%	90%	
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	90%	90%	T
Proportion of patients accepted as non- diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	44%	70%	T
Ambulatory Sensitive Hospitalisations				
Ambulatory Sensitive Hospitalisation rate in children aged 0-4 years per 100,000 population	Total	7,109[23]	6,754[24]	SLMQ
	Maaori	6,264	5,951	
	Pacific	11,977	11,378	
	Other	4,789	4,550	
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 0-4 year	Total	1,073[25]	1,019[26]	SLMc

[17] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[18] 2017/18 targets represent a 5% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[19] Baseline data is for the 12 months ended 30 September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[20] 2017/18 targets represent a 5% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[21] Note that this is a regional (Auckland DHB, Waitemata DHB and CM Health) target as included in the 2017/18 Metro Auckland SLM Improvement Plan.
[22] Baseline data is based on the calendar year (to 31 December 2016), except for adolescent measure which is Q4 2015/16.
[23] Baseline data for 12 months to September 2016. Source: Ministry of Health SI1 Quarterly data. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[24] 2017/18 targets represent a 5% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[25] Baseline data for 12 months to September 2016. Source: cellulitis and dermatisis/eczema dataset via Ministry of Health SI1 Quarterly data. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan
[26] 2017/18 targets represent a 5% increase from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
olds – skin infection subset	Maaori	1,288	1,224	Q
	Pacific	2,195	2,085	
	Other	334	317	
Rheumatic Fever				
Acute rheumatic fever first hospitalisations rates per 100,000 population	Total	7.0[27]	4.5	Q
	Maaori	13.1		
	Pacific	23.2		
Sudden Unexpected Death of an Infant (SUDI)				
SUDI deaths per 1,000 live births	Total	0.96	0.40	Q
	Maaori	2.13		
Pharmacy				
Number of prescription items subsidised	Total	7,334,818	N/A[28]	V

2.3 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

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 2015/16	Target 2017/18	Notes
Mental Health					
Percentage of population who access mental health services	Age 0-19 years	Total	3.9	3.15%	C
		Maaori	5.6	4.45%	
	Age 20-64 years	Total	3.8	3.15%	
		Maaori	8.5	7.75%	
	Age 65+ years	Total	2.5	2.60%	
		Maaori	2.8	2.60%	
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 Care Arm)	3 weeks	76%	80%	T
		8 weeks	96%	95%	
	Addictions (Hospital Care Arm and NGO	3 weeks	96%	80%	
		8 weeks	96%	95%	
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[29]		Total	78.1%	90%	T

[27] Baseline data Q1 2016/17
[28] Measure is demand driven – not appropriate to set target.

Performance Measure			Baseline 2015/16	Target 2017/18	Notes
Elective Services					
Number of Elective Surgical Discharges		Total	109% 21,650	100% 20,535	NHT V
Elective Services Standardised Intervention Rates (SIRs) per 10,000 population		Major Joints	22.39	21	C
		Cardiac Surgery	6.04	6.5	
		Cataracts	33.25	27	
Acute Services					
Emergency Department (ED) attendance rate per 100,000 population		Total	215.4[30]	211.1[31]	SLMc V
		Maaori	283.3	277.6	
		Pacific	337.6	330.8	
		Asian	135.9	133.2	
Readmissions – acute readmissions to hospital[32]		Total	7.7%	TBC[33]	V
		75+	9.7%	TBC	
Acute Inpatient Average Length of Stay		Acute LOS	2.57 days	2.50 days	Q
		Elective LOS	1.67 days	1.52 days	
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours			96%	95%	NHT T
Cancer Services					
Proportion of medical oncology and haematology patients needing radiation therapy or chemotherapy treatment (and are ready to start treatment) who receive this within four weeks from decision to treat	Radiotherapy	Total	100%	85%	T
		Maaori	100%		
		Pacific	100%		
	Chemotherapy	Total	100%	85%	
		Maaori	100%		
		Pacific	100%		
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	76%	90%	NHT T
Cardiac Services					
Percentage of high risk patients who receive an angiogram within 3 days of admission		Total	80%	70%	T
		Maaori	74%		
		Pacific	75%		
		Other	81%		
Stroke Services					
Percentage of potentially eligible stroke patients thrombolysed			11%	8%	C
Quality and patient safety					
Percentage of admissions affected by four or more triggers[34]			1.4%	<1.4%	Q
Rate of falls with major harm per 1000 bed days			0.07	<0.09	Q

[29] Source: www.mhakpi.health.nz. CM Health is developing a suite of mental health and wellbeing measures over 2017/18. 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.

[30] Baseline data for 12 months to September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.

[31] 2017/18 targets represent a 2% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.

[32] Note that the 2017/18 Metro Auckland SLM Improvement Plan includes a developmental contributory measure for acute readmission rates in 28 days. Methodology for this rate is currently in progress.

[33] The Ministry of Health OS8 Reducing Acute Readmissions to Hospital measure definition is currently under review. A target for this measure is therefore not able to be set at the time of writing (July 2017).

[34] Note that this measure replaced the previously reported 'number of adverse health care events'. This measure is from the Copeland Risk Adjusted Barometer (CRAB) tool which provides a risk adjusted view of complications, patient harm and mortality of inpatient admissions. An algorithm is applied to coded discharge data equivalent to the Trigger Tool.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
Percentage of inpatients (aged 75+) assessed for risk of falling		94%	90%	Q
Rate of S. aureus bacteraemia (SAB) per 1000 bed days		0.06	<0.06	Q
Compliance with good hand hygiene practice		82%	80%	Q
System Level Measures				
Acute hospital bed days per capita	Total	460.1[35]	450.9[36]	SLM Q
	Maaori	690.8	677.0[37]	
	Pacific	710.1	695.9[38]	
Patient experience of care – hospital inpatient survey aggregate score	Total	8.7[39]	8.5[40]	SLM Q

2.4 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 2015/16	Target 2017/18	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		81.6%	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		53.3%	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.		N/A[41]	95%	Q
Assessment, Treatment and Rehabilitation Services[42]				
Number of older people that have received in-home strength and balance retraining services	Aged 65-74	N/A	703	V
	Aged 75+			
Number of older people that have received community / group strength and balance retraining services	Aged 65+	N/A	2,325 places	V
Number of older people that have been seen by the Fracture Liaison Service (FLS) or similar fracture prevention service	Aged 65-74	N/A	300	V
	Aged 75-84		300	

[35] Baseline data for 12 months to September 2016. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[36] 2017/18 targets represent a 2% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[37] 2017/18 targets represent a 3% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[38] 2017/18 targets represent a 3% reduction from baseline per the 2017/18 Metro Auckland SLM Improvement Plan.
[39] Baseline data as at Q1 2016/17. This baseline period has been used in order to align with the 2017/18 Metro Auckland SLM Improvement Plan.
[40] 2017/18 targets is an aggregate score of 8.5 across all four domains measured (communication, partnership, coordination, physical and emotional needs) per the 2017/18 Metro Auckland SLM Improvement Plan.
[41] New measure for 2017/18 therefore baseline data not available.
[42] Note that following falls and fractures measures are new in 2017/18 as part of the ACC, MOH and HQSC Live Stronger for Longer Programme. Baseline data is therefore not available.

Performance Measure		Baseline 2015/16	Target 2017/18	Notes
	Aged 85+		300	
Palliative care[43]				
Number of Palliative Pathway Activations (PPAs) in the Counties Manukau District		N/A[44]	200[45]	V
Number of Hospice Proactive Advisory conversations between the hospice service, primary care and ARRC health professionals		N/A[46]	200[47]	V

[43] The following measures are part of the regional Better Palliative Care Outcomes Service which is being implemented and delivered in the Auckland Region from 2017/18. This service will implement 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.
[44] This is a new measure in 2017/18 therefore baseline data is not available.
[45] Target volume of PPAs for hospices in the Counties Manukau District (Franklin and Totara hospices). Regional 2017/18 target volume of 656 PPAs across all 6 hospices in the Auckland Region.
[46] This is a new measure in 2017/18 therefore baseline data is not available.
[47] Target volume of Proactive Advisory conversations in the Counties Manukau District (Franklin and Totara hospices). Regional 2017/18 target volume of 656 Proactive Advisory conversations across all 6 hospices in the Auckland Region.

3.0 Financial Performance

3.1 Introduction

CM Health and its Primary Health Organisation (PHO) partners remain fully committed to achieving the government's priorities despite the increasing fiscal constraints the health sector is facing. Clear indications from the Minister and Ministry of Health are of a continued and significant tightening fiscal position. Despite capital and operational constraints, demand on CM Health system services is expected to grow at fiscally unsustainable levels unless significant change and related innovations are implemented. This funding forecast has accelerated the scale and pace of health system transformational change needed for future sustainability.

We continue to have significant cost pressures with respect to Multi Employer Collective Agreements (MECA) and related wage and salary increases. Capacity pressures associated with growth in demand for clinical services have also added significant cost. Recent unprecedented demand growth has placed significant strain on current budgets. A historical reliance on one off gains, not available in 2017/18 has contributed to our challenge for 2017/18. Despite our commitment to an ambitious savings plan, 2017/18 funding increases have been inadequate to meet overall cost increases.

Despite these considerable challenges, we are working on a three year recovery plan that will return our organisation to a breakeven position and refocus our resources to those functions that deliver evidence based care to our communities. This will be assisted by the Ministry of Health who will be working with us. Accordingly outer year plans for 2018/19 to 2020/21 (shaded grey) should be read as indicative and will be updated once the three year recovery plan has been agreed by the Executive Leadership Team and endorsed by the CM Health Board.

As part of developing our recovery plan, we will be revisiting our investments in context of long term regional planning and exploring other opportunities to do more regionally where there are benefits. In this context we commit to ensuring that the changes we make in our decision making approach will be transparent and focus on those priorities that matter to our workforce, communities and the Government.

Important to close with an acknowledgement to our very hard working frontline staff and support services including community based providers who do their best every day to meet the healthcare needs of CM Health populations.

3.2 Forecast Financial Statements

3.2.1 Summary by funding arm

Net Result	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Provider	(11,964)	(16,922)	(24,302)	(11,652)	(9,732)	(7,828)
Governance	(392)	(8,687)	(643)	(598)	(586)	(574)
Funder	15,226	12,669	4,933	2,250	5,318	8,402
Eliminations	-	-	-	-	-	-
Operating Surplus	**2,870**	**(12,940)**	**(20,012)**	**(10,000)**	**(5,000)**	**-**
Other Comprehensive Income	45,400	(64,423)	-	-	-	-
Surplus / (Deficit)	**48,270**	**47,501**	**(20,012)**	**(10,000)**	**(5,000)**	**-**

Note: The 2017/18 MOH funding increase of $41.19m has been top sliced for Mental Health and Inter District Flows. The residual balance has been provisionally allocated to Provider, Governance and Funder based on proportionate net surplus(deficit). This will be updated following confirmation of final Production Plans and Price Volume Schedules due for completion 31 August 2017.

3.2.2 Statement of comprehensive income

Net Result	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Revenue						
Crown	1,496,414	1,538,144	1,593,800	1,645,078	1,697,920	1,752,046
Other	43,049	39,027	37,748	38,677	39,714	41,191
Total Revenue	**1,539,463**	**1,577,171**	**1,631,548**	**1,683,755**	**1,737,634**	**1,793,237**
Expenses						
Personnel	564,665	592,388	621,253	638,399	657,461	677,175
Outsourced	72,651	87,899	79,707	81,906	84,356	86,883
Clinical Support	113,865	110,384	117,481	120,898	124,684	128,601
Infrastructure	65,203	73,807	75,068	68,107	70,292	72,582
Personal Health	483,756	482,167	498,787	509,350	522,981	537,138
Mental Health	60,209	61,585	65,464	76,518	78,967	81,495
Disability Support	111,598	117,984	122,976	126,223	129,920	133,747
Public Health	2,577	3,200	1,140	1,151	1,206	1,243
Maaori	452	2,748	1,824	1,874	1,930	1,987
Operating Costs	**1,474,976**	**1,532,162**	**1,583,700**	**1,624,426**	**1,671,797**	**1,720,851**
Operating Surplus	**64,487**	**45,009**	**47,843**	**59,329**	**65,837**	**72,386**
Depreciation	30,637	31,889	31,932	32,251	32,573	32,898
Capital Charge	18,510	18,200	35,928	37,078	38,264	39,488
Interest	12,470	7,860	-	-	-	-
Net Surplus	**2,870**	**(12,940)**	**(20,012)**	**(10,000)**	**(5,000)**	**-**
Other Comprehensive Income	45,400	(64,423)	-	-	-	-
Surplus / (Deficit)	**48,270**	**(51,483)**	**(20,012)**	**(10,000)**	**(5,000)**	**-**

3.2.3 Funder

Revenue	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Crown	1,433,837	1,472,838	1,528,692	1,577,608	1,628,092	1,680,191
Other	6,228	5,058	-	-	-	-
Total	**1,440,065**	**1,477,896**	**1,528,692**	**1,577,608**	**1,628,092**	**1,680,191**
Personal Health	1,115,813	1,145,816	1,196,551	1,229,444	1,266,120	1,304,060
Mental Health	143,970	146,909	153,964	167,849	173,220	178,763
Disability Support	145,098	151,720	156,048	160,353	165,141	170,094
Public Health	2,577	3,200	1,140	1,151	1,206	1,243
Maaori	452	2,748	1,824	1,874	1,930	1,987
Governance	16,929	14,834	14,232	14,687	15,157	15,642
Total Expenditure	**1,424,839**	**1,465,227**	**1,523,759**	**1,575,358**	**1,622,774**	**1,671,789**
Net Surplus	**15,226**	**12,669**	**4,933**	(2,250)	(5,318)	(8,402)

3.2.4 Eliminations

Revenue	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Crown	(766,247)	(797,543)	(833,568)	(860,242)	(887,770)	(916,179)
Other	-	-	-	-	-	-
Total	**(766,247)**	**(797,543)**	**(833,568)**	**(860,242)**	**(887,770)**	**(916,179)**
Personal Health	(632,057)	(663,649)	(697,764)	(720,094)	(743,139)	(766,922)
Mental Health	(83,761)	(85,324)	(88,500)	(91,331)	(94,253)	(97,268)
Disability Support	(33,500)	(33,736)	(33,072)	(34,130)	(35,221)	(36,347)
Public Health	-	-	-	-	-	-
Maaori	-	-	-	-	-	-
Governance	(16,929)	(14,834)	(14,232)	(14,687)	(15,157)	(15,642)
Total Expenditure	**(766,247)**	**(797,543)**	**(833,568)**	**(860,242)**	**(887,770)**	**(916,179)**
Net Surplus	**-**	**-**	**-**	**-**	**-**	**-**

3.2.5 Provider

Revenue	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Crown	811,895	848,015	884,558	912,864	942,075	972,221
Other	35,889	32,790	37,406	38,603	39,838	41,113
Total	**847,784**	**880,805**	**921,964**	**951,467**	**981,913**	**1,013,334**
Personnel	554,003	580,568	609,223	626,037	644,729	664,062
Outsourced	71,645	83,346	77,571	79,711	82,095	84,554
Clinical Support	113,585	110,100	117,337	120,750	124,531	128,443
Infrastructure	58,898	65,764	74,275	67,292	69,453	71,717
Operating Costs	**798,131**	**839,778**	**861,533**	**885,930**	**913,140**	**941,288**
Operating Surplus	**49,653**	**41,027**	**62,698**	**67,877**	**71,188**	**74,538**
Depreciation	30,637	31,889	31,932	32,251	32,573	32,898
Capital Charge	18,510	18,200	35,928	37,078	38,264	39,488
Interest	12,470	7,860	-	-	-	-
Net Surplus	**(11,964)**	**(16,922)**	**(24,302)**	**(11,652)**	**(9,732)**	**(7,828)**
Other Comprehensive Income	45,400	(64,423)	-	-	-	-
Total Comprehensive Income	**33,436**	**(47,501)**	**(24,302)**	**(11,652)**	**(9,732)**	**(7,828)**

3.2.6 Governance

Revenue	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Crown	16,929	14,834	14,388	14,848	15,323	15,813
Other	932	1,179	72	74	76	78
Total	**17,861**	**16,013**	**14,460**	**14,922**	**15,399**	**15,891**
Personnel	10,662	11,820	12,030	12,362	12,732	13,113
Outsourced	1,006	4,553	2,136	2,195	2,261	2,329
Clinical Support	280	284	144	148	153	158
Infrastructure	6,305	8,043	793	815	839	865
Total Expenditure	**18,253**	**24,700**	**15,103**	**15,520**	**15,985**	**16,465**
Net Surplus	**(392)**	**(8,687)**	**(643)**	**(598)**	**(586)**	**(574)**

3.2.7 Balance sheet

	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Current Assets						
Cash and Bank	31,778	20,902	(6,474)	(29,364)	(36,485)	(42,338)
Trust Funds	899	883	895	906	917	928
Debtors	50,335	49,297	53,439	53,439	53,439	53,439
Inventory	1,468	7,484	7,484	7,484	7,484	7,484
Assets Held for Sale	-	33,743	5,320	-	-	-
Current Assets Total	**84,480**	112,309	60,664	32,465	25,355	19,513
Non Current Assets	**731,550**	764,338	825,393	868,004	860,164	850,386
Total Assets	**816,030**	**876,647**	**886,057**	**900,469**	**885,519**	**869,899**
Current Liabilities						
Creditors	110,047	112,752	114,234	128,296	117,466	100,966
Loans	-	-	-	-	-	-
Employee Provisions	105,845	115,170	117,718	114,187	114,187	114,187
Total Current Liabilities	**215,892**	227,922	231,952	242,483	231,653	215,153
Working Capital	**(131,412)**	(115,613)	(171,288)	(210,018)	(206,298)	(195,640)
Net Funds Employed	**600,138**	**648,725**	**654,105**	**657,986**	**653,866**	**654,746**
Non-current Liabilities						
Employee Provision	21,221	18,717	20,017	21,317	22,617	23,917
Term Loans	292,500	-	-	-	-	-
Restricted funds	873	898	898	898	898	898
Other	931	931	931	931	930	929
Total Non-Current Liabilities	**315,525**	**20,546**	**21,846**	**23,146**	**24,445**	**25,744**
Crown Equity	**284,613**	**628,179**	**632,259**	**634,840**	**629,421**	**629,002**
Net Funds Employed	**600,138**	**648,725**	**654,105**	**657,986**	**653,866**	**654,746**

