Annual Plan 2019/20

COUNTIES MANUKAU HEALTH

He Pou Koorero

(A Statement of Intention)

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

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

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

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

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

19 DEC 2018

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

Dear Mark

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

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Fiscal responsibility
Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure
My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over $10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan
I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution
I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce
I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening
The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care
I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability
Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures
As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health
The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery
High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025
I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability
I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing

carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight
As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water
You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration
Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

Hon Dr David Clark
Minister of Health

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

18 DEC 2019

Vui Mark Gosche
Chair
Counties Manukau District Health Board
mark.gosche@middlemore.co.nz

Dear Mark

Counties Manukau District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed Counties Manukau District Health Board's (DHB's) 2019/20 Annual Plan for one year together with the Minister of Finance.

I have made my expectations on improving financial performance very clear. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan with the expectation that you will continue to focus on opportunities for improving financial results for 2019/20 and into 2020/21 and beyond. The out-years have not been approved.

I am aware that you have advised the Ministry of Health (Ministry) of a flatline position across the out-years, with an understanding that you are working to improve your position. I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety, and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

It is expected that as Chair, along with your Board, you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast. Should the DHB experience liquidity issues, please keep the Ministry informed of the likely timing of the need for liquidity support. Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. The available equity is limited and applications for equity support will be subject to a rigorous prioritisation and approval process.

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I am aware you are planning a number of service reviews in the 2019/20 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders that will deliver on our Government's Wellbeing priorities.

I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions identified in your Annual Plan.

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 2019/20 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 David Clark
Minister of Health

Hon Grant Robertson
Minister of Finance

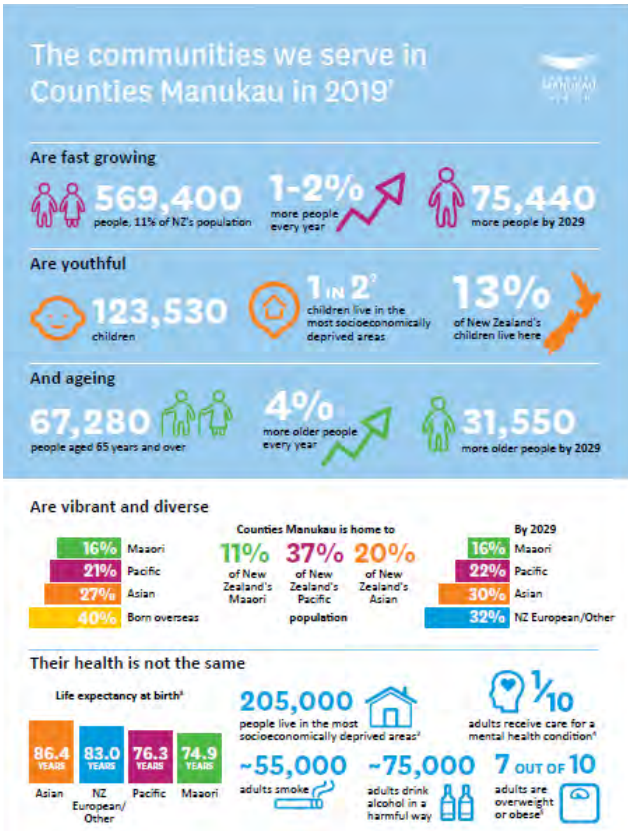
cc Fepulea'i Margie Apa
Chief Executive
Counties Manukau District Health Board
margie.apa@middlemore.co.nz

Table of Contents

1. Overview of strategic priorities

1.1 Strategic intentions and priorities

1.1.1 The communities we serve



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

The Counties Manukau District Health Board provides and funds health and disability services to an estimated 569,400[1] people in 2019 who reside in the local authorities of Auckland, Waikato and Hauraki District. We are one of the fastest growing district health board populations in New Zealand with a youthful and ageing population.

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

Across our district, the health and circumstances of our communities are not the same. Thirty-six percent of our population live in areas of high socioeconomic deprivation (NZDep2013 9&10[2]). Over 123,000 children live in Counties Manukau, with almost 1 in 2 (approximately 45 percent) living in areas of high socioeconomic deprivation. By 2025, our district is forecast to be 16 percent Maaori, 22 Percent Pacific, 29 percent Asian and 34 percent European/Other ethnicity.[3] There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau.[4] On the basis of the NZDep2013 measure, Otara, Mangere and Manurewa, home to many of our Maaori and Pacific communities, are the most socioeconomically deprived areas in our district.

Long-term mental and physical conditions do not affect all groups in our community equally[5]. Our population experiences relatively high rates of ill-health risk factors (such as smoking, obesity[6], hazardous alcohol use) that contribute to a 'package' of long term physical conditions which are responsible for the majority of potentially avoidable deaths. The rate of hospitalisation for circulatory diseases for our Maaori communities is estimated to be 88 percent higher than for non-Maaori.[7] Diabetes prevalence is higher amongst our Pacific (13.9 percent), Asian (6.9 percent) and Maaori (6.5 percent) communities compared to European/Other.[8] Increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity and reducing obesity is key to improving the health of our population.

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[1] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2013-Census Base) – 2018 update.

[2] NZDep 2013 decile 9&10. New Zealand Index of Deprivation (NZDep) is an area-based measure of socioeconomic deprivation. It measures the level of deprivation for people in each small area. It is based on nine Census variables. NZDep can be displayed as deciles or quintiles. Quintile 5, or deciles 9 and 10, represents people living in the most deprived 20 percent of these areas.

