ANNUAL PLAN 2016/17

Incorporating the Statement of Performance Expectations 2016/17 and Statement of Intent 2016/17 - 2019/20

COUNTIES MANUKAU HEALTH

Kind Manaakitanga | **Excellent** Rangatiratanga | **Valuing everyone** Whakawhanaungatanga | **Together** Kotahitanga

FRONT COVER: A collage of photos reflecting Counties Manukau's Whaanau & Families, Community and Services

Counties Manukau District Health Board Annual Plan 2016/17. PUBLISHED OCTOBER 2016

Annual Plan dated September 2016
(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

between

Her Majesty the Queen
In right of her Government of New Zealand
Acting by and through the Minister of Health

The Honourable Dr Jonathan Coleman

And

Dr Lee Mathias
Chair of Counties Manukau DHB

Geraint A Martin
Chief Executive of Counties Manukau DHB

Sandra Alofivae
Board Member of Counties Manukau DHB

Office of Hon Dr Jonathan Coleman

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

27 OCT 2016

Dr Lee Mathias
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Dear Dr Mathias

Counties Manukau District Health Board 2016/17 Annual Plan

This letter is to advise you I have approved and signed Counties Manukau District Health Board's (DHB's) 2016/17 Annual Plan for three years.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional $2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year. In order to ensure that the Strategy is informing DHB planning, and in order to ensure value and high performance throughout the health sector, I am considering changes to streamline annual plans in the future and you will be engaged in this process.

Living Within our Means

In order to assist the Government to remain in surplus in 2016/17, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning a surplus for 2016/17 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2016/17.

National Health Targets

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment* health target and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

System Integration including Shifting Services

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Counties Manukau DHB has committed to develop a 'health care home' type model of general practice in 10 general practices, develop community hubs that connect general practice, community care, specialist services and the hospital, shift wound care from district nurses to primary care, and strengthen community pharmacy integration. I look forward to being advised of your progress with this throughout the year. If this activity triggers the service change protocols you will need to follow the normal service change process.

Cross-government Initiatives and Collaboration

Delivery of Better Public Services continues to be a key focus for the Government. Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry 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.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc Mr Geraint Martin
Chief Executive
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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.

George Ngatai
Chair, Maaori Health Advisory Committee

Dr Lee Mathias
Chair, Counties Manukau District Health Board

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Foreword from the Chair and Chief Executive

CM Health is delivering more care and a broader range of healthcare services than ever before. Our population is growing faster than the rate of funding and available resources to meet those needs. To meet these challenges we have made strategic decisions. Over the past eight years we have charted a course for transformation and system integration as the way that we will best respond to those needs. A strong platform exists to launch the next phase of our journey to really accelerate integration and achieve health equity for our community. We are excited to have recently launched our 'Healthy Together' strategy that focuses on enabling strategies that will speed the rate of transformation and integration.

We are committed to providing more care closer to home within the primary and community settings. To do this we will create capacity and enable integration across the health system and with broader intersectoral partners. We will do this through enhancing general practice and investing in community health services to better support the integration of even more services such as palliative care, mental health and addictions and others.

In 2016/17 we are working with social service leaders through a whole of health and social care system approach. We have established a South Auckland Social Investment Board that will lead cross-sector collaboration. This will enhance local decision making to better support and care for our at-risk children and families.

We have strengthened our focus on actions that will improve the health of our Maaori, Pacific and Asian communities. These actions are outlined in companion plans that should be read alongside this plan. To further support this, we continue to build our workforce capacity and capability to reflect the diversity of the community we serve and better meet the needs of our people in Counties Manukau.

We would like to thank our local community for their advice and contribution to service co-design and keeping our focus on what matters for patients, whaanau and families. As well, our PHO alliance partners have been pivotal through their leadership towards our vision of health equity. We cannot achieve our goals without the dedication and hard work of our staff and providers across the district. Being truly healthy together relies on everyone coming together who collectively will transform our health system, ultimately enabling people to live well.

Dr Lee Mathias
Chair

Geraint A Martin
Chief Executive

Executive Summary

2016/17 heralds the first of a five year journey of our Healthy Together strategy. This is an evolution of our Achieving a Balance strategy creating a foundation for investments in capability and capacity to make the transformational changes outlined in our strategic intentions for the next five years to 2020. This means we will continue in our drive for quality healthcare, building on our localities and service integration across hospital and community care areas, while at the same time maintaining a balanced financial position and meeting government expectations. Advancing our integrated care approach is at the heart of our transformational commitments.

Our new strategic goal *"Together the CM Health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020"* is a commitment shared across CM Health leaders and workforces. This 2016/17 Annual Plan reflects our discussions with key stakeholders in translating our goal into meaningful action. This is a complex and very challenging ambition that will take multiple approaches and ongoing conversations within and outside the health sector. A Health Equity campaign, led by Ko Awatea, using collaborative methods to achieve ongoing improvement and support change, will be undertaken during the coming year, building cross sector learning communities from local and overseas programmes. Our strategic goal is consistent with the New Zealand Health Strategy and we look forward to sharing our learnings with the broader sector as we progress.

Our Maaori, Pacific and Asian Health Plans help lay foundations for action within this Annual Plan, leveraging and complementing established strategic and improvement initiatives as well as government targets. With an outside-in approach, our engagement with consumers and our community focuses on prevention and early intervention alongside a high performing health system and service delivery models across the district.

To measure performance, our 16 system level measures will continue to progress to include an equity focus that will 'overlay' and contribute to outcomes such as the government's Health Targets and priority areas, as well as local health equity measures. Throughout 2016/17 we will evolve our health equity measurement framework with initial focus on targeted areas of action in relation to increasing 'healthy life years' and reducing inequalities such as being smokefree and reducing and preventing childhood obesity.

To support our strategic objectives, our People Strategy will build our workforce capacity to do more in our communities to deliver care closer to home, that includes increasing our number of Maaori and Pacific peoples in our organisation so that our workforce reflects the population we serve. As well, it will shape our culture that will accelerate transformation and progress integration at pace.

We continue to work with our regional DHB counterparts, implementing regional priorities outlined in the Regional Services Plan. As well, we will support New Zealand Health Partnerships Limited's implementation of the National Oracle Solution and will work, in particular, in partnership to progress the Linen and Laundry Services, and National Infrastructure Platform.

Whilst demand on services is expected to grow at fiscally unsustainable levels we acknowledge the need for significant change and related innovations to be implemented, at the same time maintaining a strong financial position. We remain focussed on transformational change, continuous improvement and innovation whilst achieving government targets.

1.0 Context and Strategic Intentions

1.1 Background Information and Operating Environment

Counties Manukau District Health Board (Counties Manukau DHB) 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.

Counties Manukau DHB is a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004). Accountability for Counties Manukau DHB is through the Crown Funding Agreement and Annual Plan which is negotiated and agreed annually between the Minister of Health and the DHB. The Statement of Intent and Statement of Performance Expectations accountability documents are included in this Annual Plan.

As a DHB we are influenced by, and must balance, national health goals and targets set by the government, alongside regional priorities set out in the Northern Region Health Plan and our own district's population health needs.

Where services have been devolved to the DHB, responsibilities of the DHB encompass:

- Payment of providers
- Service development and prioritisation of funding
- Monitoring and audit of provider performance
- Management of relationships with providers
- Entering into, negotiating, amending and terminating contracts in accordance with section 25 of the New Zealand Public Health and Disability Act 2000 on any terms that are appropriate in the view of the DHB in order to advance the strategic objectives and outcomes outlined in the annual plan or which are needed in order to deliver the services required by statue or contract with the Crown or other parties; and
- Identification of where the agreements fit into the district's priorities

1.1.1 Treaty of Waitangi

Counties Manukau DHB aims to fulfil 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.

1.1.2 Governance

Counties Manukau DHB is governed by a Board of eleven members: seven are elected by the community, and four, including the Chair, are appointed by the Minister of Health. The role of the Board is to provide governance and to ensure that Counties Manukau DHB fulfils its statutory functions in the use of public resources. The current Board governance structure includes three statutory and two non-statutory committees that provide advice to the Board. The committees include a mix of Board members, clinicians and community representatives. Whilst the Board has overall responsibility for the DHB's performance, operational and management matters are assigned to the Chief Executive.

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.

1.1.3 Health profile of Counties Manukau populations

In 2015/16, CM Health provided health and disability services to an estimated 528,340 people who reside in Counties Manukau. Our population is growing at a rate of 1- 2 percent per year; one of the fastest growing DHB populations in New Zealand. From 2015/16 to 2025/26 the number of new residents in Counties Manukau is projected to increase by just over 84,000.

The key demographic features that inform our planning assumptions are:

- There are a diverse range of needs that can be further distinguished by four geographical locality areas that have been defined covering the Counties Manukau district: Mangere/Otara, Eastern, Manukau and Franklin
- The Counties Manukau district has an ethnically diverse population: 16 percent Maaori, 39 percent NZ European/Other groups, 24 percent Asian, and 21 percent Pacific. Twelve percent of all New Zealand's Maaori population, 37 percent of New Zealand's Pacific peoples and 21 percent of New Zealand's Asian population live in Counties Manukau
- Compared with other DHBs, Counties Manukau has the second highest number of Maaori (after Waikato), the highest number of Pacific peoples, and the second highest number of people (after Auckland DHB) who identify as Asian ethnicities
- If current population projections remain appropriate, the Asian population of CM Health will continue to increase the fastest of our ethnic groups, followed by Pacific, then Maaori, while our NZ European/Other population will show little growth
- We are a relatively young population with 23 percent of our population aged 14 years and younger. Thirteen percent of New Zealand's child population lives in Counties Manukau, and we have the highest number of 0-14 year olds of all the DHBs. The Mangere/Otara and Manukau localities are particularly youthful
- The population aged 65 and over in Counties Manukau is projected to increase on average almost five percent each year from 59,140 in 2015/16 to 88,380 by 2025/26. 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
- Overall, life expectancy at birth in Counties Manukau is similar to that of the New Zealand average at 81 years in 2014. While there is modest narrowing of the long-standing ethnic inequalities in life expectancy between Maaori and Non-Maaori, Non-Pacific groups in Counties Manukau, there is still a gap of over 9 years in life expectancy at birth. The gap between Pacific and Non-Maaori, Non Pacific groups was 6 years in 2014; this is similar to previous years
- At the time of the 2013 Census 36 percent of the Counties Manukau population lived in areas classified as being the most socio-economically deprived in New Zealand. Fifty-eight percent of Maaori, 76 percent of Pacific and 45 percent of 0-14 year olds in Counties Manukau lived in areas with a deprivation index of 9 or 10 at the time of the 2013 Census
- On the basis of the NZDep2013 measure, Otara, Mangere and Manurewa are the most socio-economically deprived areas in the Counties Manukau district
- For health service planning purposes, the rural adjustor used in the Population Based Funding Formula gives an indication of the proportion of the population identified as living in rural areas which are seen to require additional resources to deliver health services. In the DHB funding allocation for the 2015/16 financial year, CM Health was the only DHB that did not receive any 'rural adjustor' funding

1.1.4 Government focus on Better Sooner More Convenient (BSMC) services

Integrated care is central to medium to long term management of our health system demand challenges. Our commitment to this national policy is demonstrable in our established localities and system integration initiatives implemented over the last three years. We recognise that the scale and pace of system wide service configuration and integration must be accelerated if we are to meet the rising demand of an ageing and growing population within our available resources.

A summary of our key actions for 2016/17 is provided in the Executive Summary and further details in section 2.

1.1.5 Key areas of risk and opportunity

The future funding growth forecasts do not match our current health service demand projections. Our Healthy Together strategic objectives outline the action framework we have adopted to organise our response and optimise our collective CM Health capacity and capability now and in the future. This will enable us to better meet our population needs, deliver service excellence and meet the government’s expectations and targets while remaining

financially and clinically sustainable. At the same time, investing in major transformational change carries inherent risk that we will manage through robust business and change processes.

A complete summary of organisational risks, mitigation strategies and risk status are managed through our risk management framework and operational processes. Figure 1 below outlines our key strategic risks and mitigating approaches.

Figure 1: CM Health's key strategic risks and opportunities

Category	Risk / Opportunity	Management Strategy
Corporate	**Constrained public health capital funding for hard and soft assets** This has impacts for infrastructure resilience (e.g. Information Systems), facilities and equipment condition and fitness for purpose	▪ Regional prioritisation of IS infrastructure to assure business continuity and platform for future system investments, e.g. National Infrastructure Platform, electronic health record options analysis ▪ Focus on system stability and connecting up information and communication systems to enable significant model of care change to achieve seamless integration of community and hospital services and support achievement of the goals of the National Health IT Board ▪ Implement our Healthy Together transformation model to maximise resource and enable strategy alignment ▪ Reduce reliance on (new) capital for managing service demand, i.e. continue to redesign models of care, better leverage regional and private capacity and capability ▪ Collaboration with regional and national partners to leverage off aggregated savings and efficiency benefits and local system level accountability for financial and non-financial performance
Clinical	**Whole of system capacity and capability** To integrate services and increase the range and scale of community based services	▪ Our Alliancing approach, whole of system leadership and Healthy Together strategy focus on transformational change in the community enables us to most effectively use resources with a focus on the short, medium and longer term priorities ▪ We are in year three of prioritised investment in shared information and communication technology and related infrastructure systems across the whole system that support health service delivery and decision making in the most effective care setting. Implementation of change enabling technologies will continue through 2016/17 ▪ Whaanau Ora and Fanau Ola have brought a greater focus on addressing the issues of employment, housing and educational achievement, as well as working with vulnerable whaanau. Embedding this into our Integrated Care programme will be critical to strengthening population health outcomes
Revenue	**Revenue** The forecast revenue increase of 3.35 percent (inflation and growth) is less than what is anticipated to maintain operations. This is a longer term forecast constraint that has impacts for the affordability of capacity expansion	▪ This provides a common driver for increased scale and pace of system wide service integration and shared accountability to deliver services closer to where people live, intervene earlier for improved health outcomes and resulting reduction in acute service demand growth ▪ Significantly increased focus on models of care, reducing clinical variation and improving safety and acute service productivity across the health system. These are seen as critical to further cost containment and clinical leadership as an essential factor for success ▪ Acute system capacity and production planning and prioritised capability expansion to inform the most effective use of available resources, e.g. the Peak Workload Plan, production planning, daily capacity reporting and theatre scheduling ▪ Continued focus on system wide value for money reviews to challenge how effectively we are working and using available resources across the whole system, both service delivery and corporate processes

1.2 Nature and Scope of Functions / Intended Operations

1.2.1 Whole of system planning

2016/17 is year one of our five year Healthy Together strategy. This builds on our established localities[1] and service integration across our hospital and community care areas and further advancing the drive for quality and safety improvements across the district.

Planning is a collaborative commitment from leadership and workforces across the health system. Increasingly, consumers are contributing to planning through our Patient and Whaanau Centred Care Consumer Council, service co-design approaches and patient and whaanau centred care focus to improve people's experience of care.

Building on our Healthy Together strategy co-creation approach that engaged over 1,500 people, we continued this inclusive method to our 2016/17 planning process, beginning with actions that will progress our health equity strategic goal. This meant that health system workforces and leaders were supported to debate, shape and commit to actions that will make a meaningful impact for Maaori, Pacific and Asian people living in Counties Manukau with health disparities now. These actions have informed this Annual Plan – reflecting what we are seeking to achieve in this year and focusing our efforts to achieving health equity in key health indicators by 2020.

With a diverse and growing population, the Counties Manukau district has compelling social challenges. With approximately 24,600 'at-risk' children and young people, the cost of poor outcomes is significant. The social sector in general works well for the vast majority of people but for the most vulnerable with the most complex needs we are not doing so well. Using a whole of health and social care system approach, we have established a South Auckland Social Investment Board (SIB). This will bring together localised decision making allowing for greater flexibility to respond to local circumstances in an integrated, collaborative way that will serve better our at-risk children and young people.

This approach supports our Executive and Alliance leadership teams to take a district wide planning outlook and advise the Counties Manukau District Health Board of priorities for 2016/17.

1.2.2 Looking deeper at system redesign innovations across the system

To be successful, we need to be focused on our strategic priorities and be world class in enabling and sustaining change. Our deployment model will be progressively implemented in 2016/17 and centres on:

(i) Three major areas of change:

- Population health, through a multi sector approach to collaborate, test and spread district wide change
- Community and integrated care, through locality based networks, integrating technology and Community Hubs to design, build, scale and embed changes to the way we work with patients, whaanau, families and each other, and
- Hospital/specialist services, that deliver care efficiently, consistently and with an embedded improvement culture

(ii) Identify and effectively align our enabling strategies, these are:

- Health equity, patient safety and experience, people, research and evaluation, financial, technology, infrastructure, risk and building a community of implementers

(iii) Establish a Directorate of Healthy Together 2020 responsible for coordinating strategy delivery

1.2.3 Clinical leadership is essential

Clinical leadership is recognised as an essential success factor across all oversight, planning and programme/service implementation processes. Achieving this requires a comprehensive reach of clinical input across the health system from strategy to operational service delivery.

Our clinical leaders are the driving force behind service delivery redesign which focuses on improving patient experience quality and safety initiatives. They have an integrated role in executive decision-making at local and regional levels with support to provide a strong clinical voice with national linkages. They are supported through a number of mechanisms, e.g. Strategic Programme Management Office and ELT Director sponsored initiatives that span disciplines and services across the district, Ko Awatea system improvement and innovation, analytical support,

[1] Service delivery focused on four geographic areas within the Counties Manukau district. These are Mangere/Otara, Eastern, Manukau and Franklin. These structures provide a foundation to accelerate the pace of integrated care in a way that will make the most meaningful impact for our community.

system redesign and co-design, knowledge management expertise to enable implementation, monitoring, research, outcome evaluation and applied learnings.

Some of the key groups providing clinical leadership and advice are CM Health's Alliance Leadership Team, Executive Leadership Team, Clinical Directors, Clinical Nurse Directors, Associate Directors of Allied Health, and Clinical Governance Groups, Integrated Care Clinical Governance Group and the Northern Region Governance Groups and Clinical Networks.

1.2.4 Responsibilities to fund and provide services

As a funder, Counties Manukau DHB responsibilities cover the totality of CM Health services to the estimated 528,340 people living in our district. This includes funding for primary care, hospital services, 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. This includes Auckland DHB and Waitemata DHB that provide cardiothoracic, neurosurgery, oncology, forensic mental health and school dental services. Regional public health services are provided by Auckland Regional Public Health Service, under a Ministry of Health contract.

The PHO associated general practices are distributed throughout the district, with aligned general practice clusters that form the hub of our network of community based services across each locality. 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. Counties Manukau DHB operated services are largely delivered from seven inpatient facilities and numerous leased or owned outpatient and community health facilities across the district. Manukau and Middlemore Hospital sites contain the largest elective, ambulatory and inpatient facilities.

In the 2016/17 year, Counties Manukau DHB will receive $1.6 billion in funding, of this:

- $836.0m is for the provision of services delivered through the DHB's Hospital Care Arm
- $378.0m is for the provision of services delivered through contracts with NGOs
- $283.0m is for the provision of services delivered by providers or contracts that sit outside of the Counties Manukau district
- $12.0m is to cover governance and funding related capability and administration

1.2.5 Owner of crown assets

As an owner of Crown assets, Counties Manukau DHB is required to operate in a fiscally responsible manner and be accountable for the assets we own and manage. This includes ensuring strong governance and accountability, risk management, audit and performance monitoring and reporting. Counties Manukau DHB carries out formal asset management planning to determine planned future asset replacement and expected financing arrangements. Our long term investment plan outlines our district wide 10 year strategic investment intentions for infrastructure development that adds capacity aligned to our priorities, e.g. establishing Community Hubs in each of our four localities.

We revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. Counties Manukau DHB land and buildings are revalued every three years.

1.3 Strategic Intentions

1.3.1 CM Health values and strategic goal

Our current values have served us well for the last decade. However, given that our organisation has experienced tremendous growth, the community and our environment has changed, it was timely in 2015 to step back and refresh those values to make them current (refer Figure 2). In 2016/17 we will continue to focus on embedding these values into the everyday behaviours of staff and business processes across CM Health.

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

Figure 2: CM Health values

- **Valuing everyone** - make everyone feel welcome and valued
- **Kind** - care for other people's wellbeing
- **Together** - include everyone as part of the team
- **Excellent** - safe, professional, always improving

We concurrently refreshed our strategy in 2015 through a co-creation approach with patients, community and health system staff. This builds on our previous Achieving a Balance strategy outcomes and Triple Aim framework. As part of this evolution, some programmes such as project SWIFT have transitioned to become an integrated enabling strategy for technology (refer Section 5.2.3), as well, explicit system integration programmes are now wrapped up in Integrated Care as our core component for transformation.

Our refreshed strategic goal below reflects their feedback to us about how much we care about achieving health equity for our community. Our approach through the development of our Maaori, Pacific and Asian Health Plans has been explicit towards health equity in addition to government expectations, in context to our local environment. Each of these plans has been aligned with our Annual Plan to focus on actions that will allow progress at a pace required for change. Additional linkages have been provided within this plan to our other key plans. Our actions to enable progress towards our strategic goal are organised through the three strategic objectives described in Figure 3 below.

Figure 3: CM Health strategic goal and objectives

Our Healthy Together 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."

To achieve this, 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."

Delivering on our Healthy Together strategy will rely on a health and social system of care that is transformed from what we have today; to what we anticipate our community will need in the future.

1.3.2 National health sector priorities

The New Zealand Health Strategy sets a clear view of the future we want for our health system to ensure that all New Zealanders live well, stay well and get well. How CM Health's refreshed Healthy Together strategy local priorities align with the national strategic themes is outlined in Figure 4.

The 2016/17 government's Better Public Health Services and six national health targets outlined in the Minister's Letter of Expectations provides the context for our priority setting. We have a transformational focus in 2016/17 on integration of health services across our district and between community and hospital health service providers. CM Health cannot succeed in meeting these challenges without aligning key initiatives with strategic partners including other Northern Region DHBs, Counties Manukau based PHO Alliance and related service providers, and intersectoral organisations.

Our context is also shaped by the priorities set by other national agencies – Health Workforce New Zealand, National Health IT Board, Health Promotion Agency, Health Quality and Safety Commission and NZ Health Partnerships Ltd. CM Health aims to integrate and align these national entity priorities within agreed budget commitments, ensuring they are relevant and can be adapted to our local context.

Figure 4: Mapping local and national strategy priorities

NZ Health Strategy	Healthy Together Strategic Objectives	2016/17 Annual Plan Actions
People Powered	Healthy Communities Healthy People, Whaanau and Families Healthy Services	▪ Integrated care, section 2.3.1 ▪ Whaanau Ora, section 2.3.9 ▪ Improving quality, section 2.7 ▪ Technology Enabling Healthy Together, section 2.8.4
Care Closer to Home	Healthy Communities Healthy People, Whaanau and Families Healthy Services	▪ Increased immunisation, section 2.1.1 ▪ Rheumatic fever, section 2.1.2 ▪ Children's Action Plan, section 2.1.3 ▪ Prime Minister's Youth Mental Health, section 2.1.8 ▪ Healthy Families NZ, section 2.2.1 ▪ Childhood obesity, section 2.2.2 ▪ Integrated care, section 2.3.1 ▪ Improving quality, section 2.7 ▪ Technology Enabling Healthy Together, section 2.8.4
High Value & Performance	Healthy Communities Healthy People, Whaanau and Families Healthy Services	▪ Improving quality, section 2.7 ▪ Integrated care, section 2.3.1 ▪ Whaanau Ora, section 2.3.9 ▪ Technology enabling Healthy Together, section 2.8.4
One Team	Healthy People, Whaanau and Families Healthy Services	▪ Integrated care, section 2.3.1 ▪ Improving quality, section 2.7 ▪ Workforce, section 2.8.3
Smart System	Healthy Services	▪ Technology enabling Healthy Together, section 2.8.4

1.3.3 Northern region health priorities

The Northern Regional Alliance (NRA) is owned in equal shares by Waitemata, Auckland, and Counties Manukau DHBs. It continues to ensure regional alignment of plans, and appropriate stakeholder representation and involvement, by having clinical network and workgroup memberships drawn as appropriate from each of our DHBs and with representation from across the primary-secondary continuum of care.

The NRA produces a business plan each year, including budgets and key outputs for 2015/16 that will be approved by the NRA Board, comprises of shareholding DHBs and Northland DHB, will report against the business quarterly.

The 2016/17 Northern Region Health Plan (http://www.ndsa.co.nz) will continue the overall direction and strategic intent that will be aligned with the five New Zealand Health Strategy themes. The regional plan places more emphasis in 2016/17 on the scale of population growth in our region and the need for ongoing investment in capacity and capability. This means focusing the plan on actions where regional health system collaboration will make a real difference (tangible benefits) and addresses important health issues for the population.

Regional enabling work plans, such as Information Technology, workforce, procurement and supply chain and (facilities) long term investment planning, and regional clinical work plan priorities are continuous with the 2015/16 commitments.

What is different or new in 2016/17:

- First Do No Harm (quality and safety) campaign will be transitioned into DHB operational delivery by 30 June 2016
- Clinical Networks will have a greater emphasis on systematically identifying and developing equity initiatives within their work plans, and
- The new national Hepatitis C initiative to implement a clinical care pathway, assessment and treatment services across the region

CM Health is an active participant in the regional governance structure, related clinical networks and programmes of work. In addition to this, CM Health staff hold key regional leaderships roles, e.g. the Lead Chief Executive for the NRA and the Northern Region Health Plan, Chair of the Regional Radiology Network and others.

1.3.4 We care about achieving health equity for our community

Strategic planning must translate into healthcare delivery that will make a positive difference to the lives of people in contact with our health system, now and in the future. From our experience, feedback from patients and whaanau, interaction with the wider community, knowledge through our campaigns and health needs assessments, we know that non communicable diseases like diabetes, lung disease and cardiovascular disease are key contributors to ill health and mortality. Our hospitalisation rate for children and young people is above the national average. This is largely for potentially preventable conditions like sudden unexpected death in infants, lower respiratory infections, rheumatic fever, skin and gastro conditions.

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

Our Healthy Together strategic goal is our commitment to achieving health equity for our community, respecting that impacting inequities is a complex, challenging and long term process. We started to embed our strategic goal commitment into our business processes from 2016/17 planning through to implementation and performance measurement framework development.

This is a journey where we will adapt as we learn what works best. From 2016/17 Ko Awatea will lead a Health Equity campaign using collaborative methods to achieve ongoing improvement and support change. It will build cross-sector communities of learners building on learning from local and overseas programmes.

1.3.5 Measuring our performance

As part of the 2016/17 planning process, we started to consider what a measurement framework would look like with our new health equity strategic goal. Over time, we need to develop a way of telling our performance story in a meaningful way for the people living in Counties Manukau, health system leaders and workforces. This needs to acknowledge, leverage and compliment, not duplicate, action and performance measures already in place through our Maaori, Pacific and Asian health plans, government targets and established strategic and improvement initiatives.

There are a number of national frameworks in relation to equity and many jurisdictions internationally that have or are considering how they monitor progress on reducing inequities. In developing our Healthy Together measurement framework, rather than introducing elements or whole frameworks from other sources, we are building on the structure already outlined in our Healthy Together strategy and three objectives.

We know that no single programme, initiative or service change will achieve the health gains our communities deserve. To achieve our health equity strategic goal, everyone across the system needs to be able to see how their day-to-day work contributes to our goal. Workforces and services need to be challenged and supported to work out what a health equity approach means in their services, their role and to implement change to accelerate progress towards our goal. This will require capability building across the system and measures that people can use at service level to measure progress.

We will continue to use the Triple Aim[2] and evolve our 16 System Level Measures[3] (SLMs) to include a health equity focus. These will form an organising framework for measurement and we will build onto this our Healthy Together strategic objectives. This is not a simple relationship of action to outcome, but rather an 'overlay' of contribution to outcomes and involves a matrix of measurement frameworks, some prescribed (e.g. National SLMs, Health Targets etc.) and others locally selected (e.g. health equity measures).

We respect that measures are most useful and informative when there is a clear link to actions that will advance and improve the outcomes we are seeking. To achieve this, we have started developing our Health Equity Measurement Framework, initially focused on targeted areas of action where population health information suggests the most positive change can be achieved in relation to increasing 'healthy life years' and reducing inequities, e.g. being Smokefree, reducing and preventing childhood obesity. We will evolve our measures and story of accelerating health gain and improving health equity as some measures have yet to be developed, e.g. Hauora/wellness and others require measures both within and beyond the health system, e.g. reducing harm from alcohol. Figure 5 outlines our intervention logic that frames our performance story that reports to Board governance and other advisory and oversight committees.

[2] The Health Quality & Safety Commission works towards the New Zealand Triple Aim for quality improvement: 1) improved quality, safety and experience of care; 2) improved health and equity for all populations; and 3) best value for public health system resources (www.hqsc.govt.nz)

[3] These 'big dot' measures are outlined in our 16 System Level Measures and provide a useful context for interpreting performance of contributory or 'little dot' measures of key healthcare system priority areas and signalling areas where focus may be needed to improve or maintain performance.

Figure 5: CM Health intervention logic

National Vision Roadmap	**All New Zealanders live well, stay well and get well**				
	People Powered	Care Closer to Home	High Value & Performance	One Team	Smart System
Northern Region Mission Triple Aim action areas	**Improve health outcomes and reduce disparities by delivering, better, sooner more convenient services; and doing this in a way that meets future demand whilst living within our means**				
	Quality and Safety		Life and Years		The Informed Patient
CM Health 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**				
	To give back over 500,000 healthy life years to our community				
OBJECTIVES	**Healthy Communities**		**Healthy People, Whaanau and Families**		**Healthy Services**
LONG TERM Outcomes What would success look like?	**Improved population health and equity**		**Improved quality, safety and experience of care**		**Better value for public health resources**
	• Reduced and more equitable amenable mortality • Improved and more equitable life expectancy at birth		• Improved and equitable patient experience of care • Reduced rate of adverse events		• Reduced acute hospital bed days per capita • Reduced Hospital Standardised Mortality Ratio
IMPACTS How will we measure our progress?	• Reduced and more equitable number of babies who live in a smoke-free household at 6 weeks post natal* • More babies are breastfed • Equitable proportion of 8-month olds immunised on time • Reduced and more equitable childhood obesity prevalence • Improved and more equitable childhood oral health • Reduced and more equitable hazardous alcohol use prevalence* • More adults and pregnant women are offered help to quit smoking • Reduced and more equitable smoking prevalence* • More women aged 50-69 years are screened for breast cancer		• Improved and equitable patient experience of communication when accessing health services* • Increased percentage of infants who are enrolled with a general practice by three months • Improved and equitable youth access to and utilisation of youth appropriate health services* • Improved access rates to specialist mental health and addictions services across the life course • More people with CVD dispensed triple therapy • Reduced and more equitable absolute number of people with poor control of their diabetes		• Reduced Acute Rheumatic Fever first hospitalisations rates • Lower and more equitable ambulatory sensitive hospitalisation rates for 0-4 and 45-64 year olds • Improved and equitable workforce participation and retention rates • Fewer acute readmissions to hospital within 28 days • Reduced and equitable waiting time for people referred and treated for cancer • Timely access to planned and elective services • Shorter stays in Emergency Departments
OUTPUTS Services provided	**Prevention Services** Health Promotion & Education Statutory and Regulatory Population Health Screening Immunisation Well Child	**Early Detection and Management Services** Primary Health Care (GP) Oral Health Primary Community Care Pharmacist Diagnostics Mental Health	**Intensive Assessment & Treatment Services** Mental Health Elective Acute Maternity Assessment, Treatment and Rehabilitation	**Rehabilitation and Support Services** NASC Palliative Care Rehabilitation ARRC Home Based Support Life Long Disability Respite Care Day Services	
INPUTS Enabling strategies	Healthy Equity	Patient Safety & Experience	People	Research & Evaluation	Financial	Technology	Facilities	Risk Management

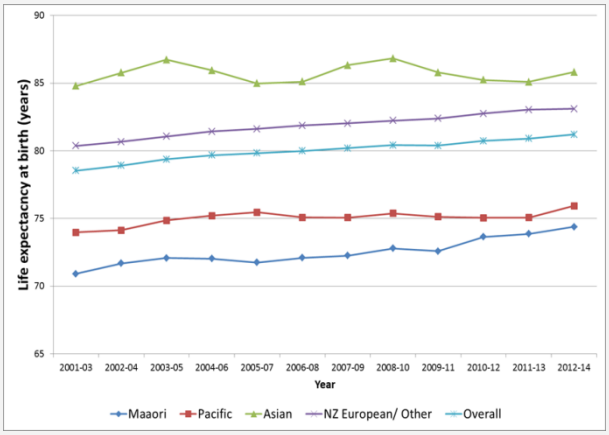
Note: Performance indicators and data collation/reporting processes in development in 2016/17*

How will we know our population is living well, staying well and getting well?

We will know we are succeeding when there is:

Continued improvement in overall life expectancy and narrowing of ethnic disparity

Life expectancy at birth in CM Health from 2001-03 to 2012-14 by ethnicity (3 year average)[4]



Life expectancy at birth is a key long term measure of health. The overall life expectancy at birth in Counties Manukau in 2014 was 81.3 years. Those of Asian ethnicities have the highest life expectancy in Counties Manukau, at 87 years.

Over the last decade life expectancy has shown a consistent upwards trend in Counties Manukau, closely reflecting the national pattern; increasing by 1.7 years from 2006 to 2014.

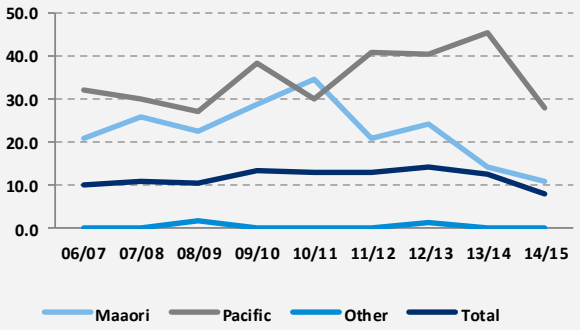
While there is modest narrowing of the long-standing ethnic inequalities in life expectancy between Maaori and Non-Maaori, Non-Pacific groups in 2014 living in Counties Manukau, there is still a gap of over 9 years in life expectancy at birth. The gap between Pacific and Non-Maaori, Non Pacific groups was 6 years in 2014; this is similar to previous years.

We remain committed to reducing these disparities, working with our communities to address the broader social determinants of the health gaps, and ensure that the highest quality health care is accessible and provided to our Maaori and Pacific communities. In 2016/17, we will complement this measure with the national System Level Measure regarding amenable mortality. Targeted actions to support the health and wellbeing of Maaori are detailed in the CM Health Maaori Health Plan, and Pacific in the CM Health Pacific Health Plan.

Data source: Mortality Collection, Ministry of Health; Estimated populations by DHB (2014), Statistics NZ

A reduction in the incidence of rheumatic fever

Counties Manukau acute rheumatic fever first hospitalisations, rates per 100,000 population



Acute rheumatic fever (ARF) is a potentially preventable, life-limiting illness. Reduction in hospitalisations for rheumatic fever is one of the government's Better Public Service goals.

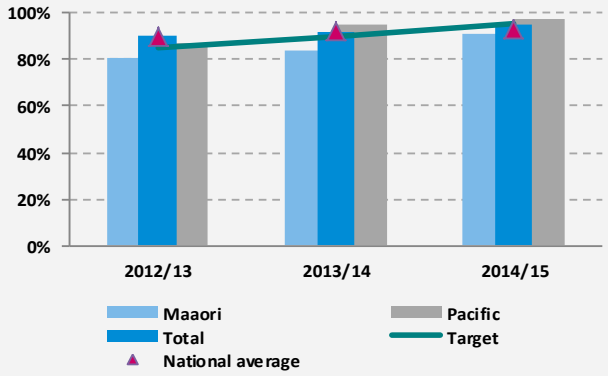
Rheumatic heart disease (RHD) and ARF are potentially preventable conditions if Group A streptococcal throat infections are prevented and/or identified and treated appropriately. ARF occurs most commonly in children aged 5-14 years and acute and chronic impacts disproportionately affect Maaori and Pacific children and communities.

The long term sequelae of RHD also result in a considerable burden of disease in the adult population. We are committed to reducing the burden of rheumatic fever in our communities and acknowledge the complexity of preventing this disease as well as the wide range of activities and investment needed if a significant reduction in cases is to be achieved.