3.2.8 Movement of equity

	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Total Equity at beginning of Period	236,762	284,613	(628,179)	(632,259)	(634,840)	(629,421)
Surplus / (Deficit) for period	2,870	(12,940)	(20,012)	(10,000)	(5,000)	-
Crown Equity injection	-	292,500	24,500	13,000	-	-
Crown Equity withdrawal	(419)	(419)	(419)	(419)	(419)	(419)
Revaluation Reserve	45,400	64,423	-	-	-	-
Total Equity at beginning of Period	**284,613**	**(628,179)**	**(632,259)**	**(634,840)**	**(629,421)**	**(629,002)**

3.2.9 Cash flows

	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Operating Activities						
Crown Revenue	1,494,489	1,545,461	1,585,764	1,645,078	1,697,596	1,751,915
Other	36,647	37,403	34,874	35,990	37,141	38,329
Interest rec.	3,355	2,075	2,604	2,687	2,773	2,862
Suppliers	(913,172)	(935,060)	(957,536)	(972,082)	(1,025,166)	(1,060,176)
Employees	(570,954)	(591,931)	(617,407)	(640,630)	(656,162)	(675,876)
Interest paid	(12,470)	(9,518)	-	-	-	-
Capital charge	(19,225)	(18,200)	(35,928)	(37,078)	(38,264)	(39,488)
GST (Net)	1,250	(1,114)	637	-	-	-
Net cash from Operations	**19,920**	**29,116**	**12,997**	**33,965**	**17,918**	**17,566**
Investing activities						
Sale of Fixed assets	-	9,987	28,423	5,320	-	-
Total Fixed Assets	(34,652)	(45,455)	(82,707)	(68,656)	(19,620)	(18,000)
Investments and Restricted Trust Funds	(8,323)	(4,105)	(10,181)	(6,100)	(5,000)	(5,000)
Net cash from Investing	**(42,975)**	**(39,573)**	**(64,465)**	**(69,436)**	**(24,620)**	**(23,000)**
Financing						
Crown Debt	-	-	-	-	-	-
Equity – Capital	(419)	(419)	24,081	12,581	(419)	(419)
Net cash from Financing	**(419)**	**(419)**	**24,081**	**12,581**	**(419)**	**(419)**
Net increase / (decrease)	**(23,474)**	**(10,876)**	(27,376)	(22,890)	(7,121)	(5,853)
Opening cash	**55,252**	**31,778**	**20,902**	(6,474)	(29,364)	(36,485)
Closing cash	**31,778**	**20,902**	(6,474)	(29,364)	(36,485)	(42,338)

3.2.10 Capital expenditure

	2015/16 Audited Actual $000	2016/17 Actual $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Baseline Capital	34,652	45,455	42,671	27,956	19,620	18,000
Strategic Capital	-	-	40,036	40,700	-	-
Total	**34,652**	**45,455**	**82,707**	**68,656**	**19,620**	**18,000**

3.3 Accounting Policies

The Counties Manukau Health (CM Health) financial statements 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 include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

The financial statements comply with NZ International Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

The accounting policies applied in the projected financial statements are set out in section 3.6.

3.4 Significant Assumptions

3.4.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2017/18 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing unutilised/approved debt facilities. To ensure we achieve a breakeven financial position where cost growth is higher than forecast revenue, CM Health will cap the level of allowable and fundable growth within hospital care and primary and community care.

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.

3.4.2 Personnel costs

Despite the international economic position, the anticipated level of clinical wage settlements will continue to be an ongoing challenge in relation to the mismatch of health worker wage/salary expectations and affordability. The annualised ongoing cost of settlement is 3 percent – 5 percent due to automatic ongoing 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.

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.

3.4.3 Third party and shared services provision

Our focus for 2017/18 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 healthAlliance with heightened reliance around realisation of tangible savings.

3.4.4 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 healthAlliance will be included in our living with our means projects.

3.4.5 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.

3.4.6 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 2017/18.

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.

3.4.7 Enabling technology infrastructure

Prioritised Information System (IS) infrastructure (technology) investment has been agreed regionally (refer 3.4.8) 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 section 2.3 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.

3.4.8 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 means 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 requires 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 2017/18.

Figure 2 below outlines likely major capital (projects greater than $10m) 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 indicative and 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: Major capital investment projects – approved

Major Capital Projects	Approved	2017/18 $000	2018/19 $000	2019/20 $000	2020/21 $000	Status
Acute Mental Health Unit	2014/15	25,356	14,172	1,620	-	Construction
Ko Awatea II	2015/16	8,780	368	-	-	Construction
Healthy Together Technology	2016/17	11,446	7,660	-	-	Implementation
MRI (addition and relocation)	2016/17	4,490	3,296	-	-	Design and construct
Scott Dialysis Expansion	2016/17	1,500	2,004	-	-	Design and construct
Scott Building Recladding	2016/17	2,800	13,200	-	-	Design and construct
Histology Expansion	2016/17	1,600	-	-	-	Design and construct
Chilled Water	2016/17	2,225	7	-	-	Design
Interventional X Ray	2016/17	1,453	80	-	-	Design
Total		**59,650**	**40,787**	**1,620**	-	

Figure 2: Major capital investment projects (>$10m) – unapproved

Major Project $000	2017/18 $000	Year 2-5 $000	Year 6-10 $000	Year 10+ $000	Total $000	Status
Kidz First Building Re-Cladding		12,000			12,000	Assessment
McIndoe Building Re-Cladding		8,000			8,000	Assessment
Manukau Building Re-Cladding		11,000			11,000	Assessment
Specialised Rehabilitation & Community Wellness		115,000			115,000	Re-scoping
Manukau Community Hub		15,000			15,000	Assessment
Mangere Community Hub		20,000			20,000	Assessment
Manukau Radiology Hub-Phase 1			21,400		21,400	Subject to NRLTIP
Papakura Community Maternity Unit			10,000		10,000	Subject to NRLTIP
Papakura Community Hub			20,000		20,000	Subject to NRLTIP
Manukau Infrastructure (Phased)			30,000		30,000	Subject to NRLTIP
Manukau Support Services			31,800		31,800	Subject to NRLTIP
Elective Surgery Centre			240,000		240,000	Subject to NRLTIP
Manukau Outpatients (Phased fit out)			28,600		28,600	Subject to NRLTIP
Radiology Department Harley Gray			16,300		16,300	Subject to NRLTIP
Manukau Radiology Hub-Phase 2			10,500		10,500	Subject to NRLTIP
Middlemore Car Parking			20,500		20,500	Subject to NRLTIP
Single Wing Ward Block				43,500	43,500	Subject to NRLTIP
Franklin (Pukekohe) Health Hub (5 stages)				54,000	54,000	Subject to NRLTIP
Botany Community Hub (6 rolling stages)				30,000	30,000	Subject to NRLTIP
New Women's Health Building				71,000	71,000	Subject to NRLTIP
Harley Grey Stage 2				80,000	80,000	Subject to NRLTIP
Manukau Education and Research				53,400	53,400	Subject to NRLTIP
Healthy Together Technology (Core Regional, Hospital, Community)	28,049	79,653	72,007		179,709	In progress

Note: (i) Annual capital investments to replace and/or maintain equipment and facilities is excluded in this table but incorporated in the financial statements; (ii) Capital costs outlined above are indicative and will be clarified as part of business case and procurement processes. This includes service capacity expansion that may be amenable to "as a service" provision rather a bricks and mortar capital investment; (iii) Current Northern Regional Long Term Investment Plan (NRLTIP) may change CM Health 2016 LTIP planned major investments after 2021.

3.4.9 Capital investment funding

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

3.4.10 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 3: Banking facilities

Facilities	Existing Limit $000,000	Utilisation at 30 June 2013 $000,000	Available Facility at 1 July 2017 $000,000
NZ Health Partnerships (working capital)	$69.9	-	$69.9
Westpac (lease facility)	$10.0	-	$10.0
Commonwealth Bank (lease facility)	$10.0	-	$10.0

Note: On 15 February 2017 the existing Crown loans held by DHBs were converted to equity.

3.4.11 Property, plant and equipment

CM Health revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. CM Health land and buildings are revalued every three years or where there is a material change. The last revaluation occurred in June 2018 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 2017/18.

3.5 Additional Information and Explanations

3.5.1 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.

3.6 Significant Accounting Policies

Subsidiaries

Subsidiaries are entities controlled by Counties Manukau DHB. Counties Manukau DHB does not consolidate its subsidiaries as they are not material.

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 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 capitalised on qualifying assets in accordance with Counties Manukau DHB's policy. All other costs are treated as an expense in the financial year in which they are incurred.

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 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;
- 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 4: Depreciation rates of assets

Class of Asset	Estimated Life	Depreciation Rate
Buildings		
Structure/Envelope	10 - 100 years	1% - 10%
Electrical Services	10 - 15 years	6% - 10%
Other Services	15 - 25 years	4% - 6%
Fit out	5 - 10 years	10% - 20%
Infrastructure	20-100 years	1% - 5%
Plant and equipment	5 - 10 years	10% - 20%
Clinical Equipment	3 - 25 years	4% - 33%
Information Technology	3 - 5 years	20% - 33%
Vehicles	3 - 6 years	16% -33%
Other Equipment	3 - 25 years	4% - 33%

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.

FPSC Rights

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by NZ Health Partnerships, whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZ Health Partnerships through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC 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% - 50%)

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 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 financial statement purposes and to be consistent with the presentation basis of the other primary 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.

Budget figures

The budget figures are derived from the Statement of Intent (SOI) as approved by the Counties Manukau District Health Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

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 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.

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 financial statements.

Appendix B: Statement of Intent 2017/18 -2020/2021

COUNTIES MANUKAU HEALTH

Statement of Intent

2017-2021

This Statement of Intent covers the years 2017/18, 2018/19, 2019/20 and 2020/21.

Statement of Responsibility

The Counties Manukau District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2011. Each DHB is categorised as a Crown Agent under the Crown Entities Act, and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident population.

This Statement of Intent has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, and Public Finance Act and the expectations of the Minister of Health. In accordance with sections 100 and 141 of the Crown Entities Act 2004, CM Health will seek the Minsiter of Health's consent to its investment in any shares or interest in a company, trust or partnership.

The document sets out our goals and objectives and what we intend to achieve, in terms of improving the health of our population and ensuring the sustainability of the Counties Manukau health system. This Statement of Intent is extracted from the DHB's Annual Plan and presented to Parliament as a separate public accountability document. This Statement of Intent can be read alongside the Counties Manukau District Health Board Statement of Performance Expectations and Counties Manukau District Health Board Annual Plan (both updated annually) to compare our planned and actual performance during each financial year, and audited results are presented each year in our Annual Report.

In signing this Statement of Intent, we are satisfied that it fairly represents our intentions and commitments. By working together as health system and in collaboration with Northern Region DHBs, we will continue to strive to improve the short to long term health and wellbeing of our community, and deliver against the expectations of Government.

Signed on behalf of the Counties Manukau District Health Board:

Dr Lester Levy
Chairman

Mark Darrow
Chair, Audit Risk and Finance Committee

XX Month 2017

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.

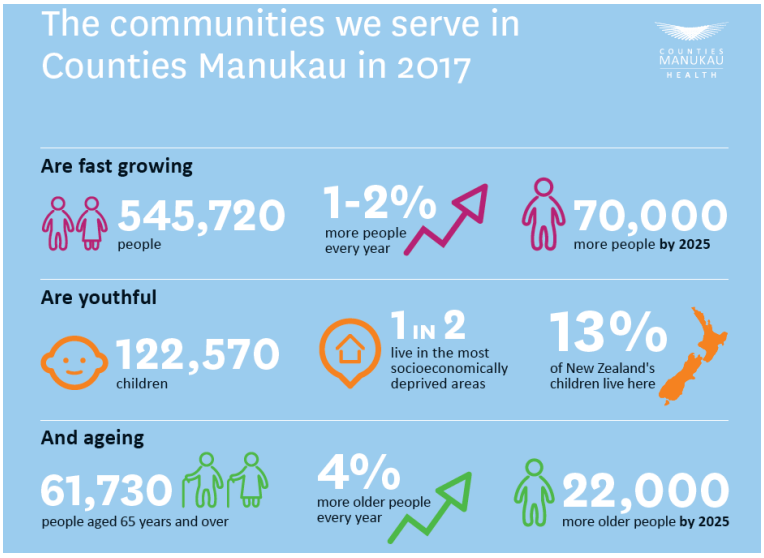
Table of Contents

1.0 About Counties Manukau Health

1.1 Who we are

Counties Manukau District Health Board is one of 20 DHBs 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.

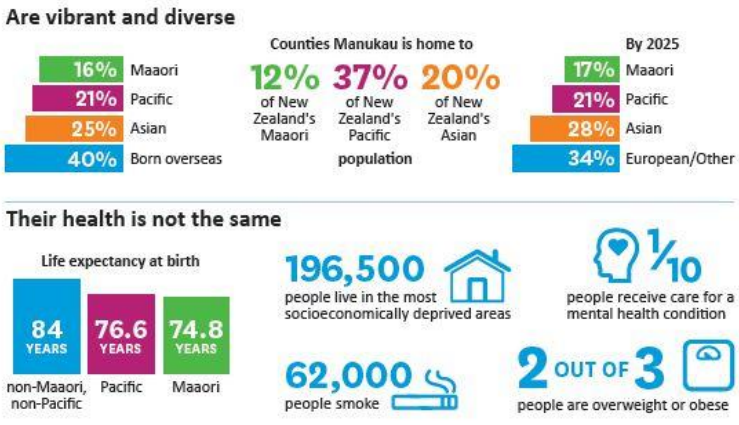
As a collective health system, Counties Manukau Health[1] provides and funds health and disability services to an estimated 545,720[2] people in 2017 who reside in the local authorities of Auckland, Waikato and Hauraki District. We are one of the fastest growing DHB populations in New Zealand with a youthful and ageing population.



Counties Manukau is home to New Zealand's second largest Maaori population, largest population of Pacific peoples, as well as fast growing Asian communities. Our population is diverse and vibrant with strong cultural values. Statistics New Zealand's first survey on Maaori well-being, Te Kupenga (2013), highlighted a number of strengths in our local Maaori. A high level of connectedness with whaanau was reported and 83 percent of people surveyed said it was 'easy' or 'very easy' to get support from their whaanau.

Across our district, the health and circumstances of our communities are not the same. Over 122,000 children live in Counties Manukau, with almost 1 in 2 (approximately 45 percent) living in areas of high socioeconomic deprivation (NZDep2013 9&10[3]). There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau.[4] On the basis of the NZDep2013 measure, Otara, Mangere and Manurewa, home to many of our Maaori and Pacific communities, are the most socioeconomically deprived areas in our district.

Related to these inequities, our population experiences relatively high rates of ill-health risk factors (such as smoking, obesity, hazardous alcohol use) for a 'package' of long term physical conditions which are responsible for the majority of potentially avoidable deaths. Increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity, and reducing obesity are key to improving the health of our population.



[1] 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.
[2] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2013-Census Base) – October 2016 update.
[3] 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 Deprviation levels 9 and 10, represents people living in the most deprived 20 percent of these areas.
[4] Chan WC, Winnard D, Papa D (2015). Life Expectancy, Leading Causes of Death and Amenable Mortality in Counties Manukau. 2015 update. Auckland: Counties Manukau Health.

1.2 What we do

The Counties Manukau District Health Board acts as a 'planner', 'funder' and 'provider' of health services to our population, as well as an owner of Crown assets. As a DHB, we have an annual budget of over $1.6 billion to cover the provision and funding of health services for the people living in the Counties Manukau district. This includes funding for primary care, hospital services, some public health services, aged care services, and services provided by other non-government health providers including Maaori and Pacific providers. Some specialist services are provided by other DHBs through regional contracts. Collectively, we refer to this as the Counties Manukau Health system. In addition, regionally managed services are provided by the Auckland DHB and Waitemata DHB. These include cardiothoracic, neurosurgery, oncology, forensic mental health and school dental services. We also provide regional and national services for people from other DHBs for specific specialties (e.g. regional spinal service, burns unit). We contribute to regional networks and service planning through the Northern Regional Alliance. Regional public health services are provided by Auckland Regional Public Health Service, under a Ministry of Health contract, managed through Auckland DHB.

Counties Manukau District Health Board operated services are largely delivered from seven inpatient facilities and numerous leased or owned outpatient and community health facilities across the district. Manukau SuperClinic and Middlemore Hospital sites contain the largest elective, ambulatory and inpatient facilities. In addition, a range of DHB and contracted community services are provided across the district, e.g. Community Mental Health, Kidz First Community and others.

Over 6,600 people are employed by Counties Manukau District Health Board in addition to those employed by primary and community health services across the district. Nursing, midwifery and Health Care Assistant staff are by far the largest clinical workforce comprising 45 percent of DHB employed staff, medical 14 percent, and allied health and technical 18 percent. Over half of CM Health's workforce is on casual and part time contracts.

1.3 National, regional and local strategic direction

CM Health operates as part of the New Zealand health system by contributing to national goals and performance expectations alongside local strategic priorities. The 2016 New Zealand Health Strategy provides the health sector with a collective vision for the future, that *"All New Zealanders live well, stay well, get well"*. Translating this vision into improved outcomes for the Counties Manukau population requires alignment and integration of the many health system expectations – local, regional and national. Our strategic priorities and performance expectations closely link, and are guided by, the current and future needs of the people living in Counties Manukau.