[3] Due to numeric rounding the total is greater than 100 percent

[4] Chan WC, Winnard D, Papa D (2016). Life Expectancy, Leading Causes of Death and Amenable Mortality in Counties Manukau. 2015 update. Auckland: Counties Manukau Health.

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

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

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

[8] Source: Health Quality and Safety Commission Atlas of Health Care Variation, Diabetes management (2016 data for CMDHB)

1.1.2 Our strategic direction and context

Counties Manukau Health (CM Health)[9] strategic intentions and priorities are presented in our Healthy Together Strategic Plan 2015-2020. This plan was developed in acknowledgement of our diverse and changing population and health needs, and communicates CM Health's strategic goal:

> ***"Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020."***

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

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

The 2019/20 financial year is the last year of our Healthy Together strategy. The CM Health Board has committed to refreshing our Healthy Together strategy for 2020/21 and beyond.

Please see our Statement of Intent for further detail about our Healthy Together strategy.

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

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

Obesity, long term conditions and mental health – Seven out of ten adults in Counties Manukau are obese or overweight and an estimated 36,000 people are morbidly obese (BMI 40+). There are approximately 8,000-9,000 more people with morbid obesity than expected given the age and ethnicity structure of our population. Obesity-related conditions such as diabetes and cardiovascular disease are a major contributor to our burden of long term conditions. Long term conditions such as coronary heart disease, diabetes, cerebrovascular diseases and obstructive pulmonary disease are the leading causes of potentially amenable mortality in Counties Manukau. In addition, nearly one in ten adults living in Counties Manukau received care for a mental health condition in 2011,[10] and in 2015 there were over 67,000 people in Counties Manukau living with one or more long term conditions.[11] The increasing prevalence of long term physical and mental health conditions is one of the major drivers of healthcare demand for our DHB.

Growing and ageing population - Counties Manukau is the third fastest growing DHB and our population is forecast to increase by 75,000 people by 2029. Our population is also ageing with an additional 2,700 - 3,000 people aged 65 years and over each year. It is this group who will place the highest demands on health services in the years to come and is a challenge particularly significant for the Franklin and Eastern localities.

[9] To better reflect a health system approach for effective resource planning to meet our population needs and health sector priorities, this document will refer to the collective delivery of all health services and related infrastructure as Counties Manukau Health (CM Health). This reflects the combined Counties Manukau DHB, PHO and related non-government organisation (NGO) service delivery and support resources.
[10] Winnard D, Papa D, Lee M, Boladuadua S, Russell S, Hallwright S, Watson P, Ahern T (2013) Populations who have received care for mental health disorders. Counties Manukau Health. Auckland: Counties Manukau Health.
[11] Chan WC, Winnard D, Papa D (2017) People identified with selected Long Term Conditions in CM Health in 2015. Counties Manukau Health. *Unpublished.*

Large high-needs population - Socioeconomic deprivation is a key driver of health inequities. In 2019 we estimate that 205,000 people in Counties Manukau, over a third of all residents, are living in areas classified as being the most socioeconomically deprived in New Zealand. This is many more people living in these circumstances than any other DHB in New Zealand and this presents a challenge for health and social sector agencies to best support our people to flourish.

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

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

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

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

We are also faced with ageing facilities infrastructure. The average age of our buildings is 40 years and certain buildings are not suitable for future long-term use. In addition, national funding and affordability constraints over the last 5 years in particular have resulted in significant deferral of key hospital building maintenance. The result is that we now face urgent remediation of our facilities and immediate service demand capacity expansion investment requirements. CM Health's Statement of Performance Expectations outlines regionally prioritised major capital investments that will add critical service capacity, as well as remediation of health and safety and clinical service risks due to aging facilities infrastructure.

Refreshing our strategic direction for 2019/20 and beyond

We plan to refresh Healthy Together for the 2020 – 2025 years. Our strategy refresh will review our population, future revenue and cost structure of delivery assumptions. We will review our priorities for the next five years in the context of the Government's priorities while working toward the achievement and maintenance of a sustainable financial position. The strategy process will commence from July 2019 and aim to complete two companion documents, Population Health Improvement and Clinical Services Plans, that show how we will deliver Healthy Together's strategic goal. The approach to clinical service planning will be considered further as part of our strategy refresh, with clinician and consumer engagement being a key element of the refresh process. We will do this in partnerhip with Mana Whenua i Tamaki Makaurau.

Within this context, our priorities for 2019/20 are to achieve our planned reduced deficit position of $38.6m by:

- Focussing resources on improving the quality of life where patients present unplanned and acutely to the system, and where CM Health is the default provider of safe, high quality care.
- Prioritising resources as they become available on opportunities to accelerate service developments, where the healthcare system is achieving less than equitable access compared to the other Metro Auckland DHBs and for high-needs populations.

The tradeoffs are that some initiatives and/or projects will be progressed more slowly during the 2019/20 year as resources are diverted to focus on core services that the DHB is required to provide. In order to meet CM Health's financial objective to return to a sustainable financial position in subsequent years, a pipeline of additional savings and cost reduction opportunities is regularly reviewed. Our Every Hour Counts and Every Dollar Counts portfolios of work will be expanded to support our sustainability.

