COUNTIES MANUKAU HEALTH

Annual Plan 2014/15

Incorporating the
Statement of Performance Expectations 2014/15
and **Statement of Intent 2014/15-2017/18**

Counties Manukau District Health Board

Front Cover: Art students from De La Salle College in Mangere present a series of words that symbolise CM Health and Ko Awatea.

Counties Manukau District Health Board Annual Plan 2014/15

Published February 2015

Annual Plan dated this 4th day of February 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

Office of Hon Dr Jonathan Coleman

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

17 FEB 2015

Dr Lee Mathias
Chair
Counties Manukau District Health Board
Private Bag 94052
Manukau City
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Dear Dr Mathias

Counties Manukau District Health Board 2014/15 Annual Plan

This letter is to advise you I have approved and signed Counties Manukau District Health Board's (DHB's) 2014/15 Annual Plan for three years.

I wish to emphasise how important annual plans are for ensuring appropriate accountability arrangements are in place. I appreciate the significant work that goes into preparing your Annual Plan and thank you for your effort.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2014, Vote Health again received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Living Within our Means
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. Improvements through national, regional and sub-regional initiatives should continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning a surplus for 2014/15 and breakeven 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 2014/15.

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.

National Health Targets
Your Annual Plan generally includes a good range of actions that will lead to improved or continued performance against the health targets. As you are aware, there is one new addition to the target set for 2014/15. From quarter two, the 62 day Faster Cancer treatment indicator has become the cancer health target with a target achievement level of 85 percent by July 2016.

Although Counties Manukau DHB is performing well in most health target areas, in the year ahead, I am asking all DHBs to particularly focus on ensuring appropriate actions are implemented to support immunisation service delivery.

Care Closer to Home

I am pleased to see tangible actions in your Annual Plan that demonstrate how you will broaden the scope of diagnostic and treatment services directly accessible to primary care.

It is important that the development of rural service level alliance teams progresses during the year. It is expected that a rural service level alliance team develops and agrees a plan for the distribution of rural funding, in accordance with the PHO Services Agreement Version 2 (July 2014).

Health of Older People

I am pleased to note your commitment to continuing price or volume increases in home and community support services, implementing your fracture liaison service, and using interRAI-based quality indicators.

Regional and National Collaboration

Greater integration between DHBs supports more effective use of clinical, financial and other resources (such as technology). In particular, clinically-led collaboration across DHBs is essential, as sharing of expertise will contribute to the realisation of regional and sub-regional benefits. I expect DHBs to make significant contributions to delivering on regional planning objectives and to priorities specific to their regions that will help lead to financial and clinical sustainability.

DHBs have also committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to factor in benefit impacts for the Finance Procurement Supply Chain Initiative where these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

Budget 2014

I also expect that you will deliver on Budget 2014 initiatives. This includes extending free doctors' visits and prescriptions for children aged under six to all children aged under 13 from July 2015.

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. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework. The National Health Board will contact you where change proposals need further engagement. You are reminded that you need to advise the National Health Board of any proposals that may require Ministerial approval as you review services during the year.

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 2014/15 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

Counties Manukau Health is well into a transformational journey for strategic change that will enable us to continue to achieve the highest quality of health care delivery, every day, for every person coming into contact with our services. An important part of the changes we have already made is to involve family/whaanau, not only in the care and support provided, but also in looking at new ways of working to improve the health of people living in Counties Manukau.

This means that families are considered partners in care and that people are at the centre of our innovations focused on how and where services are provided, closer to where people live and better supported to care for themselves. Modernising our hospital services has been supported by the rebuild of Middlemore Hospital, which is now largely completed. This enables us to best deliver 21st century services through smart design and technologies that is better for patients, allows staff to work more effectively and easier access for families and visitors.

Beyond Middlemore Hospital, the last few years have seen us build the necessary infrastructure and essential relationships with our primary health organisations and other community based primary care partners to meet the health care challenges today and into the future. This has provided a strong foundation for creating new models of care that is already supporting more of our staff to work within our local communities. In 2013/14, we shifted our home health care and district nurse services from Middlemore Hospital into localities and developed an At Risk Individual model of care. This means we can identify those who are at risk of multiple long term health problems earlier and work together with patients and families to improve their health. We now have the relationships and structures in place to roll out this innovative model across the district over the next 2 to 3 years. As a result, we estimate that approximately 30,000 people will be better supported through more integrated and effective services that will reduce the need for hospital services and keep people well.

As ever we are a leading DHB nationally and contribute actively towards national sector improvements and by working together regionally with our partner DHBs. We continue to manage our resources effectively and balance our budget through wise investment in our current service needs, alongside looking ahead to embed changes for the future.

We continue to use information and communication technologies and systems as a key strand of our strategy that will drive better ways of working together and progressing our strategic Triple Aim objectives. By the end of 2015, system change achievements will be visible through benchmarked system level measures that show CM Health as one of the best health care systems in Australasia.

A huge thank you to our local communities, staff and care partners across our health system, from community to hospital providers. We collectively contribute to improving the health and wellbeing of the people living in Counties Manukau and look forward to working together in this coming year.

Dr Lee Mathias
Chair

Geraint A Martin
Chief Executive

Executive Summary

2014/15 represents year three of our four year health system transformation goal to become the best healthcare system in Australasia by 2015. The Triple Aim provides the strategic framework for how we prioritise and organise our actions. That is, balancing the three aims to:

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

Each Triple Aim is broken into six executable strategies that will action projects alongside our operational delivery to collectively make a difference and improvement in the long term health of the people living in the Counties Manukau district.

2014/15 will be year 2 of implementation of the District Alliance Agreement that we signed with our five partner Primary Health Organisations (PHOs) in 2013/14. The District Strategic Alliance Agreement sets out our mutual commitment for ambitious system integration and redesign. This is governed by the Whole of System Strategy Board comprising PHO and CMDHB executive leadership[1].

In 2014/15 we will focus on accelerating the scale and pace of health system integration. Significant change is in progress now with community based service delivery pilots to enhance the approach in general practice care to deliver planned, proactive, patient centred care in a more equitable manner and concurrently redesign the linked hospital care continuums. Our major ICT investment programme, through Project SWIFT implementation, will enable innovative and integrated technology systems and services that will underpin redesign of health services and new models of care, and also support the achievement of the goals of the National Health IT Board.

In the 2014/15 year we will achieve:

- Our National Health Targets, contributions to the Better Public Service targets and government's system integration objectives (refer section 2.0)
- Implementation of programmes and realising the financial benefits from national and regional shared savings programmes (e.g. finance, procurement, supply chain programme)
- Achieving our national, regional and local quality and safety targets and improvements alongside service improvements informed by patient and whaanau experiences
- Implementation of year 1 of the 3-year At Risk Individuals (ARI) programme that replaces the current Chronic Condition Management (CCM) programme. This programme is a way of organising care for patients with long term conditions to support them to self-manage and keep them well and at home[2]. It includes risk stratification to identify patients at risk of unplanned hospital admissions followed by proactive assessment, care planning and coordination of care led by the general practice team and supported by multi-disciplinary team input.
- Realise benefits from expanded hospital capacity with the opening of the Harley Gray Building that includes improved patient flow for our acute services
- An increased number of services included in the District Strategic Alliance Agreement risk and gain share scope to include surgical outpatients
- Expanded range and scope of locality based multidisciplinary teams in localities to include mental health, Kidz First and maternity community teams, which align with general practice clusters and locality health needs
- Implementation of and take up of electronic information systems that aim to streamline primary and secondary communication (e.g. e-referrals, e-discharges, shared care plans)
- Improved and embedded pathways for primary care access to specialist nurse and /or doctor advice for three high demand services – gout, COPD and diabetes
- Expanded primary health care into schools teen parent units and alternative education providers in the district and designated community health service for youth in every locality

[1] The Whole of System Strategy Board meets three times per year and comprises CMDHB Executive Leadership Team and PHO Chairs, Chief Executives and Clinical Directors

[2] Further information can be accessed online from http://www.countiesmanukau.health.nz/AchievingBalance/System-Integration/system-integration-locality-patient-perspective.htm

Our close attention to safe, timely, equitable, effective, efficient, patient and whaanau centred services for patients and whaanau needing hospital services will be significantly enhanced as we open our new Harley Gray building based operating rooms and related acute patient care services. In addition, we have specific initiatives in place to ensure we make best use of available public health resources.

We recognise that successful implementation requires whole of system leadership commitment and support alongside the long term investment CM Health has made in developing Ko Awatea as the enabling quality improvement, system redesign, knowledge management and programme support to sustainable system changes and building capability across the organisation.

System integration remains a key focus for us in 2014/15 and clinical leaders supported even more ambitious system redesign through our whole of system programmes that span community to hospital services. While we look to major changes in the way we work, we are sustaining our achievements in the government's health targets and priority areas. Section 2.0 of this plan outlines our planned actions with a focus on action to achieve real benefits and continuous quality improvement. Section 4.2 describes how we expect to achieve a $3.0m surplus financial result, made possible by a one-off non-operational gain.

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.

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 of whom are elected by the community, and four, including the Chair, whom are appointed by the Minister of Health. The role of the Board is to provide governance and to ensure that CMDHB fulfils is statutory functions in the use of public resources. The current Board governance structure includes three statutory committees and five non-statutory committees (including Advisory Groups) which assist the Board to meet its responsibilities. The committees include a mix of Board members, clinicians and community representatives.

Whilst the Board maintains overall responsibility for the DHB's performance, operational and management matters are assigned to the Chief Executive.

In recognition of the strategic requirement for shared system wide accountability and integration across community and hospital care providers, CMDHB has an established district alliance and related District Strategic Alliance Agreement with the five PHO partners operating within the Counties Manukau district. 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

CM Health provides health and disability services to an estimated 521,000 people in 2014 who reside in the local authorities of Auckland, Waikato District and Hauraki District. Our population is growing at a rate of approximately 1.5 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 8,300 residents each year for the next 11 years. From 2014 to 2025 the number of new residents in Counties Manukau is projected to be 91,600.

The net impact is demand on health services above demographic growth and has significant system capacity implications. 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 have been defined covering Counties Manukau district: Mangere/Otara, Eastern, Manukau and Franklin. Each locality is diverse in terms of its population demographics and health needs.

- The Counties Manukau district has a diverse population: 38 percent Pakeha and Other, 23 percent Pacific, 16 percent Maaori, 23 percent Asian. 12 percent of all New Zealand's Maaori, 40 percent of New Zealand's Pacific people and 22 percent of New Zealand's Asian population live in Counties Manukau.
- Compared with other DHBs, Counties Manukau has the highest number of Maaori, 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 (not yet informed by Census 2013 that is unavailable at the time of this plan), the Asian population of CM Health will continue to increase the fastest of our ethnic groups, followed by Pacific, then Maaori, while our Pakeha population will reduce in absolute numbers.
- We are a relatively young population with 24 percent of our population aged 14 years and younger. 14 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. This is particularly so for the Mangere/Otara and Manukau localities.
- The population aged 65 and over in Counties Manukau is projected to increase by an average of 4.1 percent each year from 55,860 in 2014 to 90,750 by 2026, the fastest growth 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 (2010-2012 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 the same absolute rate compared with non-Maaori/non-Pacific population, the life expectancy gap between Maaori and non-Maaori/non-Pacific remains in excess of 10 years while the gap between Pacific and non-Maaori/non-Pacific is 6 to 8 years.
- At the time of the 2006 Census (2013 results awaited) 34 percent of the Counties Manukau population lived in areas classified as being the most socio-economically deprived in New Zealand. If the 2006 situation persists, 57 percent of Maaori, 79 percent of Pacific and 43 percent of 0-14 year olds in Counties Manukau live in areas with a deprivation index of 9 or 10.
- Otara, Mangere and Manurewa are the most socio-economically deprived areas in the Counties Manukau district.
- At the time of the 2006 Census, 7 percent of the CM Health population were classified as living in rural[3] areas; this was half the national average of 14 percent but more than our neighbouring DHBs (6 percent for Waitemata DHB and 0.3 percent for Auckland DHB). 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 2013/14 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 2014/15 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 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:

[3] There is no internationally recognised definition of a 'rural' area; rural areas have traditionally been residual areas not included in the urban definition

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

The most critical strategic risks and management strategies CM Health faces in 2014/15 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 2014/15 in addition to Whole of System (WoS) Programmes to look deeper at opportunities to identify and prioritise system redesign initiatives ▪ Prioritised investment in shared information systems and related infrastructure across the whole system that support health service delivery and decision making in the most effective care setting ▪ Whaanau Ora promises to bring a greater focus on addressing the issues of employment, housing and educational achievement, as well as working with vulnerable whaanau. This is consistent with a strengthened population health approach
Corporate	**Revenue** The forecast revenue increase of 2.8 percent is just over 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 ▪ System wide value for money review which is looking systematically at our costs, how we are working, how we are spending across the whole of system and revenue-generating opportunities
Corporate	**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 ▪ Development of a strong ICT platform and technical capability (known as 'Project SWIFT') 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 ▪ Whole of system strategy priorities to align facilities investment planning that continues to align with clinical leadership prioritisation of 2013/14 ▪ 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 (DHBs and Health Benefits Limited) 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 short to long term 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. To reflect a system approach to health service planning, the collective health resources and associated infrastructure to deliver services for our resident population is referred to as Counties Manukau Health (CM Health). 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 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 determining CM Health's strategic direction, priorities and performance monitoring at a district health system level. Aligned with the strategic priorities setting are the asset and infrastructure planning functions that are managed by the Business and Corporate Services Directorate, and are reviewed and aligned each year as part of the strategic planning process.

Whole of system programme groups established in early 2014 have begun to shape their areas of focus, with further details to be provided in progressive iterations of the Annual Plan. Current strategic directions for each programme are broadly reflected in Section 1.3.6; with a focus on major service groups and subgroups of our population with target conditions where a whole of system approach will add value.

1.2.2 Looking deeper at system redesign innovations across the system

The 2014/15 whole of system (WoS) priority areas identified by clinical leaders aim to increase the scale and pace of system integration. This will be achieved through active engagement and commitment across community and hospital providers to jointly challenge and redesign services to achieve the best possible system performance outcomes within available resources. Action plans will build on the gains completed to date in relation to establishment of all four Locality Clinical Partnerships, At Risk Individuals (ARI), system redesign and quality improvement activities and 20,000 Days service development and integration pilots. These plans are being developed and implemented in stages in 2014 and will be overseen by the Whole of System Strategy Board to enable sustained executive commitment to approved initiatives.

Clinical leaders will be 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 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; strategic to operational levels.

1.2.4 Provider

CM Health is a major provider of both community based and secondary health services to the estimated 521,000 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 and numerous leased or owned outpatient and community health facilities across the district – the Manukau Health Park and Middlemore Hospital sites contain the largest elective, ambulatory and inpatient facilities.

1.2.5 Funder

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 2014/15 year, CMDHB will receive $1.5 billion in funding, of this:

- $726.0m is for the provision of services delivered through the DHB's Provider Arm
- $480.0m is for the provision of services delivered through contracts with NGOs
- $279.0m is for the provision of services delivered by providers or contracts that sit outside of the Counties Manukau district
- $15.0m is to cover governance and funding related capability and administration

1.2.6 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 vision is 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.

We will do this by:

- Leading the development of an improved system of healthcare that is more accessible and better integrated
- Dedicating ourselves to serving our patients and communities by ensuring the delivery of both quality focussed and cost effective healthcare, at the right place, right time and right setting
- Being a leader in the delivery of successful secondary and tertiary healthcare, and supporting primary and community care

Integrated into our planning and related action plans are the following organisation values:

- Care and Respect - by treating people well, with respect and dignity that embraces individual and cultural diversity
- Teamwork - achieving success by working together with patients, whaanau and health service providers
- Professionalism - acting with integrity and embracing the highest ethical standards
- Innovation - constantly seeking and striving for new ideas and solutions
- Responsibility - using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions
- Partnership - working alongside and encouraging others in health and related sectors to ensure a common focus on, and strategies for achieving health gain and independence for our population

1.3.2 National health sector priorities

The 2014/15 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 Benefits Limited, 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 2014/15, 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. Particular emphasis in 2014/15 will be placed upon accelerating gains with regard to:

- Child Health
- Inequalities amongst Maaori, Pacific, and other groups
- Health of Older People

The Northern Region DHBs, assisted by the Northern Regional Alliance and regional shared services organisation healthAlliance have agreed the following priority goals as part of the Northern Region:

- First, Do No Harm - reducing harm and improving patient safety
- Life and Years - reducing disparities and achieving longer, healthier and more productive lives
- The Informed Patient - ensuring patients and their whaanau get care, information and support appropriate to their context including supporting our population to have greater involvement in their care

CM Health's Annual Plan priorities align to the Northern Region goals as shown in the high level Intervention Logic outlined in Figure 3, section 1.3.5.

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 Northern Regional Alliance (NRA) and the Northern Region Health Plan, Chair of the Regional Radiology Network and others.

The Northern Regional Alliance Limited (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.

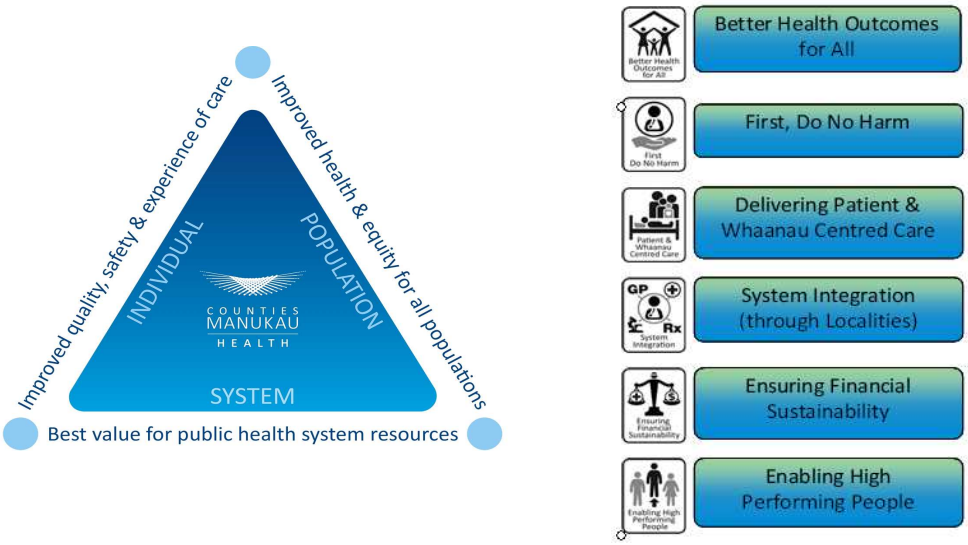
The NRA will produce a business plan, including budgets and key outputs for 2014/15, and will report both internally and to shareholding DHBs against the business plan commencing with a report in October 2014 for the first quarter of 2014/15. The NRA Annual Report for 2014/15 will report actual results against the business plan in a similar manner to that which the two amalgamated companies previously reported against their annual Statement of Intent. The shareholding DHBs will monitor NRA performance against its business plan on a quarterly basis throughout 2014/15.

1.3.4 What we are trying to achieve

In realising our vision, our strategic goal is to be the best health care system in Australasia by 2015 – delivering excellent healthcare services to our communities in a manner that is sustainable and provides best value for public resources.

We will achieve our goal through implementation of our Triple Aim strategic objectives as outlined in Figure 2 below.

Figure 2: Triple Aim and executable strategies



- *Improved health and equity for all populations* - This Triple Aim is actioned through the 'Better Health Outcomes for All' suite of projects. These aim 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* - This Triple Aim is actioned through two programmes. 'First Do No Harm' 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.
- *Best value for public health system resources* - This Triple Aim is the most complex and is implemented through the 3 executable strategies:
  - *'System Integration'* (including localities). This programme is the engine room for where system redesign and change is to be actioned. This programme has established system redesign projects and will be implementing At Risk Individuals and the quality and safety programme for primary care. This programme will also oversee the shifting and integration of primary and secondary 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. This programme ensures that we are matching our service and healthcare needs with a workforce that is fit for purpose. This includes increasing the recruitment and retention of Maaori and Pacific people into healthcare roles.

1.3.5 Our performance story

CM Health has to ensure that strategic planning translates into healthcare delivery that will make a difference to the lives of people in contact with our health system. For us, being the best healthcare system in Australasia will only be truly meaningful if it brings about a change in the health outcomes for the people of Counties Manukau. CM Health is committed to ensuring that we are able to measure and publicly report on how the multiple initiatives and strategies make an impact on health improvement in our district.

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. For example, smoking is one of the largest contributors to the five main causes of death that contribute to inequity in life expectancy between Maaori and Pacific and non-Maaori and non-Pacific. In response to this particular challenge, we continue to progress a number of actions from community through to hospital settings to increase access to advice and help to quit smoking.

We understand that greater gains in the improvement of health outcomes can be achieved by becoming more patient and whaanau centred through:

- Continued efforts in making our health system and services safer and of better quality, i.e., care is safe, timely, efficient, effective, equitable and patient centred
- A cultural shift to involve our patient and families in the management of their own care and care planning, and greater engagement in the redesign of services; and
- Improved integration of services across the health system to deliver more accessible services and continuity of care

To enable us to articulate more clearly the linkages between the performance of our healthcare system to the impacts above, we have spent the last year working on the development 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.

To deliver on planned improvements, we continue to build capability by collaborating with our locality alliances to deliver frontline improvements such as 20,000 Days, improved quality and patient safety in primary care and others. We will continue to utilise knowledge, leadership and learning opportunities to grow and nurture our improvement and innovation capability to increase the scale and pace of change.

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 Provider 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 urgently with high suspicion of cancer 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 advanced care planning discussions		

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

Our Performance Measurement Framework (refer Figure 4) sets out how we will measure the effectiveness of our healthcare system through our System Level Measures. The framework also sets out a cross section of key contributory measures which span the spectrum of our services and which collectively tell us if we are on track to meet our strategic goals and the organisational Triple Aim.

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. These measures are proxy measures which best reflect the health priorities and challenges faced by our population and are amenable to being tracked overtime to provide a good indication of whether our communities are indeed living longer, healthier and more independent lives.

We will know we are succeeding when there is:

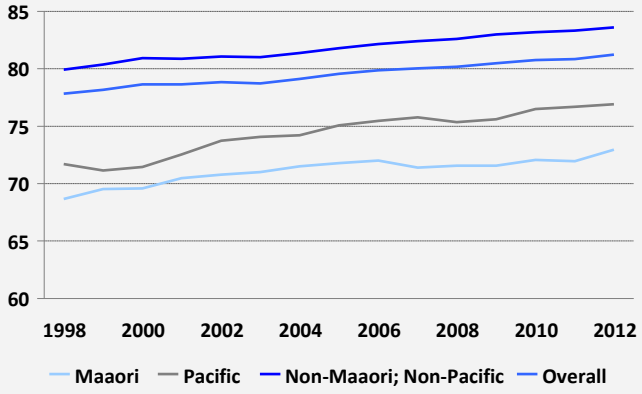
Continued improvement in overall life expectancy and narrowing of ethnic disparity

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

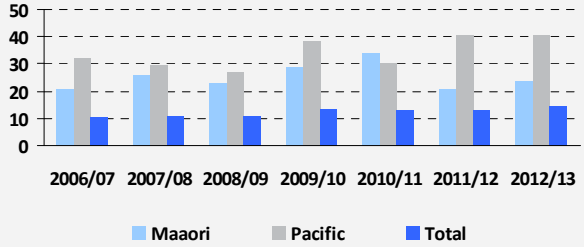
Data sourced from Mortality Collection, Ministry of Health; Estimated populations by DHB, Statistics New Zealand

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.