The Northern Region Health Plan (NRHP) demonstrates how the Government's objectives and the region's priorities will be met. The overall intent of the 2017/18 NRHP is to achieve gains across the Triple Aim Framework and the themes of the New Zealand Health Strategy, in addition to a strong focus on equity. Given the proximity of the three metropolitan Auckland DHBs - Auckland, Waitemata and Counties Manukau – CM Health will contribute to a collaborative and more integrated and aligned approach to health services planning across Auckland. We will adopt the best of each DHB and create the mindset, capacity and will for enduring change and long term sustainability. We are working with our metro-Auckland DHB partners to plan and align clinical and capital investment requirements for a shared future of integrated health service delivery across Auckland. This regional work will be supported by a stronger focus on investment and asset management locally.

Counties Manukau District Health Board has an established district alliance with the five Primary Health Organisation (PHO) partners operating within the Counties Manukau district, reflecting shared system wide accountability and integration across community and hospital care providers. This includes Alliance Health Plus, East Health Trust, National Hauora Coalition, ProCare and Total Healthcare. Increasingly district Alliances are working together on improving health outcomes through planning and measuring performance through national System Level Measures (SLMs).

1.4 Health and safety

CM Health values our staff and the people with whom we work, and aims to provide a health and safety management system that is adaptable, functional and aligned with our organisational vision and values. CM Health is committed to

achieving excellence in health and safety management and to working together, across our entire organisation, to prevent harm as a result of work activities.

CM Health will achieve this through incorporating and promoting a health and safety culture in the development of standard work practices, complying with, or exceeding the spirit of intent of relevant statutory requirements, codes of practice and other industry guidelines and standards. We encourage workers to participate in the review and improvement of the safety management system and use effective risk management methodologies to manage workplace hazards and risks. CM Health offers the appropriate rehabilitation to any worker who has suffered a work-related injury or illness.

1.5 Organisational health and capability

Refer to section 4 of the 2017/18 Counties Manukau District Health Board Annual Plan for information on how the DHB intends to manage its organisational health and capability.

1.6 Te Tiriti o Waitangi

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. As a DHB, we aim to fulfil our obligations as agent of the Crown under Te Tiriti o Waitangi. Our relationship with the tangata whenua of our district is expressed through a board-to-board relationship with Mana Whenua i Tamaki Makaurau. Counties Manukau District Health Board has adopted a principles based approach to recognising the contribution that Te Tiriti o Waitangi can make to better health outcomes for all, inclusive of Maaori.

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. Those principles also recognise the responsibility to, and importance of, DHBs enabling Maaori to contribute to decision making on, and to participate in the delivery of, health and disability services.[5]

1.7 Health gain approach

The health inequities for our Maaori and Pacific communities are stark. In addition to our Te Tiriti responsibilities to work to address Maaori inequities, we have nearly 40 percent of the Pacific population of NZ living in our rohe (district) and their well-being is a significant issue for CM Health. Counties Manukau is also home to 20 percent of the Asian population of NZ, and this diverse Asian community is growing faster than any other ethnic group. Health needs vary across our ethnic populations, and it is important to acknowledge our ethnic and health needs diversity to provide a better experience of health care and better health outcomes for our patients, their whaanau and families now and into the future.

While we acknowledge that the healthcare system is not the only determinant of health and wellbeing, we aspire to ensuring a high performing system that is accessible to all and contributes to healthy life years through the interventions we provide in collaboration with others.

1.8 Equity

Not everyone living in Counties Manukau experiences the same health outcomes and we care about achieving health equity for our community. Equity is about fairness; it acknowledges different starting points, and achieving equity requires the allocation of resources according to need. This means we need to plan for evolving workforce health literacy and cultural capabilities to match changing community needs.

The Healthy Together strategic goal is centred on achieving health equity for our community: Together, the Counties Manukau health systems will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020. We will measure the impact we have on healthy life years every year.

[5] NZ Health and Disability Act 2000.

This is our commitment to act and be deliberate in our choices and priorities. This means that people will live longer healthier lives in the community.

1.9 Key challenges

In partnership with our primary and community providers, CM Health is one of New Zealand's best performing DHBs. However, there are a number of social and health challenges facing our diverse and growing population that need to be considered in our role as a funder and provider of health services.

Growing and ageing population - Counties Manukau is the second fastest growing DHB and our population is forecast to increase to 615,830 by 2025. Our population is also ageing with an additional 2,500 - 3,000 people aged 65 years and over each year. It is this group who will place the highest demands on health services in the years to come and is particularly significant for the Franklin and Eastern localities.

Large high needs population - Socioeconomic deprivation is a key driver of health inequities. It is estimated that in 2017 196,500 people in Counties Manukau, over a third of all residents, are living in areas classified as being the most socio-economically deprived in New Zealand. This is many more people living in these circumstances than any other DHB in New Zealand and presents a challenge for health and social sector agencies to best support our people to flourish.

Prevention and management of long term conditions and mental health – 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. Nearly one in ten adults living in Counties Manukau received care for a mental health condition in 2011,[6] and in 2015 there were over 67,000 people in Counties Manukau living with one or more long term conditions.[7] The increasing prevalence of long term physical and mental health conditions is one of the major drivers of health care demand. Appropriate early detection and management of long term conditions and the associated risk factors are therefore essential to reducing potentially amenable mortality, improving the number of healthy life years and thereby protecting the sustainability of our health system.

Financial sustainability – The increasing demand on our health services presents a substantial financial challenge to CM Health and the broader health sector. The future revenue (inflation and growth) is forecast to be less than what is anticipated to maintain operations. To meet these challenges we have to make deliberate and focused strategic investments decisions through regional collaboration and locally to address the specific needs of our population.

1.10 Our response

While the above represents a significant challenge, our Healthy Together strategy provides the framework for enabling better community, patient, whaanau and family outcomes, improved experience of care and value for the health dollar. We will organise our resources to address these challenges through strategic initiatives and programmes of work (section 2.3) and measure our progress through our outcomes measurement framework (Figure 1) and national performance measurement outlined in each Annual Plan's Statement of Performance Expectations.

Our transformational challenge is *"To systematically prevent and treat ill health as early and effectively as possible for every person every day, so that people in Counties Manukau are healthier and the health system is sustainable and high quality."*

[6] 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.
[7] Chan WC, Winnard D, Papa D (2017) People identified with selected Long Term Conditions in CM Health in 2015. Counties Manukau Health. *Unpublished.*

2.0 Our Direction – Healthy Together

2.1 Introduction

Our Healthy Together strategy is a long term ambition with a transformational focus on integrated care in the community, supported by excellent hospital services. Achieving health equity in key indicators is critical to medium term population outcomes and longer term health system sustainability. Relying on treating people when they become unwell is not enough and will not achieve the health gains needed to achieve healthier longer lives in the community.

"Together, we will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020" is our strategic goal and ambition.

We aspire to live and breathe our values every day as the foundation of our strategic actions:

Valuing everyone – we make everyone feel welcome and valued

Kind - we care for other people's wellbeing

Together – we include everyone as part of a team

Excellent - we are safe, professional and always improving

To achieve our Healthy Together strategic goal, we will balance our resource investment and interventions across our three strategic objectives supported by our values as the foundation of our strategic actions.

2.2 Strategic objectives

CM Health's Healthy Together strategy comprises three key objectives: **Healthy Communities, Healthy Services** and **Healthy People, Whaanau and Families.**

Progressing **Healthy Communities** through primary (ill-health) prevention across the life course is important. There is great potential to reduce the prevalence of long term health conditions by reducing risks early in life from conception to the young adult years, e.g. smoking (direct and indirect smoke exposure), unhealthy weight and nutrition, inadequate physical activity, and harmful alcohol consumption.

Healthy Services support improved health outcomes through more collaborative ways of working to make services easier to access and more responsive/personalised to people's needs. This can enable earlier identification of diseases, earlier intervention and better management of health conditions to achieve **Healthy People, Whaanau and Families.** We aim to enable people to take a more active role in their own health and support them to self-manage for longer at home and in the community.

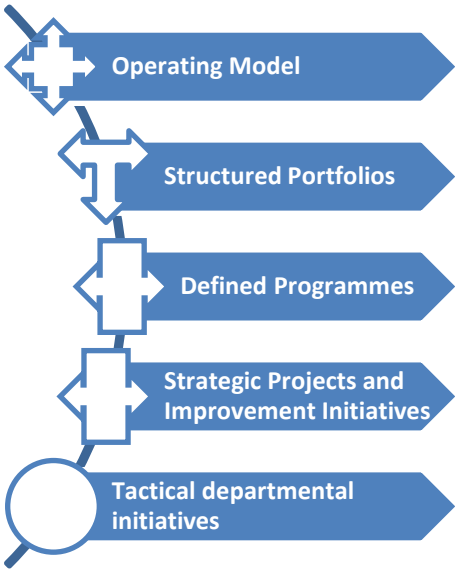
2.3 Delivering on our strategic direction

Our outcomes framework aligns with our strategic objectives and recognises that progress in one strategic objective frequently requires concurrent improvement in others. Our strategic directions do not operate in isolation.

Our **transformation challenge** is to select and clearly describe what, where, how and when we will make changes and how we will know we are progressing in the right direction. In reality this is an iterative process and prudent use of resources means that we need to monitor progress regularly, periodically assess impacts (what difference are we

making) and adapt or change direction when there is evidence to do so. Respecting this, a **single Portfolio Board,** that reports to the Executive Leadership Team, oversees overall strategic activity progress and ongoing portfolio development as we learn what works and consider emerging opportunities.

To deliver on our strategic direction, we have created **three structured portfolios** that will integrate all related programme and project delivery activities. Based upon best practice portfolio management, they will help design and delivery synergies, more effectively allocate resources and link strategic and tactical activities and benefits realisation.



(i) Excellent Care Portfolio

This portfolio promotes whole-of-system coordinated care services (including contracted providers) that transcend traditional divisional and organisational structures. Related programmes and projects focus on improving health outcomes and the patient and whaanau experience through the improvement of care models; improved access to information (and enabling technologies) and services.

(ii) Infrastructure and Assets Portfolio

This portfolio focuses on effective and fit for purpose management (business) processes, information and communication technologies (ICT) upgrades, local and regional planning for major capital developments of facilities and related assets.

(iii) Business as Usual (BAU) Portfolio

This portfolio is designed to ensure that while we are transforming the health system for the future, we are not losing focus on the need to continuously improve services today. The BAU portfolio will therefore encompass all programmes and projects that are seeking to deliver iterative improvements in quality, safety and efficiency of our existing services.

The **operating model** (or blueprint) is a tool to align and 'layer' all the aspects of strategy delivery in a way that includes the 'business as usual' systems, services and interventions. This model was redesigned in 2016 and will be used from 2017 to support the design and planning of operational services. This will enable CM Health to **actively engage and participate in regional** service review and investment forums. Within this model are seven core business capabilities that are most critical to delivery of our Healthy Together strategy. These capabilities will evolve over the Statement of Intent four year period with the following examples of programme activities:

1. **Access**: e.g. ICT to support more mobile and remote access to information systems, community out of hours and rapid response for urgent care, referral processes and protocols for triage and screening
2. **Assess Need**: e.g. integrated multi-disciplinary team assessments, general practice clusters working together, directory of services/interventions, population health data analytics systems
3. **Plan Care**: e.g. evidence based practice for delivering care, case management supported by ICT devices and systems that enable mobile services and portals to access health care plans
4. **Deliver Coordinated Care**: e.g. electronic decision support tools, supported hospital discharge and reablement, systems to coordinate all community services, quality improvement, case management
5. **Monitor and Respond**: e.g. as per Assess, Plan and Deliver to respond to changing needs
6. **Predict and Prevent**: e.g. single accurate information repository, analytic and modelling expertise

3.0 Improving Health Outcomes

3.1 Measuring our performance

To monitor progress towards Healthy Together we require a district wide outcomes framework. This framework of outcomes (medium and longer term) and contributory measures (impacts) needs to join up a complicated system of district wide health resources (inputs) and related services delivered (outputs) by a large number of providers and care setting every day. At the same time, we need to monitor and challenge progress of our Healthy Together portfolio of strategic and system wide transformation while at the same time meeting government performance expectations.

The framework is organised through our three Healthy Together strategic objectives (**Healthy Communities** - **Healthy Services** - **Healthy People, Whaanau and Families**) to provide:

- complementary perspectives in telling our overall strategy performance story,
- underpinned by the national Triple Aim[8] and aligned with the New Zealand Health Strategy (Table 1); and
- performance reporting through the Healthy Together Outcomes Framework (Figure 1)

This measurement framework includes national and local measures that encompass care across a range of district wide acute and planned health services. CM Health's performance against the outcome and contributory measures in this framework is also impacted by our activity towards the other national and local measures that exist within our broader performance context. In addition to those included in this framework, CM Health is committed to meeting and exceeding all our local and national health targets, a full list of which can be found in each year's Annual Plan.

Partnership within and outside health services is critical to achieving equitable health outcomes. For many services, the people living in Counties Manukau rely on regionally delivered services, e.g. radiotherapy, and collaboration across DHB boundaries is essential to a positive experience of care.

The CM Health Alliance Leadership Team is working regionally to implement System Level Measure Improvement Plans as part of a national health sector expectation. These activities are integrated with day-to-day service delivery, health equity campaign and other local strategic initiatives. In addition, CM Health is working with social sector leaders in developing a social investment approach combined with localised decision making to enable greater flexibility to respond to local circumstances in a more integrated way.

Two long term outcomes to monitor progress towards our health equity strategic goal

We know that not everyone in our diverse community experiences the same health outcomes. In Counties Manukau in 2015 the gap in life expectancy (LE) between Maaori (LE=74.8) and the non-Maaori /non-Pacific group (LE=84.0) was 9 years; for Pacific peoples that gap was 7 years. Consistent with most developed countries, New Zealanders are living longer lives, both healthy and unhealthy life years. **Our strategic ambition is longer healthier life years**.

Our two long term outcomes are:

- Quantity of life in terms of mortality measured by **'life expectancy at birth'** – targeting ill health risk factors, e.g. smoking and unhealthy weight, that have multiple impacts on diseases that are the leading causes of amenable mortality. The bigger changes will be in the future decades when those changes means communities will have lower ill-health risk exposure.
- Quality of life in terms of morbidity, measured by **'healthy life years'**[9] – targeting ill health risk factors plus early identification, high quality and collaborative interventions/treatment and effective disease management/self-management are all important for improving healthy life years.

[8] New Zealand Triple Aim for Quality Improvement: i) improved quality, safety and experience of care, ii) improved health and equity for all populations, and iii) better value for public health system resources. Further information is available from http://www.hqsc.govt.nz

[9] Note that recommendations for the development of this measure are being discussed with the Regional Population Health Peer Group. As a result, this measure may evolve over the Statement of Intent period.

Progress towards reducing inequities in these outcomes will require contributions from quality urgent, acute and elective universal services and targeted approaches focused on specific population groups. Our contributory measures need to engage with this scope of activities and be contextualised within physical environment and economic and social realities of our community. We also need to work with whaanau and community strengths that contribute to longer lives, e.g. whaanau support, community connectedness in a way that honours diversity, individual, whaanau and family roles.

Align our medium term outcomes and measures around the Healthy Together strategic objectives

Our outcomes measurement framework outlines the integrated contribution of CM Health's strategic objectives to the two long term outcomes. For example, a 'healthy start in life' requires a combination of health promotion and community engagement to prevent disease, e.g. healthy weight, smokefree pregnant mums, alongside health service delivery, e.g. immunisation in children, reducing potentially avoidable hospital admissions.

There is considerable complexity in the relationship between services/activities and performance measure contribution to health (and health system) outcomes. CM Health's key medium term outcome alignment was based on the medium term outcomes that have the most significant contribution. This simplifies the true contribution story but is necessary to monitor progress, achievements, challenges and opportunities to improve, in a way that enables responsive actions.