Local and national strategies are starting to show promising results with significant improvements over the last 4 years from 2010/11 to 2014/15, i.e. reduction from 34 to 11 per 100,000 in Maaori and reduction from 13 to 8 per 100,000 population overall.

Equity in immunisation rates

The percentage of Counties Manukau children fully immunised at 8 months



Childhood immunisation provides protection from a range of serious illnesses, including measles, mumps, rubella, polio, diphtheria and whooping cough, all of which can have serious complications and may cause long-term harm.

Immunisation not only provides individual protection against these diseases, but if sufficient people are vaccinated, provides protection at a population-level by reducing the incidence of infectious illnesses in the community and preventing spread to vulnerable populations. Immunisation is also an important mechanism to ensure that infants and their families are engaged with primary care services, which provides opportunities for other health issues to be addressed. We have continued to make progress increasing Maaori immunisation rates– the coverage rates for Maaori eight-month-olds has increased from 84 percent in 2013/14 to 91 percent in 2014/15.

[4] Chan WC, Winnard D, Papa D (2015) Life expectancy and leading causes of death in Counties Manukau. Auckland: Counties Manukau Health.

A reduction in acute mental health episodes

Mental health disorders are common in New Zealand and worldwide. Many New Zealanders will experience a mental illness and/or an addiction at some time 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.

A reduction in acute mental health episodes is an indication of people having access to appropriate support and thus receiving the right care at the right time.

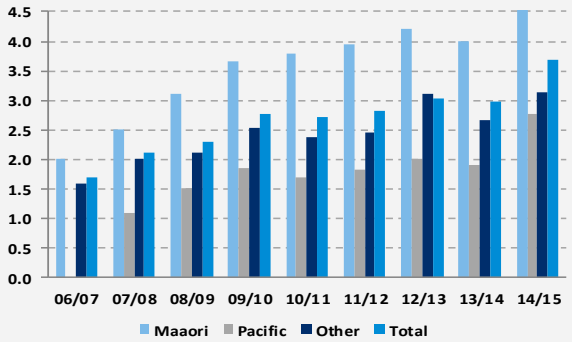
Mental health service access rates are a proxy measure for determining the impact of CM Health mental health services delivery on improving the quality of life for members of our population who are suffering from mental illness or issues with alcohol or drug addiction.

There has been a substantial amount of work done since 2006 to increase mental health access for those with severe mental illness. CM Health has invested in a number of community based support options including community support, respite and acute alternatives.

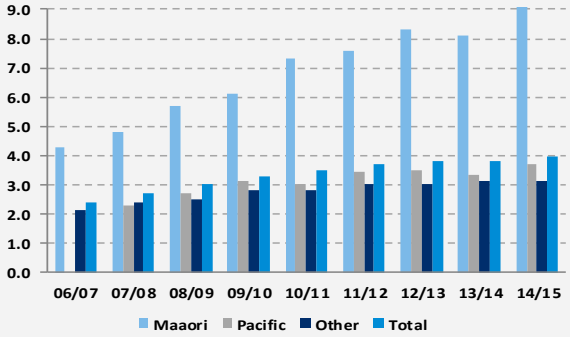
The next strategic focus is part of the broader integrated care agenda. Whilst maintaining our focus on the small percentage of the population with the most severe and enduring mental health and addiction (MH&A) needs, we plan to extend the scope of the system to intervene earlier (in the life course and in the course of a condition) providing deliberate, systematic joined-up support across primary care, specialist mental health and addictions, and NGO providers.

Delivery will be within the locality context, linking specialist mental health, addictions and NGOs to locality hubs and primary care. With MH&A community teams working in an integrated way alongside other healthcare teams, we will ensure a life course approach that supports all age groups within their local communities, whilst still retaining a Counties-wide approach to a small range of very specialised MH&A services.

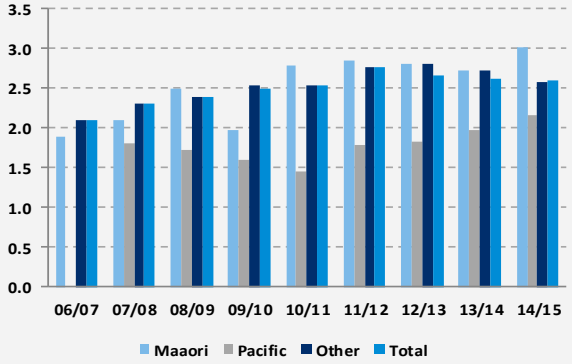
The mental health access rates for 0-19 year olds in Counties Manukau



The mental health access rates for 20-64 year olds in Counties Manukau



The mental health access rates for over 65 year olds in Counties Manukau



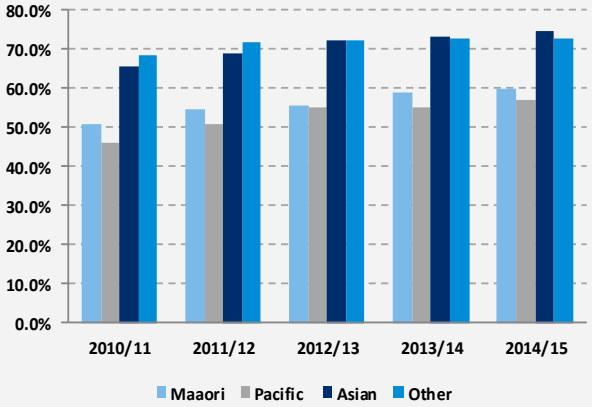
Improved control of common conditions

Diabetes and cardiovascular disease affect a substantial number of New Zealanders every year, reducing both quality of life and life expectancy. These diseases have a disproportionate effect on Maaori and Pacific peoples in the Counties Manukau community. We have selected these two conditions as they represent considerable health impacts in terms of the absolute number or people (and families) impacted. Making a positive change will significantly progress our goal of achieving health equity for Maaori, Pacific and communities with health disparities.

There is consistent evidence that early detection and good management of these conditions will improve morbidity and mortality – resulting in better health for the individual and reduced needs for acute hospital services.

For diabetes, better glucose control will reduce the progression of related conditions that cause complications, e.g. blood vessel blockages in the legs, chronic kidney

Diabetes management as measured by the percentage of people with good control of type 2 diabetes (Hb1Ac <= 64mmol/mol), by ethnicity[5]

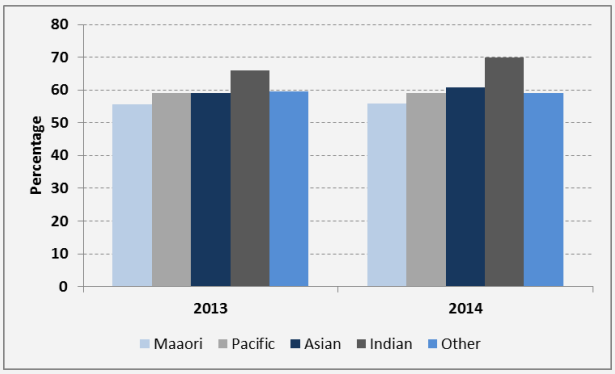


[5] Data sourced from CM practice enrolled patients participating in the Chronic Care Management and Diabetes Care Improvement Package programmes. These data are therefore a subset of the total population.

disease and others. In 2016/17, we are refining our measures of performance for people with diabetes. This will focus on the absolute numbers of people with poor control. This provides us with greater clarity of where we need to target our effort to reduce health inequity. CM Health has consistently achieved the national target throughout 2014/15, with at least 90 percent of eligible people in Counties Manukau having had their cardiovascular risk assessed in the last five years in every quarter of 2014/15.

Alongside continuing to improve our heart and diabetes risk assessments for our population, we are therefore increasing our attention on how well these diseases are being controlled in our community.

Cardiovascular disease (CVD) management as measured by the number of Counties Manukau residents who have had a previous CVD event who are on triple therapy[6]



[6] Data sourced from the National Cardiac Network Cardiac KPI report – Medicine Adherence – issued 17 April 2014. The denominator relates to all patients with relevant inpatient CVD events between 01/01/2003 and 31/12/2012 and who had a recent health contact in the Northern Region between 01/01/2011 and 31/12/2012. The numerator is based on pharmaceuticals dispensed for the defined CVD patients between 01/01/2013 and 31/12/2013.

2.0 Delivering on Priorities and Targets

This section describes the actions Counties Manukau Health (CM Health) will undertake to implement the government's priorities as expressed in the Minister's Letter of Expectations and related guidance. It incorporates key indicators from our Maaori, Pacific and Asian Health Plans. This section is structured as follows:

[7] NHT: Denotes a National Health Target

2.1 Better Public Services

2.1.1 Increased Immunisation

This target requires that 95 percent of eight month olds, 95 percent of two year olds and 95 percent of four year olds will have their primary course of immunisation on time.

Immunisation is one of the most cost effective interventions to protect and improve population health. Reaching high coverage rates is important to realise population wide benefits. CM Health aims to reach the target for all population groups in our district. Effective interventions require a whole of system approach – primary care practices and provider vaccinating, outreach information services that seek and contact hard to reach families and information systems that enable the sharing of information to track progress.

Linkages

CM Health 2016/17 Maaori Health Plan and Pacific Health Plan

Actions	**Measures**

Governance
▪ Continue to deliver targeted immunisation strategies to achieve 95 percent coverage for all children for the 8 month, 24 month and 4 year targets
▪ Monthly monitoring and evaluation of immunisation coverage by DHB National Health Target Working Group, and Immunisation Working Group (IWG). These groups will meet monthly to:
  ▪ Monitor and evaluate immunisation coverage at DHB, PHO and practice level, and manage identified service delivery gaps
  ▪ Continually review, update and implement immunisation strategies
▪ CM Health representation and attendance at regional and national immunisation forums
	▪ 95 percent of eight-month-olds and two-year-olds are fully immunised on time
	▪ 95 percent of four-year-olds are fully immunised by age 5 by June 2017
	▪ Updated coverage reports reviewed monthly
	▪ New strategies reported via MOH quarterly reports
	▪ Attendance at all national and regional forums

Prioritisation
▪ Immunisation Nurse Leader to work alongside all practices with low Maaori and high needs coverage rates and meet individually to improve performance
▪ Implement 'milestone' immunisations alerts for high risk pepe/tamariki to prompt early referral to outreach immunisation services
▪ Prioritisation of Maaori pepe and tamariki for immunisation and /or outreach Immunisation services
▪ Active follow up on declines by Immunisation Nurse Leader to provide additional support and information to parents and whaanau
▪ Children presenting to Kidz First in-patient service are status queried and referred as appropriate
▪ Implementation of 4 year action plan which includes:
  ▪ Audit of NIR against primary care to ensure an accurate baseline is established
  ▪ Immunisation reminder cards to be emailed with all Before School Check (B4SC) invitations from Q1
  ▪ Establish four weekly overdue reporting for 4 year old milestone target to Primary Care from Q2
	▪ 100 percent of practices with coverage below 95 percent visited monthly
	▪ 100 percent of declines referred to Nurse Leader for follow-up
	▪ 100 percent of children not fully immunised referred to Nurse Leader for Outreach Immunisation Service (OIS) follow-up
	▪ 100 percent of Practices audited by Q1
	▪ 100 percent of 4 year old children who reach 4 year, 9 month milestone and not fully immunised are referred to outreach from Q2

▪ Align with 8 and 24 month target ▪ Referrals to outreach immunisation services for all children who reach 4 year, 9 month milestone and not fully immunised ▪ Primary care sign off in Q1 ▪ Referrals from Q2 ▪ Immunisation being offered at Saturday B4SC clinics from Q1	▪ Saturday clinics established in Q1
Increase newborn enrolment rates ▪ Continue working with Maternity, Well Child Tamariki Ora (WCTO) and primary care partners to monitor newborn enrolment rates ▪ Work with primary care to establish a process to ensure all newborn enrolments are accepted ▪ WCTO monitor of enrolment with GP at core contact 1, and status query check at each core contact on immunisation milestones	▪ Maintain existing forum with appropriate representation
Promotional Activities ▪ Develop an immunisation communications plan jointly with primary care and NGO sector to include various promotional activities e.g. radio talk-back interviews, local papers, reminder cards, PHO incentives in Q1 ▪ Actively promote and participate in 'Immunisation Week' Q3-Q4 ▪ Work with intersectoral partners to identify and refer families who are not currently engaged with health services to outreach immunisation providers from Q2 to Q4 ▪ Undertake annual professional development day for LMCs in Q3	▪ Plan signed off by DHB National Health Target Working Group and IWG
HPV (12-year-old) ▪ Inclusion of HPV monitoring within Immunisation Working Group ▪ Inclusion of promotional activities in communication plan by Q1	▪ At least 70 percent of all 12-year-old girls will have completed all doses of their HPV vaccine Q4 (for 2016/17 it is the 2003 birth cohort measured at 30 June in 2017)
Seasonal Influenza Immunisation ▪ Support PHOs to report and monitor seasonal influenza vaccination rates for people aged 65+ by ethnicity to focus on uptake by Maaori ▪ In partnership with the Maaori Health Gains Team, develop a targeted seasonal influenza communications plan to promote the benefits of the seasonal influenza immunisation and encourage Maaori aged 65+ to be immunised by Q2 ▪ Implementation of targeted communications plan Q3-Q4 ▪ During flu season ensure that PHOs are actively promoting flu vaccinations and are targeting communications at the eligible population ▪ Trial use of pharmacies to provide funded seasonal influenza vaccine to Maaori aged over 65 years by Q1 ▪ Delivery of locality programmes to reach vulnerable groups including Maaori aged over 65 years by Q1	▪ 75 percent of those aged over 65 years receive free flu vaccinations

2.1.2 Rheumatic Fever

CM Health has the highest number of rheumatic fever notifications in comparison to all DHBs, and has an overall rheumatic fever rate of 8 per 100,000 population. There has been a large investment by CM Health in our Rheumatic Fever Prevention Plan with the aim to reduce the incidence of rheumatic fever among all tamariki and rangatahi in Counties Manukau.

Linkages

CM Health 2016/17 Maaori Health Plan and Pacific Health Plan

Actions	Measures
▪ Deliver activities and actions as per refreshed CM Health Rheumatic Fever Prevention Plan	▪ Target of 4.5 per 100,000.00

▪ As per agreed business case, implement changes to school based programme Q1-Q2:
  ▪ Contract services to new/existing providers
  ▪ Modification to model in 61 schools
  ▪ Integration of the school based programme with existing DHB integration strategies including the 'At Risk Individuals/families'
	▪ 100 percent participation by eligible schools within the programme
	▪ Student consent rates >98 percent
	▪ Monitor uptake and ongoing sustainability by primary care and secondary schools
	  ▪ Number of Practices/Schools participating
	  ▪ Number of swabs taken

▪ Work with PHOs and GP practices on an improved, service improvement approach to sore throat clinics in primary care Q1-Q2	
▪ Work with Secondary Schools on a sustainable service delivery model for sore throat clinics in schools Q1-Q2	
▪ Trial alternative options (Dental Clinics, B4SC) for sore throat clinics Q1-Q2	
▪ Work with the Northern Region Alliance on an updated communication strategy leveraging off the national annual Winter Awareness campaign	▪ Regionally agreed communications plan by Q1
▪ Develop a local health promotion calendar to drive the activity from the communication strategy by Q2	
▪ Work with the hospital arm and primary care to ensure families with children at high risk of rheumatic fever (defined as Quintile 5, Maaori and/or Pacific) living in crowded housing are referred to housing programme	▪ 100 percent being referred to Auckland Wide Housing Initiative (AWHI)
▪ Work collaboratively with primary and community service partners to develop systems that ensure people with Group A strep have begun treatment within 7 days	
▪ Continue to work with the hospital arm to ensure that the notification of acute rheumatic fever to the Medical Officer of Health occurs within 7 days	
▪ Secondary care clinicians to review cases of rheumatic fever to identify risk factors and system failure points	▪ 100 percent of cases reviewed with quarterly reporting to MOH
▪ Work with primary care to understand the number of people receiving prophylaxis through general practice rather than through community nursing services	▪ 100 percent complete case notification collected within 7 days
▪ Follow-up on any issues identified in the 2015/16 audit of recurrent hospitalisations of acute RF and unexpected rheumatic heart disease	▪ Report on identified issues from 2015/16 audit Q1 ▪ Annual audit of rheumatic fever secondary prophylaxis coverage is reported in Q4
▪ Undertake an annual audit of rheumatic fever secondary prophylaxis coverage for children aged 0-15, 15-24 and adults 25+	▪ Funding investment plan for rheumatic fever prevention is reported in Q2
▪ Confirm funding investment plan for rheumatic fever prevention	

2.1.3 Supporting Vulnerable Children

Supporting Vulnerable Children provides a framework for how the government intends to protect children in Aotearoa/New Zealand. CM Health recognises it serves a large population of children and young people and is committed to supporting initiatives outlined in the Children's Action plan to support "vulnerable children" as is appropriate.

Actions	Measures
▪ Continue to meet requirements of Vulnerable Children's Act	
▪ Children admitted to emergency department and inpatient services for Non Accidental Injury (NAI) will receive a 24 hour interagency response whereby CYF, NZ Police and CM Health formally meet to share information and develop a management plan as described within the Memorandum of Understanding with Child Youth and Family, NZ Police and DHBs	
▪ CM Health will continue to deliver the Violence Intervention Programme (VIP), including shaken baby education for appropriate areas, and undertake regular audits	▪ VIP audit (University of Auckland) completed to requested timeframes ▪ Report exceptions and remedial actions to audit scores less than 80/100 for each of the child and partner abuse components of their VIP programme

▪ Preventing deaths and injuries that arise from assault, neglect or maltreatment of children is complex and requires across sector commitment. CM Health will contribute to this by:
  ▪ Establishing a children's team initially for Papakura and Manurewa
  ▪ Continue to screen for family violence and refer as appropriate
  ▪ Maintain the National Child Protection Alert System
  ▪ Multi Agency Safety Plan (MASP) is held by the strategy agency (CYF). This is developed after the 24 hour response meeting identifying each agency's responsibility	

▪ CM Health has internal governance/engagement arrangements and with primary and community partners to provide services for:
  ▪ Vulnerable children and their families/whaanau
  ▪ Pregnant women with complex needs
  ▪ Children referred to Gateway
  ▪ Information sharing practices as agreed by the Local Governance Group (LGG)	

▪ Work with other sectors to implement the Children's Action Plan in Counties Manukau	
▪ Attend Regional Strengthening Families Meetings ensuring health is at Local Management Group meetings	
▪ Implement changes to information sharing practices that are identified in the Ministry of Health's guidance	
▪ Support NGO and community providers with the vetting of their staff working with children	▪ 100 percent of priority areas (Kidz First in patient, Community and Child and Adolescent Mental Health) safety checked before go-live
▪ Support initiatives as they are finalised for the implementation of the cross-sector standards, workforce competencies and training requirements	
▪ Monitor the implementation of Children's Teams in pilot DHBs for application to CM Health	

- Actions to support establishment of Children's Teams include:
    - Ongoing participation in planning and LLG forums
    - Participate in regional Children's Team governance and leadership involvement by DHB and non-DHB employed health professionals
    - Collaborate with other agencies to plan, test and monitor assessment processes to support early response systems, assessment processes and delivery of coordinated services for vulnerable children
    - Work to develop effective referral pathways to/from Children's Teams and primary and secondary health services
    - Enable health professionals to attend necessary training to support Children's Teams

2.1.4 Reducing Unintended Teenage Pregnancy

Over the past 5 years, the number of young women in Counties Manukau under 20 years of age having babies has dropped significantly, from 732 in 2010 to 509 in 2014. In 2014, the majority of young women were domiciled in Manurewa, followed by Mangere, Otara and Papakura. CM Health is committed to further decreasing the rate of unintended teenage pregnancy by focussing on services provided by school-based nurses.

Actions

CM Health will ensure that School Based Health Services (SBHS) contracts include explicit agreement for:

- Nurses to provide contraception choice e.g. discussion, referral, prescriptions or provision, and have sufficient access to contraceptive supplies
- Nurses to have Emergency Contraceptive Pill (ECP) endorsement and use standing orders
- Nurses to get appropriate professional support/supervision and remuneration such as:
    - Attend workforce development in relevant youth health and sexual and reproductive health issues
    - Access training from DHB nursing professional development units
    - Attend regional networks of other school nurses and/or youth health professionals
    - Be able to access clinical supervision/support from appropriate health professionals e.g. GPs

Measures

- Undertake a baseline assessment of non-DHB funded school-based nurses on providing contraception choice by Q1
- Ensure all nurses funded to provide school-based health services, provide contraception choice by Q2
- Undertake a baseline assessment of nurses with ECP endorsement and provision of standing orders by Q2
- Undertake a baseline assessment with regard to nurses' professional support/supervision and remuneration arrangements by Q3

2.1.5 Breastfeeding

Maaori and Pacific Health Plan Priority Area: Exclusive breastfeeding is recommended by the World Health Organisation for the first six months of an infant's life to support healthy infant growth and development. Breastfeeding has numerous benefits, supporting infant development and immune protection, protecting against sudden unexpected death in infancy (SUDI), respiratory illness and chronic otitis media, childhood obesity and diabetes.

Linkages

CM Health 2016/17 Maaori Health Plan and Pacific Health Plan

Supporting mothers to establish breastfeeding

- Provide information about and refer mothers and whaanau to primary care and community based breastfeeding support services on discharge

- 75 percent of infants exclusively or fully breastfed at 6 weeks
- 60 percent of infants exclusively or fully breastfed at 3 months

- Maintain Baby Friendly Hospital Initiative accreditation

Ensuring families continue to have access to appropriate breastfeeding support and information in the community and after they are discharged from birthing facility and/or their Lead Maternity Carer (LMC) to maintain breastfeeding to six months

- Identify and implement ways to improve referral processes and communication between hospital/birthing facilities and community breastfeeding support services (Te Rito Ora and B4Baby) to ensure women and whaanau are supported and connected with services as they transition from DHB care back to the community by Q4
- Provision of Te Rito Ora community based breastfeeding and baby feeding services: drop in breastfeeding clinics, Kaitipua Ora volunteers (mother-to-mother peer supporters), and community and home based lactation consultant service
- Work collaboratively with WCTO providers to strengthen the support they provide breastfeeding mothers and whaanau/fanau
- Encourage and support LMCs who are interested to become Baby Friendly Community Initiative (BFCI) accredited through educating about requirements and support with costs
- Fund set up of a community based breast pump hire service by Q2

Supporting breastfeeding services that are coordinated and delivering with a community development focus

- Establish a breastfeeding steering group and identify and appoint a Breastfeeding Champion to drive and coordinate work to improve Maaori breastfeeding rates by Q1
- Promote collaboration among maternity and child health providers

Improving health professionals breastfeeding knowledge to support a consistent standard of breastfeeding knowledge, messages and skills to be available to women and whaanau

- Support LMC to become BFCI accredited – see above
- Deliver breastfeeding education sessions to health professionals and organisations
- Develop the internal workforce mentorship capacity and capability within selected maternity and child health organisations to train and mentor their workforce in the 3-Step Health Literacy Model (Te Rito Ora Workforce Development and Training initiative) by Q1

- 65 percent of infants receive breastmilk at 6 months

2.1.6 Sudden Unexpected Death in Infancy (SUDI)

Maaori and Pacific Health Plan Priority Area: Sudden Unexpected Death in Infancy is the leading cause of preventable post-neonatal death in infancy. Maaori infants are 5 times more likely to experience SUDI than non-Maaori infants in New Zealand, with around 40 SUDI deaths among Maaori per year. These deaths can be prevented through access to a safe sleep space, smoke free pregnancy and environment, placed on back to sleep, and breastfeeding. CM Health's SUDI strategy is aligned to the NRA SUDI 5 year Action Plan

Our 2016/17 objectives are to:

- Reduce SUDI rates in Maaori infants through improved knowledge attitudes and behaviours to reducing SUDI risk factors
- Facilitate community and intersectoral linkages through monthly Safe Sleep Champion meetings and annual Community Network hui
- Facilitate education through health and community organisations, and engagement with community events e.g. Waitangi Day Manukau and Safe Sleep day
- Facilitate access to safe sleep devices for babies in unsafe sleeping environments
- Promotion of pregnancy and parenting education opportunities with Maaori whaanau incorporating key SUDI messages and support services

Linkages

CM Health 2016/17 Maaori Health Plan and Pacific Health Plan; NRA SUDI 5 year Action Plan

Safe Sleep Policy & Audits

- Safe sleep policy in place to cover all maternity, newborn, and infant environments, including antenatal and postnatal care in the community and hospitals, all maternity environments including delivery suites, birthing units, neonatal and inpatients units as well as ED
- Monthly safe sleep audits completed and documented by all maternity wards and primary birthing units

Workforce Knowledge and Development

- Training of all child health and maternity staff around safe sleep and SUDI prevention on induction and then at regular intervals
- All child health and maternity related external contracts to include training around SUDI prevention as a requirement of workforce

Improving access to and engagement in antenatal and early parenting education (which incorporates safe sleep practice, breastfeeding and smoke free health literacy)

- Implement a revised antenatal and parent education curriculum with a focus on Maaori, Pacific and teen pregnant parents Q1
- Implement and evaluate the community based SUDI initiative "Whānau Hapu Waananga" with a focus on engaging with Maaori women and whaanau Q3

Increasing early engagement and enrolment with Lead Maternity Carers (LMC) and Well Child Tamariki Ora (WCTO)

- Implement the 'High Five New Born Enrolment Initiative' referring and enrolling newborns at birth with GP, National Immunisation Register (NIR), WCTO, Hearing and Vision, and Community Oral Health Service (COHS)
- Increase the number of women who register with an LMC in their first trimester of pregnancy through:
    - GP referral pathways to encourage early referral before 10/40 to a midwife or LMC
    - GP referral pathways for pregnant women to provide consistent approaches in primary care catering for women who reside in one area but choose to birth in another

- 0.4 SUDI deaths per 1,000 live births
- 100 percent of caregivers provided with SUDI prevention information at WCTO Core Contact 1

- Increase early enrolment and engagement with WCTO
- Increase number of Maaori infants receiving WCTO Core contact 1
- Increase number of Maaori caregivers receiving safe sleep information at WCTO Core contact 1

SUDI Risk Assessment Tool

Primary Care
- Using the findings from the primary care pilot, modify the SUDI Risk Assessment Tool for use in primary care practice management systems by Q1
- Phased roll out and implementation of SUDI Risk Assessment Tool in primary care. Risk assessment screening and provision of safe sleep information for every infant at 6 week immunisation

Midwives
- Review findings from the midwifery pilot and develop implementation plan for roll out by Q2
- Roll out and implementation of SUDI Risk Assessment Tool by Q3

Research
- Repeat David Tipene-Leach study in Counties Manukau with 200 Maaori and 200 Pacific mothers and whaanau by Q4

Safe Sleep Programme
- Delivery of regional Safe Sleep Programme:
    - Provide safe sleep baby bed to whaanau identified as requiring access to a safe sleep space for their infant
    - Referral pathway in place for LMC to refer whaanau identified as requiring access to safe sleep baby bed
    - Development of referral pathway for WCTO Providers to refer whaanau identified as requiring access to safe sleep baby bed by Q2
    - Identify and train 3 WCTO providers, LMCs, DHB Community Midwives and other social sector agencies to be distributors of safe sleep baby beds by Q3

Activities to Support reduction of SUDI Risk factors i.e. P.E.P.E.; PLACE baby in own baby bed, face clear of bedding; POSITION baby on back face upward

- The safe infant sleep environment will be assessed and planned during every pregnancy and for all newborn infants and safe sleep information provided in late pregnancy, in first week of baby being born and at WCTO core contact 1. Families assessed with unsafe infant sleep environments will be referred to Safe Sleep Team to receive additional support to reduce the risk of SUDI

ELIMINATE smoking in pregnancy & protect baby with smokefree whaanau, whare & waka

- All pregnant women who smoke are offered brief advice and support to quit
    - Delivery of Smoking Cessation in Pregnancy Plan
    - Ongoing monitoring of mandatory alert of smoking in pregnancy at midwife booking

interview or admission to maternity facilities and referral to Smoking Cessation Services for follow-up

- Smoking cessation support will be offered to all mothers, fathers, and whaanau who smoke, with referral to a culturally appropriate smoking cessation service
- Reduce smoking prevalence and smoking related-harm amongst Maaori - refer section 2.2.5

2.1.7 Oral Health

Maaori, Pacific and Asian Health Priority Area: Prevention of oral disease in infants and pre-schoolers reduces the risk of dental, gingival and periodontal disease in permanent teeth and will have positive impact on their long term oral health, general health and well-being. Tamariki Maaori are three times more likely to have decayed, missing or filled teeth. Oral health therefore presents an opportunity to reduce inequalities and better target those most in need.

CM Health contracts to the Auckland Regional Dental Service (ARDS) to deliver DHB funded oral health services for children aged 0 to 12 years olds in the community, DHB based clinics and mobile dental facilities. This includes private dentists and ARDS delivering DHB funded oral health services for our adolescents from school year 9 up to and including 17 years of age. Targeted preschool oral health promotion and brushing programmes are also delivered with our partners in the Kohanga reo, Language Nest and Early Childhood Education sector.

Linkages

CM Health 2016/17 Maaori Health Plan, Asian Health Plan and Pacific Health Plan

- Proportion of children under 5 years enrolled in DHB-funded Community Oral Health Services (COHS)
- Implementation of enrolment by 5 months into COHS by Well Child Tamariki Ora Providers by Q1
- Child Health Services flyer includes preschool oral health checks with WCTO providers and enrolment in oral health services
- Increase the percentage of enrolled children caries free at age 5 years through earlier engagement and utilisation of DHB funded dental services
- Clinical examination of tamariki by 1 year of age
- Preschool examinations use a flexible model for better access, engagement and attendances by Q1:
  - Dental therapist specific screening time at a WCTO clinic –use a smaller screening van and/or portable equipment; specific weekdays and possible Saturdays to catch the working parents, or,
  - Larger preschools – using screening van and/or portable equipment, or,
  - At the COHS dental clinics/ mobile vans/ TDUs
- Pilot increased access hours for hub dental clinics through a Saturday trial at Browns Road Hub Clinic to reduce barriers to access and increase appointment capacity by Q1
- Provide incentive welcome packs for children aged 1 year for their first examination by Q1
- Oral health education is provided to parents and caregivers by WCTO providers at all core contacts, and includes Lift the Lip exam, advice on healthy nutrition, tooth-brushing, and attendance at dental clinic appointments
- Follow-up of persistent DNAs in preschool patient group through WCTO, PHN or community/Fanau Ola health workers

- 95 percent of eligible children 1 year of age are enrolled in COHS
- 55 percent of children aged 5 years are caries free
- 95 percent of eligible children 1 year of age are examined by a dental therapist
- 7 percent of enrolled preschool and primary school children aged 0-12 years are overdue for their scheduled examination
- 1.00 Mean DMFT in year 8 children
- 100 percent year 8 children are transferred to adolescent dental services
- 85 percent of eligible adolescents utilise DHB funded dental services

▪ Monitoring of preschool children identified with severe early childhood caries identified at dental examination or referred to hospital dental services for extractions under general anaesthetic ▪ Local promotion of swap sugar sweetened drinks to water or milk as part of oral health literacy promotion Q3-Q4 ▪ Review Preschool Mighty Mouth tooth brushing programme and scope feasibility to expand from 150 high needs / high Maaori and Pacific preschools to an additional 80 identified preschools Q3-Q4 ▪ Child Health Services multi-enrolment/ referral flyer includes preschool oral heal checks with WCTO Providers Q1–Q4 ▪ Reduce proportion of enrolled preschool and school children who have not been examined at a community oral health services (within 30 days of their recall date) ▪ Reduce DMFT (Decayed-Missing-Filled Permanent Teeth) in year 8 of school children (aged 12/13 years) ▪ Children in Year 8 of school (aged 12 / 13 years) are completed treatment and transferred to Adolescent dental services ▪ Increase utilisation of DHB funded dental services by adolescents school year 9 (13/14 years) up to and including 17 years of age	
Health Gain Area ▪ Develop a targeted engagement strategy with the three main Asian groups which are Indian, Chinese and Filipino communities that will link to a number of initiatives such as translation of health literature into Hindi, Mandarin and Korean **Well Child Tamariki Ora Enrolment - Pacific** ▪ Co-design and disseminate improved engagement resources to be provided within antenatal care, including 'Welcome to Child Health Services' brochure by Q1 ▪ Implementation of the WCTO quality improvement framework to achieve all core contacts due in 1st year ▪ Targeted intensive WCTO contacts to high needs Fanau including earlier contact at 2 weeks, additional contacts between core visits, and support groups ▪ Improved model of engagement shared between WCTO and LMC/midwives to target intensive services to high needs Fanau	▪ 98 percent of infants enrolled with WCTO Provider by 4-6 weeks ▪ 95 percent of infants receive all WCTO core contacts due in first year

2.1.8 Prime Minister's Youth Mental Health Project

CM Health is taking a broad strategic approach to the planning of youth health services, which includes meeting the objectives of the Prime Minister's Youth Mental Health project. Work will focus on:

- Piloting a comprehensive and integrated school based youth health service
- Developing a collaborative model for high-risk young people in Alternative Education
- Continuing a programme of continuous quality improvement in schools and general practice to improve the 'youth friendliness' of services
- Continuing to improve access to CAMHS and AOD services

Linkages

CM Health 2016/17 Maaori Health Plan

Actions	Measures
School Based Health Services (SBHS) ▪ Ensure on-going quality service provision of existing SBHS in all funded schools, including a review of the provision of SBHS in local kuras ▪ Trial a comprehensive and integrated SBHS in one low decile high school ▪ Continue with the implementation of 'Youth Health Care in Secondary Schools: A framework for continuous quality improvement' (CQI) in all funded schools ▪ Review the provision of school-based health services for rangatahi Maaori in local kuras	▪ 95 percent of students, including rangatahi Maaori, eligible for a routine health assessment (which includes a HEEADSSS assessment) receive an assessment ▪ Pilot and evaluate a comprehensive and integrated school based youth health service in one high school ▪ Ensure adherence to MOH reporting requirements for SBHS, including 100 percent completion of annual reports ▪ Offer SBHS to two additional kuras by the end of Q2
Improving the responsiveness of primary care to youth ▪ Continue to monitor the performance of the youth SLAT (Youth Health Leadership Group) ▪ Undertake a review of health services on community Alternative Education (AE) facilities and develop a collaborative service model with education and NGO partners ▪ Complete a stocktake of health services in Private Training Establishments (PTEs) in order to assess the existing level of health provision ▪ Work closely with general practice teams with linkages with schools to ensure they are 'youth friendly, by introducing an appropriate audit tool and appointing a Primary Care Youth Health Quality Advisor to assist practices with implementing the agreed actions following the assessment ▪ CM Health Alliance will work with the sector to further develop the definition and identification of data sets for the 'Youth access to and utilisation of youth appropriate health services' system level measure ▪ Increase the percentage of rangatahi Maaori accessing Alcohol Brief Interventions (ABI) and Mental Health Brief Interventions	▪ Rationalise the governance and accountability for youth health across the youth, primary care and mental health portfolios within the DHB ▪ AE health service review completed by Q2 ▪ A collaborative service model developed and agreed by Q4 ▪ PTE stocktake completed by the end of Q4 ▪ Primary Care Youth Health Quality Advisor to complete quality improvement process with 25 practices by the end of Q4 ▪ Increase in access to Alcohol Brief Interventions (ABI) and Mental Health Brief Interventions by the end of Q4
Reviewing and improving the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Other Drug (AOD) services ▪ Improve the percentage of transition plans completed for young people discharged from the CAMHS and youth AOD services	▪ Areas of improvement will be identified in order to meet the 95 percent target by Q3

Improving access to CAMHS and Youth AOD services through wait times targets and integrated case management ▪ Continue to monitor and achieve waiting time targets for access to CAMHS and youth AOD services	▪ 80 percent of youth to access services within 3 weeks ▪ 95 percent to access services within 8 weeks- completed by the end of Q4
Improving and preserving the mental wellbeing of rangatahi Maaori with a focus on depression The aim for mental health in primary care for 2016-17 is to reduce the disparity between Maaori and non-Maaori in the Chronic Care Management (CCM) Depression programme. Following the 2015-16 information gathering and discussion with stakeholders including primary and secondary care, it is proposed that the following actions be implemented in 2016/17: ▪ Partnering with Maaori providers including Te Ara WhiriWhiri (Maaori mental health collective) ▪ Programme monitoring on a monthly basis with programme KPIs reported by ethnicity with a particular focus on patient engagement KPIs ▪ Working to deliver group based CBT with a potential for rangatahi Maaori-tailored group	▪ Partner with Te Ara WhiriWhiri by Q2 ▪ Monthly monitoring of KPIs via the CMM Depression Clinical Governance Group commencing Q1 ▪ Delivery of group-based CBT tailored for rangatahi Maaori by Q4

2.2 Long Term Conditions

2.2.1 Healthy Families NZ

Two of the 10 sites for Healthy Families NZ serve areas of CM Health, covering the majority of our population who are Maaori, Pacific and/or live in NZDep2013 9 & 10 areas. The Healthy Families Manukau, Manurewa - Papakura collaborative (Alliance Health + PHO, Mana Whenua o Tamaki Makaurau and Auckland Council Southern Initiative) have now recruited their staff of approximately 30 health transformation coaches. They have undertaken considerable work to understand the complex influences on environments where people 'live, work and play' and the impact these spaces have on their health & wellbeing.