Acute rheumatic fever first hospitalisations rates 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.

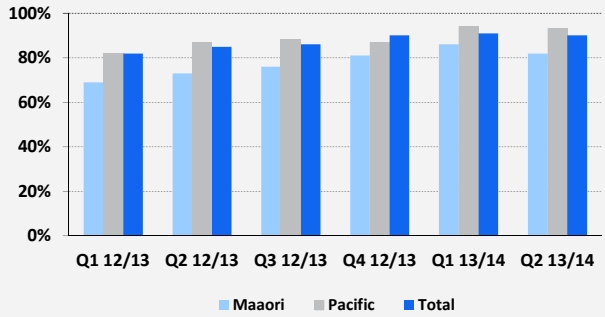
We are committed to reducing the burden of Rheumatic Fever in our communities and acknowledge the complexity of preventing this disease as well as the wide range of activities and investment needed if a significant reduction in cases is to be achieved. A range of initiatives are being implemented targeting those most at risk, in line with national strategies.

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

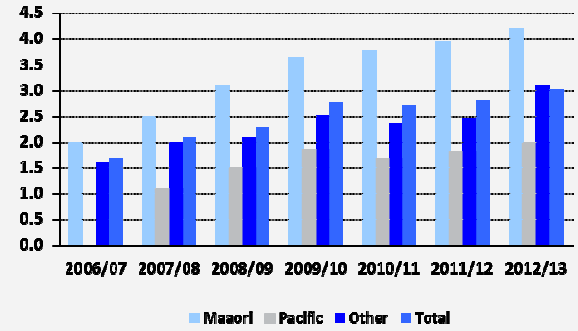
Mental health disorders are common in New Zealand and worldwide. 47 percent of New Zealanders will experience a mental illness and/or an addiction at some time in their lives, with one in five people affected within one year. It is estimated that at any one time approximately 3 percent of the population 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.

This has major implications for not only the person affected, but for the wellbeing of whaanau and families, friends and the wider community. Accessible and responsive mental health and addiction services are a key factor in supporting people who experience mental illness to have an improved quality of life and fewer acute mental health episodes.

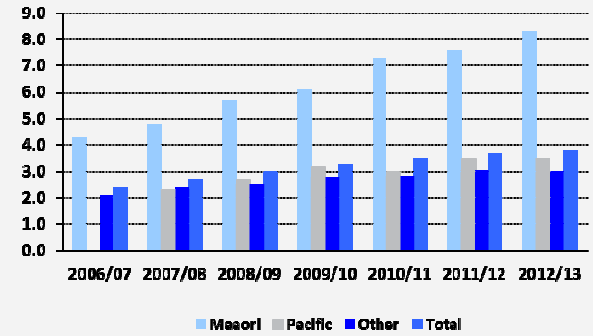
A reduction in acute mental health episodes is an indication of people having access to appropriate support and thus receiving the right care at the right time. Mental health service access rates are a proxy measure for determining the impact of CM Health mental health services delivery on improving the quality of life for members of our population who are suffering from mental illness or issues with alcohol or drug addiction.

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

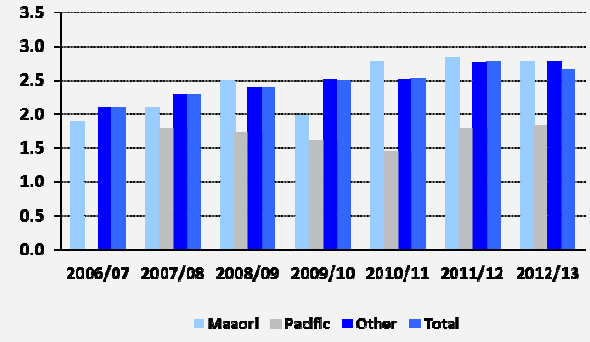
The mental health access rates for 0-19 year olds in Counties Manukau



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



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



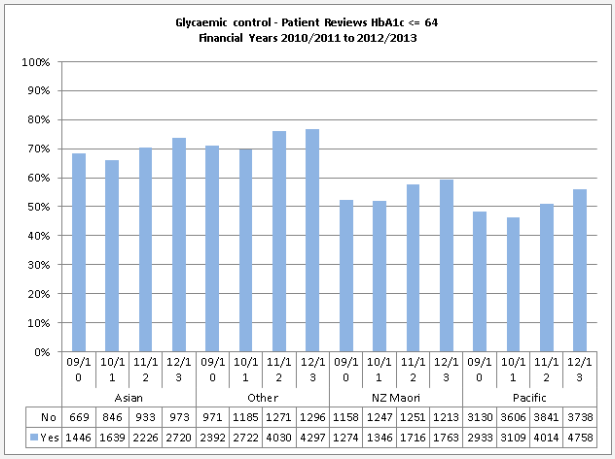
Improved control of common conditions

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 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 number of practice-enrolled people with good control of type 2 diabetes (Hb1Ac <= 64mmol/mol) [4]



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 [5].

12 mths ended 31-Dec-2013	Maaori	Pacific	Asian	Indian	Other
Proportion on Triple Therapy	55.6%	59.1%	59.0%	66.1%	59.0%

[4] 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.

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

2.0 Delivering on Priorities and Targets

This section describes the actions Counties Manukau Health (CM Health) will undertake to implement the government's priorities as expressed in the Minister's Letter of Expectations and related guidance. 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	Shorter Waits for Cancer Treatment / Faster 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	Children's Action Plan
2.2.4	Whaanau Ora
2.3	**System Integration**
2.3.1	Primary Care
2.3.2	Diabetes and Long Term Conditions
2.3.3	Stroke
2.3.4	Cardiac Services
2.3.5	Diagnostic Waiting Times
2.3.6	Maternal and Child Health
2.3.7	Mental Health Service Development Plan
2.3.8	Health of Older People
2.4	**National Entity Priorities**
2.5	**Improving Quality**
0	**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

The 'Shorter Stays in the Emergency Departments' Health target requires 95 percent of patients presenting to the Emergency Departments (EDs) to be admitted, discharged or transferred within 6 hours of presentation. Shorter stays in EDs can improve both patient experience and clinical outcomes. Long waits in emergency departments are inconvenient, often uncomfortable for patients and are linked to overcrowding, poorer clinical outcomes and reduced privacy and dignity.

This target was introduced in New Zealand in 2009; it was considered that a high level measure was required to influence change and that an ED length of stay measure best reflected the performance of the entire acute care system both in and beyond ED.

ED mandatory Quality Framework

It is accepted that the ED health target on its own is not a guarantee of quality. In particular, whilst length of stay is important, the patients experience outcomes might still be poor despite a short length of stay. Consequently a suite of measures are being developed that are more meaningful to patients. In 2010 it was agreed with the MOH that the shorter stays target would be supported by a suite of measures more directly associated with good patient care. This framework is currently under development and listed below is a summary of the proposed mandatory measures.

Actions

- CM Health is committed to the development of a quality framework for ED and will work to complete the mandatory indicators. Once finalised and agreed nationally CM Health will commit to the framework
- Local acute chest pain pathway development has been completed. An accelerated low risk pathway is now moving into the trial phase with data to be collected through ANZACS-Q1
- Diagnostic/analysis work to identify the main factors impacting on ED length of stay including:
  - Waiting time from triage to time seen by a decision making clinician
  - Unplanned representation rates within 48 hours of ED attendance
  - Mortality and morbidity review sessions
  - Sentinel events review process
  - Complaint review and response process
  - Staff experience evaluations
  - Patient experience evaluations
  - Proportion left before seeing doctor or other decision making clinician
  - Mortality rates for specific conditions benchmarked against expected rates (STEMI and # NOF)
  - Time to thrombolysis (or PCI) for appropriate STEMI/ACS
  - Time to adequate analgesia
  - Time to antibiotics in sepsis
  - Procedural and other clinical audits
  - Documentation and communication audits

Measures

- 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department within six hours
- Data collection of chest pain pathway via ANZACS-Q1 targeted to commence May 2014

Proposed measures

- 80 percent TC2 patients to be seen within 10 minutes
- 75 percent TC3 patients to be seen within 30 minutes
- <1 percent and LOS of patients in corridors
- <4 percent patients re-attending within 48 hours
- Length of stay for patients in corridors <10 minutes
- Monthly mortality and morbidity meetings
- 80 percent of complaints responded to within 30 days
- Annual staff survey
- Annual patient experience survey
- Self discharge rate <5 percent
- Short stay admission rate <15 percent
- 80 percent patients requiring PCI have a door to needle time of < 90 minutes
- 80 percent patients analgesia within 30 minutes of arrival
- 80 percent septic patients to have antibiotics within an hour of arrival

2.1.2 Improved access to elective surgery

The Improved Access to Elective surgery target requires CM Health to contribute to the national goal to increase the volume of elective surgery by at least 4000 discharges this year. Elective surgery is an important part of our healthcare system. It is important that patients who need surgery are able to access this in a timely way so that disruption to a patient's life is minimised. Meeting our elective surgery targets requires that we continue to improve how patients flow through our services from First Specialist Assessments (FSA), access to diagnostics, certainty of treatment through to discharge and, where required, follow up. CM Health will commit to seeing and treating patients in the most clinically appropriate timeframe that will involve using recognised prioritisation tools, and being 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 progress to reduce wait times for assessment and elective surgery to meet the government's target of no one waiting more than 4 months from December 2014.

Linkages

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

Actions

- Utilise Elective Initiative funding targeted to increase and improve equity of access
- Improve patient flow management to achieve further 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 CapPLAN)
- Benchmark CM Health's performance against national performance
- Participate in a lead role in the national Orthopaedic Enhanced Recovery After Surgery Collaborative
- Participate in Elective Services Productivity and Workforce Programme (ESPWP) programme – Delivery Redesign Elective Services (DRES) programme at CM Health
- Deliver the Primary Secondary interface project
- Redesign three General Surgery clinical pathways and redesign two Plastic Surgery clinical pathways
- Participate in the Urology Services regional review
- DHB sector support for Enhanced Recovery After Surgery (ERAS) initiatives implementation and potential model expansion to other surgical specialties
- Participate in activity relating to development and implementation of the National Patient Flow system, including amending data submission for FSA referrals as required

Measures

- Elective Surgical Discharge rate is at least 308 per 10000 population by June 2015
- S14 Major Joint discharge SIR is at least 21 per 10000 population by June 2015
- S14 Cataract discharge SIR is at least 27 per 10000 population by June 2015
- S14 Cardiac Surgery discharge SIR is at least 6.5 per 10000 population (this target meets current demand) by June 2015
- Elective Services Patient Flow Indicator expectations are met
- ESPI 2 patients for First Specialist Assessment: Zero patients waiting 150 days + and from January 2015 zero waiting 120 days+
- ESPI 5 patients with commitment to treatment: Zero patients waiting 150 days + and from January 2015 zero waiting 120 days+
- Number of Non-Contact First Specialist Assessments undertaken by June 2015
- Ambulatory Care Did Not Attend rate (DNA) at Manukau SuperClinic by June 2015
- Improved FSA to follow-up ratio by June 2015
- Elective Theatre Utilisation > 85 percent by June 2015
- Elective Inpatient Length of Stay Ownership Dimension (OS3) performance - 3.3 days
- Improved primary and secondary service collaboration in ORL and Orthopaedics measured by:
  - Number and percentage of patients on new referral pathway by June 2015
  - Patient satisfaction number and (percentage) by June 2015
  - Patient satisfaction on new pathway number and (percentage) by June 2015
  - Primary Care Satisfaction under new pathway by June 2015
  - Proportion of referrals from primary care which is not accepted and returned for lack of sufficient information to permit effective triage by June 2015

	▪ Review of Urology Service provision completed June 2015 ▪ National and locally based presentations undertaken involving staff from non CM Health DHBs ▪ Patient level data for referrals for FSA are reporting into new collection

Regional Priorities
▪ Contribute to the planned national 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
▪ Participate in a lead role in the national Orthopaedic Enhanced Recovery After Surgery Collaborative
▪ Redesign three General Surgery clinical pathways and redesign two Plastic Surgery clinical pathways
▪ Participate in the Urology Services regional review
	▪ Delivery against agreed volume schedule, including a minimum of 16,200 elective surgical discharges in 2014/15 towards the Electives Health Target by June 2015
	▪ New ERAS pathways developed prior to 30 November 2015
	▪ ERAS initiatives in Orthopaedics
	▪ Clinical pathway redesigns completed June 2015
	  ▪ PR bleeding
	  ▪ Varicose vein
	  ▪ Bariatric
	  ▪ Breast Reconstruction
	  ▪ Hand Carpal Tunnel Syndrome
	▪ Review of Urology Service provision completed June 2015

2.1.3 Faster tests and cancer treatment

The shorter waits for cancer treatment target requires that all patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy treatment. Faster tests and cancer treatment provides measures of system performance to ensure the time from referral to treatment start is optimised at 62 days or less.

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.

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. Chemotherapy for haematology is provided largely by CMDHB. CM Health clinicians from several disciplines participate or lead the development of national and regional cancer pathways.

Linkages

National Cancer Network; Northern Regional Cancer Governance Board; Regional Oncology Operations Group

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 into the DHB through treatment to follow-up / palliative care by:
▪ Developing improved faster cancer treatment reporting reliable data to inform service improvements
▪ Developing systems to make the faster cancer treatment
	▪ 100 percent of patients receive care within four weeks for:
	  ▪ Radiation therapy
	  ▪ Chemotherapy
	▪ 62 day faster tests and cancer treatment target: 85 percent of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management)
	▪ 31 day faster cancer treatment indicator: <10% of the records submitted by the DHB are declined
	▪ 100 percent of patients ready-for-treatment wait 4 weeks or less for radiotherapy or chemotherapy

data collection systems /processes part of business as usual

- Undertaking a review of three tumour standards (different tumour types to the review undertaken in 2013/14)
- Supporting cancer nurse coordinators

Improve waiting times and quality of endoscopy and colonoscopy services by:

- Implementing the Endoscopy Quality Improvement (EQI) programme
- Identifying and implementing improvements to colonoscopy services

Regional Priorities

- Improving the functionality and coverage of Multidisciplinary Meetings (MDMs) across the region by implementing the regionally agreed MDM priorities
- Utilising faster cancer treatment data through monthly reports to services to identify and improve patient flow and timely assessment and treatment
- Implementation of National Tumour Standards through defined regional and local pathways, including Cancer MDMs
- No overall resource impact anticipated

- 90 percent of referral details provided are "known"
- 95 percent of records outside the indicator timeframes have delay codes
- Cross check procedure established between DHBs
- At least 20 percent of records provided for the quarter are indicator 3 only
- 10 percent of patients presented at MDM from 2013/14 levels
- Diagnostic colonoscopy: 75 percent people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days); and 60 percent of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days)
- Surveillance/follow-up colonoscopy: 60 percent of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date
- Progress against specific agreed actions to support the regional objectives is demonstrated
- Improvement in coverage and functionality of MDMs as reported against the policy priority (PP24) improving waiting times – cancer multidisciplinary meetings is demonstrated
- 30 percent of tumour streams have a defined regional/local pathway in place

2.1.4 Increased immunisation

This target requires that 95 percent of all eight month olds will have their primary course of immunisation at 6 weeks, 3 months and 5 months on time by December 2014.

Immunisation is still 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. 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

Linking with Primary Care Initiatives; CM Health executable strategy for Better Health Outcomes for All, First 2000 Days Programme; CM Health Immunisation Strategy; Northern Region Health Plan – Child Health Implementation Plan; CM Health Maaori Health Plan

Actions

- CM Health representation and attendance at immunisation forums
- Regional planning with stakeholders and Auckland Regional Public Health Service (ARPHS) in response to planning for pandemic events
- DHB immunisation working group will meet monthly. This group includes PHO nurse leaders, Well Child Providers, Nurse Leader Immunisation, Nurse Leader Maaori Health and Pacific Health, and representation from Maternity Services. This group reports to the DHB Strategic Forum
- Continue working with maternity and primary care partners to monitor the newborn enrolment rates
- Establish a process to capture declined newborn

Measures

- 95 percent of eight months olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time by December 2014)
- 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)
- 85 percent of 6 week immunisations are completed (measured through the completed events report at 8 weeks)
- Coverage rates for Maaori equal to non-Maaori
- Improved handover processes from General Practitioners (GPs), Lead Maternity Carer (LMC) and

enrolments to ensure the 90 percent target is met

- Monitor and evaluate immunisation coverage at DHB, PHO and practice level, manage identified service delivery gaps
- Formally monitor and evaluate immunisation coverage via DHB National Health Target Working Group
- Continue to deliver targeted immunisation strategies that achieve 95 percent of Maaori and Pacific children aged 8 months old will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time by December 2014
- Implement standardised PHO reporting system across DHBs will be evident by 30 June 2014 with monthly evaluation of datamart reports at PHO and practice level
- Immunisation Nurse Leader will select 10 practices with lowest coverage rates and will meet individually with each practise to improve performance measured by the datamart report in the following month
- Immunisation status of all children presenting to Kidz First services will be maintained with opportunistic immunisations being provided
- Actively promote 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 to assist with promotional activities as well as tracking families not currently engaged with health services and timely referrals to outreach immunisation providers

Well Child/Tamariki Ora (WCTO) providers designed and written up by Quarter 2

- Public Sector Targets are reported on and reviewed
- Declined newborn enrolment process implemented by Quarter 2
- CM Health participates in immunisation week activities
- Immunisation education and event calendar available Quarter 1
- Monthly datamart report evaluation at DHB, PHO and Practice level

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 patients who smoke and are seen by health practitioners in primary care are offered brief advice and support to quit smoking. Within this target, an additional target will be implemented that focuses on a specialised group – 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer (LMC) are offered advice and support to quit.

At the 2013 Census, 15.9 percent of Counties Manukau residents were reported as currently smoking. This is a substantial decrease from the 2006 prevalence of 22.1 percent. Smoking prevalence amongst Maaori has decreased from 46.8 percent in 2006 to 36 percent in 2013, and Pacific from 30.3 percent to 23.2 percent. Whilst smoking prevalence has decreased, there still remains a significant equity gap, with Maaori prevalence in particular still more than double that of the overall Counties Manukau prevalence. Maaori and Pacific will continue to be prioritised across all Smokefree activities.

Smoking increases risk of respiratory and lung related disease, lung cancers and other long term conditions such as heart disease and poor oral health. These conditions contribute to the life expectancy difference between Maaori and Pacific and non-Maaori/Pacific people in Counties Manukau.

This year, CM Health will continue its commitment towards becoming a Smokefree district by 2025. Our continued emphasis is on increasing support for smokers to quit by increasing capacity for cessation services. Smokefree continues to be one of three population health priorities for CM Health. This will be the second year of a 5-year project aimed at reducing adult smoking prevalence to 12 percent as an intermediate goal towards less than 5 percent by 2025. The two key work streams are support to quit, and protection of children and youth and other vulnerable groups. CM Health also identifies this as a priority for within our Maaori Health Plan.

Our whole of system approach is shaped by the CM Health 2025 Smokefree initiatives and 3 health targets outlined above. In addition to the actions below, we will explore and review the effectiveness of our combined Smokefree contracts and other resources across community and hospital settings to ensure our interventions are as effective as they can be.

Linkages

CM Health Maaori Health Plan

Actions	Measures
Secondary Services	
▪ Continue to support hospital management and clinicians to champion Smokefree health target activity and inpatient initiatives ▪ Deliver ongoing training and continue to provide support for hospital educators to ensure all staff are trained in Smokefree ABCs ▪ Review and implement system and process improvements to streamline intervention delivery and documentation ▪ Provide regular reporting and feedback on health target performance to ensure corrective action is taken where necessary ▪ Across all tobacco health target activity, continue to ensure that Maaori in particular, and Pacific form a high proportion of those referred for on-going Smokefree support	▪ 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 ▪ Results reporting and target updates provided quarterly to Hospital Management Team Forum ▪ Smokefree service to deliver best practice and refresher training sessions for all secondary staff at minimum each quarter ▪ Determine feasibility of implementing a streamlined electronic recording system for smokefree brief intervention activity by 31 December 2014 ▪ Based on feasibility assessment, commence implementation of above system by 30 June 2015. ▪ Results reporting and target updates provided quarterly to Hospital Management Forum ▪ Maintain or exceed current referral rates for ongoing support that are for Maaori, and Pacific (baseline: Maaori (45 percent of referrals), Pacific (24 percent of referrals)) ▪ Referrals feedback is provided to all secondary care services each quarter
Primary Services	
▪ Promote the e-Module training around Smoking Cessation ▪ Ensure that patient dashboards and prompts are used when patients attend practice visits ▪ Develop reporting and clinical audit tools that report real time, and customised reports to help practices track progress against MOH targets will be utilised ▪ Provide weekly graphs showing performance against the target to all practices ▪ Provide regular staff visits to practices to discuss progress to date and share best practices from other practices ▪ Identify practice champions for smoking cessation who will provide ongoing coaching and support ▪ Ensure sufficient resource is available to make it possible to ring patients who have been identified and offering referrals to Quitline and other appropriate cessation providers ▪ Employ a GP clinical champion to support both primary care and CM Health with clinical advice and guidance	▪ 90 percent of patients who smoke and are seen by a health practitioner in primary care will be offered brief advice and support to quit smoking ▪ Patient dashboards available for use in the majority of practices by Quarter 1 ▪ Practice champions in place by Quarter 1 ▪ GP clinical champion will be in place by Quarter 1
Maternity Services	
▪ Work with LMCs and within maternity services to enable clinicians to support pregnant women who smoke to quit ▪ Establish a working group to ensure implementation of the maternity smoking health target ▪ Roll out of pregnancy pilot to one additional locality	▪ 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit by 30 June 2015 ▪ Working group formed by 1 August 2014 to support and train LMCs and to support the implementation of the maternity smoke free targets ▪ Pregnancy pilot rolled out in one additional locality

Smokefree Counties Manukau

- Implement the CM Health Smokefree 2025 plan (2013-18) which outlines the actions that will be taken to contribute to achieving a Smokefree district (defined as 5 percent prevalence or less across all groups) by 2025
- Ensure Maaori in particular, and Pacific, are prioritised in all Smokefree planning and implementation of initiatives. Actions include:
  - Planning and delivery of specialist cessation service including mental health, postnatal and inpatients
  - Further develop the district-wide triage and referrals management function, with increased reach in primary care and maternity services
  - Fund and improve reach, volumes and performance of community-based cessation services which prioritise Maaori and Pacific populations
  - Continue to deliver the Pathway to 2025 Innovation projects, and identify opportunities for roll out of the pregnancy incentives pilot

- By 2025, less than 5 percent of the DHB's population will be a current smoker. Intermediate target of 12 percent prevalence by 2018 (and 18 percent for Maaori which is a halving of the current 2012 rate)
- District-wide triage and referrals management role is increased to 1FTE by July 2014
- Planning for community-based cessation service provision model is completed by December 2014
- Implementation commences as of January 2015
- Year 2 of Quit Bus project implemented
- Year 2 of intersectoral project implemented

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 5 years. Key factors to ensure success with this target are leadership by a cardiovascular champion, quality improvement and ease of patient access to risk assessment. CM Health has the largest number of patients who are eligible for risk assessment and the largest number of eligible Pacific peoples.