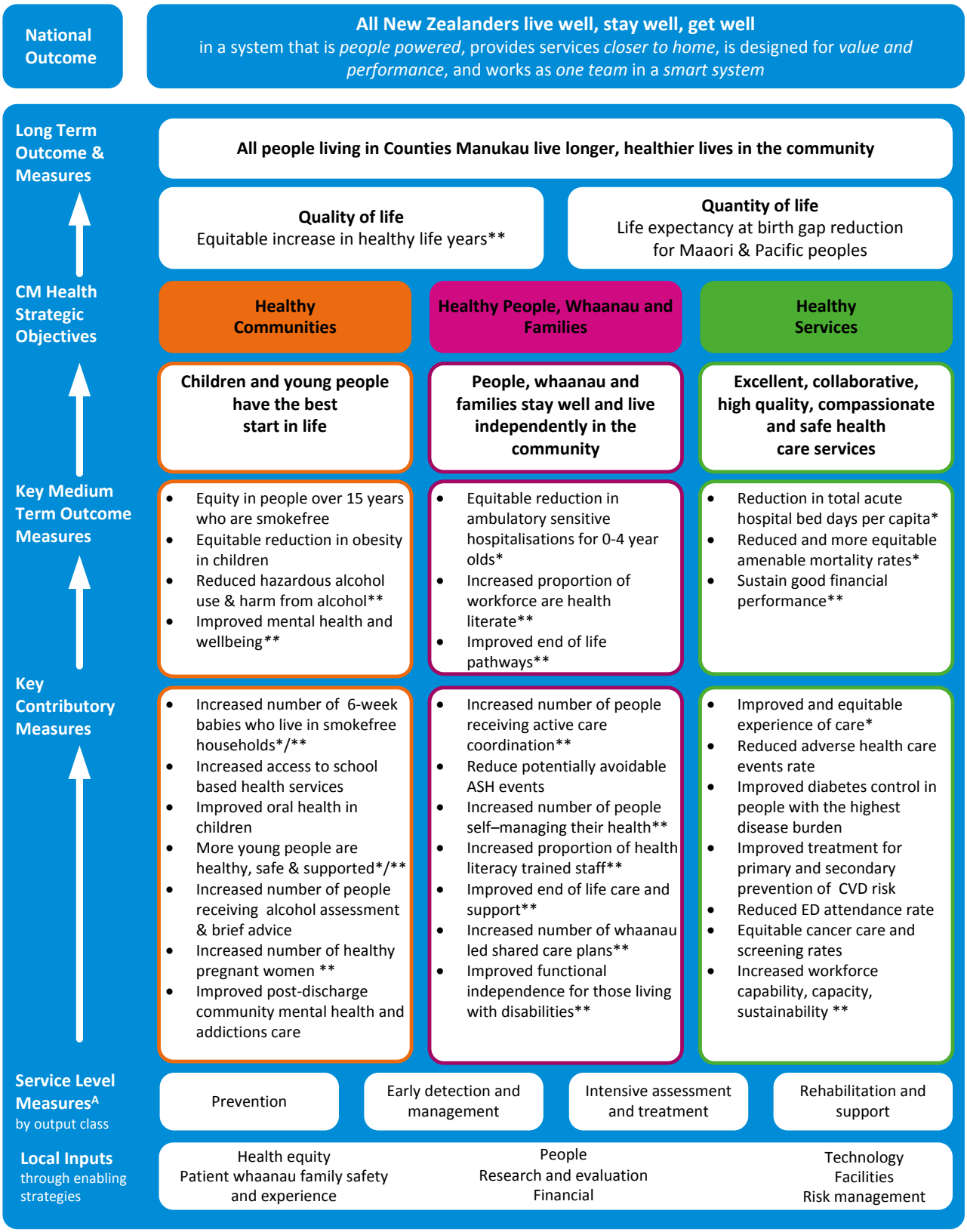
Table 1: National to local strategy and outcome measurement alignment

NZ Health Strategy Theme	CM Health's Key Strategic Objective Alignment	CM Health Medium Term Outcome Alignment[10]
People-Powered – understanding people's preferences, supporting their navigation and enabling individuals to make choices		Children and young people have the best start in life: ▪ Equitable reduction in obesity in children ▪ Equity in adults who are smokefree ▪ Reduced hazardous use and harm from alcohol**
Closer to Home – integrated health services closer to where people live that promote wellness, prevent long term conditions and support a good start in life for children, whaanau and families		Healthy people, whaanau and families stay well and live independently in the community: ▪ Equitable reduction in ambulatory sensitive hospitalisation for 0-4 year olds*
Value and High Performance - delivering better experience of care and equitable health outcomes with a culture of quality improvement and innovative investment approaches.		Excellent, collaborative, high quality, compassionate and safe health services: ▪ Reduced and more equitable amenable mortality rates* ▪ Financial sustainability**
One Team – effective and flexible teams working together with people at the centre of care		Healthy people, whaanau and families stay well and live independently in the community: ▪ Health literate workforce** ▪ Improved end of life pathways**
Smart System – reliable, accurate information at the point of care with systems that improve evidence based decisions and evaluation		Excellent, collaborative, high quality, compassionate and safe health services: ▪ Reduction in total acute hospital bed days per capita*

*Note * indicates national System Level Measures (SLMs). For 2017/18 there are a total of six SLMs, with three identified as key contributory measures in the CM Health Healthy Together Outcomes Measurement Framework. All of the national SLMs align to CM Health's strategic objectives and underpin the NZ Health Strategy theme alignments in Table 1 above.*
*Note ** denotes measures in development over the 2017/18 year*

[10] Refer Healthy Together Outcomes Measurement Framework (Figure 1) for aligned key contributory measures.

Figure 1: Healthy Together Outcomes Measurement Framework



Note denotes a National System Level Measure; each with regionally agreed Improvement Plans*

*Note** denotes measures in development over the 2017/18 year*

Note A: The planned and actual performance of CM Health's services by output class is monitored and reported annually in our Statement of Performance

3.2 Long term outcomes

"More equitable quality and quantity life"

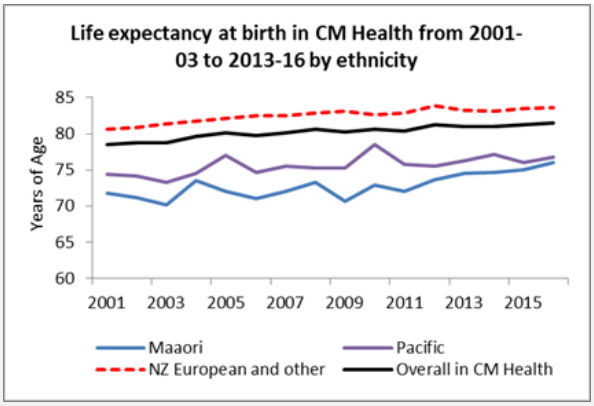
We want to achieve progress towards two long term outcomes to monitor progress towards our health equity strategic goal. What matters is that people live **longer healthier lives in the community**.

Long term outcome: Reduce the life expectancy at birth gap for Maaori and Pacific peoples

Life expectancy at birth is a key long term measure of health

The overall life expectancy at birth in Counties Manukau in 2015 was 81.7 years. Over the last decade life expectancy has shown a consistent upwards trend in Counties Manukau, closely reflecting the national pattern; increasing by 1.9 years from 2006 to 2015. However, not everyone in our diverse community experiences the same health outcomes.

In 2015 the gap in life expectancy between Maaori (life expectancy 74.8 years) and non-Maaori/non-Pacific (life expectancy 84.0 years) was 9 years. The gap between Pacific (life expectancy 76.6 years) and non-Maaori, non-Pacific was 7 years. We are committed to reducing these inequities.[11]



Data source: MOH mortality collection and Estimated population from Stats NZ (2016 edition)

To do so we will reduce ill-health risk factors where it matters most. We will deliver actions to reduce smoking prevalence, reduce the harmful use of alcohol, and prevent and manage cardiovascular and diabetes risk factors. We aim to intervene earlier to improve the quality of life for future generations through better disease management and identifying disease earlier. In addition, we will work to support our communities to address the broader social determinants of health and to ensure that the highest quality health care is accessible and provided to our Maaori, Pacific and other communities with health disparities.

Long term outcome: Equitable increase in healthy life years[12]

The quality of additional years lived impacts the individual, their whaanau, family and demand for health services

As in other countries, the improvement in estimated healthy life expectancy for New Zealand has grown more slowly than the improvement in life expectancy.[11] This means both men and women are living longer with some degree of impairment of their health than previously. This has important implications for the individual, their whaanau,and family with impacts for health and disability service demand due to increased duration of unhealthy life years.

How a "healthy" life is defined is a value judgment and will differ between people and population group. In addition, our definitions of "ill-health" will change over time. Calculating a "healthy life expectancy" is relatively complex.[13] Respecting these complexities, it is important that we measure our progress towards achieving an equitable increase in healthy life years for our population.

CM Health is enhancing approaches that will reduce risk factors and improve management of long term health conditions. Approaches include preventing potentially avoidable ill-health (e.g. smoking cessation, immunisation), delaying onset of disease through early identification of disease (e.g. cardiovascular risk assessment, cancer screening, timely diagnostic services) and effective treatment (e.g. timely elective care, effective cardiovascular and diabetes treatment) and self-management.

[11] Chan WC, Papa D, Winnard D (2015) Life Expectancy, Leading Causes of Death and Amenable Mortality in Counties Manukau. 2016 Update. Auckland: Counties Manukau Health.
[12] As this is a new outcome measure, baseline and trend data is not yet available. Note that recommendations for the development of this measure are currently being discussed with the Regional Population Health Peer Group.
[13] CM Health will use estimates from the Global Burden of Disease (GBD) study for New Zealand applied to the Counties Manukau population.

3.3 Healthy Communities

"Together we will help make healthy options easy options for everyone"

Many of the determinants of ill health are outside the control of the healthcare system. We can, however, exert our leadership role to support our communities in those issues that matter most to them; with particular expertise in population health. By locating more healthcare services that are connected and integrated in community settings, we aim to make it easier for communities to access care and support. Regional and local approaches focus on reducing tobacco use, minimising hazardous use and harm from alcohol, increasing the likelihood of being physically active and providing our community with trusted advice on healthy nutrition. To achieve healthy communities, we will focus on reducing the prevalence of risk factors for ill-health and support the **best start in life for our children and young people that will have benefits for their whaanau, families and community**.

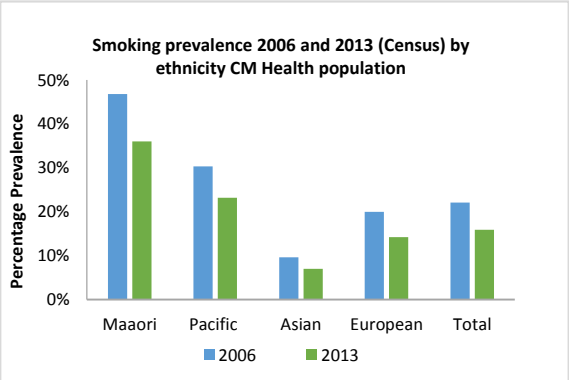
Medium term outcome: Equitable smokefree rates across Counties Manukau

Smoking is a major contributor to preventable illness and long term health conditions

Smoking increases the risk of developing heart disease, respiratory conditions and many types of cancer; all of which contribute to life expectancy inequities. Based on 2013 Census data, we estimate there are 62,000 people that smoke in the Counties Manukau district and clear inequities between ethnic groups. We continue to advance our interventions to improve the chances of people who smoke making a successful quit attempt with targeted actions for ethnic groups with health disparities and working towards achieving equity for our communities and Smokefree New Zealand 2025 (5 percent prevalence).

Data source: Census 2006 and 2013, usually resident population

Total Base	*Total Target*			
2013	*2018*	*2019*	*2020*	*2021*
16%	*10%*	*<10%*	*<10%*	*<10%*

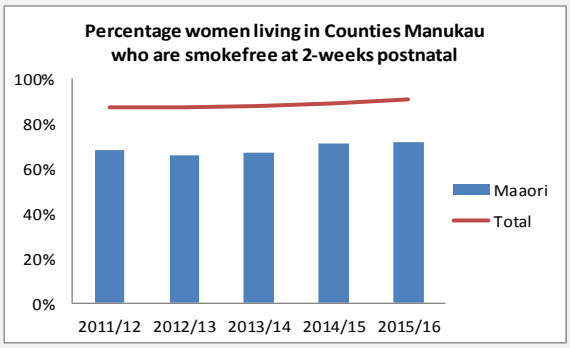


Key contributory measure: increased number of women who are smokefree at 2-weeks post natal[14]

Reducing the proportion of women who smoke during and after pregnancy will have benefits for the woman, her whaanau, family and health of her baby. This will reduce potentially avoidable ill-health and hospitalisation (e.g. respiratory infections, asthma). Smoking in pregnancy also has important risks to the baby (small for gestational age, prematurity) and contributes to sudden unexplained death in infants (SUDI), childhood respiratory infections and asthma. In Counties Manukau an estimated 51 percent of Maaori women smoke at the time of birth (hospital data). We are targeting smoking cessation support during and after birth.

Data source: Well Child Tamariki Ora

Base	*Target (for Maaori)*			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
72%	*95%*	*95%*	*95%*	*95%*



[14] From 2017/18 there is a developmental national System Level Measure focused on the proportion of babies living in smokefree households at six weeks of age. This two week indicator forms part of the national Maaori health indicators prior to 2017/18 and as such, data is available only for Maaori and total population.

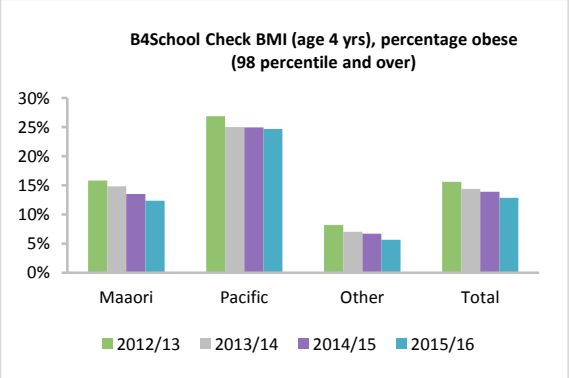
Medium term outcome: Equitable reduction in obesity prevalence in children

Childhood obesity is associated with a wide range of short to long term ill-health impacts that are potentially avoidable

Just over 13 percent of 4 year olds living in Counties Manukau are obese, with higher rates in Maaori and Pacific children (12 percent and 25 respectively, compared 6 percent for children of other ethnicities). Obesity impacts on people's quality of life and is a risk factor for many long term health conditions including diabetes, stroke, cardiovascular disease, musculoskeletal conditions and some cancers. Addressing obesity is complex requiring the health sector to work with other sectors to support wider environmental and societal change to reverse the growing prevalence of obesity in our community. CM Health is committed to progressing the national Childhood Obesity Plan and our regional Healthy Weight Action Plan for Children.

Data source: Well Child Tamariki Ora B4School Checks[15]

Total Base	*Total Target*			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
13%	*<13%*	*<13%*	*<13%*	*<13%*

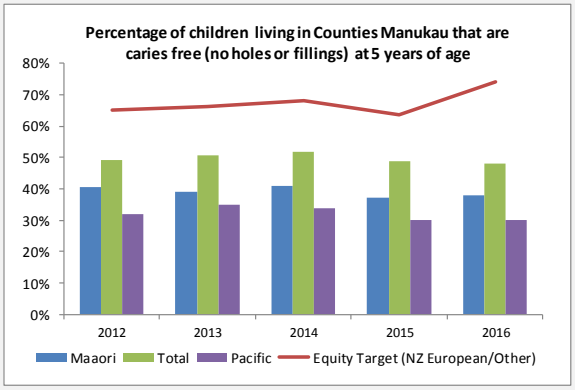


Key contributory measure: improved oral health in children

Nutrition is an important factor in reducing overweight and obesity. Poor nutrition is also directly linked to oral disease in infants and pre-schoolers and has negative impacts on long term oral health. Rates of early childhood caries (holes or fillings) are high in Counties Manukau with significant disparities for Maaori and Pacific children. The regional dental service and related provider partners are focusing on promoting good oral health (dental pain and caries free) and independence through child oral health programmes (health promotion, prevention and treatments) to reduce the prevalence of oral disease in children of pre-school age. To achieve this, district wide and targeted oral health improvement actions aim to reduce inequities in Maaori, Pacific and Asian children.

Data source: Auckland Regional Dental Service[16]

Total Base	*Total Target*			
2016	*2017*	*2018*	*2019*	*2020*
49%	*60%*	*60%*	*>60%*	*>60%*



Medium term outcome: Reduced hazardous use and harm from alcohol[17]

Hazardous alcohol use and alcohol-related harm cause large health, social, and economic burdens.

Alcohol is a contributing factor to many mental health problems, injuries, and more than 200 diseases and conditions, including alcohol dependence, liver cirrhosis, cardiovascular disease, and cancers. The use of alcohol can also result in harm to other individuals, including unborn babies through elevated risk of Foetal Alcohol Spectrum Disorder. There is an inequitable burden of alcohol related harm in Maaori, males, young people and socio-economically deprived populations. There are estimated to be approximately 50,000 hazardous, harmful, and dependent drinkers in Counties Manukau.[18] Addressing this will require broad and comprehensive public health approaches and working with a wide range of agencies and partners within and outside of the health sector.

CM Health is developing a programme of collaborative alcohol harm minimisation actions with a view to working regionally. This includes equitable delivery of the Alcohol ABC approach in general practice and the Emergency Department,[19] working with communities, regional and intersectoral partners to address social determinants contributing to hazardous alcohol use and related harm.[20]

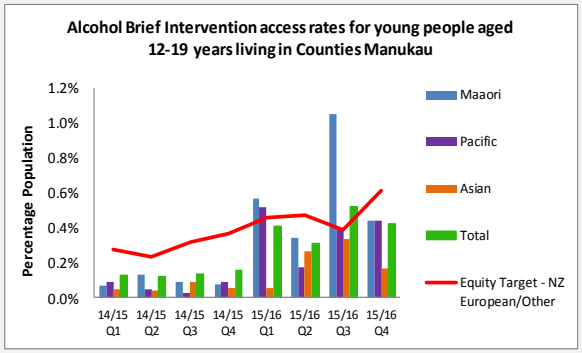
[15] Data sourced from Ministry of Health and is currently being validated (as at June 2017).
[16] This is national performance measure PP11 that includes children aged five years but before their 6th birthday at the time of their first examination.
[17] As this is a new outcome measure, baseline and trend data are not yet available.
[18] Estimated based on Estimated Resident Population Census data and NZ Health Survey prevalence data on hazardous alcohol use (2013).
[19] Some of this work is being progressed as part of CM Health's Health Equity Campaign led by Ko Awatea.
[20] Note that the prevention of alcohol related harm is one of the domains of the developmental 2017/18 youth System Level Measure.

Key contributory measure: increased number of rangatahi Maaori receiving alcohol assessment and brief advice[21]

Good health enables young people to make meaningful contributions to their families and communities. Maaori young people (rangatahi) have higher rates of mental health disorders, present later for treatment and suffer worse health outcomes than non-Maaori in Counties Manukau. CM Health aims to improve access to primary mental health and alcohol brief intervention services in general practice, as well as a focus on 'youth friendly' primary care. We will improve access to assessment and provide more integrated care pathways. We will ensure that school-based health services are widely available to all eligible rangatahi Maaori.

Data source: Quarterly PHO reports[22]

Base	*Target*			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
0.4%	*0.5%*	*>0.5%*	*>0.5%*	*>0.5%*



Medium term outcome: Improved mental health and wellbeing

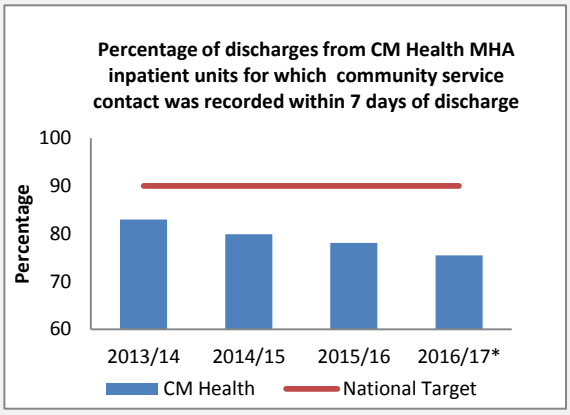
Mental health disorders are common in New Zealand and worldwide. Many New Zealanders will experience a mental illness and/or an addiction at some point in their lives with an estimated one in five people affected every year. Overall, Maaori and Pacific peoples experience higher rates of mental illness than non-Maaori, non-Pacific.

