COUNTIES MANUKAU HEALTH

Annual Plan 2015/16

Incorporating the
Statement of Performance Expectations 2015/16
and **Statement of Intent 2015/16 - 2018/19**




Healthy Together




Front Cover: A collage of photos reflecting Counties Manukau's Whaanau & Families, Community and Services.

Counties Manukau District Health Board Annual Plan 2015/16
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Annual Plan dated September 2015
(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

between

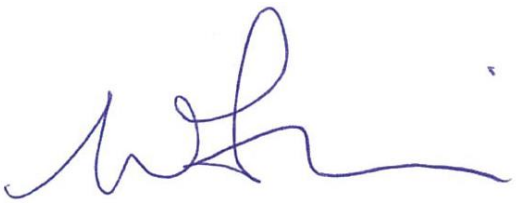
Her Majesty the Queen
In right of her Government of New Zealand
Acting by and through the Minister of Health

_____
The Honourable Dr Jonathan Coleman

And

Dr Lee Mathias
Chair of Counties Manukau DHB

Geraint A Martin
Chief Executive of Counties Manukau DHB



Wendy Lai
Deputy Chair of Counties Manukau DHB

Office of Hon Dr Jonathan Coleman
Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

19 OCT 2015

Dr Lee Mathias
Chairperson
Counties Manukau District Health Board
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Dear Dr Mathias

Counties Manukau District Health Board 2015/16 Annual Plan

This letter is to advise you I have approved and signed Counties Manukau District Health Board's (DHB's) 2015/16 Annual Plan for one year.

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 invest in key health services. In Budget 2015, Vote Health received an additional $1.7 billion in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, a refresh of the New Zealand Health Strategy is currently under way. The Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for the next three to five years for delivery of health services to New Zealanders. Thank you for your involvement to date and your continued input into the refresh.

Living Within our Means
The Government is determined to reach surplus in 2015/16. To assist with this, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order 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 2015/16 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 2015/16.

Health Shared Services Programme
DHBs have committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to include cost and

benefit impacts for the Finance Procurement and Supply Chain Initiative in Annual Plans where these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

National Health Targets

Your Annual Plan provides a good range of actions that I am confident will support strong health target performance when implemented in 2015/16. Please ensure all health target actions identified in your Annual Plan are fully implemented to help you to continue to deliver better outcomes for your population.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator became the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. I am concerned that the pace of progress needs to improve if the 85 percent target is to be achieved by July 2016. Please ensure delivery of this target remains a key priority for your teams.

System Integration

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2015/16. Shifting 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 plans to maintain primary care access to radiology, its extensive level of shifted services, and a broad based Primary Options for Acute Care programme in 2015/16. It is encouraging to see that you will continue to further strengthen integration through the development of Community Health Hubs and service models that include health and social services.

I look forward to being advised of your progress with this throughout the year. Where these services trigger the service change protocols you will need to follow the normal service change process.

Better Public Services (BPS): Results for New Zealanders

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.

It is important that DHBs continue to work closely with other social sector organisations, including non-governmental organisations, to achieve our sector goals in relation to these and other initiatives, such as Whānau Ora, Children's Action Plan and Youth Mental Health.

Tackling Obesity

I am pleased to note that your Annual Plan includes a focus on obesity, and identified a range of activities and initiatives to help tackle obesity. I have asked Ministry officials to look at what actions can be undertaken to help address childhood obesity, including, advice on a possible obesity target that will be meaningful and evidence based. I will be writing to all DHBs in coming months to outline proposed next steps.

The actions you have outlined in your plan to support the Healthy Families Manukau and Healthy Families Manurewa-Papakura initiatives will also enhance efforts in this area. DHB participation in the Healthy Families NZ initiatives will help ensure that a co-ordinated approach to obesity and other drivers of chronic disease is taken across the sector.

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 National Health Board. I am aware you have a number of service reviews under way. I have asked the National Health Board to ensure regular updates are provided as these reviews progress. Please ensure that you advise the National Health Board 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 2015/16 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

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Foreword from the Chair and Chief Executive

We are delighted to share with you our Annual Plan for 2015/16.

This plan marks a new beginning for the DHB as we build upon the foundations we have put in place to transform our healthcare system to bring about better health outcomes for our communities.

2015/16 will be a year of extraordinary challenge as we seek to manage our resources and balance our budget, with a small surplus, in a much tighter fiscal environment than last year.

We will continue the work we started through our whole of system integration of primary care, community and hospital services to bring services closer to where our communities live. 2015/16 will see more multi-disciplinary community based services set up in our localities, and an expansion of our At Risk Individuals (ARI) programme in primary care. The ARI programme will benefit many of our Maaori and Pacific whaanau by providing comprehensive care for patients with multiple long term conditions. By the end of 2015/16 we will have more than 10,000 people enrolled in this programme through their primary care providers.

Achieving "Healthy Futures for Maaori" or Paeora continues to be a priority for us and we will be working with our partners in primary care and the community to deliver the Maaori Health Plan which outlines the important work we will be doing in areas such as smoking cessation, healthy housing, child health, and early detection and management of conditions like cardiovascular disease, diabetes and cancer. Lifting the health of Maaori will result in gains for other groups facing similar health inequalities like our Pacific and groups living with high levels of socio-economic deprivation.

An exciting programme of work for the DHB over the next four years will be the implementation of Project SWIFT. We have partnered with the NZ Health Innovation Hub and IBM to deliver a major piece of work which aims to help clinicians do their jobs better, and patients and service users to make decisions that will support their health. New models of care currently being co-designed with patients and service users will be released later this year.

As we enter a new financial year, we want to express our gratitude to our local communities, staff and care partners across our health system for the important contribution they make toward improving the health and wellbeing of people living in Counties Manukau. We also thank our PHO partners for their contribution and endorsement of this Plan and look forward to working together to make a difference for our communities.

Dr Lee Mathias

Chair

Geraint A Martin

Chief Executive

Executive Summary

In the last four years, we have worked hard as an organisation to put in place the foundations for greater integration of our hospital with primary care and community services. Our strategic goal has been to achieve a balance between excellence and sustainability to be the best healthcare system in Australasia by December 2015.

We have fifteen system level measures as our key benchmarks. These tell us that we are among the best in Australasia and we are leading the sector for some indicators like our hospital mortality rates.

Our strategic programmes have given us the grounding and the impetus for significant service developments and innovation to occur with our health system partners like the:

- Establishment of our four localities and Locality Leadership Groups
- Partners in Care programme
- Aiming for Zero Patient Harm programme
- Safety in Practice programme
- At Risk Individuals programme
- Saving 20,000 bed days and Beyond Saving 20,000 bed days initiatives

These have contributed to measurable improvement in patient and service user health outcomes in the last few years and continued high performance against National Health Targets.

A significant milestone for the DHB last year was the achievement of a Health Excellence Bronze award. We are the second DHB in New Zealand to achieve this. The award demonstrates that, in spite of the fiscal challenges and complexities faced by our staff and health system, we are doing the right things in relation to improving health system performance.

In 2015/16 we will have a refreshed strategy which will build on our achievements and continue work currently underway. The three missions which make up our *Healthy Together* strategic direction to 2020 represent an evolution of our Triple Aim. These missions are centred on people from our diverse communities, to health staff working with patients, family and whaanau.

People are our greatest strategic asset. Advancing how we work together across health services in partnership with our Alliance leaders[1], thriving communities and social sector partners will be at the centre of how we will remain financially sustainable.

[1] Alliance Leadership Team membership comprises Primary Health Organisation (PHO) Chief Executives and CM Health Executive Leaders mandated by the Ministry of Health to advance the integration between primary and secondary care in the district.

We sought advice, insight and feedback from health staff and consumers about where and how to focus our actions so that we can truly be healthy together. This plan launches our refreshed strategic goal in late 2015 that will reflect CM Health's desire to measure the impact on its community by promoting, protecting, improving and extending the quality of life.

A high proportion of our Maaori and Pacific populations and those living in poverty continue to be impacted by many risk factors and health conditions, many of which are preventable. Our refreshed strategy will have a long term focus and plan for lifting the health of Maaori and reducing health inequalities for all groups facing health disparities.

We are committed to achieving the government's priorities for 2015/16, as set out in the Minister of Health's letter to DHBs, despite lower than expected revenue growth and a much tighter fiscal position than previous years. Our biggest challenge in the coming year will be to identify how we maintain momentum of savings given the extraordinary funding pressures we face. As such, our 2015/16 plan will have a continued focus on living within our means, fostering innovation, improving quality and safety, practising sustainable healthcare, and community based service expansion. Reflecting late additional 'tagged' revenue advice, we are now forecasting a small consistent surplus for the next three years. It should be noted that this surplus is subject to formal confirmation as to its appropriate treatment.

In 2015/16 we will commit to the following:

- ***Clinical leadership will continue to be a key driver of health transformation***

Our clinical leaders continue to drive significant health transformation change in Counties Manukau and in the Northern region. There is strong clinical leadership across our governance, planning and programme/service implementation processes. Clinical leaders lead the way in the development of new structures and models of care to enable more integrated health system delivery across the whole system.

- ***Continued commitment to achievement of government priorities***

We are committed to achieving our national health targets, Better Public Services and System Integration objectives. The integration work will continue the implementation of joined-up, multi-disciplinary locality-based community services and rapid expansion of the At Risk individuals programme (ARI).

- ***Enhancement of the At Risk Individuals programme***

We will enhance our ARI programme which is a model of care for primary care to work collaboratively with whaanau to provide more planned, proactive care for complex patients. Work in these areas includes expanding services provided in the community to support primary care as the healthcare home for our population. We aim to have more than 10,000 people enrolled by the end of 2015/16. Many of our Maaori and Pacific patients with long term conditions and their whaanau will be positively impacted by this.

- ***Continued commitment to improving quality and patient safety***

Four Clinical Directors lead our patient safety and quality programmes, driving continued commitment to improved quality and higher value healthcare for our patients and service users. Through their lead, we will continue to pursue and improve local, regional and national patient safety and quality programmes for hospital services and primary care in 2015/16. Ko Awatea will be fostering a culture of safety in the primary and community space with key programmes: Safety in Practice and Manaaki Hauora – Supporting Wellbeing.

- ***Implementation of the Integrated Performance and Incentive Framework (IPIF)***

Our Alliance Leadership Team will lead on the implementation of the IPIF In the district once the system level measures are agreed. A work programme will guide the implementation to meet the IPIF measures of: Capacity and Capability, Healthy Start, Healthy Ageing, Patient Experience.

- ***Implementation of Whaanau Ora initiatives***

We will continue to work with Whaanau Ora provider collectives in our district to benefit the health of whaanau in our district. This will be done by implementing Whaanau Ora hubs in each of the four localities and strengthening the Whaanau Ora model of service delivery within the hospital. A robust Hauora Performance Monitoring Framework will be developed with Manawhenua, to enable better measuring and monitoring of our collaborative efforts.

- ***Improving patient care and outcomes through Project SWIFT***

We are embarking on an exciting 4 year project to implement a range of IT solutions under the umbrella of Project SWIFT (System Wide Integration for Transformation). We will be developing new models of care which will ensure that our services are well linked and as effective as possible.

- ***Supporting delivery of regional and national priorities***

We are committed to extending the value of working together as a region and will continue to work with our regional DHB counterparts to implement the regional priorities in the Regional Services Plan. Informatics is a major focus for the region in 2015/16 and we will be looking for a shared regional vision for an electronic health record, with Project SWIFT contributing to the Regional Information Strategy.

We will continue to support Health Benefits Limited's implementation of the Finance, Procurement and Supply Chain initiative and will work in partnership with HBL to progress the Food Services, Linen and Laundry Services, and National Infrastructure Platform business cases.

1.0 Context and Strategic Intentions

1.1 Background Information and Operating Environment

Counties Manukau District Health Board (CMDHB) 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.

CMDHB is a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004). Accountability for CMDHB 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, included in this document, are also key accountability documents.

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

CMDHB 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 Manawhenua I Taamaki Makaurau. CMDHB 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

CMDHB 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 CMDHB fulfils its statutory functions in the use of public resources. The current Board governance structure includes three statutory committees and two non-statutory sub- committees which assist the Board to meet its responsibilities. 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.

CMDHB has an established district alliance and related District Strategic Alliance Agreement 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 ProCare, National Hauora Coalition, Alliance Health Plus, Total Healthcare and East Health Trust.

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

1.1.3 Health profile of Counties Manukau populations

In 2014, CM Health provided health and disability services to an estimated 524,500 people who reside in the local authorities of Auckland, Waikato District and Hauraki District. Our population is growing at a rate of 1- 2 percent per year, the second fastest growing population (after Waitemata) when compared with other DHBs. Overall, the Counties Manukau population is expected to grow by approximately 8,000-8,500 residents each year for the next 10 years. From 2015/16 to 2025/26 the number of new residents in Counties Manukau is projected to be just under 83,000.

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, 38 percent of New Zealand's Pacific people 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 24 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 by an average of just over 4 percent each year from 58,700 in 2015/16 to 86,850 by 2025/26, the fastest relative growth in this age group of all the DHBs. 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 (2011-2013 average) at birth in Counties Manukau is similar to that of the New Zealand average at 81 years. While Maaori and Pacific life expectancy have been improving at a similar absolute rate compared with non-Maaori/non-Pacific population, the life expectancy gap between Maaori and non-Maaori/non-Pacific was just under 10 years while the gap between Pacific and non-Maaori/non-Pacific was just over 8 years for 2011-2013
- 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

System integration is central to medium to long term management of our health system demand challenges. Our commitment to this national policy is demonstrable in our implementation of the localities approach. 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 2015/16 is provided in the Executive Summary and further details in section 2.

1.1.5 Key areas of risk and opportunity

The constrained future funding growth forecasts do not match our current health service demand projections. We recognise that the existing service configuration and balance of related funding across the sector is not well designed to meet our population needs within available funding.

The Northern region's Triple Aim is the measurement framework we have adopted to organise our response and proactively reorganise our collective CM Health capacity and capability to better meet our population needs, deliver service excellence and meet the government's expectations and targets while remaining financially and clinically sustainable.

A complete summary of organisational risks, mitigation strategies and status are managed through routine business review process and related register updates. In addition to these core organisational management systems key system level risks relate to:

- Revenue growth is forecast to be less than current cost growth; therefore
- The historic models of care and service configuration are unsustainable

The most critical strategic risks and management strategies CM Health faces in 2015/16 are outlined in Figure 1 below.

Figure 1: CM Health Strategic Risks and Opportunities

Category	Risk / Opportunity	Management Strategy
Clinical	**Whole of system capacity and capability** To integrate services and to increase the type and scale of primary and community care based services	• A Whole of System Strategy Board comprising PHO and CMDHB executive leaders focus on the longer term health system vision to clarify investment (hard and soft) priorities. This will determine the most effective use of resources with a focus on the short, medium and longer term priorities • System integration with an increased scale and pace of service integration and implementation focus for 2015/16 that incorporates a Whole of System (WoS) approach across system redesign • In 2014/15 we 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. Solution design, proof of concept and implementation will continue through 2015/16 • 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 redesigned systems and approach to care will be critical to strengthening our population health approach

Corporate	**Revenue** The forecast revenue increase of 1.5 percent is less than half of 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 (as for whole of system capacity and capability above), to deliver services closer to where people live, intervene earlier for improved health outcomes and resulting reduction in acute service demand • Significantly increased focus on clinical models of care, reducing clinical variation and improving acute service productivity across the health system (from primary care to hospitalisation). These are seen as critical to further cost containment and clinical leadership is an essential factor for success • Acute system capacity and production planning capability expansion to inform the most effective use of available resources, e.g. the Peak Workload Plan, production planning, daily capacity reporting • Continued focus on system wide value for money reviews to challenges, how effectively we are working and using available resources across the whole system
Funding	**Constrained public health capital funding for hard and soft assets** This has impacts for infrastructure resilience (e.g. IS), 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. regional upgrade of Microsoft software upgrades in workspace and infrastructure, shared care system implementation • Focus on system stability and connecting up information and communication systems to enable significant model change to achieve seamless integration of community and hospital services and support achievement of the goals of the National Health IT Board • Strategy refresh process in 2015 as we see out our current strategy. In this context, we will better join up all our plans, e.g. workforce, ICT, infrastructure and services development • Reduce reliance on (new) capital for managing service demand, i.e. different models of care, primary and community care (whole of system redesign), better leverage regional and private capacity and capability • Collaboration with regional and national partners to leverage of aggregated savings and efficiency benefits and local system level accountability for financial and non-financial performance

1.2 Nature and Scope of Functions / Intended Operations

1.2.1 Whole of system planning

CMDHB reshaped the governance structure in 2012/13 to better integrate whole of system thinking into organisational planning. The restructure saw CMDHB move away from being organised along traditional funding and planning functions to better align with localities development and Alliance Leadership Team (ALT) engagement. This approach supports a more collaborative approach to planning with local (community to hospital) and regional care partners. More effective integration of strategic objectives, outcomes and shared implementation planning is enabled through joined up action plans.

Planning involves close collaboration between CMDHB's Strategic Development and Primary Health and Community Services and Hospital Services Directorates and community based care providers through the ALT. The Whole of System Strategy Board, comprising PHO and CMDHB executive leadership, plays a key role in jointly endorsing CM Health's strategic direction, priorities and performance monitoring at a district health system level. Aligned with strategic priorities are asset and infrastructure planning functions that are managed by the Business and Corporate Services Directorate.

2015/16 is year four of our four year health system transformation goal to become the best healthcare system in Australasia by 2015. In the last few years, we established four Locality Clinical Partnerships. This has set the

foundations for system wide integration activity between our secondary and primary care areas, further advancing the drive for quality and safety improvements.

We have started the process of refreshing our strategic direction and focus out to 2020. From January 2016 we will be implementing a new strategic vision which will join up workforce, ICT, infrastructure and services development priorities in a cohesive story.

1.2.2 Clinical leadership is essential for effective governance

Clinical leadership is recognised as an essential success factor across all governance, planning and programme/ service implementation processes. Achieving this requires a comprehensive reach of clinical input across the health system at regional and local; and strategic to operational levels.

Our clinical leaders are supported through a number of mechanisms, for example the Strategic Programme Management Office, Ko Awatea system improvement and innovation, analytical support, system redesign and knowledge management expertise to enable implementation, monitoring, research, outcome evaluation and applied learnings.

1.2.3 Hospital Care

CM Health is a major provider of both community based and secondary health services to the estimated 524,500 people residing in the Counties Manukau district.

The PHO associated general practices are distributed throughout the district, with aligned Integrated Family Health Centres (IFHCs) that form the hub of our network of shared services across each locality. CMDHB operated services are largely delivered from seven inpatient facilities and numerous leased or owned outpatient and community health facilities across the district. Manukau Health Park and Middlemore Hospital sites contain the largest elective, ambulatory and inpatient facilities.

1.2.4 Primary and Community Care

As a funder, CMDHB funding responsibilities cover the totality of CM Health services to the people residing 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 tertiary services and services that are covered by regional contacts are provided by other DHBs. This includes Auckland DHB and Waitemata DHB 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.

In the 2015/16 year, CMDHB will receive $1.5 billion in funding, of this:

- 851.0m is for the provision of services delivered through the DHB's Hospital Care Arm
- 384.0m is for the provision of services delivered through contracts with NGOs
- $281.0m is for the provision of services delivered by providers or contracts that sit outside of the Counties Manukau district
- $14.0m is to cover governance and funding related capability and administration

1.2.5 Owner of crown assets

As an owner of Crown assets, CMDHB 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. CMDHB carries out formal asset management planning to determine planned future asset replacement and expected financing arrangements.

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

1.3 Strategic Intentions

1.3.1 Vision and values

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 is timely to step back and refresh those values to make them current.

We launched 'Living our values, together' in February 2015 and started engaging with staff, patients and their whaanau/family and carers to gather their insights and input about what matters to them.

The refreshed value statements were be considered by the CMDHB Board in July 2015 and then aligned to our Healthy Together strategy. From September 2015, our focus will be on embedding the values into the everyday behaviours of staff across CM Health.

Our refreshed strategic goal is:

"We care about achieving health equity for our community."
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.

We will measure the impact we have on healthy life years every year. This is our commitment to act and be deliberate in our choices and priorities. This means that people will live longer healthier lives in the community.

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

- **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

1.3.2 National health sector priorities

The 2015/16 government's Better Public Health Services and six national health targets as indicated in the Minister's Letter of Expectations set the context for our priority setting. We have a particular focus on the integration of health services across the region 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 District Health Boards, Counties Manukau based PHO Alliance and related service providers, and BSMC business case organisations.

Our context is also shaped by the priorities set by other national agencies – Health Workforce New Zealand, National Health Board, National Health IT Board, National Capital Investment Committee, National Health Committee, Health Quality and Safety Commission. 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.

1.3.3 Northern region health priorities

We are in year four of implementation of the Northern Region Health Plan (http://www.ndsa.co.nz) that has been developed by the four DHBs (Auckland, Waitemata, Northland and Counties Manukau) and their community care partners. For 2015/16, this builds on the region's previous three plans and with an emphasis on longer term planning, care closer to home and the provision of better integration of healthcare for patients and communities within constrained funding increases. There is a focus on demonstrative collaboration and more detailed planning to deliver against priority regional goals and delivering on regional workforce, IT and capital objectives and more detailed planning across regional priorities. This will include ongoing changes to our business support systems, and in particular the regional focus around information systems, procurement and the supply chain.

Regional planning focuses on where regional health system collaboration will make a real difference (tangible benefits) and addresses important health issues for the population.

Regional informatics is a major focus this year. CM Health will be looking to align the local Information Systems plan with regional direction and working with regional partners towards achieving an Electronic Health Record.

The Northern Region DHBs, assisted by the Northern Regional Alliance (NRA) and regional shared services organisation healthAlliance, remain fully committed to meeting national expectations but will also seek to progress regional priority initiatives. It is likely that the 2015/16 plan will signal the reprioritisation of some regional initiatives as the resourcing impact of the proposed informatics work become evident. This will be confirmed in the final draft of the regional service plan in May 2015.

CM Health's Annual Plan priorities align to the Northern Region goals as shown in the high level Intervention Logic outlined in Figure 3.

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, for example, the Lead Chief Executive for the NRA and the Northern Region Health Plan, Chair of the Regional Radiology Network and others.

The NRA is an amalgamation of two previous subsidiary companies, the Northern Region DHB Support Agency Limited and the Northern Regional Training Hub Limited. The NRA is owned in equal shares by Waitemata, Auckland, and Counties Manukau DHBs.

The NRA will produce a business plan, including budgets and key outputs for 2015/16 that will be approved by the NRA Board, and will report against the business plan. The NRA Board, which comprises of shareholding DHBs and Northland DHB, will monitor NRA performance against its business plan on a quarterly basis throughout 2015/16, commencing with a report in October 2015 for the first quarter of 2015/16.

1.3.4 What we are trying to achieve

Strategic planning must translate into healthcare delivery that will make a difference to the lives of people in contact with our health system.

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 our mortality rates. Our hospitalisation rate for children and young people is above the national average and is largely for preventable conditions like sudden unexpected death in infants, lower respiratory infections, rheumatic fever, skin conditions and meningococcal disease.

We know that our Maaori and Pacific people are disproportionately affected by these conditions and that the determinants of poor health for our community are affected by lifestyle choices.

In the last four years, we have been working towards the strategic goal of being the best health care system in Australasia by December 2015 so that we can make a difference to the health of our communities and make CM Health into one of the best places to work.

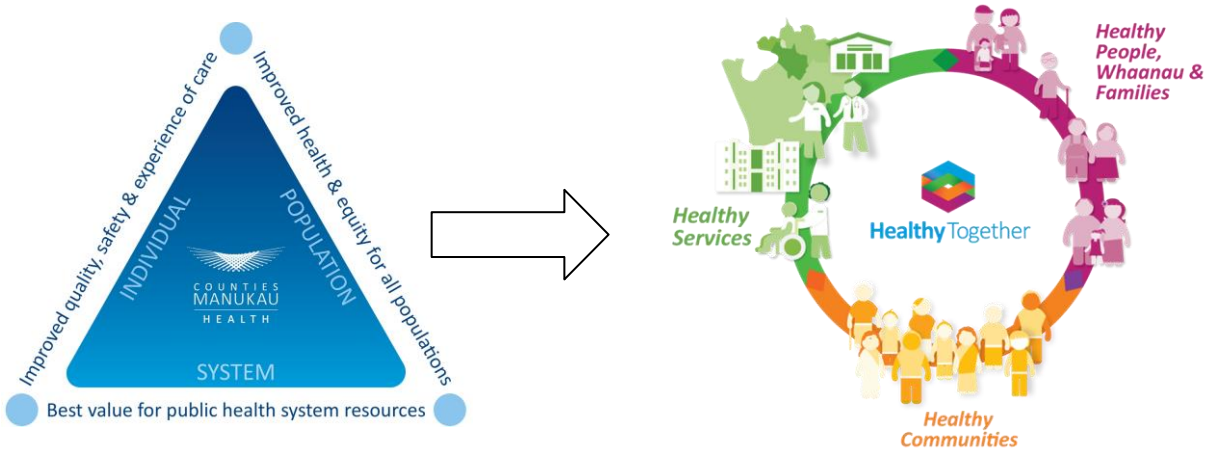
We are currently refreshing our strategy, looking to the next five years to 2020, with a view to building upon some of the excellent initiatives and programmes which have contributed to health gain in our communities.

Our commitment to the Triple Aim will continue as we transition to the refreshed Healthy Together strategy in July 2015 (refer Figure 2).

Our 2015/16 strategic priorities are likely to include some of the current programmes outlined below:

Improved health and equity for all populations	Our ***Better Health Outcomes for All*** programme aims to improve population health by reducing smoking prevalence to less than 12 percent by 2018 and 5 percent by 2025 (Smokefree 2025), improve care and services for mums and babies in their first 2000 days of life, reduce hospital admissions due to poor quality housing and improve health literacy. These population health improvement projects will specifically work with our communities to address the barriers to good health to improve life expectancy, reduce inequalities in health, and support individuals and whaanau to lead healthy lives.
Improved quality, safety and experience	Our ***First Do No Harm*** programme implements the national, regional and local quality and safety initiatives in hospital and primary care.
	The second programme ***Patient and Whaanau Centred Care*** implements tools and approaches to ensure that patient and whaanau experiences are used to improve service design and delivery throughout the care continuum. A Patient and Whaanau Centred Care Consumer Council was established in early 2015 to facilitate patient/service user and their whaanau input into service improvement and design.
Best value for public health system resources	***System Integration*** (including localities and community health integration). This programme will oversee the changing model of care in general practice and development of integrated community health services
	Ensuring Financial Sustainability. This programme oversees the savings programmes and aims to align long term financial planning with the service changes delivered through 'System Integration'
	Enabling High Performing People. This programme ensures we manage our workforce resources to deliver quality healthcare services in a manner that is sustainable and gets the best from our people. We have formalised this programme into a Workforce and Education Committee responsible for integrated workforce development planning with a whole of system focus

Figure 2: Triple Aim evolution to Healthy Together



1.3.5 Measuring our performance

To clearly show the linkages between the performance of our healthcare system and our strategic goals, we have a suite of system level measures (SLMs). These 'big dot' measures are outlined in our Performance Measurement Framework (refer Figure 4) 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.

Embedded within the framework are measures which will give us an indication over time whether our strategies are contributing toward the positive change we seek for our population. In areas where disparities are being faced by our Maaori, Pacific and Asian populations, results are disaggregated by ethnicity to give us a better picture of the health gain for these population groups and others facing similar poor health outcomes.

We also measure our performance against comparable national and international SLMs. Both big dot and little dot measures are reported on a regular basis to the Executive Leadership Team, Board and our governance committees providing full transparency of areas of strong performance as well as areas needing more focus.

Figure 3: CM Health intervention logic framework

We will contribute to the national health goal for ...	**All New Zealanders live longer, healthier and more independent lives**		
We support and align with the northern region vision to ...	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		
By contributing to regional priorities ...	Life and years	First, do no harm	The informed patient
To reach our vision for the people of Counties Manukau ...	To work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori and Pacific peoples and other communities with health disparities		
So that our community can ...	**Live longer, healthier and more independent lives**		
We commit our skills and resources to reaching our goal of ...	Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015		
By delivering our triple aim strategic objectives for	Improved health and equity for all populations	Improved quality, safety and experience of care	Better value for public health system resources
By organising and delivering our actions through six executable strategies	Better Health Outcomes for All First Do No Harm System Integration Ensuring Financial Sustainability Enabling High Performing People Delivering Patient and Whaanau Centred Care		
That work together with health service delivery by supporting our community throughout their life course with	**Prevention** Health Promotion & Education, Immunisation, Health Screening, Statutory and Regulatory	**Early Detection and Management** Primary Health Care, Long Term Conditions, Oral Health Diagnostics, Pharmacy	**Treatment** Mental Health, Elective, Acute, Maternity, Additional Patient Safety	**Rehabilitation and Support** NASC, Assessment Treatment & Rehabilitation, Palliative Care, ARRC, Home Based Support
So that all people living in Counties Manukau ... 	✓ Will be smokefree by 2025 ✓ Children will have the best start in life ✓ Will have good levels of health literacy ✓ Will experience better transitions of care ✓ Are active participants in their own health care ✓ Participate and collaborate in decision making ✓ See better value from health care funding ✓ Will have better access to services based in the community ✓ See a health care workforce that looks more like their own community		

Figure 4: CM Health performance measurement framework

To progress towards our goal of:	Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015		
We will measure our achievements through our Triple Aim …	Improved health and equity for all populations	Improved quality, safety and experience of care	Better value for public health system resources
Our collective executable strategic initiatives and service delivery performance across the whole of our health system will be monitored through 'big dot' System Level Measures (SLMs) ….	• Life expectancy at birth • Childhood immunisation status • Un-enrolled health service utilisation • Ambulatory sensitive hospitalisations • Long term conditions risk assessment (CVD/ Diabetes risk assessment) • Long term condition management • Patient experience of care • Rate of adverse events • Hospital standardised mortality rate • Acute hospital readmissions • Hospital days in the last 6 months of life • Emergency Department length of stay • Healthcare cost per capita • Timely access to diagnostics • Waitlist to elective surgery • Workforce retention		
	There are complex interactions between measures of activity and impact that collectively contribute to our Triple Aim objectives and strategic goal, so we will monitor these across the spectrum of services provided by the CM Health system		
By protecting longer term population health through early detection and improved prevention support …	• Proportion of 8-month olds who have their primary course of immunisation on time (Maaori, Pacific, Total) • Proportion of enrolled preschool and school children who have not been examined by the Oral Health Service (within 30 days of their recall date) • Proportion of the eligible population who have had their B4 School Checks • Hospitalisation rates for acute rheumatic fever per 100,000 population (Maaori, Pacific, Total) • Proportion of enrolled patients who smoke and are seen in General Practice that are offered brief advice and support to quit smoking (High Needs, Total) • Prevalence of regular smoking for those aged 15 years and over by total responses (Maaori, Pacific, Total)		
Improving population health equity and individual health through early detection and management of common conditions …	• Proportion of women aged 50-69 years who have had a breast screen in the last 24 months • Proportion of eligible people receiving cardiovascular disease (CVD) risk assessment in the last 5 years (Maaori, Pacific, Asian, Other) • Proportion of Counties Manukau residents who have had a previous CVD event who are on triple therapy (Maaori, Pacific, Asian, Other) • Total number of general practice enrolled patients with diabetes who do not have satisfactory or better diabetes management - HbA1c of greater than 64mmol/mol (Maaori, Pacific, Asian, Other)		
Improve support for people and families with mental health and addictions issues …	• Access rates to specialist mental health and addictions services across the life course (0-19 years), 20-64 years and 65+ years with greater access for Maaori (Maaori, Pacific, Other) • Proportion of people aged 0-19 years referred for non-urgent mental health of addictions services seen within 3 weeks and 8 weeks respectively (CMDHB Hospital Care and NGOs) • Percentage of people seen within 7 days of discharge from an adult inpatient mental health unit		
Providing the best value for health funding through efficient and effective service delivery …	• Percentage of surveyed patients that were 'very satisfied' with communication and coordination of experience (of care/services) • Proportion of patients referred with a high suspicion of cancer and a need to be seen within two weeks to first cancer treatment within 62 days • Patients waiting longer than 4-months for their first specialist assessment • Acute readmissions to hospital within 28 days • Improved workforce diversity as a percentage by ethnicity compared to population percentage by ethnicity (Maaori, Pacific, Asian, Other) • Number of patients having advance care planning discussions		

How will we know our population is living longer, healthier and more independent lives?