Whole of system programme directions for people with cardiovascular disease (CVD) focus on enhanced integration and performance of delivery and communication systems and services. The following high level directions are in the development phase, with further work in progress to identify specific action plans:

- Enhance health system delivery through a focus on CVD prevention management, quality improvement and a whaanau focus
- Improve communication between hospital and community health providers through targeted technology enablers to increase information sharing and enhanced ease of best practice advice and patient information access

Linkages

CM Health Maaori Health Plan; Northern Region Health Plan

Actions

- Work with primary care to support the development of PHO specific quality improvement plans which will outline how they will deliver and maintain the heath target
- Meet regularly (at least quarterly) with PHO partners to develop solutions to barriers encountered and share success strategies
- Encourage the use of Healthcare Assistants to free up nurse time for CVD risk assessment and management
- Nurses at Middlemore Hospital will continue to undertake CVD risk assessments. Patients who are high risk will be referred back to primary care after brief intervention, such as lifestyle advice
- Work in partnership with CM Health clinical staff to develop and deliver targeted education programmes to GPs and practice nurses
- Ensure practices receiving VLCA funding and increased nurse graduates are utilising the resources to increase screening and management of their population
- Employ a clinical champion who will support both primary care and CM Health with clinical advice and

Measures

- 90 per cent of the eligible adult population will have had their CVD risk assessed in the last 5 years
- CM Health will reach the health target of 90 per cent in Quarter 1 and maintain this result for the following 3 quarters
- Quality improvement plans developed by Quarter 2 that focus on maintaining the 90 percent target
- Targeted education programmes developed by Quarter 2
- Clinical champion in position by Quarter 1
- VCLA practices will see improved screening rates and management of risk factors by Quarter 2
- Design of work based screening programme in development phase by Quarter 3

guidance

- Explore opportunities with PHO partners to develop work based screening programmes
- Encourage the use of 'Taking Control' and other Heart Foundation and Health Promotion Agency resources
- Continue to fund the license fees ensuring practices will have access to PREDICT (electronic decision support)
- Extract reporting data on a regular basis and provide PHOs with up to date reports
- Utilise audit and reporting tools to identify, understand and plan effectively for their practice populations

The additional CVD risk assessment funding from budget 2013 will be spent on:

- Employing additional nurses and healthcare assistants to assist practices with implementing quality improvement strategies, leading to sustainable performance
- Enhancing reporting and audit tools so these tools can provide daily updates on patients who need to be risk assessed
- Implementation of patient dashboards that include recall systems
- Funding for practice staff who wish to complete the General Practice Assistants course.
- Additional data analyst support in order to provide accurate, timely and detailed practice level reporting

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 rate of 37.1 per 100,000. This is double the national average. CM Health aims 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

Primary Care Initiatives; CM Health executable strategy for Better Health Outcomes for All; Northern Region Health Plan (NRHP) – Child Health Implementation Plan; CM Health Maaori Health Plan; CM Health Rheumatic Fever Prevention Plan

Actions

- Implement the MOH endorsed rheumatic fever plan
- Monitor and evaluate the school based throat swabbing service being delivered within 61 schools
- Implement rapid response clinics as agreed between the MOH and the Rheumatic Fever Alliance Leadership Group
- Work with the provider 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 with 100 percent being referred 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

Measures

- Actions in rheumatic fever plan delivered by June 2015
- 25,000 children in high risk areas within CM Health have received services from the programme
- Evaluation completed by Quarter 4
- Initial hospitalisations target of 7.9 per 100,000 met by Quarter 4
- 30 rapid response clinics operational by Quarter 1
- Hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 40 percent lower than the average over the last 3 years (measured by National Minimum Data Set)
- Continuing Medical Education (CME) programme for the implementation of the National Health Foundation (NHF) guidelines is established and rolled out with primary care

- Review current notification processes of acute rheumatic fever to the Medical Officer of Health
- Secondary care clinicians will review cases of rheumatic fever to identify risk factors and system failure points
- Work with the National Hauora Coalition to deliver sore throat swabbing services to 61 schools in Counties Manukau until June 2015
- Undertake a case review process for acute rheumatic fever admissions (minimum 20/year) to identify risk factors and system failure points
- Develop and agree a sustainable pathway for the service long term by end June 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

Regional

- $150,000 of increased laboratory costs associated with rheumatic fever testing allocated within current budget

by the end of Quarter 4

- All families with children at high risk of rheumatic fever (defined as Quintile 5, Maaori and Pacific) will be managed on the appropriate pathway as they are discharged from secondary care services by Quarter 3; including being offered a Whaanau Ora support worker in community
- Systems and processes in general practice environments for the review of results and treatment plans for families with children at high risk of rheumatic fever will be audited by Quarter 1
- Recommendations following the completion of the audit will be implemented by Quarter 2
- Notification of Rheumatic Fever to the Medical Officer of Health occurs within 7 days
- Review of secondary care processes completed by Quarter 2 and implementation of recommendations of the secondary care review by Quarter 4
- Patients with a past history of rheumatic fever receive monthly antibiotics no more than 5 days after the due date by Quarter 1
- Number of injections overdue by more than 5 days is less than 20 percent by Quarter 1
- Number of patients who have annual audit of secondary prophylaxis coverage 90 percent

2.2.2 Improving youth and health – including the Prime Minister's Youth Mental Health Project

CM Health are taking a strategic approach to the planning of Youth Mental Health and Addiction services as part of a wider youth strategy, which will include meeting the objectives of the Prime Minister's Youth Mental Health project. We will work in collaboration to better meet the needs of our youth and work across sectors to develop clear inter-agency pathways. This means working more closely with other agencies and sectors, particularly education and justice to intervene earlier for those most at risk of developing mental health and addictions issues.

- We are exploring a new Youth Model of Care that unites all youth services across the many different services providers and settings. Our current strategic directions in the development stage includes the following:
- 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
- Be consistent with the CM Health System Integration Programme and the development of Locality Clinical Partnerships

Linkages

Primary Care section 2.3.1

Actions

Integrating school based clinics to localities

- Work closely with schools to develop comprehensive integrated school based health services (SBHS) that include school based nursing, specialist services and primary care to ensure comprehensive care for students most at risk

Expand the use of HEEADSSS[6] Wellness Checks in schools and primary settings by:

Measures

- Low decile secondary schools will have access to fully integrated SBHS during the 2015 school year

[6] HEEADSSS stands for Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety

▪ Continuing to deliver HEEADSSS assessment for all year 9 students and opportunistic assessment for at risk students going through school discipline process in decile 1-5 secondary schools ▪ Developing and implementing a plan to for HEEADSSS assessment training across health, education and primary care utilising and strengthening current resources and existing wellness checks	▪ Greater than 90 percent of year 9 students will receive a year 9 health assessment (HEEADSSS) in these schools ▪ Roll out of HEEADSSS training packages across health, education and primary care front line professionals ▪ Decile 1-5 secondary schools will have access to fully integrated SBHS during the 2015 school year
Improve the responsiveness of primary care to youth by implementing the newly developed model of care for the district to ensure that: ▪ Our primary health care services are more appropriate and responsive to young people ▪ The coverage and quality of school-based health services is improved ▪ Referral pathways between mental health, and addiction services and primary care are improved ▪ As part of the new model of care, refine and clarify appropriate pathways to ensure early intervention, support, advice, advocacy and mental health and addiction support ▪ Work across agencies to map current pathways through services and establish agreed shared pathways through inter-agency collaboration ▪ Contribute to the development of a competency framework for health professionals encompassing the primary, secondary and NGO workforce and including cultural competence	▪ Implementation of agreed appropriate pathways to connect young people to services (as part of new model of care) ▪ Improved integration through the establishment of agreed inter-agency pathways and information is available to professionals working in health and education (12 months) ▪ Competency framework developed that ensures a health workforce meets the needs of young people in Counties Manukau
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 by: ▪ Participate in the development of CAMHS/AOD Transition Planning Discharge Guideline and be a test site for implementation ▪ Develop shared and collaborative systems with Child, Youth and Family, Education, AOD and Forensic services ▪ Develop process to capture data on follow up of youth (12-19 years) in primary care following discharge from CAMHS and Youth AOD services ▪ Contribute to the development of a competency framework for health professionals that ensures cultural competence for the primary, secondary and NGO youth workforce	▪ Implement the National CAMHS/AOD Transition Planning Discharge Guideline in clinical operational practice (12 months) ▪ Collaborative care planning is in place for children and young people with high and complex needs (12 months) ▪ Reduction of re-referrals due to relapse through continued support within primary care (12 months) ▪ Follow up data able to be captured following discharge to primary care of youth (12-19 years) from CAMHS and Youth AOD services (12 months) ▪ Competency framework developed that ensures a health workforce meets the needs of Maaori and Pacific youth living in Counties Manukau (12 months)
Improve access to CAMHS and youth AOD services through wait times targets and integrated case management by: ▪ Further develop the draft Youth model of care to increase access and improve integration through schools and community settings ▪ Continue to support NGO AOD providers through the regional workgroup to ensure that accurate data on wait times is being captured	▪ Delivery against target: 80 percent of youth to access services within 3 weeks; 95 percent to access services within 8 weeks ▪ Decreased waiting time from referral to first contact ▪ Increased engagement and reduced DNA rate due to timely response

2.2.3 Children's Action Plan

CM Health supports the conclusions of the White Paper for Vulnerable Children and the Children's Action Plan released on October 2012 by the Minister for Social Development. Although CM Health is not one of the first pilots to develop and implement Children's Action Plan (CAP), we will closely observe learning from Lakes and Northland DHBs to ensure we are prepared for implementation when appropriate.

Linkages

Primary Care Initiatives; CM Health executable strategy for Better Health Outcomes for All, specifically the First 2000 Days Programme; CM Health Immunisation Strategy; Northern Region Health Plan – Child Health Implementation Plan; CM Health Maaori Health Plan

Actions

- Children admitted to emergency department and inpatient services for Non Accidental Injury (NAI) will receive a 24 hour interagency response whereby CYF, NZ Police and CM Health formally meet to share information and develop a management plan as described within the MoU with Child Youth and Family, Police and DHBs
- Complete a stocktake of services that support vulnerable children through the Better Public Services intersectoral group
- 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
- Implement changes to information sharing practices that are identified in the Ministry of Health's guidance
- Implement the National Child Protection Alert System
- Design and implement a specific training programme for the recognition of signs of maltreatment
- Complete a stocktake of the vetting processes used by providers working closely 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 Action Plans in pilot DHBs for application to CM Health
- Actions to support establishment of Children's Teams include:
  - 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
- DHB service planning and development activity to provide an effective continuum of services across primary and referred health services to meet the needs of:

Measures

- 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
- Violence intervention programme audit (University of Auckland) completed to requested timeframes
- Information sharing practices (as identified) will be implemented by Quarter 4
- Attendance at the Better Public Services intersectoral group that meets to coordinate regional activities
- CM Health child protection services will implement the National Child Protection Alert System (in conjunction with the local DHB system) by Quarter 2
- Frontline staff working for providers in Counties Manukau will have attended a specific training programme for the recognition of signs of maltreatment by Quarter 4
- Attendance recorded on meeting minutes
- CM Health providers working closely with children will use consistent vetting processes by Quarter 4
- The implementation of the cross-sector standards, workforce competencies and training requirements will be completed in CM Health by end of 2014
- Stocktake of various services and linkages to Children's Teams by Quarter 2
- Develop implementation plan Quarter 1
- Maternity review recommendations include vulnerable women work stream. Work being undertaken to formalise intersectoral relationships to prove more coordinated care for women with complex needs by Quarter 1
- Children in state care will be continued via the Gateway programme. An action plan has been developed to address waitlists. Reduction by Quarter 2
- Children with mental health and behavioural problems will be incorporated into our First 2000 Days project stream. A project plan is being developed under healthy attachment development and appropriate parenting skills - Quarter 4
- Refer MH section 2.3.7 'COPMIA'

- Pregnant women with complex needs covered in maternity review recommendations
- 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
- Children in state care
- Children with mental health and behavioural problems
- Mental health and addiction service users in their role as parents – Refer MH section 2.3.7 'COPMIA'

2.2.4 Whaanau Ora

CM Health and Manawhenua I Tamaki Makaurau - through the endorsement of manawhenua's Hauora Plan and its integration into our Maaori Health Plan – are committed and strongly believe in whaanau ora as an important approach to engaging and improving our healthcare delivery to Maaori in our district.

CM Health intends to continue reshaping the existing health services to ensure we are able to offer whaanau ora centric services at a local level. We will implement a multi-faceted approach to whaanau ora in order to support whaanau to achieve the health and social outcomes they desire across both primary and community based care and within the inpatient service to improve the experience of whaanau who access our services across the whole care continuum.

We have also committed in our Maaori Health Plan and the Hauora Plan to work together to determine how whaanau perspectives are incorporated in the way we report and assess impact on health outcomes of vulnerable Maaori and their whaanau. The 2014/15 year represents major service changes among providers to reflect a focused whaanau ora model of health care through the Integrated Service Agreement contracts with National Hauora Coalition (NHC) and Alliance Health+ (AH+).

We will also work with the whaanau ora collectives and the whaanau ora commissioning agencies to ensure that health and social services are joined up and integrated in how they support Maaori. The 2014/15 year is an exciting year for Maaori health in Counties Manukau – we will have in place better targeted support for Maaori whom are At Risk Individuals bringing services closer to where they live, we will have in place joined up health and social services through the TPK whaanau ora collectives and commissioning agencies. In addition, we will establish strong frameworks for engaging Maaori in evaluating and reviewing impact on outcomes to improve Ambulatory Sensitive Hospitalisation (ASH) rates, reduce smoking prevalence, increase access to care in the management of heart disease and diabetes and improve the experiences of mama, pepi and tamariki in our district.

Linkages

CM Health Maaori Health Plan; He Korowai Oranga

Actions

Build capacity and capability

- Support the development of Maaori providers within the Whaanau Ora Collectives through the administration of the MOH Maaori Provider Development Scheme, working with NHC and TPK funded provider development
- Implement Whaanau Ora Networks for each of Counties Manukau localities, providing a mechanism for the Whaanau Ora Collectives to engage in the planning and development of localities in Counties Manukau
- Hold a forum with manawhenua, whaanau ora collectives and commissioning agencies, NHC and Maaori health providers to identify workforce capability and capacity needs and actions to increase supply and support whaanau ora workforce development
- Increase number of Maaori in workforce pipeline leading to increased proportion of Maaori employed in CM Health via:
  - Supporting secondary school Health Science Academies that aim to increase Maaori secondary students participation and achievement in health sciences

Measures

- Improved Health Target performance for Maaori at the same or better than non-Maaori in CM Health
- Number of whaanau enrolled in whaanau ora services, receiving joined up health and social care plans and improved access to services
- Number of meetings held with TPK/WO commissioning agencies/collectives to enhance and maintain collaboration into the future
- Forum on Maaori health workforce capacity and capability resulting in a Maaori workforce development plan specific to CM Health and working across both health and social service development
- Two forums with TPK, NHC and whaanau ora collectives and Maaori health providers to discuss and agree actions to support capacity and capability building for Maaori providers
- Number and proportion of Maaori recruited in CM Health workforce, receiving scholarships and participating in Health Science Academies

▪ Scholarship that increase the likelihood of Maaori retention and participation in health science degrees ▪ Supported recruitment into CM Health workforce ▪ Leadership and career development that increase number of Maaori competing for clinical and managerial leadership positions	
Be outcomes focused ▪ With the endorsement of Manawhenua I Taamaki Makaurau implement and monitor providers (Maaori and mainstream) against a whaanau ora outcomes framework that aligns with MOH/TPK whaanau ora outcomes, National Hauora Coalition and manawhenua's expectations of improved whaanau ora ▪ Assess and, where relevant, support alignment of outcomes framework with results based accountability framework implementation within Maaori providers and services	▪ Outcomes framework for whaanau ora impact in place and first monitoring reports compiled and submitted to Manawhenua as part of joint governance monitoring, Maaori Health Advisory Committee (MHAC) and Board ▪ 3 community engagement forums via MHAC to engage Maaori communities in priority Maaori health issues
Implement programmes of action ▪ Implement whaanau ora collectives programmes of action that implement Whaanau Ora Practice Standards in primary care work alongside NHC, Whaanau Ora collectives, commissioning agencies and manawhenua	▪ Actions and milestones agreed as part of Programmes of Action are implemented
Support strategic change ▪ Develop a strategic and whole of system approach Maaori Health Plan with Primary Care, PHOs, Manawhenua i Tamaki Makaurau and the Whaanau Ora Collectives for the 2015/16 – 2017/18 years to ensure Whaanau Ora is fundamental to Maaori health strategy and action in the district ▪ Develop a business case for targeted and increased investment in Maaori Health in Counties Manukau that leads to improved whaanau ora and Maaori health outcomes ▪ Work with communications and marketing experts to promote whaanau ora within the organisation and across the primary/community sector	▪ Maaori Health Strategic Plan for 2015/16 – 2017/18 year with an investment plan ▪ Maaori health providers, PHOs, manawhenua engaging in planning process for DHB ▪ Whaanau ora profile has reach across CM Health healthcare system and is understood

2.3 System Integration

There is evidence that a health system built on comprehensive primary health care can deliver better outcomes at a lower cost than one that is oriented around secondary care[7]. A primary healthcare focused system can be defined as including the following attributes:

- *Comprehensive* - able to provide access to most of the health services a family requires, including preventative care
- *Continuity of care* - provides long-term continuous relationships with a primary health care team over time
- *Coordinated* - coordinates access to the complex range of services in the healthcare system
- *Person centred* - focused on facilitating the self-care and resilience of the individual and their whaanau, rather than just treating their illnesses

General practice is the heart of primary healthcare but our health system has tended to split services off from general practice as care has developed in the community. Examples of primary health care services that are not well integrated with general practice include public health and district nursing, mental health and addictions, rehabilitation and physiotherapy, community child health, pharmacy, and home and residential based older people's services.

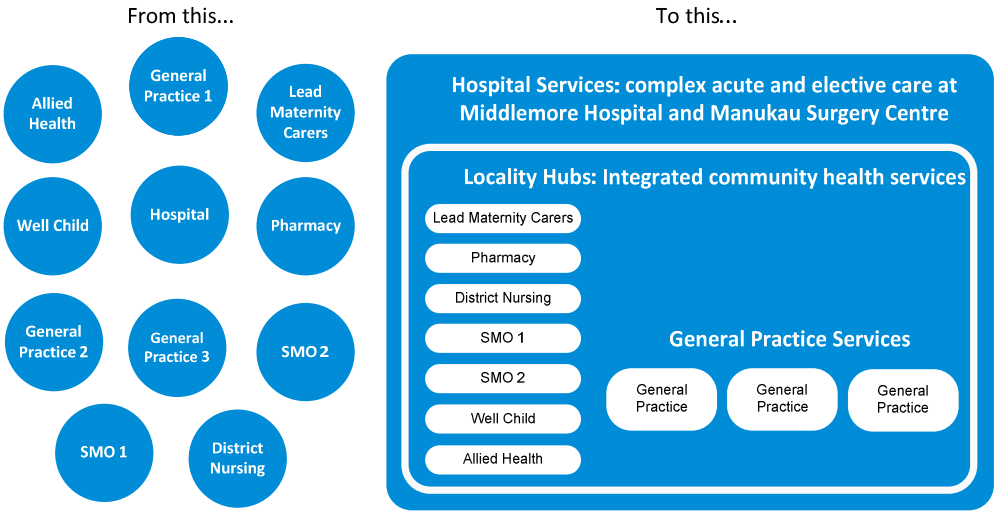
The Counties Manukau Health Systems Integration Programme aims to re-establish primary care as the central focus and coordinating mechanism of healthcare. Key aspects of the programme are:

[7] "Coordinating Primary Healthcare: an analysis of the outcomes of a systematic review"; Powell-Davies, G. etal, MJA, Vol 188, No 8, April 2008

- The development of locality clinical partnerships between hospital, primary and community care clinicians with a significant role in determining local health delivery
- Increased use of results/outcomes based alliance arrangements within a global budget (including for acute hospital care), and a shift in resources to get the right balance
- An enhanced role for comprehensive primary healthcare services, including increased accountability for outcomes and a focus on better quality and safety in primary care
- Early intervention of 'At Risk Individuals' (ARI) through a programme that organises care for patients with long term conditions to support them to self-manage and keep them well and at home[8]. It includes risk stratification to identify patients at risk of unplanned hospital admissions followed by proactive assessment, care planning and coordination of care led by the general practice team and supported by Multi Disciplinary Team (MDT) input
- Use of different workforce configurations, process re-designs, tele-technology and electronic shared records and care pathways to improve Model of Care (MoC) efficiency

The overall aim of this ambitious three to five year strategy is to re- integrate each disparate component of the health service by building a series of active clinical networks around clusters of GP practices, such that:

- Each cluster is served by multidisciplinary community health teams that provide domiciliary and clinic based health services
- General practice and community teams work seamlessly together through shared clinical pathways, patient records, close working relationships, and common systems, so that practitioners no longer need to refer individuals to each service, but rather can share tasks as part of one locality team ('the health home' for that patient)
- Each cluster is also served by a Whaanau Ora network that provides help to families with significant social needs whose living situation is impacting on their health
- The exact configuration of services differs by locality but all will include a mix of services by visiting clinicians in primary healthcare practices, services based in community hubs close to local practices, and domiciliary services
- GPs, nurses, Senior Medical Officers (SMOs), Allied Health, community health workers and patients in the network are actively involved in resource allocation decisions and exercise clinical governance over service provision with an emphasis on continuous quality improvement



Over time, most community health services (except those that are highly specialised and therefore need to remain centralised to ensure quality and provide economies of scale) will be based in these clusters and provided in a way that places more accountability on primary health care to prioritise access to health resources. In this way we aim to keep the best aspects of specialisation while also reaping the benefits of integration.

The transition of DHB community services began on 1 July 2013 with the change in line management of Home Health (district nursing and community allied health) teams to the respective Locality General Managers. Since that time,

[8] Further information can be accessed online from http://www.countiesmanukau.health.nz/AchievingBalance/System-Integration/system-integration-locality-patient-perspective.htm

Home Health teams have started working more closely with general practice, including coordinating care for 'at risk' patients (Franklin); allocating District Nurses so they are more integrated with named General Practice clusters (Otara/Mangere) and participating in multi-disciplinary case conferences led by general practice (Manukau). A comprehensive re-design of the Papakura Home Health team has been initiated, led by two Executive Leadership Team (ELT) champions and supported by Ko Awatea. The project aims to identify new ways of working and re-designed systems and processes which will allow the Home Health team to work more efficiently, effectively and be better integrated with other community teams and general practice. Papakura is a demonstration/test site for changes that will be rolled out across all Home Health teams.

2014/15 is the third year of implementing the programme, and the focus will be on further sustained devolution of services from secondary to support primary, with an equal emphasis on the re-engineering of primary care to ensure the model of care is enabled to respond to increasing secondary service demand and a new way of working. Details of the specific objectives to achieve this are outlined below.