Every Hour Counts and Every $ Counts are our two portfolios of work to achieve sustainability
Building on the learnings from 2018/19, two portfolios of work will be expanded to support our sustainability.

1. 'Every Hour Counts'
2. 'Every Dollar Counts'

The **Every Hour Counts** portfolio aim is to improve patient flow to optimise the quality of care, the experience of care, and the experience of caring whilst improving the efficiency of the system. Its focus for 2019/20 is set on seven quality improvement programmes:

- ED flow
- Bed utilisation
- Proactive discharge planning
- Optimising access to community services
- Rapid and consistent access to diagnostics
- Outpatient redesign
- Booking and scheduling services

Achieving the desired outcomes of the collective patient flow initiatives will support CM Health to deliver a more effective, timely, end to end, patient-focused system of care. This portfolio also aims to optimise and value the time of staff, by reducing the steps in patient care to get the best out of the highly skilled workforce we have.

The **Every Dollar Counts** portfolio consists of various individual projects, covering seven key programmes:

- Aligning services to need
- Environmental sustainability
- Individual service specific initiatives
- Procurement
- Corporate
- Improving match between cost and revenue
- Workforce

In order to meet CM Health's financial objective to return to a sustainable financial position in subsequent years, a pipeline of additional savings and cost reduction opportunities is regularly reviewed.

National, regional and local strategic direction

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

Counties Manukau DHB operates collectively as part of a national health system. Counties Manukau DHB is committed to the national, regional and local strategies that guide the direction of the system:

- *Implementation of Pae Ora- Healthy Futures,* the government's vision for Maaori Health.
- *Implementation,* as directed by the Ministry of Health, *of the 2016 New Zealand Health Strategy* of "All New Zealanders live well, stay well and get well," through targeting the following key health system outcomes:
    1. We live longer in good health
    2. We have improved quality of life
    3. We have health equity for Maaori and other groups
- *Implementation of the Northern Region Long Term Investment Plan and the Northern Region Health Service Plan*. This outlines the Region's strategic priorities as a foundation for the annual work plan priorities aligned with government expectations. This includes deep dives into specific areas of service and endorsing the implementation of regional service plans (e.g. cancer, ophthalmology).
- *Locally, the Alliance Leadership Team (ALT) as key primary care leadership collaborative* with the five Primary Health Organisation (PHO) partners operating within the Counties Manukau district (Alliance Health Plus, East Health Trust, National Hauora Coalition, ProCare and Total Healthcare).
- *Implementation of CM Health-specific action points from the Regional Disability Strategy*

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

Strategic areas of focus for 2019/20

Please refer to the previous section *Refreshing our strategic direction for 2019/20 and beyond* for our strategic areas of focus for 2019/20.

CM Health's strategic areas of focus for 2019/20 were agreed during the Strategic Discussion held with the Ministry of Health in May 2019. These discussions confirmed that health equity is at the heart of the 2019/20 Annual Plan with a specific focus on child wellbeing, mental health, social wellbeing and cross agency work alongside our commitment to reducing our planned deficit position.

Te Tiriti o Waitangi

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

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

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

Please see Section 2.4.3 for detail of planned activities from 2019/20 that demonstrate how we are committed to meeting our engagement and obligations as a Treaty Partner.

1.2 Message from the Chair and Chief Executive

The 2019/20 financial year will be very challenging for Counties Manukau Health. The tensions between achieving financial sustainability in a context of high population growth, the high cost of the burden of long term conditions and many of our residents living in low socioeconomic households are very real.

We see this year in a very short term context. To be financially sustainable we will need to make some difficult decisions to slow some initiatives down and reduce parts of our cost structure to achieve a much lower deficit than in the 2018/19 financial year. We want to assure our partners, stakeholders and community that many of these constraints will be short term – we believe in the need to match the growth in clinical services and investing in community based care to prevent the onset or slow the progression of disease and poor wellbeing. The next 12 months however will require a laser-sharp focus on living within our means and ensuring every dollar and every hour counts.

The future potential will be worth the short term sacrifice – achieving financial breakeven means we can attract the capital investment our healthcare services so sorely needs in the outer years. We are concerned that the national policy settings that fund our system do not reflect the 'triple challenge' we face of growth, poverty and obesity. Our stewardship role is to be transparent about how we apply the resources we have, including what trade-offs we make as a Board.

It is important that we extract maximum value out of all of our activities through our key portfolios of work – 'Every Hour Counts' is not only about improving patient flow but also that our staff and partner health professionals are able to spend their time on activities that add value to the patient experience. In addition, 'Every Dollar Counts' is about ensuring that we are delivering value and are transparent in all our resource allocation choices.

This year, clinical leadership will play an important role in our part of the healthcare system. We will be making changes to ensure that clinical expertise – this comes in many forms medical, nursing, allied health and midwifery – is applied to decision making. This includes maximising the potential our workforce can add to the care of our patients, improved value from every dollar we spend and accelerates adoption of new models of care.

We look forward to the 2019/20 year as we work to ensure that all our resources are applied to those jobs that only a DHB can do – ensure the quality and safety of care for those who rely on our system and particularly those who are acutely unwell as we work to progress equity as quickly as we can.