We will know we are succeeding when there is:

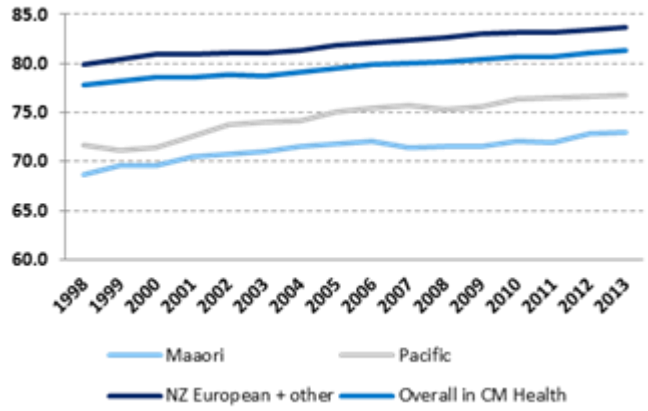
Continued improvement in overall life expectancy and narrowing of ethnic disparity

Life expectancy at birth is a key long term measure of health. Over the last decade life expectancy has shown a consistent upwards trend in Counties Manukau, closely reflecting the national pattern.

However, despite an overall increase in life expectancy, there continue to be large gaps between life expectancy at birth for Maaori and Pacific, and non-Maaori and non-Pacific groups. In addition Maaori in Counties Manukau have fallen behind Maaori nationally. The gap for Pacific, although smaller, is also of ongoing concern.

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.

The life expectancy gap of Maaori and Pacific in Counties Manukau compared to non-Maaori, non-Pacific



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.

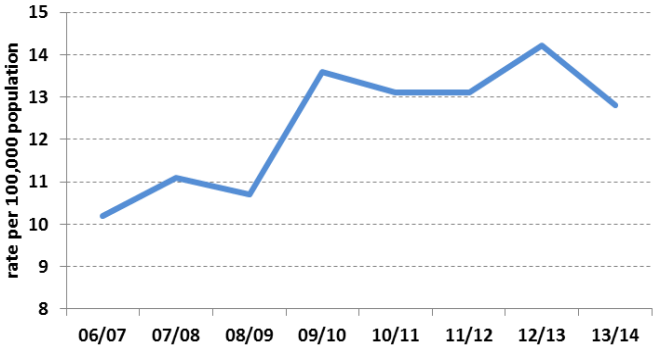
Data sourced from Mortality Collection, Ministry of Health; Estimated populations by DHB, Statistics New Zealand.

A reduction in the incidence of rheumatic fever

Acute rheumatic fever (ARF) is a preventable, life-limiting illness that continues to be diagnosed in children across New Zealand and 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.

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



CM Health has the highest number of rheumatic fever notifications in comparison to other DHBs, and has an overall rheumatic fever rate double the national average.

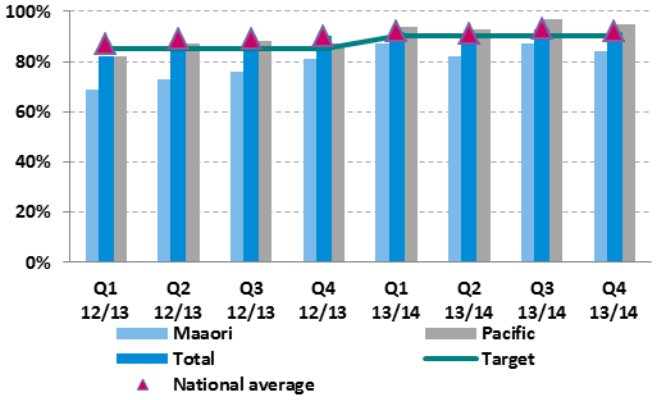
We are committed to reducing the burden of rheumatic fever in our communities and acknowledge the complexity of preventing this disease as well as the wide range of activities and investment needed if a significant reduction in cases is to be achieved. A range of initiatives implemented in line with national strategies is starting to show promising results.

An increase in immunisation rates

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.

The percentage of Counties Manukau children fully immunised at 8 months



Maaori children in Counties Manukau have lower immunisation coverage, and targeted approaches to improve this are outlined in the CM Health Maaori Health Plan.

A reduction in acute mental health episodes

Mental health disorders are common in New Zealand and worldwide. 47 percent of New Zealanders will experience a mental illness and/or an addiction at some time in their lives, with one in five people affected within one year.

It is estimated that at any one time approximately 3 percent of the population are severely affected by mental illness and/or addiction. Overall, Maaori and Pacific peoples experience higher rates of mental illness than non-Maaori, non-Pacific.

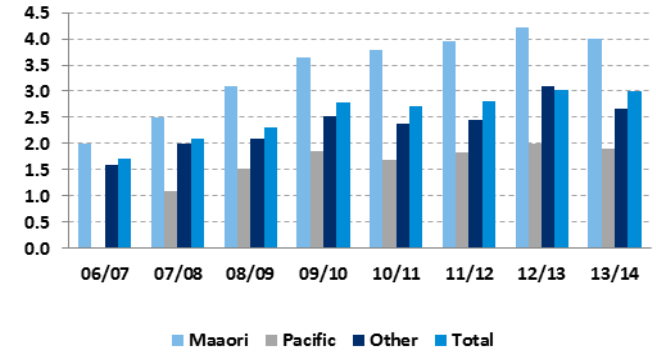
Accessible and responsive mental health and addiction services are a key factor in supporting people who experience mental illness to have an improved quality of life and fewer acute mental health episodes.

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.

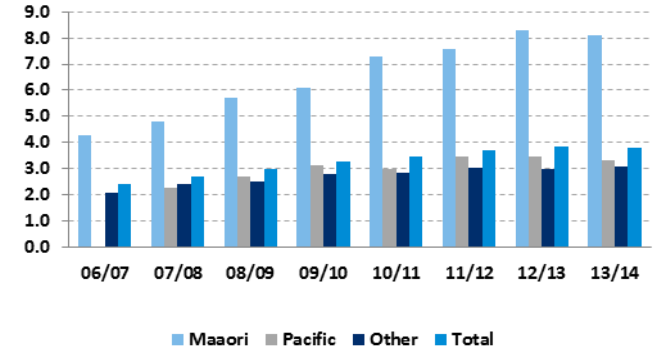
Mental health service access rates are a proxy measure for determining the impact of CM Health mental health services delivery on improving the quality of life for members of our population who are suffering from mental illness or issues with alcohol or drug addiction.

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,

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



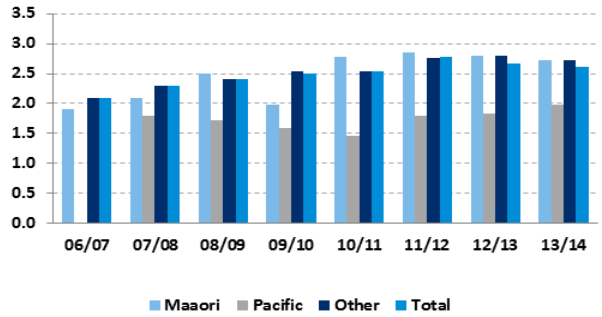
The mental health access rates for 20-64 year olds in Counties Manukau



respite and acute alternatives.

The expanded focus for the next one to five years relates to a wider group with moderate to severe illness, with a need to look at system wide models of care that builds on the gains made and further enhance the role of primary care and community based services.

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



Improved control of common conditions

In 2011, approximately 54,290 (14 percent of the adult population people aged 15 years and over) were identified with one or more long term (common) conditions. Volumes for each condition and the degree of overlap (people with more than one of the conditions) varied by ethnicity.

The largest number of people was recorded as having diabetes (33,140) and cardiovascular disease (11,780). These diseases have a disproportionate effect on the health of Maaori and Pacific people in the Counties Manukau community.

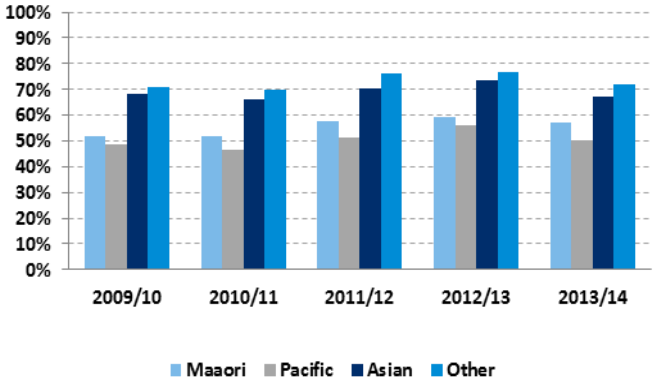
There is consistent evidence that good management of these conditions will improve morbidity and mortality – resulting in better health for the individual and reduced needs for acute hospital services.

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 disease and others.

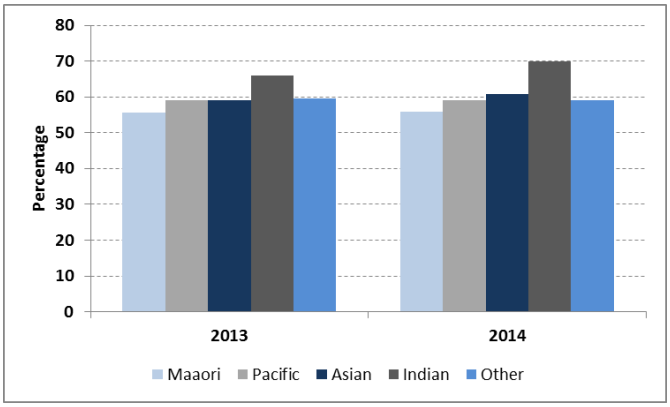
In cardiovascular disease there is good evidence that good control through proven interventions such as 'triple therapy' medicines.

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.

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



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 3.



[2] 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.

[3] 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 CM Health will undertake to implement the government's priorities as expressed in the Minister's Letter of Expectations and related guidance. This section is structured as follows:

2.1	**National Health Targets**
2.1.1	Shorter Stays in Emergency Departments
2.1.2	Improved Access to Elective Surgery
2.1.3	Faster Test and Cancer Treatment
2.1.4	Increased Immunisation
2.1.5	Better Help for Smokers to Quit
2.1.6	More Heart and Diabetes Checks
2.2	**Better Public Services**
2.2.1	Reducing Rheumatic Fever
2.2.2	Prime Minister's Youth Mental Health Project
2.2.3	Social Sector Trials
2.2.4	Children's Action Plan
2.2.5	Whaanau Ora
2.2.6	Pacific Fanau Ola
2.2.7	Healthy Families New Zealand
2.2.8	Obesity
2.3	**System Integration**
2.3.1	Primary Care
2.3.2	Integrated Performance and Incentive Framework
2.3.3	Diabetes Care Improvement Package
2.3.4	Long Term Conditions
2.3.5	Stroke
2.3.6	Cardiac Services
2.3.7	Diagnostic Waiting Times
2.3.8	Maternal and Child Health
2.3.9	Mental Health and Addictions & Rising to the Challenge
2.3.10	Health of Older People
2.3.11	Spinal Cord Impairment Action Plan
2.4	**National Entity Priorities**
2.5	**Improving Quality**
2.6	**Actions to Support Delivery of Regional Priorities**
2.7	**Living Within Our Means**

2.1 National Health Targets

2.1.1 Shorter stays in emergency departments

In July 2009 New Zealand adopted the 'Shorter stays in Emergency Departments' health target as one of the 6 health priorities. The health 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 entire acute care system both in 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. The shorter stays target is supported by a suite of measures more directly associated with good patient care.

Linkages

ED Mandatory Quality Framework; Project SWIFT

Actions	**Measures**

• Diagnostic/analysis work to identify the main factors impacting on ED length of stay (there has been a 4-6 percent increase in acute demand over the last year)
• Strategies to manage acute demand include:
  ○ Expansion of the Clinical Nurse Specialist role
  ○ Implementation of nurse facilitated discharges in Adult Short Stay Unit (ASSU)
  ○ Streamlining the flow of patients from the hospital to the community whilst maximising care in the community (refer to Integration section 2.3)
  ○ Development of pathway for acute PV bleeding for pregnant women within first 13 weeks of pregnancy using community ultrasound scanning and GP follow-up
• Streamlining processes throughout the hospital Emergency Department through the SWIFT project such as electronic referrals for radiology and other investigations (refer to section 5.2.3)
• Continued implementation of the ED Quality Framework, including:
  ○ Continued measurement of mandatory measures, and prioritised service improvement activity in response to this measurement
• Continued monitoring of non-mandatory measures including:
• Documentation
  ○ Airway
  ○ Analgesia
  ○ Sepsis
  ○ Heart – low risk chest pain pathway
  ○ Hand washing
	• 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours
	• 80 percent TC2 patients to be seen within 10 minutes
	• <2 percent and <20 minutes LOS of patients in corridors
	• <4 percent of patients re-attending within 48 hours
	• Self-discharge rate < 5 percent
	• Short stay admission rate < 15 percent
	• 80 percent of patients requiring PCI have a door to needle time of < 90 minutes
	• 80 percent of patients will have analgesia within 30 minutes of arrival
	• 80 percent of septic patients to have antibiotics within an hour of arrival
	• Nurse facilitated discharges in ASSU will commence by Quarter 1
	• Additional CNS recruited by Quarter 1
	• PV Bleeding pathway finalised by Quarter 1; pathway implemented by Quarter 2
	• Usage of inpatient ultrasound and Early Pregnancy Acute Clinic (EPAC) will reduce
	• Monthly reporting and monitoring of ED Quality Framework mandatory and non-mandatory measures

2.1.2 Improved access to elective surgery

The target is for CM Health to contribute to the national goal to increase the volume of elective surgery by an average of 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 reduce wait times for assessment and elective surgery to meet the government's target of no one waiting more than 4 months.

Linkages

Northern Region Health Plan; National Elective Productivity Plans; CM Health primary care initiatives

Actions

- Utilise Elective Initiative funding targeted to increase and improve equity of access
- Improve patient flow management to maintain reductions in waiting times for electives
- Review and enhance referral management processes
- 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
- Improve the management of follow-up volumes – review volumes and care pathways for secondary follow-up
- Increase nurse led clinics
- Ensure effective screening and preparation processes of patients prior to treatment
- Ensure effective scheduling of cases to theatre to maximise theatre utilisation and productivity
- Introduce new information technology to monitor and improve theatre scheduling processes (Theatre CAP PLAN)
- Benchmark CM Health's performance against national performance
- Participate in activity relating to development and implementation of the National Patient Flow system, including amending data submission for FSA referrals as required
- Continue to commit to use nationally recognised prioritisation tools

Regional Alignment

- Contribute to the planned national average increase in volume of 4000 elective surgical discharges to be provided year on year
- DHB sector support for Enhanced Recovery After Surgery (ERAS) initiatives implementation and potential model expansion to other surgical specialties

Measures

- Care did not attend Rate (DNA) at Manukau SuperClinic at June 2016
- Improved Elective Surgical Discharge rate is at least 308 per 10,000 population at June 2016
- SI4 Major Joint discharge SIR is at least 21 per 10,000 population at June 2016
- SI4 Cataract discharge SIR is at least 27 per 10,000 population at June 2016
- SI4 Cardiac Surgery discharge SIR is at least 6.5 per 10,000 population (this target meets current demand) at June 2016
- Elective Services Patient Flow Indicator expectations are 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 of Non-Contact First Specialist Assessments undertaken at June 2016
- Ambulatory FSA to Follow-up ratio at June 2016
- Elective Theatre Utilisation > 85 percent at June 2016
- Elective Inpatient Length of Stay Ownership Dimension (OS3) performance - 1.59 days
- Patient level data for referrals for FSA are reporting into new collection

Regional Alignment

- Delivery against agreed volume schedule, including a minimum of 19,883 elective surgical discharges in 2015/16 towards the Electives Health Target June 2016
- Delivery against the 2015/16 regional target of 57,356 elective surgical discharges
- ERAS initiatives in Orthopaedics

• Participate in a lead role in the national Orthopaedic Enhanced Recovery After Surgery Collaborative • Participate in the Urology Services regional review	• Increase in Urology Service elective surgical discharges provided locally at June 2016

2.1.3 Faster tests and cancer treatment

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 new 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 CMDHB 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

2015/16 CM Health Maaori Health Plan; 2015/16 Northern Regional Health Plan

Actions	Measures

• 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 by:
  ○ Continuing to develop improved faster cancer treatment reporting and quality reliability to inform service improvements
  ○ Improve data collection and quality aligned to specific tumour stream dataset definitions
  ○ Developing systems to make the faster cancer treatment data collection systems /processes part of business as usual
  ○ Utilise faster cancer treatment data through monthly reports to services to identify and improve patient flow and timely assessment and treatment
  ○ Developing improved pathways for urgent high suspicion of cancer patients by improving diagnostic turn-around times, optimising referral handling processes and maintaining proactive oversight of patients throughout the pathway
  ○ Standardising processes to reduce wait-times between process steps and ensure timely diagnosis and treatment
	• All patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy
	• Faster Cancer Treatment Health Target: 85 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 by July 2016
	• Improvement in the number of records being submitted with less than 5 percent of records being declined for the health target and policy priority (PP30) faster cancer treatment measures
	• 31 day indicator – (PP30A) – A focus on data quality and completeness of the 31-day records with the aim of ensuring all cancer patients are included as per the eligibility criteria
	• Monitor cancer multidisciplinary meetings improvements to the coverage and functionality of multidisciplinary meetings
	• Monitor through service improvement fund contract reporting (if funding application is successful)
	• Appropriate clinicians such as urologists and radiation oncologists receive 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
	• Supportive Care Regional plan developed implemented by July 2015
	• Supportive Care positions are recruited to and implemented by December 2015
	• Refer to Section 2.3.7 for diagnostic services and 2.3.6 for other Cardiac SIRs

○ Planning for service improvement initiatives locally and regionally for round two of the service improvement fund ○ Improving 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 • Improve waiting times and quality of endoscopy and colonoscopy services by: ○ Implementing the Endoscopy Quality Improvement (EQI) programme ○ Implementing regional colonoscopy capacity improvement work ○ Identifying and implementing improvements to colonoscopy services • Support on-going activities associated with round two of the bowel screening pilot • Implement guidance on the use of active surveillance treatment for prostate cancer care by June 2016 • Implement the Cancer Health Information Strategy (to be finalised in June 2015) • Support Budget 2014 initiatives including implementing supportive care services for cancer patients • Apply the 'Equity of Health Care for Maaori: A framework' to cancer pathways in alignment with the Maaori Health Plan • Participate in the regional approach to reviewing services against at least two national tumour standards (as agreed by the region) to improve timeliness and quality of treatment	

2.1.4 Increased immunisation

This target requires that 95 percent of eight month olds, 95 percent of two year olds and 90 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 has experienced breakthrough of vaccine preventable diseases such as measles and whooping cough in recent years. CM Health aims to reach the target for all population groups in our district. Effective interventions requires a whole of system approach – primary care practices and provider vaccinating, outreach information services who seek and contact hard to reach families and information systems that enable the sharing of information to track progress.

Linkages

2015/16 CM Health Maaori Health Plan

Actions	**Measures**
• Continue to deliver targeted immunisation strategies to achieve 95 percent coverage for Maaori children, for the 8 month and 24 month milestone targets • Maintain coverage of 95 percent for Pacific children for the 8 month and 24 month milestone age targets • Develop an immunisation action plan ensuring 95 percent of four year olds are fully immunised	• 85 percent of 6 week immunisations are completed (measured through the completed events report at 8 weeks) • 95 percent of eight months olds are fully immunised (6 weeks, 3 months and 5 months immunisation events) • 95 percent of two-year-olds are fully immunised • Coverage rates for Maaori equal to non-Maaori

• DHB Immunisation Alliance and Steering Group is made up PHO nurse leaders, Well Child Providers, Nurse Leader Immunisation, Nurse Leader Maaori Health and Pacific Health, and representation from Maternity Services. This group will meet monthly to: o Continually review and update the immunisation strategies o Monitor and evaluate immunisation coverage at DHB, PHO and Practice level, manage identified service delivery gaps o Drive service changes within the sector • Monthly monitoring and evaluation of immunisation coverage by DHB National Health Target Working Group • CM Health representation and attendance at Regional and National immunisation forums • Immunisation Nurse Leader to work with all practices with low Maaori and high needs coverage rates and meet individually with each practice to improve performance measured by the datamart report in the following month • Use a collaborative approach to offer parents, whaanau and caregivers support to attend immunisation appointments and/or offer outreach in alternative venues • Connect immunisation outreach services with the WCTO Provider who has been providing WCTO services to the pepe/tamariki to enable outreach and follow up to be done by a health professional the whaanau is familiar with • Active follow up on declines by Immunisation Nurse Leader to provide additional information to parents and whaanau on the benefits of immunisation and to address any concerns and questions • All children presenting to Kidz First services (as inpatients or ED presentations) will have their immunisation status checked and opportunistic immunisations provided. In 2015/16 we will investigate expanding the checking of immunisation status and opportunistic immunisations to outpatient appointments and advise by Quarter 4 • Increase newborn enrolment rates: o Continue working with maternity and primary care partners to monitor the newborn enrolment rates o Work with primary care to establish a process to ensure all newborn enrolments are accepted o Refer also to Primary Care section 2.3.1 • Actively promote and participate in 'Immunisation Week' • Develop an immunisation education and event calendar jointly with primary care and NGO sectors to include various promotional activities e.g. radio talk-back interviews, Reminder Cards, PHO incentives • Establish formal links with intersectoral providers and agencies to assist with promotional activities	• 90 percent of children fully immunised at 5 years of age by June 2016 • Monthly datamart report evaluation at DHB, PHO and Practice level • Immunisation action plan developed by Quarter 2 • Narrative report on DHB and intersectoral providers activity to promote immunisation week by Quarter 3 • 95 percent of newborns enrolled on the National Immunisation Register (NIR) at birth (measure NIR) • 100 percent of newborns enrolled with general practice (measured at 6 weeks, measure B code uptake) • CM Health participates in immunisation week activities • Immunisation education and event calendar available for the financial year • Public sector targets are reported on and reviewed • Narrative report on DHB and intersectoral providers activity to promote immunisation week by Quarter 3

as well as tracking families not currently engaged with health services and timely referrals to outreach immunisation providers • Regional planning with stakeholders and Auckland Regional Public Health Service (ARPHS) in response to planning for pandemic events Actions to support increasing HPV (12-year-old) immunisation rates to support the cancer strategy goal of reducing the incidence of cancer through primary prevention: • Establish a process with schools to identify new starters and leavers with the aim that the consent form can follow the student • Immunisation Advisory Centre (IMAC) MOH online learning tool implemented when released to promote knowledge benefits of the programme	• 70 percent of eligible young women receive dose 1, 65 percent receive dose 2 and 65 percent receive dose 3

2.1.5 Better help for smokers to quit

This target requires that 95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of PHO enrolled patients who smoke are offered brief advice and support to quit smoking. In addition, 90 percent of pregnant women who identify as smoking upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking. Every patient's smoking information must be documented accurately within the patient care record. In addition to sustaining target performance, CM Health's focus is on improving the rate of cessation support, particularly for Maaori and Pacific.

Counties Manukau will continue its commitment towards becoming a Smokefree district by 2025. The CM Health Executive Leadership Team and Board endorsed Smokefree as a key population health priority for five years from 2012. The CM Health Smokefree 2025 Initiative aims to reduce smoking prevalence to 5 percent or less across all groups by 2025, in line with the government's Smokefree 2025 goal. The interim target is to reduce prevalence to 12 percent (or less) by 2018 (and 18 per cent for Maaori).

Smoking prevalence is decreasing in Counties Manukau with prevalence for the overall CM population decreasing from 22.1 percent (Census 2006) to 15.9 percent (Census 2013). The prevalence of Maaori who smoke has decreased from 46.8 percent (2006) to 36 percent (2013) and Pacific from 30.3 percent (2006) to 23.2 percent (2013). There remains a significant equity gap, with Maaori prevalence in particular still more than double that of the overall CM population.

Smokefree resource has been realigned with the current MOH direction from secondary care to a broader focus across primary, secondary and maternity, and the wider community. Profiling of the current smoking population has been completed. Key priority groups for all Smokefree activity are Maaori, Pacific, pregnant women and whaanau, people with mental illness and addictions, and people with chronic conditions. Smoking is most common and most highly concentrated amongst people aged 15-49 years, and therefore activity will prioritise younger age groups overall. A key focus of the coming year will be to ensure all existing and new activity is aligned to the identified priority groups. This will include the implementation of recommendations from the 2015 needs and gap analysis.

Linkages

2015/16 CM Health Maaori Health Plan; CM Health 2015-18 Tobacco Plan

Actions	**Measures**
Smokefree 2025 • Implement Year 3 of CMDHB's Smokefree 2025 initiative	• 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 3 workplan is implemented and monitored
Secondary Care Continue to sustain secondary care target performance, and sustain or exceed the proportion of patients being referred for ongoing support via the following actions:	**Secondary Care** • Overall target: 95 percent of patients who smoke and are seen by a health practitioner in public hospitals will be offered brief advice and support to quit smoking.