2.3.1 Primary care

Actions	Measures
CM Health has a well embedded culture of alliancing, which is borne out of the excellent relationships that it enjoys with its 5 partner PHOs. In 2012/13 this was demonstrated by the development and endorsement of a District Strategic Alliance Agreement, which has become the overarching framework for the development of all system integration work, and for the ongoing establishment of localities – which is enabling local governance across 4 localities in terms of health planning and decision making. In 2014/15 the Strategic Alliance Agreement will be updated to reflect the following: ▪ An increase in the number of services that will be included in the risk and gain share agreement to include Surgical outpatients ▪ An expanded range and scope of locality based Multidisciplinary Teams (MDTs) that will include mental health, Kidz First and maternity community teams, which will align with general practice clusters	▪ Targets for the newly agreed services are currently being developed ▪ Fully integrated Multi Disciplinarily Team (MDT) support structure will be in place across all four localities by the end of Quarter 4 ▪ Expanded range and scope of locality based MDTs to include mental health, Kidz First, Needs Assessment and Service Coordination (NASC) and maternity community teams that align with general practice clusters
At Risk Individuals (ARI) Programme The At Risk Individuals (ARI) programme will be implemented in 2014/15 following two years of redesign and an effective pilot across 12 practices. This will be phased to mitigate clinical risk, and to ensure that appropriate resource is available to practices to transition. As part of the move from the Chronic Care Management (CCM) programme, we will also be providing support to practices to re-engineer their current practice models in order to more effectively manage proactive care, and to ensure that the workforce is appropriately supported to deliver ARI. This will include key objectives as follows: ▪ The redesign of CM Health 20,000 days campaign to free up Improvement Advisors and project managers to support primary care, as the next 'wave' of integration initiatives ▪ Safety in Practice Collaborative ▪ Appointment of additional clinical leadership to reflect the whole of system focus, including a secondment from the Scottish Quality and Safety Commission to champion key quality bundles in primary care ▪ All other practices will be supported to transition from CCM to ARI during the course of 2014/15	▪ Support and lead Safety in Practice collaborative for 23 General Practices across the Auckland region to develop quality improvement capability ▪ Provide 2 learning sessions to teach, mentor and support the PHOs and General Practices to implement bundles of care for at risk individuals ▪ Provide monthly PHO facilitator training sessions to develop quality and patient safety improvement methods within the practices ▪ Provide Clinical Leadership for Safety in Practice collaborative both within CM Health and from Clinical

▪ Key outcome indicators have been developed in addition to the current Diabetes Care Improvement Packages (DCIP) indicators, to measure the success of the transition, and of the resulting clinical outcomes ▪ Alignment of palliative care as a sub set of At Risk patients will also take place over the coming year to ensure a systematic approach is taken to risk stratification of patients, and a needs rather than disease based approach is applied in the allocation of care packages to enable greater management of this group in the community	Lead for Patient Safety in Primary Care, NHS Scotland
Localities Development	
The development of each of the four localities will continue. Locality specific priority initiatives in addition to the generic roll out of the ARI programme, will be actioned across all localities concurrently.	▪ Each locality will have a detailed agreed operational work plan agreed by the Locality Leadership Group and endorsed by the Whole of System Strategy Board by the end of Quarter 1, 2014/15
Franklin Locality	
▪ Complete the model of care for Franklin following evaluation completion ▪ Complete the implementation of the E-shared care implementation for palliative care patients in Franklin number of palliative patients on e-shared care ▪ The Greater Auckland Integrated Health Network (GAIHN) pathway for COPD will be rolled-out to all general practices in Franklin	▪ Evaluation completed by the end of Quarter 1 ▪ Decision to discontinue, modify or fully implement the Franklin rapid response service will be made by the Franklin Locality Leadership Group (LLG) by the end of Quarter 2 ▪ 100 percent of patients who are palliative and are managed by more than one service (GP and Hospice and / or Home Health care) will have an e-shared care plan active by the end of 2014/15 ▪ 50 percent of GP practices in Franklin will be using the pathway by the end of Quarter 2 ▪ 100 percent of Franklin GP practices will be using the pathway by the end of Quarter 4
Mangere/Otara Locality	
▪ Continue to build on the number of services that have to date been delivered out of the agreed locality health hub, at Mangere Town Centre ▪ Implement new models of care in line with the ARI programme team to focus on key population health indicators as outlined in work plan – diabetes, mental health and access to diagnostics ▪ Work with secondary care to realign locality workforce requirements, particularly nursing and allied health roles and functions	▪ Finalise the detailed business case including service design models and secure all necessary approvals for fit out of premises in the Mangere/Otara locality by end of Quarter 1 2014/15 ▪ Confirm recommendations from 2013 Locality Current State Analysis (stocktake) reports on diabetes, mental health and diagnostic services with LLG by 1 May 2014 ▪ Confirm and formalise two specialty working groups – Diabetes and Mental Health to drive service improvement in the locality by 1 October 2014 ▪ Adopt and implement recommendations from the 2013 Diabetes current state analysis (stocktake) using best practice approaches in the management of people living in Mangere with diabetes by 1 October 2014 ▪ Adopt and implement recommendations from the 2013 Mental Health current state analysis (stocktake) using best practice approaches in the management of people living in Mangere with mental health disorders by 1 October 2014 ▪ Adopt and implement service improvement recommendations from the 2013 Diagnostic current state analysis (stocktake) by 1 January 2015 ▪ Consolidate Clinical and Nursing Network Groups and

	establish four other locality professional network groups (Podiatry, Pharmacy, Social Worker and Dietician)
Manukau Locality ▪ Focus on a detailed redesign of Home Health team service provision resulting in a strengthened partnership with primary care teams as the healthcare home for the patient and family during 2014/15, which will involve a review of process', tasks and relationships with a view to re-engineering these to increase capacity and capability within this valuable but limited resource ▪ In addition, special focus will be given to the key population groups within Manukau, namely mama, pepi and tamariki. This work will consider the life transitions from conception to young adults	▪ Implement changes to locality workforce structures across both secondary and primary resources by the end of Quarter 4 ▪ Services for children including Well Child, B4 School Check, mokopuna ora, outreach immunisation, lactation support will be much more integrated ▪ Nurse led services will be developed within the locality before the end of the 2014/15 year ▪ Family Start and other parenting programs will be integrated into early intervention programs
Eastern Locality ▪ Implement the COPD dynamic clinical pathway ▪ Implement the COPD Blue Card Action plan ▪ Extend the Falls Prevention Programme ▪ Implement a Clinical Advisory Pharmacist programme to support optimal prescribing through Clinical Medication Reviews for At Risk Individuals and in Aged Residential Care, undertake Polypharmacy and other medication-related clinical audits and provide medicines information and bulletins to primary care ▪ Extend the Integrated Care Coordinator role assist with complex At Risk Individuals and to include facilitating early discharge	▪ 3 practices will be using the dynamic pathway, with 50 percent of people coded with COPD enrolled in the pathway ▪ 50 percent of the people admitted to hospital for COPD as a primary diagnosis will have a Blue Card Action Plan ▪ 50 people over 80 years old, who have fallen, will have been enrolled in the Otago Falls Prevention Programme ▪ 100 people from residential care, and 50 community based people will have received a Clinical Medication Review; 10 Medicines Information Bulletins will have been distributed ▪ 50 people who have been identified as high risk will have been reviewed through the Virtual Clinic that utilises the Integrated Care Coordinator, Senior Medical Officer and other members of the locality-based MDT
Regional After Hours Network ▪ CM Health will continue to host and lead the development of the Regional After Hours Network into 2014/15, for which the following key objectives have been agreed: ▪ A review of current access will be undertaken to ensure that after hours services can be accessed within acceptable timeframes and distance across the region ▪ Opportunities will be explored to maximise the use of telephone triage after hours ▪ Discussion will continue to focus on the improved use of District Nursing, Primary Option for Acute Care (POAC) and telephone triage to better respond to after hours needs, whilst improving linkages to the patients healthcare home ▪ In addition to the work of the regional After Hours network, significant effort will be made by the District Alliance to ensure only those people who need to access secondary or acute care services utilise Emergency Care. This will be actioned through: ▪ A review of the current thresholds for triggering risk and gain share, to ensure that any activity outside of normal seasonal variation sees a direct financial gain to the locality and its contributing PHO partners ▪ The further identification of named members of each	▪ In conjunction with the Urgent Care Network implement strategies to improve access to urgent and after hours care for people in Mangere which reduce presentations at Middlemore Emergency Care by the end of Quarter 1

locality teams, in addition to the current tranche of Senior Medical Officers	
Improve and embed the pathways for primary care access to specialist nurse and /or doctor advice for three high demand services: ▪ Gout ▪ COPD ▪ Diabetes ▪ Progress planning through existing CM Health System Integration programme including Locality Leadership Groups and At Risk Individuals work stream ▪ Align planning with development of MDTs in localities ▪ Use GAIHN clinical pathways and implementation planning to support execution of the pathways	▪ Number of practices that have completed training requirements for Gout, COPD, and Diabetes clinical pathways ▪ 10 percent increase in the number of patients on a Gout, COPD or Diabetes clinical pathway and with an e-shared Care Plan to support integrated, collaborative patient care ▪ Patients who are on a Gout, COPD or Diabetes clinical pathway have an optimal medication regime to support their long term condition ▪ Specialist nurses and / or doctors actively support embedding of clinical pathways in localities as demonstrated by their involvement in education, mentoring and providing clinical advice to improve capability in primary care ▪ Improvement in the acute demand curve for the district ▪ Improved performance of the district-wide system
ARI funding ▪ Using the District Alliance Agreement as a vehicle, we will continue to work with primary care partners to align Care Plus and Flexible Funding Pool (FFP) funding to the application of ARI funding	▪ At least 20 percent of Care Plus funding will be applied directly from PHOs to the ARI programme, for patients who qualify
Continue to work with PHOs to: ▪ Implement the government's Primary Health Care Strategy ▪ Support implementation of the PHO Services Agreement Version two ▪ Ensure that primary health care services are provided on a best for patient and best for system basis where care is provided closer to home; patient outcomes and experiences are improved and clinical and financial sustainability of the health system is enhanced ▪ Strengthen integration of health care services ▪ Support clinical leadership and clinically-led service development	▪ Improved health outcomes and reduced disparities for enrolled populations and other eligible persons ▪ Clinical and financial sustainability of the health system ▪ Enrolled populations and eligible persons receive high quality, coordinated care delivered by multidisciplinary teams that is easy to access and provided closer to home ▪ A plan for use of the Flexible Funding Pool, with measurable outcomes, is agreed by the Alliance Leadership Team and the DHB
Continue to work with Alliance Leadership Teams (ALT) to: ▪ Ensure services delivered through the flexible funding pool are jointly planned, responsive to the government's Primary Health Care priorities and are aligned with district and locality priorities and planning ▪ Improve collaborative working and integration between primary and secondary health and community providers ▪ Support a balanced focus on highest priority needs while ensuring appropriate care across all patient populations ▪ Make the best use of finite resources in planning and delivering health services to achieve improved health outcomes for our populations	▪ 100 percent of ALT plans are jointly agreed and signed off by the start of Quarter 1
Integrated Performance and Incentive Framework (IPIF) ▪ Work with the Ministry of Health and the primary care sector to plan for implementation of the Integrated Performance and Incentive Framework (IPIF)	▪ IPIF is implemented in accordance with the PHO Services Agreement ▪ PHOs have plans and strategies in place to achieve the

▪ Engage the Whole of System Strategy Board and Locality Leadership Groups in IPIF implementation planning
▪ Ensure alignment of the IPIF with the CM Health System Integration Quality Framework
▪ Progress implementation of the IPIF using strategies that support improvement in the delivery of health services by PHOs and that are consistent with the following Programme objectives:
  ▪ Build clinical governance capability within PHOs
  ▪ Further develop a population health model
  ▪ Use of information to improve performance
  ▪ Promote and improve multi-disciplinary teamwork
  ▪ Promote a CQI approach throughout the PHO
▪ Focus on achieving desired population health outcomes
	targets set out in IPIF
	▪ Implementation planning for IPIF is aligned with the CM Health System Integration Quality Framework

Rural ▪ Establish a Franklin Rural Service Level Alliance Team (SLAT) through the existing Franklin Locality structure, with membership from the DHB, LLG and PHOs and practices currently within scope for rural primary care funding ▪ Franklin Rural SLAT to undertake planning, inclusive of a whole of system view of rural health services, current state and gap analysis, engagement of relevant stakeholders and development of a long term plan for accessible, equitable rural services ▪ Current rural primary care funding, such as Rural Workforce Retention Funding and Reasonableness Roster Funding to be included within the scope of the plan	▪ Franklin Locality Rural Service Level Alliance Team established by 1 July 2014 ▪ Planning processes initiated by 1 July 2014 ▪ Planning processes are aligned with agreed processes in the PHO Services Agreement 2014/15 ▪ Plan signed off with approval from Franklin LLG and CMDHB by 1 Sept 2014 ▪ Implementation milestones met ▪ Sustainable rural primary health care services
Youth For Youth, the DHB will work across an alliance of provider groups comprising Mental Health and Addictions, Primary Care and Specialist Youth Health services to implement the model of care that will be developed for the district to ensure that: ▪ Our primary health care services are more appropriate and responsive to young people ▪ The coverage and quality of school-based health services is improved ▪ Referral pathways between mental health services and primary care are improved	▪ Refer to 'Improving youth and health' for measures around implementation of comprehensive SBHS, section 2.2.2
Advance Care Planning (ACP) Advance care planning aims to ensure patients are better informed about future care and treatment choices and health care providers are better informed about patients care preferences particularity with end of life care. CM Health aim to continually improve communication between patients and family/whaanau and health professionals and community partners around end of life care and treatment, ensuring patients and their family/whaanau have clear information to enable them to make informed	▪ 10 percent increase in patients having ACP conversation by Quarter 4 ▪ 20 percent participation in Conversations that Count Day 15 ▪ 100 Level 1 trained/certified ACP partners ▪ At least 8 ACP presentations to community groups and health providers ▪ Qualitative Research completed by December 2014

choices.

- Continue to deliver ACP training, support and leadership
- Support consumer and community partner awareness and engagement
- Participate in Advance Care Planning Maaori Task Team and pilot Maaori Tool
- Support the development the Pacific guidelines for ACP implementation

- ACP DHB Policies and Procedures updated to reflect changes in service delivery
- Resources available and disseminated to meet the specific needs of Maaori, Pacific and Asian consumers and consumers with hearing and visual disabilities
- Within each locality (primary and secondary care) ACP will be led by an ACP champion (L2 trained) supported by CM Health ACP Project Manager
- Commence recoding ACP conversations and plans in the e-shared care record by October 2014
- 4 ACP Level 2 training workshops completed by July 2015
- 40 Level 2 ACP practitioners trained by July 2015

2.3.2 Diabetes and Long Term Conditions

Effective management of people with Long Term Conditions (LTCs) is wider than better services, processes and treatment. Integration of the health care system and coordination of services is seen as part of the solution to the challenge of sustaining healthcare by approaching health service delivery with a whole systems view. Care coordination and clinical integration bring benefits to patient outcomes and the patient experience while assisting in the management of effective healthcare expenditure. CM Health is in the process of integrating the Diabetes Care Improvement Package (DCIP), with the At Risk Individuals Framework (ARI), in which models of care will be developed and implemented within an approach that strengthens primary, secondary and preventative care with a focus on patient empowerment.

Linkages

CM Health Maaori health Plan; Northern Region Health Plan

Actions

- All diabetics will be eligible for DCIP funded services. The DCIP suite of services includes:
  - Access to podiatry and diatetic expertise
  - Access to psychology services to support behavioural change
  - Support/funding for initiation of insulin
  - Clinical outcome incentives by way of payments for maintenance of well controlled diabetes and payments for improvement of poorly controlled diabetes
- Additionally, more clinically complex diabetic patients will be eligible for entry into the ARI programme which offers:
  - Care coordination
  - Care planning
  - Self-management support
  - MDT case conferencing
- A Gestational Diabetes programme being developed will capture all women with gestational diabetes, providing ability to follow family/whaanau needs
- Nurses will be awarded scholarships to attend the Manukau Institute of Technology (MIT) Diabetes Care and Management Course which is held twice per annum, progressing to post-graduate papers leading to Nurse Prescribing
- Diabetes Projects Trust to support Practices to improve the provision of care to diabetes patients through audit services and tailored support for practice staff. This service is specifically targeted towards practices with

Measures

- Linkage with Ambulatory Sensitive Admissions to Hospital (ASH) rates
- Measurement of improved diabetes outcomes using a set of clinical indicators to be developed
- Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control
- Improve or maintain appropriate management of microalbuminuria in patients with diabetes
- 10 nurses undertaking MIT course of study
- Increase in Diabetic Nurse Prescribers from 4 to 8
- 12,000 retinal screens completed in the community
- 6340 patients will be referred to Green Prescription
- 700 people will attend a Self-Management Education Group course
- 6 churches/workplaces will receive healthy lifestyle advice/self-management education
- Development of podiatry indicators by Quarter 4
- Support the implementation and evaluation of revised DSME standards and curriculum by Quarter 4

high numbers of Maaori and Pacific patients as well as those with high diabetes prevalence

- Work with PHOs to provide practice level monthly reporting of diabetes related clinical indicators based on Diabetes Annual Review data
- Patients who are diabetic or pre-diabetic will be referred to Green Prescription for exercise and lifestyle advice and support
- Continue to grow/expand access to Diabetes Self-Management Education programmes (DSME) through collaboration between primary and secondary services
- Deliver health lifestyle advice and education to workplaces and churches
- Encourage practices to identify and accurately code patients with diabetes and other long term conditions and stratify according to risk/need
- Provide a set of guidance criteria to accompany the PARR/Combine PARR tool in order to identify patients who are Very High Risk or High Risk. These patients will be enrolled on the ARI programme
- 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
- Continue to play an active role in the design and implementation of key clinical pathways which are being managed regionally through the regional clinical pathways group. Pathways prioritised for implementation in CM Health during 2014/15 include diabetes, respiratory and gout
- National Shared Care Plan will continue to be rolled out as part of the ARI implementation
- Clinical Governance at a DHB level will be overseen by the At Risk Individuals Governance Group
- Practices to utilise audit tools to identify patients who are overdue for the annual check, retinal screening, foot check or patients who have an HbA1c or blood pressure above the recommended value
- Provide electronic decision support for CVD Risk Assessment, Management and Diabetes Management

Regional

- In partnership with the Northern Region Diabetes Network:
  - Develop and publish a DSME access pathway to facilitate timely and appropriate access to those most in need
  - Support the implementation and evaluation of revised DSME standards and curriculum by Quarter 4
  - Support the implementation of the NZDSS High Risk Foot Pathway
  - Support for nurse led clinic development to manage low to moderate risk diabetic patients within the General Practice team
- No overall resource impact anticipated

2.3.3 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 DHBs and the Northern Regional Alliance (NRA) for development of regional approaches and best practice

Actions	**Measures**

▪ Develop stroke thrombolysis quality assurance procedures, including processes for staff training and audit:
  ▪ Workforce training to support thrombolysis
  ▪ Care pathways developed for thrombolysis
▪ Continue to provide dedicated stroke units or areas for management of people with stroke, thrombolysis, and transient ischaemic attack services supported by ongoing education and training for interdisciplinary teams
▪ Continue to implement the NZ Clinical Guidelines for Stroke Management 2010 (the Stroke Guidelines). This will include:
  ▪ All stroke patients receiving early active rehabilitation by a multidisciplinary stroke team
  ▪ All people with stroke will have equitable access to community stroke services, regardless of where they live
Regional
▪ Support national and regional clinical stroke networks to implement actions to improve stroke services (refer to NRSP)
▪ No overall resource impact anticipated
	▪ 8[9] percent of potentially eligible stroke patients thrombolysed
	▪ Documented training and audit processes for thrombolysis in place by end of Quarter 2
	▪ 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 rehab within 2 weeks
	▪ 75 percent of patients discharged from the stroke service are followed up in specialist outpatient clinic within 3 months
	▪ Attendance and contribution to regional stroke meetings and service plan development in conjunction with the Northern Regional DHBs

2.3.4 Cardiac services

Cardiovascular disease is the leading cause of death for people living in Counties Manukau. Mortality rates for heart disease are higher among people with lower incomes, with rates of heart disease and mortality rates significantly higher for Maaori and Pacific. Approximately 80 percent of cardiovascular issues can be influence by lifestyle changes. As a result, demand for cardiovascular procedures continues to grow at over 8 percent per year.

Acute Coronary Syndrome (ACS) which includes myocardial infarction and unstable angina, is experienced by approximately 20,000 New Zealanders every year. It is a major cause of premature morbidity and mortality and timely access to treatment is a significant factor in effectively managing these patients.

Linkages

Regional Cardiology Group; CM Health 20,000 Days initiative; MOH Diagnostic indicators; CM primary care initiatives; CM Maaori Health Plan

Actions	**Measures**
Secondary Services ▪ Work with ADHB and monitor the delivery of services against the target intervention rates for cardiac surgery which have been set in conjunction with the Auckland Regional and National Cardiac Surgery Clinical Network, to improve equity of access ▪ Continue work to monitor progress monthly through KPI	▪ Standardised Intervention Rates (SIRS) ▪ Percutaneous revascularisation: 12.5 per 10,000 of population ▪ Coronary angiography: 34.7 per 10,000 of population ▪ Improved access to diagnostics: 90 percent of people will

[9] The National target is 6%r the Regional target is 8%

reports to ensure appropriate access to cardiac diagnostics is facilitated in key areas including echocardiograms, exercise tolerance tests, holter testing etc. Corrective action will be taken when and as necessary ▪ Continue to monitor and manage waiting times for cardiac services ▪ Continue to undertake initiatives locally to ensure population access to cardiac services, including percutaneous revascularisation and coronary angiography, are appropriate and not unduly influenced by external factors Regional ▪ Continue to work with the Auckland Regional Clinical Network and the National Cardiac Network to continue to implement actions to improve outcomes for people ▪ Continue to feed in to the quarterly reporting at regional and DHB level utilising the ANZACS-Q1 register ▪ Continue to deliver on the Auckland regional plan for cardiac services working collaboratively to ensure appropriate access to cardiac surgery, percutaneous revascularisation and coronary angiography for patients residing within Counties Manukau ▪ Additional 1.0 FTE budgeted to support Echo and electrophysiology	receive elective coronary angiograms within 90 days of referral ▪ 80 percent of all outpatients who are triaged to chest pain clinics will be seen within 6 weeks for FSA and stress testing ▪ Elective Services Patient Flow Indicators: all patients wait 5 months or less for First Specialist Assessment (FSA) and treatment during 2014, and less than 4 months during 2015 ▪ 95 percent of FSA referrals are seen within 3 months before being referred ▪ 95 percent of patients with suspected cardiac chest pain are seen within 6 weeks of referral ▪ 95 percent of outpatient echocardiograms are completed within 5 months
Acute Coronary Syndrome (ACS) ▪ Continue to support the national implementation and roll out of the Cardiac ANZACS-Q1 to enable other DHBs to report on ACS measures and time to appropriate intervention data ▪ Continue to actively review processes, protocols and systems that support local risk stratification and transfer of appropriate high risk ACS patients and amend where necessary ▪ Work with the Auckland Regional and National Cardiac Networks to improve outcomes for high risk ACS patients Regional ▪ Continue to develop the after-hours primary PCI service and ensure transfers within the Northern Region and ECG transmission work ▪ Implement regionally agreed protocols, processes and systems to ensure prompt local risk stratification and management of suspected ACS patients	▪ At least 70 percent of high-risk patients will receive an angiogram within 3 days of admission. (‘Day of Admission’ being ‘Day 0’) ▪ At least 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Catheter/PCI registry data collection within 30 days ▪ At least 80 percent of patients presenting with ST elevation myocardial infarctions who are referred for Primary Coronary Intervention (PCI) are treated within 120 minutes

2.3.5 Diagnostic waiting times

Diagnostic imaging is an essential and standard part of quality healthcare expected by patients and clinicians. Evolving clinical practice increasingly relies on diagnostic imaging. Early diagnostic imaging supports earlier and more accurate diagnosis and treatment. Earlier treatment is more likely to be successful and less costly. CM Health aims to:

- Achieve identified waiting time targets by more efficient use of existing resources
- Make improvements to referral management and patient pathways
- Investing in workforce and capacity as required

CM Health understands the contribution of diagnostic tests to a patient's journey and is active in the local, regional and national settings to bring consistency to referral practice, drive efficiencies and deliver quality outcomes. The initiatives listed below reflect this approach.