Linkages
Childhood obesity; Smokefree 2025; Reducing alcohol related harm

Actions	**Measures**
▪ Support for training of Healthy Families Manukau, Manurewa - Papakura staff ▪ Set up internal processes with key analysts to access relevant data ▪ Ensure alignment of Childhood Obesity programme of work with that of Healthy Families NZ as part of health equity campaign ▪ Align delivery of CM Health's Alcohol Harm Reduction programme with that of Healthy Families NZ	▪ Provide a Quarter 4 confirmation and exception report against the examples of participation identified

2.2.2 Raising Healthy Kids

CM Health has been identified as one of the DHBs with a high rate of overweight and obese children who require additional support and advice. Thirteen percent of 4 years olds in Counties Manukau were identified as being obese (>98th centile) at the time of their B4S check in the 6 months to January 2016. Unhealthy diets and lack of physical activity are key determinants of obesity which in turn impacts on health both in childhood and in later life. The long term consequences of obesity include chronic diseases such as diabetes, CVD and osteoarthritis.

CM Health will undertake activity in order to contribute to the reduction in childhood obesity, including through contribution to the health sector actions in the national Childhood Obesity Plan. We will develop a new culturally acceptable family-based nutrition, activity and lifestyle intervention service for children, and their whaanau, who are identified as obese during their B4S check. This work will link to wider outcomes to improve health for all population groups across hospital and community groups. We will ensure that initiatives support a reduction in obesity for Maaori and Pacific families and whaanau, and children living in high deprivation areas.

Linkages

National Childhood Obesity Plan

Actions	**Measures**
Sector review ▪ Undertake a stocktake in Q1 and Q2 of current physical activity and nutrition programmes available in the region, and review evidence of effectiveness of such programmes ▪ Identify other initiatives across sectors such as Healthy Auckland Together, Active Families, family based diabetes prevention programmes such as H.O.P.E (healthy options positive eating), and H.E.A.L.S (healthy eating active lifestyles) to ensure alignment and leverage against existing programmes ▪ Work with key stakeholders across health and other sectors to support implementation of the obesity package of initiatives	▪ Stocktake completed by Q2 ▪ Appropriate alignment to avoid duplication of service
New service ▪ Develop multidisciplinary alliance with WCTO providers, primary care and community partners ▪ Implement appropriate referrals pathways to ensure families experience seamless transition and support post referral from the B4SC to Primary Care for clinical assessment ▪ Expedited pathway for Maaori and Pacific children ▪ Implement the Northern Regional (Childhood) Obesity Prevention pathway to ensure primary care have access to appropriate resources to support conversations with families, identify metabolic complications of obesity, and are clear when referral to secondary and/or family nutrition, activity and lifestyle intervention services is appropriate ▪ Implement regionally consistent guidelines and electronic growth chart solution for primary care and B4SC providers, consistent with MOH advice by Q1 ▪ Implement culturally appropriate family-based nutrition, activity and lifestyle intervention services for children identified as obese at their B4SC; services to include post-intervention framework, specifically targeted to Maaori, Pacific, and families from high deprivation communities Q2 ▪ Implement the Northern Regional (Childhood) Obesity pathway to ensure primary care have access to appropriate resources to support conversations with families, identify metabolic complications of obesity, and are clear when referral to secondary and/or family nutrition, activity and lifestyle intervention services is appropriate	▪ 95 percent of eligible 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 by December 2017 ▪ B4 School practice nurses have been trained in referral processes and guidelines and electronic growth chart solution for primary care by Q1 ▪ PHOs have been trained in process, regional guidelines, electronic growth chart solution and resources for GP practices by Q1 ▪ 100 percent of GP practices have received training, regional guidelines and resources by Q2 ▪ Implement regional guidelines, electronic growth chart solution and resources for clinical staff in secondary and tertiary care over Q1-Q2 ▪ Implementation of the family based Lifestyle Nutrition and Physical Activity intervention provider contracts by Q1 ▪ Implement Quality plan and reporting for referrals, use of the regional guidelines and electronic growth chart by Q2

▪ Implement regionally consistent guidelines and electronic growth chart solution for primary care and B4SC providers, consistent with MOH advice by Q1 ▪ Implement and monitor guidelines for clinical staff working in secondary or tertiary care response when children are assessed as obese ▪ Monitor adherence to weight assessment guidelines by clinical staff working in secondary or tertiary care ▪ Referrals to At Risk programmes for children/families who meet the eligibility criteria ▪ Liaise with school based programme "Mana Kidz" and Health Promoting Schools (HPS) to ensure they are working with schools to develop healthy food policies and health promotion around nutrition as a core part of their daily work	
Workforce development ▪ Upskill WCTO workforce on infant and family nutrition using health literacy model, and develop family-based healthy nutrition initiatives ▪ Develop a training module for primary care to upskill workforce on infant and nutrition family discussions using health literacy framework ▪ Upskill Community Oral Health services to ensure consistent nutritional advice is received by parents and caregivers of preschool children ▪ Training module and resources for ECE, preschools, language nests, kohanga reo to upskill staff and volunteers using the health literacy module and aligned to the curriculum Te Whaariki for healthy nutrition and exercise. The initial module will target ECE centres in high deprivation localities with high rolls of Maaori and Pacific children ▪ Continue to work with midwives and self-employed LMCs around the implementation of the Healthy Weight in Pregnancy guidelines	▪ 100 percent WCTO staff trained ▪ ECE resources and training developed aligned to NZ Heart Foundation programme ▪ 50 percent of ECE trained and resourced targeting high Maaori and Pacific rolls, high deprivation by Q2 ▪ Remaining ECE trained and resourced by Q4
Sector alignment ▪ Oral Health education is provided to parents and caregivers by WCTO providers at all core contacts, and includes Lift the Lip exam, advice on healthy nutrition, tooth-brushing, and attendance at dental clinic appointments ▪ Consistent nutrition messages across settings ▪ Liaising with ECE, preschools, language nests, kohanga reo in the region for implementation of nutrition and preschool activity guidelines consistent with MOH advice and aligned to Te Whaariki (ECE curriculum) ▪ Co-design a culturally relevant local promotion to WCTO, COHS, ECE of swap sugar sweetened drinks to water or milk as part of oral health literacy promotion Q3-Q4	▪ Water and milk promotion Q3-Q4

2.2.3 Cardiovascular Disease

Cardiovascular Disease (CVD) is the leading cause of death in Counties Manukau district. People with CVD and diabetes are associated with a high level of health care costs and have a significant impact on the health and social and economic wellbeing of individuals and whaanau. In 2008, Maaori had the highest age standardised CVD prevalence compared to other ethnic groups in the CM Health district. Focus on the prevention and management cardiovascular disease including management of CVD risk, diabetes and other metabolic related conditions such as gout is important for Maaori and Pacific patients.

Linkages

CM Health 2016/17 Maaori Health Plan; Northern Region Health Plan; Integrated Performance and Incentive Framework

Actions

- CM Health will continue to deliver cardiovascular services to utilise the final year of Budget 2013 funding, focussing on delivery for Maaori and Pacific peoples

CVD Risk Assessment

Quarter 1:

- Create regular monthly reports on patients including Maaori and Pacific who have not yet had a risk assessment or who need to be recalled as their last risk assessment was five years ago
- Establish new reports for Maaori and Pacific men turning 35, and Maaori and Pacific women turning 45 within the next three months and proactively target these groups for a risk assessment
- Utilise electronic decision support tools to ensure all patients receive evidence based care
- Offer phlebotomy or point of care testing to selected Maaori and Pacific patients in practice as appropriate
- Subsidised or free CVD risk assessment appointments offered, that include risk communication and risk management as appropriate for Maaori and Pacific by some PHOs
- Ensure all patients have access to appropriate resources such as The Heart Age Forecast (www.knowyournumbers.co.nz) and the healthy heart visual food guide in te reo Maaori
- Utilisation of test safe data to complete non face-to-face CVD risk assessment within all PHOs and recall people with amendable risk factors for management
- Continue to offer support via the CM Health National SLM clinical champion with clinical advice and guidance

Quarter 2:

- Work closely with marae and churches who have linkages with primary care to improve health literacy of Maaori and Pacific patients in relation to CVD risk, diabetes and metabolic conditions such as gout

Health Gain Area

- Investigate workplace risk assessment opportunities and complete a cost/benefit analysis
- Work closely with marae and churches who have linkages with primary care to encourage Maaori and Pacific patients to have a CVD risk assessment with appropriate follow up

Measures

- 90 percent of the eligible adult population will have had their CVD risk assessed in the last five years
- Percentage of 'eligible Maaori men in the PHO aged 35 to 44 years' who have had a CVD risk recorded within the past five years

CVD Management

Quarter 1:

- Management options will be discussed with all patients who have a CVD risk >10 percent enabling shared decision making
- Complete a stocktake of all exercise and nutrition programmes for Maaori and Pacific patients and ensure referral pathways are in place from primary care
- Patients with a CVD risk >20 percent will be prescribed double therapy
- Patients with known CVD will be offered triple therapy
- Include shared management decisions based on discussions between clinicians and patients at high risk of CVD
- Address transport barriers and time barriers by offering support with accessing primary care through the provision of weekend and after-hours services

Health Gain Area

- Active recall of all Maaori with a CVD risk >10 percent by text and phone calls
- Maaori with a low to high risk will be offered a referral to a culturally appropriate Self-Management Education group
- Development and/or utilisation of culturally appropriate resources such as 'know your numbers', and the healthy heart visual food guide in te reo Maaori
- Primary and Secondary care clinicians will work together in multi-disciplinary teams to manage patients with a >20 percent risk

Quarter 2:

- Implementation of communication training for primary care staff to support trusting and effective relationships including patient led decision making and goal setting via the At Risk quality improvement programme

Secondary Cardiac Services

- Work with Auckland DHB to deliver a minimum target intervention rate for cardiac surgery, set in conjunction with the National Cardiac Surgery Clinical Network, to improve equity of access
- Incorporate production planning principles into the Cardiac Investigation Unit with the aim to reduce waiting times for echocardiograms
- Manage waiting times for cardiac services, so that patients wait no longer than four months for first specialist assessment or treatment
- Ensure that planned follow up assessments are completed by the planned date
- Undertake initiatives locally to ensure population access to cardiac services is not significantly below the agreed rates - this includes cardiac surgery, percutaneous revascularisation and coronary angiography
- Continue active involvement with Auckland Regional Cardiac Clinical Network to have equity of access and improve outcomes for the CM Health population, such as:
    - Finalise a regional plan for electrophysiology services to better meet local and regional demand
    - Develop a business case for second Cardiac

- Cardiac surgery SIRs: refer to Electives section 2.3.5
- 95 percent of people will receive elective coronary angiograms within 90 days
- Patients wait no longer than four months for first specialist assessment and treatment
- Standardised Intervention Rates include:
    - Percutaneous revascularisation: a target rate of at least 12.5 per 10,000 of population will be achieved
    - Coronary angiography: a target rate of at least 34.7 per 10,000 of population will be achieved

Catheter Lab to support improved access to cardiac services ▪ Continue to provide national support to ANZACS-QI and provide regular reporting at DHB, regional and national level ▪ Accelerated Chest Pain Pathways refer to Shorter Stays in Emergency Dept section 2.3.4	
Acute Cardiac Services ▪ Continue to contribute data to the Cardiac ANZACS-QI and Cardiac Surgical registers to enable reporting measures of Acute Coronary Syndrome (ACS) risk stratification and time to appropriate intervention ▪ Work with the regional, and where appropriate the national cardiac networks, to improve outcomes for ACS patients and patients with heart failure ▪ Ensure equity of delivery of PCI regionally through local initiatives ▪ Continue to develop the acute CTCA service for non-ACS patients	▪ 70 percent of patients will receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0') reported by ethnicity

2.2.4 Living Well with Diabetes

Living Well with Diabetes is a plan for people at high risk of or living with diabetes 2015-2020. The expectation for DHBs is to continue to implement actions that will demonstrate actions to support delivery of the diabetes plan.

Linkages
CM Health 2016/17 Maaori Health Plan, Pacific Health and Asian Health Plan; Northern Regional Diabetes Plan; Ko Awatea Manaaki Hauora – Supporting Wellness

Actions ▪ Implementation of a new targeted model of care, to focus on patients with poor glycaemic control, and introducing virtual reviews between primary and secondary care to improve the management of diabetes and diabetes associated conditions such as gout and CVD risk management ▪ Implementation of a diabetes collaborative with a selected group of practices (practices with large numbers of patients with poorly controlled diabetes will be targeted) to test new targeted models of care ▪ Ensure patients with diabetes have access to podiatry, dietetic and health psychology support and that Maaori, Pacific and Asian are accessing these services at the same rates as other ethnicities by providing these services in community based settings ▪ Ensure Maaori who have high risk feet are identified proactively within primary care and referred to a podiatrist for ongoing care	**Measures** ▪ Reduction in proportion of patients with Hba1c above 64, 80 and 100 mmol/mol ▪ Monthly reporting on the number of podiatry, dietetic and health psychology visits ▪ Monthly reporting on the number of patients who have been started on insulin ▪ 14,000 patients with diabetes will have had a retinal screen in the community by Quarter 4 ▪ Referrals for patients with diabetes to Green Prescription will increase by Quarter 2 ▪ Monthly reporting of Diabetes Annual Reviews (DAR) by PHOs to monitor progress ▪ Improve, or where high, maintain the management of microalbuminuria in patients with diabetes ▪ All patients with diabetes will have access to support from general practice, Green Prescription, Diabetes Self-Management and other PHO run healthy lifestyle programmes ▪ Diabetes Projects Trust will audit 20 practices and support practice staff to improve outcomes by Q4 ▪ All practices will have access to the NZSSD Diabetes Foot Screening and Risk Stratification Tool by Q1
Prevention ▪ Continue to work with healthy lifestyle providers and general practice teams to ensure that patients who are at risk of diabetes or with diabetes, particularly those with poor diabetes control will be referred for exercise and lifestyle advice ▪ Improved communication between Green Prescription providers and primary care, including information on the patient outcomes post graduation ▪ As part of CVD risk assessment, provide appropriate exercise and nutritional support including courses if appropriate for people with diabetes or at risk of diabetes ▪ Continue with proactive recall for retinal screening and	

renal function tests to ensure the early identification of diabetes related complications

- Ensure timely recall, according to the retinal screening guidelines of all patients with diabetes for retinal screening

Effective Self-Management

- Redesign the approach to self-management education and self-management support to ensure alignment with the strategic direction and improved outcomes for the community. This will include:
    - Completion of a current state assessment and stocktake of all SME courses and SMS activity
    - Gaining stakeholder feedback
    - Development of business requirements for self-management functionality within Community Central
    - Developing a set of recommendations for the reconfiguration of services
- Ensure Diabetes Self-Management courses are delivered according to the regional Diabetes Self-Management Standards
- The self-management collaborative participating in Manaaki Hauora will continue to receive support until December 2016 (end of the campaign), and will be included in the review of the self-management model
- Localities will continue to develop closer linkages between self-management education and self-management support providers
- Clinically and socially complex patients will be eligible for enrolment into the At Risk programme which offers:
    - Care Co-ordination and care planning
    - Multi-disciplinary team meetings
    - Access to extended nurse and GP consultations

Quality

- Implementation of the 20 Quality Standards for Diabetes Care 2014 through a diabetes collaborative model with secondary care, general practice teams and allied health providers
- General Practice teams will be supported to access the regional diabetes pathways
- Up to 20 practice nurses will be offered scholarships to attend the MIT Diabetes Care and Management course
- Five diabetes indicators will be reported on by locality and ethnicity so performance can be monitored with the aim of reducing variation
- Diabetes Projects Trust will continue to support practices with an audit to identify areas of improvement with the provision of diabetes care and will be aligned with the diabetes collaborative to encourage more proactive care of patients with diabetes
- Appointment of a GP lead for diabetes to lead clinical improvement of the 20 quality standards supported by a clinical governance group
- Maaori representative to be appointed to the Diabetes Service Level Alliance Team (SLAT)

Early diabetes detection ▪ Ensure all patients receive a regular retinal screen according to the Retinal Screening Guidelines ▪ Ensure patients are assessed against the NZSSD Diabetes Foot Screening and Risk Stratification Tool with moderate to high risk feet referred to a podiatrist ▪ Cardiovascular risk assessment and management will be delivered according to the evidence based guidelines ▪ Patients with diabetes will receive an annual check for microalbuminuria ▪ Implementation of the gestational diabetes guidelines ▪ All women with diabetes and reproductive age will be counselled on contraceptive (and pre-contraceptive) issues and identified to appropriate care services when pregnant; all women with gestational diabetes mellitus (GDM) will be followed up including entry into a GDM register unless the woman wants to opt-off	
Integrated Care ▪ Locality multi-disciplinary teams will continue to progress, with specialists working in the community with primary care teams and allied health providers ▪ The Diabetes Service Level Alliance Team will provide clinical governance and leadership within CM Health for Diabetes and act as the Local Diabetes Team ▪ Shared care plans will be developed for complex patients as part of the diabetes care improvement programme and At Risk ▪ General Practice teams will request that people with poorly controlled diabetes be assessed for enrolment in the pharmacy LTC service ▪ Adolescents with diabetes will receive an annual review with a multi-disciplinary team providing youth health, health psychology, dietetic, nurse specialist and diabetologist ▪ All patients with diabetes with suboptimal metabolic control (including glycaemic control) despite engagement and adherence to management in primary care settings, will be referred or managed in association (e.g. by locality partnership) with specialist services	
Type 1 diabetes ▪ Improved coding and data collection to differentiate between the outcome measures for Type 1 (T1DM) and Type 2 (T2DM) diabetes in primary care ▪ Upskill nurses in primary care to provide a wider range and improved quality diabetes care ▪ Implementation of the Standards of Care for Children and Adolescents with Diabetes 2014 ▪ All patients with T1DM who are candidates for pump therapy (under PHARMAC guidelines) will be offered an MDT review and if suitable and willing support to initiate and manage pump therapy	
Health Gain Area ▪ Maaori with poor glycaemic control will be offered enrolment into the At Risk programme which includes a care plan, self-management assessment and named care co-ordinator	

- Practices will work to identify Maaori, Asian and others who have not had a retinal screen, or who are overdue for a retinal screen ensuring they are referred to the service or followed up
- Improved access to self-management support services, including self-management education, to enhance health literacy, healthy lifestyles, adherence to medication and overall health and wellbeing for Maaori, Asian and other patients and whaanau with diabetes
- Practice Nurses who work in practices with high numbers of Maaori and/or Pacific patients with diabetes will be encouraged to attend the Manukau Institute of Technology Diabetes Care and Management course

2.2.5 Tobacco

Based on 2013 Census data, it is currently estimated there are 62,000 people that smoke in the Counties Manukau district. Maaori and Pacific comprise almost one-third each of the smoking population (at an estimated 18,900 and 17,900 respectively), with NZ European/Other groups comprising almost one-third (estimated 20,500), and one-tenth identified as people of Asian ethnicities (estimated 6,000). There remain clear inequities in smoking prevalence in the Counties Manukau population, with Maaori in Counties Manukau still more than twice as likely to smoke (36 percent) as the total population (15.9 percent). Pacific communities as a whole are also more likely to smoke than the total population (23.2 percent), with some groups such as Cook Island Maaori (30 percent), and Tongan men (30.7 percent), considerably more likely.

CM Health has undertaken a planning and modelling process to attempt to quantify what achieving the Smokefree Counties Manukau 2025 intermediate goal of 12 percent smoking prevalence by 2018 (and 18 percent or less for Maaori) will require, in terms of the number of people that need to stop smoking and stay smokefree per year.

It is estimated that on top of the current steady state of people starting smoking, and stopping smoking, achieving this goal would mean an additional 4,200 people would need to stop smoking and stay smokefree per year to 2018.

A major focus of CM Health's Smokefree 2025 initiative is therefore to expand the reach and volume of smoking cessation support, with a focus on four key settings: brief intervention in healthcare settings, Quitline, intensive stop smoking services, and wider community settings, within our localities.

Primary Care Actions

Actions focused on sustaining performance

- Meet with PHO partners monthly to support the PHOs to achieve target by assessment performance and sharing best practice ideas and issues with other PHOs and the National SLM Clinical Champion
- Continue to promote education opportunities including both DHB and PHO CME/CNE sessions as well as the e-module ABC training
- Practices who have not met the target are supported with additional resources to assist them with implementing practice processes for opportunistic and systematic screening, and decrease the number of missed intervention opportunities
- Ensure practices have appointed smokefree champions to support ongoing coaching and mentoring to staff and patients
- Provide support to practices with regular staff visits to discuss progress and share best practice with other practices
- Provide practices with resources including advice on behavioural support and pharmacotherapy
- Ensure patient dashboards and prompts are used in all practices and encourage practices to use appointment scanners
- Produce reports and undertake audits that enable practices to help them track their progress against the target
- Support smokefree initiatives within general practice such

Primary Care Measures

- 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking within the past 15 months
- Ongoing implementation of activities to support target and increased cessation support rates

as Stoptober, World Smokefree Day and the Quit Bus
▪ Support practices to use the correct codes and record both brief advice and cessation support activity
Activities focused on improving the rate of cessation support:
▪ Behavioural support will be offered to patients within practice or via a referral to a cessation support service, including group based therapy
▪ Maaori and Pacific patients will be referred to culturally appropriate local stop smoking services
▪ Practices will be encouraged to increase the number of people offered and prescribed Nicotine Replacement Therapy (NRT) and other stop smoking medications
▪ Ensure practice and PHO staff who complete group based therapy training are supported to run group courses within the community for smokers
▪ Ensure referral relationships are built between primary care and local cessation support services and encourage e-referrals from primary care staff
▪ Improve primary care follow-up and coordination for patients receiving smokefree support in hospital
▪ Dedicated Smokefree Advisor (Primary Care) is employed by CM Health to support PHOs to improve the rates of cessation support, with a focus on Maaori and Pacific
▪ Work with care co-ordinators for At Risk patients to assist and support them to provide cessation support and referrals to cessation services
▪ Patients responding to text messages asking for cessation support will be followed up and offered a range of cessation support options and referred to an appropriate provider or offered in practice cessation support
▪ Support call centre staff to prioritise Maaori and Pacific smokers, understand cessation options and referral pathways
▪ Supporting the use of audit tools within practice:
  ▪ To identify those in need of support following the prescription of cessation medication
  ▪ Using all members of the practice by setting up a reminder process such as a patient alert and add this alert to all smokers who are overdue for ABC and those who will become overdue within the next three months
  ▪ Using a targeted approach such as a query build to identify high needs populations, such as pregnant smokers, so they can be followed up and offered support	

Maternity Care
▪ A Dedicated Smokefree Advisor (Maternity Care) is employed to support midwives to improve the rates of cessation support, with a focus on Maaori and Pacific
▪ Implement Maternity Target Action Plan - activities include:
  ▪ Provide midwives with resources including advice on behavioural support and pharmacotherapy by Q2
  ▪ Present success learnings and evaluation findings to MOH in RFP realignment funding round to move pregnancy incentives pilot into business as
	▪ 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or LMC are offered advice and support to quit smoking
	▪ Maternity Target Action Plan implemented
	▪ Pregnancy Incentives programme is rolled out in each locality (pending successful continuation of funding)
	▪ Increase in referrals of Maaori and Pacific women
	▪ 95 percent of women smokefree at 2 weeks postnatal

usual by Q1 ▪ Work with Birthing and Assessment unit midwives and WCTO to ensure smoking status and cessation support is offered at delivery and at 2 weeks from Q2 ▪ Support training opportunities for midwives and monitor training uptake ▪ Identify midwifery specialist teams and midwives working with pregnant women and postnatal (i.e. diabetes team) ▪ Implement strategies to increase referrals for Maaori and Pacific women finding it difficult to remain Smokefree following birth to achieve equity from Q2 ▪ Work with maternal mental health DHB team on most effective ways of supporting smokefree pregnancies and postnatal abstinence ▪ Monitor provision and efficacy of Quickmist or any other new non-subsidised products for pregnant and postnatal women distributed from primary birthing units and birthing ward at Middlemore hospital if engaged with ongoing support ▪ Address inconsistencies in referral rates between non-Maaori and Maaori and promote proactive referring ▪ Develop a workforce training plan in partnership with WCTO providers to ensure all WCTO are trained to deliver ABC or are aware of how to refer to cessation specialist support by Q2 ▪ Implement actions as per workforce training plan Q2 onwards ▪ Develop an action plan in partnership with WCTO providers to support postnatal and whaanau smoking cessation or abstinence in Q1 ▪ Work with Smokefree Advisor (Primary Care) and PHOs to trial an opt-out referral system in general practice for pregnant women in priority localities Q2 – Q4 ▪ All service specifications for contracted providers of local stop smoking services will include clauses and expectations of clear referral pathways for pregnant women and their whaanau, mandatory training on best practice for pregnancy women and their whaanau, clinical supervision for cessation practitioners Q1 – Q2	▪ WCTO workforce plan is developed and implemented ▪ WCTO action plan developed and implemented to support postnatal and whaanau abstinence ▪ Opt out trial is completed and findings reported to Smokefree governance group ▪ Clauses included in all service specifications from 1 July 2016
Smokefree 2025 ▪ Implement year 4 of CM Health's Smokefree 2025 Initiative ▪ The Northern Regional Alliance will coordinate a mass quitting challenge (with incentives) for mental health and addiction service users and staff by Q4 ▪ Ensure that the secondary care Health Target is moved into business as usual ▪ Reconfigure community based cessation services into localities (pending successful funding bid) ▪ Develop and train frontline health professionals to provide ABC and refer	▪ Overarching target is to reduce smoking prevalence to: ▪ 12 percent overall by 2018 ▪ 18 percent for Maaori by 2018 ▪ 5 percent across all groups by 2025 ▪ Year 4 workplan is implemented and monitored ▪ Achievement of Secondary Care Smoking target ▪ Cessation provision is set up per locality ▪ Increase in recorded frontline health professionals trained in ABC and increase in referrals

2.2.6 Mental Health & Addictions and Rising to the Challenge

Rising to the Challenge is the Mental Health and Addiction Service (MH&A) Development Plan which articulates the priority service development actions through until 2017. The Plan reflects a shift to a more integrated approach in planning and evaluating current services in order to continually improve and renew services, while balancing accountability to service users as well as those holding the budget.

The current mental health and addictions system in Counties Manukau needs to be transformed if we are to better meet the needs of our population. Good progress has been made – increased service access, enhanced workforce capability, expanded scope, and development of a wide range of community-based services - but much more needs to be achieved. Historically our focus has been on supporting the small percentage of the population (three percent) with the most severe and enduring mental health needs. Whilst retaining our focus on supporting those with the most complex needs, we want to be able to intervene earlier (in the life course and in the course of a condition), providing deliberate, systematic, joined-up support across primary care, specialist mental health and addictions, and NGO providers. Traditionally mental health and addictions has been viewed, and has functioned, as a speciality distinctly separate from the wider health system. This needs to change, with mental health and addictions embedded within, and working as part of, the wider health system.

These changes to our mental health and addictions system need to be bold if we are to effectively meet local need – and begin to address the significant, and unacceptable, health disparities that exist for people with mental health and addiction needs. These disparities not only directly affect the life expectancy and wellbeing of individuals, but also affect their family/whaanau and our wider community – an individual's ability to work, attend education or be involved in everyday activities. We know that life expectancy for those suffering with mental health and addiction illnesses, is up to 25 years less than the population average. The World Health Organisation cites depression as one of the ten leading causes of disability-adjusted life years lost, and current WHO predictions indicate that by 2030 it will be within the top three leading causes of disease burden. With a clear strategic goal for CM Health to achieve health equity for our community, including addressing the issue of alcohol related harm, it is imperative that we take significant steps to challenge the status quo for people with mental health and addition needs.

Under the current system, people access support for their mental health and addiction needs from a range of points within the healthcare system – primary care, specialist mental health teams, Community Alcohol and Drugs Service (CADS), and NGOs. Many people, professionals and non-professionals alike, are confused or uninformed about what support is available and how it can be accessed. When referrals are made/services accessed, there is often no continuity of care, or sharing of information. Shortened life expectancy is primarily a consequence of co-existing physical and mental health needs which the system has failed to diagnose or appropriately address in a holistic way. The same is true of co-existing addictions and mental illness, with individuals often advised that they need to address their addiction before their mental health needs can be assessed or vice versa, leaving people with no recourse to treatment and support, and potentially at significant risk. We are focusing on a continuum of care with mental health and addictions fully integrated with wider health teams.

This financial year we will continue with the construction phase of the Acute Inpatient Mental Health facility. The location of the new building on the same site as the current premises necessitates staging of construction to allow the continuation of operational services. The logistics of decanting, demolishing and reconstructing the acute inpatient unit will have a huge impact on service delivery, including judicial proceedings, transfer of care, crisis and emergency department, family and whaanau engagement and administration as staff work with acute inpatients across two sites.

CM Health Mental Health and Addiction services are committed to the Ministry's outcome and commissioning frameworks; the key performance indicators that will measure the success of MH&A initiatives are:

Better use of resources/value for money

- Commence construction of the Acute Inpatient Mental Health facility

Improving primary-specialist integration

- Implement the Whole of System Integration Plan for MH&A services
- Embed mental health within the At Risk programme
- Broaden the Family Whaanau engagement strategy to include consumer engagement and incorporate implementing the Supporting Parents: Healthy Children (COPMIA) guidelines

Cement and build on gains for people with the highest needs

- Develop the Intensive Community Team (ICT) Implementation Plan based on the agreed recommendations from the ICT Review
- Develop the Early Psychosis Intervention Team (EPIT) Implementation Plan based on the agreed recommendations from the EPIT Review
- Develop the Maternal Mental Health Services (MMH) Implementation Plan based on the agreed recommendations from the Maternal Mental Health Services Review
- Address the employment rates and physical health needs of people with low prevalence disorders

Enhance access for all age groups

- Further development of the acute psychiatry pathway by implementing the recommended acute psychiatric service in ED
- Pilot the Overnight Awake Nurse service

Mental Health and Addictions 2016-2017 Actions and Measures are grouped under these key performance indicators, and aligned with the planning priorities from the Ministry of Health in the table below.

Linkages
CM Health Better Mental Wellbeing for All – Making every contact count; Mental Health and Addictions Strategic Action Plan 2013-2018; Blueprint II: How things need to be (2012). Wellington: Mental Health Commission; Rising to The Challenge: The Mental Health and Addiction Service Development Plan 2012-2017 (2012) MOH; Maaori Health Plan section 6.3, section 6.5, Appendix 3; Counties Manukau DHB System Integration Programmes of Work – Whole of System, SWIFT; District Suicide Prevention and Postvention Plan 2016-2020; Review of Maternal Mental Health, Dr Helen Cooney, July 2015; EPIT Review, Dr Sue MacKersey, August 2015; Proposal for Change – Outcome from the Psychiatric Liaison and Psychology Review, November 2015; CM Health 2016/17 Maaori Health Plan

Actions	Measures
Better use of resources/value for money ▪ Commence construction of the Acute Inpatient Mental Health facility - estimated build time of the West Wing is 16 months	▪ Construction milestones met as per the Acute Inpatient Mental Health Facility Construction Project Plan

Improving integration between primary and specialist services by commencing the implementation of the Whole of System Integration Plan for mental health and addiction services
▪ Determine the range and alignment of specialist and NGO services required to provide a comprehensive and appropriate suite of MH&A services for each locality, that is reflective of population need
▪ Pilot the MH&A components of the At Risk programme in three general practices
▪ Develop a proposal to reconfigure specialist addiction services to better meet the needs of people in Counties Manukau, including better integration of community addiction services with locality primary and community health services
▪ Develop and strengthen networks between primary care, specialist MH&A services and NGO providers who work together; wrapping accessible and appropriate services around patients to improve their physical and mental health outcomes
▪ Increase education opportunities and on-going support to develop the primary care workforce's confidence in relation to mental health, enabling greater support for people with mild to moderate mental health needs and improved capability to better manage the physical health of people with severe and enduring mental health needs
	▪ Locality requirements identified and implementation plan agreed for the alignment/development of integrated MH&A specialist and NGO services by Q4
	▪ Arrangements established and in place for named specialist mental health clinicians working alongside and within each of the three pilot practices by Q1
	▪ Establish baseline data for the pilot sites by Q1, on:
	  ▪ CVD risk and smoking status for patients enrolled at each GP practice and open to secondary care
	  ▪ Number of new referrals per month from each practice
	▪ Review and evaluate outcomes including number of encounters with primary care/secondary care, CVD risk, smoking status, patient experience and level of mental health confidence/capability within each pilot practice by Q4
	▪ Pilot and evaluate an integrated team approach within a single locality hub/cluster of GP practices by Q4
	▪ 50 percent primary care practices engaged in mental health education by Q4

Consumer and family whaanau engagement
▪ Implement the Supporting Parents: Healthy Children guidelines
▪ Provide guidance to MH&A on the specific actions needed to improve the services approach to identifying, supporting and protecting children of parents with mental health and/or addiction issues
▪ Broaden the Family Whaanau engagement strategy to include consumer engagement and align MH&A services to the CM Health framework for consumer and family whaanau participation and leadership activity
▪ Identify the key workforce engagement activities to:
  ▪ Include service users and family whaanau in whole of system and co-design activity
  ▪ Encourage participation in Mental Health Awareness week activities
▪ Implement actions and measures for Real Time Feedback developed by the Steering Group Q4 of 2015/16
	▪ A CM Health COPMIA reference group is established by Q1
	▪ Each community adult and inpatient team has a named COPMIA champion by Q1
	▪ The essential COPMIA toolkit is available in two community adult services by Q3
	▪ Key outcome measures for family and whaanau inclusive practice are established:
	  ▪ The essential COPMIA toolkit is available in all community adult services by Q4

Supporting the shift to an outcomes-focussed approach ▪ Develop a robust dashboard of clinical indicators to monitor the ongoing performance of MH&A Acute Pathway, that informs the service and the teams ▪ Support and develop outcomes through capturing and utilising patient experience feedback in our non-acute community services	▪ Dashboard utilised by teams within the Acute Pathway by Q3 ▪ Real Time Feedback captured and utilised for improvement by Q2 ▪ Partnership Evaluation Recovery (PER) Team Reports are utilised for improvement by Q4
Cementing and building on gains in resilience and recovery ▪ Develop the Intensive Community Team (ICT) ▪ Implementation plan based on the agreed recommendations from the ICT Review ▪ Develop the Early Psychosis Intervention Team (EPIT) Implementation Plan based on the agreed recommendations from the EPIT Review ▪ Develop the Maternal Mental Health Services (MMH) Implementation Plan based on the agreed recommendations from the Maternal Mental Health Services Review	▪ ICT Implementation Plan developed by Q3 ▪ ICT Progress Update Report provided by Q4 ▪ EPIT Implementation Plan developed by Q2 ▪ EPIT Progress Update Report provided by Q4 ▪ MMH Implementation Plan developed by Q2 ▪ MMH Progress Update Report provided by Q4

Employment rates and physical health needs of people with low prevalence disorders
▪ Implement integrated employment strategy to include:
  ▪ Employment champions identified within each Community Mental Health Centre (CMHC) and NGO
  ▪ Review the service specifications for specialist employment services
  ▪ Develop and implement a service delivery model to prioritise access to employment support services for consumers with low prevalence disorders, with a focus on consumers from the Intensive Community Team (ICT)
  ▪ Review and amend eligibility criteria identified within the local service specifications that underpin the delivery of NGO employment support services
▪ Improve the physical health of clients supported by ICT who have low prevalence disorders by ensuring they are actively engaged with primary care providers and that their physical health needs are being met. This will be achieved by:
  ▪ Working collaboratively with identified GP providers
  ▪ Ensuring the ICT workforce (including partner NGO's) are competent in undertaking identified physical health measures
  ▪ Establishing Equally Well Steering Group across MH&A services
	▪ 75 percent of consumers receiving support from NGOs partnered with the locality CMHC, will have their employment status recorded on entry to the NGO service by Q4
	▪ 75 percent of consumers receiving support from NGOs partnered with the locality CMHC will have their vocational goals recorded by the NGO, where relevant by Q4
	▪ 75 percent of consumers receiving employment support services will have an employment transition plan in place prior to exit from the employment support service by Q2
	▪ 100 percent of consumers referred to MH&A funded integrated employment services are screened for access eligibility to MSD funded employment (by Q2) and will either:
	  ▪ Receive support to access the appropriate mainstream employment option, or
	  ▪ Receive support to source employment of their choice from specialist MH&A funded employment services
	▪ 33 percent of consumers utilising the employment support services will be current consumers of the Intensive Community Team (ICT), where eligible by Q4
	▪ Gap analysis of workforce capabilities completed by Q1
	▪ Equally Well Steering Group established
	▪ KPI's developed to monitor the outcomes of the physical health measures and reported in ICT monthly report by Q2

Enhancing access for all age groups ▪ Improve crisis response services particularly in relation to known clients being referred to crisis services by police ▪ Further develop the acute psychiatry pathway by: ▪ Implementing the recommended acute	▪ Extend MH services in ED to 24 hours to provide shorter wait times for police responding to clients in crisis ▪ Fully staffed and operational acute psychiatry service in ED by Q2

Psychiatric service in the Emergency Department (ED) ▪ Pilot the Overnight Awake Nurse service	▪ Evaluation with recommendations of pilot of Overnight Awake Nurse completed by Q2
Suicide Prevention ▪ Work with Interagency Suicide Prevention group to implement the district Suicide Prevention and Postvention Plan for 2016-2020 ▪ Review and refresh the intersectoral postvention framework ▪ Prioritise the groups to have their local training needs identified and how/where these can be integrated into the core training within the regional Workforce Development Framework	▪ Postvention Working Group established to review postvention documents and processes by Q2 ▪ Training needs for first wave of priority groups identified by Q2 ▪ Revised Postvention Accountability Framework completed by Q3 ▪ Plan to implement into core training developed by Q3 ▪ Training needs for second wave of priority groups identified by Q4 ▪ Achieve implementation milestones according to timeframes in the Suicide Prevention and Postvention Plan for 2016-2020 by Q4
Health Gain Area ▪ Enhance workforce capability: Improve workforce awareness and practices with regard to release from the Mental Health Act 1992: Indefinite Section 29 orders ▪ Implement improved information flow between stakeholders in the CTO clinical review process ▪ Improve consultation/engagement with whaanau to enhance service user recovery and ability to be released from a CTO	▪ Review staff needs for further CTO training by Q1 ▪ Review and update MHA CTO training programme by Q2 ▪ Implement refreshed in-service CTO training by Q3 ▪ Evaluate CTO training for adult community MH teams by Q4 ▪ Plan for improved processes and information flow between CTO stakeholders across the MH Division developed by Q1 ▪ Plan implemented by Q2 ▪ 95 percent Maaori service users on indefinite CTO have had a timely clinical review by Q4 ▪ Consult with whaanau of service users on an indefinite CTO to understand their consultation/engagement needs by Q1 ▪ Targets and reports to monitor levels of whaanau consultation/engagement developed by Q3 ▪ Action Plan to improve the levels of consultation/engagement with whaanau of service users on an indefinite CTO developed by Q4

2.3 System Integration

2.3.1 Integrated Care

Introduction

Integrated Care is a core component of our Healthy Together strategy with the goal of working together to achieve health equity. It aligns with the Counties Manukau health system's Healthy People, Whaanau and Families strategic objective "together we will involve people, whaanau and families as an active part of their health team".