Vui Mark Gosche
Chair

Fepulea'i Margie Apa Chief Executive

1.3 Signatories

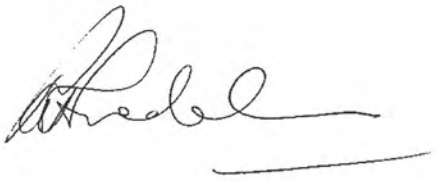
Agreement for the Counties Manukau Health 2019/20 Annual Plan

between

The Honourable Dr David Clark
Minister of Health

The Honourable Grant Robertson
Minister of Finance

Vui Mark Gosche
Chair, Counties Manukau DHB
Counties Manukau District Health Board



Pat Snedden
Chair, Audit Risk and Finance Committee
Counties Manukau District Health Board

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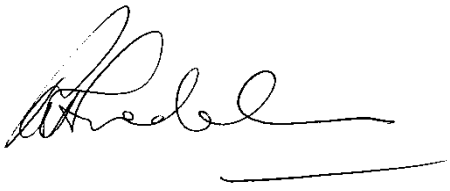


Pat Snedden
Chair, Audit Risk and Finance Committee
Counties Manukau District Health Board

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

2. Delivering on priorities

This section describes the actions that CM Health will undertake to deliver on the Government's priorities in the 19/20 year. We have used the code **'EOA'** to identify equitable outcomes actions specifically designed to reduce health equity gaps for Maaori, Pacific and Asian populations. This Plan also reflects the Metro Auckland 2019/20 System Level Measures Improvement Plan.

2.1 Health equity in DHB Annual Plans

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

On a quarterly basis, CM Health monitors progress against our universal performance targets and our Statement of Performance Expectations (SPE) by ethnicity, to track our progress toward achieving equity across our performance measures and identify areas of focus for improvement and future planning. It is acknowledged that Maaori/non-Maaori equity comparisons are important in relation to DHB Te Tiriti o Waitangi responsibilities. However, in Counties Manukau Health our Pacific and Asian communities constitute significant proportions of our non-Maaori group. This means if the total non-Maaori group are used as a comparator to consider Maaori inequities, the inequities of our Pacific population can obscure the extent of the inequities for our Maaori population. On the other hand, the healthy migrant effect for some of our Asian communities can also compound our equity comparisons. Our priority groups for equity are Maaori and Pacific peoples in the first instance, but it is also important that our Asian communities, who represent over a quarter of our population, are not invisible in our data and and that we facilitate equity comparisons for Asian communities where there are health disparities.

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

2.2 Maaori Health

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

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

Please see Section 2.4.4 for detail of planned activities from 2019/20 that demonstrate how CM Health is plans to action our obligations as a Treaty Partner.

2.3 Responding to the Guidance

The priority actions described in this document reflect the Ministry of Health's guidance and instructions for DHBs. The actions identified in CM Health's 2019/20 Annual Plan have been developed in consultation with key stakeholders across the organisation, including our PHO partners.

2.3.1 Public Health plans

Auckland Regional Public Health Service (ARPHS) is the regional provider of public health services and services the Counties Manukau District and the Metro Auckland region DHBs. ARPHS is one of New Zealand's 12 public health units (PHUs). ARPHS provides public health services through health protection and promotion, and disease

prevention. ARPHS and DHB staff works closely together to improve population outcomes for the people of Taamaki Makaurau. A key role for ARPHS is provision of regulatory public health services.

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

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

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

Key points of intersection for ARPHS with DHB activities are interfaces with primary and secondary services in managing communicable disease outbreaks, policy engagement and submissions and improving physical and social environments to support reduced harm from tobacco, alcohol and unhealthy food. Please refer to the Cross-sectoral Collaboration section in Section 2.4.3 of our Annual Plan for examples of how CM Health will work with ARPHS to address health issues for our population, including providing a response to emerging drug threats and the Regional Homelessness Plan.

2.3.2 Regional Service Planning

The Northern Region Long Term Investment Plan (NRLTIP) sets out the regional direction of travel for long-term investment. It identified the three major problems the Northern Region needs to address, along with 'Next Steps' priorities for regional work across three programme streams:

- Northern Region Health Planning;
- Information Systems Strategic Plan (ISSP) (and implementation); and
- Capital Investment.

Regional long term planning work for the 2019/20 year is focused upon further development of our Region's direction of travel across the three work programme areas set out above. We will be placing a strong emphasis upon health planning for our Region and to signal this we will be developing our plan as the Northern Region Long Term Health Plan (NRLTHP) in 2019/20. This work area will expand the first NRLTIP strategic aims; and will particularly reflect regional health service directions for primary and community services as well as population health services. The Long Term Health Planning programme of work will be structured around:

1. Health planning **'design'** work steams – this work will clarify the desired models of care for our Region and also outline the future shape of the Northern Region health service delivery system. This work will identify and agree:
    - Which priority areas of health service delivery need to change in our Region
    - How those services should change in our Region
2. Health planning **'implementation'** work streams – this work will progress the necessary changes relating to agreed priority areas of health service transformation. This work will take the prioritised and agreed new service delivery concepts and make them a reality.

The Capital Investment and ISSP work will continue to focus upon delivery of the 'enabling' capacity and capability to meet the health service delivery requirements. These programmes of work will continue to implement the existing Long Term Investment Plan and ISSP for our Region. They will also plan and deliver the enabling capital and IS changes required to support the identified health service transformations. These programme areas will reconcile existing

plans from the NRLTIP work with planned and environmental changes that may be identified by the NRLTHP during the 2019/20 year.