Linkages

Northern Region Cardiology and Radiology Networks; BreastScreen Aotearoa; National Breast Cancer Working Group; National Policy and Quality Standards; National Endoscopy Quality Improvement Programme; Bowel screening pilot at Waitemata District Health Board (WDHB), Northern Region Health Plan; Maaori Health Plan

Actions	Measures
▪ Fund additional CT and MRI capacity within the DHB leading to achievement of target indicators, more timely imaging and improved quality of care for CMDHB patients	▪ Coronary angiography – 90 percent of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)
▪ Introduce a nurse led Peripherally Inserter Central Catheter (PICC) Line service through extending the role of Radiology nurses	▪ CT and MRI – 90 percent of accepted referrals for CT scans, and 80 percent of accepted referrals for MRI scans will receive their scan within six weeks (42 days)
▪ Extend the role of MRI trained MRTs to administer Buscopan and Sedation to improve efficiency	▪ Nurse led PICC Line service in place by July 2014
▪ Reduce clinical variation through agreed protocols for scanning	▪ Extended role of MRI trained MRTs in place by July 2014
▪ Continue to refine the Access To Diagnostics programme pathway ensuring access to relevant procedures is appropriate and timely	▪ Diagnostic colonoscopy – 75 percent of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days); and 60 percent of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days)
▪ Participate in the Quality Improvement Collective (QIC); sharing and learning through regional clinical network	▪ Surveillance colonoscopy – 60 percent of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date
▪ Continue to operationalise the Paediatric Radiology Service Model in the Northern Region	▪ Representation, attendance and participation in national and regional clinical group activities
▪ Continue to work regionally to develop Sonographer training pathways and reduce shortages of Sonographers in the Northern Region	▪ Agreed system changes are implemented
▪ Implement the National Endoscopy Quality Improvement programme in Gastroenterology:	
▪ Review and streamline referrals management- centralise referral receipt, reduce number of graders, ensure referrals appropriate with GP Liaison, implement national guidelines for referral acceptance	▪ Review and streamline referral management by July 2014
▪ Improve booking and scheduling- streamline processes, improve management of waiting list – regular review of waiting list and removal where appropriate, improve data collection and integrity, develop appropriate reports	▪ Booking and scheduling improvement by December 2014
▪ Increase capacity- ensure list utilisation is 100 percent, increase number of procedure rooms/lists available, employ additional FTE, run Saturday lists, outsource where appropriate, increase use of general surgeons for lists	▪ Processes to increase capacity in place by December 2014
▪ Increase productivity- implement production plans,	▪ Processes to increase productivity in place by December 2014
	▪ Patient level data for referrals for FSA are reporting into new collection

ensure lists booked to 12 points per list (1 point- 15 min), ensure lists booked to 85 percent or more, increase number of lists

- Attend regional Bowel Screening meetings to review and discuss progress to date
- Participate in activity relating to development and implementation of the National Patient Flow system

2.3.6 Maternal and child health

14 percent of all births in New Zealand are to women living in Counties Manukau. Approximately 8500 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 30.4 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 high 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 the 2014/15 year 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), Maternity Quality Safety Improvement Plan, Prime Minister's Youth Mental Health Plan
- Regionally – Northern Regional Health Plan Child Health Plan and Youth Health Plan
- Locally – Maternity Action Plan (implementation of the recommendations from the external review of maternity care), 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 (Mangere, Manurewa and Papakura)

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

- Reduce late engagement of complex/high need women by intervening early to better manage high and complex pregnant women by (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 to access LMC care as soon as possible
  - Well Child - review 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

Linkages

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; the recommendations from the external Maternity Care Review; The Maternity Quality and Safety Programme; and the NRHSP – Child Health Implementation Plan (CHIP); Youth Health Implementation Plan; Minister's Youth Primary Mental Health Initiatives; Whaanau Ora programmes and Mana Kidz; CM Health Maaori Health Plan

Actions

The CM Health Maternity Review Action Plan describes the actions we will take as a maternity care system to respond to the Independent Panel's review. The comprehensive action plan describes the change activity that will take place so that by December 2014 (Quarter 2), we will have achieved the following under the respective key recommendation areas :

Early Pregnancy Assessment and Planning

- Increase the number of women having engaged with an LMC and maternity care before 10 weeks
- Develop key maternity messages that inform women of

Measures

- Pregnant women are booked and engaged with a Lead Maternity Carer (LMC) and have accessed Antenatal Care (ANC) by week 12 of their pregnancy whilst maintaining existing relationships with primary care
  - 50 percent by June 2014
  - 70 percent by June 2015
  - 85 percent by June 2016
- LMCs and other maternity care providers across the health care continuum will be able to access the same information via the roll out of the National Maternity

where they can go to engage with a LMC, how women can access information and why early engagement is necessary ▪ Ensure appropriate clinical capacity for vulnerable and high need women requiring secondary care is in place ▪ Ensure clear integration with community based social support services for pregnant women with social needs. This includes access to whaanau ora and family support services Ultrasound Scanning ▪ Establish a streamlined process so that LMCs and GPs referring for urgent scans can be assured their women will receive them in a clinically appropriate and timely way ▪ Prioritise vulnerable and high need women Model of Care and Workforce ▪ Increase our workforce supply of self-employed midwives to meet population demand ▪ Establish workforce development programmes to ensure we have the skill mix able to look after high and complex need women as close to home as possible Family Planning ▪ Increase access to low cost or free contraception postnatally and in as many community settings as possible Clinical Governance and Management ▪ Complete and publish a vision and strategy for maternity care for Counties Manukau women and their babies involving our key sector stakeholders Maaori and Pacific Women ▪ Pilot community based infant nutrition interventions while targeting Maaori and Pacific women e.g. mothers, grand-parents and carers ▪ Establish robust reporting and increased access to smoking cessation for pregnant women Communication and Information ▪ Implementation is well under way for the establishment of a Maternity Clinical Information System ▪ Implement and pilot health materials that are more responsive to our diverse population based on consumer panel feedback Well Child Service Delivery ▪ Well Child/ Tamariki Ora (WCTO) provider forum to discuss and agree the Tier Two WCTO schedule set up and completed Quarter 1 ▪ Develop systems for seamless handover of mother and child as they move from maternity care services to general practice and WCTO services ▪ Implement requirements within the Tier Two WCTO schedule	Clinical Information System (MCIS) ▪ Women not enrolled with a PHO remains at =or < 3 percent ▪ Seamless handover processes from GP, LMC and WC providers designed and written up by Quarter 2 ▪ New graduate midwives are supported to work in partnership with GPs and in localities ▪ Number of self-employed midwives in CM Health increases ▪ Education programmes are targeted to ethnic populations; women are ready, empowered to choose, when they want to have children ▪ Women access appropriate advice and affordable contraception in a timely manner ▪ Improve outcomes for women and infants by preventing unwanted pregnancies ▪ Training and education programmes provided quarterly to ensure timely and effective referral processes from GP to LMC ▪ Antenatal care will be provided to support increased access rate for Maaori and teenage mothers ▪ WCTO providers are briefed on the opportunities for service development within the Tier Two Service Schedule ▪ Maternity care providers to engage with WCTO providers for services as specified in Tier Two of the WCTO schedule ▪ Services are available to meet the needs of vulnerable women

Before School Checks (B4SCs) ▪ Routine contract reviews completed for B4SC providers. These include coverage reports, referral data, and participation in the case review forums	▪ At least 90 percent of all eligible children receive a B4SC, including at least 90 percent of children in most deprived regions ▪ WCTO services will work in collaboration with Kidz First Public Health (Vision and Hearing) on a joint action plan to increase coverage and ensure long term sustainability – Quarter 1 ▪ Referrals to services are completed and children access services in a timely manner ▪ Clinical support and supervision is in place for frontline clinical staff
HPV ▪ Maintenance of current coverage rates for Maaori and Pacific with strategies to increase coverage for NZ European	▪ 70 percent dose one, 65 percent dose two and 60 percent dose three
Oral Health Actions to improve oral health service access for children 0-18 years of age: ▪ Infants are enrolled with dental services at 5 months immunisation visit to increase engagement of under 2 years children; WCTO providers receive Lift the Lip training ▪ Oral health education to all preschool centres; 150 preschools in high deprivation communities get supervised tooth brushing programs ▪ Extending hours of service at community dental hub clinics to weekday evening and Saturdays subject to localised demand, to also assist in reduction DNAs ▪ SMS/text message reminder systems for preschool and school children to assist in reduction DNAs ▪ Increase access to adolescents by offering mobile dental services at secondary schools, from 28 to 30 schools	▪ PP13(a) target 85 percent of eligible 0-4 year olds enrolled with Dental Service; approximately 36,000 preschool children in 2014, Target 90 percent in 2015 ▪ Target of 95 percent of school children aged 5 years to year 8 of school (12/13 years); approximately 70,000 school children ▪ Total target as children move from preschool to school age at 5 years is 106,000 i.e. approximately 92 percent eligible population ▪ PP13(b) Reduce Scheduled Examination Arrears Rate in patients aged 0 to year 8 of school (12/13 yr.) to 7.0 percent ▪ PP11 Increase caries free at 5 years to 53 percent in 2014 and to 54 percent in 2015 ▪ PP10 Reduce DMFT in year 8 children to 1.15 in 2014 and to 1.08 in 2015 ▪ New target to come for reduction of DNAs e.g. 20 percent for preschool children, 15 percent for School children ▪ PP12 Increase utilisation of adolescent dental services to 85 percent in 2014/15
WCTO Quality Improvement Framework Implement between one and three quality improvement activities (not covered in the above guidance) from the WCTO Quality Improvement Framework relating to: ▪ Improved access – infants receive all WCTO core contacts in their first year of life ▪ Improved outcomes – infants are exclusively or fully breastfed at 6 weeks ▪ Improved quality – B4SCs are started before age four and a half	▪ Improved performance against WCTO Quality Indicators measuring access ▪ All actions completed to implement selected indicator ▪ PDSA cycle completed for implementation ▪ 86 percent of infants receive all WCTO core contacts in their first year of life ▪ 68 percent infants are exclusively or fully breastfed at six weeks ▪ 81 percent B4SCs are started before age four and a half

Maternity Quality and Safety Programme
▪ Services to pregnant women, babies, children and families are of quality and are nationally consistent:
  ▪ The Maternity Quality and Safety Programme (MQSP) provides quality improvement of services for pregnant women, babies, children and families and they are nationally consistent - the aim of the CM Health Maternity Quality and Safety programme is to bring together stakeholders to monitor maternity care to women and improve communication, teamwork and the quality of maternity care available to women and their babies.
  ▪ Consolidate the MQSP and identify actions for 2014/15 to embed MQSP as business as usual by June 2015
	▪ The measures of the MQSP will be in the Annual Report. The clinical indicators will also be summarised as a measure of success. The Annual Report will be produced in Quarter 4 and focus on the following actions:
	▪ Clear understanding of how Maternity Quality and Safety Governance Group functions
	▪ Professional stakeholders engagement regarding quality and safety activities and achievements
	▪ Assessment and dissemination of the clinical indicator data analysis with appropriate actions
	▪ Work programme completed Quarter 4
	▪ Consumer feedback Quarter 4
	▪ Review of key quality improvement target outcomes in:
	  ▪ Community
	  ▪ Primary
	  ▪ Secondary
	▪ Improved quality and safety of maternity services including improved access, outcomes and consumer satisfaction

Gestational Diabetes ▪ All women will have their first Diabetes in Pregnancy (DIP) appointment within 2 weeks of receipt of referral. They will be scheduled for a group education session and one week later will be seen by the obstetric and physician specialists and the dietician ▪ Women who require an interpreter will have their education session on a more one to one basis. Women with type one diabetes are not initially scheduled for an education session although may have one at a later date	▪ All referrals for DIP are received and triaged daily Monday – Friday ▪ Following triage , high risk referrals are seen within 2 weeks ▪ Targets will be reviewed based on roll out of national guidelines which may see a further increase in referrals for CM Health ▪ Dieticians and Diabetes Midwives provide both group and one on one education sessions and involve interpreters if and when required

2.3.7 Mental Health Service Development Plan

CM Health has developed 'Better Wellbeing For All'- the Mental Health and Addictions Strategic Plan 2013-18 that defines the actions that we will take to achieve our strategic goals for Mental Health and Addictions over the next 5 years (2013-2018). Significant stakeholder consultation has occurred in order to develop a plan that is specific to Counties Manukau and incorporates both national and local strategic directions.

Our vision is that 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. Our objectives are responsive to the unique needs of our population and our associated actions will define and shape the future of mental health and addictions service provision and associated improvements during the next 5 years. The plan builds on current strengths, whilst identifying unmet need and describes how we will work collaboratively to ensure we are using our current resources most effectively.

We will improve integration across our system and ensure better coordination and navigation through services. We will intervene early by providing targeted interventions to our mothers, babies, children and youth and will ensure that services are working together. We will provide a timely and effective acute service to those who need it and we will ensure that our services are responsive to the needs of our local communities.

We have a number of actions that we need to complete to help us achieve this and we will monitor and measure our success against the Triple Aim.

Our actions will ensure we achieve the Triple Aim objectives:

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

Whole of system programme directions includes mental health and addictions services and aim to align with national, regional

and local strategic goals. The following high level directions are in the development phase, with further work in progress to identify specific action plans:

- Seamless service integration and experience of care through locally responsive mental health and addictions services across the spectrum of community to hospital based services that recognises that mental health is part of a broader health team
- Targeted intervention focus across service and silo funding for specific life course groups have different service model change opportunities to improve access to mental health services
- Timely acute response focussing on an acute mental health services pathway that incorporates greater delivery in home and community settings, more timely access, and improved service user experience
- Mental Health promotion and information to support and build wellbeing, resilience and recovery in our population – local responses that promote positive mental health and contribute to individual and whaanau resilience

The success of this plan and planned whole of systems strategy depends on all of us working together, across our sector, the wider healthcare system, across a range of other sectors and the wider community. To achieve our objectives we will take a cross-agency intersectoral collaborative approach including working with Justice, Police, Ministry of Social Development and Housing. We will measure our success in a number of ways and we will seek feedback from all stakeholders. The plan sets clear priorities, objectives and actions, ensuring the provision of seamless, targeted and effective mental health and addiction services to people resident in Counties Manukau.

Actions	**Measures**
Rising to the Challenge- Mental Health and Addiction Service Development Plan	
Make better use of resources/value for money	
▪ Review key worker role, care and service coordination roles, across Provider, Primary Care and NGO services to reduce duplication and enable access	▪ Role and functions are reviewed by end of Quarter 2 and plan developed by end of Quarter 4 to identify actions that will improve coordination, reduce duplication and enable access
▪ Implement plan for community options (both acute and non-acute) and extend the continuum of services available for older people requiring mental health and/or addiction services	▪ Community support service in place for Older Adults by end of Quarter 2 and increased access for Older Adults by end of Quarter 4
Improve integration between primary and specialist services	
▪ Implement shared care model to enable primary care management of identified people on clozapine	▪ Through shared care model, increase management of clozapine prescriptions by GPs. Increased prescription of clozapine by GPs by end of Quarter 2 and GPs are prescribing clozapine across 4 localities by end of Quarter 4
▪ Full implementation of the acute component of Framework for Change	▪ Increase service users access to home-based treatment by end of Quarter 2. Reduction in waiting time for admission to Tiaho Mai by end of Quarter 4
Cement and build on gains in resilience and recovery	
▪ COPMIA (Children of Parents with Mental Illness and Addictions) services rolled out and programmes running in each of the locality areas	▪ Implementation and rollout out of COPMIA programmes across Counties Manukau with a minimum of 6 programmes being delivered per annum (by end of Quarter 4)
▪ Continue to reduce seclusion and restraint to reach target of 50 percent reduction in rates with a particular focus on Maaori	▪ Acute Behavioural Guidelines implemented by end of Quarter 2. Seclusion and restraint rates show reduction by end of Quarter 4
Deliver increased access for all age groups	
▪ Develop new model of care for youth services to increase access for young people through schools and community settings	▪ New youth model of care agreed by end of Quarter 2). Implementation plan initiated in line with new model by end of Quarter 4.
▪ Increased access for mothers and babies through provision of local and regional service development	▪ Additional mother and baby acute services being delivered by end of Quarter 2 and local services demonstrate increased access by end of Quarter 4
Government work programmes	
Drivers of Crime	
▪ Improving maternity and early parenting: develop maternal mental health services regionally and increase	▪ Maternal mental health services enhanced and pathways clearly documented to allow regional coordination across the continuum by end of Quarter 2. Increased access to maternal and infant mental health services by

local provision ▪ Develop plan to ensure locally responsive Youth AOD services Welfare Reforms ▪ Increase access to MSD funded supported employment services and improved outcomes for Mental Health and Addictions service users by supporting pathways to these services	end of Quarter 4 ▪ Data analysis and service utilisation review complete by end of Quarter 2. Plan for Youth AOD developed as part of AOD Service Development Plan by end of Quarter 4 ▪ Work with MSD to develop and document clear pathways from pre-employment support to MSD funded supported employment services by end of Quarter 2. Increased rates of employment for Mental Health and Addictions service users by end of Quarter 4
Suicide Prevention ▪ Extend the Mental Health First Aid Programme and ensure sustainability of the programme through management by Ko Awatea (training will be made available to community and health workers as well as whaanau and service users to enable recognition of mental health issues including risks, increased understanding and knowledge of how to get help when needed) ▪ Implement Counties Manukau Suicide Prevention and Postvention plans. These plans include cross agency collaboration and the ongoing work of the interagency suicide action group as well as postvention response ▪ As part of the implementation of the Suicide Prevention Plan, support ED to ensure opportunity for greater periods of observation in the MH short stay and access to cultural interventions ▪ Quality improvement through review of deaths by suicide	▪ Mental Health First Aid Programme being delivered across Counties Manukau with 10 programmes being delivered by end of Quarter 2. Increased understanding of mental health across the community and 240 people attended by end of Quarter 4 ▪ Counties Manukau Suicide Prevention and Postvention plans developed and submitted by end of Quarter 2. Plans implemented by end of Quarter 4 ▪ Audit of Emergency Department guidelines in response to suicide by end of Quarter 2. Update guidelines in line with recommendations from review by end of Quarter 4 ▪ Identification of key system failures to address issues identified through review by end of Quarter 2. Action plan to address identified issues by end of Quarter 4
Mental Health and Addiction service provision ring fence The calculation will include CCP and demographic increases through the development of the Strategic Action Plan and the stocktake, areas of priority for further development have been identified as follows: ▪ Increased housing specialist support to provide locally-based support in each of our locality areas for both Mental Health and Addiction consumers ▪ Increasing employment specialist services to complement MSD contracted services for both Mental Health and Addiction consumers ▪ Enhance delivery and integration of Mental Health and Addiction services to be more responsive to youth ▪ Increased responsiveness to mothers, their babies and whaanau when issues are identified ▪ Increased access to older adults and the provision of community-based services for this group	▪ Implementation of the key recommendations to facilitate increased access to locally based sustainable housing. Implement housing specialist by end of Quarter 2 and increased number of clients living in sustainable housing by end of Quarter 4 ▪ Refer to notes under Welfare Reforms, Drivers of Crime and make better use of resources/value for money
Regional Identify and deliver on at least two actions for each of the following that will lead to: ▪ Continued regional provision of eating disorder inpatient services (Midland and Northern regions to implement the recommendations from the service review to ensure sustainable inpatient and community services) ▪ Improved Mental Health and Addiction Service capacity for people with high and complex needs	▪ A reduction in waiting lists and times for people in prisons requiring assessment in forensic services. Tracking and reporting on the percentage of mentally unwell prisoner admissions to Forensic inpatient services that meet the agreed Prison Model of Care acute and sub-acute targets

- Robust regional contribution to the national network of forensic inpatient services
- Develop and implement actions for a Community Youth Forensic Service Plan with the agreed number of additional FTEs
- In the North Island, the regions Northern, Midland and Central develop and implement the appropriate options to establish a perinatal and maternal mental health service as part of a continuum of care
- Youth Forensic resource commitment: 2.0 FTE
- Perinatal and Infant Maternal Mental Health Acute Services resource commitment: 4.46 FTE
- Maternal Mental Health Support Packages of Care resource commitment: $726,027

- Increased access to community youth forensic services through the development of sustainable youth forensic services and availability of liaison officers in court. Tracking that the 2012/13 rate of availability of Court Liaison officers to Youth Courts is maintained or increased
- Increased access in the North Island to perinatal and maternal mental health services. Establishing and embedding new Acute PIMH services of:
  - 3 acute Inpatient beds at Starship
  - Augmented Maternal MH services
  - Crisis and Residential services, and
  - Northland DHB Acute Support options

2.3.8 Health of older people

Services for Older People 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.