Accessible and responsive mental health and addiction services are a key factor in supporting people who experience mental illness to have an improved quality of life and fewer acute mental health episodes. CM Health's current emphasis is on responsiveness and effectiveness of the specialist interventions, reducing inequities and earlier intervention through service integration between mental health and addictions services and primary and community care.

Mental health access rates have historically been used as an indicator for determining the impact of CM Health mental health service delivery on improving the quality of life for those who are suffering from mental illness or with alcohol or drug addiction. While CM Health will continue to monitor access rates, we are also working to mature our suite of mental health and wellbeing indicators to present a more meaningful picture of the mental health and wellbeing of our community in Counties Manukau.[23]

Source: Key Performance Indicators for the NZ Mental Health & Addiction Sector (www.mhakpi.health.nz)[24]

Base	*Target*			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
78.1%	*90%*	*>90%*	*>90%*	*>90%*



**Note that 2016/17 year data includes only July –December result.*

3.4 Healthy People, Whaanau and Families

"Together we will involve people, whaanau and families as an active part of their health team"

The chief co-ordinator of care may not be, and does not always need to be, a healthcare professional. Where patients agree, whaanau and families need to be part of our planning, conversations about what is possible and are often required to support people at home. It matters that healthcare is more holistic, that our staff and services listen, understand and are responsive to physical, mental, spiritual, and psychological needs.

[21] To note is that this indicator does not form part of the Alcohol Harm Minimisation Programme. Over the course of 2017/18 this indicator will be matured and a more comprehensive suite of meaningful Alcohol ABC indicators (Assess, Brief Advice, Counselling/referral) will be developed.
[22] Ethnicity stratified data has only been available from quarter 1 2014/15
[23] The 2017/18 SLM Improvement Plan includes a developmental youth focused mental health and wellbeing measure.
[24] In the interim and as the suite of mental health and wellbeing measures is 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.

By working better together with patients, whaanau and families, we aim to see to see reduced acute (unplanned) presentations for healthcare, increased use of primary and community services including technology that enables self-management. We want patients, whaanau and family to report improved experiences due to more connected, accessible and co-ordinated care. This will support **people, whaanau and families to stay well and live independently in the community.**

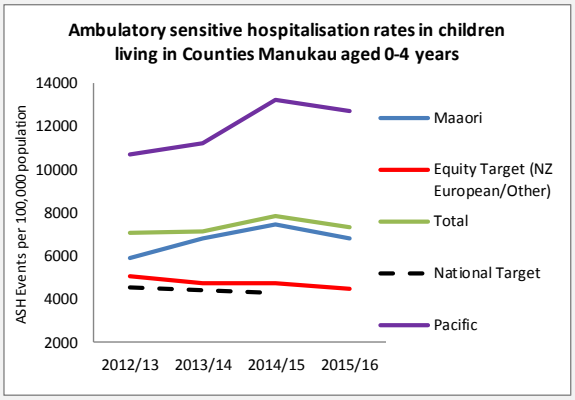
Medium term outcome: Equitable reduction in potentially avoidable hospitalisation in our 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are acute admissions that are considered potentially avoidable through access to quality, responsive primary health care

Total Base	*Total Target*[26]			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
7,348	*↓ 5%*	*↓ 5%*	*↓ 5%*	*↓ 5%*

Keeping children well and out of hospital is a key priority. Not only is it better for our community, but it frees up hospital resources for people who need more complex and urgent care. Maaori and Pacific babies and children experience health inequities in acute admissions that are considered potentially avoidable (ASH events). Leading causes of ASH events for Maaori and Pacific children in Counties Manukau are respiratory infections, asthma, dental conditions, cellulitis, upper and ear nose and throat infections and gastroenteritis. CM Health will focus on better integrating services and improving engagement with primary health services and condition specific interventions, to reduce inequities with a focus on Pacific and Maaori 0-4 year olds.

Data source: Ministry of Health Performance Reporting[25]

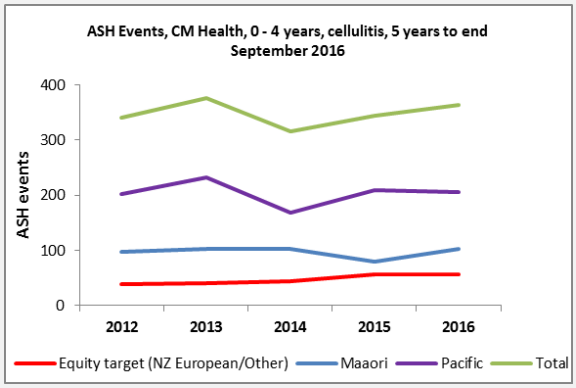


Contributory measure: hospitalisation for serious skin infections

Total Base	*Total Target*[27]			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
360	*↓ 5%*	*↓ 5%*	*↓ 5%*	*↓ 5%*

In 2016 there were over 360 potentially avoidable hospitalisations (ASH events) due to cellulitis in children aged 0-4 years. Counties Manukau Pacific and Maaori children are more likely than children of other ethnicities to be hospitalised with serious skin infections such as cellulitis. CM Health aims to improve access to early treatment of skin infections in primary care and community settings. Actions include providing information for families and whaanau to improve identification and prevention of skin infections. In recognising the impact of social factors, these actions will be complemented with local family group based services such as Whanau Ora and Fanau Ola that aim to engage whaanau and family as part of the health care team.

Data source: Ministry of Health Performance Reporting[25]



Contributory measure: improving immunisation coverage to reduce potentially avoidable hospitalisations

Total Base	*Total Target*			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
95%	*>95%*	*>95%*	*>95%*	*>95%*

Tamariki Maaori have lower immunisation coverage and are disproportionately affected by vaccine-preventable diseases compared with other children in Counties Manukau. Ensuring that vaccination coverage at 8 months exceeds the national target is an important component to enabling Maaori

[25] This is a national performance measure SI1 reflects the Ministerial priorities of timely patient care closer to home and value for money. This is also a national System Level Measure and reports are lagged by one quarter. There were national changes to the calculation of this result from quarter 1 2015/16 onwards impacting the comparability to historic results.

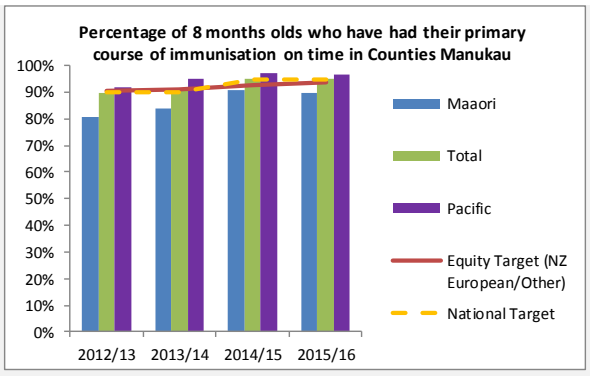
[26] The CM Health and Auckland Waitemata Alliances have committed to an annual five percent reduction in ASH events as part of their shared regional aspiration to reduce ambulatory sensitive hospitalisations. Note that the target for the outer years is a five percent reduction from the previous year's rate.

[27] The CM Health and Auckland Waitemata Alliances have committed to an annual five percent reduction in ASH events due to cellulitis and eczema/dermatitis as part of their shared regional aspiration to reduce ambulatory sensitive hospitalisations. Note that the target for the outer years is a five percent reduction from the previous year's rate.

children to achieve the best possible state of health and avoid potentially avoidable hospitalisations.

CM Health aims to achieve equity by increasing the percentage of pepi and tamariki Maaori who are immunised on time at 8 months, and 2 and 5 years.

Data source: National Immunisation Register Data Mart report



Medium term outcome: Improved end of life pathways for patients and whaanau[28]

Ensuring that the patients, whaanau and family are at the centre of end of life care

The increase in the proportion of people living with chronic health conditions along with the ageing population means there is a gradual increase in the number of deaths. This has impacted on the demand and complexity of palliative care services and the need for more personalised and culturally appropriate advance care planning in a range of health care settings. There are important differences in the place of death between ethnic groups therefore CM Health strategies will engage with hospices, aged residential care facilities, hospital and home based services.

CM Health aims to strengthen the capacity and capability of district wide services to enable living well and dying well regardless of where the patient is in their journey. This means ensuring that patients and whaanau are at the centre of end of life care approaches and that the social, financial, emotional and spiritual needs of patients, families and whaanau are recognised in that care.

3.5 Healthy Services

"Together we will provide excellent services that are well-supported to treat those who need us safely, with compassion and in a timely manner"

People are at the heart of healthcare services. We will add healthy life years and reduce the potentially avoidable rate of acute (unplanned) hospitalisations. To achieve this we need to ensure our workforces across the district are well trained, health literate, knowledgeable and come to work because they want to do their best for patients and whaanau. For the current Counties Manukau residents living with long term health conditions, we will support them to better manage and control their health through **excellent, collaborative, high quality, compassionate and safe health care services to improve experience of care.**

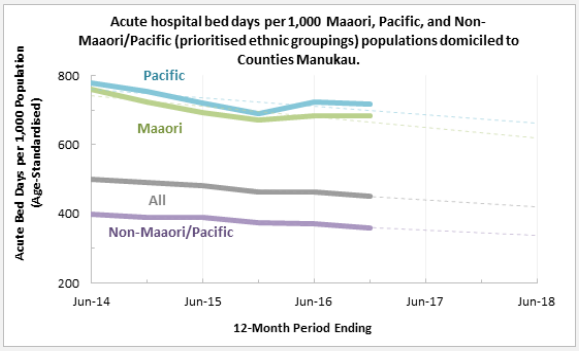
Medium term outcome: Reduction in acute hospital bed days

All of system approach to ensure safe delivery of care and reduce potentially avoidable hospitalisation[29]

Acute hospital bed days per capita is a measure of acute demand on hospital care that is amenable to reduction or avoidance. This is positively impacted by good upstream primary and community care, acute admission prevention, good hospital care and discharge planning, integration of services and transitions between care sectors, good communication between primary and secondary care.CM Health aims to reduce inequities through an 'all of' system experience of care for patients and their families underpinned by teamwork and patient-centred care.

Data source: Ministry of Health Performance Reporting[30]

Total Base	*Total Target*[31]			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
463.6	*↓ 2%*	*↓ 2%*	*↓ 2%*	*↓ 2%*



[28] As this is a new outcome measure, baseline and trend data are not yet available.

[29] The acute hospital bed days (acute inpatient event) per capita rates will be illustrated using the number of bed days for acute hospital stays per 1,000 population (estimated resident) domiciled to Counties Manukau. This will be measured every six months for the preceding (rolling) 12-month period. Age-standardised to overall New Zealand 2013 Census Usually Resident population.

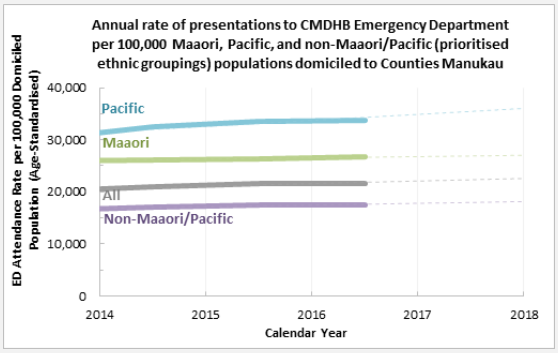
[30] This is a national performance measure SI7 – reporting through PP22. DHBs are expected to provide jointly agreed (by district alliances) System Level Measure improvement plans, including improvement milestones (and related targets).

Key contributory measure: reduced ED attendance rate[32]

Providing high quality, timely and integrated services will help people, whaanau and families stay well and live independently in the community. Improved prevention of risk factors and management of key long term conditions such as diabetes and cardiovascular disease will contribute to an overall reduction in ED presentation rate (residents 0-74 years per 1,000 population). CM Health aims to reduce inequities and overall rates by continuing to address risk factors for long term health conditions, appropriate access to primary options for acute care and expand the range of planned, proactive and more personalised health services.

Data source: CM Health Hospital ED Data & StatsNZ Estimated Resident population

Total Base	*Total Target*[33]			
2016	*2017*	*2018/19*	*2019/20*	*2020/21*
21,640	*↓ 2%*	*↓ 2%*	*↓ 2%*	*↓ 2%*



Key contributory measure: improved and more equitable experience of care

Understanding patients' experience is vital to improving patient safety and the quality of care. Improving their experience reflects the safety and quality of care[34] and contributes to better health outcomes. The aim is to enable patients (and whaanau) to take a more active role in their own health. Current hospital patient surveys provide insights into how to improve patient experiences by focusing on activities to improve the quality of care provided. More than half for our patients say that communication is an aspect of care that can make the most difference to them. Patients want to discuss their care and treatment with us and to have their views respected. In addition to the hospital survey, a primary care survey has been piloted[35] that focuses on coordination and integration of care and will be rolled out further in 2017/18. This will augment our current reporting with 'whole of health' system patient experience insights and opportunities for improvement.

Data source: Health Quality and Safety Commission National Patient Experience Survey Report[36]

Total Base	*Total Target*			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
8.4	*>8.5*	*>8.5*	*>8.5*	*>8.5*

[31] Note that the target for the outer years is a two percent reduction from the previous year's rate.
[32] Rate of presentations to CM Health Emergency Department per 100,000 population (estimated resident) domiciled to Counties Manukau. Age-standardised to New Zealand 2013 Census Usually Resident population.
[33] Note that the target for the outer years is a two percent reduction from the previous year's rate.
[34] Manary M, Boulding W, Staelin R, et al. The Patient Experience and Health Outcomes. N Engl J Med 2013; 368:201-203
[35] Two PHOs in Counties Manukau were involved in the pilot phase in 2016 (Procare Networks, National Hauora Coalition) with roll out to other PHO practices in 2017/18. This primary care survey forms part of the SLM work for 2017/18 and the outer years.
[36] Accessible online with national comparisons from the Health Quality Evaluation page of http://www.hqsc.govt.nz. There are four question domains that are (scored out of 10 with average results reported each period. Targeted overall survey average is greater than 8.5.

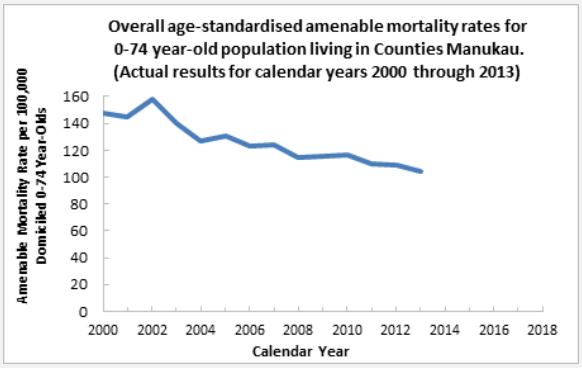
Medium term outcome: Reduced and more equitable amenable mortality rates[37]

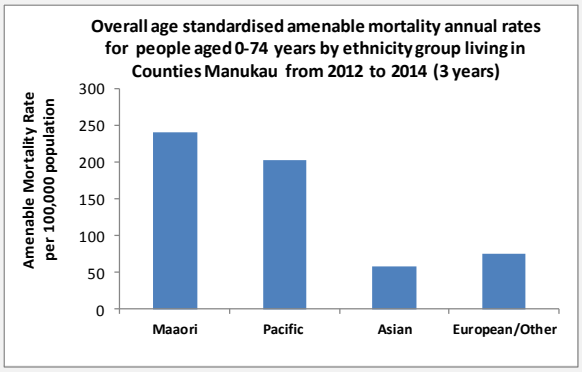
Target improvement in the leading causes of potentially preventable deaths

The four leading causes of amenable mortality Counties Manukau - cancer, cardiovascular disease (particularly heart attacks and stroke), chronic obstructive pulmonary disease (COPD) and diabetes - share common risk factors.[38] Regional and local approaches will focus on delivering actions to reduce unhealthy diet, physical inactivity, smoking and harmful use of alcohol risk factors. Proportionally, Maaori have a higher amenable mortality in smoking-related diseases such as cardiovascular disease and COPD. Pacific people have a higher proportion of diabetes related deaths.

Data source: National Mortality Data Collection[39] (definition based on MOH Sep 2016 version on defining amenable mortality)

Total Base	*Total Target[40]*			
2012-14[41]	*2017/18*	*2018/19*	*2019/20*	*2020/21*
109	*↓ 2%*	*↓ 2%*	*↓ 2%*	*↓ 6%*



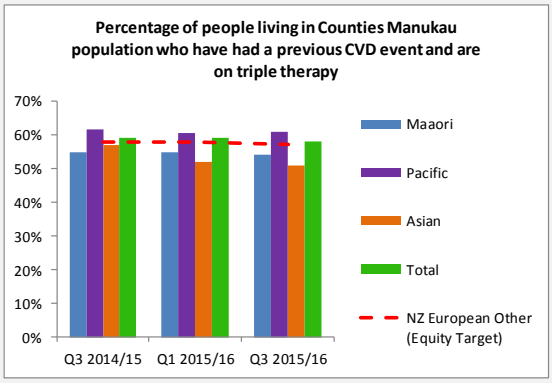


Key contributory measure: better treatment of people with cardiovascular disease (CVD)

There is good evidence that for those with a previous CVD event, 'triple therapy'[42] medicines can reduce future risk of CVD events and death. Triple therapy as defined as statins, antiplatelet/ coagulants, and blood pressure lowering medicines dispensed in at least three quarters in the year. While the current percentage of people who have had a previous CVD event who are receiving triple therapy for the CM Health population is at the upper end of results for the Northern Region DHBs, there is considerable room for improvement for people of all ethnicities. As a region, we aim to increase the rates of people who have had a prior CVD event and are on triple therapy by 5 percent each year.