CM Health is committed to providing more care closer to home within primary and community settings – to do this we need to create capacity and improved ways of working to enable integration not only across the health system but with broader intersectoral partners to better support our population to live well, make healthy choices around lifestyle and to self-manage their conditions. Integration across the system will also support the improvements required to achieve the system level measures under the revised Integrated Performance and Incentive Framework for the 2016/17 year. The Integrated Care change portfolio contains a number of initiatives, each project with a specific goal, but all have the needs of the patient and family/whaanau at its core.

Enhanced Primary Care

Enhanced Primary Care is a collaborative between the DHB, PHOs and a number of early adopter practices within the district working together to transform the primary care model of care to operate in a more integrated and inter-disciplinary way to:

- Create a more sustainable model of primary care – increasing system capacity and capability, better engaging and bringing care closer to the patient, thus reducing demand for hospital based services
- Develop an enhanced primary care model of care to enable practices to work in a more integrated way, to create capacity within their workflows to work more flexibly with complex patients
- Enhance platform capabilities with implementation and integration of technology platforms to enable real time clinical information to facilitate timely triage, proactive care and improved coordination

Community Health Services Integration

We are currently transforming the way these community health services work to provide an integrated community health service for all people in the Counties Manukau district. This involves a move away from the specialist team approach – with the roles and skills of multiple separate teams becoming integrated into locality community health teams. These teams will operate in an integrated team within general practice and adopt an interdisciplinary approach to delivering services with a core focus on reablement, supported discharge, rapid response and rehabilitation.

Development of Community Hubs

In 2016/17, CM Health intends to progress the establishment of six Community Health Hubs within Localities. The hubs will offer a core suite of services that are beyond the typical scope of general practice and require specialised facilities, equipment or volume to be viable in a community setting. Each hub will also offer some services that are specific to the needs of the local population. In addition, they will be the physical base for DHB community teams.

Integrated Palliative Care Services

The CM Health Palliative Care Clinical Working Group provides strategic leadership for development of integrated palliative care planning and service delivery for the district. The Group will oversee development of a three year implementation plan for palliative care services that are integrated, coordinated and responsive to patient and family choice for end of life care. Support will also be provided to hospices to implement new 'Innovations Fund' palliative care initiatives in primary, community and aged residential care settings.

Supporting people with long term conditions

The At Risk model of care is now well embedded within Counties Manukau. This model supports a primary care led, planned and proactive approach to long term condition care utilising a goal based care planning and care co-ordination approach. We are now growing this philosophy of care more broadly across frail elderly, mental health and child health and strengthening our approach to self-management to improve outcomes for a broader group of patients.

Mental Health & Addictions

As part of the broader integration agenda, there will be a focus on integration across the mental health and addictions system. Whilst maintaining our focus on the small percentage of the population with the most severe and enduring mental health needs, we want to extend the scope of the system to intervene earlier (in the life course and in the course of a condition) providing deliberate, systematic joined-up support across primary care, specialist mental health and addictions, and NGO providers.

Delivery will be within the locality context, linking specialist mental health, addictions and NGOs to locality hubs and primary care. With MH&A community teams working in an integrated way alongside other healthcare teams, we will ensure a life course approach that supports all age groups within their local communities, whilst still retaining a Counties-wide approach to a small range of very specialised MH&A services. Our focus for the whole of system transformation agenda for mental health and addictions is to improve health outcomes for people with mental health and addiction needs, and to improve their experience (and the experience of their family/whaanau) of the mental health and addictions system.

To achieve this, we need a comprehensive approach that supports both physical and mental health, as well as the broader determinants of wellbeing that impact on people's lives – key to this is mental health and addictions embedded firmly as part of the wider health system.

Integrated Child and Maternity Services
Over the past five years Counties Manukau Health has consistently achieved or exceeded child and maternity related targets and government priority programmes. These programmes include:-

- Increased immunisations
- Reducing the incident of rheumatic fever
- Reducing SUDI rates
- Smoke free pregnancies
- B4 School checks

Whilst these programmes have continually produced impressive results, they continue to be delivered in a silo'd manner. This results in additional complexity for families/whaanau with a range of providers attempting to track and deliver services to them. There is therefore an imperative for closer collaboration between programmes and the associated providers to allow for a more cohesive approach to support our children and whaanau.

We will therefore focus our efforts on integrating services to ensure a holistic approach irrespective of who is delivering the service. Specific actions will be undertaken to work alongside providers within maternity, Well Child Tamariki Ora and school based health services. These areas are aligned with the early identification of our most vulnerable children and whaanau.

Complex Households
A range of initiatives are being developed to enhance the existing At Risk approach to have a greater focus on engaging and supporting complex households. These include:

- CM Health locality clinical leads, pacific health and CM Health social workers from hospital and community teams meeting with PHO and NGO social workers in a series of workshops to agree a way of working together in locality integrated models of health and social care. The aim is to achieve better health outcomes for at risk individuals and complex families living in each geographical area.
- The PATHS (Providing Access to Health Solutions) programme is an intersectoral initiative between the Ministry of Social Development (MSD), Work and Income and CM Health. It uses an intensive individualised case management model aimed at reducing health barriers to employment. The case management approach involves the development of an individualised care plan developed in collaboration with the participant, health professionals engaged in their care and Work and Income.
- The Warm Up-Counties Manukau Programme insulates for free the homes of low income households/families with high health needs in Counties Manukau. The programme is delivered in partnership with the Energy Efficiency Conservation Authority (EECA), Autex Industries Limited, Installed and other third party funders.

Clinical pathways
Clinical pathways assist in achieving consistent quality and delivery of care, reducing risk and unexplained variation, improving outcomes for patients, developing a clearer understanding and response to the increasing diversity of our population and contribute to some of the issues related to health equity. The pathways will continue to be an integral component of other system wide programs of work, especially those seeking to establish a more integrated and collaborative approach to care.

There are two components to the program of work:

I. Auckland Regional HealthPathways –static (look up) pathways –based on the Canterbury HealthPathways model of care. CM Health is the host DHB and holds the contract on behalf of the three Auckland DHBs and the seven PHOs, funded 50:50 between the metro DHBs and seven PHOs

II. Nexxt™ dynamic enabler tool –patient specific real time IT enabled pathways that sit within the patient management system at the point of care. HealthAlliance holds the contract on behalf of the region and involves the four Northern DHBs and the associated nine PHOs. This is funded solely through the four Northern DHBs

Integrated Community Health Services
CM Health will increase the capability and capacity of Integrated Community Health Services so that they can:

I. Better support primary care Healthcare Homes to proactively manage the needs of at risk individuals and complex households living in the four Localities within Counties Manukau

II. Provide timely and intensive interventions which will then enable patients and whaanau to continue to self-manage their health and wider psycho-social needs

III. Reduce unnecessary demand on hospital services and aged residential care facilities

Actions	**Measures**
▪ Establishment of a central community service intake and coordination capability for the district	▪ All locality community teams centrally co-ordinated by Community Central
▪ Community service intake, screening and coordination	▪ Number of referrals received by Community Central

processes will be centralised and streamlined ▪ All locality based community teams will have access to mobile technology to improve efficiencies ▪ Implement a reablement response across the district ▪ Realign and extend the capacity and scope of DHB community teams to better enable patients and whaanau to regain function, self-management and independence ▪ Intensive short term reablement and rehabilitation services will be provided to restore function and independence, prior to assessment for any long term supports ▪ Routine wound care will be undertaken by primary care rather than district nursing ▪ Implementation of a community based early supported discharge response before Q1 ▪ Develop and implement Clinical Nurse Specialist (CNS) liaison roles (inreach) to coordinate discharge and community response before Q1 ▪ Review of locality medical support roles ▪ Develop and implement a Rapid Response/Admission Avoidance component of reablement. This will involve a co-design process with primary care, St Johns and community pharmacists by Q2 ▪ Development and implementation of a HCA workforce within locality community health teams	▪ Number of staff enabled to work in a mobile manner ▪ Number of reablement referrals received by locality ▪ Carry out consultation and subsequent implementation of the Community Integration proposal for change ▪ Increased direct patient contact time for Locality Community Team clinicians

Development of Community hubs

Community hubs to improve local access to services and reduce demand on congested hospital sites.

These hubs will operate as part of a broader service delivery network that connects general practice, community care, specialist services, Middlemore Hospital and the Manukau Super Clinic.

Actions	Measures
▪ Master-planning for existing DHB sites proposed for hub development, along with engagement with the private sector regarding potential sites and services ▪ Detailed service analysis and consultation with local providers and the local community ▪ Determine specific services for each hub	▪ Confirmed sites and services for each hub by Q4

Primary Care

A sustainable model of General Practice will be implemented progressively across Counties Manukau – starting with an early implementer group of 10 practices. Our technology platforms will be integrated – ensuring that key clinical and patient information is current, correct and can be shared between care providers. Patients will no longer need to repeat their information and history multiple times and they will have a smoother journey between primary, community and specialist settings – seeing it as one coherent care team supporting their journey.

We will create increased capacity within General Practice by supporting redesign of the model of care – enabling more flexibility to support complex patients including extended consultations and adapting the workforce skill mix. We will enable patients and their whaanau to have greater control over their care by utilising technology to engage with their General Practice team, self-manage their long term condition and access their information.

▪ 10 practices across Counties Manukau selected to take part in Enhanced Primary Care phase 1 ▪ Practices undertake process reviews to develop areas for redesign and develop an implementation plan for improvement which includes associated financial and business planning analysis ▪ Early implementer practices will participate in a quality improvement collaborative to share learnings and apply	▪ Number of practices confirmed and issued contracts to participate in the programme ▪ Number of practices with implementation plans approved by the practice leadership team and agreed with their PHO ▪ Number of practice staff attending collaborative learning sessions ▪ Number of primary care staff enrolled in Quality

quality improvement methodologies to their approach ▪ Up to 36 primary care staff undertake formal Quality Improvement training provided by Ko Awatea to develop their understanding of quality improvement methodologies ▪ Development of a data reservoir which will provide increased sources for connected data across the system ▪ Development of care analytics capability to provide insights to clinical information – enabling a proactive approach to care	Improvement training ▪ Data reservoir established, with multiple data sources feeding in ▪ Number of providers with available views of care analytics ▪ Measures in place ▪ CM Health Alliance Workplan agreed for the 2016-17 year

Counties Manukau Health Alliance

Collaborative planning to support CM Health's strategic direction and national primary care priorities.

We will work with our Alliance Leadership Team to refresh the CM Health Alliance work plan to support system integration and the achievement of the Healthy Together goals. A key focus for the Alliance during the 2016/17 year will be development and implementation of the National System Level Measure Improvement Plan (formerly Integrated Performance and Incentive Framework - IPIF). The plan will outline the key milestones required for the four system level measures (total acute hospital bed days, ASH rates for 0-4 year olds, patient experience of care and amenable mortality) along with the agreed contributory measures for each of the four system level measures.

There will be better integration of community pharmacy services within health system to support people to stay well throughout their lives.

A revised model for the delivery of After Hours services in the Auckland region will be implemented in partnership with the Auckland Regional After Hours Network and other stakeholders. The After Hours care model will include free access for children under the age of 13, aligned opening hours and a range of subsidies for other high needs groups.

▪ Develop an National SLM Improvement Plan with improvement milestones for the four system level measures, selected contributory measures and with final approval from all Alliance members ▪ Develop a local National SLM Improvement Plan which includes the specific activities to meet selected contributory measures and the improvement milestones for the system level measures, including a reporting and accountability framework and an investment logic ▪ Refresh the CM Health Alliance annual work plan to reflect the National SLM plans and other agreed priorities that support the Healthy Together strategy ▪ Work with Alliance partners to support implementation of the National SLM Improvement Plans	▪ National SLM Improvement Plan is approved by the alliance and submitted to MOH by end of Q1 ▪ Local National SLM Improvement Plan is developed and approved by the Alliance by the end of Q1 ▪ National SLM reports and milestones are monitored by the Alliance on a quarterly basis ▪ Locally-agreed initiatives in the Pharmacy Action Plan are developed and implemented once the Pharmacy Action Plan is agreed nationally ▪ A narrative description of initiatives to support patients with Long Term Conditions will be provided on a quarterly basis ▪ A narrative description of locality-based initiatives will be provided on a quarterly basis
▪ Work with the Auckland Regional After Hours Network and other relevant stakeholders to implement the regionally-agreed model for After Hours services in the Counties Manukau district ▪ Develop and implement locality-based initiatives that improve medicine adherence, medicine optimisation, health literacy and improved health outcomes ▪ Support implementation of the Pharmacy Action Plan including increased integration between community pharmacy and general practice ▪ Support work being undertaken nationally by the 20 DHBs to develop a National Framework for Pharmacist Services in the Community and the implementation of the services outlined in the framework to meet the needs of the CM Health population ▪ Commit to participating in the national process to plan the commissioning of pharmacist services in the community that cost effectively matches modern supply	▪ Revised After Hours Services model is successfully implemented within the Counties Manukau district ▪ There is continuity of service delivery with no negative impact on current levels of access to subsidised After Hours care during the transition to the revised After Hours services arrangements ▪ New project lead employed for gout management initiative by Q1 ▪ Further refinement of pharmacy standing order by Q1 ▪ Gout pilot expanded to at least two additional pharmacies and associated general practices by Q2 ▪ Report on outcomes of pilot and assess possible roll-out of service by Q4 ▪ Secure funding and develop MUR project plan with the software vendor by Q1 ▪ Pilot pharmacy chosen and first MUR recorded in electronic format by Q2

to the needs of our community
▪ Support the implementation of a sustainable solution to pharmaceutical margin and other supply chain issues
▪ Facilitate improved pharmacy management of patients with Long Term Conditions and enhance coordinated care through the use pharmacy involvement in multi-disciplinary meetings and the use of the Shared Care platform
▪ Develop a collaborative approach to gout management "Owning My Gout" (OMG) involving the patient, community pharmacist, general practice and nursing staff that will improve the quality of life of gout sufferers through:
  ▪ Optimising prescribed gout treatments
  ▪ Providing a support package enabling patients to self-manage
▪ Transfer the Medicine Use Review (MUR) service from current paper based system to an online system using a localised version of the Canterbury Medicines Management Service in SharedCare environment to:
  ▪ Allow the primary care team real-time access to information gathered on medication regimen adherence as the pharmacist records them
  ▪ Provide automated invoicing and reporting of the service
	▪ Localisation of MUR module complete and tested by Q3
	▪ Roll out to all MUR contracted pharmacies

Integrated Palliative Care Services There will be significant growth in older age groups in the CM Health population over the next 15 years. This will create significant pressure on palliative care services. The greatest growth is likely to occur in non-cancer patients driven not only by the ageing population but by the growth in aged-related conditions and complex co-morbidities. The CM Health Palliative Care Clinical Working Group provides strategic leadership for development of integrated palliative care planning and service delivery for the district. The group will oversee development of a three year implementation plan for palliative care services that are integrated, coordinated and responsive to patient and family choice for end of life care.	
▪ Complete a current state analysis of palliative care services in CM Health ▪ Carry out stakeholder engagement to develop a three year implementation plan for integrated palliative care services in CM Health ▪ The CM Health Palliative Care Clinical Working Group will work with hospices to provide support for implementation of new initiatives in primary, community and aged residential care settings that are approved through the Palliative Care Innovations Fund Business Case process	▪ Review completed by the end of Q2 ▪ CM Health Integrated Palliative Care Implementation Plan approved by the end of Q4 ▪ A narrative description of progress on implementation of Innovations Fund initiatives will be provided on a quarterly basis
Supporting people with long term conditions Enhancing the At Risk philosophy of care to support patients with long term conditions to self-manage	
▪ Review the self-management support and self-management education offering across the district to improve engagement and completion ▪ Continue to develop the At Risk quality improvement initiative, with all At Risk practices developing care planning quality improvement plans ▪ Implementation of a new targeted model of care, to focus on patients with poor glycaemic control, and introducing virtual reviews between primary and secondary care to improve package of care related to	▪ 5 percent of CM Health population enrolled in At Risk programme ▪ Number of patients dis-enrolled from At Risk programme as they have progressed to self-management ▪ Number of frail elderly patients enrolled in At Risk programme ▪ The percentage of older population enrolled in At Risk programme ▪ Number of practices with a care planning quality

management diabetes associated conditions including CVD risk, etc. ▪ Implementation of a diabetes collaborative with a selected group of practices (practices with large numbers of patients with poorly controlled diabetes will be targeted) to test new targeted models of care ▪ Carry out a review of end-to-end systems, processes and contractual arrangements for self-management within Counties Manukau and reconfigure services to better meet the needs of our population and integrate with the At Risk approach ▪ Carry out the Manaaki Hauora – Supporting Wellness campaign aiming to provide self-management support for 50,000 people living with long term conditions across Counties Manukau by Q2	improvement plan ▪ Number of practices with completed care planning quality improvement plans ▪ Reduction in proportion of patients with HbA1c above 64, 80 and 100 mmol/mol ▪ 69 percent of patients will have an HbA1c <64mmol/mol ▪ Monthly reporting on the number of podiatry, dietetic and health psychology visits ▪ Monthly reporting on the number of patients who have been started on insulin ▪ Self-management current state assessment complete ▪ Implementation plan for reconfiguration of self-management services developed ▪ Number of patients receiving self-management support

Clinical Pathways
Seeking to establish a more integrated and collaborative approach to care

▪ Continue to localise Tier 1 static pathways ▪ Agree priority T2 & 3 pathways for localisation ▪ Maintain 92 pilot practice sites for the Nexxt™ tool ▪ Prioritise and scope up to four integration interfaces for the Nexxt™ enabler ▪ Develop a high level benefits realisation plan	▪ Number of (static-look up) Auckland Regional HealthPathways localised ▪ Number of registered users to (static-look up) Auckland Regional HealthPathways ▪ Number of GPs trained and utilising Nexxt™ (dynamic enabler) clinical pathways ▪ Number of patients on a Nexxt™ clinical pathway

Ethnicity Data – Health Gain Area

Accurate ethnicity data is a "necessary and critical step" in tackling health inequalities. Issues with misclassification of ethnicity data arise in all health data sources, including in primary care, resulting in an undercount of Maaori, Pacific and Asian ethnicities. Self-reported ethnicity data is important, not only for the accurate monitoring and reporting of programme performances, but also for appropriate targeting of individual patients and resources for certain programmes.

Accurate ethnicity data is important for informing the public and the health sector, identifying health need, service planning and funding, and monitoring activities. However there is currently inconsistency in the quality of health sector ethnicity data collection.

▪ Complete analysis of ethnicity data for 9000 patients collected in Stage 3 of EDAT implementation; identify ethnicity misclassification issues and work with each PHO to develop a quality improvement plan to address issues ▪ Complete analysis of the enrolment forms used by general practices in each of the CM Health PHOs to ensure they align with the Ethnicity Data Protocols and the NES Business Rules ▪ CM Health will work with PHOs to produce a small ethnicity data quality guide for PHOs; this will include learning and practical tips garnered from the 2015-16 EDAT implementation ▪ PHOs to ensure that 100 percent of CM Health practices are using enrolment forms that are aligned with the Ethnicity Data Collection Protocols ▪ PHOs to set up systems for all new practice staff (and new practices coming into their PHO) to be provided with training on the Ethnicity Data Protocols, the importance / relevance of ethnicity data, accuracy in recording ethnicity and tips on how to ask patients about their ethnicity ▪ PHOs to conduct an annual query on each of their practices' PMS to find the number of 54 and 61 'Other'	▪ Each PHO has an ethnicity data quality improvement plan completed by the end of Q2 ▪ Analysis of PHO enrolment forms in CM Health PHOs and practices is completed by the end of Q1 ▪ An ethnicity data quality guide for CM Health PHOs is completed by the end of Q1 ▪ 100 percent of CM Health general practices are using enrolment forms that are aligned with the Ethnicity Data Collection Protocols by the end of Q4 ▪ All CM Health PHOs have systems in place to provide training to new practices / new practice staff on the Ethnicity Data Protocols, the importance of ethnicity data, accuracy in recording ethnicity and tips on how to ask patients about their ethnicity by the end of Q4 ▪ Training on Ethnicity Data Protocols is provided by PHO for new practices and practice staff from Q2-Q4

codes (often used when the patient's ethnicity is unknown). PHOs will work with each practice to follow up with patients to ask about and update their records with accurate ethnicity details	
PHO Enrolment- Health Gain Area Primary care is the point of continuity in health – providing services from disease prevention and management through to palliative care. Increasing PHO enrolment will improve access to primary care services that enable early intervention and reduce health disparities.	
Improving Maaori enrolment in PHOs ▪ PHOs to ensure that all practices are aware of the Maaori enrolment target Q1 ▪ DHB and PHOs review, compare and monitor Maaori enrolment data on a quarterly basis ▪ Work with PHOs to develop key messages and promotional material targeted at improving Maaori enrolment in a PHO. Support PHOs to deliver the awareness messages and promotional activities Q3-4 ▪ Work with Maaori community health services providers to raise awareness of the importance and benefits of enrolment with a PHO	▪ Discussions held with PHOs on Maaori enrolment rates on a quarterly basis ▪ PHOs and Maaori community providers are engaged in delivery of key messages and awareness raising activities that focus on improving Maaori enrolment in PHOs
Increasing Maaori and Pacific newborn enrolment rates ▪ Work with PHOs to review each PHO's newborn enrolments plan, activities and performance on a quarterly basis ▪ Support PHOs to identify and address issues where performance is not improving sufficiently to meet the target of 98 percent of newborns enrolled by 3 months. ▪ Co-design and develop an improved newborn enrolment processes and protocols, engaging health sector stakeholders including LMCs, antenatal, maternity, GPs, PHOs, and WCTO providers	▪ PHO newborn enrolment plans and performance reviewed on a quarterly basis ▪ Quality improvement initiatives developed and implemented on a quarterly basis where relevant
Complex Households Developing an intersectoral approach to supporting complex households to build resilience and wellness	
▪ Implement the PATHS Programme in partnership with the Ministry of Social Development/Work and Income to improve employment opportunities for people in receipt of a benefit with a medical certificate ▪ To co-ordinate the generation of referrals for the Warm-Up Counties Manukau Programme ▪ Lead an engagement process with key health and social service stakeholders to agree an integrated approach to service delivery across the system, with social workers working in hospital and community settings for district health boards, primary health organisations and non-government organisations	▪ Enrol a maximum of 200 voluntary participants onto the PATHS programme ▪ Number of Warm-Up referrals received from eligible households ▪ A locality integrated model of health and social care is agreed by key stakeholders ▪ Integrated health & social care referral criteria and an intervention model is agreed by key stakeholders ▪ An integrated health & social care centralised triage, screening and allocation model is agreed ▪ Key performance indicators are agreed
Integrated Mental Health & Addictions Improve integration between primary and specialist services by commencing the implementation of the Whole of System Integration Plan for mental health and addiction (MH&A) services	
▪ Determining the range and alignment of NGO services required to provide a comprehensive and appropriate suite of MH&A services for each locality, that is reflective of population need ▪ Piloting the MH&A components of the At Risk Individual (ARI) programme in three general practices ▪ Develop a proposal to reconfigure specialist addiction	▪ Locality requirements identified and implementation plan agreed for the alignment/development of integrated MH&A NGO services ▪ Arrangements established and in place for named specialist mental health clinicians working alongside and within each of the three pilot practices Q1 ▪ Establish baseline data for the pilot sites, on:

services to better meet the needs of people in Counties Manukau, including better integration of community addiction services with locality primary and community health services. ▪ Develop and strengthen networks between primary care, specialist MH&A services and NGO providers who work together; wrapping accessible and appropriate services around patients to improve their physical and mental health outcomes ▪ Increase education opportunities and on-going support to develop the primary care workforce's confidence in relation to mental health, enabling greater support for people with mild to moderate mental health needs and improved capability to better manage the physical health of people with severe and enduring mental health needs	▪ CVD risk and smoking status for patients enrolled at each GP practice and open to secondary care ▪ Number of new referrals per month from each practice ▪ Review and evaluate outcomes from At Risk pilots including number of encounters with primary care/secondary care, CVD risk, smoking status, patient experience and level of mental health confidence/capability within each pilot practice by Q4 ▪ Negotiations commenced for the reconfiguration of specialist addiction services by Q2 ▪ Pilot and evaluate an integrated team approach within a single locality hub/cluster of GP practices by Q4 ▪ 50 percent of primary care practices engaged in mental health education by Q4
Integrated Child, Youth & Maternity Services Improved integration between child, youth and maternity services with a focus on our most vulnerable children and their whaanau.	
Maternity ▪ Primary Care LMC Liaisons appointed to work alongside GPs, LMCs and Well Child Providers on systems and processes that will improve the timely delivery of services to pregnant women, babies and whaanau: ▪ Early registration of pregnant women with LMC ▪ Timely handover from LMC to Well Child providers ▪ Referrals as appropriate to At Risk programme ▪ Improved information sharing between LMC, GP and Well Child providers	▪ 2 x 0.5 FTE appointed by Q1 ▪ 100 percent women who confirm their pregnancy with a GP register with an LMC within 5 days ▪ 100 percent handover of new-borns to Well Child Providers (WCP) by 6 weeks by Q2
Child ▪ Implementation of agreed model of school based health services to primary and intermediate schools in Counties Manukau ▪ Rheumatic Fever – refer to section 2.1.2 ▪ Children's Action Plan – refer to section 2.1.3 ▪ Raising Healthy Kids – refer to section 2.2.2	▪ Model to be implemented Q1-Q4
Youth School Based Health Services (SBHS) ▪ Ensure on-going quality service provision of existing SBHS in all funded schools, including a review of the provision of SBHS in local kuras ▪ Trial a comprehensive and integrated SBHS in one low decile high school ▪ Improve the responsiveness of primary care to youth ▪ Work closely with general practice teams with linkages with schools to ensure they are 'youth friendly' by introducing an appropriate audit tool and appointing a Primary Care Youth Health Quality Advisor to assist practices with implementing the agreed actions following the assessment	▪ Ensure that 95 percent of students eligible for a routine health assessment (which includes a HEEADSSS assessment) receive an assessment by Q2 ▪ Pilot and evaluate a comprehensive and integrated school based youth health service in one high school by Q4 ▪ Primary Care Youth Health Quality Advisor to complete quality improvement process with 25 practices by Q4

2.3.2 Stroke

More than 600 people in the Counties Manukau district suffer from a stroke event per annum. The long term impact of stroke on patients and their families can be significant due to loss of mobility and function across many facets of daily life.

Stroke services are provided across acute and rehabilitation environments, including community settings, early thrombolysis intervention and acute management in a stroke unit optimise the acute period and impact following stroke onset. Timely rehabilitation ensures the best possible recovery following a stroke.

Linkages

Northern Regional Health Plan

Actions

CM Health will continue to provide an organised stroke service as recommended in the NZ Clinical Guidelines for Stroke Management 2010 (the Stroke Guidelines). This will include:

- People with stroke admitted to hospital and treated in the stroke unit under the care of the interdisciplinary stroke team
- All eligible patients continue to have access to thrombolysis (as per the 24/7 stroke thrombolysis indicator)
- On-going education/training support for EC, general medicine SMO and Registrar workforce:
    - Education video and other standardised resources ongoing development
    - Direct clinical support, including access to afterhours clinical support for decision-making
- On-going quarterly audit of ischaemic stroke patients and feedback on thrombolysis actual and potential procedures, with action plans developed where gaps in service provision are identified
- Continued maintenance of a thrombolysis register
- Improved access to CT following implementation of an emergency department-based scanner in Q2 2015/16
- Continue with and maintain stroke thrombolysis quality assurance procedures, including processes for staff training and audit:
    - Care pathways reviewed and updated as needed for thrombolysis
    - Provide care management plans/services for people who have had a stroke, thrombolysis, transient ischaemic attack
- Rehabilitation services supported by on-going education and training for interdisciplinary teams
- All stroke patients receive early active rehabilitation by a multidisciplinary stroke team
- All people with stroke have equitable access to community stroke services, regardless of age or where they live. Community-based and outpatient options will continue to be provided to enhance access to care. Community-based services will have ongoing access to interpreter and cultural support as required to maximise care benefits
- All members of the multidisciplinary stroke team participate in ongoing education and training according

Measures

- ≥6 percent of potentially eligible stroke patients thrombolysed 24/7
- 80 percent of stroke patients admitted to a stroke unit or organised stroke service
- 80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission (also report percent of acute stroke patients transferred to inpatient rehabilitation)

to the Stroke Guidelines

- Continue to provide lead clinicians designated to stroke (Medical and Nursing)

Service Development

- Develop a stroke management strategy in consultation with cultural and community representatives to ensure fair access, especially to at-risk populations (including Maaori and Pacific) by Q2
- Implement improvement initiatives following the development of a stronger, more integrated care pathway between acute and rehab settings. This is aimed at improving timely and seamless transfers of care between various settings as measured by the 80 percent of patients admitted with acute stroke who are transferred to in-patient rehabilitation service, and the proportion of these transferred within 7 days of acute stroke admission by Q4

Regional Alignment

- Support and participate in national and regional clinical stroke networks to implement actions to improve stroke services

Regional Alignment

- Attendance and contribution to regional stroke meetings and service plan development in conjunction with the Northern Regional DHBs and the Northern Regional Alliance

2.3.3 Cancer Services

Cancer is a leading cause of death, accounting for 30 percent of all deaths. The impact on people diagnosed with cancer and their whaanau can be devastating for months and sometimes years. A whole of system approach via tumour streams is improving access to services and waiting times for patients, with strong multidisciplinary expertise and standard care pathways. Notwithstanding the success of our approaches to date, cancer remains a significant concern for our population and health services.

The Faster Tests and Cancer Treatment Health Target provides measures of system performance to ensure the time from referral to treatment start is optimised at 62 days or less and the time from decision-to-treat to treatment is within 31 days. This health target is being used to drive system improvements across the cancer care pathway, ensuring timely treatment for patients with urgent cancer needs.

Auckland District Health Board (ADHB) provides non-surgical cancer services and some surgical cancer treatment services for Counties Manukau DHB domiciled patients. All chemotherapy for oncology is provided through ADHB, aside from haematology, which is provided locally. CM Health clinicians from several disciplines participate or lead the development of national and regional cancer pathways.