Whole of system programme directions for older people aligns to national, regional and local strategy goals for system integration and expanded capability in community settings. The following high level directions are in the development phase, with further work in progress to identify specific action plans:

- Frail Elderly (>75yrs) – whole of system integration of At Risk Individuals with a focus on proactively identifying older people through locality based service delivery model changes and increased access and capacity of community based services
- Acute Hospital Redesign - to improve acute service/care integration for older people with a view to more collaborative care while in hospital and timely transfers to community based care
- Older Persons Rehabilitation – collaborative and preventative care approaches to improve the service delivery model across Provider and community based services with a view to more timely transfers to community based 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

Actions	**Measures**
Rapid response and discharge management services (wrap around services):	
▪ Continue to develop an acute care for the elderly (ACE) model of care to improve rapid response discharge planning, patient outcomes and bed utilisation efficiency and effectiveness of older people	▪ Achieve a 7 day acute length of stay for ACE patients ▪ Decrease length of stay for ACE to ATandR patients from 25 days to 20 days

▪ Integrate the Franklin Locality Rapid Response Pilot to promote supported discharge and avoidable admissions and:
  ▪ Measure number of referrals to Rapid Response Coordinator
  ▪ Measure referral source and outcome
  ▪ Measure estimated admission / length of stay savings in the pilot period
	▪ Decrease 7-day readmissions rates of over 65 year old patients back to acute hospital services from 6 percent to 4 percent
	▪ Decrease the step down in level of care rate from 14 percent to 8 percent for ACE patients

▪ Participate in ACC Pilot Programme on Non Acute Rehabilitation Redesign	
Home and Community Support Services for Older People	
▪ Provide additional high complex clients with new hours or higher high and complex additional hours	▪ Evidence of continued volume increases based on receipt of Budget 2013 funding

▪ Develop and implement 'At Risk Individuals' programme (ARI)
▪ Provide Home Based Support Service (HBSS) provider training for a "restorative" model of care
▪ Implement quality measures for Home and Community Support Services identified by the DHB HOP Steering Group
▪ CM Health will provide additional HBSS services in 2014/15 in addition to those delivered 2013/14 HBSS budget + (425K)additional 2013/14 volumes (baseline)
	▪ Utilising additional funding for additional HBSS services for older people:
	  ▪ Baseline: current spend, current clients
	  ▪ Measure: additional spend, addition clients
	▪ Additional elderly new clients will be assessed by GPs with HBSS
	▪ 30 GP practices will undertake interRAI training by Quarter 4
	▪ Report on core quality measures

Dementia Care Pathways
We will apply best practice in dementia care into a pathway that provides clarity of access to services across the continuum as set out in the National Dementia Care Pathway Framework (2013) including:
▪ Continue to Implement and evaluate the Dementia Care Pathway (Quarter 1 – Quarter 4)
▪ Provide ongoing engagement with Primary and Community Care promoting the integrated care model and raising awareness for Dementia, both for the development of the pathway phase (completed) and the implementation phase
▪ Provide ongoing awareness programmes for Primary and Community care on the new service model; and key issues for patients and carers (driving, referral process, diagnosis, carer support, legal matters)
▪ Roll out dementia pathway to GP practices and primary care practices
▪ Undertake a 12 month evaluation by Auckland University
▪ Collect data to enable analysis after 12 months as to the impact on:
  ▪ Delay in placement to residential care
  ▪ Avoided admissions
  ▪ Reduced length of stay
	▪ 30 percent of new patients referred with dementia will be seen by the Dementia Care Service
	▪ Report number of referrals by general practice
	▪ Report total case load/by number of clinicians
	▪ Report number of referrals diagnosed with dementia
	▪ Provide 12 month evaluation report (June2014) Further evaluation timeframes will be established based on the outcomes of June 2014 report

Fracture Liaison Service Implement a fracture liaison service –that will identify fragility fracture sufferers ensuring preventative measures are implemented to minimise the risk of future fractures including: ▪ Work with orthogeriatricians, Emergency Care and Primary care (AandMs) to identify and implement falls and fracture preventions interventions ▪ Coordination of future care for fragility fracture sufferers to ensure preventative measures are implemented to minimise the risk of future fractures ▪ Increase identification rate for fragility fractures by establishing a screening process where patients suffering potential fragility fractures are triaged for follow up and assessment by a fracture liaison service ▪ Increase treatment rates for fragility fracture sufferers by better identifying and screening these patients as they pass through secondary care and providing	Targets to be established during implementation of fracture liaison service, recommended measures include: ▪ 50 percent of fracture clinic patients are identified for fragility fractures ▪ 100 percent of all identified fragility fracture patients will be investigated and offered interventions to prevent second fragility fractures ▪ Monitor rate of further fractures for patients having suffered a previous fracture

appropriate treatment through a fracture liaison service	
Comprehensive Clinical Assessment in residential care (interRAI) ▪ Increase the number of Age Related Residential Care (ARRC) facilities trained or engaged in training in the use of interRAI ▪ Support the uptake of interRAI training ▪ Continue to support groups already trained in LTCF interRAI to embed practice ▪ Participate in the development of Franklin Memorial Hospital as a trial InterRAI development site (pilot with BUPA)	▪ 100 percent of all residential aged facilities will be either fully engaged in the training process with national interRAI project or implementing interRAI LTCF during the 2014/15 year ▪ 100 percent of all residential aged facilities will be fully competent in the interRAI LTCF assessment tool by 1 July 2015 ▪ All residential aged care facilities invited to participate in local initiatives such as national interRAI project team update in October 2014 and quarterly ARRC forums ▪ Monitor interRAI LTCF implementation and discuss with residential aged care management if trends identify competent facilities not implementing interRAI LTCF
Health of Older People (HOP) specialists ▪ Continue to provide proactive support to ARRC and primary care by Gerontology Clinical Nurse Specialists (CNS) and Geriatricians ▪ Work with the Geriatric Community speciality team to establish a Nurse Practitioner role in ARRC ▪ Continue to provide regular educational sessions to Registered Nurses in ARRC ▪ Continue ATTRACT training support ▪ Ensure workforce planning in Geriatricians and Clinical Nurse Specialists supports this objective ▪ Review baseline for 'inappropriate' admissions between the community and residential care and provide support and training to ARRC as required ▪ Maintain the number of hours specialist HOP Services consult with health professionals in primary care	▪ Provide 25 hours Geriatrician support per month to 5 primary care practices including clinics and education sessions with GPs ▪ Provide 26 hours Geriatrician support per month to 6 ARRC Providers for medication review case conferences ▪ Maintain the number of proactive advanced nursing practice support programmes provided in ARRC facilities ▪ Maintain attendance rate for nursing education sessions at 500 people per year ▪ Maintain the number of inappropriate presentations to Emergency Care from Residential Care at current level - 20 per month
Elder Abuse Guidelines ▪ Implement the Elder Abuse Guidelines through the development and sign off of an Elder Abuse procedure	▪ Develop and implement Elder Abuse Guidelines (Quarter 1 – Quarter 4) ▪ The Elder Abuse procedure drafted and presented to the Clinical Governance Group by 30 June 2015 for final approval
Spinal Impairment Services ▪ Implement the recommended actions for year one of the New Zealand Spinal Cord Impairment Action Plan	▪ Provide a summary of evidence of work towards New Zealand Spinal Cord Impairment Action Plan
Regional ▪ Continue to participate in Health of Older People regional clinical networks and align service plans and key performance indicator measures accordingly ▪ Support regional approach to Health of Older People Services through standardisation of Needs Assessment Service Coordination and Long Term Care Facilities interRAI processes and guidelines and patient safety	

initiatives (First do no harm) ▪ Continue to support Aged Residential Care and Primary Care Safety Campaigns ▪ Continue with medication reviews in Aged Residential Care and with General Practices in primary care practices ▪ No overall resource impact anticipated	

2.4 National Entity Priorities

Actions	**Measures**
Health Benefits Ltd	
▪ Finance, Procurement and Supply Chain (FPSC)	▪ Implementation of HBL's FPSC initiative, and fully factor in expected budget benefit impacts within the nationally approved budget ($88.0 million) on the basis of achieving the savings in the original business case
▪ Food Services, Linen and Laundry Services	▪ Work in partnership with HBL to progress the Food Services, Linen and Laundry Services business cases, with committed resources to the decision reached in relation to these detailed business cases
▪ National Infrastructure Platform	▪ Work in partnership with HBL to progress the National Infrastructure Platform business cases, committing resources to the decision reached in relation to this Business Case
▪ Human Resources Management Information Systems	▪ Commit resources to the decision reached in relation to progressing the Indicative Case for Change for the Human Resources Management Information Systems initiative to the next stage
▪ Banking and Insurance	▪ Commit 2014/15 levels of funding of $18,000
National Health IT Board	
▪ eMedicines Reconciliation (eMR) with eDischarge – refer section 0 ▪ National Patient Flow – refer section 0 ▪ Self-Care Portals – refer section 0	
Health Quality and Safety Commission	
▪ Surgical site infection programme (SSIP) ▪ Patient experience indicators - refer section 2.5 ▪ Capability and Leadership ▪ E-medicine / E prescribing– refer section 0	▪ Continue development of infection management systems ▪ Meet expectations in accordance with sections 9.3 and 9.4.6 in the Operational Policy Framework
Health Workforce New Zealand	
▪ 100+ diabetes mellitus nurse prescribers either in employment or in training by 1 July 2014 – refer section 0 ▪ Implementation of training requirements for GPEP2 registrars to train with doctors of other vocational scopes – refer section 0 ▪ Sonographer workforce – refer section 2.3.5	

▪ Implementation of the new 70/20/10 funding criteria for post-entry training in medical disciplines, effective from 1 January 2014 – refer section 0	
National Health Committee (NHC)	▪ Actively support NHC through their various programmes of work including staff participation and activity on a number of committees
Health Promotion Agency ▪ Health Targets – refer section 2.1 ▪ Alcohol and Pregnancy ▪ Implementation of alcohol law reform	▪ Support work preventing Foetal Alcohol Spectrum Disorder ▪ Comply with requirements of the Sale and Supply of Alcohol Act 2012
PHARMAC ▪ Medical Devices and Pharmaceutical Management	▪ Support PHARMAC including commencing its interim procurement role for hospital medical devices implementing new national medical device contracts; progress hospital pharmaceuticals management function

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 patients safely 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; 2014/15 regional 'First Do No Harm' and 'The Informed Patient; CM Health 'Aiming for Zero Patient Harm'; CM Health Quality Account

Actions	**Measures**

Continued commitment to:
▪ The development of the 2013/14 Quality Accounts in line with the advice provided by the Health Quality and Safety Commission
▪ The annual release of Serious Adverse Events report
▪ The national 'Open For Better Care Campaign', alignment of local activity, meeting and exceeding thresholds for the Quality Safety Markers
▪ 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:
  ▪ Medication Safety
  ▪ Reducing harm related to Falls and Pressure Injury
  ▪ Central Line Associated Bacteraemia (CLAB)
	▪ Quality and Safety Markers, Health Quality and Safety Commission
	▪ 90 percent of older patients (75+ years) are given a falls risk assessment
	▪ 90 percent compliance with procedures for inserting central line catheters
	▪ 80 percent compliance with good hand hygiene practice
	▪ All three parts of the World Health Organisation surgical safety checklist used in 90 percent of operations
	▪ 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

- Venous Thomboembolism (VTE) prevention
- Infection control and prevention and hand hygiene

- This work will be championed by Clinical Directors (patient safety, infection services, medication safety), and supported by working groups to improve, measure and report progress
- We will reduce peri-operative harm and surgical site infection by building clinical leadership so that a culture of patient safety thrives. We will build clinical leadership so that a culture of patient safety thrives. We will train staff in assessments and interventions that will lead to a reduction in harm to our patients. We will re-design our systems so that the safest thing is the easiest thing to do
- We will develop the capability in innovation and improvement methods for CM Health
- 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 ARRC sectors
- CM Health is supporting primary care providers to develop their patient safety systems and processes by using the collaborative improvement methodology. The Safety in Practice collaborative aims to:
  - Build capability and capacity at a general practice, PHO, and Locality level in quality and patient safety improvement methods and processes to improve and sustain patient safety in a general practice environment
  - Develop systems, processes and tools to identify, monitor and prevent potentially harmful episodes to patients
  - Provide an opportunity to general practices to collaborate across PHOs and Localities to learn from each other's experience
- Leadership by the Patient and Whaanau Centred Care programme (championed by Director of Nursing, and Clinical Director PWCC), together with Ko Awatea
- We have five work streams which will help our patients, family and whaanau be more involved in decision making (at all levels) to improve their patient experience:
  - Family/whaanau as partners in care – partnership is a key to achieving the best possible health outcomes
  - Improved face to face engagement – every staff interaction needs to make a positive contribution towards patient and whaanau centred care
  - Improved patient and whaanau feedback – a broad range of opportunities to provide feedback about their experiences of using CM Health services
  - 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
  - Patients and whaanau are members of key decision making groups – roles on key decision making committees
- Development and implementation of System Level Measures (SLMs) which will enhance evaluation of the quality of our health system and reflect the

patients having appropriate skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine

Five workstream measures to improve patient experience include:

- Roll out of the Patient and Whaanau Centred Care Strategy and operational plans
- Strengthened internal capability to support the roll out
- Experience based co-design of services
- The roll out of quarterly patient feedback electronic survey and portal commencing July 2014 with regular reporting
- The routine use of advance care planning where appropriate in primary care – particularly for chronic care conditions with a focus on renal disease

- Development of contributory measures for SLMs and engage research for SLM comparative analysis
- Reporting on a monthly basis against SLMs to commence in 2014/15
- Complete 4-6 events on prioritised patient pathways by December 2014
- Produce How to Guides for 8 Collaborative teams
- Deliver learning session and support sustainability of changes
- Support collaborative teams to implement changes permanently by June 2015
- Deliver master classes on innovation, patient safety and

performance of services provided across the continuum of care ▪ Rapid Improvement Events	improvement methods for 400 CM Health staff members by June 2015 ▪ Report on measures for improvements to both internal and external stakeholders

2.6 Actions to Support Delivery of Regional Priorities

Actions	Measures
Workforce ▪ Build and align the capability of the workforce to deliver new models of care ▪ Collation of regional workforce metrics to provide understanding of age and skill mix, part time and full time status, ethnicity ▪ Review of professional development and learning and development functions to ensure development offerings are appropriate, aligned with organisational strategy and offer value to the organisation ▪ Promote and increase under graduate training and new graduate employment placements in primary and community care by engaging with PHOs, Residential Care and other community providers ▪ Increase number of new graduate positions in priority service areas, by ring fencing Nurse Entry to Practice (NETP) places ▪ Increase the profile of nurses working in research ▪ Focus on increasing Nursing new graduate numbers across the sector by active management of skill mix ▪ Align HWNZ post graduate nursing funding with increasing future nurse prescribers ▪ Develop interdisciplinary Dedicated Education Unit framework ▪ Identify opportunities to better utilize the non-regulated workforce by piloting Allied Health Support worker development programme ▪ Support the development of potential / emerging leaders through the Ko Awatea leadership academy ▪ Regional DHB development and implementation of E Learning best practice sharing of modules between subject matter experts ▪ Regional stocktake to be undertaken in 2014 ▪ Local and Regional review of mandatory training ▪ Scope feasibility of regional training passport for mandatory training. ▪ Grow the capacity and capability of our Maaori and Pacific workforce ▪ Develop 2 new Health Science Academies for Pacific Students across Auckland to 'go live' in 2015 ▪ Design and develop a 'virtual' science academy for Maaori students ▪ Pathways project manager recruited to work with joint	▪ NRA has sufficient workforce metrics to be able to create a comprehensive regional view of the current DHB workforce ▪ Education committee established by Quarter 2 to monitor course evaluation and utilisation ▪ Increased undergraduate places and new graduate positions in primary and community care by 10 percent ▪ Nursing graduate numbers employed to increase in 2014/5 by 20FTE ▪ Build on Nursing Honours programme inaugural intake from 3 to 6 ▪ Pilot programme commenced by Quarter 1 ▪ Current cohort of leadership academy participants successfully complete the core development programme ▪ Stocktake completed by Quarter 2 ▪ Gaps identified and plan developed for sharing modules across the region developed ▪ Revised mandatory training policy developed and implemented for CM Health by Quarter 1 ▪ Plan for implementing regional training passport developed ▪ Two new academies implemented in schools across Auckland by Quarter 3 ▪ Virtual academy for Maaori students developed and implementation plan in place by Quarter 3 ▪ Tertiary mentoring programme developed and implemented by Quarter 2 ▪ Percentage of Maaori and Pacific people employed by CMDHB increased by 3 percent ▪ Monthly reporting on Maaori and Pacific starters and leavers ▪ Two new nurse prescribers during 2014/15 ▪ 75 percent of staff are vaccinated against Flu ▪ Schedule of Mindfulness programmes in place for 2014/15

venture partners to improve retention rates of Maaori and Pacific students ▪ Implementation of regional tertiary mentoring programme for Pacific students ▪ Ongoing delivery of Kia Ora Hauora programme ▪ Full implementation of 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 including new graduates ▪ Promote advanced practice roles and working at top of scope ▪ Work with primary care partners to increase the numbers of Diabetic Nurse prescribers – refer section 2.3.2 ▪ Tikanga and Pacific cultural training is included as part of mandatory training schedule for all staff ▪ Culturally and Linguistically Diverse (CALD) training courses are available for all staff to attend ▪ Adopt a regional HR approach to developing a healthy and engaged workforce ▪ Increased uptake of Flu vaccinations by staff ▪ Build organisational resilience through the delivery of Mindfulness and resilience workshops ▪ The DHB will work in conjunction with the Regional Director of Training, the Regional Clinical Leads group and the Operational Management group to support the following national priority areas: ▪ The General Practice Education Programme (GPEP) 2 registrars training, career advice, guidance and support to all HWNZ funded trainees and meeting the 70/20/10 funding criteria for post-entry training in medical disciplines are managed by the Regional training hub. Strategies to support these priority areas have been developed and signed off by the Operational Management Group with actions are included in the regional workforce plan. In addition to this a regional project to increase the number of trainee sonographers has commenced with support from the DHB.	
Information Technology CM Health will work with the Northern Region to undertake the following including expected resource requirements over and above business as usual in brackets: ▪ Upgrade Regional RIS/PACs platform ▪ Participate in Regional PAS selection ▪ ePharmacy implementation[10] ($700,000) ▪ eMedicines reconciliation	▪ Improve system uptime and performance 100 percent by Quarter 2 ▪ Regional PAS vendor selected by Quarter 3 ▪ Monitor Regional ePharmacy implementation ▪ Continue to roll out eMedicines for Discharge Summaries

[10] CM Health supports this regional commitment however this commitment will not be progressed at a local level in 2014/15

▪ ePrescribing[10] ($300,000)	
▪ Electronic referral triage rollout ▪ Electronic inter and intra hospital referrals	▪ Electronic referral triaged completed by Quarter 4 ▪ Inter and intra hospital referrals implementation completed by Quarter 4
▪ Maternity Clinical Information System ▪ National Patient Flow (nationally funded)	▪ Maternity Clinical IS competed by Quarter 2 ▪ Phase 1 of National Patient Flow (1 July 2014): Collection of FSA Referral information including outcomes of referrals; Phase 2 (July 2015): collection of other non-admitted and associated referral information including diagnostic tests
▪ Shared Care roll out for At Risk Individuals (ARI)	▪ Improved uptake of Shared Care roll out demonstrated by system usage measure
▪ Clinical pathways pilot ▪ Clinical pathways rollout ($400,000) ▪ teleHealth ($250,000)	▪ Clinical pathway pilot completed by Quarter 2 ▪ Pathway rollout initiated by Quarter 3 ▪ Preferred supplier for teleHealth selected by Quarter 1; implemented into localities by Quarter 2
▪ Project Swift - Transformational Change Programme ($5.0M)	▪ Strategic Relationship Agreement by Quarter 1; Roadmap validation by Quarter 1; business case and statement of work completed by Quarter 2; execution initiation by Quarter 3
▪ Patient Self Care Portal ▪ Objective document management ($300,000) ▪ WiFi infrastructure ($200,000)	▪ Support patient self care in conjunction with primary care partners through the investigation and adoption of patient care portal or texting solutions ▪ Mobility enabled for staff BYOD (Bring Your Own Device) and patient wireless internet access option available by Quarter 3
Major Trauma ▪ Work with the Northern Region Alliance (NRA) to develop and refine regional actions plans and implement regionally agreed priorities ▪ CM Health's major trauma data set will provide the required information to inform and align with the New Zealand Major Trauma Minimum Dataset (NZMTMD) ▪ CM Health has appointed a trauma clinical lead and trauma nurse co-ordinator who will represent CM Health on the Major Trauma clinical network ▪ No overall resource impact anticipated	▪ Report quarterly on NZMTMD from 1 July 2014 as required

2.7 Living Within Our Means

Practising Sustainable Healthcare

The challenge of living within our means cannot be overstated given the forecast revenue increase of 2.8 percent is just over half of what is anticipated to maintain operations. This challenge also comes in a year when we are commissioning our Clinical Services Building at an additional annual cost of $40.0m.

The magnitude of savings required to meet our objective of a $3.0m surplus Annual Plan, necessitates the Executive Leadership Team's (ELT) commitment to achieving all recommendations from the Creating a Sustainable Future Programme Board, a subcommittee of the ELT. This means that we are constantly looking at configuration of services to improve patient service delivery and physical access without negatively impacting on the region.

All proposed sustainability projects are to be presented to the Programme Board with an accompanying business case that will be scrutinised by the Board before being presented for final approval to the full ELT. The purpose of establishing the Programme Board is to ensure one comprehensive organisational view of all sustainability projects, that the business cases are robust without jeopardising commitments to national health targets and service coverage, that there are appropriate

performance indicators set and a tight monitoring and post evaluation process scheduled.

All approved business cases will come within the (renamed) 'Thriving in Difficult Times' to become the Practising Sustainable Healthcare programme, underpinned by the Triple Aim. Practising Sustainable Healthcare is a significant step up from the 'Thriving in Difficult Times' programme with enhanced attention to tight cost control through budget management, productivity enhancement and efficiencies, in addition to initiatives related to procurement opportunities, process realignment, integration and new models of care.

We remain committed to Health Benefits Ltd (HBL) and its intentions across many service improvement and savings opportunities. We are however concerned regarding the ability to achieve the indicative savings within timeframes and available resources.

Linkages

CM Health Whole of System Programmes and related regional work plans; national entity health sector expectations, notably HBL, Health IT Board, Health Quality and Safety Commission, Health Workforce NZ

Actions

Practising Sustainable Healthcare

- Procurement opportunities: Through a new negotiated contract price per unit, costs "avoided", rationalisation of product choice, reduced processing, deliver or stock holding costs
- Clinical stock management: Improved supply chain and inventory control to reduce overstocking, track consumables and improve the efficiency of the process
- Environmental sustainability opportunities: Energy consumption savings, improved waste management
- Revenue maximisation through improved capture of ACC patients
- Improving clinical processes: Electronic ordering of laboratory tests, pathways of care
- Enhancing local delivery of care, closer to the patient's home: Management of menorrhagia in the community, providing chemotherapy services through localities and home based care, providing secondary elective urology services locally

Whole of System Programme innovations

Challenge and redesign service with a whole of system approach to maximise patient and whaanau outcomes within available resources.