Data source: Northern Region Cardiac KPI Report[43]

Total Base	*Total Target[44]*			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
58%	*↑5%*	*↑5%*	*↑5%*	*↑5%*



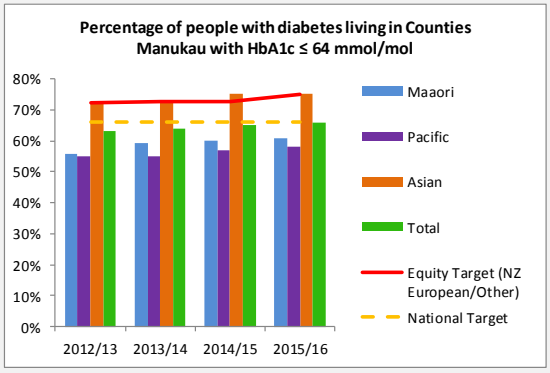
[37] Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist.
[38] Chan WC, Papa D, Winnard D (2015) Life Expectancy, Leading Causes of Death and Amenable Mortality in Counties Manukau. 2015 Update. Auckland: Counties Manukau Health.
[39] It takes several years for some coronial cases to return verdicts. As a result the Ministry is unable to release provisional cause of death information until around two years after the end of the year. Reports are made available annually with a rolling five years data set.
[40] Consisent with the 2017/18 Auckland, Waitemata and Counties Manukau Alliance System Level Measures Improvement Plan the following reduction in amenable mortality rates targets have been set for CM Health: 2% reduction (on single year baseline) by June 2018 and a 6% reduction (on the 2013 baseline) by June 2020.
[41] Refered to as the "2013 baseline"
[42] Cardiovascular disease (CVD) management as measured by the percentage of Counties Manukau residents aged 30 to 80 who have had a previous CVD event who are on triple therapy. Triple therapy as defined as statins, antiplatelet/coagulants, BP lowering dispensed in at least 3 quarters in the year.
[43] *CVD Prevention Medication Report* based on PHO enrolment for Quarter 4, CV Risk Assessment extracts and TestSafe dispensing data
[44] Note that the target for the outer years is a five percent increase on the previous year.

Key contributory measure: improved diabetes control in people with the highest disease burden

Better glucose control will reduce the progression of micro-vascular complications, chronic kidney disease, retinal disease and others. A modified Diabetes Care Improvement Package Programme is being rolled out. The objective is to provide optimal clinical management for all people with diabetes, which includes good glycaemic control (HbA1c ≤ 64 mmol/mol) appropriate cardiovascular risk management, prevention and management of diabetes related complications such as albuminuria, neuropathy and retinopathy. We aim to reduce inequities with a focus on populations with the highest disease burden, i.e. Pacific, Maaori and Indian residents.

Data source: Ministry of Health Performance Reporting[45]

Total Base	*Total Target*			
2009-13	*2017/18*	*2018/19*	*2019/20*	*2020/21*
65%	*69%*	*>69%*	*>69%*	*>69%*

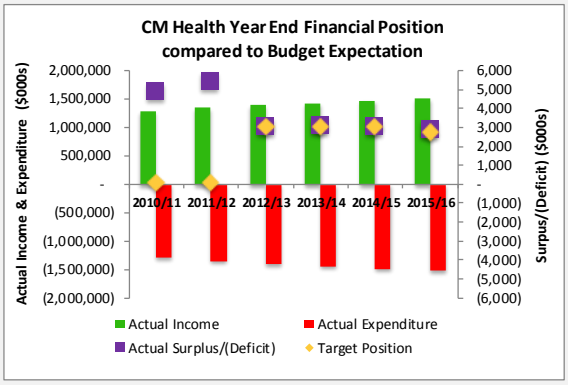


Key contributory measure: living within our means

District Health Boards (DHBs) exist to improve, promote and protect the health of the public and specifically the people that live in their districts. This is achieved through provision and funding of services, the allocation and long-term stewardship. To deliver this, each DHB must responsibly and effectively live within its means and achieve the best possible outcomes within available funding. CM Health works to be efficient in its service delivery now, while at the same time investing in innovation and future health system changes so that we can be financially sustainably in the medium to long term. This includes working collaboratively with the metro Auckland DHBs to provide the full range short to long-term services for our community.

Data source: CM Health Annual Reports[46]

Position Base ($000)	*Position Target ($000)*			
2015/16	*2017/18*	*2018/19*	*2019/20*	*2020/21*
2,870	*(20,012)*	*TBC*[47]	*TBC*	*TBC*



[45] This is a national performance measure PP20 reflects the Ministerial priorities for improvement treatment for people with long term health conditions. Note that CM Health currently uses the PHO CDIP 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.

[46] Accessible online from http://countiesmanukau.health.nz

[47] Note that we are working on a three year recovery plan that will return our organisation to a breakeven position. Accordingly our outer year plans for 2018/19 to 2020/21 should be read as indicative and will be updated once the three year recovery plan has been agreed by the Executive Leadership Team and endorsed by the CM Health Board.

APPENDIX C: Metro Auckland 2017/18 System Level Measures Improvement Plan

Note that this version of the Metro Auckland 2017/18 System Level Measure (SLM) Improvement Plan was submitted to the Ministry of Health on 30 June 2017. It has received preliminary approval subject to alteration of the developmental Babies in Smokefree Households SLM to reflect newly available data.

System Level Measures Improvement Plan

Auckland, Waitemata & Counties Manukau Health Alliances

2017 2018

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

Photo Credit (cover): John Hettig Westone Productions

CONTENTS

1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitemata Alliance Leadership Teams (the Alliances) have jointly developed a 2017-18 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. Building on the work outlined in the 2016-17 System Level Measures Improvement Plan, in 2017-18, improvement milestones and contributory measures for each of the system level measures (SLMs) have been prioritised, in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Alliances are firmly committed to including more contributory measures over the medium to longer term, once the structures, systems and relationships to support improvement activities are more firmly embedded. This plan reflects a strong commitment to the acceleration of Māori health gain and the elimination of inequity for Māori.

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

- Auckland DHB;
- Waitemata 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;
- Total Healthcare PHO, and
- Comprehensive Care.

The diagram below shows an overview of the measures chosen for this improvement plan.

AMBULATORY SENSITIVE HOSPITALISATIONS 0-4 YEARS

Improvement Milestone

5% reduction in rate by June 2018

- Children Fully Immunised by 8 Months of Age
- Skin Infections
- Oral Health
- Respiratory Conditions Potentially Prevented by Special Immunisations

Keeping children out of hospital

ACUTE HOSPITAL BED DAYS

Improvement Milestone

2% reduction – 438.7 standardised acute bed days/1000 by June 2018

3% reduction for Māori populations – 604.6 standardised acute bed days/1000 by June 2018

3% reduction for Pacific populations – 729.6 standardised acute bed days/1000 by June 2018

- Emergency Department Attendance Rate
- Acute Readmission Rates in 28 Days

Using health resources effectively

PATIENT EXPERIENCE OF CARE

Improvement Milestones

PHC Patient Experience Survey: 50% of each PHO practices participating in the Primary care survey by June 2018

Hospital inpatient survey: Aggregate score of 8.5 across all four domains measured

- District Health Board Inpatient Survey
- E-portals
- Participation in PHC Patient Experience Survey

Ensuring patient-centred care

AMENABLE MORTALITY

Improvement Milestone

6% reduction for each DHB (on 2013 baseline) by June 2020

- Cardiovascular Disease Risk Assessment (CVD RA) for Māori
- Cardiovascular Disease Management
- Smoking Cessation

Preventing and detecting disease early

YOUTH ACCESS TO AND UTILISATION OF YOUTH-APPROPRIATE HEALTH SERVICES

Improvement Milestones

Sexual and reproductive health: 80% of pregnant women 15-24 years are screened for chlamydia during pregnancy

Other domains: Establish baselines

- Sexual and Reproductive Health
- Youth Experience of the Health System
- Mental Health and Wellbeing
- Alcohol and Other Drugs
- Access to Preventive Services

Youth are healthy, safe and supported

PROPORTION OF BABIES WHO LIVE IN A SMOKE-FREE HOUSEHOLD AT SIX WEEKS POST-NATAL

Improvement Milestone

Establish baseline referral to smoking cessation services for pregnant women identified as current smokers

- Better help for smokers to quit – pregnancy health target
- Maternal Smoke-free Services
- Smoking Cessation
- Maternal Smoking Prevalence Data

Healthy start

2. PURPOSE

This document outlines how the 2017-18 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the high-level activities that will be fundamental to this improvement. Please note that, as further discussed in section 3.2, implementation planning will be developed to sit under this document to provide a higher level of detail.

3. BACKGROUND

The New Zealand Health Strategy outlines a new high-level direction for New Zealand's health system over the next 10 years 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 been working 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:

a) Four SLMs, which were implemented from 1 July 2016:
   - ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds;
   - acute hospital bed days per capita;
   - patient experience of care, and
   - amenable mortality rates.

b) Two developmental SLMs, to be implemented from 1 July 2017:
   - youth access to and utilisation of youth-appropriate health services, and
   - proportion of babies who live in a smoke-free household at six weeks post-natal.

c) For each SLM, an improvement milestone to be achieved in 2017-18. The milestone must be a number that either improves performance from the baseline or reduces variation to achieve equity.

d) For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally.

3.1 Process

In 2016, the Counties Manukau Health and Auckland Waitemata Alliances agreed to a joint approach to the development of the System Level Measures 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.

Working groups are responsible for drafting contributory measures and identifying the related interventions to be included in the implementation planning. Each working group is chaired by a PHO lead. Working group membership consists of senior primary care and DHB clinicians, personnel and portfolio managers. Groups have public health physician support. This year, there has been further work to involve other areas of the sector in the working groups including pharmacy and maternity.

The steering group and working groups will continue to meet in 2017-18, in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs.

In 2016, working groups completed in-depth analytics to inform development of the improvement plan. This was built upon again in the development of the 2017-18 plan. The selection of contributory measures and activities was guided by the impact that measures could have on each SLM, current activity or models of care in an area, and amenability of a contributory measure to change. The process also included a review of national and regional data, analysed by DHB, facility, ethnicity, deprivation and condition. The groups considered both an overarching approach and a condition-specific approach for each SLM. Among the factors considered were the number of hospitalisation events (as well as rates), readmission rates, bed days, general practitioner (GP) visits, DHB inpatient experience survey rates, condition specific amenable mortality rate recent trends, and evidence to support improvement activities and the ability to address equity gaps.

Working groups have engaged with key stakeholders in the process of drafting and selecting contributory measures. In 2017, this included engaging more broadly than primary and secondary care; in particular, the babies in smoke-free households SLM working group included pharmacy and maternity stakeholders. Stakeholder engagement included a sector-wide socialisation workshop, cultural consultation workshops, and a presentation of draft measures, milestones and interventions to the Alliances. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

This plan reflects a strong commitment to the acceleration of Māori health gain and the elimination of inequity for Māori. Each working group has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those most disadvantaged.

The 2017-18 Improvement Plan has been shared with the Māori, Pacific and Asian health teams at Auckland, Counties Manukau and Waitemata DHBs and their feedback has been incorporated. The Māori health gain teams across the region were invited to workshop the final draft of the plan and provided valuable input. The 2017-18 SLM Improvement Plan has been designed to align with the Auckland and Waitemata DHBs Māori Health Plan and the Counties Manukau DHB Maaori Health Plan. Consultation with the relevant cultural groups and equity partners has been an essential part of this process.

Reporting processes, both at a local and regional level, are in development. The data to inform this reporting will comply with the Metro Auckland Data Sharing Framework, agreed by the Alliances in 2015.

3.2 Regional Working

As in 2016-17, a single improvement plan has been developed in 2017-18 for the Alliances and three Metro Auckland DHBs. The rationale for this is that a number of PHOs cross the Metro Auckland DHB boundaries and are members of both Alliances. It was not considered to be practicable or achievable, given limited resources, to have two improvement plans with different contributory measures. 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. SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

The following section outlines the specific improvement plan for each of the six SLMs for 2017-18. For each, a system level milestone is set. Under these milestones, contributory measures provide the structure which direct and measure improvement activity. This ensures activities support the improvement of the system as a whole, and the milestone in particular.

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

<table>
<tr><td>System level outcome</td><td colspan="4">Keeping children out of hospital</td></tr>
<tr><td>Improvement milestone</td><td colspan="4">5% reduction in total rate by 30 June 2018</td></tr>
<tr><td>Baseline</td><td colspan="4">Ambulatory sensitive hospitalisation rates for 0-4 year olds, by DHB and ethnicity (per 100,000 population) 12 months to September 2016:

<table>
<tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>6,071</td><td>8,025</td><td>14,379</td><td>7,661</td></tr>
<tr><td>Waitemata</td><td>4,879</td><td>5,940</td><td>10,825</td><td>5,694</td></tr>
<tr><td>Counties Manukau</td><td>4,789</td><td>6,264</td><td>11,977</td><td>7,109</td></tr>
<tr><td>Metro Auckland</td><td>5,213</td><td>6,494</td><td>12,305</td><td>6,758</td></tr>
</table></td></tr>
<tr><td>Rationale and context</td><td colspan="4">Ambulatory sensitive hospitalisations are admissions considered potentially preventable through prophylactic 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 assigned. 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 that could be taken.

Exposure to smoking and quality of housing has an impact on this measure; the intention is to recognise the linkages to existing smoke-free activity in the amenable mortality SLM and with the babies in smoke-free households SLM.

Overarching activities
Connect this work with the Better Public Services target Keeping Kids Healthy: ‘By 2021, a 25% reduction in the rate of hospitalisations for avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019’. The avoidable hospitalisations include dental conditions, respiratory conditions (such as bronchiolitis, pneumonia, asthma and wheeze), skin conditions (such as skin infections, dermatitis and eczema), and head injuries.</td></tr>
<tr><td>Linkages</td><td colspan="4">Ambulatory sensitive hospitalisation rates: See the Access to Care section of the Auckland DHB and Waitemata DHB Māori Health Plan and the Hospitalisations section of the Counties Manukau DHB Maaori Heath Plan for more information.
Immunisation: See the Immunisation sections of the Auckland DHB and Waitemata DHB Māori Health Plan, Counties Manukau DHB Maaori Heath Plan and the Increased Immunisation Better Public Service and Health Target in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.
Oral health: See the Oral Health sections of the Auckland DHB and Waitemata DHB Māori Health Plan and Counties Manukau DHB Maaori Health Plan and the Child Health section of the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.</td></tr>
<tr><td colspan="5">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future</td><td>Improvement activities</td></tr>
</table>

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<tr><td></td><td></td><td></td><td>state</td><td></td></tr>
<tr><td>Māori Children Fully Immunised by 8 Months of Age</td><td>Immunisations are required to prevent serious communicable childhood illnesses, which can lead to hospitalisations. Despite great progress there is still an equity gap for Māori babies.

This target may support maintenance or lowering of vaccine preventable disease rates and related hospitalisations, including for rotavirus/gastrointestinal and pneumococcal pneumonia.

This is a National Health Target.</td><td>Immunisation rate for babies 8 months of age, Q1 2016/2017, by PHO (enrolled patients):

<table><tr><th>PHO</th><th>Total</th><th>Māori</th></tr><tr><td>Alliance Health Plus</td><td>93%</td><td>89%</td></tr><tr><td>Auckland PHO</td><td>92%</td><td>88%</td></tr><tr><td>East Health Trust</td><td>96%</td><td>96%</td></tr><tr><td>National Hauora Coalition</td><td>95%</td><td>92%</td></tr><tr><td>ProCare Networks</td><td>93%</td><td>88%</td></tr><tr><td>Total Healthcare Charitable Trust</td><td>94%</td><td>86%</td></tr><tr><td>Comprehensive Care</td><td>93%</td><td>91%</td></tr></table></td><td>95% of Māori babies fully immunised by 8 months of age.</td><td>Current immunisation programme (primary care coordinators, general practice systems, outreach immunisation service, Māori and Pacific providers, secondary care).
Continue to develop specific activity to improve Māori coverage (including ways to improve timeliness of immunisation), with leadership from Māori health gain teams and Māori leaders within primary care.
Develop links between immunisation outreach services and Māori Tamariki Ora providers to improve immunisation coverage for their enrolled children.
Investigate the possibility of Well Child Tamariki Ora nurses providing immunisation.
Utilise Whānau Ora services for immunisation of hard to reach children.
Promote immunisation in antenatal classes.
Investigate whether significant numbers of Māori babies are not engaged with general practice, with a view to include improvement activities to connect Māori whānau into the current newborn enrolment work.</td></tr>
<tr><td>Skin Infections</td><td>There are high and growing rates of serious skin infections in Metro Auckland, particularly for Māori and Pacific and those living in areas of high deprivation. Skin infections have not received sufficient attention in primary care and community settings.

The proportion of ASH admissions due to skin infections is higher (nearly double at 14%)</td><td>Skin infection subset of ambulatory sensitive hospitalisation data (per 100,000 population), 12 months to September 2016*:

<table><tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr><tr><td>Auckland</td><td>371</td><td>1,432</td><td>2,323</td><td>812</td></tr><tr><td>Counties Manukau</td><td>334</td><td>1,288</td><td>2,195</td><td>1,073</td></tr><tr><td>Waitemata</td><td>467</td><td>1,248</td><td>2,306</td><td>800</td></tr><tr><td>Metro Auckland</td><td>399</td><td>1,303</td><td>2,226</td><td>907</td></tr></table>*Cellulitis and dermatitis/eczema dataset via Ministry</td><td>Reduction in hospitalisation rate by 5% by 30 June 2018 (compared to baseline).</td><td>These activities build on those already developed by the skin infection working group of the regional Child Health Network.
Delivery of an educational package for skin infections to primary care, urgent care, Well Child Tamariki Ora services, and early childhood education centres. Use forums such as the Pacific Community Child Health Network (managed by TAHA, the Well Pacific Mother and Infant Service) to reach community groups.
Use DHB nurse educators and other health</td></tr>
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<td></td>
<td>in Metro Auckland than elsewhere in New Zealand.

Although resources are available, there is not consistent access to or use of resources across the system. In addition there is a lack of consistent messaging and interventions. There is potential to improve opportunities for prevention, early detection and treatment in primary care..