• Provide and/or resource Nurse Educators, Smokefree Champions and other clinical staff to provide ongoing best practice training, orientation training and refreshers • Formalise the Smokefree Champions programme, and ensure there is an identified Champion in all services • Support and resource Smokefree Champions to promote commitment to Smokefree Best Practice • Ensure there is an identified Smokefree lead in all services • Audit and feedback processes including monthly target and referrals reporting and coordination about missed interventions • Acknowledgement of top referrer of the month across secondary services • Continue to provide the three Annual Awards acknowledging Smokefree Best Practice • Continue to roll-out support for Manukau Super Clinic modules and other satellite sites to implement Smokefree Best Practice • Trial an 'opt out' referrals system for all patients that smoke in at least one additional hospital ward • Identify additional DHB Hospital Care services for roll-out of Smokefree Best Practice • Implement the Stop Smoking project for people with Long Term Conditions within the organisation's 50,000 Self-Management Support campaign • Determine feasibility of establishing a smokefree support pathway for elective surgery patients • Trial new initiatives in secondary services aimed at increasing access to smokefree support for patients and whaanau, visitors and staff	Local targets: A minimum of one-third of inpatient, and one-third of other hospital services referrals will be for Maaori, and one-third for Pacific • Ongoing implementation of activities to support target and referral rates (Quarter 1-Quarter 4) • Ongoing roll-out of Smokefree Best Practice across selected modules and satellite sites (Quarter 1-Quarter 4) • 'Opt-out' referrals system trialled by Quarter 4 • Additional sites identified by Quarter 4 • Implementation of Long Term Conditions Stop Smoking Project commences Quarter 1, completed by Quarter 4 • Feasibility of pathway for elective surgery patients investigated by Quarter 2. If feasible, planning would commence by Quarter 3 • New initiatives trialled Quarters 1-4
Primary Care Activities focused on sustaining target performance: • Meet with PHO partners monthly to support the PHOs to achieve target by assessing performance and sharing best practice ideas and issues with other PHOs and the Clinical Champions for IPIF • Continue the e-module training around smoking cessation • Ensure that patients' dashboards and prompts are used when patients attend practice visits • Produce reports and undertake audits that enable practices to help them track their progress against MoH targets • Produce weekly graphs showing performance against the target to all practices • Provide support to practices with regular staff visits to discuss progress to date and share best practice with other practices • Ensure practices have smoking champions for smoking cessation who will provide ongoing coaching and support to patients and staff • Support practices to call appropriate patients to offer referrals to cessation support services • Utilise existing resources e.g. VLCA nurses, He Puna Oranga nurses to assist practice to achieve targets	• 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 referrals rates (Quarters 1-4) • Feasibility of pharmacy pilot assessed by Quarter 2. If feasible, planning to commence in Quarter 3

• Work with care coordinators for At Risk Individual (ARI) patients to assist and support them to provide cessation support and referrals to cessation services • Ensure that appropriate self-management support for smoking cessation is in place within all CM Health localities **Activities focused on improving the rate of cessation support:** • IPIF Clinical Champions to support CM Health and PHOs with guidance and advice to increase the rate of smoking cessation • Dedicated Smokefree Advisor (Primary Care) is employed by CM Health to support PHOs to improve the rate of cessation support, with a focus on Maaori and Pacific. Activities include: • Analyse PHO/practice performance in relation to cessation support and provide tailored support to prioritised practices • Work with CM Health and PHOs to build referral relationships with local smoking cessation services • Coordinate and/or deliver Smokefree Best Practice training and other relevant education opportunities • Undertake a stocktake of current activity in relation to patients 'given or referred to cessation support' (indicator four) to understand current performance and identify areas for improvement • Improve primary care follow-up and coordination for patients receiving smokefree support in hospital • Ensure primary care records reflect patient access to smoking cessation support by linking with external Smokefree initiatives and services • Support Smokefree initiatives in general practice such as Stoptober, World Smokefree Day and Quit Bus • Coordinate with other screening activity to deliver smokefree messages (e.g. CVD risk assessments, cervical screening) • Investigate the development of a pilot project aimed at increasing reach to smoking cessation support via Pharmacies in priority localities	
Maternity • Governance Group continues to guide implementation and monitoring of Maternity Target Action Plan • Implement Maternity Target Action Plan Activities to include: • Promoting proactive referrals by midwives to specialist Smokefree services • Review strategies and resources implemented in 2014/15 that increased referrals and continue those that were effective • Promote the importance of reducing smoking prevalence in pregnancy, particularly for Maaori, via newsletters, monthly meetings with self-employed midwives and internal communications • Support training opportunities for midwives and monitor training uptake (Te Hapu Ora and e-learning tool)	• 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking • Local target: 50 percent of pregnant women who smoke in Counties Manukau referred to the Smokefree Services (60 percent for pregnant Maaori women who smoke) • Governance Group meets monthly Quarters 1-4 • Maternity Target Action Plan implemented Quarters 1-4

• Showcase successful quitting stories with a focus on Maaori and Pacific • Support a smokefree focus within key maternity initiatives including the SUDI Action Plan and the Maternity Services campaign • Implement Year 3 of the Pregnancy Incentives project, which includes: • Continuing to deliver the project in the Manurewa and Mangere/Otara localities • Rolling-out the pilot in a third locality planned for Papakura • Scoping the addition of incentives after delivery to support postnatal smoking abstinence • Trial and evaluate a QuickMist promotion to increase self-referrals to specialist services • Collaborate with providers and community settings with high reach to pregnant women to increase delivery of Smokefree messages and referrals to specialist services • Take a targeted approach to addressing low referral rates within existing DHB and community services • Investigate incentivising referrers for referrals of smoking pregnant women • Work with Smokefree Advisor (Primary Care) and PHOs to trial an opt-out referral system in general practice for pregnant women in priority localities • Work collaboratively with Well Child Tamariki Ora and other providers to deliver smokefree interventions with whaanau • Implement recommendations of market research activity completed in 2015 in relation to pregnant women and whaanau	• Deliver Pregnancy Incentives Project Quarters1-4 • Addition of incentives postnatally is scoped by Quarter 4 • Ongoing promotion Quarters 1-4 • Trial Quickmist promotion during Quarter 1 • Ongoing identification of key stakeholders and community settings Quarters 1-4 • Identify areas with low referral rates by Quarter 2, address with key stakeholders during Quarters 2-4 • Determine feasibility Quarters 1-2 • Implementation and review of trial with one practice Quarters 3-4 • Commence work with WCTO and other providers Quarter 2

2.1.6 More heart and diabetes checks

This target requires that 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. CM Health has the third largest numbers of patients who are eligible for assessments, the second largest number of eligible Maaori patients and the largest number of eligible Pacific people. CM Health will continue the whole of system approach with a focus on CVD prevention and management in 2015/16 with increasing collaboration and sharing of information between primary and secondary care.

Linkages

CM Health Maaori Plan; Northern Region Health Plan

Actions	**Measures**
• Meet monthly with the health partners (PHOs) to look at monthly performance, develop solutions to barriers encountered and share success strategies • Encourage the use of Health Care Assistants to free up nurse time for CVD risk assessment (CVDRA) and management Clinical champions continue for all four quarters to support the CVDRA target • Continue to explore the possibility of inter-sectoral and workbase screening • Continue to work with the Northern Regional Cardiac Network and the MOH to establish CVD management indicators	• 90 percent of the eligible adult population will have had their CVD risk assessed in the last five years • CM Health will maintain the target of 90 percent for the 4 quarters of 2015/16 year • Quality improvement plans are submitted by PHOs to outline how the target will be achieved by Quarter 1 • Quarterly reporting on performance against the target and progress on specific actions

• Work in partnership with health partners (PHOs) to develop and deliver targeted education programmes to GPs and practice nurses • Utilisation of existing resources including VLCA and He Puna Oranga nurses to assist practices to achieve their targets • Continue to offer support via the CM Health clinical champion with clinical advice and guidance for CVDRA target • Continue to promote the use of Heart Foundation resources • Support practices with funding for the PREDICT electronic decision support tool in conjunction with the regional approach to licence • Monthly reports provided by PHOs to practices in order to monitor, understand and plan effectively for practice populations • Utilise additional funding from the MOH to support practices to enhance reporting, audit tools and systems including additional data analyst support • Continue to support practices to check HBA1c and lipid levels by encouraging phlebotomy skills in practice staff	
Regional Alignment • Number of people with diabetes who have had a CVD event and are on triple therapy	**Regional Alignment** • Total number of people with diabetes who have been an inpatient with a cardiac event in the last 10 years, who have had a recent health contact in the Northern Region (last 2 years)

2.2 Better Public Services

2.2.1 Reducing rheumatic fever

CM Health has the highest number of rheumatic fever notifications in comparison to all DHBs, and has an overall rheumatic fever baseline rate of 13.2 first hospitalisations per 100,000 population (based on 2009/10 to 2011/12 data). 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 in CM Health. This is also a priority in the CM Health Maaori Health Plan.

Linkages

CM Health Maaori Health Plan

Actions	**Measures**
Deliver activities and actions as per current CM Health Rheumatic Fever Prevention Plan: • Review the school based throat swabbing service, in view of evaluation findings and the withdrawal of MoH funding, with the aim of developing a sustainable model within funding constraints • Work with the National Hauora Coalition to deliver sore throat swabbing services to 61 schools in Counties Manukau until December 2015 • Work with CM localities to enhance the delivery of school based rheumatic fever prevention programme • Work in partnership with the Ministry of Health to agree funding for sore throat swabbing services when contracts end in 2015	• 25,000 children in high risk areas CM Health can access throat swabbing services through targeted school based programmes free of charge (Mana Kidz) • Initial Hospitalisation rate reduced to 5.9 per 100,000 by Quarter 4 • Support ongoing Continuing Medical Education (CME) sessions on the appropriate management of sore throats in primary care • All children admitted to secondary care who meet the criteria are referred to AWHI • Notification of rheumatic fever to the Medical Officer of Health occurs within 7 days

• Develop and agree a sustainable pathway for the service • Continue with the rapid response clinics as agreed between the MOH and the Rheumatic Fever Alliance Leadership Group • Work with the Hospital Care arm and primary care to develop systems to identify families with children at high risk of rheumatic fever (defined as Quintile 5, Maaori and/or Pacific) living in crowded housing and refer to Auckland Wide Housing Initiative (AWHI) • Work collaboratively with primary and community service partners to develop systems that ensure that people with Group A strep have begun treatment within 7 days • Continue to work with the provider arm to ensure that the notification of acute rheumatic fever to the Medical Officer of Health occurs within 7 days • Secondary care clinicians will review cases of rheumatic fever to identify risk factors and system failure points • Work with Primary Care to understand the number of people receiving prophylaxis through General Practice rather than through community nursing services • Review and update the Rheumatic Fever Prevention Plan by Quarter 1 • Deliver activities and actions as per the updated Plan	• Patients with a past history of rheumatic fever receive monthly antibiotics no more than 5 days after the due date • Pathway developed by Quarter 1 • Number of injections overdue by more than 5 days is less than 10 percent • Provide an updated rheumatic fever prevention plan by Quarter 1 • Provide a quarterly report to MoH on the actions taken as a result of the case review process
Regional • Regional Technical Advisory Group will meet monthly • Regional Child Health Network Steering Group will maintain a line of sight across the Northern Region DHBs Rheumatic Fever plans • Auckland Regional Rheumatic Fever Database will operate from a new IT platform and with new clinical data governance structure	

2.2.2 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. The new youth health model of care will unite youth services across many different service providers and settings. Working collaboratively across the sector and with other agencies, we will develop clear inter-agency pathways between health, education and justice, in order to intervene earlier for those most at risk of developing mental health and addictions issues. The model of care focusses on:

- A comprehensive and effective model of school based youth health services
- Integrated youth health services including primary care, mental health and addictions services and the Centre for Youth Health
- Alignment with the CM Health System Integration Programme and the development of Locality Clinical Partnerships

School Based Health Services • Ensure on-going implementation of School Based Health Services (SBHS) in all funded schools • Trial aligning school-based clinics with primary care and mental health and addiction services for at-risk young people, with a focus on lead coordination, better information sharing, reduced referral/assessment barriers with timely wrap-	• All funded schools receive SBHS and 90 percent of Year 9 students in funded schools receive a HEEADSSS assessment • Pilot and evaluate a school- based integration approach for at-risk young people in two high schools by Quarter 4

around support and follow up • Continue with the implementation of 'Youth Health Care in Secondary Schools: A framework for continuous quality improvement' in all funded schools	• Adherence to MOH reporting requirements for SBHS
Youth Primary Mental Health • Primary health care services are more appropriate and responsive to young people, particularly Maaori, Pacific and low decile youth • Appropriate pathways, aligned with the new model of care, are refined to ensure early intervention, referral, support, advice, advocacy and mental health and addiction support • A competency framework for health professionals is developed encompassing the primary, secondary and NGO workforce and includes cultural competence	• Primary mental health initiatives are accessible in all alternative education settings • Appropriate pathways are implemented to connect young people to services (as part of the new model of care) • Development of a competency framework to ensure the health workforce meets the needs of young people in Counties Manukau
Improve the responsiveness of primary care to youth • Review the governance arrangements of the youth-specific Service Level Alliance Team (SLAT) so that it better align its functions with the Prime Minister's Youth Mental Health project and implementation of the whole of system Youth Health Model of Care • Complete an additional stocktake of some services to ensure complete identification of gaps in responsiveness, access, service provision, clinical and financial sustainability, prior to implementation of the whole of system Youth Health Model of Care • Development of an implementation plan for the whole of system Youth Health Model of Care	• Update the Terms of Reference of the Youth-specific SLAT by Quarter 1 • Stocktake of some youth health services undertaken to complement previous stocktake by Quarter 2 • An implementation plan for the whole of system Youth Health Model of Care is developed by Quarter 3
Review and improve the follow-up care for those discharged from Child and Adolescent Mental Health Service (CAMHS) and Youth Alcohol and Other Drugs (AOD) services • A process is developed to capture data on follow up of youth (12-19 years) in primary care following discharge from CAMHS and Youth AOD services • Focus on improving communications with primary care	• Establish baseline data on the percentage of follow-up plans given to primary care providers and the activation of these plans by Quarter 2 • Audit communication with primary care around patient medication changes by Quarter 2
Improve access to CAMHS and youth AOD services through wait times targets and integrated case management • Continue to meet and monitor waiting time targets for access to CAMHS and youth AOD services using the Kotahi Ra (first/Choice) electronic booking system and PRIMHD • Increase access and improve integration for at-risk young people through the school-based clinic trial, with a focus on lead coordination, better information sharing, reduced referral/assessment barriers with timely wrap-around support and follow up	• 80 percent of youth to access services within 3 weeks; 95 percent to access services within 8 weeks (12 months) • Establish DNA baseline and agree appropriate action • Pilot and evaluate a school- based integration approach for at-risk young people in two high schools (as above) by Quarter 4

2.2.3 Social Sector Trials

• Actively engage with Social Sector Trials working groups which relate to services for youth who reside in Counties Manukau DHB catchment area • Inclusion of Social Sector Trials as a part of the Youth Model of Care being developed by CM Health – Q1 2015/16	• Ongoing engagement with Social Sector Trials working groups throughout Quarters 1-4 • Social sector Trials are included as part of the Youth Model of Care by Quarter 1

2.2.4 Children's Action Plan

The Children's Action plan 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 appropriate. Counties Manukau has been identified as one of the next districts to establish a Children's team with the expectation that a Children's team will be established in Quarter 2.

Actions	**Measures**
• Continue to meet requirements of Vulnerable Children's Act – refer section 0 • Children admitted to emergency department and inpatient services for Non Accidental Injury (NAI) will receive a 24 hour interagency response whereby Child Youth and Family (CYF), NZ Police and CM Health formally meet to share information and develop a management plan as described within the Memorandum of Understanding with CYF, Police and DHBs • Complete a stocktake of health services that support vulnerable children through the establishment funding of Children's Teams • CM Health will continue to deliver Violence Intervention Programme (VIP), including shaken baby education for appropriate areas, and undertake regular audits • 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 • Continue to screen for family violence and refer to appropriate services	• Stocktake of health services that support vulnerable children completed by Quarter 2 • Violence Intervention Programme (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
• Maintain the National Child Protection Alert System (NCPAS) • 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 • DHB 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 identified) will be implemented by Quarter 4	• Monitor implementation of NCPAS and other child protection information systems by 30 June 2016 • Children in state care will be continue to be seen via the Gateway programme
• Work with other sectors to implement the Children's Action Plan in Counties Manukau: • Attend regional 'Strengthening Families' meetings and ensure health is at the Local Management Group meetings	• Attendance at the Better Public Services intersectoral group that meets to coordinate regional activities

• 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 • 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 learnings and application to CM Health • Actions to support establishment of Children's Teams include: • Appoint an interim Project Manager to lead health sector engagement • Complete a stocktake of current services • Participate in planning and Locality Leadership Groups (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 • Service planning and development activity to provide an effective continuum of services across primary and referred health services to meet the needs of: • Vulnerable children and their families • Children in state care • Children with mental health and behavioural problems • Continue work to identify appropriate support for pregnant women with complex social needs • Vulnerable children and their families will be supported through the implementation of the Children's Team with an emphasis on care coordination and information sharing • Mental health and addiction service users in their role as parents – refer section 2.3.9 • Support implementation of Rising to the Challenge - refer section 2.3.9 • Healthy Beginnings: Developing perinatal and Infant Mental Health Services in NZ - refer section 2.3.9	• Project Manager appointed by Quarter 1 • Implementation plan Quarter 1 • Stocktake completed by Quarter 1

2.2.5 Whaanau Ora

CM Health has the second largest Maaori population in the country. The role of tribal and Maaori community leadership in the Counties Manukau district is pivotal if we are to enable and support Whaanau to achieve their Whaanau Ora aspirations in our district.

The Whaanau Ora philosophy articulated by the Whaanau Ora Taskforce, as it relates to health, provides the philosophical base for the CM Health's approach to Whaanau Ora.

The characteristics of the philosophy that give Whaanau Ora definition and distinctiveness are as follows:

- Recognises a collective entity (whaanau)
- Endorses a group capacity for self-management and self-determination
- Has an intergenerational dynamic. That is, Whaanau Ora is about on-going intergenerational transfers towards the goal of increasing sustainability of improved health outcomes
- Is built on a Maaori cultural foundation
- Asserts a positive role for whaanau within society
- Can be applied across a wide range of social and economic sectors

To progress Whaanau Ora in our district we will proactively work with:

- Whaanau
- Manawhenua
- Te Kotahitanga (Whaanau Ora Provider Collective)
- Te Pou Matakana (Whaanau Ora Commissioning Agency)
- Maaori Health Providers
- Other key stakeholders

Overall, CM Health will take a collaborative leadership approach with a diverse range of stakeholders to implement Whaanau Ora across the district and in all localities with in our district.

Delivery of this measure supports the overarching outcomes for the health and disability system of:

- New Zealanders living longer, healthier and more independent lives, and
- The health system is cost effective and supports a productive economy supports sector outcomes of:
- Improved health and equity for all populations
- Best value for public health system resources
- Improved quality, safety and experience of care
- Government priorities:
- Better Public Services
- Health Targets
- System Integration

Linkages

2015/16 CM Health Maaori Health Plan; He Korowai Oranga

Actions	**Measures**
Whaanau Ora Model of Care – Hospital	
• Implement new co-designed Whaanau Ora services within CM Health (formerly known as Te Kaahui Ora)	• Implementation of new Whaanau Ora model of care commences Quarter 1
Whaanau Ora Collective	
• CM Health will strengthen the relationship with our local Whaanau Ora Provider collective through: • Working with the Kotahitanga Collective to identify and agree areas where the DHB can support capacity and capability building of the collective to improve whaanau health outcomes • Involve Whaanau Ora providers and Kotahitanga Whaanau Ora Collective in strategic planning	• Active participation by the Kotahitanga Collective in the design and implementation of an intersectorial co-design process of the Whaanau Ora Outcomes Framework. • Quarterly meetings to be held to identify areas of opportunity to improve Whaanau health outcomes and support of capacity and capability

Whaanau Ora Commissioning Agency • CM Health will continue to work with Te Pou Matakana to identify and implement opportunities for co-investment and service design • Engage with Te Pou Matakana Commissioning Agency to identify opportunities to support Whaanau Ora providers • Implement agreed joint initiatives	• Quarterly meetings will be held with Te Pou Matakana • Identify and agree to a joint initiative to implement with Te Pou Matakana by Q2
Whaanau Ora Information Systems • Participate in processes led by the Ministry of Health to obtain a broader health sector view on Whaanau Ora implementation, including support to providers using the Whaanau Ora Information System • Contribute to the development of the Whaanau Ora Information System • Provide support to local Whaanau Ora providers that implement the use of the Whaanau Ora Information System (Mahere)	• Support the Kotahitanga Whaanau Ora Collective and the Maaori providers involved with this group to implement the use of the Whaanau Ora Information system. These providers being Turiki Health, Papakura Marae and Te Kaha o Te Rangitahi
Whaanau Ora Outcomes Framework • A Whaanau Ora Outcomes Framework is developed in alliance with Maaori health providers and other key stakeholders	• A Whaanau Ora Outcomes Framework is developed and implemented by Quarter 3

2.2.6 Pacific Fanau Ola

Pacific people number 120,000 in Counties Manukau representing about 23 percent of our population. We have embedded a Fanau Ola (Pacific Whaanau Ora) approach in our work in the hospital and through the integrated Pacific provider contracts. Pacific people living with complex conditions need care that is able to be sustained and supported within their fanau settings, and we recognise the fanau as being and important part of the healthcare team.

Linkages

CM Heath Accelerating Pacific Health Gain Plan 2017

Actions	**Measures**
• Strengthen and refine the Fanau Ola Support Service provided by the Pacific Fanau Ola hospital team • Redesign Fanau Ola toolkit • Implement the Lotu Moui & Community Plan, with a focus on Fanau Ola initiatives • Align Pacific Providers to the Pacific Fanau Ola Outcomes Framework and implement an Integrated Services Agreement with Alliance Health Plus as Lead Provider to support their delivery and achievement • Engage with Pacific Whaanau Ora Commissioning Agency to align Fanau Ola strategies • Implement a Fanau Ola technology system to enable the delivery of Fanau Ola across secondary, primary, and community care • Continue to work with CMH across whole of system with a focus on key initiatives to include Fanau Ola as integral to development including: • Localities • At Risk Individual • Self-Management Education • Emergency Care	• Quantity of Pacific Patients / Fanau engaged in Fanau Ola; Quality of experience / achievement • Pacific Fanau Ola toolkit completed • Lotu Moui & Community Plan implemented / initiatives development / achieved • Pacific Providers agreement to delivery Fanau Ola / Quantity; ISA Contract implemented; Quantity of Pacific Clients / Fanau engaged; Quality of experience / achievement • Commissioning Agency engagement • Fanau Ola technology system designed, developed, implemented, resources; quantity and quality of operationalization • Engagement across CMH initiatives (quantitative / qualitative), including: • Localities • At Risk Individual • Self-Management Education • Emergency Care

2.2.7 Healthy Families New Zealand

Encouraging New Zealand families to live healthy, active lives – by making good food choices, being physically active, sustaining a healthy weight, quitting smoking and moderating alcohol consumption – is part of the Government's approach to supporting the underlying causes of good health. Healthy Families NZ is a new initiative that aims to improve people's health where they live, learn, work and play by taking a dynamic systems approach to preventing chronic disease. The systems approach helps us to better understand both the complex systems that are the cause of public health issues we face, and the characteristics of prevention systems that might hold the solutions.

Healthy Families NZ will build on existing activities through a programme of targeted investments that draws upon the right mix of leadership, encouragement, information and resources. The most visible aspect of Healthy Families NZ is the establishment of Healthy Families communities. Healthy Families for the Manukau Ward and the Manurewa-Papakura Wards will support local leaders to galvanise voluntary action across multiple settings and implement initiatives that encourage families to live healthy, active lives. For these local communities, evidence suggests that significant health gains can be made by strengthening the prevention system for Maaori and Pacific peoples, and for those living in deprivation 9 and 10 areas.

The Tāmaki Healthy Families Alliance (THFA) comprises three partner organisations: Ngā Mana Whenua o Tāmaki Makaurau (Tāmaki Iwi Collective), The Southern Initiative – Auckland Council and Alliance Health Plus Trust. The Ministry of Health is also a member of the Alliance. The Alliance was established following a successful tender process for the Healthy Families New Zealand (HFNZ) programme in the Manukau and the Manurewa-Papakura wards.

Linkages

Health Promoting Schools; Infant Nutrition Project; Mana Kidz, ECE; ARPHS led Healthy Auckland Together; Smokefree initiatives

Actions	**Measures**
CM Health will support the Taamaki Healthy Families Alliance by: • Participating in the Tamaki Healthy Families Alliance governance group(s) • Increasing awareness amongst CM Health services and staff of the initiative • Aligning existing and new CM Health health promotion initiatives and projects with the aims of HFNZ where appropriate • Participating in the Prevention Partnership Group	

2.2.8 Obesity

The prevalence of obesity (BMI ≥30 kg/m2) in New Zealand adults is one of the highest internationally and there are clear disparities between ethnic groups, with higher prevalence for Maaori and Pacific communities, and higher prevalence for those living in the most socioeconomically deprived areas compared with those living in more advantaged communities. Childhood obesity also continues to increase in New Zealand whereas it appears to have plateaued in some countries. Those patterns are clearly very important for CM Health, given our youthful and ethnically diverse population. In the 2011-13 regional NZ Health Survey results, Counties Manukau had the highest age-standardised prevalence of adult obesity at 40.5 percent compared with 29 percent for the total NZ population. In addition 18.6 percent of children aged 2-14 years in the Counties Manukau survey sample were obese compared with 10.8 percent nationally.

The NZ Burden of Disease study clearly highlights the reality that CM Health clinicians face daily - the impact from this high level of obesity on the health of our population and on our health system. However it is also clear that there is no magical silver bullet to 'fix' obesity but a need for multilevel actions across multiple actors in communities and society. The interventions of most importance for obesity prevention and management are those related to the systemic and environmental drivers; those interventions are also the most challenging and those about which we have least certainty of evidence. In the context of Counties Manukau this means we need to act where we can, and work with regional and national partners to influence those systemic and environmental drivers.

Actions	Measures

• Infant Nutrition Project
• Regional Child Health Action Plan
• Healthy Families New Zealand (HFNZ)
• Health Food and Beverages Guidelines:
  ○ Work with regional working group to implement guidelines throughout Counties Manukau
  ○ Share implemented learnings
• Healthy Auckland Together Programme (HATP)
• Bariatric surgery
• B4 School Checks
	• Breastfeeding - Refer to section 2.3.8
	• Consistent measurement tools across the region within Emergency Department settings with a view to denormalising conversations with parents and caregivers
	• HFNZ - Refer to section 2.2.7
	• HATP - Delivery of an inter-agency regional plan for action, led and coordinated by Auckland Regional Public Health Service (ARPHS) in collaboration with regional health and other sector stakeholders

2.3 System Integration

Over the last year the implementation of the At Risk Individuals (ARI) programme across CM Health has introduced a model of care for the wider Primary care team to work collaboratively with a family/whaanau to provide more planned, proactive care for complex patients. Most primary care practices within Counties Manukau have transitioned to this model with over 7,000 patients enrolled in the programme. The introduction of the Very High Intensive User (VHIU) programme, followed by the implementation of ARI in 2014 and other locality initiatives, has developed key linkages between primary and secondary clinicians.

Multidisciplinary community teams are forming around general practice clusters in each locality to better support primary care as the central focus and co-ordinating mechanism of healthcare – the 'Healthcare Home'. Locality leadership groups are providing governance locally to implement new models of care and cluster arrangements. Over time, most community services (except those that are highly specialised) will work within integrated, multi-disciplinary locality-based clusters.

Integral to the success of this integrated approach are the principles of developing a "Healthcare Home" model of care within general practices.

Key principles of a "Healthcare Home" Model of Care are:

- Comprehensive, including but not limited to:
  - Proactive, coordinated care
  - Improved integration with specialty, community and social care teams
- Accessible, including but not limited to:
  - Extended hours
  - Patient portals
  - Virtual consultations e.g. phone/email
- Efficient, including but not limited to:
  - Re-engineered business processes e.g. triage, call management
  - Improved facility design
- Sustainable, including but not limited to:
  - New professional roles
  - Self management support for patients/whanau
- Standardised, including but not limited to:
  - Shared electronic health record
  - Utilisation of best practice Care Pathways

CM Health intends to support "Healthcare Home" model of care principles by:

1. Continuing to invest in the At Risk Individuals (ARI) program
2. Partnering with our PHOs to identify opportunities that will encourage the establishment of "Home Healthcare" principles in their member general practices

We are now embarking on a programme of work to redesign our community health services in order to improve the health and outcomes for people in our community and determining how we can best support them as they progress through their life journey. This programme will be delivered through three workstreams:

Locality reablement services: The locality community teams will aim to assist people to be as well as they can be at home ("reablement"), particularly during and after an acute deterioration. This includes continuation of work commenced to refocus district nursing, allied health and Needs Assessment/Service Co-ordination teams to work effectively within the locality model. Key principles include:

- Integrated with primary care practice clusters to support the healthcare home model
- Patient and whaanau centred care plans
- Maximising patient's strengths, function and ability to maintain life roles
- Focus on health literacy and self-management
- Focus on health promotion and minimising disease progression
- Equity of access
- Redesign of the district nursing role to enable increased capacity for acute assessments to avoid hospital admission and complex clinical interventions

Implementation of this new model includes the core functions of:

- Supported discharge for adults (18 plus) going home from Middlemore Hospital;
- Direct access from primary care and community to avoid an Emergency Centre (EC) attendance or hospital admission; and for sub-acute services to avoid the risk of these outcomes as well as residential care admission;
- Pre-planned interventions to enable at risk adults to receive an intensive Interdisciplinary community rehabilitation programme that will aim to support self-management and reduce hospital admission risk;
- Rapid response for adults at risk of Middlemore Hospital admission
- Intake service for all people referred for long term home care or requiring 'rest home' placement, if clinical discretion allows
- These core enablement functions within Community Health Services are referred to as ReaCH

Restorative community services: A redesign of currently contracted home and community support services is required to align care delivery, support integration and the healthcare home model going forward. CM Health currently contracts with HCSS providers largely for traditional services that focus on personal care such as showering and household management support. Our intention is to undertake a co-design process with service providers and key stakeholders to develop a holistic, patient centred, goal based and flexible approach to support older people in the community. This will include key elements such as targeted assessments, client goal facilitation, functional ADL (activities of daily living) exercises, supported working training and enhanced supervision, care management and better alignment of health professional roles.

Community Central: Will be one point of contact and referral for all, enabled by a technology solution that supports a 'first response' request for services, triaging, allocating resources, capacity planning and telehealth capability. This is centrally organised, but locality driven including:

- Intake of all community health services
- Referrals management (NASC, Home Healthcare, community mental health, child health), including e-referrals
- Screen and triage function
- Communication & co-ordination
- Re-direct and access DHB and non-DHB services
- Customer Services or Information Centre
- One point of contact
- 7-day service
- Information for clients, referrers, social agencies etc.
- Problem solving and directing
- Ability to network with health and social agencies
- Telehealth monitoring and support
- Workforce capacity and production planning
- Visible workforce (geographical position support)
- Access to inpatient and outpatient services

The focus of this programme is to ensure community health services support patients as they progress through their life journey and the co-ordinating role of the healthcare home. For most people, the on-going point of continuity is their general practice. We will no longer see episodes of care in other services (such as a hospital admission) as a transfer of care; instead we will see it as a continuous journey that involves episodes where extended care and support is required.

The key principles of this programme of work include:

- Remembering that we are here for the people and their whaanau and that everything we do should be geared to support this
- Valuing those that are working at the frontline to provide the services to support our people and their whaanau
- Recognising the holistic needs of whaanau and that health determinants are more about social factors than our health services
- Recognising that we are working in a complex adaptive system with skilled individuals who will evolve care delivery over time if enabled
- Allowing a variety of operational models to respond to unique population needs but aim to achieve good outcomes and equity. By definition achieving equity for our populations means that some must receive different inputs from others

Enablers are critical to the work of integration, in particular information systems development. Notwithstanding good system enablers, integration is a 'contact sport' between people that are working in the system and is dependent on relationships that develop. Finally, our work should be clinically led supported by enabling management.

Mangere – Integrated Public Services Pilot

CM Health plans to work with and support the Alliance Health+ PHO to develop and implement a new model for integration of health, social and other services within the Mangere locality. The proposal for his integrated public services pilot is presently being considered by the minister of Finance and offers potential for roll-out to other high needs communities.

At Risk Individuals Phase 2 – Next Steps

The target is that 3 percent of the Counties Manukau population will be either currently enrolled, or enrolled and discharged successfully from the programme by the end of Quarter 4 (2015).

GP clusters will be consolidated and a further roll out of multi-disciplinary case conferencing will commence.

VIVID technology will be implemented to enable virtual case conferences for High Risk Individuals, specialist-led group education / case study sessions for general practices, and to allow general practitioners / practice nurses to link with Home Health Care staff who are at a patient's home.