Key population health determinants such as obesity, alcohol will be further developed in 2 3-year action plans are currently in development

- Programmes relate to major health service groups with prioritised actions for 2014/15 include:
  - Mental Health and Addictions
  - Health of Older People
  - Youth Health
  - First 2,000 days and Child Services
- Programmes relate to major diagnostic groups with prioritised actions under development include:
  - Metabolic syndrome
  - Cardiovascular
  - Respiratory
  - Digestive/Gastrointestinal
  - Musculoskeletal

Measures

- Reduction in costs of consumables
- Increased capture of revenue for ACC patients
- Contained Cost Per Capital
- System level measures (SLM)

Efficient, safe, timely hospital services through: ▪ Enhanced Recovery After Surgery (ERAS) initiatives ▪ Elective Services Productivity and Workforce Programme (ESPWP) ▪ Delivery Redesign Elective Services programme (DRES) ▪ Clinical Pathway redesigns in General Surgery and Plastic Surgery ▪ Very High Intensive Users (VHIU) ▪ Medical Assessment Unit (MAU) ▪ Safer Medicines Outcomes On Transfer Home (SMOOTH) ▪ Development of a business case to include potential options to meet renal haemodialysis demand e.g. renal haemodialysis System Redesign through Systems Integration Programme	▪ Refer to Improved Access to Elective Surgery section 2.1 ▪ Ownership OS3: Inpatient Length of Stay ▪ Ownership OS8: Reducing Acute Readmissions to Hospital ▪ System Integration: Ensuring delivery of Service Coverage

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

	2012/13 Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Revenue	**17,718**	**14,319**	**16,621**	**17,451**	**18,322**	**19,237**
Personnel Costs	3,991	5,541	5,049	5,301	5,566	5,844
Outsourced Services	1,811	1,881	1,609	1,689	1,773	1,862
Clinical Supplies	1,193	(3,738)	843	885	929	975
Infrastructure and Non-Clinical Supplies	357	457	1,531	1,608	1,688	1,772
Other	10,366	10,178	7,589	7,968	8,366	8,784
Total Costs	**17,718**	**14,319**	**16,621**	**17,451**	**18,322**	**19,237**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**	**-**

3.2.2 Early detection and management

	2012/13 Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Revenue	**215,678**	**201,339**	**211,828**	**222,419**	**233,540**	**245,217**
Personnel Costs	-	-	-	-	-	-
Outsourced Services	-	-	-	-	-	-
Clinical Supplies	-	-	-	-	-	-
Infrastructure and Non-Clinical Supplies	-	-	-	-	-	-
Other	215,678	201,339	211,828	222,419	233,540	245,217
Total Costs	**215,678**	**201,339**	**211,828**	**222,419**	**233,540**	**245,217**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**	**-**

3.2.3 Intensive assessment and treatment

	2012/13 Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Revenue	**1,086,346**	**1,125,056**	**1,145,250**	**1,159,329**	**1,181,982**	**1,202,810**
Personnel Costs	507,422	522,200	542,679	551,520	565,788	580,023
Outsourced Services	60,695	63,579	54,608	57,017	58,466	59,909
Clinical Supplies	107,872	110,382	106,977	106,181	108,930	111,675
Infrastructure and Non-Clinical Supplies	95,602	108,057	117,815	118,875	121,938	124,992
Other	311,743	317,807	320,164	325,724	326,845	326,198
Total Costs	**1,083,334**	**1,122,025**	**1,142,243**	**1,159,317**	**1,181,967**	**1,202,797**
Surplus (Deficit)	**3,012**	**3,031**	**3,007**	**12**	**15**	**13**

3.2.4 Rehabilitation and support

	2012/13 Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Revenue	**108,355**	**100,611**	**118,665**	**124,598**	**130,828**	**137,369**
Personnel Costs						
Outsourced Services						
Clinical Supplies						
Infrastructure and Non-Clinical Supplies						
Other	108,355	100,611	118,665	124,598	130,828	137,369
Total Costs	**108,355**	**100,611**	**118,665**	**124,598**	**130,828**	**137,369**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**	**-**

3.2.5 Total

	2012/13 Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Revenue	**1,428,097**	**1,441,325**	**1,492,364**	**1,523,797**	**1,564,672**	**1,604,633**
Personnel Costs	511,413	527,741	547,728	556,821	571,354	585,867
Outsourced Services	62,506	65,460	56,217	58,706	60,239	61,771
Clinical Supplies	109,065	106,644	107,820	107,066	109,859	112,650
Infrastructure and Non-Clinical Supplies	95,959	108,514	119,346	120,483	123,626	126,764
Other	646,142	629,935	658,246	680,709	699,579	717,568
Total Costs	**1,425,085**	**1,438,294**	**1,489,357**	**1,523,785**	**1,564,657**	**1,604,620**
Surplus (Deficit)	**3,012**	**3,031**	**3,007**	**12**	**15**	**13**

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
0	**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		2014/15 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		96%	Quarter 2 2013/14	95%	June 2015	NHT MHP Efv
Proportion of enrolled patients who are smoke and are seen in General Practice are offered brief advice and support to quit		69%		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		96.7%[11]		90%		
Breastfeeding We have lactation consultants at our Baby Friendly Hospital Initiative sites and work with Well Child providers to encourage and support breastfeeding.						
Percentage of infants exclusively breastfeed at 6 weeks	Total	50%	Quarter 2 2013/14	74%	June 2015	MHP
	Maaori	45%				
	Pacific	50%				
Percentage of infants exclusively breastfeed at 3 months	Total	33%		63%		
	Maaori	27%				
	Pacific	30%				

[11] The nationally calculated result for CM Health is 96.7 percent but the result is definitive as only information on 80 percent of pregnancies nationally were captured

Percentage of infants exclusively breastfeed at 6 months	Total	12%		27%	June 2015	MHP
	Maaori	8%				
	Pacific	10%				
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)[12]	Partner Abuse	96	May 2013	=> 140 combined score	June 2015	S
	Child Abuse and Neglect	98				
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	82%	Quarter 3 2013/14	95%	June 2015	NHT NRHP MHP SLM T
	Pacific	93%				
	Total	93%				
Proportion of older people (65+) who have had their flu vaccinations		69%	Dec 2013	75%	Dec 2014	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	68.5%	Dec 2013	70%	June 2015	MHP Efv
	Pacific	72.2%				
	Total	68.9%				
Cervical Screening ▪ We fund primary care providers to deliver free cervical screening for women aged 20 – 70 years						
Proportion of women aged 20 - 70 years who have had a cervical smear in the last three years	Maaori	59%	Dec 2013	80%	June 2015	MHP Efv
	Pacific	64%				
	Total	70%				
Well Child/ Tamariki Ora and Children's Services ▪ We fund Well Child/ Tamariki Ora providers to deliver services to support new mothers and their infants. This includes Well Child Checks, home visits and Before School Checks (B4SC) ▪ The B4 School Check includes hearing and vision, oral health, weight and height checks. It is the final core Well Child/ Tamariki Ora check which ensures that any health problems are identified early and children are ready for learning and to reach their full potential						
Proportion of the eligible population who have had their B4 School Checks		100% (7,023 of which 3,061 were High Deprivation, Quarter 5)	June 2013	90% (8,058 or which 3,612 will be High Deprivation, Quarter 5)	June 2015	Efv

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

Proportion of newborns born at CM Health maternity facilities screened before discharge from hospital	81%	2013	90%	June 2015	T
Proportion of newborns born at CM Health maternity facilities screened by 12 weeks	93%	2013	95%	June 2015	T
Hospitalisation rates for acute rheumatic fever per 100,000	13.2	Average of 2009/10 to 2011/12	7.9	June 2015	MHP Efv
Statutory and Regulatory Services					
The Auckland Regional Public Health Service (ARPHS) is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau DHB and Waitemata DHB under a contract with the Ministry of Health. The service provides statutory and regulatory public health services including responding to outbreaks, environmental hazards and other emergencies. They also deliver health promotion services and advise and/or advocate for healthy public policy The following baselines and targets are regional and relate to all 3 metro-Auckland DHBs					
Enforcement of alcohol legislation Number of license premises (on, off club and special) risk assessed	n/a[13]	FY 2013/14	4000 est.	FY 2014/15	
Enforcement of the Smokefree Environments Act 1990 Number of retailer compliance checks conducted	457	FY 2013/14	300	FY 2014/15	
Number of retailers visited where Controlled Purchase Operations (CPOs) were conducted	498	FY 2013/14	300	FY 2014/15	

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		2014/15 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	78.4%	Quarter 2 2013/14	90%	June 2015	NHT Efv
	Pacific	82.6%				
	Total	83.3%				

[13] Due to legislative changes (implementation of the Sale and Supply of Alcohol Act 2012), no accurate baseline in available

Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c of equal to or less than 64 mmol/mol)	Maaori	59%	Quarter 2 2013/14	66%	June 2015	IDP Efv
	Pacific	53%				
	Total	62%				
Number of additional patients enrolled in Self Management (SM) programmes		500	June 2013	700	June 2015	Efv
Percentage of all At Risk Individuals (ARI)[14] who have a: ▪ Care Plan ▪ Electronic Summary Record ▪ Self-Management Assessment ▪ Named Care Coordinator		N/A[15]	-	80%	June 2015	Efv
Oral Health Services						
▪ We contract the Auckland Regional Dental Service (ARDS) to deliver free oral health services for children aged 0 to 12 years old at our community and DHB based clinics and mobile dental facilities ▪ We contract with private dentists and ARDS to deliver free oral health services for our adolescents from school year 9 up to and including 17 years of age ▪ We deliver targeted preschool oral health promotion and brushing programmes with our partners in the kohanga reo, language nest and early childhood education sector						
Proportion of children under 5 years enrolled in DHB-funded oral health services		77%	Dec 2013	85% 90%	Dec 2014 Dec 2015	IDP Efv
Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)		8.60%		7% 7%	Dec 2014 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% 100%	Dec 2014 Dec 2015	IDP Efc
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services		80%		85% 85%	Dec 2014 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	60%	Jan 2014	90%	June 2015	NRHP IDP T
	MRI	64%		80%		
Proportion of patients accepted as priority 1 for diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)		64.6%	Feb 2014	75%	June 2015	
Proportion of patients accepted as priority 2 for diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)		22.4%		60%	June 2015	
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date		100%		60%	June 2015	

[14] 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

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		2014/15 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 long term clients with a transition discharge plan	Child and Youth	Maaori	N/A[15]		95%	June 2015	IDP Efv
		Total	N/A[15]				
	Adult (20+)	Maaori	N/A[15]				
		Total	N/A[15]				
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 (Provider Arm)	3 weeks	N/A[15]		80%	June 2015	IDP T
		8 weeks	N/A[15]		95%		
	Addictions (Provider Arm and NGO)	3 weeks	N/A[15]		80%		
		8 weeks	N/A[15]		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)			0.2%	Dec 2013	0%	Dec 2014	T SLM
ESPI 5: Proportion of patients given a commitment to treatment but not treated within four months			0.1%		0%		
Number of Elective Surgical Discharges			8822	Quarter 2 2013/14	15,635	June 2014	NHT
					16200	June 2015	
Elective Services Standardised Intervention Rates (SIRs) per 10,000 of population[16]		Major joints	22.31	YTD Dec 2013	21	June 2014	IDP Eq
		Cardiac	5.95		6.5		
		Cataracts	42.2		27		

[15] New measure

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

		Baseline		2014/15 Forecast Performance		Reference
Outpatient Did Not Attend (DNA) rates	Maaori	14%	Feb 2014	<10%	June 2015	P
	Pacific	12%		<10%		Efc
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[17]	Total	7.7%	Quarter 2 2013/14	<= 7.4% standardised	June 2015	IDP SLM Efv
	75+	11.37%		<= 10.1% standardised		
Acute Inpatient Average Length of Stay[18]		4.18 days	Quarter 2 2013/14	3.88 days	June 2015	IDP Efv
Emergency Department Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours		96%	Quarter 2 2013/14	95%	June 2015	NHT SLM T
Cancer Services We work in collaboration with the Northern Region Cancer Network to improve cancer wait times and access to diagnosis and treatment to ensure cancer patients and their families have access to good information about support services available						
Proportion of medical oncology and haematology patients needing radiation therapy or chemotherapy treatment (and are ready to start treatment) who receive this within four weeks from decision to treat	Radio-therapy Maaori	100%	Quarter 2 2013/14	100%	June 2015	NHT NRHP T
	Radio-therapy Pacific					
	Radio-therapy Total					
	Chemo-therapy Maaori	100%		100%		
	Chemo-therapy Pacific					
	Chemo-therapy Total					
Proportion of patients referred urgently with high suspicion of cancer to first cancer treatment (62 days)		58.8%	YTD Dec 2013	85%	June 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 6 weeks for cardiology assessment and stress test		80%	Quarter 2 2013/14	80%	June 2015	NRHP T
Proportion of outpatient coronary angiograms with a waiting time of < 3 months		97%	Quarter 2 2013/14	90%	June 2015	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		68%	Quarter 2 2013/14	70%	June 2015	NRHP T

[17] 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

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

Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions (PCI) who receive this within 120 minutes	92%	Quarter 2 2013/14	80%	June 2015	NRHP T
Quality and Patient Safety					
We aim to provide services that are of a high quality and are safe so that patients will have a better patient experience when they use our services. Our services are part of a health system wide quality and safety programme which spans national, regional and local health quality and patient safety priorities.					
Average rate of Central Line Associated Bacteraemia (CLAB) in the Intensive Care Unit per 1,000 line days	0[19]	CY 2013	0	June 2015	NRHP S
Rate of falls causing major harm per 1000 bed days	0.08[20]	CY 2013	0.07	June 2015	NRHP S
Proportion of pressure injuries hospital wide per 100 patients	3%[19]	CY 2013	<3.5%[21]	June 2015	S
Hand hygiene compliance (based on Gold Audit)	71.9%	Mar 2014	80%	June 2015	S

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		2014/15 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.					
Proportion of CM Health NASC staff who have participated in interRAI training and can deliver appropriate assessments in the community and allocate support using CM Health contracted HBSS	100%	Dec 2013	100%	June 2015	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.					
Community Services Provision of AT and R services for the Franklin locality through Pukekohe hospital	56%	Dec 2013	100%	June 2015	P
Hospital Services Average length of stay in AT and R (Pukekohe hospital beds)	17.3 days	Dec 2013	<15 days	June 2015	Efv
Average length of stay for patients included in acute geriatric pilot at Middlemore Hospital	Average of 7 days	Dec 2013	4.5 days	June 2014	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					
Proportion of residential facilities in the DHB area using or training their nurses to use the interRAI Long Term Care Facility assessment tool	86%	Dec 2013	100%	June 2015	Efv

[19] Baseline is a median figure for the calendar year
[20] Baseline is an average figure for the calendar year
[21] Monthly average of less than 3.5 percent prevalence of inpatients developing pressure injuries at CM Health

Number of potentially avoidable EC presentations from ARRC per month[22]	Average of 16 per month	Dec 2013	20 per month	June 2015	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 12 months	63.8%	2013	95%	June 2015	T

[22] 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

Counties Manukau Health (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 late 2013 National Capital Committee indicative business cases approval to proceed to detailed business case for acute mental health services; shortly to be followed by specialised rehabilitation.

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 $3.0m surplus financial position in 2014/15. 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 two 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[23] for population outcomes, 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 2014/15 priorities are further outlined in the Executive Summary.

A major cost structure change for primary care scheduled for implementation 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 will 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 will be 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.

[23] 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 has budgeted for a $3.0m surplus financial position for 2014/15 and break even for the three outer years.

4.2.1 Summary by funding arm

Net Result	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Provider	(5,836)	(4,929)	(3,990)	(3,316)	(3,384)	(3,447)
Governance	(1,539)	(860)	1	2,475	2,541	2,606
Funder	10,387	8,820	6,996	853	858	854
Eliminations	-	-	-	-	-	-
Operating Surplus	3,012	3,031	3,007	12	15	13
Other Comprehensive Income	19,645	-	-	-	-	-
Surplus (deficit)	22,657	3,031	3,007	12	15	13

4.2.2 Statement of comprehensive income

Net Result	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Revenue						
Crown	1,389,965	1,404,025	1,455,667	1,492,456	1,532,498	1,571,619
Other	38,132	37,300	36,697	31,341	32,174	33,014
Total Revenue	**1,428,097**	**1,441,325**	**1,492,364**	**1,523,797**	**1,564,672**	**1,604,633**
Expenses						
Personnel	511,413	527,741	547,728	556,821	571,354	585,867
Outsourced	62,506	65,460	56,217	58,706	60,239	61,771
Clinical Support	101,481	96,720	97,040	96,858	99,385	101,910
Infrastructure	58,945	68,484	67,470	65,739	67,455	69,168
Personal Health	477,135	460,051	482,995	491,965	505,778	518,660
Mental Health	60,937	58,041	58,076	68,958	70,889	72,874
Disability Support	104,137	108,925	114,331	117,382	120,445	123,504
Public Health	1,776	1,293	1,378	1,414	1,451	1,488
Maaori	2,157	1,625	1,466	990	1,016	1,042
Operating Costs	**1,380,487**	**1,388,340**	**1,426,701**	**1,458,833**	**1,498,012**	**1,536,284**
Operating surplus	**47,610**	**52,985**	**65,663**	**64,964**	**66,660**	**68,349**
Depreciation	23,594	30,775	34,156	35,693	36,622	37,551
Capital Charge	12,738	12,869	13,140	13,485	13,837	14,188
Interest	8,266	6,310	15,360	15,774	16,186	16,597
Operating Surplus	**3,012**	**3,031**	**3,007**	**12**	**15**	**13**
Other Comprehensive Income	19,645	-	-	-	-	-
Surplus (Deficit)	**22,657**	**3,031**	**3,007**	**12**	**15**	**13**

4.2.3 Funder revenue

Net Result	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Crown	1,342,421	1,355,232	1,402,261	1,439,784	1,478,449	1,516,195
Other	2,043	5,942	5,185	3,106	3,187	3,268
Total	**1,344,464**	**1,361,174**	**1,407,446**	**1,442,890**	**1,481,636**	**1,519,463**
Personal Health	1,049,153	1,055,165	1,097,148	1,119,663	1,149,701	1,178,716
Mental Health	139,203	137,953	139,991	152,449	156,718	161,106
Disability Support	128,973	141,539	148,057	152,008	155,974	159,935
Public Health	1,776	1,293	1,378	1,414	1,451	1,488
Maaori	2,157	1,625	1,466	990	1,016	1,042
Governance	12,815	14,779	12,410	15,513	15,918	16,322
Total Expenditure	**1,334,077**	**1,352,354**	**1,400,450**	**1,442,037**	**1,480,778**	**1,518,609**
Net Surplus	**10,387**	**8,820**	**6,996**	**853**	**858**	**854**

4.2.4 Eliminations revenue

	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Crown	(687,935)	(722,419)	(742,204)	(761,328)	(781,199)	(801,041)
Other						
Total	**(687,935)**	**(722,419)**	**(742,204)**	**(761,328)**	**(781,199)**	**(801,041)**
Personal Health	(572,018)	(595,114)	(614,153)	(627,698)	(643,923)	(660,056)
Mental Health	(78,266)	(79,912)	(81,915)	(83,491)	(85,829)	(88,232)
Disability Support	(24,836)	(32,614)	(33,726)	(34,626)	(35,529)	(36,431)
Public Health	-	-	-	-	-	-
Maaori	-	-	-	-	-	-
Governance	(12,815)	(14,779)	(12,410)	(15,513)	(15,918)	(16,322)
Total Expenditure	**(687,935)**	**(722,419)**	**(742,204)**	**(761,328)**	**(781,199)**	**(801,041)**
Net Surplus	**-**	**-**	**-**	**-**	**-**	**-**

4.2.5 Provider revenue

	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Crown	722,664	756,433	783,200	798,400	819,241	840,052
Other	35,792	31,252	31,512	28,235	28,987	29,746
Total	**758,456**	**787,685**	**814,712**	**826,635**	**848,228**	**869,798**
Personnel	503,484	517,732	539,637	548,033	562,336	576,619
Outsourced	61,298	64,627	55,550	58,022	59,537	61,051
Clinical Support	101,481	96,720	96,920	96,736	99,260	101,782
Infrastructure	53,431	63,581	63,939	62,208	63,834	65,457
Operating Costs	**719,694**	**742,660**	**756,046**	**764,999**	**784,967**	**804,909**
Operating surplus	**38,762**	**45,025**	**58,666**	**61,636**	**63,261**	**64,889**
Depreciation	23,594	30,775	34,156	35,693	36,622	37,551
Capital Charge	12,738	12,869	13,140	13,485	13,837	14,188
Interest	8,266	6,310	15,360	15,774	16,186	16,597
Net Surplus	**(5,836)**	**(4,929)**	**(3,990)**	**(3,316)**	**(3,384)**	**(3,447)**
Other Comprehensive Income	19,645	-	-	-	-	-
Total Comprehensive Income	**13,809**	**(4,929)**	**(3,990)**	**(3,316)**	**(3,384)**	**(3,447)**

4.2.6 Governance revenue

	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Crown	12,815	14,779	12,410	15,600	16,007	16,413
Other	297	106	-	-	-	-
Total	**13,112**	**14,885**	**12,410**	**15,600**	**16,007**	**16,413**
Personnel	7,929	10,009	8,091	8,788	9,018	9,248
Outsourced	1,208	833	667	684	702	720
Clinical Support	-	-	120	122	125	128
Infrastructure	5,514	4,903	3,531	3,531	3,621	3,711
Total Expenditure	**14,651**	**15,745**	**12,409**	**13,125**	**13,466**	**13,807**
Net Surplus	**(1,539)**	**(860)**	**1**	**2,475**	**2,541**	**2,606**

4.2.7 Total revenue

	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Crown	1,389,965	1,404,025	1,455,667	1,492,456	1,532,498	1,571,619
Other	38,132	37,300	36,697	31,341	32,174	33,014
Total Revenue	**1,428,097**	**1,441,325**	**1,492,364**	**1,523,797**	**1,564,672**	**1,604,633**
Expenses						
Personnel	511,413	527,741	547,728	556,821	571,354	585,867
Outsourced	62,506	65,460	56,217	58,706	60,239	61,771
Clinical Support	101,481	96,720	97,040	96,858	99,385	101,910
Infrastructure	58,945	68,484	67,470	65,739	67,455	69,168
Personal Health	477,135	460,051	482,995	491,965	505,778	518,660
Mental Health	60,937	58,041	58,076	68,958	70,889	72,874
Disability Support	104,137	108,925	114,331	117,382	120,445	123,504
Public Health	1,776	1,293	1,378	1,414	1,451	1,488
Maaori	2,157	1,625	1,466	990	1,016	1,042
Operating Costs	**1,380,487**	**1,388,340**	**1,426,701**	**1,458,833**	**1,498,012**	**1,536,284**
Operating surplus	**47,610**	**52,985**	**65,663**	**64,964**	**66,660**	**68,349**
Depreciation	23,594	30,775	34,156	35,693	36,622	37,551
Capital Charge	12,738	12,869	13,140	13,485	13,837	14,188
Interest	8,266	6,310	15,360	15,774	16,186	16,597
Operating Surplus	**3,012**	**3,031**	**3,007**	**12**	**15**	**13**
Other Comprehensive Income	19,645	-	-	-	-	-
Surplus (Deficit)	**22,657**	**3,031**	**3,007**	**12**	**15**	**13**

4.2.8 Balance sheet current assets

	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Cash and Bank	1,028	870	870	870	870	870
Debtors	35,383	41,550	42,500	42,500	42,500	42,500
Inventory	946	3,990	4,490	4,490	4,490	4,490
Assets Held for Sale		12,503				
Current Assets total	**37,357**	**58,913**	**47,860**	**47,860**	**47,860**	**47,860**
Non-Current Assets	609,704	625,093	621,350	627,501	620,904	614,083
Total Assets	**647,061**	**684,006**	**669,210**	**675,361**	**668,764**	**661,943**
Current Liabilities						
Creditors	88,994	71,331	41,643	47,181	39,968	32,533
Loans	5,000	40,000	-	40,000	30,000	25,000
Employee Provisions	114,156	107,263	118,543	118,543	118,543	118,543
Total Current Liabilities	**208,150**	**218,594**	**160,186**	**205,724**	**188,511**	**176,076**
Working capital	**(170,793)**	**(159,681)**	**(112,326)**	**(157,864)**	**(140,651)**	**(128,216)**
Net Funds Employed	**438,911**	**465,412**	**509,024**	**469,637**	**480,253**	**485,867**
Non-Current Liabilities						
Employee Provision	17,713	16,600	17,620	18,640	19,660	20,680
Term Loans	232,600	257,600	297,600	257,600	267,600	272,600
Restricted funds	854	856	860	860	860	860
Total Non-Current Liabilities	**251,167**	**275,056**	**316,080**	**277,100**	**288,120**	**294,140**
Crown Equity	**187,744**	**190,356**	**192,944**	**192,537**	**192,133**	**191,727**
Net Funds Employed	**438,911**	**465,412**	**509,024**	**469,637**	**480,253**	**485,867**

4.2.9 Movement of equity

	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Total Equity at beginning of period	**165,506**	**187,744**	**190,356**	**192,944**	**192,537**	**192,133**
Surplus / (Loss) for period	3,012	3,031	3,007	12	15	13
Crown Equity injection						
Crown Equity withdrawal	(419)	(419)	(419)	(419)	(419)	(419)
Revaluation Reserve	19,645	-	-	-	-	-
Total Equity at beginning of period	**187,744**	**190,356**	**192,944**	**192,537**	**192,133**	**191,727**

4.2.10 Cash flows from operating activities

	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Operating Activities						
Crown Revenue	1,352,932	1,398,182	1,451,863	1,492,576	1,532,618	1,571,739
Other	36,733	35,567	29,316	30,109	30,910	31,718
Interest received	1,399	1,733	1,200	1,232	1,264	1,296
Suppliers	825,322	880,013	876,793	912,394	923,266	946,807
Employees	501,794	535,710	535,520	555,921	570,454	584,967
Interest paid	12,675	6,310	15,364	15,774	16,186	16,597
Capital charge	12,571	11,662	12,188	13,485	13,837	14,188
GST (Net)	(5,110)	-	-	-	-	-
Net cash from Operations	**43,812**	**1,787**	**42,514**	**26,343**	**41,049**	**42,194**
Investing activities						
Total Fixed Assets	(91,515)	(53,645)	(10,156)	(24,247)	(24,925)	(25,623)
Investments and Restricted and Trust Funds	(4,365)	(4,859)	(5,265)	(5,000)	(5,000)	(5,000)
Net cash from Investing	**(95,880)**	**(58,504)**	**(15,421)**	**(29,247)**	**(29,925)**	**(30,623)**
Financing						
Crown Debt	-	-	-	-	-	-
Equity - Capital	40,000	60,000	-	-	-	-
Net cash from Financing	**(419)**	**(419)**	**(419)**	**(419)**	**(419)**	**(419)**
Net increase / (decrease)	39,581	59,581	(419)	(419)	(419)	(419)
Opening cash	(12,487)	2,864	26,674	(3,323)	10,705	11,152
Closing cash	**6,165**	**(6,322)**	**(3,458)**	**23,216**	**19,893**	**30,598**

4.2.11 Capital expenditure

	2012/13 Audited Actual $000	2013/14 Forecast $000	2014/15 Plan $000	2015/16 Forecast $000	2016/17 Forecast $000	2017/18 Forecast $000
Baseline Capital	33,860	22,940	8,076	24,247	24,925	25,623
Strategic Capital	57,655	30,705	2,080	-	-	-
Total	**91,515**	**53,645**	**10,156**	**24,247**	**24,925**	**25,623**

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 2014/15 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 $3.0m surplus financial position where cost growth is higher than forecast revenue, CM Health will cap the level of allowable and fundable growth within provider and funder arms. The 2014/15 surplus is only achieved by a one-off non-operational gain.