Linkages

2016/17 Northern Regional Health Plan

Actions

- Maintain timeliness of access to radiotherapy and chemotherapy by:
    - Monitoring the Auckland DHB regional Cancer and Blood Service regularly through weekly and monthly reports
    - Continuing participation in the Northern Regional Oncology Operations Group to identify and manage issues
- Improve timeliness and quality of the cancer patient pathway from the time patients are referred through treatment to follow-up / palliative care (as measured by the Faster Cancer Treatment health target) by:
    - Continuing to develop improved faster cancer treatment reporting and quality reliability to inform service improvements

Measures

- All patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy
- 90 percent of patients 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
- 31 day indicator – at least 85 percent of patients with a confirmed diagnosis of cancer receive their first cancer treatment (or other management) within 31 days of decision to treat
- Monitor cancer multidisciplinary meetings improvements to the coverage and functionality of multidisciplinary meetings
- Monitor through service improvement fund contract reporting

        - Improve data collection and quality aligned to specific tumour stream dataset definitions
- Achieve the Faster Cancer Treatment Health Target through:
    - Utilising faster cancer treatment data through monthly reports to services to identify and improve patient flow and timely assessment and treatment
    - Utilise pathway improvement processes to actively manage patients care from referral to first treatment, ensuring sustainable, business as usual solutions are in place. Focus areas will include: Diagnostic turnaround times, referral and grading pathways, MDM participation and quality and inter-departmental/organisation transfers of care
    - Implement service improvement initiatives as part of round two of the service improvement fund
- Continue to improve the functionality and coverage of multidisciplinary meetings (MDMs) across the region by implementing the regionally agreed MDM priorities
    - Supporting cancer nurse coordinators and tumour streams in process improvement initiatives
- Support on-going activities associated with round two of the bowel screening pilot
- Improve productivity in preparation for the roll out of the National Bowel Screening Programme
- Implement the prostate cancer management and referral guidance through a coordinated regional approach during 2016/17
- Work with Local Decision Support Services and the Northern Regional Cancer Network to identify and consolidate cancer health information, aligned with the Cancer Health Information Strategy
- Continue implementation of supportive care services for cancer patients under the Cancer Psychological and Supportive Care initiative
- Apply the 'Equity of Health Care for Maaori: A framework' to cancer pathways in alignment with the Maaori Health Plan
- Review reasons for equity issues with the CM Health population and develop improvement strategies to address them, aligned with the Maaori Health Plan and Faster Cancer Treatment
- Review current service delivery against the provisional tumour standards and identify and implement service improvement plans, including through streamlining diagnostic and treatment processes. This is aligned to regional activity and Faster Cancer Treatment pathway improvement initiatives
- Subject to a regional process outlined below and any service change requirements, CM Health will commence local provision of medical oncology that will:
    - Provide care closer to home
    - Reduce health inequities for our population
- Appropriate clinicians such as urologists and radiation oncologists receive and are supported to implement the guidance on the use of active surveillance treatment for prostate cancer
    - Care pathways and MDM proformas are updated to include the guidance on the use of active surveillance treatment for prostate cancer
- Productivity improvement and achievement of MOH targets for all upper and lower GI cancers
- Reduction in waiting lists
- Refer to Improve waiting times and quality of endoscopy and colonoscopy services – refer to Access to Diagnostics Section 2.3.6

▪ Reduce the burden of travel for most of the population ▪ Support ongoing development and continued best practice in the provision of cancer services for patients and their families across the Northern Region	
Regional Alignment ▪ Support and participate in regional and national cancer networks to implement actions to improve cancer services, aligned with the Northern Regional Cancer Strategic Plan. This will be enabled through: ▪ Active participation in regional groups (Cancer Governance Board, Regional Oncology Operations Group, regional tumour stream groups) ▪ Progress the regional planning elements required to move toward a Local Delivery of Oncology model which is aligned to the National Medical Oncology Models of Care projects that will include increased standardisation of processes, procedures and workforce across the region ▪ Support regionally consistent training of nurses for local chemotherapy delivery	
Cervical Screening ▪ Carry out analysis to better understand the barriers to cervical screening for Maaori women in the CM Health district to inform service planning ▪ CM Health and the PHOs in the district will work together to update the district-wide and PHO level cervical screening action plans that will focus on improving screening coverage for Maaori and other Priority Group Women, particularly those who are unscreened and under-screened ▪ CM Health PHOs will ensure there is a named coordinator in the PHO and cervical screening champions in practices who are responsible for actions to improve cervical screening coverage ▪ CM Health will improve access to cervical screening for Maaori women by contracting with PHOs to provide free smears for Priority Group Women ▪ Each PHO will access the monthly cervical screening data match reports and will use the reports to carry out data matches, to identify women who are overdue for their three yearly cervical smears and to target recall, invite, engagement and smear-taking activity at this group ▪ CM Health will work with PHOs to provide training for practice staff on how to have the conversations about cervical screening ▪ CM Health will work with PHOs, practices and Independent Service Providers (ISP) to implement the cervical screening referral pathway for Priority Group Women ▪ CM Health will employ a High Needs Cervical Screening Coordinator to work with general practice teams that have low screening coverage rates for Maaori and Asian women and to assist with smear-taking, recall and invite and quality improvement systems ▪ The CM Health High Needs Cervical Screening Coordinator will work closely with Maaori health care	▪ 80 percent of eligible women aged 25-69 years who have had a cervical smear in the past 36 months ▪ Analysis on barriers to cervical screening is completed by Q1 ▪ Cervical screening action plans are completed by Q1 ▪ Cervical Screening Action Plans prioritise actions and outcomes for Maaori and Asian and other priority group women ▪ Cervical screening coordinator and cervical screening champion roles in place by Q4 ▪ Contracts with each PHO for free smears for Priority Group Women are in place by Q1 ▪ Number of training sessions provided for CM Health practices on how to have the conversations about cervical screening by Q4 ▪ Quarterly description of activity related to the ISP (independent service provider) cervical screening referral pathway for Priority Group Women ▪ Quarterly description of support provided within practices ▪ Three yearly cervical screening coverage rates for Maaori ▪ Quarterly description of smear taking activity / clinics provided in community settings ▪ Quarterly description of activity to raise cervical screening awareness, particularly amongst Maaori women

providers and PHOs to deliver smear-taking clinics in settings that are appropriate and acceptable for Maaori and Asian women ▪ The CM Health High Needs Cervical Screening Coordinator will work within community settings and with local media to raise cervical screening awareness and to ensure messages are targeted at Maaori and Asian women **Colposcopy** ▪ Ensure early engagement with Maaori and other vulnerable women who require colposcopy services by using a dedicated community health worker to facilitate access to care ▪ Develop and implement colposcopy education sessions with primary care GPs and nurses to raise awareness of the service and with a focus on Maaori and other vulnerable women Q3-4	▪ 10 percent reduction in Maaori DNA rate for colposcopy services by Q3 ▪ Patient satisfaction with the colposcopy service is greater than 80 percent of very good and excellent by Q4
Breast screening Identification of women who have not been screened or are under screened by: ▪ Data matching with primary care practices – data matching allows for identification of women who are not enrolled in the BreastScreen Aotearoa (BSA) programme and also provides updated contact details for women who are enrolled but may have moved or changed their telephone numbers ▪ Data matching with CM Health patient management system provides the same outcomes as primary care data matching but may also identify women who are not attending primary care services (e.g. using the hospital emergency department) ▪ Promotion of BreastScreen to Maaori Women ▪ In conjunction with the other Auckland BSA providers, promote the BSA programme at the Maaori Women's Welfare League National (MWWL) Conference in Auckland ▪ Promote the programme through Poukai, Marae, Hapu and Iwi events and other events where high numbers of priority women may attend ▪ Work with Whare Oranga and other Maaori health and social providers to promote the programme to Maaori women. ▪ Supporting women to screening and assessment services and results clinics ▪ Follow up of Maaori women who do not respond to invitation to screening through the generation of DNA/DNR lists ▪ Provide transport to screening, assessment and result appointments ▪ Follow up of Maaori women who are reluctant to attend assessment or results clinics including the provision of support and transport as required ▪ Participation in regional planning processes ▪ BSCM co-ordinates the development, monitoring and reporting of the regional co-ordination plan ▪ A minimum of 2 regional co-ordination meetings held each year	▪ 70 percent of eligible women aged 50-69 years who have had a BSA mammogram in the past 24 months ▪ 100 percent of primary care practices are visited and offered data matching during the year ▪ Data match with PIMs once a year ▪ Promotion held at MWWL conference ▪ Promotional activities carried out in the community ▪ 100 percent of Maaori women on DNR lists are followed up ▪ 100 percent of women referred by breast care nurses who are reluctant to attend clinics are followed up

2.3.4 Shorter Stays in Emergency Department

In July 2009 New Zealand adopted the 'Shorter Stays In Emergency Departments' health target as one of the health priorities. The target is defined as '95 percent of patients presenting to Emergency Departments (ED) will be admitted, discharged or transferred within 6 hours of presentation'. It was considered that a high level measure was required to influence change and that an ED length of stay (LOS) measure best reflected the performance of the acute system both within and beyond ED. It is accepted that the ED health target on its own is not a guarantee of quality and that outcomes might still be poor despite a short length of stay and for this reason a suite of measures was developed nationally which are more directly associated with quality patient care.

Linkages

Cardiac Services

Actions

- Continue implementation of the national Quality Framework and suite of quality measures, prioritising service improvement activity in response to these measurements
- Processes and systems to allow monitoring of all the mandatory and non-mandatory measures of the ED Quality Framework are in place by Q4
- Continue monitoring of clinical quality measures including Airway (first pass rate); Time to Analgesia; Time to antibiotics in Sepsis and Time to PC

Cardiac Services in ED

- Review and audit Accelerated Chest Pain Pathways (ACPPs) in Emergency Departments

Measures

- 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours of presentation
- Reporting of the ED health target will be stratified to show Maaori and Pacific ethnicity with appropriate processes established to ensure good data quality
- Monthly progress monitoring against the ED mandatory quality measures
- 80 percent of TC2 patients to be seen within 10 minutes
- Less than 2 percent and less than 20 minutes length of stay of patients in corridors
- Less than 4 percent of patients will re-attend within 48 hours
- Self-discharge rate will be less than 5 percent
- Short stay admission rate will be less than 15 percent
- 80 percent of patients requiring PCI have door to needle time of less than 90 minutes
- 80 percent of patients will have analgesia within 30 minutes of arrival
- 80 percent of septic patients to have antibiotics within one hour of arrival
- Monthly monitoring of compliance with ACPPs

2.3.5 Access to Elective Surgery

The target is for CM Health to contribute to the national goal to increase the volume of elective surgery by at least 4000 discharges this year. Elective surgery is an important part of our healthcare system. It is important that patients who need surgery are able to access this in a timely way so that disruption to a patient's life is minimised. Meeting our elective surgery targets requires that we continue to improve how patients flow through our services from First Specialist Assessments (FSA), access to diagnostics, certainty of treatment through to discharge and, where required, follow up. CM Health will commit to seeing and treating patients in the most clinically appropriate timeframe that will involve using recognised prioritisation tools, and begin in accordance with assigned priority and waiting times. We will work with primary care to implement pathways where it is feasible for primary care to support FSAs through GPs with Specialist Interest (GPwSI) training and Follow-Ups to facilitate early discharge. CM Health will continue to manage wait times for assessment and elective surgery to meet the government's target of zero patients waiting more than four months.

Linkages

Northern Region Health Plan; National Elective Productivity Plans; CM Health 2016/17 Maaori and Pacific Health Plans

Actions

- Utilise Elective Initiative targeted funding to increase and improve equity of access for elective surgical procedures
- Utilise Budget 2015 investment to provide additional orthopaedic and general surgery elective procedure

Measures

- Elective Surgical Discharge rate is at least 308 per 10000 population at June 2017
- Delivery against Elective Surgery Health Target volumes of 20,395 discharges

discharges ▪ Review CM Health performance against SIR rates and referral volumes when considering service allocation of Elective Initiative funding ▪ Enhance patient flow management systems to maintain reductions in and compliance with waiting times for FSA and electives outputs ▪ Review and enhance referral management processes including the wider introduction of e-referral and e-triage systems ▪ Support a wider range of service provision in localities and community with greater linkages to primary care ▪ Improve capacity of outpatient clinics to increase available appointments, to include identification of use of providers in locality based settings to assist in volume management ▪ Enhance the management of follow-up volumes – review volumes, and care pathways for secondary follow-up ▪ Increase nurse led clinics for follow up and procedural based clinics ▪ Ensure effective screening and preparation processes of patients prior to treatment ▪ Review and optimise scheduling of cases to theatre to maximise theatre utilisation and productivity ▪ Introduce further information technology to monitor and improve theatre scheduling processes ▪ Benchmark CM Health's performance against national performance ▪ Improve consistency of prioritisation of patients through participation in national working parties and introduction of new prioritisation tools as available ▪ Participate in activity relating to development and implementation of the National Patient Flow system	▪ Delivery against planned 290 additional Orthopaedic and General Surgery volumes ▪ Major Joint discharge SIR is at least 21 per 10,000 population by Q4 ▪ Cataract discharge SIR is at least 27 per 10,000 population by Q4 ▪ Cardiac Surgery discharge SIR is at least 6.5 per 10,000 population (this target meets current demand) by Q4 ▪ Elective Services Patient Flow Indicator expectations met ▪ ESPI 2 - patients for First Specialist Assessment: Zero patients waiting 120 days + ▪ ESPI 5 - patients with commitment to treatment: Zero patients waiting 120 days + ▪ Number Non-Contact First Specialist Assessments by Q4 ▪ Improved FSA to Follow-up ratio by Q4 ▪ Elective Theatre Utilisation > 85 percent by Q4 ▪ Elective Inpatient Length of Stay Ownership Dimension (OS3) performance 1.59 days ▪ New National prioritisation tools are implemented within implementation timeframes ▪ ESPI 8 - The proportion of patients who are prioritised using approved nationally recognised processes or tools is 100 percent ▪ Patient level data is reported into the NPF Collection in line with the specified requirements and accepted remediations in cognisance to the limitations of the Patient Administration System
Regional Electives ▪ Contribute to the planned national increase in volume of 4000 elective surgical discharges to be provided year on year	▪ Delivery against agreed volume schedule, including a minimum of 20,395 elective surgical discharges in 2016/17 towards the Electives Health Target by Q4 ▪ Increase in Urology Service elective surgical discharges provided locally by Q4

2.3.6 Access to Diagnostics

Actions	**Measures**
▪ Introduce Radiology e-referrals into secondary care environment by Q2 ▪ Develop additional MRI capacity through extended hours and additional facilities ▪ Continue to use production planning principles to reduce waiting times across all modalities ▪ Continue to develop the CT colonography service to ensure timely access ▪ Participate in activity relating to implementation of the	▪ 95 percent of accepted referrals for CT scans will receive their scan within six weeks (42 days) ▪ 85 percent of accepted referrals for MRI scans will receive their scan within six weeks (42 days) ▪ Agreed NPF system changes are implemented

National Patient Flow (NPF) system, including adapting data collection and submission to allow reporting to the NPF as required ▪ Implement regional agreed FCT imaging pathways	

Colonoscopy/Endoscopy
▪ Utilise the Global Rating Scale as part of the National Endoscopy Quality Improvement programme (NEQIP)
▪ Identify and implement improvements to colonoscopy services through:
  ▪ The National Referral Criteria for Direct Access Outpatient Colonoscopy
  ▪ Standardised and streamlined triage and management for all referrals
▪ Increasing CTC rates in appropriate patients
▪ Continued participation in regional collaboration
▪ Implementation of the Nurse Endoscopist Programme
▪ Continue to support ongoing activities of the Waitemata Bowel Screening Pilot
▪ Preparation for National Bowel Screening
	Colonoscopy/Endoscopy
	▪ 85 percent of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100 percent within 30 days
	▪ 70 percent of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100 percent within 90 days
	▪ Surveillance colonoscopy – 70 percent of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100 percent within 120 days
	▪ GRS Self Surveys and Action Plans reported quarterly
	▪ Nurse Endoscopist commences training by July 2016

2.3.7 Health of Older People

The Health of Older People Service's continued focus is to ensure older people have access to the right services across the continuum at the right time and as close to home as possible whilst at the same time decreasing avoidable acute hospital admissions and increasing access to services to support their wellness and rehabilitation needs.

In alignment with best practice literature on improving services for older people, service planning and delivery requires consideration of all components of care, since many older people use multiple services, and the quality, capacity and responsiveness of any one component will affect others. The key components we will ensure we consider in the delivery of services include:

- Health, active ageing and supporting independence
- Living well with simple or stable long term conditions
- Living well with complex co-morbidities, dementia and frailty
- Rapid support close to home in times of crisis
- Good acute hospital care when needed
- Good hospital discharge planning and post-discharge support
- Good rehabilitation and reablement after acute illness or injury
- High-quality nursing and residential care for those who need it
- Choice, control and support towards the end of life
- Integration to provide person-centred co-ordinated care

Integration Strategy

CM Health Alliance and ACC are working together to plan and implement an evidence-based falls prevention programme. The goal of the proposed programme is the prevention of falls and fall related injuries among community dwelling older people aged 75 years and older. Interventions will be delivered primarily through evidence based strength and balance retraining exercise programmes. These are likely to include a combination of home-based Otago Exercise Programme and community-based group strength and balance training programmes. The programme will be well integrated with other key CM Health initiatives such as the At Risk Programme and Reablement.

Linkages

Acute Medical and Surgical Services; CM Health Primary Care; Aged Related Residential Care (ARRC); Home and Community Services (HCSS); Emergency Department; NGO/Community Services and other Community and Speciality Services such as District Nurses, NASC and Palliative Services

Actions	**Measures**
System Integration for Older People ▪ Continue enhancing the At Risk philosophy of care to support patients with Long Term Conditions to self-	▪ Refer to Supporting people with Long Term Conditions,

manage. The focus this year will be growing the philosophy more broadly across for our frail elderly, strengthening the approach to self-management to improve outcomes ▪ Increase the capability and capacity of integrated community health services to reduce unnecessary demand by older people on hospital services and aged residential care facilities. This will be done through establishment of centralised community service intake and coordination of all community referrals, access to reablement, supported discharge, long-term home and community support services and rapid response as required	Integrated Care Section 2.3.1

Integrated Falls and Fracture
▪ Work with ACC, HQSC and the Ministry of Health to develop and measure the progress of an integrated falls and fracture prevention services. This includes, but is not limited to, identifying:
  ▪ Older people at risk of falls
  ▪ The number of older people referred from primary and secondary care into the fracture liaison services
  ▪ The number of older people referred to, and seen by, a strength and balance retaining service
  ▪ The number of older people referred to osteoporosis management programmes
	▪ Provide narrative on how older people are being assessed on their risk of falls in hospital services
	▪ Report the number of older people identified in secondary care for the fracture liaison service as a proportion of the expected number of fragility fractures passing through secondary care (specifying the proportion referred from each)
	▪ 90 percent of identified fragility fracture patients presenting in secondary care will be investigated and offered interventions to prevent second fragility fracture
	▪ 50 percent of older people referred through the Fracture Liaison Service to a strength and balance programme will participate in the programme
	▪ Report the number of older people within the Fracture Liaison Service that were prescribed medication for osteoporosis management

Falls Integration Programme ▪ Work in conjunction with ACC, HQSC, primary care providers and the Ministry of Health to develop and implement the Falls Prevention Initiative in CM Health localities ▪ Establish a Falls Prevention Steering Group with membership from consumers, general practice, PHOs, secondary care and ACC to provide ongoing oversight of programme development and implementation ▪ Provide quarterly updates on progress including reporting on key measures once these have been finalised through the business case process	▪ Provide quarterly updates on progress including reporting on key measures once these have been finalised through the business case process
interRAI: Comprehensive Clinical Assessment in home and community support settings ▪ Monitor and report the number and percentage of older people who have received long-term home and community support services and who have had an interRAI home care or contact assessment and completed care plan in the last three months ▪ Older people referred for an interRAI assessment to access publicly funded care services will undergo the assessment and have a service allocated/declined in a timely manner ▪ Compare our performance using interRAI with other Northern Region DHBs and identify opportunities for	▪ 90 percent of older people receiving long-term home and community support within the previous 3 months will have an interRAI assessment ▪ 65 percent of complex patients will be seen within 15 working days of referral for a contact assessment ▪ 70 percent of non-complex patients will be seen within 15 working days of referral for a contact assessment

quality improvement with support of the TAS National Reporting Services reports ▪ Continue to collaborate with Central TAS to develop through their new integrated interRAI service the comparative standardised interRAI quality reporting measure	
interRAI: Comprehensive Clinical Assessment in residential care ▪ Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment ▪ The 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 months prior to that first LTCF assessment ▪ Use National reporting service benchmark report to identify opportunities for quality improvement with other DHBs and DHB regions	▪ 95 percent of older people in aged residential care by facility will have a second interRAI assessment completed 230 days after assessment as per the report provided by TAS National Reporting Services ▪ 95 percent of LTCF clients admitted to an aged residential care facility will be assessed using an interRAI Home Care assessment tool in the six months prior to admission to the facility
Home and Community Support Services for Older People ▪ Continue to support Part A of the In Between Settlement agreement outcomes ▪ *Awaiting recommendations on Part B*	▪ Report on In Between Settlement
Dementia Care Pathways ▪ Continued development of dementia care pathways, that is proactive and co-ordinated and builds on previous work ▪ Continue 12 month pilot outreach programme with Waiuku Medical Centre ▪ Develop a strategy for spreading and sustaining the pilot model ▪ Continue to support and develop a Primary Care led identification and management of mild cognitive impairment. This will utilise current tools (ARI and Dynamic Cognitive Pathway) and models of care (GP Champion and Nurse led clinics) ▪ Utilise expertise and skills of the Memory Team to support Primary Care team ▪ Continue to develop an integrated patient and carers centred service using current services and skills ▪ Maintain and increase the Memory Team Service Coverage of CM Health, Increase the capacity of primary care	▪ Narrative report at the end of 12 month pilot with implementation plan for spread across CM Health Q2 ▪ Provide a report on the 'sustain and spread strategy' Q3 ▪ Report quarterly on the number of patients enrolled on the NEXXT pathway with 30 patients enrolled as at Q3 ▪ Report quarterly on the education/support and joint MDTs (baseline data to be established 2016/17) ▪ Report quarterly on the number of patients from the pilot that are jointly managed with Alzheimer's Auckland Key workers (2015/16 baseline data to be provided) ▪ Report quarterly on the number of referrals to the Memory Team, from the pilot practice that required MT intervention ▪ Report on the plan for increased coverage of memory Team – resources and capacity identified from pilot and Memory Team Q2

2.3.8 Spinal Cord Impairment Action Plan

Spinal cord impairment (SCI) is rare but complex. Every year in New Zealand approximately 80 to 130 people are diagnosed with SCI through injury or medical/congenital causes. This affects their lives and those of many others, especially their family and whaanau. SCI can occur at any age from birth, during childhood or as an adult. Due to medical advancements most people with SCI now have a near normal life expectancy, but this brings with it progressive complexity for people and their lifelong self-management.

The overarching purpose of the Spinal Cord Impairment Action Plan is to support people with SCI by:

I. Maximising opportunities for optimal improvements and maintenance of function

II. Reducing risks of complications and physical and mental wellbeing deterioration in the short and long term

III. Enabling independence and community participation

IV. Supporting family, whaanau, carers and employers who help people with SCI

Linkages

Canterbury DHB; ACC; Ministry of Health

Objective 3 - Improve information sharing	
▪ Implement and operationalise the recommended Rick Hansen Institute registry ▪ Collaborate with Canterbury DHB to ensure consistency of data collection and reporting	▪ Data points agreed by Q1 ▪ Agreed data collected and inputted by Q2 ▪ Generate reports by Q4
Objective 4 – provide nationally consistent and high quality rehabilitation services	
▪ Identify and agree a quality framework for monitoring and strengthening services that could be used across Counties Manukau and Canterbury DHB spinal services ▪ Implement a patient experience tool within BSU that is consistent with Canterbury DHB	▪ Identify a range of potential frameworks Q2 ▪ Evaluate frameworks and agree with Counties Manukau DHB on which one to use Q3 ▪ Provide plan on how to implement the agreed framework within the services Q4 ▪ Identify a patient experience tool to test and implement by Q2 ▪ Finalise process and mode for collection Q3 ▪ Report patient experience data Q4

2.3.9 Whaanau Ora

Linkages

CM Health 2016/17 Maaori Health Plan

Mental Health	
▪ Reduced rate of Maaori committed to compulsory treatment relative to non-Maaori	▪ Refer to Health Equity in Section 2.2.6
Asthma	
▪ Reduced asthma and wheeze admission rates for Maaori children (ASH 0-4 years)	▪ Refer to ASH section in CM Health 2016/17 Maaori Health Plan
Oral Health	
▪ Increase in the number of children who are caries free at age 5	▪ Refer to Section 2.1.7
Obesity	
▪ 95 percent of obese Maaori children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions	▪ Refer to Raising Healthy Kids Section 2.2.2

Tobacco ▪ 95 percent of all pregnant Maaori women smokefree at two weeks post-natal	▪ Refer to Tobacco Maternity Care Section 2.2.5

Whaanau Ora Commissioning Agencies
▪ Create a mechanism for systematic national WO Commissioning Agency engagement with Tumu Whakarae
▪ Work locally with Te Pou Matakana to:
  ▪ Align outcome frameworks and contracting approaches with Whaanau Ora providers
  ▪ Identify and implement opportunities for co-funding
  ▪ To share intelligence pertaining to the achievement of whaanau ora in our community
▪ Engage with Pasifika Futures to:
  ▪ Align Fanau Ola frameworks
  ▪ Share intelligence on Fanau Ola achievement
  ▪ Identify opportunities for community partnering
	▪ WO Commissioning Groups for the North Island and South Island have a standing item on the Tumu Whakarae National Hui Agenda from 1 July 2016
	▪ Counties Manukau DHB integrated service agreement contracts will be aligned to the TPM outcomes framework where relevant from 1 July 2016
	▪ Pacific peoples can access Fanau Ola programmes and services
	▪ Pasifika Futures have an opportunity to partner with CM Health Pacific community projects

2.4 Living Within Our Means

The challenge of living within our means remains a significant challenge with forecasted revenue increases representing half of what is anticipated to maintain operations. The cost headwinds include contractual compensation commitments, increasing volumes and growing acute hospital demand.

The CM Health Executive Leadership Team (ELT) is taking a whole of system approach to value creation, quality and safety, productivity enhancement and efficiency aligned with the Healthy Together 2020 strategy. This approach includes consistent focus on clinical leadership, process improvement, system integration and new models of care.

Linkages

National Entity health sector expectations – Section 2.5; Financial Performance – Section 4.0

Supportive Systems	**Value**	**Risk**
▪ Enhancing rostering systems, production planning and leave management	Medium	Medium
Procurement opportunities ▪ National price harmonisation initiatives, regional/national new contract negotiations, rationalisation of clinical supply contract	Medium	Medium
Reducing Variation ▪ Clinical supplies, non-clinical supplies	High	Medium/High
Inventory and Supply Chain management ▪ Process and systems improvement to enhance consumable tracking and stocking levels, and rationalisation of catalogue item use	Medium	Medium
Environmental initiatives ▪ Energy consumption savings, enhanced fleet efficiency and improved waste management	Low	Medium

▪ Revenue maximisation through improved capture of ACC patients	Medium	Medium
Diagnostic variation ▪ Combining data analytics and education initiatives to improve the choices available	Medium	Low
Improving clinical processes ▪ Electronic ordering of pharmacy and laboratory tests	Low	Medium
Theatre optimisation ▪ Process improvement to increase utilisation and reduce outsourcing	Medium/High	Medium
Whole of System ▪ Community Integration programmes including At Risk, Community Central, Enhanced Primary Care	Medium	High

2.5 National Entity Initiatives

Health Promotion Agency ▪ Health Targets – refer to Sections 2.1.1; 2.2.2; 2.2.3; 2.2.5; 2.3.3; 2.3.4; 2.3.5 ▪ Alcohol Pregnancy and Alcohol Screening and Brief Intervention	▪ Support national health promotion activities around the health targets ▪ Support alcohol screening and brief interventions ▪ Support provision of routine and consistent advice to women of child bearing age about alcohol and pregnancy
HQSC ▪ Surgical site infection programme (SSIP) – refer to Section 2.7 ▪ National inpatient patient experience survey and reporting system ▪ Capability and Leadership ▪ Primary care - patient experience survey and reporting system	▪ Commit to meeting infection control expectations in accordance with Operational Policy Framework Section 9.8 ▪ Continue development of infection management systems at local level ▪ Continue to survey patient experience of care received using the national core survey quarterly ▪ Meet expectations in accordance with Operational Policy Framework Section 9.3 & 9.4.6 ▪ Hold contract with PHOs but initiative funded directly by MOH for 3 year period, no DHB financial implications
Health Workforce NZ ▪ Expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses ▪ Increase the number of sonographers ▪ Create new nurse specialist palliative care roles ▪ Expand the role of specialist nurses to perform colonoscopies ▪ Increase the number of medical physicists ▪ Increase the number of medical community based training places and providing access to primary care/community settings for prevocational trainees	▪ Refer to Workforce Section 2.8.3
National Health IT Board ▪ National Maternity Information System (MISP-NZ) ▪ electronic Prescribing and Administration (ePA)	▪ Refer to Technology Enabling Healthy Together Section 2.8.4 and 5.2.3

▪ National Patient Flow ▪ Regional CWS, CDR, PAS ▪ Health IT Programme 2015-2020	
Other Priorities ▪ Once finalised, CM Health will work with the MOH on the work programme of the former National Health Committee	

2.6 NZ Health Partnerships Ltd

National Oracle Solution ▪ The National Oracle Solution will design and build a single financial management information system ready for DHB implementation. The designing of the programme will be co-creational with the sector, leveraging existing DHB experience	▪ CM Health will commit resources to the implementation of the Oracle system, factoring in budget benefit impacts
Food Services ▪ Food Services contract has been implemented within CM Health	
Linen and Laundry Services ▪ NZ Health Partnerships will continue to work with DHBs that are open to considering a collective arrangement for outsourced Linen and Laundry Services ▪ The three Auckland Metro DHBs will continue to work together with the incumbent supplier to maximise operational gains from agreed initiatives focussed on reducing variation and waste	
National Infrastructure Platform ▪ This aims to achieve qualitative, clinical and financial benefits through a national approach to IS infrastructure consumption. The national approach is driven by converging 40 infrastructure facilities into a single infrastructure platform delivered from two data centre facilities. It will align the health sector's infrastructure services with the government's overall Information Communications Technology goal of harnessing technology to deliver better, trusted public services	▪ CM Health will work collaboratively to progress the National Infrastructure Platform, committing resources to the decision reached in relation to the implementation of the programme

2.7 Improving Quality

Quality and safety is embedded into daily clinical and operational practice and is the foundation of CM Health's Healthy Together Strategic Plan initiatives and campaigns to advance quality and improvement of our healthcare system. Our two strategic objectives - 'Healthy People, Whaanau and Families' and 'Healthy Services' contribute most directly toward improving the quality and safety experience of patients, whaanau and families accessing healthcare services.

Our 'Healthy Services' strategic objective focus is on delivering excellent, consistent, high quality, safe and compassionate healthcare across our system leading to a more reliable experience for patients, whaanau and families. Living our values (refer section 1.3.1) and engaging with patients, whaanau and families to redesign services is at the heart of involving them as an active part of their health team so we can be truly Healthy Together.

Linkages

NZ Health Strategy 'Value and High Performance' action themes relating to quality, safety and experience; National quality and

safety markers; regional patient safety network; CM Health 'Aiming for Zero Patient Harm'; CM Health Quality Accounts; Ko Awatea quality improvement campaigns and programmes: System Level Measures, Beyond 20,000 Days, Manaaki Hauora – Supporting Wellness, Patient and Whaanau Centred Care, Community Organising, Early Childhood Education intersectoral work, faculty training programmes.

Actions	Measures
National Quality and Safety Markers	
Exceed thresholds for the national Quality Safety Markers including:	
▪ Falls - maintain the focus on falls risk assessment and individualised care planning through the local 'Aiming for Zero Patient Harm' programme that provides analysis of data and direction for a targeted reduction in serious harm from falls	▪ 90 percent of older patients are given a falls risk assessment ▪ 98 percent of older patients assessed as at risk of falling receive an individualised care plan addressing the risks identified
▪ Hand hygiene – ▪ Hand hygiene is a top priority for a health system wide, hospital focused improvement project ▪ Commitment to meet and sustain achievement at or above the identified QSM threshold for hand hygiene compliance ▪ Invest in trained hand hygiene auditors by running a one-day workshop five times a year for maximum of 15 people aiming to have two gold auditors on every ward ▪ Develop role of Gold Auditors to become a champion and ward educator for hand hygiene promoting front line ownership to improve practice ▪ Continue promotion of good hygiene to staff, patients and visitors including development of new promotional material/reminders in the workplace	▪ 80 percent compliance with good hand hygiene practice ▪ Provide quarterly hand hygiene progress reports from national audit with area specific results and recommendations distributed to key stakeholders
▪ Safe surgery (reduce peri-operative harm) - commitment to ensure that the checklist is being used in paperless form, as a teamwork and communication tool rather than an audit tool. Commitment to working with the Commission to continue to implement briefing and debriefing for each theatre list	▪ All three parts (sign in, time out and sign out) of the surgical safety checklist are used in 100 percent of surgical procedures, with levels of team engagement with the checklist at 5 or above, as measures by the 7-point Likert scale, 95 percent of the time ▪ CM Health is committed to sustaining an achievement at or above the old QSM threshold of all three parts of the WHO surgical safety checklist (sign in, time out and sign out) being used in a minimum of 90 percent of operations
▪ Surgical site infections - attain the thresholds for the use of antibiotics and appropriate skin preparation for hip and knee replacement surgery through redesign of systems and education of staff. Regular reflection on results to improve safety and quality	▪ 90 percent compliance with procedures for inserting central line catheters ▪ 100 percent of primary hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision
▪ Medication Safety - continued commitment to the use of electronic medication reconciliation by engaging team based pharmacists and Resident Medical Officers	▪ 95 percent of hip and knee replacement patients receive >2g of cefazolin or >1.5g of cefuroxime as prophylaxis
Other Medication safety initiatives	▪ 100 percent of primary hip and knee replacement patients having appropriate skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine
▪ Assess the safety of medicine practices at Middlemore hospital. Identify areas for remedy and/or improvement and compare against similar hospitals	▪ 80 percent of high risk patients have electronic medication reconciliation completed within 48 hours of admission
▪ Information technology - electronic prescribing implementation to improve medication safety	▪ Complete self-assessment using Institute of Safe Medicine Practices (ISMP) developed tool and initiate improvements in areas of deficiency by Q2
▪ Information technology - improve access to electronic medicines information at ward level to improve medication safety	▪ Start implementation of MedChart at Middlemore site with two wards implemented MedChart by Q2, followed
▪ Identify actions to reduce patient harm including but not	

limited to pressure injury prevention: ▪ Encourage clinicians to complete ACC 45 and ACC 2152 (treatment injury claim) forms for all grades of pressure injury except grade one in order to provide a more accurate picture of the incidence on pressure injuries occurring while in care ▪ Report to HQSC all pressure injuries grade three and above as serious adverse events ▪ Improve classification and documentation of pressure injuries by grade in the patient record and ensure they are coded ▪ Implement evidence based structured risk assessment to support clinical judgement and implement effective prevention	by an incremental roll out ▪ Implement the roll out IT infrastructure in medication rooms on wards to improve access to medicines information ▪ Roll out completed in 80 percent of wards by December 2016 ▪ Measure and report pressure injury prevalence regularly and consistently
Enhance Quality and Experience of Care ▪ Develop a patient experience team under a new Patient Experience Director ▪ Hospital services initiatives ''Aiming for Zero Patient Harm" to address patient safety including: ▪ Reducing harm related to pressure injuries ▪ Central line associated bacteraemia (CLAB) ▪ Venous thromboembolism (VTE) prevention ▪ Reducing hospital standardised mortality ratio (HSMR) through improved end-of-life care, after hours care, prevention and management of sepsis ▪ Participation as part of the strategic pressure injury working group under ACC, HQSC and the MOH ▪ Collaboration with other social sectors to make improvements that impact social determinants of health ▪ Ko Awatea collaboration with Ministry of Education on Early Childhood Education to increase oral language for 3-4 year olds ▪ Ko Awatea will continue to support the Faster Cancer Treatment project to: ▪ Improve the quality and timeliness of care for cancer patients ▪ Work with the cancer tumour streams to redesign and optimise the pathway for cancer patients ▪ Ko Awatea will lead Manaaki Hauora – Supporting Wellness Campaign to: ▪ Provide self-management support for 50,000 people living with long term conditions by Q2 ▪ Establish and support 18 Collaborative Teams across CM Health to achieve aims that contribute to the Campaign aim ▪ Ko Awatea will continue to lead the Safety in Practice collaborative to: ▪ Increase capacity in PHO and general practices in patient safety methods and processes by 30 June 2017	▪ Patient Experience Director will be in position by Q1 ▪ Reduction in pressure injuries grade 3 and 4 'never events' to zero in the acute sector ▪ <1 CLAB per 1000 line days ▪ Percentage of major joint surgery patients who have a VTE risk assessment at pre-admission clinic or within 24 hours of admission (measure to be confirmed by VTE Group) ▪ To have the lowest HSMR in Australasia measured against comparable hospitals ▪ Increase participation to 98 percent of three/four year olds in early learning education and increase oral language for three and four year olds ▪ See Faster Cancer Target Section 2.3.3 ▪ Establish infrastructure to co-ordinate the peer support leaders workforce and network ▪ Increased numbers of people accessing self-management programmes ▪ Increased number of people enrolled in and supported in At Risk programme ▪ Reduction in unplanned visits to Emergency Department and general practices ▪ Support Collaborative teams to implement charters, aims and measurement plans