In general technology will be used to run more efficient meetings, eliminating the time and cost of travel. Technology enabled (video) multidisciplinary case conferencing capability is available to all enhanced general practice teams, and is established in willing practices in the Franklin Locality.

The At Risk Individuals Model of Care will be developed to better provide for complex families, children, palliative care patients and their carers, and patients and families with mental health and addictions.

The development of a quality improvement and training plan for At Risk Individuals Multi-Disciplinary Team meetings is underway in all localities.

E-shared care plans and Partners in Health assessments are undertaken in line with requirements of the programme as per the enrolled population.

Renal patients will be the first cohort group in Pharmacy integration, and pharmacy support for practice teams for ARI in general will occur.

Localities	
Actions **Community Health Hub Development** **East** • Work with East Health PHO, East Care, BUPA and Sapere to establish a viable and dynamic Community Health Hub in the Eastern Locality that will be a leading showcase internationally of inter-sectorial, vertically and horizontally integrated health care provision **Manukau** • In Manukau work with PHO's, health and Social service providers and Sapere has commenced to undertake a service needs analysis and develop a master services plan for the locality. This work will identify opportunities for development of integrated family health services and community health hubs **Franklin** • Primary care and Social service providers in Franklin are helping to identify services that can be delivered from the Locality Hub – Pukekohe Hospital or from General Practice locally. This will include a service needs analysis and development of a master services plan for the locality **Otara/Mangere** • A leased facility will be fitted out in Mangere to create a shared services hub, which is able to deliver a more intermediate level of care out in the community to the Locality population. Services will be identified that can be delivered outside of the hospital, within the locality, and the scale required to make it feasible • Consideration will be given to what else should be in the hub from the community's perspective. The hub will be a central focus point where people feel comfortable to access resources to keep them well. Specifications include a community accessible meeting space, resource rooms, telecommunications equipped • A facility will be leased in Otara and equipped with technologies that enable multidisciplinary case conferencing with secondary care specialist service providers	**Measures** • Production of a master services plan detailing devolution of services by type and volume by Quarter 1 • Health Hub established and functional within existing infrastructure by Quarter2 • All plans signed off and agreed for the new Health Hub building by Quarter 4 • Completion of consultation process with key stakeholders and service needs analysis by Quarter 1 • Master service plan that informs the development of community health hubs by Quarter 2 • Completion of Service Needs analysis (type and volume) by Quarter 1 • Plans developed for services which can be provided from the Locality Hub by Quarter 2 • Building upgrade requirements identified for the Locality Hub – Pukekohe Hospital to deliver new service model by Quarter 4 • Completion of Service Needs analysis (type and volume) and agreement on service mix with key stakeholders by Quarter 1 • Plans developed for services which can be provided from the Locality Hub by Quarter 2 • Building fit out started by Quarter 4
Franklin 'Help You Help Me' Project • The Franklin 'Help You Help Me' Project is intended to support primary care develop holistic care packages for patients/family/whaanau by the provision of relevant, local, information in a familiar format and location. It will also support Franklin residents in identifying and locating services and support groups for their own self-management • Over time, the project will secure a comprehensive on-line searchable data-base of community health & social care providers, peer support groups, and self-development programmes	• Achieve listing of first 24 services/groups by Quarter 1 • Commence measurement of impact through "hits" on site and patient/client feedback. Identify and commence listing of second tranche of providers/groups by Quarter 2 • Review progress, adjust presentation and measures as necessary, and identify third tranche for listing by Quarter 3

Dementia Care Pathway • Develop and pilot an integrated dementia care pathway in the Franklin Locality, building on the work of the Memory Team currently operating in Mangere, Otara and Manukau Localities	• Integrated primary model in one GP Practice in Franklin by Quarter 1 • Develop an education package on dementia identification and management with the Primary Care team, The Memory Team and Alzheimer's Auckland Trust • Education sessions will be held for the members of the pilot practice. • Case reviews will be conducted as part of the integrated pathway; a process will be developed to assist this by Quarter 2 • 80 percent of referrals for cognitive assessment and management from the identified General Practice will be managed through the new integrated pathway by Quarter 4 • Evaluate the effectiveness of the integrated pathway and it's suitability to spread to other Practices both within Franklin locality and other localities
Otara maternal and child health services integration project (until 31 January 2016) • Increased level of integration between stakeholder providers of care for pregnant women and their young children • Embedding a network of local general practitioners, practice nurses and midwives to work together on maternity and child health related topics. • A simple, hand held tool for sharing information between midwives and general practices (the pregnancy journey card) • Increased use of assessments and screening, care planning, case coordination and referral pathways by stakeholders • General practice systems to support assessment, care planning and track referrals for pregnant women • Streamlining of processes to enrol newborns at general practice • Increased use of appropriate services by women and young children • Pregnancy packs of information given by general practices to newly pregnant women • Tapuaki pregnancy and parenting learning sessions are provided in Otara • Local midwives directory to support early engagement with antenatal care	• Regular (six monthly) network meetings, discussion and actions around common areas of care • Quarter One: All Otara general practices are using the pregnancy journey card • A majority of Otara general practices have embedded systems to help them plan and coordinate the care of pregnant women • All Otara general practices are using the pregnancy packs and local midwives directory • Women in Otara have access to fit for purpose, local pregnancy education by Quarter 3
Integrated Podiatry Project **People live better with diabetes** • Better uptake of smoke free initiatives • Better uptake of self management support • Better access to foot care information & tools **Better identify risk** • Do more foot checks • Learn and use the Ipswich Touch Test • Using a common foot assessment and risk stratification method	• Increased volumes of referrals to community podiatry by Quarter 1 • NZSSD foot check and referral guideline implemented within integrated primary and community teams by Quarter 4 • All PHOs have sufficient podiatry providers delivering clinics in the localities • Training needs analysis and training plan completed by end of quarter one and implemented by Quarter 4

Provide BSMC and better integrated treatment and care • Agree intervention thresholds for low, moderate, high and active foot disease • Used shared care plan for people with high risk & active foot disease • Provide services locally where need exists • Credential for competency in management of high risk foot • Network and learn together **Continuously monitor results** • Use a common framework to measure better integrated and more effective foot care **Outcomes** • Reduced mortality and morbidity rates for people living with diabetes • Reduced unplanned ED presentations for diabetes related episodes • People with diabetes have a good knowledge of their condition and know how to access information and services • Keep people in low/moderate groups longer (slow down progression to high/active risk)	
Joint Replacement Alternative Pathway (JRAP) • To reduce osteoarthritis morbidity through an alternative programme for those people with moderate to severe osteoarthritis who are not eligible for the joint replacement waiting list in Counties Manukau Health (CMH) through the use of a primary-care based physiotherapist-led inter-professional team • Provision of evidence informed, coordinated, inter-professional, conservative care for people with osteoarthritis of the knee and / or hip joint to delay or prevent the need for hip joint replacement. • The core components of the programme are: • Self-management – group and individual sessions • Exercise – a home-based individually tailored strength and aerobic exercise programme • Healthy eating – advice and management • Pharmalogical assessment including medication review • Disease management education • Social and psychological related referrals if required	• Program commenced in the Eastern Locality – aim to reach target numbers by Quarter 1 • Evaluate program implementation and effectiveness with a view to confirming model of care for roll out to other localities by Quarter 2 • Roll out to other localities dependent on funding Quarters 3 & 4

2.3.1 Primary Care

CM Health has strengthened its involvement in the PHO Services Agreement Amendment Protocol Group (PSAAP) and will continue with proactive participation in PSAAP to develop and make decisions on variations to the PHO Services Agreement. The PSAAP Group takes a partnership-based approach to decision-making. For CM Health, this provides us with the opportunity to more directly contribute to the strategic environment and emerging issues related to primary care through the Alliance Leadership Team as a vehicle for collaborative DHB and PHO recommendations.

The Integrated Performance Incentive Framework (IPIF) provides CM Health with a platform to enhance system integration and to further align primary care activity with health system objectives to better deliver on government and district priorities. The CM Health Alliance Leadership Team (ALT) will underpin the IPIF once system level measures are agreed. This will enable more strategic and local alignment on key dimensions of improved quality, safety and experience of care, improved health and equity for all populations and best value for public health system resources.

Regional After Hours • Complete the tender for the new regional provider(s) of after hours in order to maintain a network of After Hours service providers with agreed geographical coverage across both the Counties and the broader Auckland region – consistent service provision until 10pm, 365 days a year • Ensure that there is maximum uptake of the new free service for under 13s across after hours providers • Continue to provide uniform reductions in co-payments for eligible patients, including those Over 65 years of age, those with Community Services Cards or High User Health card (HUHC) holders and Quintile 5 residents • Provision of telephone triage and advice supporting GP practices around the Auckland region • Increase public awareness of relevant care options available along with where and when they are available • Use telephone triage/St John diversion programme to more effectively direct patients to appropriate health facility. • Ensure coordinated monitoring and evaluation – facilitate improved service delivery and development across the network • Ensure necessary data is provided to meet the relevant monitoring requirements	• Tender for provider of after hours completed by Quarter 1 • Establish provision by the end of quarter one to procure and maintain a supplier or suppliers of overnight clinics providing overnight care (10 pm – 8 am) • Ensure co-payments are reflective of GP co-payments –in each locality where the after hours clinic is based
• Implement free day time and after hours visits and prescriptions for under 13s including: • Universal (voluntary) day time roll out in CM Health • Implementation through contracted after hours providers for out of hours	• Work towards Free access to day time primary care for under 13s in 90 percent of CM Health practices by June 2016 • Free access to after-hours primary care for under 13s in 100 percent of contracted after hours providers in CM Health
Advance Care Planning (ACP) • Continue to deliver ACP training support and leadership • Support consumer and community partner awareness and engagement	**Workforce development** • Four ACP Level 2 training workshops completed by Quarter 4 **Quality Improvement** • Annual audit of the ACP policy and processes to reflect changes across the sector by 2 July 2016 • Support the review the ACP consumer resources

	Implementation • 90 percent of ACP Level 2 Practitioners to undertake a minimum of 2 ACP conversations a month (24 conversations in the year) • 20 percent increase from the 2014/15 in patients having ACP conversations by Quarter 4 **Community engagement** • 20 percent increase in Conversations that Count • Resources available and disseminated to meet specific need in Maaori and Pacifica and Asian consumers, and consumers with hearing and visual disabilities • Provide mentorship for the CTC Trainers who will support their CM Health CTC Communicators to facilitate a minimum of 10 community CTC sessions a year • Participate in Advance Care Planning Maaori Task Team and pilot Maaori tool as it is developed
Continue to support the Franklin Rural Service Level Alliance Team (SLAT) and develop and implement a plan for distribution of the Rural Primary Care Funding according to the agreed processes in the PHO Services Agreement. This will include the following: • Continue work with the Franklin Rural SLAT to further develop rural primary care planning and services including: • Development of an annual workplan with sign off from the ALT • Service planning alignment with the Franklin Locality Leadership Group	• Annual work plan for the Franklin Rural SLAT signed off by the ALT by end of Quarter 2 • Planning processes are aligned with the PHO Services Agreement 2015/16 • Implementation milestones met for the 2015/16 year • Sustainable rural primary health care services
• Implement the National Enrolment Service • Work with the MOH and primary care sector to implement roll out of the National Enrolment Service	• National Enrolment Service is implemented in line with MOH expectations/timeframes and requirements in the PHO Services Agreement
Northern Region Clinical Pathways • Continue with the localisation and socialisation of the Northern HealthPathways platform (static pathways) for the Northern Region • Complete the pilot and evaluation phases of clinical pathway enabler Nexxt™ (dynamic pathways) to inform next steps	• Write across 54 Healthpoint pathways into the new HealthPathways format • Complete localisation of 17 HealthPathways prioritised pathways to give a total of 71 localised pathways by November 2015 • Effective communications strategy to primary and secondary care regarding static and dynamic clinical pathways and how this all fits together for the region

2.3.2 Integrated performance and incentive framework (IPIF)

The CM Health Alliance Leadership Team (ALT) will continue to work together to achieve the IPIF System Level Measures and to develop and achieve local contributory measures. During the 2015/16 year, the ALT will develop a work programme to identify the actions required to meet the following IPIF measures:

- Capacity and capability
- Healthy Start
- Healthy Ageing
- Patient Experience

Linkages

2015/16 Northern Region Plan; PHO Services Agreement; 2015/16 CM Health Maaori Health Plan

Actions	**Measures**
• Agree on the CM Health IPIF contributory measures to meet the IPIF System Level Measures • Participate in the Peer Review Panels to review the PHO Minimum Requirements self-assessments • Support PHOs to achieve IPIF requirements including: • IPIF quarterly targets • Implementation of quality improvement processes to address self-assessment feedback from the Peer Review Panels • Implementation of the Health Quality and Safety Commission Patient Experience survey once it is developed • Achievement of the Royal NZ College of GPs Foundation Standard • Implement clinical champion roles in PHOs and the DHB who will work together to support achievement of the IPIF targets with a particular focus on: • Early registration with an LMC within the first 12 weeks of pregnancy • Early enrolment with a PHO within 4 weeks of birth • 95 percent of children receive all scheduled immunisations by 8 months of age • 95 percent of children have received all scheduled immunisations by 2 years of age • More Heart and Diabetes Checks • Better Help For Smokers to Quit • 80 percent cervical screening coverage • Over 65 year olds who are prescribed 11 or more medications • The proportion of patients with access to online healthcare	• CM Health Contributory Measures for each of the IPIF System Level Measures are determined by the end of Quarter 1 • PHO Minimum Requirements Self Assessments are reviewed by the regional review panels and feedback provided to PHOs by the end of Quarter 2 • Clinical champion roles are actively engaged in improving the quality of care in primary care in relation to IPIF targets • Achievement of quarterly IPIF targets

2.3.3 Diabetes Care Improvement Package

CM Health has the largest diabetes population in New Zealand at approximately 37,000. Diabetes is a growing public health issue with rates of diabetics growing exponentially. NZ MoH predictions are that the diabetes rates will grow by 78 percent in the next ten years. Maaori and Pacific people have a higher prevalence of diabetes with CM Health having the largest Pacific population and the second largest Maaori population in NZ.

Key to successfully managing the diabetes population in Counties Manukau will be health promotion, prevention, identification of pre-diabetics and unknown diabetics, regular monitoring for complications including retinopathy, neuropathy renal disease and interventions to alleviate the progression of these. An emphasis on self-management skills, health literacy and adherence to medication will enable the patient to manage their condition in conjunction with health professionals.

CM Health is working towards aligning DCIP funding with ARI (At Risk Individuals) funding. This will give greater flexibility for GPs and practice staff to tailor the funding available to the patients' needs. . The current DCIP model will be in place for the first quarter with the intention to transition this to the ARI programme by Quarter 3. A sub group of the ARI project board has been working on the integration of this in consultation with all stakeholders.

Linkages

CM Health Maaori Health Plan; Northern Regional Plan; Ko Awatea Beyond 20,000 Days; Manaaki Haurora – Supporting Wellness

Actions	**Measures**
• Support practices to promote the diabetes toolkit • Measure diabetes outcomes using the clinical indicators approved monthly • All diabetes patient will be eligible for DCIP funded services – this includes: • Support for the funding of insulin initiation • Increase support to practices by funding health psychology • Increase support to practices by funding Podiatry visits for diabetic patients • Increase support to practices by funding dietician visits for diabetes patients • District Alliance agreed indicators will be reported on and met • Funding for nurses to attend the Manukau Institute of Technology (MIT) Diabetes care and Management course. This can enable the nurse to progress to post graduate qualifications (Diabetes Nurse Specialist) which enable to nurse to prescribe diabetes medication. • Work with PHOs to provide practice level monthly reporting of diabetes related clinical indicators based on Diabetes Annual Review data • Podiatry project undertaken in the 2015 year to be expanded to a regional project • There will be consumer representation on both the ARI project Board and the ARI/DCIP working group	• All diabetic patients have access to support from general practice, green prescription, DSME and Active families to improve their health • All practice staff are aware of and follow the diabetes toolkit from the MOH guidelines by Quarter 3 • Monthly reporting of all health psychology, dietetics , insulin initiation and podiatry visits by PHOs • Podiatry project completed and used by all practices and podiatry indicators instilled into clinical pathway by Quarter 3 • 14,000 diabetic patients will have had a retinal screen in the community by Quarter 4 • Monthy PHO reporting of District Alliance indicators Diabetic referrals to Green prescription will increase by Quarter 2 • Utilisation of the regional DSME standards and curriculum in primary care diabetic self-management courses in place by Quarter 2 • Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control • Improve or, where high, maintain the management of microalbuminuria in patients with diabetes • Diabetic self-management courses will be available in all localities to all practices by Quarter 3 • Health psychology, dietetics and podiatry numbers will increase to at least 75percent of quota by Quarter 4 • The full quota of nurses have been referred to and have completed the MIT nurses post graduate Diabetes care and management course • Monthly reporting of Diabetes Annual Review (DAR) by PHOs to monitor progress • DCIP/ARI working group will be set up by Quarter 2 with consumer representation • ARI project Board will have consumer representation by Quarter 1

Prevention • Work with Green prescription providers and general practice to ensure that patients who are pre-diabetic or diabetic will be referred to green prescription for exercise and lifestyle advice • Increase self-management programmes and courses available for practices to refer or patients to self-refer to across the CM Health district	**Prevention** • Green prescription diabetic referrals will increase 10 percent by Quarter 3 • In collaboration with the Ko Awatea Self-Management campaign support the teams who are supporting diabetic patients to learn how to improve their self-management and health literacy skills to manage their diabetes and prevent further exacerbations and complications
Identification • Ensure that all patients who have been identified as pre-diabetic are followed up by General practice • Continue proactive recall for retinal screening and renal function tests to ensure the early identification of diabetes related complications • Improve consistency and coverage of foot checks for diabetic patients	**Identification** • Consistent risk stratification and available resources to prove adequate timely foot checks by Quarter 2
Management • Implementation of the 20 Quality standards of Diabetes care using the Quality Standards for Diabetes toolkit 2014 throughout PHOs and practices • Closer collaboration with the diabetes centre for primary care including the integration of DCIP into the ARI programme • Formation of a diabetes subgroup of the ARI project board to provide clinical leadership and governance for diabetes management • Ensure that all practice are able to refer patients to a diabetic self-management course within their locality • Continue to expand the Diabetic self-management courses within the district using the regional Diabetic Self-Management guidelines. • Work with the Pacific and Maaori teams to ensure that culturally appropriate diabetes self-management courses are available in all localities • Utilise practice audit tools to identify patient who are overdue for the annual check, retinal screening, foot check or patient who have an HBA1c or blood pressure above the recommended value • Clinically complex patients will be eligible for entry into the ARI programme which offers: • Care coordination • Care planning • MDT case conferencing • Referral to other services e.g. retinal screening, self-management • Maintain data match practice system diabetes register against the virtual diabetes register across all practices	**Management** • All practices have access to diabetes self-management courses within their locality by Quarter 2 • Diabetes Projects Trust supports practices in the 2015/16 year by auditing diabetic patients treatment and supporting staff to improve outcomes • Reduction of proportion of patients with HbA1c above 64, 80 and 100 mmol/ml • DNS increase work /education in primary care • Integration of quality standards across practices with the support of the DCIP/ARI working group. • Diabetes subgroup formed with a clinical champion in place by Quarter 2

2.3.4 Long term conditions

Goal – that New Zealanders with Long Term Conditions (LTCs) live longer, healthier and more independent lives with the assistance of an integrated health system

Linkages

2015/16 Northern Region Plan, 2015/16 CM Health Maaori Health Plan; Ko Awatea Beyond 20,000 Days; Manaaki Haurora – Supporting Wellness

Actions	**Measures**
• All At Risk Individuals (ARI) are identified by risk stratification and enrolled on to the ARI programme for patient centred planning, care coordination, electronic care record and review by MDT • Practices will have access to funding to enable extended consults, home visits and other value add services which will be provided by the broader primary care team in order to prevent unplanned admissions to hospital , prevent further complications and improve the patient's quality of life • Monthly meeting with the PHOs to monitor IPIF (CVDRA and smoking) targets • Culturally appropriate self management programmes and courses are accessible and effective across the Counties Manukau • Continue to play an active role in the design and implementation of the key clin8ical pathways which are being managed regionally through the regional clinical pathways group • Provide electronic decision support for CVDRA, CVD management and diabetes management • Provision of IT systems to support case management, shared care and clinical information sharing • Increased staff training and education around Long Term Conditions including goal setting, motivational interviewing and shared decision making concepts • Clinical Governance of Long Term Conditions will be managed under the ARI Project Board and link in with the Metro Auckland Clinical Governance Group • Continue to work with Regional cardiac and Diabetes networks to improve prevention, identification, and management of CVD and Diabetes	• ARI programme enhanced and roll out completed with phase two implemented by Quarter 4 • Health targets (CVDRA and Smoking) are met and exceeded • Ambulatory Sensitive Admissions to hospital for patients with Long Term Conditions are reduced by Quarter 4 • 8270 patients will be referred to green prescription • 120 people will be referred to Active Families • 50,000 people will be assisted to self manage their Long Term condition by December 2016 as part of Ko Awatea self management support campaign "Manaaki Haurora – Supporting Wellness" • Self management courses are accessible by all practices across all localities by Quarter 3 • Self management courses for Pacific people are able to be accessed via the church networks • Self management programmes will be measured for effective outcomes • Shared care electronic shared care record accessible for all patients under the ARI programme in Counties Manukau
Prevention	**Prevention**
• Early identification, stratification and management of Long Term Conditions	• Self-management campaign and the ARI programme(including care coordinators) will increase staff awareness and raise skills in motivational interviewing, goal setting and shared care concepts
Identification of risk	**Identification of risk**
• Practices will have access to electronic decision support tools to carry out CVDRA on eligible patients • Practices will have access to audit tools to identify patients who are overdue for annual check, retinal screening, foot check or microalbuminuria	• 90 percent of eligible population will have had a CVDRA in the past five years to identify cardiovascular risk • All diabetic patients will have risk stratification for foot disease/neuropathy, retinopathy, renal disease when attending primary care

	• Regular HBA1c • Diabetic Annual Reviews

2.3.5 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 and the Northern Regional Alliance (NRA); Ko Awatea Beyond 20,000 Days

Actions	**Measures**
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 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 • Direct clinical support, including access to after hours clinical support for decision-making • 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 through implementation of an emergency care-based scanner by end of Q2 2015/16 • Continue with and maintain stroke thrombolysis quality assurance procedures, including processes for staff training and audit: • Care pathways developed 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 • All members of the multidisciplinary stroke team participate in ongoing education and training according to the Stroke Guidelines • Continue to provide lead clinicians designated to stroke (Medical and Nursing)	• 6 percent (8 percent regional target) of potentially eligible stroke patients thrombolysed • Staff education materials developed and in use by Quarter 1; Quarterly thrombolysis audit and improvement action plan • EC-based CT scanner operational by Quarter 1; Quarterly thrombolysis audit and improvement action plan • Quarterly thrombolysis audit and improvement action plans by Quarter 4 • 80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway • 90 percent of eligible patients will be transferred to rehabilitation within 2 weeks • 70 percent of patients with acute stroke who are transferred to in-patient rehabilitation service within 10 days of acute stroke admission

• Collect data to establish a baseline for ongoing reporting to assist, support and clarify data definitions, to test the proposed 2016/17 delivery of 60 percent: • Proportion of patients admitted with acute stroke who are transferred to in-patient rehabilitation service, and the proportion of these transferred within 10 days of acute stroke admission • Proportion of patients admitted with acute stroke referred to community rehabilitation, and the proportion of these undergoing face-to-face community assessment within five days of discharge from hospital	
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

2.3.6 Cardiac services

Cardiovascular disease is the leading cause of death for people in Counties Manukau. This is because mortality rates for heart disease are higher among people with lower incomes. The rates of heart disease and mortality are also significantly higher for Maaori and Pacific. This means that the burden of cardiovascular disease in the CM Health population is high. Demand for cardiovascular procedures has continued to grow at over 8 percent per year for the last 7 years.

Approximately 80 percent of cardiovascular issues can be influenced by lifestyle changes and this is an area that the DHB continues to work on.

Linkages

2015/16 CM Health Maaori Health Plan; 2015/2016 Northern Region Cardiology Plan

Actions	**Measures**
Secondary Services • Work with ADHB to deliver the target intervention rates for cardiac surgery ensuring timely equity of access for CM Health patients • Ensure appropriate access to cardiac diagnostics areas such as echocardiograms, angiography, exercise tolerance tests and holter monitoring, and monitor wait times in these areas monthly taking corrective actions are required • Monitor and manage FSA wait times • Undertake local initiatives to ensure the CM Health population access to cardiac services is not significantly below the agreed rates for coronary angiography and PCI • Continue to work with Auckland Regional Cardiac Clinical Network to have equity of access and improve outcomes for the CM Health population • Continue to provide national support to ANZACS-QI and provide regular reporting at DHB, regional national level	• 95 percent of people will receive elective coronary angiograms within 90 days • CM Health patients will wait no longer than four months for first specialist assessment and referral for treatment • Percutaneous revascularisation rate of 12.5 per 10,000 of population • Coronary angiography rate of 34.7 per 10,000 of population • Cardiac surgery SIRs : refer to Electives section 2.1.2
Accelerated Chest Pain Pathways • Continue the development of the Accelerated Chest Pain in the Emergency Care (EC) Department • Refinement and retesting of pathway as part of a continuous and iterative improvement process	• Discharge from EC within 6 hours • Reduction in overnight admissions for patients with low risk chest pain aiming towards saving a bed a day • Revise current pathway to increase eligibility by Quarter 2

	• Implement findings of first audit by Quarter 2 • Processes streamlined to reduce variation
Acute Coronary Syndrome • Continue to support ANZACS- QI nationally and collect data for the Cardiac register. This will enable CM Health to provide appropriate intervention and ACS risk stratification progress monthly • Work within CM Health and the regional group , to improve outcomes for ACS patients using the ANZACS-QI data	• 70 percent of patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0'), reported by ethnicity • Continue to monitor wait list times to sustain current performance • 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days
Heart Failure • CM Health will work with the Auckland region, as well as continuing local initiatives, to improve outcomes for patients with heart failure	
Regional Alignment • Work with the ADHB to finalise the regional plan for Electrophysiology Services to better meet the patient demand for all patients in the Auckland region • Continue to work in collaboration with St John Ambulance and ED staff, continue to monitor ECG transmission to support rapid transit of ST elevation MI patients direct to a PCI Centre • Continue to work with the region to improve access to Echo at CM Health	

2.3.7 Diagnostic waiting times

Actions	**Measures**
National Radiology Service Improvement Initiative • Develop a forecast of demand and identify actions to meet demand – formalise a "Production Plan" • Improve transparency of Radiology demand and activity within the hospital to aid discharge decisions • Begin to develop feedback reports to referrers and work with services to understand and mitigate outliers • Review capacity and model of operation in each modality to ensure standardisation of process and optimal productiveness	• Agreed National Patient Flow system changes are implemented • Representation, attendance and participation in national and regional clinical group activities
MRI/CT • Extend the role of MRI trained MRTs to administer Buscopan™ to improve efficiency • Reducing clinical variation through agreed protocols for scanning	• 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) • TBC percent of accepted referrals for CT Colonography will receive their scan within than 6 weeks (42 days)

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 • Single wait lists • Standardised triage for colonoscopy referrals • Participation in regional collaboration- Introduction of Nurse Endoscopists; Increase CTC rates; Regional Growth; Preparation for National Bowel Screening; Upgrade of IT (Provation) • Continue to support ongoing activities of Round Two of the Waitemata Bowel Screening Pilot	• 75 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 • 65 percent of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100 percent within 120 days • Surveillance colonoscopy – 65 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
Increasing capacity through: • Robust production/capacity modelling • Developing real-time production planning tools • Increasing facilities (more procedure rooms) • Increasing workforce (SMO & nurses) • Improving ways of working- implement different models for contracting current and all new gastroenterologist • Outsourcing as a planned strategy	• Capacity modelling by Quarter 2 • Production planning tools by Quarter 2 • Increased number of procedure rooms by July 2015 • Increased workforce by July 2016 • Improved ways of working by July 2016 • Outsourcing strategy implemented by July 2015
Community Radiology • Access to community radiology maintained at 14/15 levels. Review of access and appropriateness on-going as part of Access To Diagnostics programme	
Regional Alignment • Waitemata DHB with Auckland regional DHB partners: • Continue to observe and support Bowel Screening pilot • Work on regional solutions to capacity issues • Work regionally to leverage contracts for outsourcing, equipment, and consumables • Continue to participate in the Regional Clinical Network and to provide guidance to other regional clinical networks • Continue to operationalise the Paediatric Radiology Service Model in the Northern Region • Continue to work regionally to develop Sonographer training pathways and reduce shortages of Sonographers in the Northern Region • Continue participation in the development of regionally agreed guidelines for CT colonography	

2.3.8 Maternal and child health

14 percent of all births in New Zealand are to women living in Counties Manukau. Approximately 8000 babies a year are born in Counties Manukau of whom more than 50 percent are born to Maaori or Pacific mothers and a high proportion who live in areas of high socioeconomic deprivation. Women of childbearing age make up approximately 30 percent of the total CM Health population. While our maternity and child health system is well regarded for the quality of care it delivers, CM Health has more women with high social and health needs during pregnancy than any other part of the country. High needs include obesity, smoking in pregnancy, teenage pregnancy, older women, women with high parity as well as women with diabetes and other co-morbidities. Social needs include high deprivation, poor health literacy, family violence and drug and alcohol abuse. CM Health wants to see improvements in our overall maternal and child health services that deliver clinically and socially integrated care.

The ongoing challenge in 2015/16 is to ensure that the multiple national, regional and local drivers of change in the maternal and child health system are well integrated. CM Health will focus on ensuring that these initiatives are consistent, connected and integrate well for our mothers and babies.