The Northern Regional Child Health Skin Infection Project has undertaken significant developmental work in this area. The resources and enablers could be more systematically applied and delivered in primary and community settings.</td>
<td>of Health SI1 Quarterly data</td>
<td></td>
<td>promotion resources in a coordinated way, so that health promotion messages reach early childhood education centres and other organisations that connect with families of young children. Currently Counties Manukau DHB and Auckland DHB have nurse educators; Waitemata DHB does not.
• Link in to early childhood education centre health promotion activities delivered Auckland Regional Public Health Service.
• Consider further development of primary care skin clinics.
• Consider new approaches for providing access to care, e.g. community outreach, pharmacies, parish nurses.
• Consider the opportunities for community pharmacy to provide more education on the best use of topical and oral products.
• Consider targeted outcomes for Pacific and Māori children.</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Poor oral health is a significant and increasing health issue for Pacific (Tongan in particular) and Māori children.

Poor oral health outcomes lead to dental decay, extractions and general anaesthetics. Dental decay is linked to range of other health conditions.

There are opportunities in primary care to provide health promotion messages and address barriers to care for Pacific children, and link with messaging in the child healthy weight space.

Although enrolment is not an ideal measure, further measures</td>
<td>Percentage of pre-school children enrolled in DHB-funded oral health services, 2016 calendar year:

<table>
<tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>86.6%</td><td>64.8%</td><td>84.4%</td><td>83.3%</td></tr>
<tr><td>Counties Manukau</td><td>90.0%</td><td>73.2%</td><td>85.9%</td><td>84.7%</td></tr>
<tr><td>Waitemata</td><td>100%</td><td>71.9%</td><td>80.3%</td><td>93.0%</td></tr>
<tr><td>Metro Auckland</td><td>93.7%</td><td>71.2%</td><td>84.4%</td><td>87.3%</td></tr>
</table>
</td>
<td>95% enrolment with oral health services amongst preschool children.</td>
<td>From the Draft 2017 Pre-school Oral Health Strategy:
• Oral health promotion at national, community and individual level. Focus on Pacific churches and parenting groups.
• Messaging to align with Raising Healthy Kids National Health Target.
• Increase awareness of free dental services.
• Upskill primary care, Well Child Tamariki Ora and secondary care providers in lift-the-lip assessments, knowledge of dental services and referral processes.
• Engage with the newborn enrolment project, which is: implementing systems to refer newborns for enrolment with the National Immunisation Register, general practice, oral health providers, Well Child Tamariki Ora providers and newborn hearing screening services.</td>
</tr>
</table>

	will be developed over the coming year.			• Increased number of extended hours and Saturday dental clinics in appropriate locations. • Consider a targeted intervention for Pacific and Māori children to address inequity.

Respiratory Conditions Potentially Preventable by Special Immunisations	This measure provides an opportunity to have a more coordinated and focused approach to doing special immunisations for children, thereby reducing hospitalisations for relevant respiratory illness and preventing readmissions.
	
	Vaccination of pregnant women is a Ministry of Health priority, especially for pertussis for newborns who are too young to be vaccinated. Current uptake is low (around 20%) and many women are unaware.
		Baseline setting year.	Increase flu vaccination coverage by (absolute) 10% for children aged 0-4 who are hospitalised for respiratory illness.
			
			Establish baseline data to measure pertussis and flu vaccines coverage rates for pregnant women.
				• Develop the current activity to identify and vaccinate all children aged 0–5 who qualify for the free influenza vaccine.
				• Build on current activity to support both influenza and pertussis vaccine offer to all pregnant women, e.g. vaccinator at antenatal clinics, promotion campaigns, lead maternity carers education opportunities.
				• Undertake activities in primary and secondary care:
				  • Secondary care
				  ○ Develop a documented, consistent system for providing lists of hospitalised children to PHOs and monitoring through the Influenza season (when the vaccine is available);
				  ○ Make it mandatory to fill in the sections on discharge letters on eligibility for special immunisations, and
				  ○ Promote vaccinations to patients and their families and proactively refer patients back to GPs for vaccinations.
				  • Primary care
				  ○ Immunisation coordinators in PHOs provide education to general practice staff on special immunisations while visiting practices, and
				  ○ The Immunisation Advisory Centre will provide education and support to general practice, to improve understanding of who is

				eligible for special immunisations and to enhance processes for identification and recall, through continuing medical and nursing education sessions. • Develop systems for measuring the impact of these activities, e.g. on readmissions for respiratory illness. • Consider the feasibility of offering Influenza vaccination to all children aged 0-4 years. • Pregnancy related immunisations: develop data definitions and agreed consistent process steps and monitoring points.

4.2 Acute Hospital Bed Days per Capita

<table>
<tr><td>System level outcome</td><td colspan="5">Using health resources effectively</td></tr>
<tr><td>Improvement milestone</td><td colspan="5">2% reduction for total population – 428.9 standardised acute bed days/1000 by June 2018
3% reduction for Māori populations – 604.6 standardised acute bed days/1000 by June 2018
3% reduction for Pacific populations – 729.6 standardised acute bed days/1000 by June 2018</td></tr>
<tr><td>Baseline</td><td colspan="5">Acute hospital bed days per capita, (age standardised) year to September 2016, by ethnicity:

<table>
<tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>375.7</td><td>595.8</td><td>851.1</td><td>433.6</td></tr>
<tr><td>Counties Manukau</td><td>370.2</td><td>690.8</td><td>710.1</td><td>460.1</td></tr>
<tr><td>Waitemata</td><td>390.3</td><td>554.8</td><td>730.6</td><td>422.3</td></tr>
<tr><td>Metro Auckland</td><td>380.4</td><td>623.3</td><td>752.2</td><td>437.7</td></tr>
</table></td></tr>
<tr><td>Rationale and context</td><td colspan="5">Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, 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 bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific milestones 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 conditions that contribute most to acute hospital bed days. Conditions identified as highest priority are Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and the frail elderly. Risk stratification to identify patients at highest risk of readmission will be undertaken by Counties Manukau Health stakeholders and explored by those in Auckland and Waitemata DHBs.</td></tr>
<tr><td>Linkages</td><td colspan="5">Emergency department attendance rate: See the Shorter Stays in Emergency Departments Health Target and the Primary Care Integration section in the Auckland DHB and Waitemata DHB annual plans for more information. Acute hospital readmission: See the Primary Care Integration section in the Counties Manukau DHB Annual Plan for more information.</td></tr>
<tr><td colspan="6">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td colspan="2">Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
<tr><td>Emergency Department (ED) Attendance Rate</td><td>Overall reduction in ED presentations will result in fewer admissions and lower bed day use.

Improving the appropriate use of Primary Options in Acute Care (POAC) should reduce ED attendance. Currently there is wide variation in POAC use at</td><td colspan="2">ED attendance per 1000 population by ethnicity (standardised), 12 months to 30 September 2016:

<table>
<tr><th>DHB</th><th>Other</th><th>Asian</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>196.9</td><td>170.1</td><td>260.0</td><td>351.1</td><td>206.0</td></tr>
<tr><td>Counties Manukau</td><td>187.0</td><td>135.9</td><td>283.3</td><td>337.6</td><td>215.4</td></tr>
<tr><td>Waitemata</td><td>224.1</td><td>150.6</td><td>275.3</td><td>382.9</td><td>222.3</td></tr>
<tr><td>Metro Auckland</td><td>206.1</td><td>150.2</td><td>274.0</td><td>349.3</td><td>214.3</td></tr>
</table></td><td>Reduce the ED attendance rate by 2% by June 2018 by promoting and supporting more effective use of POAC.</td><td>Primary Options in Acute Care (POAC) activities:
• Determine baseline utilisation of POAC across the region, including an ethnicity-level and a practice-level analysis.
• Identify gaps and areas for potential improvement.
• Convene expert group to determine and agree</td></tr>
</table>

	a practice level.			consistent interventions. • Monitor POAC utilisation, intervention rate and impact. • Develop and implement an education programme to promote appropriate use of POAC. • Explore current barriers to general practices using POAC. • Develop practice-level reports showing POAC usage relative to peers. Pilot new and innovative ways to encourage patients to use primary care services appropriately, e.g. social media campaigns, vouchers for after-hours care.
Acute Readmission Rates in 28 Days	Current clinical processes associated with discharge planning focus on quality of care in hospitals. The risk of readmission is partly determined by this care, but the literature also suggests that factors such as presence of a social network after discharge and the patient's capacity for managing their own care also influence the likelihood of being readmitted. The focus is on understanding the discharge planning processes that are currently undertaken in hospitals and augmenting them with interventions that support effective transitions of care. The proposed intervention involves identifying patients	Methodology for this rate currently in progress and data will be supplied once confirmed.	Target TBC, considering an equity reduction target once data is available.	• Determine baseline readmission rates by ethnicity, by PHO and across the region. • Explore the potential of risk stratification to identify patients at highest risk of readmission. • Review discharge planning processes across the hospital systems. • At the point of discharge and in primary care, target patients discharged with CHF, COPD and the frail elderly. • Encourage active follow up of patients discharged from hospital with a relatively high risk of readmission, in particular for those with CHF, COPD and the frail and elderly • Ensure that patients discharged from hospital with

	discharged from hospital who have a relatively high risk of readmission and developing a care plan with them to prevent avoidable admissions in the future. While it is expected that it will reduce the rate of readmissions, it will also provide the necessary infrastructure for risk stratification and care planning.			a relatively high risk of readmission have a patient centred care plan and, ensure Advance Care Plans (ACP) are in place, with a focus on initiating the ACP in primary care settings.

4.3 Patient Experience of Care

<table>
<tr><td>System level outcome</td><td colspan="4">Ensuring patient-centred care</td></tr>
<tr><td>Improvement milestones</td><td colspan="4">• Hospital inpatient survey: aggregate score of 8.5 across all four domains measured.
• Primary care survey: 50% of each PHO's practices (approximately 166 practices) are participating in the Primary Health Care Patient Experience Survey (PHC PES) by June 2018.</td></tr>
<tr><td>Improvement outcome</td><td colspan="4">Improved clinical outcomes for patients in primary and secondary care, through improved patient safety and experience of care</td></tr>
<tr><td>Context and rationale</td><td colspan="4">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) scores domains covering key aspects of a patient's experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs.

Hospital Inpatient PES: This has been in place since 2014. A stretch milestone has been selected to improve on gains made in the 2016-17 year.

Primary Health Care PES: The PHC PES was developed more recently and has not yet been implemented widely, in part due to the slower than expected roll out of the National Enrolment Service. Before reporting on PES scores, the focus must be on ensuring participation in the PES at a PHO and practice level. This is the focus for the 2017-18 year. A milestone of 50% participation has been selected as achievable based on the PHC PES pilot evaluation and the experience of the two Auckland PHOs (ProCare and National Hauora Coalition) that participated in the PHC PES pilot. Practice participation in the PHC PES will require a great deal of developmental work by PHOs (for example, infrastructure, practice engagement, capacity building, and patient communication).</td></tr>
<tr><td>Linkages</td><td colspan="4">DHB inpatient survey: See the Improving Quality section in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.</td></tr>
<tr><td colspan="5">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities (equity and communication lens)</td></tr>
<tr><td>DHB Inpatient Survey Communication Score</td><td>Communication is an essential component of patient experience of care and as such is one of the four domains that make up the PEC score.

Our focus across the three DHBs will be on communications and equity aspects in recognition of the fact the survey cannot adequately address all domains in a concentrated or focussed way. These will</td><td>DHB Inpatient Survey Results for Q1 2016-17 by domain:

<table><tr><th>Domain</th><th>Auckland</th><th>Counties Manukau</th><th>Waitemata</th></tr><tr><td>Communication</td><td>8.7</td><td>8.7</td><td>8.2</td></tr><tr><td>Partnership</td><td>8.6</td><td>8.5</td><td>8.2</td></tr><tr><td>Coordination</td><td>8.6</td><td>8.9</td><td>8.5</td></tr><tr><td>Physical and emotional needs</td><td>8.5</td><td>8.7</td><td>8.7</td></tr><tr><td>Aggregate across domains</td><td>8.6</td><td>8.7</td><td>8.4</td></tr></table></td><td>Aggregate 8.5/10 for four domains.</td><td>• Individual DHB focus areas via annual planning will be worked on at a local level. For 2017-18 there will be a particular focus on enhancing connections through improved communication and addressing equity gaps, via specific programmes and initiatives, which will be locally delivered.
• A regional DHB group for patient experience of care meets monthly via teleconference and quarterly face-to-face. The SLM Improvement Plan will become core business for this group.
• Develop long-term strategies in response to specific equity challenges (Pacific and Māori specialist team engagement), and broaden communication and conversations for patients</td></tr>
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<td>mirror activities already recognised as part of the district annual plans and will include aspects such as the discharge planning programme, Friends and Family Test, patient experience week improvement activities, and engagement with consumer literacy groups.</td>
<td></td>
<td></td>
<td>to improve their experience and journey of care.
• Share individual DHB learning and harness opportunities to replicate successes across Metro Auckland.</td>
</tr>
<tr>
<td>E-portals</td>
<td>E-portals can enhance patient experience by giving patients more control over ordering prescriptions, booking appointments and viewing lab results. Research shows that the use of patient portals is associated with higher patient retention rates, lower appointment no-shows, improved communication, increased trust and confidence in their healthcare providers and an increase in patients feeling that they are able to take a more active role in their health care and decision-making. This measure is linked to the Youth SLM and the potential to positively affect the youth experience of healthcare via a mode of engagement that is relevant, safe and supported.</td>
<td>E-portal implementation by PHO, February 2017 data:

<table>
<tr><th>PHO</th><th>Percentage of practices registered with a portal</th><th>Percentage of enrolled patients (18+) with login access to a portal</th></tr>
<tr><td>Auckland</td><td>40%</td><td>10%</td></tr>
<tr><td>Alliance Health Plus</td><td>66%</td><td>5%</td></tr>
<tr><td>Waitemata</td><td>42%</td><td>12%</td></tr>
<tr><td>East Health</td><td>27%</td><td>24%</td></tr>
<tr><td>ProCare</td><td>64%</td><td>15%</td></tr>
<tr><td>Total Healthcare</td><td>100%</td><td>5%</td></tr>
<tr><td>National Hauora Coalition</td><td>0%</td><td>0%</td></tr>
<tr><td>Metro Auckland</td><td>52%</td><td>13%</td></tr>
</table>

Note: later data sets will not restrict data to 18+ enrolled.</td>
<td>Increase to 55% of each PHO’s practices registered with a portal.

Increase to 15% of each PHO’s enrolled population who have login access to a portal.</td>
<td>• E-portal ambassadors and provider options will continue to be socialised amongst clinicians and consumers via PHOs and practices.
• PHO teams will provide support to practices to implement e-Portal enrolment systems.
• Portal options are explored by practices and adopted in a staged approach relative to level of clinician confidence and consumer request. These will include:
○ access to clinical data – diagnoses, notes, allergies, immunisations, lab results;
○ access to communications – messaging to doctor or nurse, repeat prescription, requesting appointments, self-scheduling;
○ access to education – condition specific information, websites with merit, self-management activities, and
○ PHOs will access resource materials and actively use these to support e-Portal implementation in practices and e-Portal uptake by patients.</td>
</tr>
<tr>
<td>Practice Participation in the PHC PES</td>
<td>Patient experience is a good indicator of the quality of primary health services. The PES is the mechanism by which this can be measured and improved. Further</td>
<td>Two Auckland PHOs participated in the PHC PES pilot (ProCare and the National Hauora Coalition). All of the National Hauora Coalition’s (12) and 25% of ProCare’s practices (53) participated.</td>
<td>50% of each PHO’s practices participate in the PHC PES</td>
<td>• Ensure socialisation of resources and support for practice-related activities, such as, PHOs follow HQSC/Ministry of Health ‘Getting Started’ resource pack and advice.
• PHOs advise Cemplicity of PHO name and contact for survey, and IT key contact to enable</td>
</tr>
</table>

	activity and input into its ongoing evaluation and modification through the Ministry of Health and the HQSC is expected in order for it to more ably serve the needs of our diverse Metro Auckland population, particularly for service users with English as a second language.			log on via email address. • Practices are supplied with and follow getting started guide and resources. • Practices provide PHO with details to appear on survey invitation email, text message and online survey. • Marketing of the survey week (one week every quarter), process and survey intent across practices is enabled. • Practices check email addresses of all patients 15 years and over and save preferences. • Follow up by PHO and practices to view real-time patient experiences and appropriately respond to request for contact or any indicated follow up required. • Once survey is closed, practices and PHOs will review the final results of the survey.

4.4 Amenable Mortality Rates

<table>
<tr><td>System level outcome</td><td>Preventing and detecting disease early</td></tr>
<tr><td>Improvement milestone</td><td>6% reduction for each DHB (on 2013 baseline) by June 2020</td></tr>
<tr><td>Baseline</td><td>Amenable mortality rate per 100,000 population (age standardised), 0–74 year olds, using New Zealand estimated resident population as at June 30:

<table>
<tr><th>DHB</th><th>2013</th><th>2009–2013</th></tr>
<tr><td>Auckland</td><td>72.9</td><td>87.5</td></tr>
<tr><td>Counties Manukau</td><td>104.4</td><td>113.0</td></tr>
<tr><td>Waitemata</td><td>65.6</td><td>74.6</td></tr>
<tr><td>Metro Auckland</td><td>80.2</td><td>89.4</td></tr>
</table></td></tr>
<tr><td>Context and Rationale</td><td>There were four contributory measures for the Amenable Mortality SLM for 2016-17: cardiovascular disease risk assessment (CVD RA) and management; smoking cessation; hepatitis C (identification and support to treatment); and breast screening (data matching to improve Māori coverage). Of these, only the first two contributory measures will be retained for the 2017-18 Improvement Plan. The reasons for discontinuing hepatitis C and breast screening are:
• Insufficient capacity for primary care to deliver against a large number of indicators;
• Hepatitis C is currently already in the Northern Regional Alliance workplan, and
• Breast screen data matching is still pending Ministry of Health progress against resolving confidentiality and privacy issues.

Therefore the decision was made to continue with the two contributory measures that have the greatest evidence-based impact on amenable mortality – 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.