▪ Promote culture of safety, develop practice systems and processes to increase patient safety and prevent or reduce harm and improve the quality of care for patients with chronic conditions	▪ Deliver three to four learning sessions to train, share knowledge and ideas across the sector ▪ Each Collaborative team will measure improvements and develop dashboards for the data ▪ Report monthly on progress for all Collaborative teams within the campaign ▪ Support up to 70 general practices in phase 3 to implement improvement using the model for improvement methodology ▪ Complete monthly audits for measuring improvement ▪ Deliver three learning sessions for all general practices to train, share knowledge and ideas ▪ Culture surveys to be completed in general practices ▪ Trigger tool to be completed in general practices ▪ Evaluation to be completed to report on objectives achieved ▪ Audit data to be analysed to measure improvements ▪ Evaluation to be completed and report on improved quality of care for patients and whaanau
Improve Consumer Engagement • Ko Awatea, in collaboration with the Patient and Whaanau Centred Care Board, will lead service redesign projects through patient co-design training and projects to improve patient experience • Use a range of methods to better understand and improve patients, family and whaanau experience of care: ▪ Improved patient and whaanau feedback - a broad range of opportunities to provide feedback about their experiences of using CM Health services, including both national and internal patient experience survey, complaints, compliments, face-to-face contact, forums ▪ Maintain a concerted focus on obtaining patient email addresses so that more electronic responses can be captured ▪ Keeping patients and whaanau informed – timely, accurate and useful information to enhance effective participation in decision making about their care and achieve the best possible clinical outcomes	▪ Enhanced capability in patient experience methods ▪ The routine use of advance care planning where appropriate in primary care ▪ Utilise patient experience survey feedback at all levels of the organisation to improve the patient experience ▪ Improved response rate to both national and internal patient experience survey ▪ Reporting to governance group and different levels in the organisation
• Patient and Whaanau Centred Care Board, in collaboration with Ko Awatea, will lead and facilitate Patient Experience Week to: ▪ Further raise awareness and promote the benefits of healthcare staff, patients and whaanau working in partnership in order to design services that meet the needs of our local communities ▪ Focus on how we can work with patients, whaanau and staff to improve communication ▪ Reinforce the explicit links between patient and staff experience and CM Health Values ▪ Patient and Whaanau Centred Care board will work regionally to standardise consumer remuneration	▪ Undertake a listening event with at least five patients and 20 health students ▪ Create a short film which focusses on the importance of communication ▪ Provide and evaluate a learning session on mindfulness to promote the concept of caring with compassion and providing a patient experience that recognises kindness and compassion ▪ Create opportunities for staff to experience 'empathy' activities and evaluate their learning following their experience ▪ Ko Awatea will lead Handle the Jandal Campaign: ▪ Develop model for Open Studio school for educating Poly youth

▪ Ko Awatea will lead in innovation and improvement methods for CM Health to advance strategic objective performance
▪ Ko Awatea will continue to work with the community to improve health and wellbeing through the development of an active network of Poly (Maaori and Pacific) youth leaders to mobilise groups of youth to take charge of their own health and wellbeing
▪ Advance our commitment to involve patients, family and whaanau be more involved in decision making (at all levels):
  ▪ Patients and whaanau are represented in policy, planning and system development by participation in groups such as the Consumer Council, locality groups
  ▪ Consumer Council will develop a package to support consumers in their engagement
  ▪ Patients and whaanau are members of key decision making groups, such as Disability Advisory Committee (DiSAC), Patient Safety & Experience group and Information Services Governance Group (ISGG)
  ▪ Patients and whaanau have roles on key decision making committees, such as Advanced Care Planning, Cancer treatment redesign, Diabetes campaign, Values and Strategy review
▪ Enhance our capability for quality improvement and innovation by continuing to develop capability in innovation and improvement methods for CM Health
  ▪ Ko Awatea will lead in innovation and improvement methods for CM Health using community organising methodology
	▪ Deliver two leadership training events
	▪ Deliver ten fono (workshops) for 200 youth and community members
	▪ Service delivery times meet key performance indicators
	▪ Reduction in DNA rates and reduced length of inpatient stay
	▪ Reduction in hospital admissions and increased health and well days
	▪ Number of staff trained in improvement and innovation methods and involved in improvement projects
	▪ Number of initiatives that work cross-sector to improve health determinants

Enhance visibility of quality and safety performance
▪ The further development of annual quality accounts to include consistent reporting with relevant measures
▪ Include data within quality accounts as outlined in the HQSC quality accounts guidance
▪ Enhance the focus on the whole of system and continuous quality and safety
▪ Showcase patient /whaanau centred care activity
▪ Support national mortality and morbidity review processes by resourcing identified roles within CM Health to attend and participate in the committees
▪ Health and Disability Sector Standards Certification and the Health Excellence Framework (HEF) which is aligned to the Baldrige Excellence Framework
▪ Ko Awatea facilitating System Level Measures (SLM) to:
  ▪ Measure dimensions of quality and progress toward the Healthy Together strategic objectives
  ▪ Determine the achievement of the CM Health organisational goal being the best healthcare system in Australasia by December 2015
▪ Ko Awatea facilitates a campaign supporting achievement of health equity on key health indicators utilising the Break Through Series Collaborative structure
	▪ Complete an accessible annual quality account that will be published on the CM Health website
	▪ Regular reporting on quality to relevant Board sub-committees
	▪ Appropriate maintenance of appropriate mortality and morbidity review systems
	▪ Continued contribution to national mortality review committee data collection
	▪ Continued response to advice and recommendations from mortality review committee annual reports
	▪ Continued certification/accreditation and progress towards gold award in Business Excellence Framework (BEF)
	▪ Analysis and reporting of dashboard comprised of 16 SLMs
	▪ SLMs drill-downs with a focus on health equity, explaining special cause variation, and addressing the contributory measures that influence SLM performance
	▪ Findings of the comparative analysis of CM Health performance with local and international healthcare organisations to be reported

to accelerate the spread of effective methods	▪ Incorporate knowledge and expertise from CM Health SLMs towards addressing System Level Outcome Measures priority and implementing National SLM Framework ▪ Support integration of healthcare for children and young people in schools ▪ Increase access to long term conditions management ▪ Build capability to strengthen the equity focus across healthcare services

2.8 Actions to Support Delivery of Regional Priorities

2.8.1 Major Trauma

Actions	Measures
▪ Continue to develop and review the Clinical Care Pathway for the Hospital Transfer of Trauma Patients ▪ Continue to work with the Regional Trauma Network to develop guidelines for the management of trauma patients ▪ Contribute to quarterly reports against the defined performance indicators for the region ▪ Continue to collect, update and maintain Collector database ▪ Support and host the regional multidisciplinary team based trauma teaching forum	▪ Pathway developed and regularly reviewed ▪ Attendance and active involvement in the Regional Trauma meetings ▪ Lead clinician actively involved in the Regional Trauma Network ▪ CM Health regularly reporting to Regional Group as requested ▪ Up to date CM Health data collection for Trauma Data ▪ Training opportunities available for CM Health staff

2.8.2 Hepatitis C

In 2015/16 implementation began on a revised approach to the delivery of Hepatitis C services across New Zealand. This involves the development of more integrated regional Hepatitis C services where the focus will be on a coordinated primary and secondary care model with regional clinical leaders[8].

As part of the new configuration of Hepatitis C services, resources will primarily be directed towards targeted detection, management and treatment of Hepatitis C virus (HCV) in populations who are at increased risk. Primary and secondary care services will be extended to provide improved assessment and follow up services for all people with HCV. CM Health will participate in the northern region Hepatitis C Working Group to support coordinated development and implementation of integrated Hepatitis C assessment and treatment services across primary and secondary care in the Northern Region.

Linkages

Ministry of Health; Metro Auckland Clinical Governance Forum; CEO/CMO Forum; District Alliances including PHOs; Regional Information Clinical Leadership group; Clinical/Consumer forums; healthAlliance

Regional Actions	Measures
▪ CM Health will work with the Northern Region to develop hepatitis C services that are integrated across the region ▪ Support and work with the region to develop a clinical pathway, service delivery options and an implementation plan	▪ Regional Hepatitis C services implementation plan developed by Q1 ▪ Implementation of the Hepatitis C clinical pathway and services by Q1
Local Actions	
▪ Work with the CM Health Alliance and other stakeholders to ensure a whole of system approach and	▪ Number of people diagnosed with HCV per annum by age and ethnicity

[8] Clinical leaders include physicians and nurse specialists in primary and secondary care, including community alcohol and drug services and corrections services.

strong clinical leadership for the implementation of integrated Hepatitis C services
▪ Support implementation of the clinical pathway including raising GP and community awareness, identification and assessment and patient access to testing and care
▪ Support the Nurse Practitioner to work in the new model of care delivery
	▪ Number of HCV patients who have had a Fibroscan by age and ethnicity in the last year as well as
	  ▪ New patients
	  ▪ Follow up
	▪ Number of people receiving PHARMAC funded antiviral treatment per annum by age and ethnicity

2.8.3 Workforce

CM Health is one of the largest employers in the Counties Manukau District employing more than 7,000 people in more than 100 different roles at more than 20 sites across the District. A further estimated 5,000 more people are employed in the health and disability system outside DHB employment – many of which are funded by the DHB.

People are at the heart of healthcare services. CM Health's People Strategy aims to ensure "safe, quality healthcare services are provided by professionals whom are well trained, knowledgeable and come to work because they want to do their best for patients, users of services and our communities". A values led workforce is critical to effective engagement of people power in the District. Strategies are less likely to be effectively implemented if values that underpin organisation culture are neglected.

CM Health's People Strategy priorities that will underpin support for local and regional workforce action priorities are:

- Embedding **values and culture** in the way we do business
- Growing **capability** to transform the health system and respond better to changing health needs
- Building our workforce **capacity** and diversity to do more in communities and deliver care closer to home
- Providing effortless **systems and processes** that enable people to do their best

Linkages

CM Health's People Strategy; CM Health's Healthy Together Strategic Plan; Northern Regional Health Plan; Health Workforce NZ (HWNZ) Strategic Plan

Actions	**Measures**

Culture and Values
▪ Embed CM Health Values:
  ▪ Measure values by identifying behaviour which reflect our values and use them to drive culture change (Reward & Recognition Programme)
  ▪ Introduce values based recruitment
  ▪ Deliver Train the Trainer values programmes to ensure behaviours are embedded into all development
  ▪ Facilitate a culture of constructive feedback and positive reinforcement using (ABC[9] & BUILD[10])
▪ Implement a staff Wellness programme
▪ Develop a Diversity & Inclusion Plan supported by specific programmes (including Ko Awatea Scholarship; Pu Ora Mataini; Kia Ora Hauora National mentoring project)
▪ Develop a Staff Engagement plan aligned to Patient Experience
▪ Introduce a review and prevention programme for bullying and harassment	

Capability and Capacity ▪ Work in partnership with professional leaders, primary care, professional bodies and unions, to progressively extend the scope of practice for roles to support CM	

[9] The ABC of appreciation (Action, Benefit, Continue)
[10] BUILD more constructive behaviours (Behaviour, Understand, Impact, Listen, Differently)

Health's transformation priorities and where there are identified shortages and/or key roles:

  - Support and train increased numbers of Nurse Prescribers including Diabetes, and for Long Term Conditions when available
  - Support the registered nurse assistant to the anaesthetic initiative
  - Development of new and hybrid roles, particularly those which increase flexibility to work across hospital and community settings
- Develop and implement an organisational competency framework
- Introduce a system for effective talent identification and support
- Plan and deliver a programme of targeted Management Masterclasses
- Actively support and contribute to the HWNZ Nursing Workforce Programme as initiatives are clarified, such as:
  - Support the creation of new palliative care specialist nurse
  - Support the regional approach to expanding the role of specialist nurses to perform colonoscopies
- Refocus/expand the role of nurse practitioners and clinical nurse specialists
- Develop a regional approach to better utilise our workforce through improved modelling and forecasting of workforce requirements:
  - Improve workforce planning using the national Workforce Intelligence and Planning Framework across workforces in Items 1 and 12 of this plan
- Promote and develop a workforce with more generic skills which is flexible to work across hospital and community settings
- Promote and increase undergraduate training and new graduate employment placements in priority services including primary and community care by engaging with PHOs, Residential Care and other community providers for all workforces as appropriate
- Support the Kaiawhina Workforce Action Plan identifying opportunities to better utilise and develop the low paid and non-regulated workforce:
  - Identify new opportunities and existing initiatives that could be expanded, e.g. investigate feasibility of formalising existing informal interpreting services already provided
  - Identify new opportunities and existing initiatives that could be expanded to increase access to education and development pathways
- Align regional strategies to enhance Maaori and Pacific achievement:
  - Work with Tertiary Education Commission

(TEC) and tertiary education providers to improve Maaori and Pacific undergraduate completion rates

    - Explore new funding opportunities for primary healthcare clinical placements for Maaori and Pacific undergraduate students

- Develop and provide access to a leadership development pathway for our Maaori and Pacific workforces
- Improve the monitoring and reporting of the health workforce, particularly focussing on the Maaori, Pacific and Asian workforce
- Continue to deliver local, regional and national initiatives to support a "pipeline" or student driven approach to workforce development e.g. "Grow our Own" initiatives
- Deliver nationally based Kia Ora Hauora initiatives
- Align regional strategies to enhance graduate success and overcome barriers to workforce participation
- Implement a CM Health recruitment and retention strategy for Maaori and Pacific staff including:
    - Policies in regard to affirmative action for recruitment of Maaori and Pacific peoples into the workforce
    - Staff satisfaction surveys and exit interviews for Maaori and Pacific staff to inform retention initiatives
- Promote and support national workforce development programmes e.g. Nga Manukura o Apopo and Aniva initiatives
- Develop and implement strategies to ensure future sustainability of the vulnerable workforces
- Strengthen the regional development and implementation of e-learning modules:
    - Regionalise 3 mandatory programmes per year
- Strengthen Health Leadership & Management through:
    - Staged implementation of the national Leadership Domains Framework
    - Develop a Health Management development pathway
- Development of a DHB Leadership & Management Development approach
- Continue building on the cultural competency development of our staff:
    - Evaluate the process and impact of the Tikanga and Pacific cultural training programmes regionally
- Lead the development of consistent approaches of minimum standards for RMO education and training across the region, consolidating training resources and standardising at least four PGY 1/2 programmes annually (aligned with national and regional service needs)
    - Supporting all Medical trainees to develop and implement career plans, providing access to career guidance and mentoring services for RMOs
    - Administer voluntary bonding, Advanced

Trainee Fellowship Scheme and other HWNZ innovations ▪ Support the HWNZ Medical Workforce programme ▪ Provide reporting and analysis of regional workforce trends ▪ Maximise the placement of NZ graduates who are New Zealand Citizens or New Zealand Permanent Resident ▪ Develop opportunities for primary care/community based experience for PGY 2s in line with the MCNZ requirements for General Registration ▪ DHB placement for GPEP trainees to support integration between primary and secondary care	
Additional Maaori workforce development ▪ Develop and implement a robust performance monitoring system that will enable accurate reporting of Maaori health workforce results including but not limited to: ▪ Implementation of an online registration process and single database to track, monitor and report on all tauira (students) who engage in any CM Health workforce programmes ▪ Monitoring and reporting on the number of Maaori job applicants; applicants taken to interview; applicants offered employment and new hires ▪ Auditing and improving the process for the collection, analysis and reporting of CM Health employee/workforce ethnicity data ▪ Track and monitor Maaori staff turnover and reasons for exit to inform retention strategies ▪ Review the current 'end to end' recruitment pathway (including marketing, sourcing, applicant selection and appointment) and associated HR policies, processes and procedures to identify barriers and/or implement measures to ensure more equitable employment outcomes for Maaori[11] including but not limited to: ▪ Auditing CM Health's compliance with Good Employer obligations ▪ Work with HR team to revise HR policies and implement values based recruitment organisation-wide ▪ QR review of the NETP (new graduate nurse) recruitment process and candidate assessment model Q1 ▪ Expansion of the CM Health cadetship and internship programmes ▪ 38-40 new hires who identify as Maaori each quarter (155/pa) ▪ Implement an integrated Rangatahi programme aimed at	

[11] Both the Human Rights Act 1993 and the New Zealand Bill of Rights Act 1990 recognise that to overcome discrimination positive (or restorative) actions may be needed to enable particular groups to achieve equal outcomes with other groups in our society. These actions are not discriminatory if they assist people in certain groups to achieve equality. Any special measure must be based on information that shows that the present position is unequal.

increasing the number of Maaori recruited into tertiary level health programmes. This will include but not be limited to: ▪ Regional alignment with ADHB and Waitemata DHB Rangatahi Programme activity Q1 ▪ Integration of all school-based and CM Health based workforce activity offered under existing workforce programmes Q1 ▪ 200 new Maaori students participate in programme activity each year ▪ Restart the Pu Ora Mataini nursing programme to include a focus on increasing the supply of Maaori registered nurses, enrolled nurses and health care assistants into the CM Health and primary care workforce ▪ Develop a Leadership Development Programme to strengthen Maaori clinical leadership and management capability including but not limited to: ▪ Identifying and promoting existing leadership development programmes Q1 ▪ Creating learning opportunities to share and implement best practice in terms of indigenous health excellence Q2-4 ▪ 6-8 Maaori staff undertake dedicated leadership development programme Q2-4 ▪ In partnership with clinical leaders, educators and senior managers, develop and implement a cultural competence programme that improves the skills, knowledge and ability of the wider workforce to engage with and improve the quality of care provided to Maaori whaanau ▪ Scope options for delivering a programme to the entire CM Health workforce Q1-2 ▪ Design and implement programme Q2-4 ▪ 80 percent of all new hires complete any mandatory programme requirements Q3-4	
Systems and Processes ▪ Standardise DHB data-sets in line with the ANZSCO job classification system, and the Statistics NZ statistical standard for ethnicity, and agree on the level of ethnicity data that the region will collect ▪ Work towards implementation of e-passport capability, by investigating the feasibility of aligning the e-learning platforms and training records ▪ Continue to develop an effective regional RMO service to support DHBs recruit and retain an RMO workforce aligned with service delivery and training requirements	
Transformation ▪ Actively support Regional Clinical Networks, including: ▪ Electives ▪ Stroke ▪ Health of Older People ▪ Major Trauma ▪ Identify opportunities to develop and implement new	

and hybrid roles to support new models of care, including: ▪ Community Care Coordinator role ▪ Hybrid / blended roles across the Allied Health, Scientific and Technical professions ▪ Support CM Health's Localities work ▪ Review and develop appropriate models of engagement and remuneration ▪ Map and develop a plan for workforce transformation requirements for 2016/17 and beyond	

2.8.4 Technology Enabling Healthy Together

Through Project SWIFT (System Wide Integration For Transformation), CM Health is poised to accelerate delivery of the National Health IT Board's priority foundation investments as part of CM Health's transformational journey and commence implementation of solutions required to enable new community-based models of care and improved hospital efficiencies.

These investments will address CM Health's immediate strategic priorities and provide a platform for future roll-out of a regionally agreed full electronic health record and digital hospital blueprint.

Linkages

CM Health's Healthy Together Strategic Plan; Regional Information Services Strategy; National Health IT Board priority initiatives

Actions	**Measures**
National Priorities – Digital Hospital	▪ Electronic laboratory orders rolled out fully across the organisation
▪ Laboratory Orders	▪ Electronic Radiology Orders implemented within CM Health
▪ Radiology Orders	▪ First implementation completed
▪ Inpatient Medication Prescribing	▪ Business case for full roll out approved
	▪ Full roll out underway subject to issues impacted patient safety are satisfactorily resolved by the vendor
▪ Clinical Documentation	▪ Development of business requirements for a clinical documentation solution and prioritisation of workforce implementation
	▪ Evaluate e-vitals and product suites already implemented within CM Health if fit for purpose and consistent with architectural principles
	▪ Prepare a business case
	▪ Initiate implementation
▪ National Patient Flow	▪ Implement Phase 3 requirements where possible
▪ Electronic Health Record	▪ Completion of Northern Region Implementation Planning Study with Epic and Business case completion
	▪ Develop 10 year Northern Regional IS Strategic Plan
▪ Maternity Clinical Information System	▪ Implement additional functionality to resolve clinical safety concerns and optimise clinical workflow
	▪ Roll out across CM Health
	▪ Implement Growth Chart functionality
	▪ Participate in National steering group and clinical reference group
	▪ Refresh/develop separate business case to implement the neonatal module and consumer portal
	▪ Provide advice to other DHBs on implementation

	methodology and resources required
National Priorities – Care Connect	
▪ Clinical Pathways	▪ Initiate deep dive option to focus on change management, understand barriers to use and integration points ▪ Prioritise the integration interfaces with a clinical reference group ▪ Commence development of the integration points ▪ Identify next group of pathways to be converted into electronic format ▪ Limited roll out of tool beyond the existing 92 practices ▪ Begin roll out of integration interfaces
▪ E-Referral intra and inter DHB referrals	▪ Inter and Intra hospital referrals implemented and being rolled out across CM health ▪ Paper referrals no longer accepted for eligible practices ▪ Web referrals implemented and received well
▪ Shared Care	▪ Regional data sharing repository implemented ▪ Integration with PMS improving clinical workflow and increasing usage ▪ Single sign on in place
▪ Patient Portals	▪ Ongoing monitoring of patient portal offerings via Care Connect Governance ▪ Define regional approach to consolidate portal offerings
Resource Optimisation	
▪ Capacity Planning upgrade V7	▪ Enables Web Reporting, integration between CapPlan and Onestaff as a pre-requisite for additional tools to be implemented (below)
▪ One Staff modules	▪ Upgrade One Staff to enable performance and visibility to be implemented
▪ Performance visibility	▪ Aggregates real-time information from various systems and displays it on electronic whiteboards throughout the hospital to monitor patient flow, address bottlenecks and maximise volumes
▪ Telehealth	▪ Provide a platform within the Auckland Regional DHB network and into the community for telehealth
ICT Platform Transformation	
▪ Standardise regional Integration platform	▪ Preferred supplier contracted ▪ Migration plan developed
▪ Select and initiate implementation of enterprise Service Bus supplier and API gateway	▪ Requirements prioritised and implementation underway to support transformation initiatives for CM Health
▪ Data Reservoir	▪ Data governance defined ▪ Preferred supplier contracted ▪ Implementation underway to support transformation initiatives for CM Health

▪ Mobility Platform and Services	▪ Implement mobile device management ▪ Complete WIFI enablement to all clinical areas ▪ Mobile devices implemented for community workers to support smart scheduling and access to and collection of clinical information at point of care
▪ Application Portfolio Management	▪ CM Health Applications loaded into APM tool and GCIO requirements met to establish an application registry and management plan

▪ Unified Communications	▪ Strategy defined to meet the following requirements
	  ▪ Secure clinical email
	  ▪ Secure texting
	  ▪ Telehealth services
	  ▪ Skype for business
	▪ Upgrade of telecommunications contract and services

▪ Capacity & Lifestyle management	▪ Provision for growth and computer and storage lifecycle management
▪ Data Analytics	▪ Analytics and information management strategy defined ▪ 3-5 year Investment roadmap defined ▪ Implementation of services to support enhanced primary care programme
Controls and Risk Management	
▪ ICT risk assurance	▪ Risk assurance plan monitored monthly by hA ▪ Quarterly reviews with DHB Audit Risk and Finance Committee ▪ Implementation of priority mitigations
▪ hA services	▪ Service Delivery Manager Appointed to CM Health ▪ Service level agreement and performance metrics in place
▪ Privacy Controls	▪ Remediation plan implemented ▪ Improve monitoring and response ▪ Malware protection and threat management
System Currency and Optimisation	
▪ Patient Management System ▪ Clinical Portal ▪ Emergency Clinical Information System ▪ Electronic Discharge including medication module ▪ Regional Éclair upgraded ▪ Incident management/Reporting, Feedback and Risk register ▪ Internet Explorer	▪ iPM upgraded and additional NPF phase 2 requirements met ▪ Concerto Portal 8 implemented and regular upgrade scheduled and resourced ▪ ED whiteboard upgraded ▪ SMT upgrade with single instance across CM & WDHB (consolidation) ▪ Pre-requisite to e-ordering ▪ Incident reporting upgraded to support IE upgrade and provide additional functionality ▪ Upgraded to IE11

3.0 Statement of Performance Expectations

3.1 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 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 Statement of Performance Expectations (SPE).

This SPE is a separate document to the Statement of Intent and has a threefold purpose of enabling the responsible Minister to participate in setting the annual performance expectations of the DHB as well as providing Parliament with information on these expectations. It also provides a base against which actual performance can be assessed. Actual results of service performance against what was forecast here will be published in our 2014/15 Annual Report.

The annual forecast financial statements will be provided as part of the Statement of Performance Expectations in accordance with the CE Amendment Act 2013.

3.2 Input Levels against Output Classes

3.2.1 Prevention

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Revenue	**23,452**	**46,291**	**53,316**	**55,027**	**56,780**	**58,577**
Personnel Costs	10,940	26,890	28,070	28,968	29,895	30,852
Outsourced Services	2,889	2,700	8,035	8,292	8,557	8,831
Clinical Supplies	3,356	3,162	2,752	2,840	2,931	3,025
Infrastructure and Non-Clinical Supplies	307	1,407	1,667	1,720	1,775	1,832
Other	5,960	12,132	12,792	13,207	13,622	14,037
Total Costs	**23,452**	**46,291**	**53,316**	**55,027**	**56,780**	**58,577**
Surplus (Deficit)	-	-	-	-	-	-

3.2.2 Early detection and management

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Revenue	**211,510**	**213,144**	**213,636**	**220,564**	**227,491**	**234,421**
Personnel Costs	-	-	-	-	-	-
Outsourced Services	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-
Infrastructure and Non-Clinical Supplies	-	-	-	-	-	-
Other	211,510	213,144	213,636	220,564	227,491	234,421
Total Costs	**211,510**	**213,144**	**213,636**	**220,564**	**227,491**	**234,421**
Surplus (Deficit)	-	-	-	-	-	-

3.2.3 Intensive assessment and treatment

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Revenue	**1,155,081**	**1,147,365**	**1,186,282**	**1,224,767**	**1,263,194**	**1,301,607**
Personnel Costs	537,734	537,778	562,530	580,785	599,004	617,204
Outsourced Services	66,425	69,568	69,869	72,138	74,398	76,651
Clinical Supplies	115,874	120,052	110,096	113,666	117,232	120,798
Infrastructure and Non-Clinical Supplies	116,479	116,061	123,003	126,993	130,980	134,968
Other	315,552	301,036	316,284	326,631	336,970	347,314
Total Costs	**1,152,064**	**1,144,495**	**1,181,782**	**1,220,213**	**1,258,584**	**1,296,935**
Surplus (Deficit)	**3,017**	**2,870**	**4,500**	**4,554**	**4,610**	**4,672**

3.2.4 Rehabilitation and support

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Revenue	**113,700**	**113,839**	**119,052**	**122,915**	**126,776**	**130,639**
Personnel Costs	-	-	-	-	-	-
Outsourced Services	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-
Infrastructure and Non-Clinical Supplies	-	-	-	-	-	-
Other	113,700	113,839	119,052	122,915	126,776	130,639
Total Costs	**113,700**	**113,839**	**119,052**	**122,915**	**126,776**	**130,639**
Surplus (Deficit)	-	-	-	-	-	-

3.2.5 Total

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Revenue	**1,503,743**	**1,520,639**	**1,572,286**	**1,623,273**	**1,674,241**	**1,725,244**
Personnel Costs	548,674	564,668	590,600	609,753	628,899	648,056
Outsourced Services	69,314	72,268	77,904	80,430	82,955	85,482
Clinical Supplies	119,230	123,214	112,848	116,506	120,163	123,823
Infrastructure and Non-Clinical Supplies	116,786	117,468	124,670	128,713	132,755	136,800
Other	646,722	640,151	661,764	683,317	704,859	726,411
Total Costs	**1,500,726**	**1,517,769**	**1,567,786**	**1,618,719**	**1,669,631**	**1,720,572**
Surplus (Deficit)	**3,017**	**2,870**	**4,500**	**4,554**	**4,610**	**4,672**

3.3 Output Classes

This section is structured as follows:

3.3.1	**Prevention Services**
	Health Promotion and Education Services ▪ Smoking cessation ▪ Breastfeeding ▪ Family violence prevention Immunisation Services Health Screening ▪ Breast screening ▪ Cervical screening ▪ Well Child/ Tamariki Ora and Children's Services Statutory and Regulatory Services
3.3.2	**Early Detection and Management Services**
	Primary Health Care Services (GP) ▪ Long Term Conditions Management Oral Health Services Diagnostics
3.3.3	**Intensive Assessment and Treatment Services**
	Mental Health Elective Services Acute Services ▪ Readmissions ▪ Emergency department ▪ Cancer services ▪ Cardiac services Quality Patient and Safety
3.3.4	**Rehabilitation and Support Services**
	Needs Assessment and Coordination Service (NASC) Assessment, Treatment and Rehabilitation Services Aged Related Residential Care (ARRC) Home Based Support
3.3.5	**Maaori Health Plan Indicators**
	National Indicators Local Indicators

Outputs are measured against six dimensions of quality:

Figure 6: Dimensions of Quality

Dimension	What this means for our services
Safe	No unnecessary harm
Timely	No unnecessary waiting
Efficient	Reduce waste
Equity	Services matched to the level of social and health need to provide equal opportunity of health outcomes
Effective	Doing things which are evidence based
Patient Centred	Involve patients in their care and in system improvements

Past performance (baseline data or current performance) is included where possible along with performance targets. A number of key measures of output and impact for each output class which best reflect activities that make the largest contribution to CM Health's achievement of key strategic objectives have been included in this Statement of

Performance Expectations, however, it is not intended to be a comprehensive outline of all performance measurement activity within the organisation.

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

Reference Key			
NHT	National Health Target	**S**	Safe
NRHP	Regional target	**T**	Timely
IDP	Indicator of DHB Performance	**Efc**	Efficient
SLM	System Level Measure	**Efv**	Effective
MHP	Maaori Health Plan	**Eq**	Equitable
		P	Patient Centred

3.3.1 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.

		Baseline		2016/17 Forecast Performance		Reference
Health Promotion and Education Services						
Smoking Cessation We deliver smoking cessation advice and support in secondary and primary care and fund community based programmes to support people to become smokefree.						
Proportion of enrolled patients who smoke and are seen in General Practice are offered brief advice and support to quit		89%	Q3 2016	90%	June 2017	
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		100%		90%		
Breastfeeding **All Counties Manukau facilities are Baby Friendly Hospital Initiative (BFHI) accredited sites.**						
Percentage of infants exclusively or fully breastfeed at LMC discharge (4-6 weeks)	Total	58%	Q2 2016	75%	June 2017	MHP
	Maaori	52%				
	Pacific	53%				
Percentage of infants exclusively or fully breastfeed at 3 months	Total	46%		60%		
	Maaori	37%				
	Pacific	39%				
Percentage of infants receiving breast milk at 6 months	Total	62%		65%		
	Maaori	48%				
	Pacific	59%				
Family Violence Prevention We deliver coordination of the Violence Intervention Programme which includes training staff in adult and children's emergency department, and children's surgical and medical wards in family violence intervention and screening for partner and child abuse and neglect.						
Hospital Responsiveness to Family Violence, Child and Partner Abuse	Partner Abuse	98/100	March 2016	=>180 combined	June 2017	S

		Baseline		2016/17 Forecast Performance		Reference
Programmes Audit Score (self audit using AUT tool)[12]	Child Abuse and Neglect	99/100		score		
Immunisation Services						
We work in collaboration with immunisation providers (including general practice, outreach, school and other community settings) to deliver 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	Maaori	89%	Q3 2016	95%	June 2017	NHT NRHP MHP SLM T
	Pacific	96%				
	Total	94%				
Proportion of two year olds who are fully immunised	Maaori	91%	Q3 2016	95%	June 2017	T
	Pacific	97%				
	Total	94%				
Proportion of five year olds who are fully immunised	Maaori	69%	Q3 2016	95%	June 2017	T
	Pacific	74%				
	Total	74%				
Proportion of older people (65+) who have had their flu vaccinations+	Maaori	66%	Q2 2015/16	75%	June 2017	MHP Efv
	Total	67%				
Health Screening						
Breast Screening We provide free breast screening services for women aged 45 to 69 years old through the BreastScreen Aotearoa programme						
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months	Maaori	64%	Q3 2015/16	70%	June 2017	MHP Efv
	Pacific	75%				
	Total	66%				
Cervical Screening We fund primary care providers to deliver free cervical screening for women aged 20 – 69 years						
Proportion of women aged 20 - 69 years who have had a cervical smear in the last three years	Maaori	67%	Q3 2015/16	80%	June 2017	MHP Efv
	Pacific	80%				
	Total	74%				
Well Child/ Tamariki Ora and Children's Services We fund Well Child/ Tamariki Ora providers to deliver services to support new mothers and their infants. This includes Well Child Checks, home visits and Before School Checks (B4SC). The B4 School Check includes hearing and vision, oral health, weight and height checks. It is the final core Well Child/ Tamariki Ora check which ensures that any health problems are identified early and children are ready for learning and to reach their full potential						
Proportion of four year olds who have had their B4 School Checks		73%	Q2 2015/16	90%	June 2017	Efv

[12] The audit score is a measure of the quality of the integrated family violence and child and partner abuse programmes implemented within health services like routine enquiry and child assessments in Emergency Departments and health professional training method

3.3.2 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.

		Baseline		2016/17 Forecast Performance		Reference
Primary Health Care Services (GP)						
Long-Term Conditions Management In conjunction with our primary care and community partners we fund the delivery of targeted programmes aimed at people with high health needs due to long term conditions to reduce the incidence and impact of their conditions through early detection and intervention and better management in primary care and community care settings. These include: ▪ Early detection and intervention services such as diabetes checks and minor skin lesions surgery provided by GPs ▪ Education programmes to support patients' self-management of long term conditions ▪ Structured primary care programmes aimed at better management of individuals with chronic conditions such as the Diabetes Care Improvement Package, At Risk Individuals (ARI), Self-Management Education and the Primary Options for Acute Care						
Eligible people receiving CVD risk assessment in the last 5 years	Maaori	88%	Q3 2015/16	90%	June 2017	IDP Efv
	Pacific	92%				
	Total	92%				
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)	Maaori	61%	Q3 2015/16	69%		IDP Efv
	Pacific	58%				
	Total	67%				
Proportion of PHO enrolled population enrolled within At Risk Individuals (ARI)[13] programme		4.1%	Q3 2016	5%	June 2017	
Percentage of patients enrolled on the ARI programme who have a: ▪ Care Plan ▪ Electronic Summary Record ▪ Self-Management Assessment ▪ Named Care Coordinator		100% (19,299)	Q3 2016	80%	June 2017	Efv
Oral Health Services						
We contract the Auckland Regional Dental Service (ARDS) to deliver free oral health services for children aged 0 to 12 years old at our community and DHB based clinics and mobile dental facilities. We contract with private dentists and ARDS to deliver free oral health services for our adolescents from school year 9 up to and including 17 years of age. We deliver targeted preschool oral health promotion and brushing programmes with our partners in the kohanga reo, language nest and early childhood education sector						
Proportion of children under 5 years enrolled in DHB-funded community oral health services		76%	Dec 2015	95%	Dec 2016	IDP Efv
Proportion of enrolled preschool and school children who have not been examined at a community oral health services (within 30 days of recall date)		15%		7%	Dec 2016	IDP MHP T
Percentage of enrolled children Caries free at		49%		55%	Dec 2016	IDP

[13] Note: The ARI Programme allows for those with Chronic Conditions and complex health needs to actively manage their health in primary care in the community. This in turn leads to decreased acute admissions and avoidable mortality

		Baseline		2016/17 Forecast Performance		Reference
age 5 years						MHP
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children (12/13 years)		1.05		1.00	Dec 2016	MHP Efv
Proportion of Year 8 children who have their treatment completed and are transferred to the adolescent dental service		100%		100%	Dec 2016	IDP Efc
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services		73%	Dec 2015	85%	Dec 2016	IDP Efv
Diagnostics						
We have agreements with health care providers to provide laboratory and diagnostic services which are necessary to support management of conditions						
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	90%	March 2016	95%	June 2017	NRHP IDP T
	MRI	69%		85%		
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)		87%		85%		
Proportion of patients accepted as non-diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)		39%		70%		
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date		67%		70%		

3.3.3 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.