Those drivers include but are not limited to:

- Nationally - Better Public Services; Supporting Vulnerable Children and the government's Children's Action Plan, Rheumatic Fever, National Health Target (Immunisations) and Prime Minister's Youth Mental Health Plan
- Regionally – Northern Regional Child Health Plan and Youth Health Plan
- Locally –1st 2000 Days (Whole of System integration of services from conception to the start of school) Otara Maternal and Child Health pilot, development of Locality Whaanau Ora networks and Maternity Quality and Safety Programme

Whole of system planning strategy directions that enhance initiatives already in progress include:

- Reducing late engagement of women by intervening early to better manage high and complex pregnant women (and thereby reducing acute demand)
- Building resilience in our community to intervene early or get help sooner through targeted health literacy and community engagement campaign to support being a healthy weight and lifestyle if you plan to get pregnant, and, if you are pregnant accessing LMC care as soon as possible
- Well Child - reviewing the value of existing activity across health and non-health providers for children aged 0-4 years
- While these initiatives aim to achieve the same objectives, they must work together efficiently and effectively with the mothers and babies of CM Health at their centre. We will continue to plan and work with our wider sector including Primary Care providers, Lead Maternity Carers (LMCs), WCTO (Well Child Tamariki Ora) providers and Community Oral Health Services (COHS) to plan actions and deliver improvements

Linkages

2015/16 CM Health Maaori Health Plan; Green Paper; White Paper; Children's Action Plan; Primary Care Initiatives; the CM Health Executable Strategy for Better Health Outcomes for All, specifically the First 2000 Days Programme; CM Health Immunisation Strategy; NRHP – Child Health Implementation Plan (CHIP); Youth Health Implementation Plan; Minister's Youth Primary Mental Health Initiatives; Whaanau Ora programmes and Mana Kidz

Actions	**Measures**
Maternity • Increase the number of women who receive continuity of primary maternity care during their pregnancy and increase the number of women who register with an LMC in their first trimester through: • Implementation of GP referral pathways to encourage early referral before 10/40 to a Midwife. The referral pathway triggers either direct referral to a Self Employed Midwife for women suitable for Primary Care or to the DHB referral system	• 95 percent of pregnant women receive continuity of primary maternity care (through a community or DHB LMC by reducing the number of un-booked women. • 80 percent of women who register with an LMC do so in their first trimester • Production of an Annual Maternity Report in Quarter 4

• Regional development of GP referral pathways for pregnant women to provide a consistent approach in Primary Care to cater for women who reside in one area but choose to birth in another • Implementation of a marketing campaign encouraging pregnant women to engage with an LMC in the first trimester of pregnancy • Continue to deliver Maternity Quality and Safety Programme which includes reviewing local performance against the New Zealand Maternity Standards and the New Zealand Clinical Indictors and developing actions to address identified issues • Retender pregnancy and parenting education services with a focus on Maaori, Pacific, teen and other higher need pregnant women • Scope and investigate development of the High Five New Born Enrolment Initiative (enrolment at birth with GP, National immunisation register, Well Child Tamariki Ora, Hearing and Vision and Community Oral Health Service)	• Improved quality and safety of maternity services including improved access, outcomes and consumer satisfaction and reduced variation in performance against the NZ Maternity Clinical Indicators • Retendering of pregnancy and parenting education services with a focus on Maaori, Pacific and Teen parents. Implementation and service delivery to be led by Locality Leadership Groups • 30 percent of Maaori, Pacific and teen pregnant women complete DHB funded pregnancy and parenting education • 98 percent of newborns enrolled by 3 months • Scoping of 'High Five New Born Enrolment Initiative' completed by Quarter 1
Gestational Diabetes • Implementation of the National Diabetes in Pregnancy Guideline • All women will be offered HBa1C test with booking bloods • Develop health promotion and education materials	• National Diabetes in Pregnancy Guideline implemented by 30 June 2016
Well Child Service Delivery • Develop systems for seamless handover of mother and child as they move from maternity care services to general practice and WCTO services	• New born enrolment Alliance Group to be established with PHOs and Primary care partners by Quarter 1 • Action plan to be developed by Quarter 1 • Refer to WCTO quality Framework
WCTO Quality Improvement Framework • Implement WCTO Quality Improvement Framework	• Improved performance against WCTO Quality Indicators, particularly in areas where DHB is currently an outlier • WCTO Quality Improvement Lead appointed by Quarter 1 • Framework implemented in Quarters 1-4
Before School Checks (B4SCs) • Routine contract reviews completed for B4SC providers. These include coverage reports, referral data, and participation in the case review forum • Improve quality by ensuring B4SCs are started before age four and a half • Increase coverage for Maaori, Pacific and Quintile 5 by offering Saturday clinics and delivering Hearing and Vision checks at the same time as the Nurse check • Vision and Hearing pilot undertaken by Well Child Tamariki Ora Providers by quarter 2 • Move toward a locality based approach by quarter 2 • Roll out of additional after hours clinics by quarter 1	• 90 percent of four-year-olds receive a B4SC, including 90 percent of Maaori and Pacific children living in areas of high deprivation • Movement toward a locality based approach by Quarter 2 • Additional after-hours clinics rolled out by Quarter 1

SUDI **Workforce Knowledge and Development** • Encourage and support heath providers involved with families in the antenatal and postnatal period to access SUDI training options available Quarters 1 to 4 • All CM Health child health and maternity related contracts will include SUDI training as part of workforce development programmes by Quarter 4 **Primary Care SUDI risk screening and utilisation of the Risk Assessment tool** • In collaboration with PHOs, pilot of Prof. Ed Mitchell's SUDI risk assessment tool for use in patient management systems in Primary Care • Collaborate with PHOs to ensure that every child immunised at 6 week check is screened using the screening question (1) Smoking in Pregnancy 2) bed-sharing, to identify higher risk infants; provision of SUDI risk information and PEPE messaging is documented Q1 to Q2; Northern Regional collaboration to support implementation of tool being piloted in specific PHOs • Phased implementation with PHOs of (MEDTECH) Screening pop-up questions (1) Smoking in Pregnancy 2) bed-sharing, to identify higher risk infants who are then automatically linked to the full SUDI Risk Assessment tool Quarters 3 to 4 **CM Health SUDI strategy is aligned to the NRA SUDI 5 year Action Plan** • Increase the number of women who register with an LMC in their first trimester of pregnancy through: o Implementation of GP referral pathways to encourage early referral before 10/40 to a Midwife. The referral pathway triggers either direct referral to a Self Employed Midwife for women suitable for Primary Care or to the DHB referral system by Quarter 2 o Regional development of GP referral pathways for pregnant women to provide a consistent approach in Primary Care to cater for women who reside in one area but choose to birth in another by Quarter 2 o Implementation of a marketing campaign encouraging pregnant women to engage with an LMC in the first trimester of pregnancy by Quarter 1 • Ensure a minimum of 30 percent of Maaori pregnant women access antenatal and early parenting education o Develop revised curriculum with a focus on Maaori, Pacific and teen pregnant parents by Quarter 1 o Retender pregnancy and early parenting education services to identify and contract culturally appropriate providers to provide targeted antenatal and early parenting education to Maaori and Pacific pregnant women by Quarter 2	• Quarterly reports on # of health providers working with families in antenatal and postnatal period completed Safe Sleep / SUDI education • Quarterly PHO report percent and number of babies identified for risk screen tool • Quarterly monitoring of access rates and participation in antenatal and early parenting education by ethnicity

o Develop and provide alternate methods of delivery of antenatal and early parenting education suited to Maaori, Pacific and teen pregnant mothers - refer to "Whanau Hapu Waananga" section below o Ongoing monitoring of access rates and participation in antenatal and early parenting education • Increase newborn enrolment rates o Scope and investigate development of the 'High Five New Born Enrolment Initiative' (enrolment at birth with GP, National Immunisation Register, Well Child Tamariki Ora, Hearing and Vision and Community Oral Health Service by Quarter 1 o Review referral and enrolment protocols as part of the WCTO Quality Improvement Framework Quarters 2 to 4 • Develop a process to ensure ongoing sustainability of safe sleep programme • Review and develop a regional safe sleep programme model of distribution of safe sleep devices for high risk population and resource required for on-going management	
• Safe Sleep policy and PEPE messaging is implemented in all maternity wards and primary units and monthly safe sleep audits completed and recorded o All babies in unsafe sleeping environments at risk of SUDI are identified and referred to Safe Sleep Team for intervention of Safe Sleep programme and if required a safe sleep device Quarter 1 to 4 o 100 percent compliance with safe sleep policy in all CM Health Primary and Birthing units and maternity ward by Quarter 2 o Plan developed for regional safe sleep programme management of safe sleep devises and resource by Quarter 3 o Process for ongoing sustainability of safe sleep programme developed by Quarter 4	• Audits reported monthly to Quality and Risk Manager Kidz 1st & Womens Health and SUDI Governance, 6 monthly to NRA
Activities to Support SUDI Risk factors i.e. P.E.P.E. **PLACE baby in own baby bed, face clear of bedding** • LMC/midwife in 1st week visit assesses sleep environment and baby bed, provision of safe sleep information and PEPE messaging documented. Referral of whanau with unsafe sleeping environment to Safe Sleep team for intervention o Q1-2: Work programme developed by Safe Sleep Coordinator in partnership with LMC to improve service quality to ensure safe sleep environment by Quarter 2 o Development of a referral process for LMCs to assist parents in accessing safe sleep devices by Quarter 2 • Implement and monitor provision of SUDI risk information and PEPE messaging at WCTO Core Contact 1 via WCTO Quality Improvement Framework	• Referrals to Safe Sleep team actioned, monthly reporting of reason for referral, and actions taken

o LMC and WCTO assessment of sleeping environment, provision of SUDI risk information and PEPE messaging is documented, and intervention strategy for whanau initiated where required Quarters 1 to 4 **ELIMINATE smoking in pregnancy & protect baby with smokefree whanau, whare & waka** • All pregnant women who smoke are offered brief advice and support to quit o 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 o Develop automated referral system to smoking cessation support for all pregnant women who smoke by Quarter 2 • Implement Smoking Cessation in Pregnancy Plan **ENCOURAGE and support Mum to breastfed** • Increase the percentage of Maaori infants breastfed **Community based SUDI initiative with focus on engaging with Maori in "Whanau Hapu Waananga"** • Stakeholder engagement to develop the Community based initiative to engage Maaori whanau early in pregnancy in a series of "Whaanau Hapu Waananga" (comprehensive childbirth and post-natal education programme to reduce SUDI risk factors) • Identification, development and training of the SUDI initiative with community organisations. Waananga to be held in four CM Health localities • Identified community organisations support hapu Mama and whanau with an open invitation to participate in Waananga • Waananga will provide activities and information on key SUDI messages, antenatal wellbeing & healthy eating, smoking cessation, alcohol free pregnancy, breast feeding and baby care including Safe Sleep messaging • Opportunity for Mothers to create (weave) a safe bed for their baby whilst learning a traditional skill (weaving) in a well-supported Kaupapa Maaori framework • Project plan and specifications agreed for "Whanau Hapu Waananga" with stakeholders by Quarter 1 • Identification, development, procurement and training of the SUDI initiative with community organisations by Quarter 2 • Implementation of the Waananga Quarter 2, 2015 through to Quarter 1, 2016	• Quarterly Reporting of referrals to Smoking Cessation and utilisation of pregnancy incentive programme Quarterly reporting: • Number of Waananga, coverage localities and community organisations • Number of Maaori hapu Mama and whanau support participating • 100 percent of hapu Mama participants are enrolled in maternity services • Number of participants referred to Smoking Cessation services • 100 percent of hapu Mamas have a safe baby bed planned for their baby • Evaluation feedback form at Waananga; participation in post-natal support • Percent and number of Waananga participants utilise breast feeding support

Breastfeeding Develop and deliver a workforce development and training initiative to maternity, child health, primary and secondary care health professionals working in Counties Manukau to improve health providers: a) understanding and awareness of the barriers and challenges identified in the needs assessment regarding breastfeeding and the introduction of first foods; b) responsiveness and sensitivity to provide non-judgemental and culturally appropriate care; c) engagement with the wider whaanau/family when discussing breastfeeding, infant and toddler feeding and nutrition; d) understanding of health literacy • Develop key project messages • Initial engagement meetings with maternity, child health, primary and secondary care health professionals working in CMDHB • Develop workforce training, framework, curriculum and resources • Deliver training to 100 priority 1 workforce • Deliver mentoring of workforce who have completed the training In response to the need assessment findings and recommendations (which was completed in phase 1 of the project), develop and deliver a public health community initiative to support and improve breastfeeding and the introduction of first foods with a focus on Maaori, Pacific and South Asian whaanau and communities • Scope community models and service delivery options • Develop project plan • Implement activities according to project plan • Project evaluation activities completed by external evaluator **Other actions** • New outcomes framework implemented • Complete stocktake of community breast feeding support and lactation services • Work collaboratively with Well Child Tamariki Ora providers to strengthen their breast feeding support services • Seek learnings from other DHB who have high breastfeeding rates • Six monthly monitoring and review of breast feeding data from Plunket and Turuki • All health professionals employed or access holders to CM Health Maternity Services undertake Baby Friendly Hospital Initiative education • Review CM Health Breastfeeding policy • Community based organisations, self-employed and community midwives provide breastfeeding support	**Breastfeeding** • 75 percent of babies exclusive or fully breastfed at discharge from birthing facility • 75 percent exclusive or fully breastfed at LMC discharge (4-6 weeks) • 60 percent exclusive or fully breastfed at 3 months • 65 percent receiving breast milk at 6 months • Maaori women have equitable access to breastfeeding advocates and lactation support services • Key project messages developed by Quarter 1 • Engagement meetings with primary care completed by Quarter 1 • Workforce training, framework, curriculum and resources developed by Quarter 1 • 100 priority 1 workforce completed training by Quarter 1 • On-going mentoring of workforce who have completed the training • Complete scoping of community models and service delivery options by Quarter 1 • Project plan developed by Quarter 1 • Activities implemented according to project plan with a focus of Maaori as one of the three target groups in Quarters 2 to Quarter 4 • Project evaluation activities completed Quarter 1 to Quarter 4 • Outcomes framework implemented by Quarter 4 • Stocktake of community breast feeding support and lactation services completed by Quarter 1 • All Health professionals employed or access holders to CM Health Maternity Services completed Baby Friendly Hospital Initiative education Quarters 1 to 4 • CM Health Breastfeeding policy reviewed and updated by Quarter 1 • Deployment of Tapuaki pregnancy and parenting by Quarter 2

• Deployment of Tapuaki pregnancy and parenting programme via personal app on smartphones from TAHA to supports and influence breastfeeding • Maintain BFHI (Baby Friendly Hospital Initiative) accreditation	
School based Health Services for Primary and Intermediate schools • Review and develop sustainable model for school based health services for primary and intermediate schools • Refer to Rheumatic Fever Section 2.2.1 and Primary Care section 2.3.1 for further details and linkages	• Model reviewed and developed by Quarter 1
Human Papillomavirus (HPV) • Refer to 'Increased Immunisation' section 2.1.4 • Maintenance of current coverage rates for Maaori and Pacific with strategies to increase coverage for NZ European	• 70 percent of eligible young women receive dose 1, 65 percent receive dose 2 and 60 percent receive dose 3
Oral Health Improve Oral Health service access and improve Oral Health outcomes for children 0-18 years of age: • Review of Preschool and Adolescent Oral Health strategy to better meet targets and improve Oral Health outcomes for Children and Young people • Review the process for enrolment, risk assessment and signed consent of babies by WCTO providers in Community Oral Health Services (COHS) at the 9 month check to facilitate the uptake of examinations in COHS clinic by 12 months • Scope early enrolment in COHS at 3 months for high risk, focussing on earlier enrolment of children from Maaori, Pacific and high deprivation communities • Training of 'Lift the Lip' to be offered to Primary Care / WCTO providers • Oral Health education is provided to Parents/Caregivers by WCTO Providers at all core contacts, and includes advice on healthy nutrition, tooth-brushing, and attendance at dental clinic appointments • WCTO providers deliver 'Lift The Lip' examination at every core contact and refer any concerns to COHS • All children to be examined in a COHS dental clinic by their 1st birthday • Oral Health education is provided to all preschool centres, ECE, Kohanga Reo, Language nests, and Kindergartens to facilitate enrolments, referrals and liaison with COHS • Extending hours of service at community dental hub clinics to weekday evening and Saturdays subject to localised demand and to assist in reduction of DNAs • SMS/text message reminder systems to parents of preschool tamariki to assist in reduction DNAs • Develop process for follow-up of persistent DNAs in preschool patient group through WCTO, PHN or community health workers	• 95 percent of eligible children aged 0-4 years enrolled in the COHS (preschool enrolments, PP13a) by December 2016 (variable DHB targets until then) • 97 percent enrolment of eligible children aged 5 years up to and including year 8 of school in the COHS • Reduction in Examination Arrears to target 7 percent in COHS (PP13b) • Increase in caries free percentage in 5 years child population; one target for all ethnicities • Reduction of preschool extractions under General Anaesthetic (measurement to be developed) • Reduction of mean DMFT at year 8 of school (12/13 years); one target for all ethnicities • Reduction of COHS DNAs to target – School 10 percent, and Preschool 20 percent • 100 percent year 8 children completed by COHS, 100 percent transfer to Adolescent Oral Health Services • 85 percent of eligible adolescents utilise free oral health services from year 9 of school up to and including 17 years (Adolescent Utilisation, PP12) • Process for earlier enrolment, risk assessment and signed parent consent of babies by WC/TO providers completed by Quarter 2 • Lip The Lip training for all WC/TO providers using a health literacy lens to be delivered annually for new staff or refresher for current staff Quarters 1 to 4 • Oral Health education to all preschools supervised tooth brushing program in preschools with high percentage of Maaori and Pacific children Quarters 1 to 4 • Process developed for follow-up of persistent DNAs by Quarter 2 • Examination of preschool children in a COHS clinic by their 1st birthday or according to their risk assessment Quarters 1 to 4

• Increase access to Oral Health Services for Adolescents by offering mobile dental services at all secondary or composite schools to pick up adolescents not attending any dentist • Investigate access for out of school system adolescents at Teen Parenting Units (TPU), Alternate Education (AE), and Private Training Enterprises (PTE)	• Increase mobile Oral Health Services for Adolescents to all CMH secondary or composite schools from 28 to 30 schools Quarter 4

2.3.9 Mental health and addictions & 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. This balanced approach builds on the significant gains made in recent years while advocating new and innovative ways of providing better, sooner and more readily accessible services.

The key performance indicators that will measure the success of MH&A initiatives are:

Better use of resources/value for money

- Increase the percentage of time workers spend in direct service delivery
- Increase the number of consult liaison contacts from specialist services to primary care

Improving primary-specialist integration

- Increase access to primary care response for people with mental health and addiction problems
- Reduce waiting times to specialist services
- Increase access to specialist services for all age groups

Cementing and building on gains for people with the highest needs

- Reduce and eliminate the use of seclusion in mental health inpatient settings
- Increase access to specialist services for youth offenders
- Increase employment and education opportunities for people with low prevalence conditions

Intervening early in the life cycle to prevent later problems

- Reduce waiting times for child and youth services
- Increase access to child and youth services

These strategies are responsive to the unique needs of the Counties Manukau population and drive attainment of the MH&A vision where the communities of Counties Manukau will support mental health and wellbeing and be able to get support when they need it, quickly and easily, in their local community. MH&A services and action plans are aligned with national, regional and local strategic health goals, and support and progress the CM Health Triple Aim objectives:

- Improved health and equity for all populations
- Best value for public health system resources
- Improved quality, safety and experience of care

This financial year we are continuing to focus on value for money, optimisation of resources and efficiencies both within the health disciplines and intersectorally through a collaborative, interdisciplinary, whaanau-centred approach to better meet the needs of those we serve. An important objective of MH&A intersectoral and service-user engagement when designing and implementing solutions is to achieve greater awareness of health and health equity consequences of policy decisions and organisational practice to improve the accessibility, quality and transparency of Mental Health services and practice throughout the health continuum. This is achieved by co-designing and planning the configuration and transition of services into the community collaboratively with Primary Care organisations, NGO's and service users and their whaanau.

We acknowledge the important role NGOs play in delivering mental health and addiction services to our local population. As part of service planning, we will involve NGOs in discussions about how we configure relevant services to meet the needs of our population. Our Executive Leadership Team is routinely advised on how NGO providers are performing and the challenges they face. Significant issues may also be advised to our Board.

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;CMDHB System Integration Programmes of Work – Whole of System, SWIFT; Ko Awatea lead Mental Health First Aid, Beyond 20,000 Days: Kia Kaha	
Actions Actions are grouped under the four over-arching goals from the Rising to the Challenge: MH&A Service Development Plan: **Better use of resources/value for money** • Recommendations will be implemented from the 2014/2015 Key Worker Review to reduce duplication and improve access and coordination across Hospital Care, Primary Care and NGO services • Progress the capital investment, redevelopment and construction of the Acute Inpatient Mental Health facility • We will be responding to changes from the Ministry-led commissioning and funding framework project	**Measures** • A final Recommendations report is completed by the end of Quarter 2 identifying any outstanding issues and learning's from the project • Completion of the detailed Construction and Decanting Project Plan by Quarter 1, and works commenced by Quarter 4 2015 • Priorities for actions are identified by Quarter 2
Improve integration between primary and specialist services • Co-design workshops undertaken within localities to identify what matters most to Service Users & families • Influence and implement the Whole of System (WOS) Integration Plan for MH&A services • Establish project to formalise the Framework for Change Phase II; show alignment and integration with the Whole of System initiative	• Findings from consultations and workshops collated, categorised and prioritised by end of Quarter 2 • Implementation Plan for WOS Integration Plan (with scope, timeframes & measures) agreed by end of Quarter 3 • Project Brief for Framework for Change Phase 2 completed in Quarter 1. Implementation Plan for Framework For Change Phase II (with scope, timeframes & measures) agreed in Quarter 3
Cement and build on gains in resilience and recovery • Review the recommendations from the ICT (Intensive Community Treatment) Review completed in Quarter 4	• Recommendations from the ICT Review implemented for the Adult MH&A Service by the end of Quarter 4
Intervening early in the life cycle to prevent later problems • Review recommendations from the Maternal Mental Health Services Review completed in Quarter 4 2014	• Implement high priority recommendations from the Maternal Mental Health Services Review by Quarter 4
Government work programmes • Further refinement of initial COPMIA (Children of Parents with Mental Illness and Addictions) services that have been transitioned into business as usual with programmes running in each of the locality areas	• We will continue to work with the Ministry to refine services as required, subsequent to the release of the implementation guidance for COPMIA service provision in March 2015
Welfare Reforms • Undertake a review of current specialist employment services to enable a more innovative, intersectorial and outcome driven service delivery model for individuals with low prevalence disorders	• Post-review recommendations identified to drive a more innovative, intersectorial and outcome driven service delivery model for individuals with a mental illness and/or addiction by Quarter 2. Commence implementation of prioritised recommendations by Quarter 4

• Increase access and utilisation of MSD managed employment initiatives for eligible individuals with low prevalence disorders through improved intersectorial pathways	• Procurement/Service variation plan developed by end of Quarter 2 • 80 percent of consumers referred to MH & A funded specialist employment services are screened for access eligibility to MSD funded employment initiatives by Quarter 4
Suicide Prevention • Development of the district Suicide Prevention and Postvention Plan for 2016-2021 to build upon the current district Suicide Prevention and Postvention Plan 2013-15 • Create a Workforce Development Framework to identify and support the recognition of those at risk from self-harm and suicide and enable referral to appropriate services	• District Suicide Prevention and Postvention Plan Terms of Reference agreed by the Interagency suicide prevention group by the end of Quarter 1. • Interagency Suicide Prevention Plan for 2016 – 2021 completed by the end of Quarter 4 • Framework for evidence based suicide prevention training completed by end of Quarter 2. Three year training schedule completed by Quarter 4
Maaori Health Plan • Identify and review the factors influencing the health disparity for Maaori with regards to the higher rate of compulsory community treatment orders (CTO's) under the Mental Health Act 1992: Section 29 • Review the process to monitor compliance and timeliness of Mental Health Act reviews • Identify and review the factors influencing application for and release from the Mental Health Act 1992: Section 29	• Identify factors that contribute to the higher rate of Maaori service users under a CTO in CM Health mental health services by the end of Quarter 2 • 100 percent compliance of s76(3) certificate medical reviews completed within legislated timeframes for all patients under a CTO by the end of Quarter 3 • Propose a prioritised solution to address the higher rate of Maaori service users under a CTO in CM Health mental health services by Quarter 4
Regional Alignment The Ministry of Health's 2015⁄16 Planning Priorities for Regional Service Plans identifies five key objectives, and the Northern Region will carry forward a number of objectives from 2014⁄15. Initiatives in the plan will consider a systems level approach, including DHBs, PHOs, NGOs and other community and intersectoral organisations as appropriate, and identify opportunities to address inequities within the activity undertaken. Counties MH&A services will contribute to the following Northern Regional Health plan priorities identified for Mental Health	
• Improve availability of and access to the range of eating disorders services • Increase capacity and improve responsiveness of MH&A services for people with high and/or complex needs • Improve access to and experience of perinatal and infant mental health service options across a service continuum • Improve capacity and responsiveness of youth forensic services • Improve secondary service support to primary care settings • Review child and youth MH&A services	• Contribute to the governance group and process once established by Quarter 1 • Contribute to the development of a working draft service delivery framework by Quarter 4 • Contribute to progressing options analysis and business case development for regional minimum secure inpatient service by Quarter 2 • Contribute to developing an interim solution to provide options for supporting people with high and/or complex needs who require a contained environment by Quarter 4 • Measure increased access to perinatal and maternal mental health services. I.e. current numbers x to be increased to y with progress measured quarterly • Measure and report improved access to youth forensic services – court liaison, CYF youth justice residences and community • Implement consult liaison reporting across the range of mental health and addiction services • Agree and implement a regionally consistent metabolic screening tool to support the physical health of people with low prevalence conditions • Increase information sharing and support shared care through utilising CareConnect portal

	• Contribute to utilisation review of Child and Family Unit by Quarter 2 • Contribute to mapping the current range and utilisation of local, regional and supra-regional child and youth mental health and addiction services by Quarter 4

2.3.10 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:

- Healthy, 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 re-ablement 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

Linkages

Acute medical surgical services; CM primary care initiatives; Aged Related Residential Care (ARRC); Home Based Support Services (HBSS); Emergency Department; NGO/Community Services e.g. District Nursing, Palliative Care; , Ko Awatea Beyond 20,000 Days: Acute Care of Elderly

Actions	**Measures**
Dementia Care Pathways (PP23) • Report number of referrals by General Practice • Report Total Case load/by number of clinicians • Report Number of referrals diagnosed with dementia • Provide data on number of admission to the acute service 6 months pre referral to the Memory Team and 6 months post intervention • Continue to monitor time from dementia diagnosis to admission to residential care (ARRC)	• 30 percent of patients referred for cognitive assessment/review to Health of Older People outpatients will be managed by the Dementia Care Service • Report on progress on the Integrated Dementia Care Pathway (Franklin Pilot) Quarter 2
Home and Community Support Services for Older People (PP23) • Implement home and community support providers the allocation of specific funding for in-between travel • Participate in any working groups to implement aspects of the negotiated in-between travel settlement • Confirm the funding resultant of the in-between travel settlement is transferred from the DHBs to the contracted home and community based support service providers, to the qualifying employees for qualified travel time and qualified travel cost	• Evidence of allocation of funding from in-between travel settlement • Evidence of participation on the in-between travel working groups (where applicable)

Rapid response and discharge management services (wrap around services PP23) • CM Health will participate in the Regional/National working group on Hospital to Home Rehabilitation review in collaboration with Accident Compensation Corporation and Ministry of Health • The review will include, but not be limited to: • Inpatient rehabilitation (AT&R) • Wrap around services including: • Rapid response/admission avoidance • Supported discharge and integrated community rehabilitation • Rehabilitation in-reach into acute settings • Non weight bearing episodes • Transition within the continuum of rehabilitation services	• Evidence of participation in the hospital to home rehabilitation review for injured older people
Comprehensive Clinical Assessment in residential care - LTCF (interRAI PP23) • Continue to support groups already trained in LTCF interRAI to embed practice • Measure use of the interRAI as a primary assessment tool for needs assessment of older people • Report on the percentage of older people in aged residential care by facility who have a second InterRAI assessment completed 230 days after admission – Data will need to be provided by the National InterRAI Team Administrator	• 100 percent of facilities competent in using the LTCF interRAI • Summary of support provided • Evidence of use of InterRAI in Residential Care as a primary assessment tool and support provided by DHB Shared Services • Percentage of older people in aged residential care by facility who have a second interRAI assessment completed 230 days after admission as per the report provided by DHB Shared Services
Comprehensive Clinical Assessment for NASC Community Services (home or residential) (Link with National Data) • 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 to NASC for an interRAI assessment to access publicly funded care services will undergo the assessment in a timely manner • We will compare our performance using interRAI with other Northern Region DHBs and identify opportunities for quality improvement	• Report on the number and percentage of older people who have received long-term home and community support following an interRAI assessment in the previous three months • 100 percent of new clients entering residential care will have an up to date interRAI homecare assessment • Collaborate with Central TAS to develop through their new integrated interRAI service the comparative standardised interRAI quality reporting measure
HOP specialists (PP23) • CM Health will maintain optimal levels of use of specialist HOP People Services to advise and train health professionals in primary care and aged residential care	• Maintain Geriatrician and Gerontology nurse specialists support per month to 5 primary care practices including clinics and education sessions with GPs • Maintain Geriatrician and Gerontology nurse specialists support per month to 6 Age Related Residential Care Providers for medication review case conferences • Reduce the number of inappropriate presentations to Emergency Care from Residential Care to 15 per month, and throughout the year develop a process for analysing the reasons for admission and develop a support plan for identified Aged Residential Care Facilities by Quarter 3

	• Maintain the number of hours specialist HOP Services consult with health professionals in primary care –number of hot line calls
Fracture Liaison Service (PP23) • Monitor performance measures of the operations of the Fracture Liaison Service • Provide information to confirm the number of people who are seen by the service and the intervention rates to prevent secondary fractures • Increase identification rate, utilising the Fracture Liaison Service Coordinator, of target population under and over 65 years outside the geriatric and ortho-geriatric areas such as Emergency Care and acute wards	**Key reporting measures will include:** • Treatment implementation rate • 100 percent of appropriate fragility fracture patients are provided osteoporosis medication • Report on percentage of referrals to fall prevention programmes to establish baseline • Monitor rate of further fractures for patients having suffered a previous fracture • 70 percent of identified fragility fracture patients will be investigated and offered interventions to prevent second fragility fractures • 50 percent of the target population are screened for fragility fractures by end of Quarter 1 (reporting from Q2) • 67 percent of the target population are screened for fragility fractures by the end of Quarter 4

2.3.11 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; maximising opportunities for optimal improvements and maintenance of function, reducing risks of complications and physical and mental wellbeing deterioration in the short and long term, enabling independence and community participation and supporting family, whaanau, carers and employers who help people with SCI.