The Ministry of Health's Regional Service Planning guidance for 2019/20 identifies areas of regional work that are well aligned to our Region's priority areas of Long Term Health Planning 'design' and 'implementation' work. Our regional action plan to meet the Ministry requirements is detailed in 'The Northern Region Service Plan 2019/20' developed under the governance and oversight established for our regional long term planning portfolio of work. Any Ministry regional planning expectations that do not align with our Region's long term planning work priorities will be progressed outside of this NRLTHP portfolio; with separate regional oversight and governance arrangements. Each of the agreed Ministry work streams will be structured to enable quarterly reporting on progress; with action plans that define the deliverables, milestones and performance indicators for achievement by our Region during 2019/20.

2.4 Government planning priorities

The following sections identify CM Health's key response actions to deliver improved performance against the Government's 2019/20 Planning Priorities. A number of these actions are specifically targeted to accelerate health gain and to reduce inequities for our Maaori and Pacific populations.

The 2019/20 Planning Priorities are:

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

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

2.4.1 Improving child wellbeing

Child and youth wellbeing is a priority work programme for Government, the Ministry of Health and District Health Boards. This section identifies annual planning guidance for children and young people that contributes to the development and delivery of New Zealand's first Child and Youth Wellbeing Strategy (the Strategy) and preparing the Health and Disability sector for system transformation over time.

There is an expectation that annual plans reflect how DHBs are actively working to improve the health and wellbeing of infants, children, young people and their whaanau with a particular focus on improving equity of outcomes.

Annual plans should inform a comprehensive approach to prevention and early intervention services (primary and community health) provided to women of child bearing age, infants, babies, pre-school and school-aged children and youth and their families/carers.

DHBs should draw on the most relevant information necessary to evidence their approach.

Immunisation					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Increase collaboration between Outreach Immunisation Services (OIS) and Maaori well child providers (WCP)to support access and timely immunisation where families are not easily located. **(EOA)**	**1a.** Setup of multidisciplinary meetings to assist with location of whaanau.	Q1	95% immunisation target reached for Maaori pepe and the total population Number of Maaori whaanau who take up the incentive scheme 100% of Maaori and Pacific whaanau, who do not attend during the week offered Saturday appointments Number of children who attend Saturday clinic versus Primary care 100% of Maaori whaanau who receive the incentive attend the Saturday clinic	We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child
2. Pilot a programme to increase childhood immunisations for Maaori pepe in the eight-month target cohort, through providing appropriate incentives for engaging in immunisation appointments with OIS team. **(EOA).**	**2a.** Implementation of the pilot.	Q1 –Q4			
3. OIS to increase capacity for Saturday home visiting service to support prioritisation of Maaori and Pacific families who have not been contactable prior, while evaluating its effectiveness in response to community need. **(EOA)**	**3a.** Training of additional OIS Nurses and commencement of the Saturday service.	Q1			
4. Offer a targeted incentive to whaanau for travel to the Saturday B4SC clinic, for those whaanau with children aged 4 years and 10 months.	**4a.** Commencement of the pilot.	Q1			

School-based health services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Implementing Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS: The DHB will continue to provide high quality, quantitative reports in quarters 2 and 4 for all schools that receive funding for SBHS. Each school nursing team will continue to provide an annual quality improvement plan, based on the 'Youth Health Care in Secondary Schools: A framework for continuous quality improvement' document. The DHB has two actions within SBHS for 2019/20 for improving the responsiveness of primary care to youth, as described below.					
1. Continued expansion of GP/Nurse Practitioner (NP) services in SBHS schools to three new schools. This increases the coverage of GP/NP clinics in SBHS schools from 74% to 96% of eligible students. This also increases coverage from 75% to 92% of eligible Maaori students and from 87% to 98% of eligible Pasifika students. **(EOA)**	**1a.** On-site GP/NP clinic for three new schools established.	End of Q1	CW12: Youth mental health initiatives CW12: Percentage of eligible students who have access to SBHS Percentage of students with access to an on-site GP/NP clinic CW12: Percentage of students eligible for a routine health assessment (including HEEADSSS assessment) who have had an assessment	We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child
2. Increase contraception education and uptake of Long Acting Reversible Contraception (LARC) within SBHS schools, with a particular focus on providing LARCs for Maaori and Pasifika students and those in Quintile 5 schools.	**2a.** Delivery of a sexual health training package for all school nurses.	End of Q2	Number of nurses who received the sexual health training package	We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child

School-based health services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	2b. Appointment of a roving LARC nurse to undertake LARC delivery and sexual health screening for Maaori and Pacific students and those in Quintile 5 schools.	Q1	Number of consultations/conversations delivered by roving LARC nurses: • Target of 1689 for Maaori and Pasifika students by Q4 Number of LARCs delivered: • Target of 247 LARCs for Maaori and Pasifika students by Q4		
The youth service level alliance team (SLAT) The DHB commits to providing quarterly narrative reports on the actions of the SLAT and as outlined above, to improve health of the DHB's youth population. The DHB commits to ensuring the continued high performance of the SLAT through: • Reporting monthly to the Alliance Leadership Group, with a particular focus on delivery of the Rheumatic Fever Prevention Programme • Engaging with the Regional Youth Health Network bimonthly • Seeking to improve engagement with PHOs, with the goal of providing more youth-appropriate primary care			CW12: Youth mental health initiatives		