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 'Thriving in Difficult Times' 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 relatively high 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 have 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 reduce 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 2014/15 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 and Health Benefits Ltd (HBL); 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 through HBL. Despite remaining committed to HBL and its intentions across a number of areas for savings opportunities, we are concerned at the ability to achieve the indicative savings within timeframes and resources.

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 funder contracts

There is a forecast 2013/14 'surplus' within the ring fenced Mental Health spend which is essentially a timing issue rather than a permanent under-spend. These benefits offset the demand driven cost increases occurring within the Funder Arm, particularly Health of Older People, and Pharmaceutical costs.

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.

In 2013/14, CM Health integrated its Whaanau Ora contracts with Maaori and Pacific providers through funding devolvement to the National Hauora Coalition and Alliance Health Plus.

4.4.7 IS infrastructure

Prioritised Information System (IS) infrastructure investment has been agreed regionally (refer section 0) 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 0 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

Commissioning of the new Clinical Services Block (CSB) Stage 1 project in 2013/14 has fully utilised all existing available cash funding, 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

The CSB Stage 1 [$208m] was completed in 2013/14, with approved service migrations staggered over a 7 month period to enable business continuity. Despite planned efficiencies as a result of more effective department floor layouts, building flows and models of care, this investment materially impacts on our operating financial position, notably due to service functions such as gas, power and non-clinical support services.

There are no major capital investment projects currently approved for the 2014/15 year.

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 2013/14 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 detailed business cases for acute mental health and specialised rehabilitation services in addition to related local and regional IS and other capital planning processes.

Figure 6: Major capital investment projects – future

Project	Budgeted Approval	Project Finish Date	Indicative Value	Status
Acute Mental Health	2014/15	2017/18	$55.0m	Detailed business case development
Specialist Rehabilitation	2014/15	2017/18	$65.0m	Indicative business case for approval and detailed business case development
Southern Car Park (Middlemore site PPP)	2017/18	2019/20	$19.0m	Business case development
Laboratory	2014/15	2014/15	$10.5m	Local/Regional Capital Planning Intentions ($10m/year for 10 years)
Women's Health (Middlemore site)	2020/21	2021/22	$55.0m	Within the Strategic Investment Programme Tranches. No action planned for 2014/15
Project SWIFT (strategic partnering and risk sharing arrangement)	2014/15	-	$75.0m[24]	Indicative business case with total value range estimated $40.0m-$100.0m over a 5-10 year timeframe
Outpatient Capacity	2014/15	-	Not scoped at this stage	Scoping requirement currently investigating new models of care, IT enablers, and capacity options in primary care and community
Operating Theatre Capacity	Capacity step required 2014/15	-	Not scoped at this stage	Theatre utilisation rates and other areas being investigated prior to scoping

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 one 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).

[24] This value is indicative only and subject to business case validation

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 2010 on an "Optimised Depreciated Replacement Costs" basis.

There is currently a single proposed asset sale of part of our Botany site within the time period of this Annual Plan. 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 2014/15 (refer 5.1.8 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

Counties Manukau Health (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 were formed in the last year to reflect this development:

- District Alliance of Primary Health Organisation (PHO) and CM Health Chief Executives
- 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 CM Health 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.

In the last year, CM Health has worked on the development of 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 is currently being 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.

5.1.3 Financial management

The Minister of Health and National Health Board has indicated constrained funding increases for 2013/14 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 2.8 percent that is just over 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 2014/15 plan will be targeted to a $3.0m surplus financial result and a commitment to achieve our national health targets. This surplus is only achieved by a one-off non-operational gain.

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 both healthAlliance and Health Benefits Limited (HBL) to leverage aggregated savings and efficiency benefits and local system level accountability for financial and non-financial performance. We remain committed to HBL and its intentions across many service improvement and savings opportunities. We are however increasingly 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 Audit, Risk and Finance Committee quarterly to ensure effective escalation, appropriate and timely attention to enable effective risk management.

5.1.5 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 0 for the CM Health approach to implementation
		CM Health
		▪ First, Do No Harm (combines quality and safety initiatives)
		Regional
		▪ First, Do No Harm
		▪ National (Health Quality and 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
		▪ Target CLAB Zero (locally lead for NZ)

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 such as the Beyond 20,000 Days campaign, localities development ▪ Capability building sessions in creativity and innovation- Innovation Intensives ▪ CM Health wide programme on working with patients and whaanau to co-design services ▪ Innovation Hub 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 with development and methodology for (e.g.: coaching support, master classes, change workshops) ▪ Early Learning 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 (HBL) ▪ 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 ▪ Locality information systems and Project SWIFT Regional ▪ Refer section 0 ▪ National (Health IT Board and Others) ▪ eMedicines programme ▪ National Solutions ▪ Regional (DHB) Information Platforms ▪ Integrated (Shared) Care Initiatives ▪ Maternity Shared Care

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 (Health Benefits Limited) ▪ Procurement and Supply Chain

5.1.6 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 Counties Manukau 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, and Galbraith Building vacated to the new Clinical Services Block, 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

5.1.7 Asset management

The work of the IPSG will inform the Asset Management Plan. It will also provide advice and input to the annual review of the CM Health Asset Management Plan

In addition to this, in order to improve the Asset Management Planning process at CM Health, we have advanced a business cases for an Enterprise Asset Management system (EAM), which was approved by the ELT early February 2014. This is now to be a Regional solution and being actioned by CM Health in collaboration with the other Northern Region DHBs through the Northern Region Capital Committee.

5.1.8 Whole of system redesign through enabling technologies

Clinicians from across the CM Health system identified information and communication technology (ICT) and related integration as the number one priority for investment over the next five years to enable system redesign and new models of care. Over the last three years we have been increasing the pace of change through piloting new ways of working to bring care closer to where people live. These integration pilots have identified a number of key ICT requirements to provide more timely access to information and the ability to leverage new technology to support multidisciplinary teams across locations to provide proactive coordinated services, and to support the patient to be an active member of their own care team.

Central to our strategy for ambitious health system redesign is development of an ICT-enabled change programme (known as 'Project SWIFT') to successfully support:

- Improved patient care through easier and more comprehensive shared information for clinicians across all care settings – home, community, primary care and hospital
- Implement significant model change to achieve seamless integration of community and hospital services
- Data analytics, workforce development and mobility to target services where they are the most effectively provided
- Streamlining and reducing costs of service delivery so that we can sustainably support and improve the health of our community
- Patients and whaanau to care for themselves or be supported at home within communities

We are designing this programme in conjunction with the National Health IT Board to progress local, regional and national ICT strategic goals. We anticipate that Project SWIFT will act as a catalyst for local change and greatly inform regional and national ICT directions. This must be within an overriding financial and organisational structure that recognises the ongoing CM Health severe fiscal constraints and structures in a cash neutral and profit neutral-to-positive manner in a planned partnership with a skilled third party integrator over the longer term.

5.1.9 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 facts for all clinicians involved in a patient's care.

In 2014/15 the focus will continue to be on infrastructure and applications upgrades to ensure these remain on supportable platforms and provide resilience and performance to address the continuity risk for IS services in the region. 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 and allow new developments to be implemented as per user demand and investments made by vendors and other parties
- Continue to support regional consolidation of systems as part of system upgrade planning
- Refresh service catalogue and service level agreements with healthAlliance IS to clarify service provision, roles and responsibilities of parties and performance measures.
- Improve resilience of (existing) IS systems to improve system availability, access, data integrity and security
- Communicate and collaborate regionally to reduce coordinate demand on IS services

Consistent with the direction set by the National Health IT Board, commit to delivering the priority foundation systems over a 3-year time period of the plan. Subject to funding 2014/2015 will look to deliver:

Figure 9: Regional investment priorities

Importance	Investment
Critical	▪ RIS/ PACs system resilience and performance investment ▪ Participate in Regional PAS selection

Important	▪ ePharmacy[25] (NZULM/NZF) ▪ ePrescribing[25] (to follow ePharmacy and may be 2015/16) ▪ 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

5.2 Workforce

5.2.1 Strengthening our workforce

As at 1 Jan 2014, CM Health employed a headcount of 6,829 people, who worked an equivalent of 5,752 FTEs. Nursing is by far the largest clinical workforce comprising 45 percent of staff, medical 14 percent, allied health 19 percent, and care and support workers 7 percent. Over a third of CM Health's workforce are on casual and part time contracts.

In the last five years, from 2009 to 2013, 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 10: CM Health FTE by workforce group

Workforce Group	2013
Administration and Management	832
Allied Health and Technical	1097
Medical	826
Non-Clinical Support	407
Nursing/Midwifery/HCA	2590
Grand Total	5752

Figure 11: CM Health workforce representation by ethnicity

Workforce Ethnicity	All Staff	Clinical	CM Health Population
Asian	26%	29%	22%
Maaori	5%	5%	16%
Pakeha and Other	59%	59%	38%
Pacific	10%	7%	23%

[25] CM Health supports this regional commitment however this commitment will not be progressed at a local level in 2014/15

5.2.2 Whole of system collaboration

In order to be able to transform our health system, and provide the highest quality of care to our patients we need to ensure that we have the right people with the right skills in the right place at the right time. In order to do this we need robust strategies to attract, retain, develop and motivate key performers, those with high potential or sought after skills and where possible 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 5.2.7) through the Human Resources General Manager and Director of Nursing contributing to the Clinical Leads Group and 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. In 2014/15 we will be working collaboratively with WDHB and ADHB to implement a Ministry funded contract for additional health science academies and a tertiary mentoring programme for pacific students.

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. This complements the integrated human resources framework that has a number of initiatives being developed across the employee lifecycle.

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

5.2.3 Capability

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

- Reviewing 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 will also include the development of an Organisational Development and Learning strategy
- Reviewing mandatory training in conjunction with the Regional Director of Training in order to explore opportunities to align e-learning and training packages across the region and develop a regional training passport
- 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
- Development of a competency and performance development framework that aligns individual work plans with organisational strategy and priorities
- Workforce scope of practice and role changes to support integrated models of care, including a review of the support workforce requirements within primary care
- Continuation of career development service through a dedicated consultant to guide career planning for staff

5.2.4 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 retaining quality health professionals and employees within our organisation. 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 Health Science Academies, high school programmes, tertiary scholarships and the implementation of a tertiary mentoring programme for pacific students. In addition to this CM Health has implemented 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 and retain the workforce in hard to fill and new positions e.g. sonographers
- Strengthening training capacity through strategic partnerships with tertiary education providers and undergraduate inter-professional trainee placements
- Implementing new models of employment, e.g. Earn and Learn programmes
- A strategic workforce analyst who will play a pivotal role in establishing workforce requirements for new models of integrated care and pipeline approach to growth in the workforce

5.2.5 Culture

Our Enabling High Performing People programme recognises the importance of staff engagement in order to build organisation capacity and capability that enables our people to deliver their best in a changing environment. Key activities associated with include:

- Staff Satisfaction Survey – the baseline completed in October 2012, continues to allow us to compare our 2013/14 progress against previous results and identify any ongoing or new 'hotspots'. We will continue to work with employee representative groups to work through key improvement areas identified and monitor progress against these over the next twelve months
- Introduction of a competency based HR framework that identifies core competencies across the organisation and incorporates them into all HR/people initiatives such as recruitment and performance planning and development.
- Strategies which increase opportunities for engagement from employees and their representative groups e.g. 2013/14 whole of system strategy forming process
- 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

5.2.6 Change leadership

The health system faces a number of challenges in achieving a balance between the delivery of excellent health care and maintaining sustainability. In order to meet this challenge we will need good clinical leadership and consumer participation to 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, such as the current Leadership Academy, aimed at developing emerging leaders, and clinical staff involvement in improvement initiatives such as the 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
- 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 our Patient and whaanau centred care strategy we are engaging patients and whaanau in specific service feedback and service redesign

5.2.7 Regional workforce

The accountability for the delivery of the regional workforce goals is shared between the DHBs, the clinical networks (which work regionally) and the Northern Regional Alliance which encompasses the Northern Region Training Hub.

The Northern Region Workforce and Training Hub has a key role in supporting workforce development for all post entry workforces. The Hub also collaborates with other regional training hubs and HWNZ to share ideas and initiatives that can be rolled out to other professional groups and hubs.

The region has identified 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. There are opportunities to better utilise the non-regulated workforce, and engage with primary care 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 in key areas
- *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

- *Build a workforce that engages effectively with the community it serves* - 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
- *Promote advanced practice roles and working at top of scope* - 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
- *Adopt a regional HR approach to developing a healthy and engaged 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

5.2.8 Safe and competent workforce: the Vulnerable Children's Bill

The Vulnerable Children's Bill is expected to receive Royal assent in June 2014 which 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 take appropriate action to build on existing recruitment processes to date to ensure the organisation meets it's obligations under the proposed Bill.

5.3 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 staff satisfaction survey every 2 years. 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.

5.3.1 Maaori participation in decision making

We will strengthen this aspect of our governance in 2014/15 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.

5.3.2 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.

5.4 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.

5.5 Associate and Subsidiary Companies

5.5.1 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 be working in close alignment with HBL to build on these gains for both local and national benefit.

5.5.2 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.

5.5.3 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 additional strategic developments in 2013, which will need to be considered in line with the Alliance objectives for the 2014/15 year.

6.0 Service Configuration

The Northern Region DHBs have agreed that service reviews and related distribution will be promoted in a way that strengthens our region overall, creating the opportunity for certain services to be provided locally whilst not destabilising any particular DHB within the region. Service distribution process will be collaborative, shifting the paradigm from service ownership to ensuring a service is provided for patients in the right place at the right time.

Service Area	Type of Service Change	Description of Service Change
Chemotherapy	Outpatient treatment service provision	To provide chemotherapy services at CM Health whilst remaining under the governance of the Northern Region Cancer Network and Regional Oncology Operating Group. Services will be provided closer to home for CM Health residents with integration of primary and secondary care.
Urology	Elective service provision	To provide adult urology inpatient and related outpatient services to enhance continuity of care for patients, whilst meeting demand and continuing to meet government targets. This service would integrate primary and secondary care dimensions through our locality strategy.
Spinal Surgery	Service provision	Implement a single site location for management of patients with acute spinal cord impairment.
Specialised Rehabilitation	Change in model of care	Model of care change to reduce dependency of rehabilitation services on hospital level resources by remodelling the patient care flow.
Alcohol and Other Drugs (AOD)	Model of care review	A regional model of care review across all AOD services including Community Alcohol and other Drugs Services that may result in service and contractual changes.
Localities	Workforce development in the community	Expanded range and scope of locality based Multidisciplinary Teams in localities to include mental health, Kidz First and maternity community teams, which align with general practice clusters and locality health needs. Needs Assessment and Service Coordination (NASC) will transition from hospital to locality based management.

7.0 Performance Measures

7.1.1 Performance priorities dimension

Performance Measure and Description			2014/15 CM Health Target	2014/15 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 Provider 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 (Provider Arm and NGOs) PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds		3 weeks	80%	80%	
		8 weeks	95%	95%	
			2014	2015	
PP10: Oral Health DMFT Score at year 8			1.15	1.08	-	Annual
PP11: Children caries free at 5 years of age			53%	54%	-	Annual
PP12: Utilisation of DHB funded dental services by adolescents (School Year 9, up to and including age 17 years)			85%	85%	85%	Annual
PP13: Improving the number of children enrolled in DHB funded dental services	Children enrolled 0-4 years		85%	90%	-	Annual
	Children not examined 0-12 years		7%	7%	-	
PP18: Improving community support to maintain the independence of older people	The percentage of older people who have received long-term home-support in the last three months who have a Comprehensive Clinical Assessment and a completed individual care plan		95%		95%	Quarterly
PP20: Improved management for long term conditions (CVD, diabetes and Stroke) Focus area 1: Long term conditions			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
Focus area 4: Stroke services	Percentage of potentially eligible stroke patients thrombolysed	8%[26]	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
PP22: Improving system integration		Report on delivery of the actions and milestones identified in the Annual Plan		Quarterly
PP23: Improving Wrap Around Services – Health of Older People		Report on delivery of the actions and milestones identified in the Annual Plan		Quarterly
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings		Report on delivery of the actions and milestones identified in the Annual Plan		Quarterly
PP25: Prime Minister's Youth Mental Health Project		Provide narrative progress reports against the local alliance Service Level Agreement plan to implement named initiatives/actions to improve primary care responsiveness to youth. Include progress on named actions, milestones and measures.		Quarterly
PP26: The Mental Health and Addiction Service Development Plan		Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2014/15 and for any actions which are in progress/ongoing in 2014/15.		Quarterly
PP27: Delivery of the Children's Action Plan		Report on delivery of the actions and milestones identified in the Annual Plan		Quarterly
PP28: Reducing rheumatic fever	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 40% lower than the average over the last 3 years	Provide a progress report against DHBs' rheumatic fever prevention plan with case reviews		Quarterly
		7.9 per 100,000	40% lower than the average over the last 3 years	
PP29: Improving waiting times for diagnostic services	Coronary angiography – percentage of patients who are referred for elective coronary angiography and receive their procedure within 3 months (90 days)	90%	90%	Monthly
	CT – percentage of patients who are referred for CT and	90%	90%	

[26] National target is 6% and Regional target is 8%

	receive their scan within than 6 weeks (42 days)			
	MRI – percentage of patients who are referred for CT and receive their scan within than 6 weeks (42 days)	80%	80%	
	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)	60%	60%	
	c. Surveillance colonoscopy - Percentage of people waiting for a surveillance colonoscopy who wait no longer than twelve weeks (84 days) beyond the planned date	60%	60%	
PP30: Faster cancer treatment Part A	Percentage of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management)	85% (by 1 July 2016)	85% (by 1 July 2016)	
PP30: Faster cancer treatment Part B	Percentage of patients wait 31 days or less to receive their first treatment for cancer from date of decision-to-treat	<10% of the records submitted by the DHB are declined	<10% of the records submitted by the DHB are declined	
PP30: Faster cancer treatment Part C	Percentage of patients ready-for-treatment wait 4 weeks or less for radiotherapy or chemotherapy	100%	100%	

7.1.2 Ownership dimension

Performance Measure and Description		2014/15 CM Health Target	2014/15 National Target	Reporting Frequency
OS3: Inpatient length of stay	Elective LOS	3.3 days	3.18 days	Quarterly
	Acute LOS	3.88 days	Maintenance of, or improvement on 2013 baseline performance	
OS8: Reducing acute readmissions to hospital	Total Population	<=7.4% standardised	DHB to state year-end targets. The Ministry will assume a 25% improvement towards target can be made each quarter unless otherwise specified.	Quarterly
	75+ years	<=10.1% standardised		
OS10: Improving the quality of data within the NHI and data submitted to National Collections	New NHI registration in error	Greater than 2% and less than or equal to 4%	Greater than 2% and less than or equal to 4%	Quarterly
Focus area 1: Improving the quality of identity data	Recording of non-specific ethnicity	Greater than 0.5% and less than or equal to 2%	Greater than 0.5% and less than or equal to 2%	
	Update of specific ethnicity value in existing NHI record with a non-specific value	Greater than 0.5% and less than or equal to 2%	Greater than 0.5% and less than or equal to 2%	
	Validated addresses unknown	Greater than 76% and less than or equal to 85%	Greater than 76% and less than or equal to 85%	
	Invalid NHI data updates causing identity confusion	-	-	
Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS	Greater than or equal to 97% and less than 99.5%	Greater than or equal to 97% and less than 99.5%	
	National collections file load success	Greater than or equal to 98% and less than 99.5%	Greater than or equal to 98% and less than 99.5%	
	Standard vs. edited descriptors	Greater than or equal to 75% and less than 90%	Greater than or equal to 75% and less than 90%	
	NNPAC timeliness	Greater than or equal to 95% and less than 98%	Greater than or equal to 95% and less than 98%	
Focus area 3: Improving the quality of the Programme for Integration of Mental Health Data (PRIMHD)	PRIMHD File Success Rate	Greater than 95%	Greater than 95%	
	PRIMHD data quality	Routine audits undertaken with appropriate actions where required		

7.1.3 System integration dimension

Performance Measure and Description		2014/15 CM Health Target	2014/15 National Target	Reporting Frequency
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	101%	-	Six monthly
	Age 45-64	127%	-	
	Age 0-74	114%	-	
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)		Quarterly
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
	Cardiac surgery	6.5 per 10,000	6.5 per 10,000	Quarterly
	Percutaneous revascularization	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		Report progress on planned activities with providers to improve service delivery and develop mature providers		Annually

7.1.4 Output dimension

Performance Measure and Description		2014/15 CM Health Target	2014/15 National Target	Reporting Frequency
OP1: Mental health output delivery against plan	Variance of planned volumes for services measured by FTE	+/-5%	+/-5%	Quarterly
	Variance of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day	+/-5%	+/-5%	
	Actual expenditure on the delivery of programmes or places is within +/-variance of the year-to-date plan	+/-5%	+/-5%	

7.1.5 Developmental measure

Performance Measure and Description	2014/15 CM Health Target	2014/15 National Target	Reporting Frequency
DV4: Improving patient experience	No performance target set		

8.0 Appendices

8.1 PHOs Letter of Support

15 May 2014

Dear Geraint,

RE: Endorsement for Counties Manukau Health 2014/15 Annual Plan

Thank you for the ongoing engagement and opportunity to jointly develop the Counties Manukau Health 2014/15 Annual Plan.

As a District Alliance group of Primary Health, we acknowledge and value the purposeful inclusion of primary health care and PHOs as partners in planning, delivery and accountability. We support and endorse the overall direction outlined in the Annual Plan, and in particular the service integration and primary care commitments.

We look forward to working in partnership with you in 2014/15 to achieve the goals outlined in the plan to improve health and reduce inequalities for the Counties Manukau populations.

Yours sincerely,

Steve Boomert
Chief Executive Officer
Procare Health Limited

Loretta Hansen
General Manager
East Health Trust

Mark Vella
Chief Executive Officer
Total Healthcare Charitable Trust

Alan Wilson
Chief Executive Officer
Alliance Health Plus

Simon Royal
Chief Executive Officer
National Hauora Coalition

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