Linkages

Canterbury DHB,; ACC; Ministry of Health

Actions	**Measures**
Objective 1 of the NZ Spinal Cord Impairment Action Plan.CM Health will: • Collaborate with Canterbury DHB to implement the acute referral and destination pathway for SCI including a communication plan • Engage with ambulance providers to implement the SCI pre-hospital destination • Develop a standardised plan for identifying and decanting patients when required between units to ensure access to specialist care (acute and rehabilitation) **Objective 3** • Implement shared care planning for SCI patient follow up with healthcare home • In conjunction with CDHB we will explore options for the capture and reporting of spinal cord impairment data in NZ to optimise quality and consistency of care delivered, both acutely and in rehabilitation services	• Quarter 2: Submit a confirmation and Exception Report submitted on progress made against actions in the Spinal Cord Impairment Action Plan in 2014/15 and to date in 2015/16 • Quarter 4: Submit a Confirmation and Exception Report on actions identified in the Quarter 2 report • Report on the number and percentage of acute patients who follow the destination guideline as signed off by SCI National Governance Group • Disseminate guidelines to all DHB's by June 2016 • Consistent communication plan around the guidelines developed and circulate to other DHB by June 2016 • Provide report on progress and recommendation of next steps Quarter 4 • Provide evaluation of pilot by end Quarter 2, providing recommendations for a national register roll out by end of Quarter 4 • Commence with patient experience questionnaires; develop process and mode for collection by end of Quarter 4 • Meet with ACC/MOH reps and contribute to process between July 2015 and June 2016

Objective 4 • Explore a Quality Framework that could be used across Canterbury DHB and CM Health Spinal services (WOS) commencing with standardised patient experience questionnaires **Objective 5** • Participate with ACC and MoH to improve access to modified housing and specialised equipment to maximise community reintegration	

2.4 National Entity Priorities

Actions **Health Shared Services** • Finance, Procurement and Supply Chain • Food Services, Linen and Laundry Services, and National Infrastructure Platform business cases	**Measures** • Commit resources to the implementation of HBL's FPSC initiative, and fully factor in expected budget benefit impacts • Commit to working in partnership with HBL to progress Food Services, Linen and Laundry Services and National Infrastructure Platform business cases. The DHB will support the decision reached in relation to these Detailed Business Cases
Health Quality and Safety Commission • Surgical Site Infection Programme – refer to Section 2.5 • Patient Experience Indicators– please refer to Section 2.5 • Capability and Leadership – refer to Sections 1.2.2and Section 5.0 • Primary Care Patient Experience – please refer to Section 2.3.2	• Commit to meeting infection control expectations in accordance with Operational Policy Framework, refer Section 9.8 • Commit to meeting expectations in accordance with Operational Policy Framework, Section 9.3 & 9.4.6 • Produce a Quality Account in accordance with HQSC guidance
National Health Promotion Agency • Health Targets – refer to Section 2.1 • Alcohol and Pregnancy • Alcohol Screening	• Support national health promotion activities around: • health targets • alcohol consumption during pregnancy • alcohol screening and brief intervention
Health Workforce New Zealand • Increasing the number of sonographers – refer to Section 2.3.7 • Expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses – refer to Section 2.6, Workforce • Create new nurse specialist palliative care educator and support roles – please refer to Section 2.6, Workforce • Expanding the role of specialist nurses to perform colonoscopies – please refer to Section 2.6, Workforce • Increasing the number of medical physicists – refer to Section 2.6, Workforce • Increasing the number of medical community based training places and providing access to primary care/community settings for prevocational trainees – refer to Section 2.6, Workforce	

National Health Information Technology Board • eMedicines Reconciliation (eMR) with eDischarge summary – N/A • Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR) – N/A • Replacement of Legacy Patient Administration Systems – N/A • National Patient Flow MoH contribution to National Patient Flow – refer to Section 2.6, Information Technology • Patient and Provider Portals (formerly self care portals) –refer to Section 2.6, Information Technology	
National Health Committee (NHC)	• Work collaboratively with the NHC by: engaging with and providing advice through the National Prioritisation Reference Group; referring technologies that are driving fast growing expenditure to the NPRG; using emerging technologies based on NHC recommendations or holding technologies until such a time as the NHC has completed assessment of; and providing clinical and business expertise and research time to design and run field evaluations
Pharmac • Hospital Medical Devices – Pharmac Procurement Activity	• Support Pharmac's national contracting activity for hospital medical devices. • Support the implementation of any product standardisation undertaken by Pharmac

2.5 Improving Quality

Whilst all CM Health's strategic initiatives address quality and improvement of our healthcare system, the 'Delivering Patient and Whaanau Centred Care' and 'First Do No Harm' executable strategies are specifically working to improve the quality and safety experience of patients in our healthcare system.

Our aim is to have the best overall performance, by comparison with Australasian peers, on an agreed suite of measures of quality by December 2015.

Our 'First Do No Harm' strategy is responsible for implementing quality improvement and safety initiatives across our healthcare system. This includes participation in national initiatives and regional campaigns. We also need to ensure that quality and safely is incorporated into all local activities. This includes activities spanning the entire sector from hospital to primary care and residential care.

Linkages

National 'Open for better care' campaign; regional 'First Do No Harm'; CM Health 'Aiming for Zero Patient Harm'; CM Health Quality Account; 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 Learning Education intersectoral work, faculty training programmes

Actions	**Measures**
Continued commitment to: • Health and Disability Sector Standards Certification and the Business Excellence Framework (BEF) which is aligned to the Baldrige Performance Excellence Framework • The national 'Open for better care campaign', meeting and exceeding thresholds for the Quality Safety Markers including:	• Continued certification/accreditation and progress towards gold award in Business Excellence Framework (BEF) • Quality & Safety Markers, Health Quality & Safety Commission: • 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

• Falls – maintain the focus on falls risk assessment and individualised care planning through the local 'Zero Patient Harm' DHB programme that provides analysis of data and direction for a targeted reduction in serious harm from falls • Hand Hygiene - invest in trained hand hygiene auditors. Continue promotion of good hygiene to staff, patients and visitors. Develop the frontline ownership model within the DHB • Peri-operative harm - refocus the use of the surgical safety checklist as a teamwork and communication tool (rather than an audit tool). Introduce briefing and debriefing for each theatre list • Surgical Site Infection - 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 • Medication Safety - further promote the use of electronic medication reconciliation by engaging team based pharmacists and Resident Medical Officers • The further development of annual quality accounts to include consistent reporting with relevant measures. 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 the DHB to attend and participate in the committees • The regional patient safety programme: 'First Do No Harm – safer care together' • Hospital Services 'Aiming for Zero Patient Harm' initiatives to address patient safety during admissions including: o Medication Safety o Reducing harm related to Falls and Pressure Injury o Central Line Associated Bacteraemia (CLAB) and Venous Thromboembolism (VTE) prevention o Infection control and Prevention and Hand Hygiene • We will leverage from the success of CM Health's hospital based patient safety programme 'Aiming for Zero Patient Harm' in order to continue to expand quality and safety focussed initiatives into Primary Care and Age Related Residential Care sectors • We will use a range of methods to help our patients, family and whaanau be more involved in decision making (at all levels) to improve their patient experience: o 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	addressing these risks • 90 percent compliance with procedures for inserting central line catheters • 80 percent compliance with good hand hygiene practice • All three parts of the WHO surgical safety checklist used in 90 percent of operations • Work with Health Quality & Safety Commission and regional partners to roll-out a new measure aimed at ensuring the surgical safety checklist is used in at least 90 percent of operations focusing on its use as a teamwork and communication tool • 100 percent of primary hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision • 95 percent of hip and knee replacement patients receiving 2g or more of cefazolin • 100 percent of primary hip and knee replacement patients having appropriate skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine • 80 percent of high risk patients have electronic medication reconciliation completed within 48 hours of admission • Completed an accessible quality account that will be published on the CM Health website • 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 • Enhanced capability in patient experience methods • Improved response rate to both national and internal patient experience survey • Utilised patient experience survey feedback at all levels of the organisation to improve the patient experience • The routine use of advance care planning where appropriate in primary care • Reporting to governance group and different levels in the organisation

o Maintain a concerted focus on obtaining patient email addresses so that more electronic responses can be captured o Keeping patients and whaanau informed – timely accurate and useful information to participate effectively in decision making about their care and achieve the best possible clinical outcomes o Patients and whaanau are members of key decision making groups – roles on key decision making committees • Consolidation of System Level Measures (SLM) - comparative analysis of CM Health performance with local and international healthcare organisations, dissemination of SLM reports and post-implementation review of SLMs • Developing the capability in innovation and improvement methods for CM Health • Improving the efficiency of hospital services (e.g. current work in Radiology and Pharmacy Dispensary to improve turnaround times) • Improving the efficiency and effectiveness of Acute Mental Health and Gastroenterology referrals • Ko Awatea lead Beyond 20,000 Days, Manaaki Hauora – Supporting Wellness campaign, Safety in Practice and quality improvement programmes and projects • Ko Awatea developing the capability in innovation and improvement methods for CM Health Community organising – Ko Awatea will continue to work with the community to improve health and wellbeing through the development of an active network of youth leaders to mobilise groups of youth to take charge of their own health and wellbeing • Ko Awatea will lead patient co-design training and projects – working with staff and patients to redesign services to improve patient experience • Reducing hospital-based mortality through improved end-of-life care, after hours care, prevention and management of sepsis • 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 • Ko Awatea will lead Safety in Practice to: o Increase capacity in PHO and general practices in patient safety methods and processes by 30 June 2016 o Promote culture of safety o Develop practice systems and processes to increase patient safety o Prevent or reduce harm and improve the quality of care for patients with chronic conditions	• Comparative analysis of SLMs • Post-implementation review completed • Service delivery times meet Key Performance Indicators • Reduction in 'Do Not Attend' 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 • Ko Awatea/MoE ECE campaign will increase participation to 98 percent of three/four year olds in early learning education • Ko Awatea will lead Safety in Practice to: o Support up to 70 general practices in phase 1 & phase 2 to implement improvement using the model for improvement methodology o Complete monthly audits for measuring improvement o Deliver three learning sessions for all general practices to train, share knowledge and ideas o Culture surveys to be completed in general practices

• Ko Awatea lead Manaaki Hauora – Supporting Wellbeing: o Provide self-management support for 50,000 people living with long term conditions by 1 December 2016 o Establish and support 20 Collaborative teams across CM Health to achieve aims that contribute to the Campaign aim	o Trigger tool to be completed in general practices o Evaluation to be completed to report on objectives achieved o Audit data to be analysed to measure improvements. o Evaluation to be completed and report on improved quality of care for patients and whaanau • Ko Awatea lead Manaaki Hauora – Supporting Wellbeing: o Establish infrastructure to co-ordinate the peer support leaders workforce & network o Increased numbers of people accessing self-management programmes o Increased number of people enrolled in and supported in ARI o Reduction in unplanned visits to Emergency Care and general practices o Establish collaborative teams with charters, aims and measurement plans. o Deliver three-four learning sessions to train, share knowledge and ideas across the sector o Each collaborative team will measure improvements and develop dashboards for the data o Report monthly on progress for all collaborative teams within the Campaign

2.6 Actions to Support Delivery of Regional Priorities

Major Trauma **Actions** • 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 • Lead clinician identified and actively involved in the Regional Team • Contribute to quarterly reports against the defined performance indicators for the region • Continue to collect, update and maintain Collector database • Develop a training plan for CM Health staff in relation to regional trauma	**Measures** • Pathway developed and regularly reviewed • Attendance and active involvement in the Regional Trauma meetings. • Clinical Lead actively engaged with Regional Trauma Group • 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
Workforce **Actions** • Work in partnership with professional leaders, primary care, professional bodies and unions, to progressively extend the scope of practice for roles 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	

• Develop a regional workforce programme to address bowel screening • Support ADHB to pilot the RN Anaesthetic Assistants Initiative • 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 and educator positions • 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 utilising our workforce through improved modelling and forecasting of workforce requirements • Improve workforce planning using the national Workforce Intelligence & Planning Framework across workforces in Items 1 and 12 of this plan • Actively support Regional Clinical Networks, including: o Electives o Stroke o Health of Older People o Major Trauma • Promote and develop a workforce with more generic skills which is flexible to work across hospital and community settings • Hold a regional "think-tank" workshop to identify opportunities to develop new and hybrid roles to support new models of care, including: o Community Care Coordinator role o Hybrid / blended roles across the Allied Health, Scientific and Technical professions • Develop a strategy to implement recommendations from the "think-tank" • Progressively implement findings from the CM Health's At Risk Individual (ARI) managed care model to support patients with long term conditions • Promote and increase undergraduate training and new graduate employment placements in primary and community care by engaging with PHOs, Residential Care and other community providers for all workforces as appropriate • Engage with regional partners in the education sector (including University of Auckland, AUT, and Massey University) to discuss clinical placements, internships and employment of new graduates • Increase NETP placements in priority services • Allied Health and/or midwifery actions here to be confirmed • Identify opportunities to better utilise and support the non-regulated workforce: • Undertake a stocktake of existing support programmes for the unregulated workforce in each DHB	

• 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 • Increase access to education and training pathways, e.g. by providing formal qualifications to Orderlies, Kitchen Assistants, and Healthcare Assistants • Identify initiatives for implementation/support arising from the Kaiawhina Workforce Action Plan • Identify opportunities to better support the low paid workforce • Determine who our low paid workforces are • Identify new opportunities and existing initiatives that could be expanded to increase access to education and training pathways • Align regional strategies to enhance Maaori and Pacific undergraduate achievement and increase clinical placements in primary care • 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 • Support CM Health's Localities work • Support NDHB Neighbourhood Healthcare Homes work • Improve the monitoring and reporting of the health workforce, particularly focussing on the Maaori, Pacific and Asian workforce • 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 • Implement compulsory requirement for ethnicity information (refer new employment Application Form Item 14) • Systematically collect ethnicity data of existing employees for whom this information is missing • Extend data capture to contracted providers in primary and community care • Implement local, regional and national initiatives to support a "pipeline" or student driven approach to workforce development such as "Grow our Own" initiatives through secondary, tertiary, and/or "second chance" learners' programmes, opportunities for work experience placements and exposure to health care settings, and scholarships for tertiary study • Implementing nationally based Kia Ora Hauora initiatives • Ensure that the various MoH funding sources for workforce programmes in DHBs are joined up to maximise impact and value for the Maaori and Pacific workforces • Undertake stocktake of funding sources (Year 1) • Align regional strategies to enhance graduate success and overcome barriers to workforce participation	• A minimum of a 200 Maaori and 200 Pacific students enrolled in high school based health career programmes • A minimum of 200 Maaori and 200 Pacific students offered: • Gateway programmes, or • Work experience placements, or • work exposure in a DHB • 50 Maaori and 50 Pacific people offered scholarships for tertiary health studies • Recruit a minimum of 200 Maaori students to a health study pathway in this region • Support at least 20 Maaori into first year tertiary study

• Implement a dedicated regional recruitment and retention strategy (end to end support) for Maaori and Pacific staff including:
  o Policies in regard to affirmative action for recruitment of Maaori and Pacific people into the workforce
  o Staff satisfaction surveys and exit interviews for Maaori and Pacific staff to inform retention initiatives
• Promote and support the development of Maaori and Pacific Clinical and Cultural Leaders
• Promote and support the Nga Manukura o Apopo Maaori Nurse and Midwifery workforce development programme
• Promote and support Aniva initiatives, with particular focus on midwifery
• Monitor the number of Maaori and Pacific staff participating in Management/Leadership programmes
• Identify opportunities to increase Maaori and Pacific leadership capability within DHBs
• Increase numbers of graduates and experienced Maaori and Pacific staff in the health workforce, to reflect the Maaori and Pacific patient population
• Identify vulnerable workforces and develop strategies to ensure future sustainability
• Undertake workforce(s) "scan" utilising key indicators to identify vulnerable workforces for attention. In particular:
  o Medical Physicists
  o Orthoptists
  o Clinical Coders
  o The Palliative Care and Cancer workforce
  o The ageing workforce
  o MRTs
• Implement existing and new initiatives:
  o Sonographer Trainee pilot
  o AP Scientific & Technical workforce plan (continuance)
  o Anaesthetic Technicians Initiative
  o Midwifery in hard to staff areas
• Support the regional approach to addressing key workforce requirements with regard to the medical physicist workforce
• Jointly identify, develop and implement policies and procedures / processes across the region for:
• Standardised approach to student clinical placements through extension of HSPnet pilot
• Implement standardised employment Application Form
• Develop a regional Health and Safety Policy (including workforce wellbeing)
• Strengthen the regional development and implementation of e-learning modules:
  o Regionalise 3 mandatory programmes per year
	• Confirm current state and In particular increase participation by 10 percent per year across :
	• Nursing
	• Midwifery
	• Medicine
	• Allied Health

• Work towards implementation of e-passport capability, by investigating the feasibility of aligning the e-learning platforms and training records
• Strengthen Health Leadership and Management through:
  o Staged implementation of the national Leadership Domains Framework, commencing with pilot at WDHB
  o Develop a Health Management Training Pathway – determine model and develop implementation plan
• Continue building on the cultural competency training to all staff:
  o Tikanga and Pacific cultural training is included as part of mandatory training schedule for all staff
  o Evaluate the process and impact of the Tikanga and Pacific cultural training programmes regionally
• Continue to develop an effective regional RMO service to support DHBs recruit and retain an RMO workforce aligned with service delivery and training requirements
• 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
• Regional roll-out of Ko Awatea lead Health Science Academies and mentoring for Pacific students
	• 400 per DHB for CMDHB / ADHB / WDHB staff enrolled in Culturally and Linguistically Diverse (CALD) courses annually
	• Train 120 people through the level 1 and 30 Advance Care planning programme

Information Technology (IT) • Northern Region IT Strategy	• Refreshed Northern IS Strategic Plan • Roadmaps that reflect CM Health investment journey
Northern Electronic Health Record (EHR) • Participation in an implementation planning study for PAS/HER	• Regional implementation schedule and business case • Refresh on Information Systems Strategic Plan to ensure alignment of new IT investment and ongoing delivery of National Health IT Board priorities

Regional Patient Administration System (PAS) Upgrade • CM Health to upgrade iPM as an interim measure ahead of the regional PAS implementation initiated in 2014/15 • Implementation of new modules to support CM Health urgent business capabilities	• Successful upgrade of existing modules • New module implemented where funding allows
SQL system upgrades • System upgrade with a review of infrastructure to meet resilience and DR processes for Tier 1 applications	• Systems and hardware upgraded as required to meet SQL licensing, performance and reliability requirements
Electronic Prescribing and Administration (ePA) • Implementation of Medchart	• Medchart implementation for first services and business case for full rollout
Electronic Pharmacy (subject to availability of regional instance)	• Implementation of Regional ePharmacy following NDHB implementation
Maternity Portal • Complete rollout of Clinical Information System (CIS) including to private midwives (if available nationally) • Implementation of Maternity Portal to CM Health service users	• Compliance with HISO standards • Rollout of CIS • Portal offered to service users
Shared Care • Implementation barriers removed and rolled out to more practices, services and consumers	• Roll out schedule in place and milestones met • Compliance with HISO standards
Patient Portal • Patient Portal to be offered by 90 percent of practices	• Targets of practices offering portals defined and met • Compliance with HISO standards
Emerging regional priorities: • Roll out of Clinical Pathway as defined in business case • Implementation of the National Infrastructure Programme for the Northern Region • Mobility strategy and extension of telehealth offerings: • Mobile options implemented for community workers across services and within community integration programme • Telehealth and collaboration tools available and being used	• Compliance with HISO standards • Rollout of additional dynamic pathways • Integration with other initiatives to improve clinical workflow (i.e. eReferrals) • Migration plan completed and pre-migration initiatives underway • Regional mobile strategy developed • Implementation initiated across community workforce • Telehealth and collaboration tools offered and being utilised as anticipated • Compliance with telehealth standards
Refresh regional governance and service catalogue with Northern DHBs and healthAlliance	• Accountabilities and responsibilities clear with limited delays to approval against plan • Service provision and performance measures met • ICT Risk assessment and assurance plans in place
National Patient Flow	• Phase 3 and non-compliant Phase 2 requirements delivered where possible

2.7 Living Within Our Means

Introduction

The 2015/16 fiscal year will see the introduction of the Practising Sustainable Healthcare programme, formerly Thriving in Difficult Times, which is structured to optimise our spend by reducing waste and duplication in our processes and systems. For the 2014/15 fiscal year the programme in its entirety has delivered a $37.5 million budgetary saving.

The programme is clinically focused and each year has grouped together a range of initiatives within both the Hospital Care arm, Primary and Community Care arm, and corporate services that enables CM Health to deliver a small surplus without reducing patient access to services. We take a whole of system approach to delivery of services looking to see how we can enhance delivery of care in the right place for the patient at the right time and streamlining the pathway of care.

The second component of the programme is the collaboration Counties Manukau Health has with healthAlliance Procurement with a range of national price harmonisation initiatives, regional and national new contract negotiations and rationalisation of clinical supply contract. At the date of this Plan we are on target to deliver $5.0 million budgetary savings to the Hospital Care arm for clinical and non-clinical services and supplies. In addition to price harmonisation benefits, areas contributing to the target savings are delivery of a regional record storage contract, new print devices as Part 1 of our managed print service, local rationalisation of wound care products, and implementation of new waste contracts to include recycling.

The third component is the collaboration between CM Health and healthAlliance Inventory and Supply chain that will see all clinical and non-clinical stocks managed through the national inventory system from 1 July 2015. In addition, we will also have the Oracle catalogue updated to increase compliance from 60 percent to over 90 percent prior to progressing to a national Catalogue. Process to enhance introductions of new clinical products to the organisation has also been strengthened under the governance of the Clinical Board's, Product Safety and Infrastructure Group. The combined benefits of inventory initiatives have saved $600,000 in the 2014/15 year.

For 2015/16 we will be building on the wide platform we have developed in 2014/15 and previous years to ensure we deliver a small surplus in 2015/16.

Linkages

National Entity health sector expectations including Health IT Board; Health Quality and Safety Commission; CM Health related workplans.

Actions	**Measures**
Practising Sustainable Healthcare • Procurement opportunities: National price harmonisation initiatives, regional/national new contract negotiations, rationalisation of clinical supply contract • Inventory and Supply Chain: All clinical and non-clinical stocks to be managed through a national inventory system, improved processes for new clinical products through new governance oversight • Environmental initiatives: waste contracts to include recycling	• Reduction in cost of products and consumables
Whole of System (WoS) CM Health has embedded WoS programmes (musculoskeletal, cardiovascular, metabolic syndrome, digestive/gastrointestinal) into our business through health service groups Programmes providing efficiencies within hospital services: • Enhanced Recovery After Surgery (ERAS) initiatives	• Refer to Improved Access to Elective Surgery section 2.1.2

• Delivery Redesign Elective Services programme (DRES) • Theatre CAP Plan • Safer Medicines Outcomes On Transfer Home (SMOOTH)	
Project SWIFT • Providing better information sharing and integration between hospital, primary and community services; more efficient hospital services; increased capacity of primary and community care services to meet the needs of our population	• Refer to section 5.2.3

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

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Revenue	**23,397**	**25,980**	**35,390**	**38,803**	**39,658**	**44,065**
Personnel Costs	6,298	9,913	16,005	18,406	21,167	24,343
Outsourced Services	1,257	2,771	2,407	2,768	3,183	3,660
Clinical Supplies	627	3,355	1,318	1,516	1,743	2,004
Infrastructure and Non-Clinical Supplies	960	114	896	1,030	1,185	1,363
Other	14,255	9,827	14,764	15,083	12,380	12,695
Total Costs	**23,397**	**25,980**	**35,390**	**38,803**	**39,658**	**44,065**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**	**-**

3.2.2 Early detection and management

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Revenue	**209,289**	**212,130**	**216,096**	**219,336**	**222,627**	**225,968**
Personnel Costs	-	-	-	-	-	-
Outsourced Services	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-
Infrastructure and Non-Clinical Supplies	-	-	-	-	-	-
Other	209,289	212,130	216,096	219,336	222,627	225,968
Total Costs	**209,289**	**212,130**	**216,096**	**219,336**	**222,627**	**225,968**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**	**-**

3.2.3 Intensive assessment and treatment

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Revenue	**1,114,497**	**1,145,392**	**1,158,114**	**1,162,896**	**1,167,123**	**1,170,754**
Personnel Costs	520,376	542,634	552,596	560,675	568,865	577,166
Outsourced Services	64,226	53,620	62,943	63,796	64,658	65,528
Clinical Supplies	110,493	107,406	115,211	116,922	118,658	120,419
Infrastructure and Non-Clinical Supplies	111,062	118,854	114,128	115,790	117,475	119,181
Other	305,286	319,870	310,535	303,010	294,766	285,755
Total Costs	**1,111,443**	**1,142,385**	**1,155,412**	**1,160,193**	**1,164,422**	**1,168,049**
Surplus (Deficit)	**3,054**	**3,007**	**2,702**	**2,703**	**2,701**	**2,705**

3.2.4 Rehabilitation and support

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Revenue	**113,606**	**118,665**	**114,487**	**116,204**	**117,949**	**119,719**
Personnel Costs	-	-	-	-	-	-
Outsourced Services	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-
Infrastructure and Non-Clinical Supplies	-	-	-	-	-	-
Other	113,606	118,665	114,487	116,204	117,949	119,719
Total Costs	**113,606**	**118,665**	**114,487**	**116,204**	**117,949**	**119,719**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**	**-**

3.2.5 Total

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Revenue	**1,458,951**	**1,492,364**	**1,521,398**	**1,544,219**	**1,567,385**	**1,590,898**
Personnel Costs	526,819	547,728	560,813	569,225	577,765	586,432
Outsourced Services	65,483	56,217	63,113	64,060	65,022	65,997
Clinical Supplies	111,120	107,820	117,220	118,978	120,762	122,573
Infrastructure and Non-Clinical Supplies	112,022	119,346	116,906	118,659	120,439	122,244
Other	640,453	658,236	660,644	670,594	680,696	690,945
Total Costs	**1,455,897**	**1,489,347**	**1,518,696**	**1,541,516**	**1,564,684**	**1,588,191**
Surplus (Deficit)	**3,054**	**3,017**	**2,702**	**2,703**	**2,701**	**2,707**

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

Outputs are measured against six dimensions of quality:

Figure 5: 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		2015/16 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 hospitalised patients who smoke that are offered brief advice and support to quit smoking		95%	Q3 2014/15	95%	June 2016	NHT Efv
Proportion of enrolled patients who smoke and are seen in General Practice are offered brief advice and support to quit		95%		90%		
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		96.9%		90%		
Breastfeeding All Counties Manukau facilities are Baby Friendly Hospital Initiative (BFHI) accredited sites.						
Percentage of infants exclusively or fully breastfed at discharge from birthing facility[4]	Total	86%	Dec 2014	75%	June 2016	MHP
	Maaori	87%				
	Pacific	82%				
Percentage of infants exclusively or fully breastfeed at LMC discharge (4-6 weeks)	Total	57%		75%		
	Maaori	52%				
	Pacific	51%				

[4] Middlemore data only, excludes Primary Units and babies admitted to neonatal care

		Baseline		2015/16 Forecast Performance		Reference
Percentage of infants exclusively or fully breastfeed at 3 months	Total	46%		60%		
	Maaori	38%				
	Pacific	44%				
Percentage of infants receiving breast milk at 6 months	Total	61%		65%	June 2016	MHP
	Maaori	46%				
	Pacific	44%				
Family Violence Prevention We deliver coordination of the Violence Intervention Programme which includes training staff in adult and children's emergency care, 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 Programmes Audit Score (self audit using AUT tool)[5]	Partner Abuse	98	May 2014	=>180 combined score	June 2016	S
	Child Abuse and Neglect	99				
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	88%	Q3 2014/15	95%	June 2016	NHT NRHP MHP SLM T
	Pacific	95%				
	Total	93%				
Proportion of two year olds who are fully immunised	Maaori	93%	Q3 2014/15	95%	June 2016	T
	Pacific	97%				
	Total	95%				
Proportion of older people (65+) who have had their flu vaccinations		67%	Q2 2014/15	75%	June 2016	MHP Efv
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	67.9%	Q3 2014/15	70%	June 2016	MHP Efv
	Pacific	78%				
	Total	71.1%				
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	62%	Q2 2014/15	80%	June 2016	MHP Efv
	Pacific	73.2%				
	Total	71.5%				
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						

[5] 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

	Baseline		2015/16 Forecast Performance		Reference
Proportion of four year olds who have had their B4 School Checks	79%	Q3 2014/15	90%	June 2016	Efv
Proportion of newborns enrolled by 3 months[6]	90%	Q2 2014/15	98%	June 2016	T

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		2015/16 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	86.6	Q3 2014/15	90%	June 2016	NHT Efv
	Pacific	91.3				
	Total	91.2				
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c of equal to or less than 64 mmol/mol)	Maaori	59%	Q3 2014/15	66%	June 2016	IDP Efv
	Pacific	58%				
	Total	66%				
Proportion of PHO enrolled population enrolled within At Risk Individuals (ARI)[7] programme		1.2%	Q3 2014/15	5%	June 2016	
Percentage of patients enrolled on the ARI programme who have a: • Care Plan • Electronic Summary Record • Self-Management Assessment • Named Care Coordinator		80%	Q3 2014/15	80%	June 2016	Efv
Average Length of Stay for patients within ReACH (Locality Reablement) service		New Measure Baseline to be established -		4 weeks	June 2016	
Increased clinical care time for community health resources		0%	Q3 2014/15	10%	June 2016	

[6] Births are only Counties Manukau domiciled but patients can be enrolled in any PHO

[7] 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		2015/16 Forecast Performance		Reference
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 oral health services		76%	Dec 2014	85% 95%	Dec 2015 Dec 2016	IDP Efv
Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)		8.5%		7%	Dec 2015	IDP MHP T
Proportion of Year 8 children who have their treatment completed and are transferred to the adolescent dental service		100%		100%	Dec 2015	IDP Efc
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services		75%		85%	Dec 2015	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	70.2%	Q3 2014/15	95%	July 2016	NRHP IDP T
	MRI	58.6%		85%		
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)		76.8%		75%		
Proportion of patients accepted as non- diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)		28.6%		65%		
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date		85%		60%		

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.