Midwifery workforce – hospital and LMC					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
There has been a longstanding midwifery shortage, both employed and self-employed, at Counties Manukau Health. Our workforce strategies over the past ten years have led to an improvement in workforce capacity. Our aim is for the midwifery workforce to meet the needs of the community we serve. We want to achieve appropriate workforce capacity across the maternity care continuum to provide quality care that is women centred and reflects the NZ maternity model of care.					
1. Improve the ethnicity profile of midwifery workforce to match the population demographic **(EOA)**: • Attaining ongoing funding for the Maaori and Pasifika Midwifery Scholarship and wrap around programmes. These are jointly run with Auckland University of Technology. • Recruit and retain Maaori and Pasifika midwives to employment at CM Health and self employed LMC practice.	**1a.** Funding attained for a further three years from The Tindall Foundation for Maaori.	Q1	Increase the Maaori Midwifery workforce to 10% and Pasifika to 5% by Q4	We have improved health equity (healthy populations)	Support healthier, safer and more connected communities
	1b. New funding requested and attained for Pasifika programme.	Q2			
2. Support graduate midwives into practice, both employed and self-employed: • Graduate midwifery programme continues which is inclusive of employed and self-employed. • Evaluate midwifery graduates' requirements for clinical support.	**2a.** Evaluation completed and plan of support completed.	Q3	25 graduate midwives employed per annum	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities

Midwifery workforce – hospital and LMC					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
3. To make the best use of other health workforces to support both midwives in their roles and pregnant people, CM Health has the following in place: • Recruitment of registered nurses (RNs) and placing them through a Maternity RN programme to work within maternity/postnatal area under the direction of a registered midwife. • Community Health workers also assist the Community Midwifery teams in engagement and certain tasks they are credentialed for with the Diabetes Midwifery team.	Ongoing	Ongoing		We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities
4. Implement CCDM for Maternity Services, including the following core activities: • Establish an operational safe staffing committee. • Implement the patient acuity tool for maternity services	**4a.** Implement the identified core activities.	Q4			

Family and Sexual Violence					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Over the 2019/20 year CM Health will continue to implement the CM Health Violence Intervention Programme (VIP), which recognises the importance of improving equity for both Maaori and Pacific people. The 2016 VIP guidelines are aligned with both the He Korowai Oranga (Maori Health Strategy 2014) and Nga Vaka o Kaiga Tapu (Ministry of Social Development Taskforce for Action on Violence within Families 2012). The guidelines encompass a framework based on leadership, knowledge and commitment to effective identification and response processes to intimate partner violence. CM Health will also implement the following activities in 2019/20:					
1. Support recognition of family violence as a health issue with ELT oversight: • Embed routine enquiry into core health business • ELT to actively encourage SMO and senior medical staff complete core training	**1a.** SMO workforce trained in VIP.	Q4	80% SMO workforce trained in VIP.	We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child
2. Formation of a Maternity Care, Child Wellbeing and Protection Multiagency Group which will focus on: • Work with an inter-sectoral framework to provide early intervention and attempt to reduce risk • Work collaboratively and information share to prevent siloed working • Greater support of Lead Maternity Carers (LMCs) with an allocated social worker to support early intervention with vulnerable pregnant mothers.	**2b.** Group to be formed.	Q4	100% of LMC workforce to be supported by NGO Social Work provision.		
3. Safety Assessment Meeting (SAM): • Ensure the necessary resource and skill set of health professionals as active participants • Consider a Health Broker position to traverse across primary and secondary services to offer best health outcomes	**3a.** SAM Health representatives appointed/confirmed.	Q2	100% attendance by Health at North and South tables.		

SUDI					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Babies identified at greatest need of SUDI protection are those with an absolute risk of SUDI ≥0.4 per 1000 live births. In CM Health area there is a stark disproportionality for SUDI death for Maaori and Pacific infants. Over 2011-2016, 45 babies in total died of SUDI with all being either Maaori (27) or Pacific (18) ethnicities. **All of the below activities are EOAs for Maaori and Pacific** as they ensure our focus remains on our Maaori and Pacific Island populations, young mothers and those of our women and whaanau disadvantaged by living in low socio-economic areas. These are new initiatives in CM Health with the focus being on collecting baseline data to better inform around these activities and future measures.					
1. Risk Assessment Framework: Implement a universal SUDI risk assessment using the Safe Sleep Calculator (SSC) for an individualised, objective, evidence-based risk assessment to be completed for all mother-infant dyads in CM Health. **(EOA)**	**1a.** Integration of the SSC into Midwifery practice.	Q2	Monitor the number of women (total and by ethnicity) receiving the SUDI electronic risk assessment throughout their pregnancy journey	We have improved health equity (healthy populations	Make New Zealand the best place in the world to be a child
	1b. Provision of baseline data as obtained from the SSC reporting capabilities.	Q4			
2. SUDI protection wrap-around-care: Develop and trial Well Child Tamariki Ora (WTCO) providers in a key-worker wrap-around-care model, providing clinical leadership and partnership with whaanau to facilitate and enable early health, wellbeing and social care. Babies identified at greatest need of SUDI protection will be referred into wrap-around-care. **(EOA)**	**2a.** Develop a WCTO provider model to deliver wrap-around-care support.	Q2	Number of babies (total and by ethnicity) referred to their preferred wrap-around-care service provider		
3. Access to safe sleep baby beds: Trial the inclusion of baby beds within the wrap-around-care model ensuring seamless, easy access of culturally appropriate baby beds for whaanau. This will include integration of weaving wahakura/haapu mama opportunities. **(EOA)**	**3a.** Develop a safe sleep bed distribution model within the WCTO provider model to deliver wrap around support.	Q2	Monitor access of safe sleep beds as per MoH NSPP reporting		