The burden of CVD falls disproportionately on Māori and Pacific populations, and there are well-documented inequities in CVD mortality, case fatality and incidence. Reducing these inequities is a high priority and can be achieved through increased use of evidence-based medical management of high-risk patients.

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.

For the first financial year we plan to achieve 2% reduction for each DHB (on single year baseline) by June 2018.</td></tr>
<tr><td>Linkages</td><td>See the Long Term Conditions and the Ambulatory Sensitive Hospitalisation 45-65 years of age sections of the Auckland DHB and Waitemata DHB Māori Health Plan, the Cardiovascular Disease section of the Counties Manukau DHB Maaori Health Plan and the Living Well with Diabetes and Better Help for Smokers to Quit Health Target section of the Auckland DHB, Counties</td></tr>
</table>

<table>
<tr><td></td><td colspan="4">Manukau DHB and Waitemata DHB annual plans for more information.</td></tr>
<tr><td colspan="5">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
<tr><td>Cardiovascular Disease Risk Assessment (CVD RA) for Māori</td><td>CVD RA for Māori is lower than the 90% national target.

Successful implementation of dual therapy replies on identification of people with CVD RA ≥20%.</td><td>CVD RA eligible patients who received a CVD RA, Quarter 1 2016-17:

<table><tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr><tr><td>Auckland DHB</td><td>92.7%</td><td>88.7%</td><td>91.5%</td><td>92.2%</td></tr><tr><td>Counties Manukau DHB</td><td>93.1%</td><td>88.6%</td><td>91.4%</td><td>92.0%</td></tr><tr><td>Waitemata DHB</td><td>91.7%</td><td>86.7%</td><td>90.2%</td><td>91.1%</td></tr><tr><td>Metro Auckland</td><td>92.4%</td><td>88.1%</td><td>91.3%</td><td>91.8%</td></tr></table></td><td>90% CVD RA for Māori.</td><td>• Follow up phone calls (evenings) for practice generated CVD RA recall letters to Māori.
• Pilot of phlebotomy services in the practices or point-of-care testing when Māori males visit opportunistically.</td></tr>
<tr><td>Cardiovascular Disease (CVD) Management</td><td>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.

Increasing dual or triple therapy for those with a CVD RA ≥20% or a prior CVD event should lead to morbidity and mortality gains.</td><td>1. Cardiovascular disease management contributory measures (Percentage of enrolled patients with a CVD risk assessment score ≥20% dispensed dual therapy pharmaceuticals, and
2. Percentage of enrolled patients with a prior CVD event dispensed triple therapy pharmaceuticals.</td><td>5% increase (relative) in dual therapy for those with CVD RA greater than 20%.

5% increase (relative) in triple therapy for those with a prior CVD event.</td><td>• Identification of patients at a NHI level who have had a CVD event and are not dispensed triple therapy. Feedback and comparison of these results to GPs via PHOs.
• Total population and specific interventions for Māori, Pacific and Asian peoples to improve uptake and adherence to dual and triple therapy.
• Post-event medication counselling and other rehabilitation services in hospital.
• Ongoing medication counselling by community pharmacists.
• Consider an activity focussed on ensuring access to prescription subsidy cards and reducing prescription co-payments.
• Establish a single process to report CVD indicators from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.</td></tr>
<tr><td colspan="5"></td></tr>
</table>

Percentage of enrolled patients who are on dual or triple therapy (dispensing records), by ethnicity, 12 months ended 30 September 2016:

Ethnicity	% CVD RA ≥20% on dual therapy			
	Auckland	Counties Manukau	Waitemata	Metro Auckland
Māori	37.8%	48.3%	43.3%	45.1%
Pacific	54.2%	49.2%	50.0%	50.5%
Asian	45.7%	43.4%	38.2%	42.2%
Indian	44.4%	51.3%	45.7%	48.1%
Other	36.4%	44.2%	39.4%	40.2%
Total	41.6%	49.1%	41.4%	44.4%

Ethnicity	% CVD on triple therapy			
	Auckland	Counties Manukau	Waitemata	Metro Auckland
Māori	51.9%	55.1%	55.0%	54.4%
Pacific	57.4%	61.7%	60.5%	60.4%
Asian	46.9%	50.5%	46.0%	47.5%
Indian	61.7%	69.1%	65.6%	65.7%
Other	51.3%	56.5%	53.2%	53.7%
Total	52.7%	58.1%	53.8%	55.0%

Smoking Cessation	This contributory measure sits both under this SLM and the Babies in Smoke-free Households SLM. Smokers lose at least one decade of life expectancy compared with those who have never smoked. Cessation before the age of 40 years reduces the risk of death associated with continued smoking by about 90%. Aim: an increase in smokers who successfully quit, and a reduction in smoking prevalence. This supports the Better Help for Smokers to Quit National Health Target.	Better Help for Smokers to Quit (Primary Care) 2016/2017 Indicator 4: Cessation support received by enrolled patients, Q1 2016/2017: **DHB** / **Cessation support rate** **Auckland** 24.7% **Counties Manukau** 24.4% **Waitemata** 32.9% **Metro Auckland** 27.0%	An increase in cessation support by 10% (desegregated by ethnicity).	• Analyse reasons for historical low referrals to smoking cessation providers. • Improve referral pathways to smoking cessation providers. • Improve feedback to referrers from smoking cessation providers. • Access aggregated data for Auckland population. • Establish a single process to report smoking from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions. • Benchmark 'access to smoking cessation' READ codes across PHOs: i.e. the number of patients with codes 1, 2 and 3: 1. ZPSC10 – referral to smoking cessation support; 2. ZPSC20 – prescribed smoking cessation medication, and 3. ZPSC30 provided smoking cessation behavioural support.

4.5 Youth Access to and Utilisation of Youth-appropriate Health Services

System level outcome	**Youth are healthy, safe and supported**
Domains	**Youth access to and utilisation of youth-appropriate health services as measured via:** • **Youth experience of the health system: Child and Adolescent Mental Health Services Mārama Real-Time Survey results for 10–24 year olds;** • **Sexual and reproductive health: chlamydia testing coverage for 15–24 year olds – percentage of age group tested in one year;** • **Mental health and wellbeing: intentional self-harm hospitalisations (including short-stay hospital admissions through ED) for 10–24 year olds;** • **Alcohol and other drugs: alcohol-related ED presentations for 10–24 year olds, and** • **Access to preventive services: utilisation of DHB-funded dental services by adolescents from school Year 9 up to and including 17 years of age.**
Improvement milestone	**Sexual and reproductive health: 80% of pregnant women aged 15–24 years are screened for chlamydia during pregnancy**
Context and rationale	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 can lead to increased risk for poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours, in terms of drug and alcohol abuse and criminal activities. **Youth experience of the health system:** Evidence shows that young people who do not have positive interactions with health care services and providers do not return, which can lead to increased risk for poor health as adults. Research suggests that lapses in healthcare can lead to overall poor life outcomes. **Chlamydia testing coverage:** Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most commonly diagnosed in females aged 15-19 years and in males aged 20–24 years. There is significant variation in rates and testing between males and females and between Māori, Pacific and non-Māori. Males, Māori, and Pacific young people are under-tested in Auckland laboratory data, reflecting inequities in the services and systems to meet the needs of these populations. Māori and Pacific youth are more frequently hospitalised with sexually transmitted infection complications and pregnancy-related conditions than young people of other ethnicities. International modeling suggests that testing coverage needs to be between 30–40% to begin to reduce prevalence of infection. 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. **Intentional self-harm:** Intentional self-harm is a mal-adaptive coping mechanism indicating young people who are in distress and coping with that distress in an unhealthy way. It is often associated with low mood, depression, anxiety, wider family or peer group issues and events, stress, bullying, bereavement, relationship issues, trauma, intense or difficult feelings, or being in a group that self-harms. **Alcohol-related ED presentations:** Identifying and monitoring alcohol-related ED presentations enables better understanding of the contribution of excessive alcohol consumption to health outcomes in young people and supports appropriate public health responses. **Utilisation of DHB-funded dental services by adolescents:** There is strong evidence that dental care is associated with improved oral health outcomes. This measure is a marker of inequalities in utilisation and youth engagement into health services by deprivation and ethnicity.

<table>
<tr><td></td><td colspan="4"></td></tr>
<tr><td>Linkages</td><td colspan="4">See the Youth Mental Health section of the Auckland DHB and Waitemata DHB Māori Health Plan, Mental Health (Youth) section of the Counties Manukau DHB Maaori Health Plan and the Prime Minister's Youth Mental Health Project in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans, and the Mental Health section of the Counties Manukau DHB Annual Plan for more information.</td></tr>
<tr><td colspan="5">Contributory measures – Sexual and Reproductive Health</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
<tr><td>Development of Future Sexual and Reproductive Health Contributory Measures</td><td>Baseline data is required for planning, identifying appropriate contributory measures and developing improvement activities.</td><td>To be determined.</td><td>Establish baseline.</td><td>• Analysis of SLM data by age, ethnicity, and PHO.
• Identify gaps and potential areas for improvement.
• Review the literature to identify options for improving access to chlamydia testing for Māori and Pacific youth including school-based services, pharmacy, community laboratories, primary care, outpatients, justice systems, and other opportunistic settings.</td></tr>
<tr><td>All Pregnant Women are Screened for Chlamydia</td><td>Screening during pregnancy is recommended in current national guidelines including pre-termination of pregnancy. A 2015 publication of implementation of this guideline for pregnant women could be strengthened, expanding screening to male partners.</td><td>To be determined.

Screening in pregnancy, Middlemore and Auckland Hospitals:<table><tr><th>Hospital</th><th colspan="3">% screened</th></tr><tr><th></th><th><19 yrs</th><th>19-23 yrs</th><th><25 yrs</th></tr><tr><td>Middlemore*</td><td>74%</td><td>65%</td><td></td></tr><tr><td>Auckland**</td><td></td><td></td><td>68%</td></tr></table>*2011 **2013</td><td>80% of pregnant women aged 15–24 years are screened for chlamydia.</td><td>• Workforce development activities for lead maternity carers.
• Data analysis looking for missed opportunities, e.g. primary care visits during pregnancy.
• Data analysis looking for the potential to report back screening rates to lead maternity carers.</td></tr>
<tr><td>Chlamydia Burden of Disease</td><td>The purpose of increasing chlamydia screening is to reduce the disease burden. It is important to monitor this to assess the impact of screening activities on health outcomes.</td><td>To be determined.</td><td>Baseline.</td><td>• Establish regular reporting of chlamydia prevalence by age, ethnicity and locality.</td></tr>
<tr><td colspan="5">Contributory measures – Other Domains</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
<tr><td>Health Care Utilisation by 15–24 year olds</td><td>Understanding where and how frequently youth access health care services across</td><td>To be determined.</td><td>Analysis completed.</td><td>• Explore the availability of data across services potentially accessed by youth and the feasibility of data linkage to</td></tr>
</table>

	the system will support planning for improving access.			explore systems-wide youth health service utilisation and identify gaps. • Baseline primary health care enrolment and utilisation.
Participation in Child and Adolescent Mental Health Services Mārama Real-Time Survey	Baseline data is required for planning, identifying appropriate contributory measures, and developing improvement activities.	To be determined.	Establish baseline.	• Analysis of SLM data. • Engage with Mārama, the regional child and adolescent Mental Health Service group, and service providers to identify gaps and potential areas for improvement.
Development of Baseline Data for Youth Domains: alcohol and other drugs, access to preventative services, mental health and wellbeing	Baseline data is required for planning, identifying appropriate contributory measures and developing improvement activities.	To be determined.	Establish baseline.	• Analysis of SLM data by age, ethnicity, and PHO. • Identify gaps and potential area for improvement.

4.6 Proportion of Babies Who Live in a Smoke-free Household at Six Weeks Post-natal

System level outcome	**Healthy start**
Improvement milestone	**Establish baseline referral to smoking cessation services for pregnant women identified as current smokers**
Context and rationale	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. Currently, the data for smoke-free households is not available. In order to provide context for planning, maternal smoking prevalence during pregnancy and at 2 weeks postpartum is reported here from the National Maternity Collection. Note that maternal smoking prevalence at 2 weeks postpartum is measured at hand-over to the Well Child Tamariki Ora provider, and does not measure whether the infant lives in a smoke-free home. Data, and a resulting numerical improvement milestone, is anticipated by the end of Quarter 1 2017-18. Smoking status at pregnancy registration 2015 calendar year National Maternity Collection:

Smoking at pregnancy registration

DHB	Auckland		Counties Manukau		Waitemata		Metro Auckland	
Ethnicity	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Asian	4	0.2	3	0.2	9	0.5	16	0.3
European or Other	37	1.6	100	5.1	141	3.9	278	3.5
Māori	154	23.1	573	30.5	287	24.7	1,014	27.3
Pacific	85	8.6	194	7.7	65	8.1	344	8.0
Total	**280**	**4.7**	**870**	**10.6**	**502**	**6.6**	**1,652**	**7.6**

Smoking at 2 weeks post-partum

DHB	Auckland		Counties Manukau		Waitemata		Metro Auckland	
Ethnicity	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Asian	4	0.2	5	0.3	7	0.4	16	0.3
European or Other	19	0.8	89	4.6	101	2.8	209	2.6
Māori	93	13.9	386	20.5	220	19.0	699	18.8
Pacific	36	3.7	136	5.4	37	4.6	209	4.9
Total	**152**	**2.6**	**616**	**7.5**	**365**	**4.8**	**1,133**	**5.2**

Linkages	*See the Tobacco section of the Auckland DHB and Waitemata DHB Māori Health Plan and the Death in Infants, the Babies Exposed to Smoking section of the Counties Manukau DHB Maaori Health Plan, and the Better Help for Smokers to Quit Health Target in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.*			
	Contributory measures			
	Rationale	**Current state**	**Target future state**	**Improvement activities**

Better Help for Smokers to Quit – pregnancy health target	This National Health Target is designed to prompt providers to routinely ask about smoking status as a clinical vital sign, and then to provide brief advice and offer quit support to current smokers. There is strong evidence that brief advice is effective at prompting quit attempts and long-term quit success. There is a specific part of the National Health Target related to pregnancy – 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.	Not yet available. This data is routinely reported to the Ministry of Health by DHB-employed lead maternity carers. However, the data is incomplete. Need to investigate obtaining a more complete dataset from local data sources.	Obtain robust, timely data.	• Improve regional data collection so women who are pregnant and are current smokers are identified and the provision of brief advice and quit support can be monitored.
Maternal Smoke-free Services Pregnant smokers referred to cessation support by lead maternity carers. Referrals of pregnant smokers to stop smoking services (SSS).	Ensuring that pregnant women who smoke are offered referral to cessation support is a crucial step in the pathway to them becoming smoke-free. This measure has two components. One looks at the proportion of pregnant smokers referred to cessation support using data collected from DHB employed midwives and from lead maternity carers using the Midwifery and Maternity Providers programme. As this dataset does not currently give a complete picture of the number of pregnant smokers offered intervention, it is supplemented by the second component, the number of referrals received by SSS.	Due to the number of referral services and inconsistent systems for recording referrals sent and referrals received, accurate data is not available. Available data is of poor quality but suggests that referral rates are low.	Baseline data.	• Improve regional data collection so that referral to SSS for women who are pregnant and are current smokers are identified can be monitored. • Analyse reasons for historical low referrals to smoking cessation providers, particularly for Māori women. • Promote regional pathway for first trimester visit (includes smoking cessation referral) with a focus on Māori women. • Facilitate early enrolment of pregnant women with lead maternity carers. • Provide lead maternity carers and GP training on smoking cessation. • Provide feedback to lead maternity carers on their referral rates. • Provide pregnancy SSS incentives programme. • Arrange for SSS providers to attend pregnancy and parenting classes in the community (particularly those for Māori and Pacific). • Explore innovative ways of engaging pregnant smokers to quit, with a focus

				on Māori women, e.g. through use of a Sudden Unexpected Death in Infancy App.
Maternal Smoking Prevalence Data	While data are available for maternal smoking at registration and 2 weeks post-partum from the National Maternity Collection, this data is not available quarterly. The data is required to monitor the impact of activities on population maternal smoking prevalence health and inequalities.	Not yet available.	Obtain robust, timely data. Need to investigate obtaining a more complete dataset from combining local data.	• Improve regional data reporting such that smoking rates in pregnant women at birth can be calculated in a timely, consistent manner across all three DHBs.
Smoking Cessation	**Whānau:** Smokers who live in the same household as babies and young children may be reached through community, primary care and secondary care. Offering cessation support, stop smoking therapy or referral to SSS is important to assist whānau members to become smoke-free. The use of other settings to identify and support smokers that live with young children will also be explored. A focus on activities that will increase quit rates for Māori and Pacific is particularly important given the higher prevalence of smoking in these ethnic groups. **Other:** This contributory measure sits both under this SLM and the Amenable Mortality SLM. A total population approach undertaken in the amenable mortality SLM will support an overall increase in quit rates.	Whānau smoking cessation support information is not yet available. As per data supplied in amenable mortality SLM.	Obtain robust, timely data. Scoping complete data for smoking exposure and prevalence through Well Child Tamariki Ora, and scope data collection in DHBs. Scope providing whānau smoking cessation through maternity services and Well Child Tamariki Ora for 2018-19 plan.	• Review and align data collection processes for SLM measure across WCTO providers and provide SOPs for data collectors. • Scope processes to identify household members of pregnant women and newborns who are current smokers, including data collection processes. • Explore opportunities to offer smoking cessation support to whānau of newborn inpatients and outpatients, and paediatric ED attendances. • Explore additional ways of offering smoking cessation support to whānau of young children, e.g. pharmacy initiatives, Well Child providers. • Support the work undertaken in the Amenable Mortality SLM.

5. GLOSSARY

CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular disease
CVD RA	Cardiovascular disease risk assessment
DHB	District health board
ED	Emergency department
GP	General practitioner
HQSC	Health Quality and Safety Commission
NHI	National Health Index
PES	Patient experience survey
PHC PES	Primary health care patient experience survey
PHO	Primary health organisation
POAC	Primary Options in Acute Care
SLM	System level measures
SSS	Stop smoking services

COUNTIES
MANUKAU
HEALTH