			Baseline		2015/16 Forecast Performance		Reference
Mental Health							
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							
Proportion of clients with a transition discharge plan	Child and Youth	Total	87%	Q3 2014/15	95%	July 2016	IDP Efv
Proportion of people referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks for 0-19 years	Mental Health (Hospital Care Arm)	3 weeks	73%	Q3 2014/15	80%	July 2016	IDP T
		8 weeks	92.8%		95%		
	Addictions (Hospital Care Arm and NGO)	3 weeks	83%		80%		
		8 weeks	86%		95%		
Elective Services							
We provide and purchase elective inpatient and outpatient services							
ESPI 2: Proportion of patients who wait longer than four months for their first specialist assessment (FSA)			zero	Q3 2014/15	zero		T SLM
ESPI 5: Proportion of patients given a commitment to treatment but not treated within four months			2.8%		zero		
Number of Elective Surgical Discharges			12,859	Q3 2014/15	19,883	July 2016	NHT
						July 2016	
Elective Services Standardised Intervention Rates (SIRs) per 10,000 of population8		Major joints	23.87	31 Dec 2014	21	July 2016	IDP Eq
		Cardiac	6.71		6.5		
		Cataracts	40.34		27		
Outpatient Did Not Attend (DNA) rates		Maaori	11%	Q3 2014/15	10%		P Efc
		Pacific	8%		10%		

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

			Baseline		2015/16 Forecast Performance		Reference
Acute Services							
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 • Good access to support services in the community or primary care level to support patient recovery							
Readmissions Acute readmissions to hospital[9]		Total 75+	7.4% 9.8%	Q3 2014/15	Commitment to improve on baseline target	July 2016	IDP SLM Efv
Acute Inpatient Average Length of Stay[10]			2.58	Q3 2014/15	2.63	July 2016	IDP Efv
Emergency Department Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours			96%	Q3 2014/15	95%	July 2016	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 Pacific Total	100%	Q3 2014/15	100%	July 2016	NHT NRHP T
	Chemo-therapy	Maaori Pacific Total	100%		100%		
Proportion of patients who receive their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks			57.7%	Q3 2014/15	85%	July 2016	NRHP 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[11]			100%	Q3 2014/15	80%	July 2016	T
Proportion of outpatient coronary angiograms with a waiting time of < 3 months			100%	Q3 2014/15	95%	July 2016	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			86.9%	Q3 2014/15	70%	July 2016	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			81%	Q3 2014/15	80%	July 2016	NRHP T

[9] 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

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

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

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 palliative care services, home-based support services and residential care services.

On a continuum of care these services will provide support for individuals.

	Baseline		2015/16 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 current clients receiving long term HBSS that have an interRAI clinical assessment within the previous 24 months	New Measure Baseline to be established		65%	July 2016	Efv
Assessment, Treatment and Rehabilitation Services					
We provide readily accessible Assessment, Treatment and Rehabilitation Services (AT and R) both within the hospital and in the community.					
Percentage of identified fragility fracture patients will be investigated and offered interventions to prevent second fragility fracture	New Measure Baseline to be established		70%	July 2016	Efv
Age Related Residential Care (ARRC)					
We provide access to subsidised beds based on assessed need We fund a sufficient supply of contracted beds available to people assessed as requiring long term residential care					
Number of potentially avoidable EC presentations from ARRC per month[12]	13	Q3 2014/15	<15	July 2016	Efv
Home Based 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 Providing Home and Clinic based specialist Nursing Services and Allied Health Services to support community care					
Proportion of CM Health NASC clients receiving Home Based Support Services who have a comprehensive interRAI assessment completed in the last 3 months	New Measure Baseline to be established		To be established	July 2016	T

[12] Fewer EC 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

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 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 change needed for future sustainability; as a result, some 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 strategic shape 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. This has been reaffirmed through our newly received approval for investment in acute mental health services. In parallel, CMDHB is working closely with the New Zealand Health Innovation Hub, Health IT Board and National Health Board 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. This will support CM Health's clinical leaders to drive cross-sector improvement in prioritised whole of system programme areas at pace consistent with new models of care and continued health system integration ambitions through established Locality Clinical Partnerships and district Alliance.

Acknowledging the significant fiscal challenges the whole health sector is facing, we are committed to achieving a small surplus financial position in 2015/16 enhanced by the late addition of 'tagged' revenue ($2.7m). While the outer years are anticipated to be increasingly challenging, CM Health is focused on continuous improvement, innovation and constrained cost growth as a way of living within our means.

4.1.2 Cost structure changes to effect integration

The first three years of our transformation journey focused on establishment of Locality Clinical Partnerships, risk/gain budget holding at a practice level to incentivise system performance, shared accountability[13] for population outcomes, and targeted system redesign initiatives with proof of concept pilots and organisational change to enable progressive expansion in the range of services provided in the community. Our cornerstone health system integration (Better Sooner More Convenient) investments, achievements and 2015/16 priorities are further outlined in the Executive Summary.

A major cost structure change for the primary care schedule was implemented in 2014/15 relates to year one transition of the Chronic Care Management (CCM) funding for primary care, plus DHB enhancement of $1.5m, to the At Risk Individual (ARI) programme. This flexible funding pool is to enable primary care and locality multidisciplinary teams to expand the range and scope of planned, proactive and patient centred care in a more equitable manner in a community setting. Funding has being allocated based on the Care Plus algorithm to each practice, with 25 percent to fund transition and setup costs, 25 percent to related outcomes and education, and the remaining 50 percent for interventions. All practices will transition from CCM to ARI by June 2015.

[13] Shared Accountability Services are those specialist or hospital level services which are provided across localities, but over which the primary healthcare and community sector has an important influence. This may include, inter alia, acute medical surgical services, emergency services, elective inpatient and outpatient services, diagnostic services, specialist mental health services, pathology services, and residential care services. The cost of these services will be apportioned across localities according to transparent allocation mechanisms, such as actual or forecast utilisation.

4.2 Forecast Financial Statements

CM Health had initially budgeted for a breakeven financial position for 2015/16 and break even for the three outer years. Reflecting late additional 'tagged' revenue advice, we are now forecasting a small consistent surplus for the next three years. It should be noted that this surplus is subject to formal confirmation as to its appropriate treatment.

4.2.1 Summary by primary & community care arm

Net Result	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Provider	(3,197)	(3,990)	(12,421)	(12,605)	(12,794)	(12,983)
Governance	(2,367)	1	230	232	235	239
Funder	8,618	7,006	14,893	15,076	15,260	15,451
Eliminations	-	-	-	-	-	-
Operating Surplus	3,054	3,017	2,702	2,703	2,701	2,707
Other Comprehensive Income	6,930	36,856	-	-	-	-
Surplus (deficit)	9,984	39,873	2,702	2,703	2,701	2,707

4.2.2 Statement of comprehensive income

Net Result	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Revenue						
Crown	1,422,084	1,455,667	1,482,736	1,504,978	1,527,554	1,550,467
Other	36,867	36,697	38,662	39,241	39,831	40,430
Total Revenue	**1,458,951**	**1,492,364**	**1,521,398**	**1,544,219**	**1,567,385**	**1,590,897**
Expenses						
Personnel	526,819	547,728	560,813	569,225	577,765	586,432
Outsourced	65,483	56,217	63,113	64,060	65,022	65,997
Clinical Sup.	101,192	97,612	106,408	108,004	109,623	111,267
Infrastructure	67,678	64,602	63,014	63,959	64,919	65,893
Personal Health	466,404	482,985	482,101	489,373	496,755	504,243
Mental Health	60,430	58,076	66,036	67,028	68,035	69,057
Disability Support	109,262	114,331	110,131	111,782	113,460	115,163
Public Health	2,806	1,378	1,908	1,936	1,964	1,993
Maori	1,551	1,466	468	475	482	489
Operating Costs	**1,401,625**	**1,424,395**	**1,453,992**	**1,475,842**	**1,498,025**	**1,520,534**
Operating surplus	**57,326**	**67,969**	**67,406**	**68,377**	**69,360**	**70,363**
Depn.	29,923	35,693	35,856	36,393	36,939	37,492
Capital Chg.	15,527	13,485	14,136	14,348	14,563	14,781
Interest	8,822	15,774	14,712	14,933	15,157	15,384
Operating Surplus	**3,054**	**3,017**	**2,702**	**2,703**	**2,701**	**2,706**
Other Comprehensive Income	6,930	36,856	-	-	-	-
Surplus (Deficit)	9,984	39,873	2,702	2,703	2,701	2,706

4.2.3 Primary & community care revenue

Net Result	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Crown	1,367,172	1,402,261	1,428,444	1,449,872	1,471,621	1,493,695
Other	5,395	5,185	3,528	3,580	3,634	3,689
Total	**1,372,567**	**1,407,446**	**1,431,972**	**1,453,452**	**1,475,255**	**1,497,384**
Personal Health	1,062,828	1,097,138	1,109,464	1,126,146	1,143,079	1,160,262
Mental Health	140,332	139,991	149,064	151,301	153,572	155,876
Disability Support	141,502	148,057	143,851	146,009	148,201	150,426
Public Health	2,806	1,378	1,908	1,936	1,964	1,993
Maori	1,551	1,466	468	475	482	489
Governance	14,930	12,410	12,324	12,509	12,697	12,887
Total Expenditure	**1,363,949**	**1,400,440**	**1,417,079**	**1,438,376**	**1,459,995**	**1,481,933**
Net Surplus	**8,618**	**7,006**	**14,893**	**15,076**	**15,260**	**15,451**

4.2.4 Eliminations revenue

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Crown	(723,496)	(742,204)	(756,435)	(767,782)	(779,299)	(790,988)
Other						
Total	**(723,496)**	**(742,204)**	**(756,435)**	**(767,782)**	**(779,299)**	**(790,988)**
Personal Health	(596,424)	(614,153)	(627,363)	(636,773)	(646,324)	(656,019)
Mental Health	(79,902)	(81,915)	(83,028)	(84,273)	(85,537)	(86,819)
Disability Support	(32,240)	(33,726)	(33,720)	(34,227)	(34,741)	(35,263)
Public Health	-	-	-	-	-	-
Maori	-	-	-	-	-	-
Governance	(14,930)	(12,410)	(12,324)	(12,509)	(12,697)	(12,887)
Total Expenditure	**(723,496)**	**(742,204)**	**(756,435)**	**(767,782)**	**(779,299)**	**(790,988)**
Net Surplus	-	-	-	-	-	-

4.2.5 Hospital care revenue

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Crown	763,478	783,200	797,991	809,961	822,111	834,443
Other	31,428	31,512	34,615	35,134	35,662	36,198
Total	**794,906**	**814,712**	**832,606**	**845,095**	**857,773**	**870,641**
Personnel	516,889	539,637	551,645	559,919	568,319	576,844
Outsourced	64,971	55,550	62,609	63,548	64,502	65,469
Clinical Sup.	101,192	97,492	106,228	107,821	109,437	111,078
Infrastructure	60,779	61,071	59,841	60,738	61,650	62,576
Operating Costs	**743,831**	**753,750**	**780,323**	**792,026**	**803,908**	**815,967**
Operating surplus	**51,075**	**60,962**	**52,283**	**53,069**	**53,865**	**54,674**
Depreciation	29,923	35,693	35,856	36,393	36,939	37,492
Capital Charge	15,527	13,485	14,136	14,348	14,563	14,781
Interest	8,822	15,774	14,712	14,933	15,157	15,384
Net Surplus	**(3,197)**	**(3,990)**	**(12,421)**	**(12,605)**	**(12,794)**	**(12,983)**
Other Comprehensive Income	6,930	36,856	-	-	-	-
Total Comprehensive Income	**3,733**	**32,866**	**(12,421)**	**(12,605)**	**(12,794)**	**(12,983)**

4.2.6 Governance revenue

	2013/1 Audite Actual	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Crown	14,930	12,410	12,736	12,927	13,121	13,318
Other	44	-	519	527	535	543
Total	**14,974**	**12,410**	**13,255**	**13,454**	**13,656**	**13,861**
Personnel	9,930	8,091	9,168	9,306	9,446	9,588
Outsourced	512	667	504	512	520	528
Clinical Sup.	-	120	180	183	186	189
Infrastructure	6,899	3,531	3,173	3,221	3,269	3,317
Total Expenditure	**17,341**	**12,409**	**13,025**	**13,222**	**13,421**	**13,622**
Net Surplus	**(2,367)**	**1**	**230**	**232**	**235**	**239**

4.2.7 Total revenue

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Crown	1,422,084	1,455,667	1,482,736	1,504,978	1,527,554	1,550,468
Other	36,867	36,697	38,662	39,241	39,831	40,430
Total Revenue	**1,458,951**	**1,492,364**	**1,521,398**	**1,544,219**	**1,567,385**	**1,590,898**
Expenses						
Personnel	526,819	547,728	560,813	569,225	577,765	586,432
Outsourced	65,483	56,217	63,113	64,060	65,022	65,997
Clinical Sup.	101,192	97,612	106,408	108,004	109,623	111,267
Infrastructure	67,678	64,602	63,014	63,959	64,919	65,893
Personal Health	466,404	482,985	482,101	489,373	496,755	504,243
Mental Health	60,430	58,076	66,036	67,028	68,035	69,057
Disability Support	109,262	114,331	110,131	111,782	113,460	115,163
Public Health	2,806	1,378	1,908	1,936	1,964	1,993
Maori	1,551	1,466	468	475	482	489
Operating Costs	**1,401,625**	**1,424,395**	**1,453,992**	**1,475,842**	**1,498,025**	**1,520,534**
Operating surplus	**57,326**	**67,969**	**67,406**	**68,377**	**69,360**	**70,363**
Depn.	29,923	35,693	35,856	36,393	36,939	37,492
Capital Chg.	15,527	13,485	14,136	14,348	14,563	14,781
Interest	8,822	15,774	14,712	14,933	15,157	15,384
Operating Surplus	**3,054**	**3,017**	**2,702**	**2,703**	**2,701**	**2,707**
Other Comprehensive Income	**6,930**	**36,856**	**-**	**-**	**-**	**-**
Surplus (Deficit)	**9,984**	**39,873**	**2,702**	**2,703**	**2,701**	**2,707**

4.2.8 Balance sheet

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Cash and Bank[1]	21,580	56,152	38,397	23,986	(8,214)	23,825
Debtors	34,083	46,019	51,078	46,000	46,000	46,000
Inventory	1,434	1,320	1,320	8,486	8,486	8,486
Assets Held for Sale	12,503	12,503	-	-	-	-
Current Assets total	**69,600**	**115,994**	**90,795**	**78,472**	**46,272**	**78,311**
Non Current Assets	624,964	664,720	683,904	695,297	729,781	723,630
Total Assets	**694,564**	**780,714**	**774,699**	**773,769**	**776,053**	**801,941**
Current Liabilities						
Creditors	96,832	99,374	94,550	97,792	97,794	97,794
Loans	40,000	-	5,000	30,000	35,000	20,000
Employee Provisions	113,638	129,576	126,086	118,543	118,543	118,543
Total Current Liabilities	**250,470**	**228,950**	**225,636**	**246,335**	**251,337**	**236,337**
Working capital	**(180,870)**	**(112,956)**	**(134,841)**	**(167,863)**	**(205,065)**	**(158,026)**
Net Funds Employed	**444,094**	**551,764**	**549,063**	**527,434**	**524,716**	**565,604**
Non Current Liabilities						
Employee Provision	16,984	20,283	20,283	16,200	16,200	16,200
Term Loans	227,600	292,500	287,500	267,500	262,500	301,100
Restricted funds	864	882	898	864	864	864
Other	1,337	1,337	1,337	1,540	1,540	1,540
Total Non Current Liabilities	**246,785**	**315,002**	**310,018**	**286,104**	**281,104**	**319,704**
Crown Equity	**197,309**	**236,762**	**239,045**	**241,330**	**243,612**	**245,900**
Net Funds Employed	**444,094**	**551,764**	**549,063**	**527,434**	**524,716**	**565,604**

1. The high cash position forecast by year 2018/19 reflects the need to find the as yet unapproved Strategic Capital i.e. Radiology and Spinal

4.2.9 Movement of equity

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Total Equity at beginning of period	**187,744**	**197,309**	**236,762**	**239,045**	**241,330**	**243,612**
Surplus / (Loss) for period	3,054	3,017	2,702	2,703	2,701	2,707
Crown Equity injection	-	-	-	-	-	-
Crown Equity withdrawal	(419)	(419)	(419)	(418)	(419)	(419)
Revaluation Reserve	6,930	36,855	-	-	-	-
Total Equity at beginning of period	**197,309**	**236,762**	**239,045**	**241,330**	**243,612**	**245,900**

4.2.10 Cash flows from operating activities

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Operating Activities						
Crown Revenue	1,344,791	1,341,443	1,475,816	1,515,752	1,530,254	1,553,167
Other	16,917	129,612	36,963	37,517	38,081	38,654
Interest rec.	2,240	3,043	1,699	1,724	1,750	1,776
Suppliers	764,587	871,038	893,248	916,009	922,958	936,801
Employees	521,516	533,593	566,803	578,152	577,765	586,432
Interest paid	8,521	12,506	14,712	14,933	15,157	15,384
Capital charge	13,108	15,273	14,526	13,348	14,563	14,781
GST (Net)	2,381	2,784	-	(2,054)	-	-
Net cash from Operations	**53,835**	**38,904**	**25,189**	**34,605**	**39,642**	**40,199**
Investing activities						
Sale of Land and Buildings			12,503			
Total Fixed Assets	(48,072)	(26,572)	(43,240)	(48,425)	(66,423)	(26,341)
Investments and Restricted & Trust Funds	(7,442)	(2,263)	(11,784)	(5,172)	(5,000)	(5,000)
Net cash from Investing	**(55,514)**	**(28,835)**	**(42,521)**	**(53,597)**	**(71,423)**	**(31,341)**
Financing						
Crown Debt	30,000	24,900	-	5,000	-	23,600
Equity - Capital	(419)	(401)	(419)	(419)	(419)	(419)
Net cash from Financing	**29,581**	**24,499**	**(419)**	**4,581**	**(419)**	**23,181**
Net increase / (decrease)	27,902	34,568	(17,751)	(14,411)	(32,200)	32,039
Opening cash	(6,322)	21,580	56,148	38,397	29,763	(2,437)
Closing cash	**21,580**	**56,148**	**38,397**	**23,986**	**(2,437)**	**29,602**

4.2.11 Capital expenditure

	2013/14 Audited Actual $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Forecast $000	2017/18 Forecast $000	2018/19 Forecast $000
Baseline Capital	48,072	23,586	24,240	31,425	32,423	26,341
Strategic Capital	-	2,986	19,000	17,000	34000	-
Sub Total	**48,072**	**26,572**	**43,240**	**48,425**	**66,423**	**26,341**
Strategic Capital (Unapproved)				21,000	36,000	2,000
Total	**48,072**	**26,572**	**43,240**	**69,425**	**102,423**	**28,341**

1. The high cash position forecast by year 2018/19 reflects the need to find the as yet unapproved Strategic Capital i.e. Radiology and Spinal

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 2015/16 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 significantly stepped up our 'Practising Sustainable Healthcare' programme to promote not only tight cost control through budget management, productivity enhancement and efficiencies, but also include initiatives related to procurement opportunities, 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 between 0.7 percent to 1.5 percent for 2014/15, 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

The System Integration Investment programme remains a core enabler of system level change. Our focus for 2015/16 continues to be alignment of localities development and related primary care/community based capital investment (e.g. integrated family healthcare centres). The form that this programme 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 local Practising Sustainable Healthcare programme.

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 2016/17.

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 IS infrastructure

Prioritised Information System (IS) infrastructure investment has been agreed regionally (refer section 2.6) 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 2.6 for an outline of regional IS investments and local innovations through collaboration with the New Zealand Health Innovation Hub.

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

4.4.8 Capital servicing

The commissioning of the new Clinical Services Block (CSB) Stage 1 project in 2013/14 has fully utilised all existing available cash funding in 13/14, sourced from either current or accumulated depreciation or remaining available approved debt funding or approved equity/debt.

This will have a material valuation change to Land and Buildings.

4.4.9 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 organisation 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 2015/16 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 CM Health Board, NHB 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 has been approved for the 2015/16 year.

Figure 6: Major capital investment projects – approved and unapproved

Project	Budgeted Approval	Project Finish Date	Indicative Value	Status
Acute Mental Health	2014/15	2018/19	$53.6m	Ministry funding approved. Preliminary design being undertaken
Spinal Unit and Rehabilitation cohort	2016/17	2019/20	$56.0m	Indicative Business Case development
Diagnostic (Labs/ Radiology)	2015/16	2024/25	$10.0m	Local/Regional Capital Planning Intentions ($1m/year for 10 years)
Women's Health (Middlemore site)		2022/23	$60.0m	Within the Strategic Investment Programme Tranches. No action planned for 2014/15
Project SWIFT/EPIC (strategic partnering and risk sharing arrangement)	-	-	-	Business cases being developed
Southern Carpark (strategic partnering and risk sharing arrangement)	-	-	-	Business cases being developed

Note: This table provides planned but unapproved projects and is indicative only. It does not include the cash flow impact and initial operating expense impacts of unapproved business cases.

4.4.10 Capital investment funding

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

4.4.11 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 HBL via Westpac which is the only relationship falling under this remaining covenant, together with lease/finance facilities with both Commonwealth Bank and Westpac.

Figure 7: Banking facilities

Facilities	Existing Limit $000,000	Utilisation at 30 June 2013 $000,000	Available Facility at 1 July 2014 $000,000
Crown Debt	$297.6	$297.6	-
HBL / Westpac (working capital)	$64.4	-	$64.4
Westpac (lease facility)	$10.0	-	$10.0
Commonwealth Bank (lease facility)	$10.0	-	$10.0

4.4.12 Pharmaceutical budget

CM Health is committed to supporting the effective implementation of the three-year Community Pharmacy Services Agreement (1 July 2012 to 30 June 2015).

There were significant changes included in this Agreement that came into effect from 1 July 2012. Changes included incentivising pharmacists to better use their clinical medicines management expertise; re-orienting community pharmacy services around the patient and facilitating increased integration with prescribers across all settings, in particular with primary care; and linking funding to patient outcomes.

4.4.13 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 currently a single proposed asset sale of part of our Botany site by June 2015. This ‘sale’ is directly related to the expanding the provision of integrated health services in the community by third party providers. As part of the long term 10 Year System Integration Strategic Investment programme, we will be identifying any other potential surplus assets that may be disposed of to assist in funding future developments.

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 roll out scheduled for 2015/16 (refer 5.2.3 for more 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 CMDHB.

Investments in Associates and Jointly Ventures

Associates are those entities in which the Group has significant influence, but not control, over the financial and operating policies. Significant influence is presumed to exist when the Group holds between 20 percent and 50 percent of the voting power of another entity. Joint ventures are those entities over whose activities the Group has joint control, established by contractual agreement and requiring unanimous consent for strategic financial and operating decisions.

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 income

Rental income 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 CMDHB region is domiciled outside of Counties Manukau. The MOH credits CMDHB 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 CMDHB.

Interest income

Interest income 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 construction projects with a capital cost greater than $100m, all other costs are treated as an expense in the financial year in which they are incurred with the exception of those cost deemed to relate to a capital project over $100m.

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 and plant
- Clinical equipment, IT and motor vehicles
- Other equipment
- Infrastructure

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

Revaluations

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

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

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

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

Additions

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

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	10% - 20%
Plant and equipment	5 - 10 years	10% - 20%
Clinical Equipment	3 - 25 years	4% - 33%
Information Technology	3 - 7 years	14% - 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.

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 2-7 years (14 percent - 50 percent)

Impairment of Property, Plant and Equipment and Intangible Assets

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

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

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

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

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

The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the

asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

For assets not carried at revalued 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 based on an independent actuarial calculation which is 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
- 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, sabbatical 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. CMDHB post budget approval changed its policy to capitalise borrowing costs against capital projects greater than $10m.

Cost Allocation

CMDHB 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, Management 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 12.

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
- 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 16 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.

CMDHB has entered into a contract for services with several providers for laboratory services. Services are provided across several DHBs' districts. CMDHB makes payments to the service providers on behalf of the all DHBs receiving services and these DHBs will then reimburse CMDHB for the costs of the services provided in their districts. There is a Memorandum of Understanding that sets out the relationships and obligations between each of the DHBs. Based on the nature of the relationship between CMDHB and the other DHBs, Counties Manukau has assessed that it has acted as an agent for the other DHBs. Therefore, the payments and receipts in relation to the other DHBs are not recognised in the Counties Manukau's financial statements.

Standards, amendments, and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the DHB, are:

- NZ IFRS 9 Financial Instruments will replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1: Classification and Measurement, Phase 2: Impairment Methodology, and Phase 3: Hedge Accounting. Phase 1: Has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.
- The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. The DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.
- Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

5.0 Stewardship

5.1 Managing Our Business

CM Health has an established and robust governance 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

Our Board and Chief Executive hold overall responsibility for the performance, operation and management of the DHB and are supported at all levels of strategic and operational decision making by the Executive Leadership Team (ELT) of clinical and managerial leaders, the Clinical Governance Group and sub-committees, networks and advisory 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. For example, the Regional Radiology Network, including managerial and clinical leaders, was tasked with making recommendations on DHB MRI and CT capital investment proposals. This integrated leadership approach is a critical approach to ensure dual attention to financial and clinical sustainability.

At a local level, our health system governance and accountability has been structured to reflect the ongoing integration of primary/community care and hospital based services. The following governance groups are in place:

- Alliance Leadership Team which is an alliance of Primary Health Organisation (PHO) Chief Executives and CM Health Executive Leaders
- Geographically based Locality Clinical Partnerships (and related community advisory networks)
- A Whole of System Strategy Group (and related expert working groups) combining our PHO Executives and CMDHB Executive Leadership Team including clinical and managerial leaders

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 (CMDHB).

5.1.2 Performance management

The Institute of Healthcare Improvement'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.

CM Health has worked on the development of a performance measurement framework which includes System Level Measures (SLMs). These are 'big dot' measures of our healthcare system and are reflective of the performance of services provided in different settings and locations across the continuum of care. Work continues to be undertaken on the contributory measures – 'little dot' measures – which contribute or flow into the SLMs. These measures focus on the quality of specific healthcare services and/or outcomes for a defined patient. The rationale for this

performance framework is based on the need for robust information to support progress towards our strategic goals. The SLMs are reported to the ELT on a quarterly basis together with a summary report of DHB performance against planned actions/activities.

5.1.3 Financial management

The Minister of Health and National Health Board has indicated constrained funding increases for 2015/16 and beyond which will require a highly effective financial planning and management system. Due to combined impacts of increased health service demand and reduced revenue increase of 1.5 percent is less than half of 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 3 to 4 times our funded cost growth. However, the 2015/16 plan will be targeted to a small surplus financial result and a commitment to achieve our national health targets.

We are committed to maintaining a secure and balanced financial position and are working to meet these financial challenges in a positive manner through national and regional collaboration, working in partnership with healthAlliance to leverage aggregated savings and efficiency benefits and local system level accountability for financial and non-financial performance.

We remain committed to our many service improvement and savings opportunities but are concerned regarding the ability to achieve the indicative savings within timeframes, cost saving levels and available resources.

CM Health utilises industry 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 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.

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

Organisation level corporate and clinical risks are managed centrally through established policy and procedures that enables consistent risk identification, mitigation/actions reporting and management. Organisation risks are reviewed by operational divisions for local management and are presented to CM Health Executive Leadership Team monthly, and to the Board, and Finance and Audit Committee to ensure effective escalation, appropriate and timely attention to enable effective risk management.

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 8: High Level Summary of Capability Drivers and Related Plans

Quality and Safety	Delivering excellence while being sustainable requires integration of quality and safety from the campaign/initiative stages into business as usual See section 2.5 for the CM Health approach to implementation	**CM Health** • First, Do No Harm (combines quality and safety initiatives) • Better health outcomes for all • Delivering Patient & Whaanau Centred Care • Scale up and spread of Beyond 20,000 Days • Manaaki Hauora – Supporting Wellness • Safety in Practice **Regional** First, Do No Harm National (Health Quality & Safety Commission and others): • Improving medication safety • Infection prevention and control (preventing healthcare-associated infections) • Reducing harm from falls in healthcare settings • Making surgery safer • Enhanced Recovery After Surgery • Ko Awatea lead Target CLAB Zero
Service Innovation	Essential requirement for health system transformation and building capability in non-traditional service approaches in order to enable future health system sustainability	**CM Health** • System Integration Programme including initiatives lead by Ko Awatea such as the Beyond 20,000 Days campaign, Manaaki Hauora – Supporting Wellness localities development • Capability building sessions in creativity and innovation- Innovation Intensives • Patient and Whaanau Centred Care Consumer Council • Innovation Hub • Fanau ola **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 MOE • Well Child • Auckland Wide Housing Initiative (AWHI) • Health Science Academy - developing 2-3 new health science academies for Pacific and Maaori students across Auckland **National** • Innovation Hub (joint venture with Counties Manukau, Auckland, Waitemata and Canterbury DHBs) • Shared services, supply chain and procurement • Leading the National Partners in Care Programme
Information Technology and Information Intelligence	How and where health information is accessed, data analyses and health scenarios modelling combined with hard infrastructure – these are critical clinical and service enablers	**CM Health** • Project SWIFT • Implementation of CostPro **Regional** • Refer section 2.6 • Northern Region IT Strategy Refresh • Implementation Planning Study for a Regional PAS/EHR • National (Health IT Board and Others)Shared Care • Patient Portal • National Infrastructure Platform

		• Clinical pathways • eMedicines programme • National Patient Flow • Maternity Information System Rollout and Portal • SQL upgrades • Mobile workforce • Wifi for patients
Capital Investment	An integrated asset management plan (equipment, hard infrastructure) that links service requirements (maintenance and developmental) with fixed and non-fixed investments	**CM Health** • Investment Strategy (10 year – in development) • Facilities Masterplan aligned with the Asset Management Plan • Enterprise Asset Management System **Regional** • Regional Capital Group • National • Procurement and Supply Chain

5.2.1 Capital and infrastructure development

An Integrated Infrastructure (Investment) Planning Steering Group (IPSG) has been established by CM Health. The role of the IPSG is to deliver affordable capital infrastructure solutions across the whole health system in an environment of increasing demands for better services and constrained budgets.