SUDI					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
4. **Primary care:** Development of the Northern Early Pregnancy Assessment Tool (NEPAT) and Northern Infant Six Week Assessment Tool (NISAT) to optimise primary care opportunities to advance early SUDI protection by identifying and mitigating the factors that impact on risk. The Safe Sleep Calculator will be incorporated into the NEPAT and NISAT**.** (**EOA)**	**4a.** Completion of Early pregnancy Assessment tool.	Q2	Monitor access and utilisation of the advanced forms within primary care	We have improved health equity (healthy populations	Make New Zealand the best place in the world to be a child
	4b. Completion of Infant Six Week Assessment tool.	Q4			
5. **Post-SUDI Care:** Establishment of working group to develop recommendations for a pathway for post-SUDI care including **(EOA)**: • Early notification of services within the community • Grief support and accessibility and required funding • Clinical support to ensure whaanau understanding of causes of SUDI and safe sleep practices for whaanau or in future pregnancies	**5a.** Develop a pathway.	Q2	Monitor access & utilisation of the pathway		
	5b. Evaluate utilisation of pathway.	Q4			

First 1,000 days					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Increasing planned pregnancies: Develop a long activing reversible contraception (LARC) strategy to support all women in the Counties Manukau area to have access to appropriate and timely long acting reversible contraception by a skilled professional in the immediate postnatal period and for the postnatal period of six weeks.	**1a.** LARC strategy developed and approved by ELT.	Q1	Full strategy implemented within 2019/20 Baseline data to be gathered	We have improved health equity (healthy populations	Make New Zealand the best place in the world to be a child
2. Increasing maternal immunisations: Develop a maternal immunisations strategy to: • Increase awareness of health professionals and consumers about the importance of pertussis and influenza (Fluvax and Boostrix) vaccination during pregnancy, through promotion of information/resources and educational opportunities. • Explore improving access to immunisations for outpatients and inpatient facilities.	**2a.** Maternal Immunisation strategy developed.	Q2	Maternal immunisations across all ethnicities is increased by 2%		
Increasing the proportion of children at a healthy weight in their first 1000 days (2-years-old): In 2019/2020 CM Health will build on previous work and continue to: • Deliver community based cooking workshops to pregnant women identified at risk of anaemia, obesity and GDM, in addition to whaanau of infants and toddlers aged 0-2 years. • Deliver Te Rito Ora & B4Baby Breastfeeding Support Service with a target of 80% of women enrolled with Te Rito Ora and B4Baby being Maaori or Pacific. • Refer pregnant women to the Green Prescription programme. • Provide training opportunities to support health professionals to be confident to initiate conversations with families and talk about healthy weight and lifestyle changes. New activities to be undertaken in 2019/20 are identified on the following page.					

First 1,000 days					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
3. Identify and implement recommendations from the evaluation of child healthy weight initiatives in CM Health.	**3a.** Recommendations implemented.	Q4		We have improved health equity (healthy populations	Make New Zealand the best place in the world to be a child
4. In collaboration with HAT and Healthy Families NZ, engage intersectorally to support a gap analysis of healthy food environments in and around Kohanga reo, Pacific Language nests and ECEs to determine areas for future DHB support. **(EOA)**	**4a.** Gap analysis completed.	Q2			
Well Child Tamariki Ora					
5. Support CM Health WCTO Providers to drive change to improve WCTO quality improvement indicators with a focus on the following indicators: a. Indicator 02: Infants receive core contact 1 before 50 days of age b. Indicator 06: Infants are exclusively or fully breastfed at three months c. Indicator 08: All women are screened for family violence at least 3 times during baby's first year	**5a.** PDSA plans developed and implemented.	Q2	a. % of infants who receive core contact 1 before 50 days of age b. % of infants who are exclusively or fully breastfed at three months c. % of women who are screened for family violence at least 3 times during baby's first year	We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child
Please refer to the actions under the SUDI section for our actions related to reducing SUDI rates.					

2.4.2 Improving mental wellbeing

The Government has a vision of a mental health, addiction and wellbeing system without barriers, that is easy to navigate, where no door is the wrong door. DHBs have an important role to play in achieving this vision.

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

There is an expectation that annual plans reflect how DHBs will embed a focus on wellbeing and equity at all points of the system, alongside an increased focus on mental health promotion, prevention, identification and early intervention.