<table>
<tr><th colspan="4"></th><th>Baseline</th><th>2016/17 Forecast Performance</th><th>Reference</th></tr>
<tr><td colspan="7">Mental Health</td></tr>
<tr><td colspan="7">We provide and contract a matrix of comprehensive and specialist inpatient, residential or community based mental health and addiction services covering child, adolescent and youth; adult; and older adult age bands.
The matrix of services comprise:
▪ Acute and intensive services
▪ Community based clinical treatment and therapy services
▪ Services to promote resilience, recovery and connectedness</td></tr>
<tr><td>Proportion of clients with a transition discharge plan</td><td>Child and Youth</td><td>Total</td><td>86%</td><td rowspan="5">Q3 2015/16</td><td>95%</td><td>June 2017</td><td>IDP
Efv</td></tr>
<tr><td rowspan="4">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</td><td rowspan="2">Mental Health (Hospital Care Arm)</td><td>3 weeks</td><td>77%</td><td>80%</td><td rowspan="4">June 2017</td><td rowspan="4">IDP
T</td></tr>
<tr><td>8 weeks</td><td>96%</td><td>95%</td></tr>
<tr><td rowspan="2">Addictions (Hospital Care Arm and NGO)</td><td>3 weeks</td><td>82%</td><td>80%</td></tr>
<tr><td>8 weeks</td><td>86%</td><td>95%</td></tr>
<tr><td colspan="7">Elective Services</td></tr>
<tr><td colspan="7">We provide and purchase elective inpatient and outpatient services</td></tr>
<tr><td colspan="3">ESPI 2: Proportion of patients who wait longer than four months for their first specialist assessment (FSA)</td><td>0.9%</td><td rowspan="2">Q3 2015/16</td><td>zero</td><td rowspan="2">June 2017</td><td rowspan="2">T
SLM</td></tr>
<tr><td colspan="3">ESPI 5: Proportion of patients given a commitment to treatment but not treated within four months</td><td>0.4%</td><td>zero</td></tr>
<tr><td colspan="3">Number of Elective Surgical Discharges</td><td>105%</td><td>Q3 2015/16</td><td>20,395</td><td>June 2017</td><td>NHT</td></tr>
<tr><td rowspan="3">Elective Services Standardised Intervention Rates (SIRs) per 10,000 of population14</td><td colspan="2">Major joints</td><td>22.69</td><td rowspan="3">Q3 2015/16</td><td>21</td><td rowspan="3">June 2017</td><td rowspan="3">IDP
Eq</td></tr>
<tr><td colspan="2">Cardiac Surgery</td><td>5.65</td><td>6.5</td></tr>
<tr><td colspan="2">Cataracts</td><td>32.23</td><td>27</td></tr>
<tr><td rowspan="2">Outpatient Did Not Attend (DNA) rates</td><td colspan="2">Maaori</td><td>12%</td><td rowspan="2"></td><td>10%</td><td rowspan="2">June 2017</td><td rowspan="2">P
Efc</td></tr>
<tr><td colspan="2">Pacific</td><td>11%</td><td>10%</td></tr>
<tr><td colspan="7">Acute Services</td></tr>
<tr><td colspan="7">We provide an emergency and acute care service with the following characteristics:
▪ Timely access to all service components (including diagnostics) and appropriate timely discharge
▪ Capacity to meet needs
▪ Right treatment in the right place
▪ Timely patient transfer to appropriate services from Emergency Department</td></tr>
</table>

[14] The SIRs target rates reflect equitable levels of access to elective surgery

			Baseline		2016/17 Forecast Performance		Reference
▪ Good access to support services in the community or primary care level to support patient recovery							
Readmissions Acute readmissions to hospital[15]		Total	7.6%	Q3	TBC	June 2017	IDP SLM Efv
		75+	9.8%				
Acute Inpatient Average Length of Stay[16]			2.58 days	Q3 2015/16	2.60 days	June 2017	IDP Efv
Emergency Department Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours			95%	Q3 2015/16	95%	June 2017	NHT SLM T
Cancer Services We work in collaboration with the Northern Region Cancer Network to improve cancer wait times and access to diagnosis and treatment to ensure cancer patients and their families have access to good information about support services available							
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	Radio-therapy	Maaori	100%	Q3 2015/16	100%	June 2017	NRHP T
		Pacific					
		Total					
	Chemo-therapy	Maaori	100%		100%		
		Pacific					
		Total					
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			69%	Q3 2015/16	90%	June 2017	NHT IDP T
Cardiac Services We provide intensive treatment and assessment services for patients with cardiovascular disease							
Proportion of all outpatients triaged to chest pain clinics who are seen within 4 weeks for cardiology assessment and stress test[17]			100%	March 2016	80%	June 2017	T
Proportion of outpatient coronary angiograms with a waiting time of < 3 months			99%	March 2016	95%	June 2017	NRHP IDP T
Proportion of patients presenting with an acute coronary syndrome who are referred for angiography and receive it within 3 days of admission			72%	March 2016	70%	June 2017	NRHP T
Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions (PCI) who receive this within 120 minutes			76%	March 2016	80%	June 2016	NRHP T

3.3.4 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.

[15] Unplanned acute readmissions to hospital can occur as a result of the care provided by the health system, related to inadequate length of stay, and puts pressure on hospital resources. Reducing unplanned hospital readmissions can be interpreted as an indication of improving quality of acute care in the hospital and/or the community

[16] As stated above, inadequate length of stay can lead to increased readmission. Optimal inpatient LOS ensures patients receive sufficient care to avoid readmission

[17] The 4 week target is for CM Health whilst the Regional target is 6 weeks

	Baseline		2016/17 Forecast Performance		Reference
Needs Assessment and Service Coordination (NASC)					
We provide timely access to assessment, treatment and support services for older people with complex health needs. We provide information and support to older people and their carers about community support options.					
Percentage of Complex Patients seen within five (5) working days of referral for a home care assessment	New reporting methodology-baseline to be established		65%	June 2017	Efv
Percentage of Non-Complex Patients seen within fifteen (15)working days of referral for a contact assessment	56.6%	Q3 2015/16	70%	June 2017	Efv
Assessment, Treatment and Rehabilitation Services					
We provide readily accessible Assessment, Treatment and Rehabilitation Services (AT & R) both within the hospital and in the community.					
Percentage of identified fragility fracture patients presenting in secondary care will be investigated and offered interventions to prevent second fragility fracture	New baseline to be established		90%	June 2017	Efv
Number of older people referred through the Fracture Liaison Service to a community strength and balance programme who participated in the programme	New baseline to be established		50%	June 2017	Efv
Age Related Residential Care (ARRC)					
We provide access to ARRC based on assessed need We support ARRC staffing through nursing and Geriatrician Specialist education/advice					
Number of potentially avoidable ED presentations from ARRC per month[18]	13	Q3 2015/16	<15	June 2017	Efv
Percentage of people in ARRC who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of previous assessment	73%		95%	June 2017	
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	64%		95%	June 2017	
Home Based and Community Support					
We improve Home Based Support by: Promoting the use of the InterRAI tool to ensure people who need home based support services receive them in a consistent way					
Proportion of CM Health NASC clients receiving Home Based Support Services who have a comprehensive interRAI assessment completed at any time prior	93%	Q3 2015/16	90%	June 2017	T
Percentage of current clients receiving long term HBSS that have an interRAI clinical assessment within the previous 24 months	91%		65%	June 2017	

[18] Fewer ED presentations from ARC should result from effective services put in place to support ARRC like specialist input into ARRC, enhanced access to assessment and intervention within ARRC, including diagnostics and point of care testing, and consistent access to in and after hours acute assessment and treatment

3.3.5 Maaori Health Plan Indicators

			Baseline		2016/17 Forecast Performance		Reference
National Indicators							
Percentage of general practices in 2 CM Health PHOs who have completed the 3 stages of EDAT			99%	Q3 2015/16	100%	June 2017	MHP
Percentage of Maaori enrolled in PHOs			95%	Q3 2015/16	100%	June 2017	MHP
Ambulatory Sensitive Hospitalisation rates per 100,000 population	Age 0-4	Maaori	6,811 per 100,000	Q3 2015/16	5,650 per 100,000	June 2017	MHP
		Total	7,348 per 100,000		N/A		
	Age 45-64	Maaori	8,457 per 100,000		6,029 per 100,000		
		Total	4,547 per 100,000		N/A		
Breastfeeding – refer output table 3.2.1							
Cervical Screening - refer output table 3.2.1							
Breast Screening – refer output table 3.2.1							
Percentage of women who are smokefree at 2 weeks postnatal		Maaori	53%	Dec 2014	95%	June 2017	MHP
		Total	71%				
Immunisation (Tamariki) – refer output table 3.2.1							
Acute rheumatic fever first hospitalisations rates per 100,000 population		Maaori	8.5 per 100,000	2015/16	No target[19]	June 2017	MHP
		Total	6.0 per 100,000		4.5 per 100,000		
Oral Health – refer output table 3.3.2							
Mental Health Act: Section 29 Indefinite CTO rates per 100,000 population		Maaori	132 per 100,000	Q3 2015/16	No target[20]		MHP
		Total	50 per 100,000				
SUDI deaths per 1,000 live births		Maaori	2.13 (1.38 – 3.14)	2010-14[21]	0.4	June 2017	MHP
		Total	0.96 (0.69 – 1.30)				
Percentage of caregivers provided with SUDI prevention information at WCTO Core Contact 1		Maaori	58%	Q2 2015/16	100%[22]	June 2017	MHP
		Total	62.7%				
Local Indicators							
CVD - refer output table 3.3.2							
Percentage of CM Health employees who are Maaori		Whole organisation	6.8%	Q3 2015/16	8%	June 2017	MHP
		Hospital Directorate	7.2%				
Percentage of rangatahi accessing Alcohol Brief Interventions (via general practice)		Maaori	0.3%	Q2	0.5%	June 2017	MHP
Percentage of rangatahi accessing Mental Health Brief Interventions (via general practice)		Maaori	0.1%	Q2	0.4%		

[19] No target for Maaori, total population target only
[20] No targets set by MOH for 2016/17
[21] Five year annualised data. Source: MOH
[22] MOH target is 70 percent, CM Health local target is 100 percent

4.0 Financial Performance

4.1 Introduction

4.1.1 Tightening financial position

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. As a result, increasingly tough decisions have been made and will continue to be required to maintain access in a time of having to reprioritise spending to achieve transformational change within our strategic shape.

Consistent with our Healthy Together strategy is prioritised upfront investment (capital, operational and resources) in our clinically endorsed services and Information and Communications Technology (ICT) innovations to enable more sustainable and effective long-term models of care and configuration of resources. In parallel, CM Health is working closely with the National Health IT Board and Ministry of Health in the critical need for a fully integrated end-to-end patient focused information system that will enable change across the whole health sector at a scale not possible today. However, whether this is a national, regional or local solution, it must be affordable, achievable and sustainable. This will support CM Health's clinical leaders to drive cross-sector improvement in prioritised areas at pace consistent with new models of care and continued health system integration ambitions through our Healthy Together transformational programmes and district Alliance support.

We are committed to achieving a small surplus financial position for 2016/17. While the outer years are anticipated to be increasingly challenging, CM Health is focused on transformational change, continuous improvement, innovation and constrained cost growth as a way of living within our means.

4.1.2 Cost structure changes to enable integration

CM Health has four geographically based localities as our platform to invest further in "whole of system" integration under our overarching Healthy Together strategy. The Integrated Care portfolio contains a number of initiatives to enable us to advance integration of community and hospital based care alongside our intersectoral partners. Our three strategic objectives provide the framework for enabling better community, patient, whaanau and family outcomes, improved experience of care and value for the health dollar.

The At Risk model of care is now well embedded within Counties Manukau. This model supports a primary care led, planned and proactive approach to long term condition care and we are now growing this philosophy of care more broadly across frail elderly, mental health and child health and strengthening our approach to self-management to improve outcomes for a broader group of people. This programme will receive an ongoing additional $600k on top of the current $5m.

The Board has approved our Community Health Services Integration programme , a multi-facetted initiative investing how community and hospital teams of nurses and allied health personnel are deployed and managed, including transitioning skill sets to better meet the patient's holistic and reablement needs with prompt access to specialist services when required. This will require extensive investment in technology, change management and workforce management. The planned operating cost of $4.6m over the current year will be ongoing. Concurrent capital investment programme work is in progress to establish six Community Hubs to support this model into the future.

Creating capacity in general practice is crucial to enable patients to be managed in the community in a more sustainable manner rather than further burdening hospital resources. The Enhancing Primary Care initiative will better equip general practice via technology, lean thinking and service model delivery changes to be more efficient and provide better care. This will require initial 2016/17 operating investment of $500k with more capital investment still to be determined.

As a result, part of the process to achieve this requires the hospital and primary & community arm teams working together to align operational and investments commitments with a stronger emphasis on primary and community care to slow the demand growth in hospital services.

4.2 Forecast Financial Statements

4.2.1 Summary by funder

Net Result	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Hospital arm	(6,238)	(11,964)	(19,879)	(20,523)	(21,167)	(21,811)
Governance	(2,769)	(392)	(2,501)	(2,583)	(2,665)	(2,747)
Primary & community	12,024	15,226	26,880	27,660	28,442	29,230
Eliminations	-	-	-	-	-	-
Operating Surplus	3,017	2,870	4,500	4,554	4,610	4,672
Other Comprehensive Income	36,857	45,400	-	-	-	-
Surplus (deficit)	**39,874**	**48,270**	**4,500**	**4,554**	**4,610**	**4,672**

4.2.2 Statement of comprehensive income

Net Result	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Revenue						
Crown	1,366,927	1,395,478	1,447,074	1,493,010	1,539,890	1,586,799
Other	137,118	143,985	149,470	154,316	159,161	164,010
Total Revenue	**1,504,045**	**1,539,463**	**1,596,544**	**1,647,326**	**1,699,051**	**1,750,809**
Expenses						
Personnel	548,674	564,665	595,211	613,939	633,217	652,507
Outsourced	68,931	72,651	79,385	81,959	84,531	87,105
Clinical Sup.	110,901	113,865	105,502	108,507	111,914	115,323
Infrastructure	68,903	65,203	76,718	79,204	81,690	84,177
Personal Health	479,044	483,756	474,084	489,551	505,012	520,478
Mental Health	56,353	60,209	74,520	76,934	79,346	81,761
Disability Support	109,207	111,598	116,736	120,523	124,309	128,096
Public Health	1,345	2,577	1,236	1,276	1,316	1,356
Maaori	1,456	452	1,080	1,115	1,150	1,185
Operating Costs	**1,444,814**	**1,474,976**	**1,524,472**	**1,573,008**	**1,622,485**	**1,671,988**
Operating surplus	**59,232**	**64,487**	**72,072**	**74,318**	**76,566**	**78,821**
Depn.	28,435	30,637	34,728	35,855	36,982	38,109
Capital Chg.	15,273	18,510	18,144	18,732	19,320	19,909
Interest	12,506	12,470	14,700	15,177	15,654	16,131
Operating Surplus	**3,017**	**2,870**	**4,500**	**4,554**	**4,610**	**4,672**
Other Comprehensive Income	36,857	45,400	-	-	-	-
Surplus (Deficit)	**39,874**	**48,270**	**4,500**	**4,554**	**4,610**	**4,672**

4.2.3 Primary & community

Net Result	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Crown	1,411,026	1,433,837	1,494,852	1,542,338	1,590,767	1,639,227
Other	637	6,228	1,188	1,227	1,266	1,305
Total	**1,411,663**	**1,440,065**	**1,496,040**	**1,543,565**	**1,592,033**	**1,640,532**
Personal Health	1,099,981	1,115,813	1,145,160	1,181,399	1,218,582	1,255,785
Mental Health	139,190	143,970	157,872	162,989	168,104	173,223
Disability Support	142,299	145,098	150,456	155,337	160,217	165,098
Public Health	1,345	2,577	1,236	1,276	1,316	1,356
Maaori	1,456	452	1,080	1,115	1,150	1,185
Governance	15,368	16,929	13,356	13,789	14,222	14,655
Total Expenditure	1,399,639	1,424,839	1,469,160	1,515,905	1,563,591	1,611,302
Net Surplus	**12,024**	**15,226**	**26,880**	**27,660**	**28,442**	**29,230**

4.2.4 Eliminations

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Crown	(752,917)	(766,247)	(801,504)	(826,506)	(852,458)	(878,426)
Other						
Total	**(752,917)**	**(766,247)**	**(801,504)**	**(826,506)**	**(852,458)**	**(878,426)**
Personal Health	(621,620)	(632,057)	(671,076)	(691,848)	(713,570)	(735,307)
Mental Health	(82,837)	(83,761)	(83,352)	(86,055)	(88,758)	(91,462)
Disability Support	(33,092)	(33,500)	(33,720)	(34,814)	(35,908)	(37,002)
Public Health	-	-	-	-	-	-
Maaori	-	-	-	-	-	-
Governance	(15,368)	(16,929)	(13,356)	(13,789)	(14,222)	(14,655)
Total Expenditure	**(752,917)**	**(766,247)**	**(801,504)**	**(826,506)**	**(852,458)**	**(878,426)**
Net Surplus	**-**	**-**	**-**	**-**	**-**	**-**

4.2.5 Hospital care

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Crown	795,145	811,895	844,902	871,311	898,670	926,046
Other	33,497	35,889	43,479	44,888	46,297	47,707
Total	**828,642**	**847,784**	**888,381**	**916,199**	**944,967**	**973,753**
Personnel	539,450	554,003	583,571	601,921	620,821	639,733
Outsourced	68,120	71,645	78,449	80,993	83,535	86,079
Clinical Sup.	112,727	113,585	105,094	108,086	111,480	114,876
Infrastructure	58,368	58,898	73,574	75,958	78,342	80,727
Operating Costs	**778,665**	**798,131**	**840,688**	**866,958**	**894,178**	**921,415**
Operating surplus	**49,977**	**49,653**	**47,693**	**49,241**	**50,789**	**52,338**
Depreciation	28,435	30,637	34,728	35,855	36,982	38,109
Capital Charge	15,274	18,510	18,144	18,732	19,320	19,909
Interest	12,506	12,470	14,700	15,177	15,654	16,131
Net Surplus	**(6,238)**	**(11,964)**	**(19,879)**	**(20,523)**	**(21,167)**	**(21,811)**
Other Comprehensive Income	36,857	45,400	-	-	-	-
Total Comprehensive Income	**30,619**	**33,436**	**(19,879)**	**(20,523)**	**(21,167)**	**(21,811)**

4.2.6 Governance

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Crown	15,368	16,929	13,644	14,086	14,528	14,970
Other	987	932	(17)	(18)	(19)	(20)
Total	**16,355**	**17,861**	**13,627**	**14,068**	**14,509**	**14,950**
Personnel	9,224	10,662	11,640	12,018	12,396	12,774
Outsourced	1,194	1,006	936	966	996	1,026
Clinical Sup.	-	280	408	421	434	447
Infrastructure	8,706	6,305	3,144	3,246	3,348	3,450
Total Expenditure	**19,124**	**18,253**	**16,128**	**16,651**	**17,174**	**17,697**
Net Surplus	**(2,769)**	**(392)**	**(2,501)**	**(2,583)**	**(2,665)**	**(2,747)**

4.2.7 Balance sheet

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Current Assets						
Cash and Bank	56,138	32,677	40,075	17,950	59,573	78,017
Debtors	46,019	50,335	49,135	47,935	46,735	45,535
Inventory	1,320	1,468	1,468	1,468	1,468	1,468
Assets Held for Sale	12,503	-	-	-	-	-
Current Assets total	**115,980**	**84,480**	**90,678**	**67,353**	**107,776**	**125,020**
Non-Current Assets	664,720	731,551	745,932	776,404	771,784	766,805
Total Assets	**780,700**	**816,031**	**836,610**	**843,757**	**879,560**	**891,825**
Current Liabilities						
Creditors	109,686	103,680	162,891	162,891	132,890	228,089
Loans	-	5,000	(35,000)	(35,000)	(20,000)	(67,600)
Employee Provisions	122,645	116,293	126,774	132,174	137,575	142,976
Total Current Liabilities	**232,331**	**224,973**	**254,665**	**260,065**	**250,465**	**303,465**
Working capital	**(116,351)**	**(140,493)**	**(163,987)**	**(192,712)**	**(142,689)**	**(178,445)**
Net Funds Employed	**548,369**	**591,058**	**581,945**	**583,692**	**629,095**	**588,360**
Non-Current Liabilities						
Employee Provision	16,888	17,141	23,909	26,509	29,109	31,709
Term Loans	292,500	287,500	267,500	262,500	301,100	253,500
Restricted funds	882	873	911	923	935	947
Other	1,337	931	931	931	931	931
Total Non-Current Liabilities	**311,607**	**306,445**	**293,251**	**290,863**	**332,075**	**287,087**
Crown Equity	**236,762**	**284,613**	**288,694**	**292,829**	**297,020**	**301,273**
Net Funds Employed	**548,369**	**591,058**	**581,945**	**583,692**	**629,095**	**588,360**

4.2.8 Movement of equity

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Total Equity at beginning of period	**198,173**	**237,644**	**285,486**	**289,567**	**293,702**	**297,893**
Surplus / (Loss) for period	3,017	2,870	4,500	4,554	4,610	4,672
Crown Equity injection	-	-	-	-	-	-
Crown Equity withdrawal	(419)	(419)	(419)	(419)	(419)	(419)
Revaluation Reserve	36,873	45,391	-	-	-	-
Total Equity at end of period	**237,644**	**285,486**	**289,567**	**293,702**	**297,893**	**302,146**

4.2.9 Cash flows from operating activities

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Operating Activities						
Crown Revenue	1,341,443	1,491,442	1,551,177	1,602,429	1,652,707	1,703,017
Other	129,612	39,694	30,518	31,507	32,496	33,486
Interest rec.	3,043	3,355	2,004	2,069	2,134	2,199
Suppliers	(871,048)	(909,608)	(922,439)	(968,578)	(964,107)	(993,560)
Employees	(533,592)	(574,518)	(587,174)	(605,939)	(625,216)	(644,506)
Interest paid	(12,506)	(12,470)	(14,700)	(15,177)	(15,654)	(16,131)
Capital charge	(15,273)	(19,225)	(17,819)	(18,732)	(19,320)	(19,909)
GST (Net)	(2,784)	1,250	-	-	-	-
Net cash from Operations	**38,895**	**19,920**	**41,567**	**27,579**	**63,040**	**64,596**
Investing activities						
Sale of Land and Buildings	-	-	-	-	-	-
Total Fixed Assets	(26,572)	(34,652)	(38,796)	(39,309)	(39,622)	(40,757)
Investments and Restricted & Trust Funds	(2,299)	(8,323)	(4,966)	(4,988)	(4,988)	(4,988)
Net cash from Investing	**(28,871)**	**(42,975)**	**(43,762)**	**(44,297)**	**(44,610)**	**(45,745)**
Financing						
Crown Debt	24,900	-	10,000	(5,000)	23,600	-
Equity - Capital	(419)	(419)	(419)	(419)	(419)	(419)
Net cash from Financing	**24,517**	**(419)**	**9,581**	**(5,419)**	**23,181**	**(419)**
Net increase / (decrease)	34,537	(23,474)	7,386	(22,137)	41,611	18,432
Opening cash	20,715	55,252	31,778	39,164	17,027	58,638
Closing cash	**55,252**	**31,778**	**39,164**	**17,027**	**58,638**	**77,070**

4.2.10 Capital expenditure

	2014/15 Audited Actual $000	2015/16 Actual $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Baseline Capital	25,580	34,650	31,880	35,850	36,980	38,100
Strategic Capital (see note 1 below)	-	-	26,830	34,200	-	-
Sub Total	**25,580**	**34,650**	**58,710**	**70,050**	**36,980**	**38,100**
Strategic Capital (unapproved)	-	-	3,990	11,950	12,330	12,700
Total (see note 2 below)	**25,580**	**34,650**	**62,700**	**82,000**	**49,310**	**50,800**

Note 1: Includes $55M Mental Health development, $20M pre-approved from Crown funding.

Note 2: The above table reflects reinvestment of depreciation together with an additional 25% investment in strategic capital. NOTE that the additional investment signalled in Scenario 3 of the Long Term Investment Plan will require significantly greater capital investment over the 6 year period to 2021/22. This includes initial investment in the Specialised Rehabilitation and Living Well Centre development planned to commence in 2018/19.

4.3 Accounting Policies

The 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 4.6.

4.4 Significant Assumptions

4.4.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2016/17 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 small surplus 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.

4.4.2 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 average national Agreement were settled at around 2 percent for 2016/17, overall personnel cost increase is about 3.5 percent – 4.5 percent due to automatic ongoing step functions, on-cost implications and increasing entitlements. Combined, these largely nationally set Agreement costs are greater than the Crown Funding growth and will 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.

4.4.3 Third party and shared services provision

Our focus for 2016/17 continues to be alignment of localities development and related primary care/community based capital investment and services (e.g. community hubs and community technology platform). 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.

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.

4.4.4 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.

4.4.5 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. CM Health contributes to the regional Better Sooner More Convenient business cases through an expanded investment in Primary Options for Acute Care (POAC) and Access to Diagnostics to better manage significant volume pressures through more effective service access in the community.

The continuing committed (albeit constrained) investment in priority initiatives aligned with the Northern Region Health Plan, including those focused on lessening the growth of hospital services and improving quality clinical outcomes.

4.4.6 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.

4.4.7 Enabling technology infrastructure

Prioritised Information System (IS) infrastructure (technology) investment has been agreed regionally (refer section 5.2.4) 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 and has been endorsed as a strategic priority by the CM Health Board. This investment will target IS infrastructure resilience that will provide a sound foundation for shared clinical and business information systems. Refer to section 5.2.3 for an outline of regional IS investments and local innovations.

The net financial impacts will include both capital and operational costs.

4.4.8 Capital investment

CM Health recognises the need 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. In line with this, forecast inpatient bed capacity expansion investments will continue to be deferred to prioritise investment in primary and community services integration and expansion to mitigate forecast requirements. In order to manage risks due to potential lag time, likely future requirement for (reduced scale) inpatient hospital bed expansion will be managed as a contingency investment in order to maintain the focus and prioritisation on health system change.

The changing Crown funding forecasts from 2016/17 onwards have required a reassessment of local capital investment prioritisation. Figure 6 below outlines likely major capital investment projects, recognising that this is subject to confirmation by the Counties Manukau District Health Board, MOH and Treasury through submission of indicative and detailed business cases in addition to related local and regional IS and other capital planning processes.

A new 76-bed acute mental health facility was approved in the 2015/16 year, detailed design and construction continuing through 2016/17.

Figure 7: Major capital investment projects – approved and unapproved

Project	Budgeted Approval	Project Finish Date	Indicative Value ($m)	Status
Acute Mental Health Inpatient Unit	2014/15	2017/18	55	Construction progressing
Laboratory Services Fit Out	2014/15	2016/17	14	Construction progressing
Technology platform and services to support integrated care & hospital efficiencies	2015/16	2025/26	105	Business case development
Car Parking (strategic partnering and risk sharing arrangement)	2016/17	2017/18	20	Business case development
Community Hubs & Services (blend of DHB and private developments)	2016/17	2019/20	138	Business case development
Specialised Rehabilitation & Living Well Centre (including Spinal Unit)	2016/17	2019/20	115	Business case development
Middlemore Building Re-Cladding	2016/17	2020/21	17	Business case development
Manukau Site Infrastructure	2016/17	2018/19	43	Strategic Assessment
Manukau Radiology Hub - Stage 1	2016/17	2018/19	22	Strategic Assessment
Manukau Support Services	2016/17	2021/22	32	Strategic Assessment
Middlemore Radiology Fit Out	2016/17	2018/19	16	Strategic Assessment
Elective Surgery Expansion	2017/18	2019/20	238	Strategic Assessment

Project	Budgeted Approval	Project Finish Date	Indicative Value ($m)	Status
Northern Electronic Health Record	2017/18	2025/26	382	Business case development
Single Wing Ward Block	2018/19	2021/22	43	Subject to LTIP update
Manukau Radiology Hub - Stage 2	2019/20	2021/22	12	Subject to LTIP update
New Women's Health Building	2019/20	2022/23	72	Subject to LTIP update
Harley Gray Stage 2	2020/21	2022/23	80	Subject to LTIP update
Manukau Education & Training	2020/21	2022/23	58	Subject to LTIP update
Manukau Building Re-Cladding	2021/22	2022/23	11	Subject to LTIP update

Note: (i) Long Term Investment Plan (LTIP) will be updated every 1-2 year; (ii) Individual projects over $10m estimated capital investment (with estimated inflation) only are included in this table; (iii) Annual capital investments to replace and/or maintain equipment and facilities is excluded in this table but incorporated in the financial statements; (iv) Some capital costs outlined above are highly 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; (v) Northern Region Electronic Health Record phasing and investment requirements will be clarified as part of a regional scoping project.

4.4.9 Capital investment funding

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

4.4.10 Banking

CM Health operates under no banking covenant, with all its term debt facilities transitioned fully across to Ministry of Health (MOH). The Board maintains a working capital facility with New Zealand Health Partners via Westpac which is the only relationship falling under this remaining covenant, together with lease/finance facilities with both Commonwealth Bank and Westpac.

Figure 8: Banking facilities

Facilities	Existing Limit $000,000	Utilisation at 30 June 2013 $000,000	Available Facility at 1 July 2015 $000,000
Crown Debt	$322.5	$292.5	$30.0
NZHP / Westpac (working capital)	$69.9	-	$69.9
Westpac (lease facility)	$10.0	-	$10.0
Commonwealth Bank (lease facility)	$10.0	-	$10.0

4.4.11 Property, plant and equipment

We revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. CM Health land and buildings are revalued every three years. The last revaluation occurred in 2014 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 2016/17 (refer section xx for further detail).

4.5 Additional Information and Explanations

4.5.1 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.

4.6 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 20% and 50% 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.

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 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 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 revenue and expense 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 revenue and expense 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 will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

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 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 9: 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 Health Benefits Limited (HBL), 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 HBL 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 revenue and expense 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 revenue and expense 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 sabbatical 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 as incurred.

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 two years up to a specified maximum amount. At the end of the two-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 as approved by the 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.

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 are disclosed in note 13.
- 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 and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets
- Asset replacement programs
- Review of second-hand market prices for similar assets; and
- Analysis of prior asset sales

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

Retirement and long service leave

Note 17 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

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 determined a number of lease arrangements are 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 and these DHBs will then reimburse Counties Manukau DHB for the costs of the services provided in their districts. Where Counties Manukau 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's financial statements.

5.0 Stewardship

5.1 Managing our Business

CM Health has an established and robust Board governance, oversight and management structure to meet our responsibilities to plan, provide, purchase and manage performance of health services for the Counties Manukau population. This section outlines how we organise our resources and systems in a manner that promotes best use of public health funding to deliver planned services.

As a District Health Board (DHB), we must balance government financial and non-financial targets and priorities alongside our own district's population health needs and the community's expectations about priorities for health, within our available funding.

5.1.1 Governance

The Counties Manukau District Health Board provides governance and ensures that Counties Manukau DHB fulfils its statutory functions in the use of public resources. Whilst the Board maintains overall responsibility for the DHB's performance, operational and management matters are assigned to the Chief Executive.

Our Board and Chief Executive are supported at all levels of strategic and operational decision making by the Executive Leadership Team (ELT) of clinical and managerial leaders, Clinical Governance Group and range of advisory networks and committees.

All newly appointed Board members are provided with training on what their responsibilities are in relation to performance management and in accordance with the New Zealand Public Health and Disability Act 2000 (NZPHD Act 2000) and every member of the Board must receive Tikanga Maaori training.

CM Health clinical leadership is integrated with regional governance groups and associated regional work plans. The regional clinical networks have representation from each DHB and are clinically led. For example, any issues raised at a regional network or DHB level are communicated and managed back through the DHB leadership fora. Clinical leadership is also integrated at an executive level in relation to major capital investments. This integrated leadership approach is a critical approach to ensure dual attention to financial and clinical sustainability.

At a local level, health system accountability and responsibilities have been structured to reflect the integrated way we work. The following oversight groups are in place:

- Alliance Leadership Team – this is an alliance of Primary Health Organisation (PHO) and CM Health executive clinical and managerial leaders
- Integrated Care Clinical Governance Group – clinician advice and oversight for Primary and Community, the integrated care strategic programme and related initiatives across the district
- Clinical Governance Group – clinician and managerial advice and oversight with a hospital services focus
- Community and Hospital Management Integration Team – clinical and managerial advice and oversight forum to enable whole of system discussion and advice to ELT

In recognition of our more integrated governance and service delivery structures we now reference our collective district services as Counties Manukau Health (CM Health). All official and legally binding documents will also contain our legal name of Counties Manukau District Health Board (Counties Manukau DHB).

5.1.2 Performance management

The Healthy Quality Safety Commission's 'Triple Aim' of improving population health, patient experience and delivering better value for money shapes our performance management framework.

Firstly, 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 sub-committees, i.e. the Hospital Advisory Committee (HAC) and Community and Public Health Advisory Committee (CPHAC) and others.

Secondly, as our locality developments start to take hold, we are developing a more integrated performance management framework to reflect the greater sharing of accountability for population health outcomes with our primary care alliances.

Building on our current measurement framework, and as part of the 2016/17 planning process, we have started to consider what a measurement framework would look like with our new healthy equity strategic goal. Refer to section

1.3.5 for a summary of how we measure our performance and plans to evolve this in line with our health equity strategic goal.

5.1.3 Financial management

The Minister of Health and Ministry of Health have indicated constrained funding increases for 2016/17 and beyond which will require a highly effective and efficient financial planning and management system. Due to combined impacts of increased health service demand and indicative revenue increases that are less than what is anticipated to maintain operations, the financial management challenges over the next three years represent a significant and unprecedented challenge for CM Health.

The major driver of cost increases continues to be the total clinical wages impact, which inclusive of the automatic step functions, is double our funded cost growth. Acknowledging the significant fiscal challenges the whole health sector is facing, we are committed to achieving a small surplus financial position for 2016/17, while committed to achieving our national health targets and other priorities.

Our objective is to maintain a secure and balanced financial position. We are working to meet these financial challenges in a positive manner through national and regional collaboration, working in partnership with healthAlliance and NZ Health Partnerships Ltd to leverage aggregated savings and efficiency benefits and local system level accountability for financial and non-financial performance.

We remain focused on our many service improvement and savings opportunities but are concerned regarding the ability to achieve the increasingly material level of indicative savings required within timeframes, cost saving levels and available resources.

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, funding providers requires a commercial approach to ensure our non-government organisation (NGO) providers remain viable.

Within this plan, CM Health financial projections are fully reconciled to the latest information from the joint Northern Region plans over the next three years for enhanced procurement benefits arising from the Northern Region ownership of healthAlliance. Albeit at a forecast continuing lower level than previous years, as the procurement benefits become more marginal.

Refer to section 4.0 for details of how the funding envelope will be allocated and related service volumes managed.

5.1.4 Risk management

Managing risk is the responsibility of everyone across CM Health. To ensure that risks are managed consistently in the right place, at the right time, we need a risk framework that enables comprehensive, transparent and effective risk management.

In 2015 we refreshed our existing risk management framework to improve risk maturity. This resulted in a simplified risk assessment matrix, integration of health and safety alongside our clinical and corporate risks within the same target operating model. The refreshed operating model has enhanced allocation of responsibility for identifying and managing risk across the organisation. Operational processes and expectations are outlined in our refreshed policy, procedures and key committee terms of reference that describe risk management responsibilities from operational leadership through to oversight groups.

Risk management is a journey with CM Health committed to improving risk maturity and continuous improvement.

5.2 Building Capability

Quality improvement and patient safety processes, workforce, information and technology services, information intelligence, assets, and other infrastructure are all critical enablers to deliver our strategic goals and effect national and regional collaboration.

Building capability in an environment of transformational change requires more than alignment of typical enablers. It needs a strategic approach to change management and transparency of investment prioritisation to optimise outcomes. Based on our strategic priorities, capability building is centred on the following systems, each benefiting from local, regional and national initiative alignment. An example of transformation change capability building is reflected in the delivery and offering of master classes such as the Innovation Intensive, Improvement Science in Practice, Quality Academy and Patient Safety Intensive.