Infrastructure planning will be ongoing and integrated, designed to ensure our capital infrastructure meets our business requirements to deliver the Triple Aims.

Specific functions

The IPSG will prioritise, plan and make recommendations to the ELT on the following capital infrastructure functions. In doing so, it will integrate some of the functions of the former Facilities Modernisation Project Steering Group.

Two specific documents form the foundation information upon which all prioritisation and planning will be conducted by the IPSG; The CM Health Affordability Model, managed and updated by the Deputy CFO Corporate and Business Services and the Base Case Demand Model, managed and updated by the Population Health Team under the guidance of Dr Wing Cheuk Chan and validated by Cranleigh Consulting.

The specific functions of the IPSG are:

- Infrastructure Planning – current Master Plans - review the current Middlemore Campus and Manukau Health Park Master Plans and associated assumptions to update these for 2014/15 – 2024/25. This review will be conducted in context of the current funding environment, the Strategic Investment Programme existing capital business cases, Project SWIFT, other programmes and initiatives including CM Health's commitment to the Northern Region Health Plan
- Capital Affordability – communication - alongside the review of the Master Plans provide transparency and clear messaging of capital affordability within the health sector (Ministry of Health/Treasury advice and forecasts) and the implications for CM Health and the Northern Region
- Spatial Planning - as the Master Plans are revised the allocation and reallocation of space will be the responsibility of the IPSG
- Building Upgrades and Renewals - annually review and prioritise the building upgrade and renewal programme with recommendations presented to ELT
- Infrastructure Maintenance - the IPSG will work with the General Manager Engineering and Property (and his Team) to oversee and confirm the annual building and plant infrastructure budget prioritisation and allocation
- Asset and Capital Committee -review current scope of Asset and Capital Committee for 2014/15 taking into consideration implications for capital expenditure relating to the Localities' development within Counties Manukau

5.2.2 Asset management

CM Health embarked on implementing an Enterprise Asset Management System (EAM) two years ago and are currently implementing a hosted solution through providers Certus using Maximo as the system software, similar to

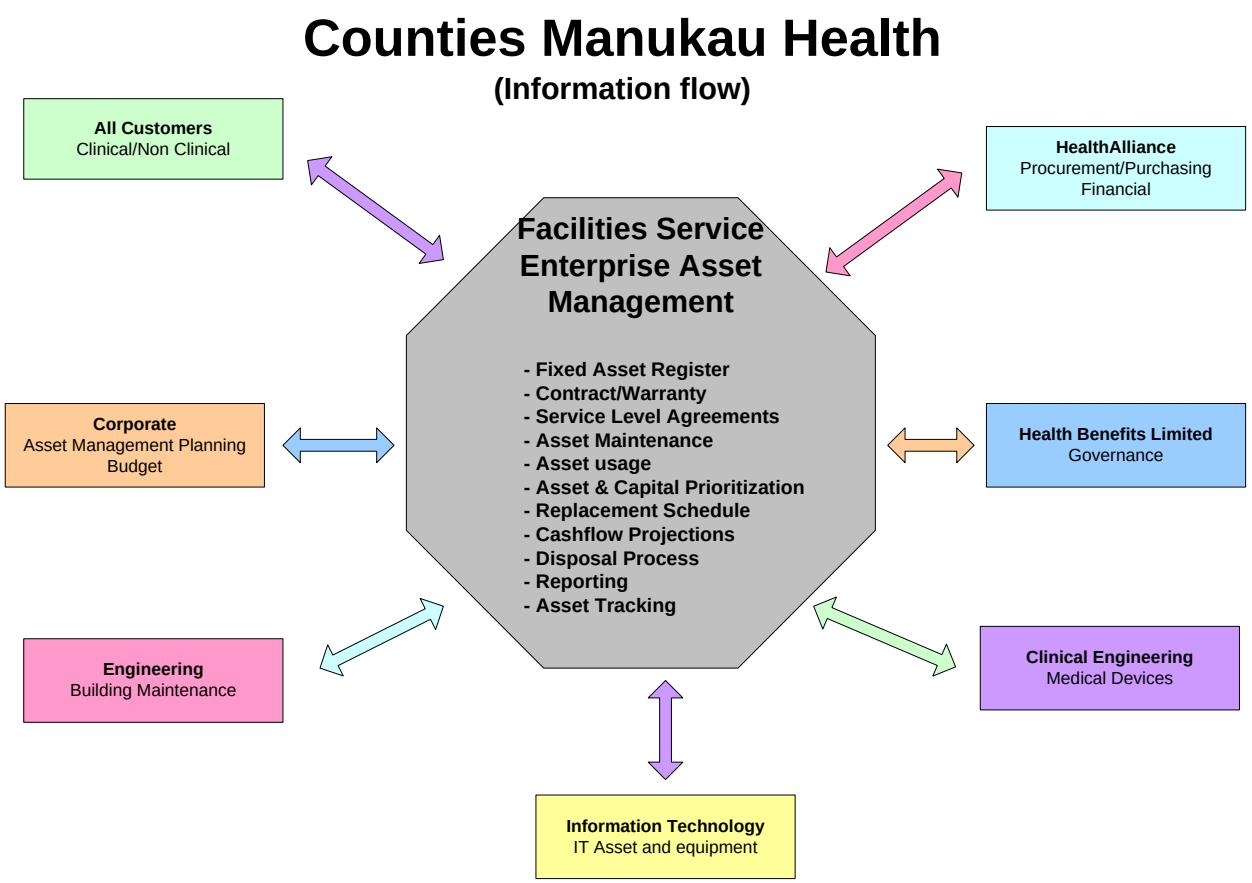
Canterbury DHB. We are implementing this across a number of fronts within our operation, having first spent considerable time on perfecting the processes.

EAM implementation – The EAM System will allow the organisation to use information from the current processes in making strategic, financial and operational decisions on asset replacement and effective life. The Implementation is now in Phase 1, Stage 1 focusing on the processes below:

- 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

The full potential of this initiative that is able to be realised is best illustrated in Figure 9:

Figure 9: Enterprise Asset Management (EAM) System overview



- The system is being implemented in three phases:
- Phase 1 (year 1) – Incorporating the recently completed Clinical Services Block and the inclusion of all Clinical Engineering (Biomedical) devices with full interface with Oracle financials and asset Register
- Phase 2 (year 1-2) – incorporating replacement of Biems (current work order system for maintenance), T Docs interface (tracking of surgical instruments and SSU interface), Radiology equipment and Laboratory Equipment
- Phase 3 (year 2-3) – incorporating all other fixed assets and other external developments and expansion

5.2.3 Whole of system redesign through enabling technologies

Project SWIFT (**S**ystem **W**ide **I**ntegration **F**or **T**ransformation) is a change program involving the whole CM Health system. It is focussed 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.

To do this, Project SWIFT requires smarter ways of connecting people and information. CM Health is partnering with IBM to achieve this and has entered into a 10 year relationship with an initial investment of 4 years. CM Health and

IBM have defined a number of priority initiatives to undergo detailed solution design with joint clinical and consumer teams. Investment business cases will be presented in early 2015/16 for consideration.

Initiatives Include:

eReferral enhancement to improve the usage and take-up of electronic referrals by primary care teams and improve collaboration with secondary services. Introduction of online/virtual collaboration tool to enable GPs and hospital clinicians to communicate about patients more effectively

Improved medical ordering for radiology, laboratory and pharmacy services, giving clinicians a convenient way to place, monitor and receive electronic medical orders for laboratory tests, imaging and pharmacy scripts

Optimisation of resources providing an integrated workforce rostering and scheduling system to enable efficient, effective resource allocation and a whole of hospital services resource demand prediction capability

Orchestration of care – a workflow solution that will automate and streamline work practices within the acute care setting

Point of care information making information easily accessible and recordable at the point of care and across all care settings in order to reduce staff effort and improve patient health outcomes

Marketplace enabling community care teams to have point-of-care access to information and tools which manage tasks and workload, and support care delivery

However, rather than look at these seven initiatives in isolation during solution design, a 'whole of system' review of pathways, business processes and workflow is being undertaken. Reflecting lessons learnt from successful internal change programmes, this is being clinically and consumer led, with an initial focus on three clinical areas:

(i) Cancer care
(ii) Cardiovascular disease
(iii) Respiratory disease

The three areas chosen align with Ministry of Health and DHB priorities. The approach underway is to, for example, look at cancer care across the continuum and identify opportunities for service and workflow enhancements which can be translated into requirements and enable development and assessment of solution options.

In addition to Quick Wins and Solution Design, the CMDHB Board agreed to support a **Proof of Concept** for the future model of care in the community. This aligns strongly with the CM Health system's focus on localities, development of general practice as the 'healthcare home' and support for patient and whaanau self-management.

The Proof of Concept is being undertaken in partnership with primary healthcare organisations.

The key areas being explored in the Proof of Concept are enhancement of General Practice (via lean redesign), eHealth Services to improve patient access; Integrated pharmacy services and Consumer engagement (including use of the patient portal).

The core assumption underlying the Model of Care business case is that:

a) A change in service model (including use of eHealth tools) will lead to greater capacity within General Practice (including the wider multidisciplinary team), and that

b) This capacity will allow General Practice to undertake activities that will ultimately lead to a decrease in demand for secondary health services (including moving care to the most appropriate setting)

SWIFT is a significant transformational change programme with impacts on our workforce and community. Ko Awatea is leading a significant change programme to support SWIFT in understanding impacts, preparing for and leading

change activities throughout the SWIFT programme delivery.

5.2.4 Regional information systems

Information systems (IS) are fundamental to the Northern Region's ability to deliver on the whole of system approach to health service delivery. A key clinical driver is to improve the continuity of care for patients in our region across primary, secondary and tertiary care. This relies on consistent and reliable access to core clinical documents and information for all clinicians involved in a patient's care.

In 2015/16 the focus will continue to be on infrastructure and applications upgrades to ensure these remain on the latest versions of software and provide resilience and performance to address the continuity risk for IS services in the region. These upgrades will be aligned with National Infrastructure Migration planning to ensure applications are updated and on supportable platforms before migrating to the National Infrastructure Platform. IS investment will be reprioritised to address these underlying service risks in the following areas:

- Back end software and infrastructure upgrades to keep licensing at formally supported levels
- Clinical and business systems upgrades to ensure systems can operate in these upgraded infrastructure environments ready for migration to National Infrastructure Platform. Prioritise upgrades as required to align with supportable SQL database and SQL server versions
- Refresh regional governance, service catalogue and service level agreements with the Northern Regional DHBs and healthAlliance IS to clarify roles and responsibilities, accountabilities, service provision and performance measures
- Improve user support services to include self-service options to reduce demand and ensure better use of resources and introduce service delivery management
- Refresh of the Information Systems Strategic Plan to ensure alignment of new IT investment and ongoing delivery of the National Health IT Board priorities. This is likely to include establishing a regional office to oversee investments in regional PAS/EHR. 2015/16 will see CM Health participate in an implementation planning study for a regional PAS/EHR
- As part of regional alignment the current stage of SWIFT, CM Health is determining with IBM:
- Those business requirements which will be deferred and incorporated as part of the PAS/EHR implementation
- Where there are business benefits, solutions which will be put in place to meet immediate needs but are expected to be subsequently replaced by the PAS/EHR
- Solutions which are required to support CM Health business strategy longer term and will complement investment in the PAS/EHR and offer additional capabilities to other DHBs

Figure 10: Regional investment priorities

Importance	Investment
Critical	RIS/ PACs system resilience and performance investment Participate in Regional PAS selection
Important	ePharmacy (NZULM/NZF) ePrescribing eReferral triage rollout and web access eReferral inter/intra hospital referrals Regional/ National Cancer Information system Maternity Clinical Information System National Patient Flow Continued rollout of shared care portal (at risk population) Self care portal in primary care
Emerging	Clinical Pathways Telehealth

5.3 Workforce

Strengthening our workforce

As at 1 Jan 2015, CM Health employed a headcount of 7,123 people, who worked an equivalent of 6,191 FTEs. Nursing is by far the largest clinical workforce comprising 48 percent of staff, medical 8 percent, allied health 20 percent, and care and support workers 7 percent. Over a third 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 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 people on our staff while clinical staff may take longer.

Figure 11: CM Health Headcount and FTE by workforce group, at 31 December 2014 (excluding casual employees)

Workforce Group	Headcount	FTE
Administration and Management	996	870
Allied Health and Technical	1,593	1,400
Medical	1,008	919
Non-Clinical Support	455	382
Nursing/Midwifery/HCA	3,071	2,619
Grand Total	7,123	6,191

Figure 12: CM Health workforce representation by ethnicity

Workforce Ethnicity	All Staff	Clinical	CM Health Population
Asian	28%	30%	22%
Maaori	7%	6%	16%
Pakeha and Other	54%	55%	38%
Pacific	11%	9%	23%

Whole of system collaboration

In order to be able to transform our health system, and provide the highest quality of care to our patients and the families we need to ensure that we have the right people with the right skills in the right place at the right time. To do this, we need robust strategies to attract, engage, retain, and develop a high performing workforce who are representative of the community we serve.

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 (see section 2.6) through the General Manager, Human Resources and the Clinical Leads Group, in conjunction with the Building Capability Lead.

An example of CM Health's contribution to the regional workforce plan implementation is the development of a revised model for training sonographers across the Auckland region. We continue to work closely with our Auckland metro DHB colleagues in the delivery of the Ministry funded contract for additional health science academies and a tertiary mentoring programme for pacific students. In addition to this we are aiming to achieve a regional training passport for mandatory training by Quarter 4 of 2015/16 year.

The approach we take to workforce development is underpinned by our workforce 'pipeline' of increased numbers of future Maaori and Pacific graduates in clinical roles.

Furthermore we are refreshing and embedding the organisational values and competency framework across the spectrum of primary and secondary care. .

The following sets out the four dimensions of capability, capacity, culture and change leadership that are core to our workforce strategy.

Capability

Our health system requires new skills, roles and integrated ways of working that enable a more sustainable health system that includes 'fit for purpose' role scope, education, training, support and supervision. Core strategies include:

- Embedding the review and restructure of the professional development and learning and development functions to ensure development offerings are appropriate, aligned with organisational strategy and offer value to the organisation. This work also includes the development of an Organisational Development and Learning strategy
- Development of a revised mandatory training policy in conjunction with the Regional Director of Training in order to explore opportunities to align e-learning and training packages across the region
- Working with tertiary institutions through our joint venture partnership to ensure future health professionals are able to meet the changing demands of the health system they will be working in
- Utilising Ko Awatea faculty programmes and Ko Awatea Learn web platform to new and enhance existing capabilities across all functions
- Development of Ko Awatea lead Leadership Academy to engage leaders from within our own staff to further improve and guide strategic and operational matters for the future
- Development of a competency and performance development framework that aligns with organisational values, strategies and priorities. This will inform the design and delivery of management and leadership development programmes, workforce scope of practice and role changes to support integrated models of care, including a review of the support workforce requirements; this will include identification of contractual implications
- Establishment of a workforce and education governance committee aimed at providing strategic oversight, governance and guidance for workforce, development and learning activity

Capacity

In order to meet future service requirements we need to attract and recruit the right staff with the right skills and have robust mechanisms for engaging and retaining quality health professionals and employees. Activity will include:

- Increasing the numbers of Maaori and Pacific people in the workforce through an expansion both at CM Health and regionally of 'pipeline' activities including Ko Awatea Health Science Academies, high school programmes, tertiary scholarships and the delivery of a tertiary mentoring programme for Pacific students. In addition to this CM Health is implementing a Maaori and Pacific recruitment and retention strategy aimed at attracting and retaining increased numbers of Maaori and Pacific people at all levels of the organisation
- Working regionally to find innovative workforce solutions to develop, recruit, engage and retain the workforce in hard to fill, vulnerable workgroups and new roles
- Strengthening training capacity through strategic partnerships with tertiary education providers and undergraduate inter-professional trainee placements
- Implementing new models of employment, e.g. Cadet programmes
- Identification of workforce implications that are driven by the changes in the organisations business processes resulting from the transformation which will be delivered by the SWIFT work streams

Culture

- We recognise the importance of staff engagement in building organisation flexibility, capacity and capability that enables our people to deliver their best in a changing environment. Key activities associated with include:
- Embed the standards and behaviours identified through the organisational values refresh through large scale employee engagement initiatives to support the delivery of excellent patient and whaanau centred care
- Strategies which increase opportunities for engagement from employees and their representative groups
- Effective staff communication to keep our people informed regarding key strategies, projects and initiatives through a range of forums including our local intranet (SouthNet sites about our key programmes, CEO Blog, HR Newsletter and others), consolidated email information (Daily Dose) and participation in work streams and projects

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 and consumer participation to continually improve and redesign services. Activities to support this include:

- Developing the capacity for change leadership at all levels of the organisation through improvement and leadership development programmes lead by Ko Awatea, such as the current Leadership Academy, aimed at developing emerging leaders, and clinical staff involvement in improvement initiatives such as the beyond

20,000 days campaigns, innovation and improvement intensives, also pipeline initiatives such as the Health Science Academy

- Strategic Programme Management Office to continue to support processes and resources to assist managers and staff to respond to changes across the organisation
- Ko Awatea building organisational resilience and capability to respond proactively to meet changing demands with support from mindfulness, system innovation and improvement, and patient centred care workshops and master classes
- Through Ko Awatea lead Patient and Whaanau Centred Care strategy we are engaging patients and whaanau in specific service feedback and service redesign

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 regulated 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 six workforce objectives which are aligned with both national HWNZ strategies and local DHB activity. These are:

- Enable workforce flexibility and affordability to manage rising demand – we will continue to develop and implement regional strategies to increase the flexibility of the workforce to better utilise our workforce regionally and to manage peaks and troughs in demand
- Build and align the capability of the workforce to deliver new models of care - we need to have a workforce that is prepared and capable of delivering new models of care, particularly to support the focus of integrated care and a greater level of complex care provided in the community
- We will continue to invest in piloting and implementing new models of care delivery utilising advanced practice roles in areas such as Aged Care, Mental Health, Diabetes, Primary and Community Care. To do this we will work in partnership with professional leaders, primary care and unions to progressively extend scope of practice for key roles
- Grow the capacity and capability of our Maaori and Pacific workforce - a regional strategy will be developed to increase the capacity and capability of the Maaori and Pacific workforce. We will promote and support the Nga Manukura o Apoppo Maaori nurse and midwifery workforce development programme and the Leadership Academy, and development programmes for Maaori and Pacific staff. We will continue to implement regional Kia Ora Hauora activity across the region
- Optimise the pipeline and improve the sustainability of priority Workforces – we will identify opportunities to better utilise the non-regulated workforce, and engage with PHOs, NGOs and residential care to participate in training and post-graduate placements. We also need to be at the forefront of evaluating and implementing new roles
- Adopt a regional HR approach to developing an engaged and capable workforce - we will take a regional approach on specific workforce initiatives to strengthen our efficiency and effectiveness. In particular we will review and jointly develop HR policies and procedures/processes across the region, standardise our approach to student clinical placements and contracts- we will continue to invest in building the cultural competency of staff to achieve a workforce that can engage effectively with the community we serve

Safe and competent workforce: the Vulnerable Children's Bill

The Vulnerable Children's Act will see a further strengthening of the CM Health's recruitment process. Currently all Doctors, Registered Nurses, Registered Midwives, Health Care Assistants and Allied Health Staff acting in a role predominantly involving the care and protection of a child, young person or more vulnerable members of society have as a condition of their employment been required to undergo a comprehensive police check.

CM Health's recruitment process currently requires all new staff to undergo police checks and produce appropriate identification (including identification and police checks for overseas sourced employees to maintain its accredited employer status with New Zealand Immigration). Reference checks are comprehensive in nature and will be further revised to include specific questions on working with children and young people where appropriate.

The requirements of the Act will be:

- S38 (3) The chief executive may require any specified organisation to provide details to the chief executive of any safety check done on a named person and the person's work history, including—
- (a) how the person's identity was confirmed; and
- (b) all information provided about the person in the course of the safety check; and
- (c) the risk assessment of the person; and
- (d) the date or dates on which the person has been employed or engaged by the organisation and the nature of the work that he or she is or has been engaged in.

We will be able to currently comply with (a),(b) and (d) for any employee as our recruitment process includes verification of identity using documents such as passport, driver's licence or birth certificate; copies of these, along with the criminal vetting report is kept in the employee's personnel files. The work history is recorded both in hard copy by records of employment contracts offered and in the electronic payroll system. These retention schedules for these files are determined by the Public Records Act requirements. It is not clear yet what the requirements for risk assessment for employees will be as Section 32 of the Act specifies that the requirements for risk assessments will be made by an Order in Council. Once these are clear we will establish a process. We will need to review our processes for volunteers, contractors or similar roles once the final assent version of the legislation is available. CM Health will make appropriate changes to build on existing recruitment processes to date to ensure the organisation meets its obligations under the revised legislation.

Additional actions put in place with regard to child protection policies:

- A compliant Child Protection policy has been created and posted on the DHB's SouthNet website which is accessible to all staff
- The DHB has prepared a policy and drafted appropriate sections in the recruitment policy and currently await details on process specifics through government regulation
- As per section 32 of the Act, a national DHB working group has formed to provide guidelines and we are currently liaising with Staff Service Centre (Payroll) to affect the triennial check in accordance with sections 25 and 27 of the Act
- Currently CM Health is logging information into the Leader HRMIS and payroll system and await guidelines in respect of the requirements of section 26 of the Act to ensure our processes are compliant

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, 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 2015/16 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 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

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 the DHB.

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 and will have HBL integrated into it by the end of June 2015, which will allow 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 Locality Clinical Partnerships

The collaborative agreement between ourselves and our PHO partners that outlines our respective commitments for the establishment of localities has been in place for one year. The District Alliance Agreement contains detail on key integration and performance metrics such as the risk and gain share agreement, the outcomes framework and milestones for the devolution of secondary staff and services to community.

In addition, key roles and responsibilities in terms of the alliance are outlined in the document, as are partnership principles and a commitment to quality and safety through data sharing across practices and PHOs. The Alliance Agreement will be refreshed and updated to reflect Alliance Leadership Team agreed objectives for the 2015/16 year.

6.0 Service Configuration

Service Area	Type of Service Change	Description of Service Change
Rheumatic Fever	Service provision	Ministry of health funding for the rheumatic fever programme will reduce at the end of the 2015 year. CM Health will need to work with providers to develop a sustainable primary and intermediate school based service in line with the change. This will take into consideration the needs of schools in the CM district and alignment with other activities and priorities in the child health area and will be implemented at the beginning of the 2016 school year.
Community Health Service Integration	Change in model of care	The focus of this programme of work is on improving the health and outcomes for the people in our community and determining how we best support them. Rather than episodic care as transfer of care between services, we will see a continuous pathway involving episodes where extended care and support is provided. The key steps are 1. Existing workforce in the community - Continuation of work commenced to refocus district nursing, allied health and NASC teams to work effectively within the locality model. 2. Consider best way to deliver home and community support services - in a way that aligns with the direction of an integrated model. This will include looking at options such as shifting to a restorative model of care and funding arrangements that best meet client needs. 3. Community Central – development of a one point of contact for all that will support triaging, allocation of resources, request for services, capability planning and telehealth, all supporting efficient specialist service interaction.

7.0 Performance Measures

7.1.1 Performance priority dimensions

Performance Measure and Description			2015/16 CM Health Target		2015/16 National Target	Reporting Frequency
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	Maaori	4.45%		-	Six monthly
		Total	3.15%			
	Age 20-64	Maaori	7.75%		-	
		Total	3.15%			
	Age 65+	Total	2.7%		-	
PP7: Improving mental health services using transition (discharge) planning and employment	Long Term Clients		Provide a report as specified			Six monthly
	Child and Youth		95%		95%	
Mental Health Hospital Care Arm PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	3 weeks		80%		80%	Six monthly
	8 weeks		95%		95%	
Addiction (Hospital Care 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	1.08	1.08	Annual
			Year 2	1.03	1.03	
PP11: Children caries free at 5 years of age			Year 1	54%	54%	Annual
			Year 2	55%	55%	
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	90%	90%	Annual
			Year 2	95%	95%	
	Children not examined 0-12 years		Year 1	6%	6%	
			Year 2	5%	5%	
PP20: Improved management for long term conditions (CVD, diabetes and Stroke) Focus area 1: Long term conditions			Report on delivery of the actions and milestones identified in the Annual Plan			Quarterly
Focus area 2: Diabetes Management (Microalbuminuria and on an ACEi or ARB and HbA1c)	Percentage of patients with good or acceptable glycaemic control		Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control			Quarterly
Focus area 3: Acute coronary syndrome services	Percentage of high-risk patients who receive an angiogram within 3 days of admission ('day of admission' being 'Day 0')		70%		70%	Quarterly
	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%	Quarterly

Performance Measure and Description		2015/16 CM Health Target		2015/16 National Target	Reporting Frequency
	Percentage of patients undergoing cardiac surgery at regional cardiac surgery centres	>95%		95%	Quarterly
Focus area 4: 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%	Quarterly
PP21: Immunisation coverage	Percentage of two year olds who are fully immunised	95%		95%	Quarterly
	Percentage of five year olds who are fully immunised	By 2015/16	90%	90%	Quarterly
		By 2016/17	95%	95%	
	Percentage of girls immunised with 3 doses of HPV	65% for dose 3		65% for dose 3	Quarterly
PP22: Improving system integration		Report on deliver of the actions and milestones identified in the Annual Plan			Quarterly
PP23: Improving Wrap Around Services – Health of Older People		Report on deliver of the actions and milestones identified in the Annual Plan			Quarterly
		Percentage of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan			Quarterly
PP24: Improving Waiting Times – Cancer Mulit-disciplinary Meetings		Report on deliver of the actions and milestones identified in the Annual Plan			Quarterly
PP25: Prime Minister's youth mental health project		Provide narrative progress reports against Initiatives 1, 3 & 5			Quarterly
PP26: The Mental Health & Addiction Service Development Plan		Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2015/16 and for any actions which are in progress/ongoing			Quarterly
PP27: Deliver of the children's actions plan		Report on deliver 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 are 55 percent lower than the average over the last 3 years	5.9		5.9	Quarterly
PP29: Improving waiting times for diagnostic services	Elective coronary angiography – percentage of patients who are referred and receive their procedure within 3 months (90 days)	95%		95%	Monthly

Performance Measure and Description		2015/16 CM Health Target	2015/16 National Target	Reporting Frequency
	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 CT 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)	75%	75%	
	b. Diagnostic colonoscopy – percentage of people who are accepted for an diagnostic colonoscopy and receive their procedure within six weeks (42 days)	65%	65%	Monthly
	c. Surveillance colonoscopy - Percentage of people waiting for a surveillance colonoscopy who wait no longer than twelve weeks (84 days) beyond the planned date	65%	65%	
PP30: Faster cancer treatment Part A – 31 day indicator	Percentage of patients wait 31 days or less to receive their first treatment for cancer from date of decision-to-treat	<10% of records submitted by the DHB are declined	<10% of records submitted by the DHB are declined	Quarterly
PP30: Faster cancer treatment Part B – Radiotherapy & chemotherapy	Percentage of patients ready-for-treatment wait 4 weeks or less for radiotherapy or chemotherapy	100%	100%	Monthly

7.1.2 Ownership dimensions

Performance Measure and Description		2014/15 CM Health Target	2015/16 National Target	Reporting Frequency
OS3: Inpatient length of stay (LOS)	Elective LOS (days)	1.59	1.59	Quarterly
	Acute LOS (days)	2.63	2.63	
OS8: Reducing acute readmissions to hospital	Total Population	Commitment to improve on baseline target		-
	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 < or = to 4%	> 2% and < or = to 4%	Quarterly
	Recording of non-specific ethnicity	> 0.5% and < or = to 2%	> 0.5% and < or = to 2%	
	Update of specific ethnicity value in existing NHI record with a non-specific value	> 0.5% and< or = to 2%	> 0.5% and< or = to 2%	
	Invalid NHI data updates causing identity confusion	TBC	TBC	
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 %	
	Standard vs. edited descriptors	≥75% to <90%	≥75% to <90%	
	NNPAC timeliness	≥95% to <98%	≥95% to <98%	
Focus area 3: Improving the quality of the Programme for Integration of Mental Health Data (PRIMHD)	PRIMHD data quality	Routine audits undertaken with appropriate actions where required		

7.1.3 System integration dimensions

Performance Measure and Description		2014/15 CM Health Target	2015/16 National Target	Reporting Frequency
SI1: Ambulatory sensitive (avoidable) hospital admissions[14]	Age 0-4	-	-	Six monthly
	Age 45-64	-	-	
	Age 0-74	-	-	
SI2: Delivery of Regional Service Plans		Provision of a single progress report on behalf of the region agreed by all DHBs within that region (the report includes local DHB actions that support delivery of regional objectives)		
SI3: Ensuring delivery of Service coverage		Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage		
SI4: Elective services standardised intervention rates	Major joint replacement procedures	21 per 10,000	21 per 10,000	Annually
	Cataract Procedures	27 per 10,000	27 per 10,000	Annually

[14] Note: There is currently work underway at the MOH towards developing new measures for ASH, therefore until this is confirmed the MOH do not expect DHBs to put baselines and targets in their Annual Plans.

	Cardiac surgery	6.5 per 10,000	6.5 per 10,000	Quarterly
	Percutaneous revascularisation	12.5 per 10,000	12.5 per 10,000	Quarterly
	Coronary angiography services	34.7 per 10,000	34.7 per 10,000	Quarterly
SI5: Delivery of Whaanau Ora		Provision of a qualitative report identifying progress within the year that shows that the DHB has delivered on its planned Whaanau Ora activity and what the impact of the activity has been		Annually
SI6: IPIF Healthy Adult - Cervical Screening	Percentage of eligible women have received cervical screenings services within the last 3 years	80%	80%	

7.1.4 Output dimensions

Performance Measure and Description		2014/15 CM Health Target	2015/16 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 percent 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%	

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