Figure 10: High Level Summary of Capability Drivers and Related Plans

Quality, Safety and Experience	Delivering excellence while being sustainable requires integration of quality and safety from the campaign/initiative stages into business as usual	**CM Health** ▪ Hospital services 'Aiming for Zero Patient Harm' initiatives ▪ Safety in Practice collaborative ▪ Reducing harm from pressure injuries ▪ Ko Awatea led patient experience week **Regional** National Health Quality & Safety Commission Quality & Safety Marker priority areas: ▪ Falls ▪ Hand hygiene ▪ Safe surgery ▪ Surgical site infection ▪ Medication safety
Service Innovation	See xx for the CM Health approach to implementation	**CM Health** ▪ Integrated Care Programme including initiatives led by Ko Awatea such as the Manaaki Hauora – Supporting Wellness ▪ Health Equity Campaign ▪ Patient and Whaanau Centred Care Consumer Council ▪ Faster Cancer Treatment collaborative to redesign service delivery and per ▪ Fanau Ola and Whaanau Ora approaches in community services **Regional** ▪ Better Sooner More Convenient (BSMC) business cases, e.g. Care Pathways, Primary Options for Acute Care etc., Whaanau Ora ▪ Ko Awatea provides initiative support through faculty programmes with development and methodology for (e.g. coaching support, master classes, change workshops) ▪ Early Childhood Education Ko Awatea and Ministry of Education ▪ Well Child Tamariki Ora **National** ▪ Shared services, supply chain and procurement ▪ Leading the National Partners in Care Programme
Information Technology and Information Intelligence	Essential requirement for health system transformation and building capability in non-traditional service approaches in order to enable future health system sustainability	**CM Health** ▪ Technology Enabled Change investments ▪ Integrated business information **Regional** ▪ Refer section 1.3.3 for Northern Region initiatives
Capital Investment	How and where health information is accessed, data analyses combined with hard infrastructure – these are critical clinical and service enablers	**CM Health** ▪ Long Term Investment Plan priority investments to enable health system transformation in the community ▪ Enterprise Asset Management System to maximise use of the assets we have and need for the future **Regional** ▪ Regional Capital Group ▪ National Infrastructure Platform ▪ Procurement and Supply Chain

5.2.1 Capital and infrastructure development

Integrated infrastructure (Investment) planning is a function within asset and capital management. This integrated approach was implemented in 2014 to enable transparent strategic investment decision-making to deliver affordable infrastructure solutions across our whole health system in an environment of increasing demands for better services and constrained budgets.

The Integrated Infrastructure (Investment) Planning Steering Group provides advice to the Executive Leadership Team on strategic infrastructure investments. This group comprises executive, clinical management and financial leaders that provide advice and support for the following:

- District wide spatial master planning, prioritisation and affordability
- Annual (facilities and ICT) capital investment prioritisation including major building maintenance, upgrades and renewals
- Strategic investment projects from business case through to post-implementation benefits realisation

Annual capital prioritisation and submission is managed by an Asset and Capital Committee. The substantive focus is on replacement and new clinical and non-clinical equipment.

5.2.2 Asset management

CM Health embarked on implementing an Enterprise Asset Management (EAM) System two years ago and is currently implementing a hosted solution through providers Certus using Maximo as the system software. We are implementing this across a number of fronts within our operation, having first spent considerable time refining the processes.

The EAM System will allow CM Health to use information from the current processes in making strategic, financial and operational decisions on asset replacement and effective remaining life. This strategic asset management approach is particularly important with due cognisance of limited capital capacity and rapid changes of technology facilitating more robust business cases and balancing between pursuit of new technology and capacity against an extended or shortened effective life of a current asset.

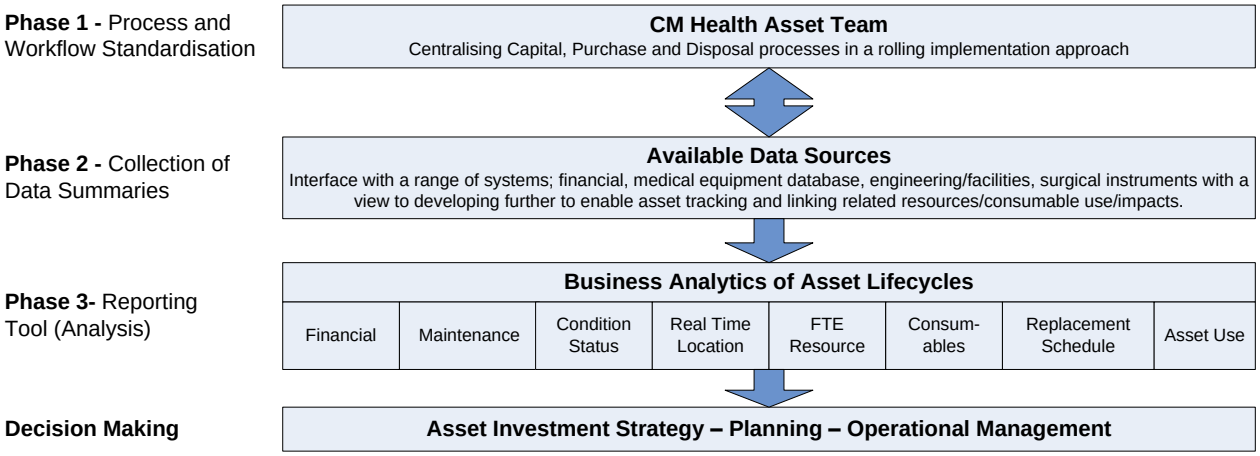
Phase 1 development is now complete and we are in the operational implementation phases. These are:

- CAPEX Process - support the Capital Purchase Process
- Disposal Process - regular equipment and asset disposal
- Work order - provide a single self-service portal for purchase, disposal and maintenance
- Purchase process - provide a simple process of selection, purchase and approval supporting the existing Oracle financial system

Roadmap for implementation

This core business system and related process implementation is organisation wide and outlined Figure 11 below. This recognises our 2015/16 Phase 1 achievements and trialling of an Asset Location system and business intelligence capability that will continue through into 2016/17.

Figure 11: EAM System Implementation Roadmap



5.2.3 Enabling technologies

Information availability is vital to ensure services can be delivered and received appropriately, safely and in a timely manner. Investments in information and technology capability will deliver smarter ways of connecting people and information and give the healthcare workforce the tools they need to deliver quality care anywhere that is personalised to an individual's needs.

Our current Information Systems across the whole health system are fragmented, many are out of date and unable to efficiently share information between systems or deliver information to remote or mobile workers. Data collected is poorly shared, leading to increased clinical risk, frustrating staff and patient experience, lost productivity and compromised decision making.

Simply applying technology to existing processes alone will not allow us to make the kind of transformation we need. For this reason, our Healthy Together strategy provides the framework to review our services to allow us to work more efficiently and more effectively with each other and with our patients and communities supported by modern technology.

Modern technology plays an ever increasing part in our lives. From online banking and supermarket shopping to booking travel or entertainment tickets online, we have come to expect more convenient services, supported by quick and easy self-service access to information. Yet many parts of our health system still rely on face-to-face contact and paper based transactions, even when it is neither necessary nor appropriate. Technology increasingly needs to enable health care services to come to the patient, not requiring the patient to have to come to health care facilities to receive services.

Every area of CM Health is required to deliver significant quality improvements and efficiencies. CM Health has performed well maintaining services and living within our needs, but many improvement initiatives see a lack of information sharing, mobility and access to reporting as a barrier to fully achieving benefits.

CM Health is aiming to increase 'whole of CM Health system' service capacity and clinical productivity, and integrate information, processes and workflow across the system (spanning patient, community, hospital, and intersectoral activities). The focus is on improving the wellness of the people who live in Counties Manukau by transforming the way health services work together and giving people greater control and access to services.

At the heart of this transformation is an enhanced model of care, which has:

- Patients, consumers and whaanau truly at the centre of everything
- An advanced model of supported self-care and self-management
- Primary care teams managing a broader scope and range of community based intervention
- Efficient and effective secondary service that are responsible to and integrated with primary care
- Integrated health and social services supporting primary care teams, and
- A modern technology platform that meets the needs of today and enables innovation and new ways of working

Planning in 2015/16

Project SWIFT (System Wide Information for Transformation) was to gather the information required to plan the 'whole of CM Health system' transformation. Supported by IBM, CM Health has completed an analysis and planning phase to understand where technology can enable necessary changes in the way health practitioners and care providers offer services. The approach looked at care delivery across an individual's healthcare journey and the interface between Primary, Community, and Specialist Secondary Care services. SWIFT deliberately sought to understand what good healthcare feels like from users' and healthcare service providers' perspectives.

When capability requirements were identified, people, process and technology improvements were explored. The highest priority initiatives have been identified and the CM Health Board has approved strategic initiatives across primary, community, and secondary care. These initiatives enable an innovative and transformational approach towards a healthcare system that is more effective and adds to the care delivery model.

Implementation in 2016/17

As we are now moving from a planning phase to implementation, one of the key recommendations from the recent Gateway review of Project SWIFT was to transition SWIFT back into the wider DHB strategic programmes. The objective of Project SWIFT, to research and plan for system wide transformation, has been fulfilled, and the "SWIFT" brand name, no longer adequately describes the implementation process moving forward.

The programme will be aligned to the Healthy Together programmes for achieving the organisations strategic goal. The proposed programme will form the Technology Enabling component for Healthy Together.

Healthy Together Technology Programme

Delivering a 'whole of system' transformation is a complex process. There are teams of people throughout the CM Health system working on projects to improve service delivery towards achieving Healthy Together. A dedicated team is required to support and enable the technology improvements and associated change activities across the whole CM Health system.

The aim is to work collaboratively with all teams across primary and community care, and hospital services for the enabling technology aspects of Healthy Together.

The planned initiatives are outlined in Figure 12 below.

Figure 12: CM Health enabling technology priorities

Priorities	Initiatives
Enhanced Primary Care	▪ Shared Information Platform ▪ Patient & Clinical portals ▪ Population Health analytics and risk stratification
Community Health Services Integration	▪ Mobile care teams ▪ Technology platform to enable Information sharing and analytics
Patient & Whaanau engagement	▪ Youth Health Service demonstrator ▪ Self-management for stable Long Term Conditions ▪ Remote Monitoring for unstable conditions
Hospital Services	▪ Medical Ordering ▪ Inpatient Prescribing ▪ System Upgrades ▪ Mobility Services ▪ Resource Optimisation ▪ Order Set Management ▪ Clinical Documentation
NEHR Implementation Planning Study & Business Case	▪ Steering Group ▪ Business Group ▪ Clinical Applications Group ▪ Patient Administration Group ▪ Technical Group ▪ Commercial & Business Case

Change and Benefit Management

Healthy Together will deliver a significant transformational change programme with impacts on our workforce and community. Ko Awatea is leading a change programme to support the programme in understanding impacts, preparing for and leading change activities throughout the programme delivery. The team includes a benefit management lead who is establishing benefit measures, targets, timeframes and benefit owners accountable for their delivery.

5.2.4 IS Regional and National alignment

The Northern Region is at the midway point in delivering its Regional Information Services Plan (RIS 10-20). Progress has been made over the last five years to implement RIS 10-20 however the region recognises the need to accelerate progress towards implementing a 'person-centric, regional electronic health record that will be shared by, and will integrate between the key stakeholders in a person's care'.

In 2016/17 the Northern Region continue the work started to refresh and further develop a Regional e-Health Vision and Strategy so that there is a clear and appropriate framework to guide our information system investment decisions over the next decade to support the implementation of comprehensive e-Health capability across the Northern Region.

The Healthy Together Technology Programme for hospital services is implementing the NHITB priorities and improving the delivery of a digital hospital consistent with the EMRAM maturity development. The initiatives identified have or are being implemented elsewhere regionally and CM Health will leverage the work undertaken by the other DHBs and apply lessons learnt.

Enhanced Primary Care and Community Services Integration is extending the current Care Connect offerings and improving integration between Care Connect system as well as building on the emerging mobility platform being implemented by healthAlliance.

Healthy Together 2020 aligns well to the National Health Strategy, to guide planning priorities and ensure focus on the critical areas to drive change:

- People powered
- Care closer to home
- High value and performance
- One team
- Smart system

5.3 Workforce

5.3.1 Strengthening our workforce

As at 1 Jan 2015, CM Health employed a headcount of 6,640 people (excluding casual staff), who worked an equivalent of 5,744 FTEs. Nursing, midwifery and Health Care Assistant staff are by far the largest clinical workforce comprising 44 percent of staff, medical 16 percent, allied health and technical 19 percent, and care and support workers 7 percent. Over a half of CM Health's workforce is on casual and part time contracts.

In the last five years, from 2010 to 2014, Counties Manukau DHB Full Time Equivalent (FTE) workforce numbers have increased by approximately 14 percent overall.

CM Health's workforce is an aging one, with almost half of our employees aged between 30 and 49 years – a mature and experienced core. A third of our staff are likely to retire in the next 20 years. While clinical and all staff have similar ethnic ratios, when compared to the population we serve, there is much we must to do to address the significant under-representation of Maaori and Pacific workforce in clinical staff groups. At the same time, emphasis on growing our non-regulated and non-clinical workforce would greatly increase the proportion of Maaori and Pacific peoples on our staff while clinical staff may take longer.

Figure 13: CM Health Headcount and FTE by workforce group, at 31 December 2015 (excluding casual employees)

Workforce Group	Headcount	FTE (rounded)
Administration and Management	989	865
Allied Health and Technical	1,239	1,081
Medical	1,050	955
Non-Clinical Support	460	383
Nursing/Midwifery/HCA	2,902	2,462
Grand Total	6,640	5,746

Figure 14: CM Health workforce representation by ethnicity

Workforce Ethnicity	All Staff	Clinical	CM Health Population
Asian	29%	31%	24%
Maaori	5%	5%	16%
Paakehaa and Other	56%	56%	39%
Pacific	10%	8%	21%

Note: Population figures from the 2015 update using Census 2013 as the base year for projections.

5.3.2 Whole of system collaboration

The People Strategy for Counties Manukau Health has been developed to support our Healthy Together Strategic Plan, which focuses on transformation and system integration to better meet the needs of the community we serve. It aims to establish Counties Manukau 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.

This means our people are able to effortlessly navigate and connect across the whole system. Our people will reflect the diversity of the community we serve and are valued and engaged so that together, we can provide excellent, collaborative, high quality, compassionate and safe healthcare.

CM Health has a number of local initiatives (outlined below) and supports the Regional Director of Training in the development and delivery of the regional workforce plan through the Director of Human Resources in conjunction with the Building Capability Lead, reporting through CM Health's Workforce and Education Committee.

5.3.3 Values and Culture – "embedding our values and culture in the way we do business"

Teamwork depends on a willingness to cooperate, coordinate, and communicate while remaining focused on a shared goal of achieving the best for all patients, whaanau and families we see.

Our Organisational Culture and Values defines the way our staff relate to each other, their work and the outside world.

These values, set the minimum expected behaviour for everyone in our organisation, and help to lay the ground work for our organisational culture.

The following key system wide actions will help translate this objective into reality, in 2016/2017 we will:

- Embed CM Health values
- Introduce Values based recruitment
- Deliver Train the Trainer values programmes to ensure behaviours are embedded into all development
- Roll-out values activities which focus on one value at a time
- Measure values by identifying behaviour which reflect our values and use them to drive culture change. (Reward and Recognition Programme)
- Facilitate a culture of constructive feedback and positive reinforcement using (ABC[23] & BUILD[24])
- Implement a Wellness and Safety programme (including Mindfulness)
- Develop a Diversity and Inclusion Plan supported by specific programmes (including Ko Awatea Scholarship; Maaori Nursing Scheme; Kia Ora Hauora National mentoring project)
- Develop a Staff Engagement plan aligned to Patient Experience
- Introduce a review and prevention programme for bullying and harassment

5.3.4 Capability – "growing capability to transform systems and respond better to changing health needs"

Our health system requires new skills, roles and integrated ways of working that includes 'fit for purpose' role scope, education, training, support and supervision. We are committed to the continuous development of our staff, to ensure that everyone has the knowledge, skills and experience necessary to perform their roles to the required level of competence.

We do, and will, continue to provide learning opportunities, facilities and financial assistance to support this commitment. We need to better assess the core skills and competencies of our staff and focus development around the critical key areas that will ensure that staff at all levels are able to best serve the needs of our patients, their whaanau, and those who care about them.

The following key system wide actions will help translate this objective into reality, in 2016/2017 we will:

- Develop and implement capability framework (Core; Leadership; Management and Improvement)
- Develop Leadership and Management Development Plans
- Develop the capacity for change leadership across the system
- Build organisational resilience and capability to respond proactively to meet changing demands
- Maximise the opportunity for system wide development through targeted initiatives
- Introduce a system for effective talent identification and support
- Plan and deliver a programme of targeted Management and Leadership Masterclasses
- Progressively extend the scope of practice for roles to support CM Health's transformation priorities

[23] The ABC of appreciation (Action, Benefit, Continue)
[24] BUILD more constructive behaviours (Behaviour, Understand, Impact, Listen, Differently)

- Support the Kaiawhina Workforce Action Plan and identify opportunities to better utilise and develop the low paid and non-regulated workforce
- Identify new opportunities and existing initiatives that could be expanded, e.g. investigate the feasibility of formalising existing informal interpreting services already provided by staff
- Develop and deliver activities to enhance Maaori and Pacific achievement
- Continue building on the cultural competency development of our staff

5.3.5 Capacity – "building our workforce capacity and diversity to do more in communities and deliver care closer to home"

To meet future service requirements we need to become an employer of choice and attract people with the right skills and have robust mechanisms for engaging and retaining high quality health professionals and employees. We are committed to increasing the numbers of Maaori and Pacific peoples in our organisation so that our workforce reflects the population we serve.

The following key system wide actions will help translate this objective into reality, in 2016/17 we will:

- Map and develop a plan for Healthy Together 2020 workforce transformation requirements for 2016/17 and beyond
- Develop a regional approach to better utilising our workforce through improved modelling and forecasting
- Implement a CM Health recruitment and retention strategy for Maaori and Pacific staff
- Develop and implement strategies to ensure future sustainability of the vulnerable workforces
- Identify opportunities to develop and implement new and hybrid roles to support new models of care
- Review and develop appropriate models of engagement and remuneration

5.3.6 Systems and Processes – "Providing effortless systems and processes that enable people to do their best"

We recognise the need to ensure that our people can work efficiently as possible. Functional and effective systems and processes are vital to supporting this.

The following key system wide actions will help translate this objective into reality, in 2016/2017 we will:

- Enable the effective utilisation of the data warehouse across the organisation
- Undertake a comprehensive review of our Human Resource Information Management Systems
- Business Information
- Learning Management System – Learning Portal
- Payroll
- Recruitment
- Occupational Health and Safety System
- Electronic People Workflows
- Self-service KIOSK
- Rostering systems
- Develop a set of People focused KPIs and management reporting suites
- Introduce a number human resource workflow processes

5.3.7 Change leadership

The health system faces an ongoing challenge to achieve the balance of the delivery of excellent health care and sustainability. In order to meet this challenge we will need good leadership, system innovation and consumer participation to continually improve and redesign services. Activities to support this include:

- Strategic Programme Management Office to continue to support processes and resources to assist managers and staff to respond to changes across the organisation

- Developing the capacity for change leadership at all levels of the organisation through improvement training and leadership development programmes led by Ko Awatea, such as:
    - Ko Awatea's Leadership Academy, aimed at developing emerging leaders
- Clinical staff involvement in improvement initiatives such as the 20,000 Days and Beyond 20,000 Days campaigns
- Ko Awatea's APAC Forum – an annual three day conference providing innovation and improvement intensives and workshops
- Pipeline initiatives such as the Health Science Academy
- Ko Awatea building organisational resilience and capability to respond proactively to meet changing demands with support from mindfulness, system innovation and improvement, masterclass in codesign and coaching for patient centred care activities
- Through Ko Awatea led Patient and Whaanau Centred Care strategy, we are engaging patients and whaanau in service redesign, organisational initiatives and strategy
- Ko Awatea led cross sectoral improvement programmes, such as:
    - Improving Together (Ministries of Health, Education and Social Development and Health Safety Quality Commission) providing leadership and training for public sector staff for better service delivery in New Zealand
    - Early Childhood Education (Ministry of Education), providing leadership and training in improvement methods to early learning centres to raise educational outcomes for children in South Auckland

5.3.8 Regional workforce

The accountability for the delivery of the regional workforce goals is shared between the DHBs, the clinical networks (which work regionally) and the Northern Regional Alliance which encompasses the Northern Region Training Hub. The Northern Region Workforce and Training Hub, has a key role in supporting workforce development for all post entry workforces. The Hub also collaborates with other regional training hubs and HWNZ to share ideas and initiatives that can be rolled out to other professional groups and hubs.

The region has identified seven workforce objectives which are aligned with both national HWNZ strategies and local DHB activity. These are:

- Strengthen leadership and management capability throughout the workforce
- Grow the capacity and capability of our Maaori and Pacific workforce
- Increase the flexibility and affordability of the workforce to manage rising demand
- Build and align the capability of the workforce to deliver new models of care
- Optimise the pipeline and improve the sustainability of priority workforces
- Adopt a regional approach to developing an engaged and capable workforce
- Optimise the capacity and capability of the Resident Medical Officer (RMO) workforce

5.4 Organisational Health

CM Health is committed to having a workplace where everyone is able to participate and compete equitably, develop their full potential and be rewarded fairly for their contribution regardless of gender, ethnicity, disability, sexual orientation, and age or family circumstances. Management and staff have a responsibility to behave according to the organisation values and codes of conduct particularly those related to fairness and non-discriminatory behaviour.

CM Health monitors organisational health via a variety of key performance indicators and undertakes a number of initiatives to assess staff engagement. In addition, CM Health promotes a culture of leadership and accountability. Occupational health and safety, recruitment, selection and induction processes, flexible hours and work design are core to organisational health goals and in line with Equal Employment Opportunities principles.

5.4.1 Maaori participation in decision making

We will strengthen this aspect of our governance in 2016/17 to ensure that Maaori are engaged and participate in decision making and in the development of plans and strategies to improve health outcomes for Maaori.

CM Health has two types of relationships and two governance forums with Maaori:

- As agents of the Crown, we engage in a Treaty based relationship with the tangata whenua of our district. The CM Health Board has established a Board-to-Board strategic relationship with Mana Whenua i Tamaki Makaurau representatives Board
- As a DHB responsible for services to all Maaori in the district, CM Health has established a sub-committee to the Board, the Maaori Health Advisory Committee (MHAC), to provide a channel for engagement with all Maaori communities in the district and robust advice to improve the effectiveness of our operational for our Maaori population

Our Maaori Health Plan will continue to be the key document outlining priority areas for Maaori health and the activities the DHB will be undertaking to improve Maaori health outcomes.

5.4.2 Pacific leadership

We are home to the largest Pacific population in New Zealand and many of our Pasifika communities bear a disproportionate burden in terms of non-communicable disease and poorer health outcomes. We recognise that engagement with our Pasifika communities is essential to improving their health outcomes and we are currently working with them to determine how we can best develop and enhance Pacific leadership across CM Health.

Our health data tells us where we have made improvements and where we need to focus our health gain action commitment. Our Pacific Health Plan reflects the areas where we can make the most meaningful impact on achieving health equity for Pacific peoples in Counties Manukau i.e. focusing on infant and child health and adults with long-term health conditions. This means working well with families/fanau across and within health and importantly with other public sector agencies.

CM Health continues to demonstrate Pacific leadership through:

- Implementing an Integrated Services Agreement with our PHO Alliance Health Plus, who work directly with their Pacific provider network to deliver packages of care to over 300 Pacific patients and their fanau to achieve better health and Fanau Ola outcomes
- Working with Pacific churches and community groups to refocus LotuMoui to deliver programmes that support increasing health literacy and patient and fanau management education, and to combat childhood obesity and long-term conditions
- Improving and increasing the pipeline approach to successful job attainment at the DHB, including engaging more schools, effective grant systems, and stronger partnerships with tertiary organisations

5.4.3 Asian leadership

In Counties Manukau, approximately 25 percent of people have identified themselves as 'Asian' which is recognised as the most diverse and fastest growing population group. Our population and service utilisation information tells us there are growing Asian community health needs that require us to work differently together. To achieve the best health outcomes requires a leadership focus on community health and wellbeing through community engagement, as well as ill-health prevention and early intervention, this means working in partnership with Asian communities, networks and service providers. In response, CM Health has stepped up its Asian health leadership in 2016/17 by:

- Building on the regional DHB Asian leadership relationships to share learnings and expertise
- Raising the visibility of our established Asian mental health service development activity
- Implementing a new district wide Asian Health Coordinator role to support service leaders to develop targeted Asian health improvement approaches
- Supporting locality based community health leaders to connect with and work alongside existing Asian networks and providers

5.5 Reporting and Consultation

CM Health will undertake to consult/notify the Minister if the following takes place, and before making a decision:

- Significant changes to the way in which we invest/deliver services (as per MOH Guidelines)
- Entering into new arrangements such as the changes in shareholding with healthAlliance NZ Limited, and Ko Awatea and the Innovation Hub
- Any proposal for significant capital investment or the disposal of Crown land

We will also comply with requirements in relation to any specific consultation expectations that the Minister communicates to us.

5.6 Associate and Subsidiary Companies

5.6.1 HealthAlliance NZ Limited

CM Health together with Waitemata DHB established healthAlliance NZ Limited, a non-clinical shared services agency ten years ago as an early commitment to ensuring a value for money approach to health. This has been extremely successful in all areas of activity in both consistently achieving considerable savings and ensuring a standardisation of approach wherever possible. It was expanded in April 2011 to include Auckland DHB and Northland DHB with Health Benefits Limited (HBL) integrated into it in June 2015, allowing it to build on gains for both local and national benefit.

5.6.2 Innovation Hub

CM Health together with Auckland DHB, Waitemata DHB and Canterbury DHB jointly established The Hub - a national innovation hub which will engage with the industry to develop, validate and commercialise health technologies and services improvement initiatives that will deliver health and economic benefits to New Zealand.

5.6.3 Alliancing approach

The CM Health District Alliance Agreement outlines the collaborative arrangement between Counties Manukau DHB and our PHO partners to achieve whole of system integration. Our Alliance Agreement contains a set of principles to guide shared decision-making for how best to apply resources to achieve identified outcomes.

We will refresh the Alliance work plan in 2016/17 to focus key activities on delivery of our Healthy Together strategic objectives, in particular to strengthen integration and initiatives that provide care closer to home. The Alliance work plan for the 2016/17 year will also reflect the government's priorities for primary and integrated care including development and implementation of a local improvement plan for National System Level Measures - formerly known as the Integrated Performance and Incentive Framework (IPIF).[25]

[25] Further information can be accessed through the New Zealand Ministry of Health website from http://www.health.govt.nz

6.0 Service Configuration

There are no significant service coverage or service change exceptions identified for the 2016/17 year.

We continue to work with the Northern region to shape how services are structured and delivered in a collaborative environment that will:

- Strengthen the region overall
- Create the opportunity for certain services to be delivered locally
- Not destabilise any particular DHB

7.0 Performance Measures

7.1.1 Performance priorities dimension

Performance Measure and Description			2016/17 CM Health Target		2016/17 National Target	Reporting Frequency
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	Maaori	4.45%		4.45%	Six monthly
		Total	3.15%		3.15%	
	Age 20-64	Maaori	7.70%		7.70%	
		Total	3.15%		3.15%	
	Age 65+	Maaori	2.60%		2.70%	
		Total				
PP7: Improving mental health services using transition (discharge) plan	Long Term Clients		Provide specific report			Six monthly
	Child and Youth		95%		95%	
Mental Health Provider Arm PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	3 weeks		80%		80%	
	8 weeks		95%		95%	
Addiction (Provider Arm and NGOs) PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	3 weeks		80%		80%	
	8 weeks		95%		95%	
PP10: Oral Health DMFT Score at year 8			Year 1	1.0%	1.10%	Annual
			Year 2	0.95%	1.05%	
PP11: Children caries free at 5 years of age			Year 1	55%	55%	Annual
			Year 2	57%	57%	
PP12: Utilisation of DHB funded dental services by adolescents (School Year 9, up to and including age 17 years)			% year 1	85%	85%	Annual
			% year 2			
PP13: Improving the number of children enrolled in DHB funded dental services	Children enrolled 0-4 years		% year 1	95%	95%	Annual
			% year 2			
	Children not examined 0-12 years		% year 1	7%	7%	
			% year 2			
PP20: Improved management for long term conditions Focus area 1: Long term conditions			Report on delivery of the actions and milestones identified in the Annual Plan			Quarterly
Focus area 2: Diabetes services	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c)					Quarterly
	And reporting on implementation of actions in the Diabetes plan "Living Well with Diabetes"					
Focus area 3: Cardiovascular (CVD) health	Indicator 1: Percentage of the eligible population will have had their cardiovascular risk assessed in the last five years		90%		90%	Quarterly
	Indicator 2: Percentage of 'eligible Maaori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years		90%		90%	
	Report on delivery of the actions and milestones identified in the annual plan					Quarterly
Focus area 4: Acute heart services	Percentage of high-risk		70%		70%	Quarterly

Performance Measure and Description		2016/17 CM Health Target	2016/17 National Target	Reporting Frequency
	patients who receive an angiogram within 3 days of admission ('day of admission' being 'Day 0')			
	Percentage of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days	95%	95%	
	Patients undergoing cardiac surgery at the five regional surgery centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge	95%	95%	
	Report on deliverables for acute heart services identified in annual plan and actions and progress in quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI			
Focus area 5: Stroke services	Percentage of potentially eligible stroke patients thrombolysed	6%	6%	Quarterly
	Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%	80%	
	Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%	80%	
	Report on delivery of the actions and milestones identified in the annual plan			
PP21: Immunisation coverage	Percentage of two year olds who are fully immunised	95%	95%	Quarterly
	Percentage of five year olds fully immunised	95%	95%	
	Percentage of eligible girls fully immunised - human papilloma virus (HPV)	70%	70%	
PP22: Improving system integration		Report on delivery of the actions and milestones identified in the annual plan		Quarterly
PP23: Improving Wrap Around Services – Health of Older People		Report on delivery of the actions and milestones identified in the annual plan		Quarterly
PP25: Prime Minister's Youth Mental Health Project		Initiative 1: School Based Health Services (SBHS) in decile one to three secondary schools, teen		Quarterly

Performance Measure and Description		2016/17 CM Health Target	2016/17 National Target	Reporting Frequency
		parent units and alternative education facilities. Provide quarterly quantitative reports on the implementation of SBHS, as per the template provided Provide quarterly narrative progress reports on 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 Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: • early identification of mental health and/or addiction issues • better access to timely and appropriate treatment and follow up • equitable access for Maori, Pacific and low decile youth populations Provide quantitative reports using the template provided under PP26		
		Initiative 5: Improve the responsiveness of primary care to youth Provide quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in local alliancing arrangements. Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per SLAT(s) work programme		
PP26: The Mental Health and Addiction Service Development Plan		Provide reports as specified for each focus area: Primary Mental Health • District Suicide Prevention and Postvention • Improving Crisis response services • Improve outcomes for children • improving employment and physical health needs of people with low prevalence conditions		Quarterly
PP27: Supporting vulnerable children		Report on delivery of the actions and milestones identified in the annual plan		Quarterly
PP28: Reducing rheumatic fever	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever	Provide a progress report against rheumatic fever prevention plan		Quarterly
		Reports on progress in following up known risk factors and system failure points in cases of 1st episode & recurrent rheumatic fever		
		4.5	1.4	

Performance Measure and Description		2016/17 CM Health Target	2016/17 National Target	Reporting Frequency
PP29: Improving waiting times for diagnostic services	Coronary angiography – percentage of patients who are referred for elective coronary angiography and receive their procedure within 3 months (90 days)	95%	95%	Monthly
	CT – percentage of patients who are referred for CT and receive their scan within than 6 weeks (42 days)	95%	95%	
	MRI – percentage of patients who are referred for MRI and receive their scan within than 6 weeks (42 days)	85%	85%	
	a. Urgent diagnostic colonoscopy – percentage of people who are accepted for an urgent diagnostic colonoscopy and receive their procedure within two weeks (14 days)	85%	85%	
	b. Diagnostic colonoscopy – percentage of people who are accepted for an diagnostic colonoscopy and receive their procedure within six weeks (42 days)	70%	70%	
	c. Surveillance colonoscopy - Percentage of people waiting for a surveillance colonoscopy who wait no longer than twelve weeks (84 days) beyond the planned date, & 100% within 120 days	70%	70%	Monthly
PP30: Faster cancer treatment Part A	Percentage of patients wait 31 days or less to receive their first treatment for cancer from date of decision-to-treat	85%	85%	Quarterly
PP30: Faster cancer treatment Part B	Percentage of patients ready-for-treatment wait 4 weeks or less for radiotherapy or chemotherapy	100%	100%	Monthly
PP31: Better help for smokers to quit in public hospitals	Percentage of hospital patients who smoke	95%	95%	Quarterly

Performance Measure and Description		2016/17 CM Health Target	2016/17 National Target	Reporting Frequency
	and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking			

7.1.2 Ownership dimension

Performance Measure and Description		2016/17 CM Health Target	2016/17 National Target	Reporting Frequency
OS3: Inpatient length of stay	Elective LOS	1.59 days	1.55 days	Quarterly
	Acute LOS	2.60 days	2.35 days	
OS8: Reducing acute readmissions to hospital	Total Population	To be confirmed in 2016/17 year		Quarterly
	75+ years			
OS10: Improving the quality of data within the NHI and data submitted to National Collections Focus area 1: Improving the quality of identity data	New NHI registration in error	> 2% and < to 4%	> 2% and ≤ to 4%	Quarterly
	Recording of non-specific ethnicity	> 0.5% and < to 2%	> 0.5% and ≤ to 2%	
	Update of specific ethnicity value in existing NHI record with a non-specific value	> 0.5% and < 2%	> 0.5% and ≤ 2%	
	Validated addresses unknown	>76% and <85%	>76% and ≤85%	
	Invalid NHI data updates causing identity confusion	-	No target confirmed	
Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS	≥97% to <99.5%	≥97% to <99.5%	
	National collections file load success	≥98% to <99.5%	≥98% to <99.5%	
	Assessment of data reported to NMDS	≥75%	≥75%	Quarterly
	NNPAC timeliness	≥95% to <98%	≥95% to <98%	

7.1.3 System integration dimension

Performance Measure and Description		2016/17 CM Health Target	2016/17 National Target	Reporting Frequency
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	A jointly agreed SLM improvement plan, including improvement milestones, will be provided at the end of Q1 2016/17 via PP22		Six monthly
	Maaori Age 45-64	6,029 per 100,000	3,600 per 100,000	
	Pacific Age 45-64	6,424 per 100,000		
SI2: Delivery of Regional Service Plans		Provision of a single progress report on behalf of the region agreed by all DHBs within that region		Quarterly
SI3: Ensuring delivery of Service coverage		Progress report as required		Six monthly
SI4: Elective services standardised	Major joint	21.0	21.0	Annually

intervention rates	replacement procedures			
	Cataract Procedures	27.0	27.0	Annually
	Cardiac surgery	6.5	6.5	Quarterly
	Percutaneous revascularisation	12.5	12.5	Quarterly
	Coronary angiography services	34.7	34.7	Quarterly
SI5: Delivery of Whaanau Ora		Performance expectations are met across all the measures associated with the five priority areas		Annually
SI7: SLM total acute hospital bed days per capita		A jointly agreed SLM improvement plan, including improvement milestones, will be provided at the end of Q1 2016/17 via PP22		Quarterly
SI8: SLM patient experience of care	Hospital	A jointly agreed SLM improvement plan, including improvement milestones, will be provided at the end of Q1 2016/17 via PP22		Quarterly
	Primary care			
SI9: Amenable mortality		A jointly agreed SLM improvement plan, including improvement milestones, will be provided at the end of Q1 2016/17 via PP22		Quarterly

7.1.4 Output dimension

Performance Measure and Description		2016/17 CM Health Target	2016/17 National Target	Reporting Frequency
OP1: Mental health output delivery against plan	Variance of planned volumes for services measured by FTE	+/- 5%	+/- 5%	Quarterly
	Variance of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day	+/- 5%	+/- 5%	
	Actual expenditure on the delivery of programmes or places is within +/-variance of the year-to-date plan	+/- 5%	+/- 5%	

7.1.5 Developmental measures

Performance Measure and Description	2016/17 CM Health Target	2016/17 National Target	Reporting Frequency
DV6: SLM youth access to and utilisation of youth appropriate health services	No performance target set		Quarterly
DV7: SLM number of babies who live in a smoke-free household at six weeks post-natal	No performance target set		Quarterly

Kind
Manaakitanga

Excellent
Rangatiratanga

Valuing everyone
Whakawhanaungatanga

Together
Kotahitanga

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