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

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

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Embedding a Wellbeing Focus: CM Health will embed a wellbeing focus through promoting wellbeing and equity for Maaori and Pacific people, including through: • *Supporting the ongoing development and implementation of the recently established Kaupapa Maaori District-wide team (Rapua Whaioranga):* The functions of this team include improving engagement with Service Users and whaanau with high and complex needs; providing Maaori clinical-cultural consultation; supporting effective working relationships between specialist services and NGO Kaupapa Maaori providers; identifying & supporting enhanced cultural competence in the workforce as well as identifying and supporting Maaori clinicians and staff working in CM Health MH&A services • *Pacific Cultural Clinical Liaison:* The focus of the recently established district-wide Faletoa team is to work purposefully with primary care partners to identify and coordinate appropriate health and social care supports earlier in the life course. Our aim is to improve cultural capability and competency across the health and social care sectors to improve outcomes and experience of Pacific people accessing MH&A services.					
1. Embed the Rapua Whaioranga Clinical Cultural Liaison (CCL) model of care across MH&A Specialist services.	**1a.** Roadshows and communications delivered to all MH&A teams and external providers.	End of Q1	**MH01:** Improving the health status of people with severe mental illness through improved access 10 x Roadshows to provider-arm MH services. 5 x Roadshows to NGO services	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	1b. Improve access to cultural and clinical assessment and interventions for Maaori service users.	End of Q2	80% of Maaori service users seen by Rapua Whaioranga on entry to service will have a documented cultural assessment and intervention plan by end of Q2		
	1c. Increase whaanau involvement in assessment and treatment for Maaori.	End of Q2	80% of service users under the care of Rapua Whaioranga will have whaanau involved in care documented in HCC		

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. Strengthen workforce cultural capability to improve engagement and treatment uptake for Maaori, including increasing the range of culturally appropriate treatment options for Maaori. **(EOA)**	**2a**. Rapua Whaioranga staff are trained in clinical/cultural assessment and formulation	End of Q2	100% of Rapua Whaioranga staff are trained and using the HCC clinical/cultural assessment and formulation tool by end Q2		
	2b. Maaori service users and whaanau have access to cultural expertise on entry to MH services	End of Q4	100% of Rapua Whaioranga staff are trained and using the "Dynamics of whanaungatanga" model of care by end Q4		
	2c. Enhance the cultural competency of all staff across MH services	End of Q4	% of new Mental Health staff have completed the CM Health Maaori responsiveness training *(target TBC)*		
3. Embed the Faletoa Clinical Cultural Liaison (CCL) model of care across MH&A Specialist services. **(EOA)**	**3a.** Roadshows delivered to all MH&A teams and external pacific providers & NGOs.	End of Q1	**MH01**: Improving the health status of people with severe mental illness through improved access 80% Pacific Service Users accessing Faletoa CCL services assessed using either the Matalafi or Tutonu	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	3b. 100% Faletoa CCL trained & practicing the Matalafi Matrix-Pacific Cultural Formulation tool.	End of Q1			

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	3c. 100% Faletoa CCL trained in the TuTonu Model.	End of Q2	model by end of Q3		
Whole of System Integration/Inquiry response: Continue the development of primary care-facing specialist teams comprised of a DHB and NGO clinical and non-clinical workforce. The focus is on early intervention and keeping people well through the provision of liaison and advice, initial assessments and brief interventions, without the need for formal referrals to specialist services.					
4. Grow integrated Locality Care (ILoC) to improve physical and mental health outcomes for people with mental health and addiction conditions.	**4a.** ILoC working in 20 general practices in Counties Manukau.	End of Q3	**MH04:** Mental Health and Addiction Service Development – FA1: Primary Mental Health 10% of specialist MH FTE doing ILoC work by end of Q1	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	4b. Fifth ILoC team established in Papakura-Manurewa as part of the Rapua te Ao Waiora community team and aligned with the Maaori CCL approach.	End of Q4	20% of specialist MH FTE doing ILoC work by end of Q4		
5. Provide clarity to the NGO sector about their role in the development of an integrated model of care and the commissioning and contracting approach that will underpin that.	**5a.** Formal communications regarding the collaborative NGO procurement process completed.	End of Q4	**MH04:** Mental Health and Addiction Service Development – FA1: Primary Mental Health		
	5b. Any increased cost pressure funding from Budget 2019 will be contracted through NGO	End of Q4	Funding distributed equitably $ increase per locality		

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	suite of services procurement				
Continue existing primary mental health initiatives and align with future direction of He Ara Oranga: CM Health is implementing a new approach, to provide primary mental health care in general practice s, in order to support the mental health needs of the community. The new model is a response to having listened to the CM Health community of both patients and health professionals and is based on the principles of being kind, clear, continuous and effective care for patients. A key benefit of the **Wellness Support model** is providing funded early interventions for people who have mental health and addictions issues, including those with milder symptoms. Wellness Support opens access to any enrolled person (irrespective of age or symptom score) with a mental health need for whom the primary care practice nurse (PN) or general practitioner (GP) and patient both decide it is likely to be useful. Whilst the model is accessible for all, interventions within the model are targeted at addressing the inequities that currently exist such as providing Rongoa services through a marae based clinic and identifying interventions that are more acceptable to youth such as webinars.					
6. Implement findings and recommendations from Wellness Support evaluation.	**6a.** Improved access to Wellness Support programme for CM Health general practices.	End of Q4	**MH04:** Mental Health and Addiction Service Development – FA1: Primary Mental Health • 50% of CM General Practices have access to wellness support by end of Q4 • 10% increase in Maaori and Pacific, and youth <18 years engaging with Wellness Support by end of Q4	We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	6b. Monitor youth, Maaori, Pacific and Asian engagement with Wellness Support	Ongoing			
	6c. Deploy dashboard to engaged primary care general practices.	End of Q2			
Strengthen support across the full continuum of care: Please refer to actions 1 – 6 above.					
Strengthen and increase focus on MH promotion, prevention, identification and early intervention: Please refer to actions 1 – 6 above.					
Suicide Prevention and Postvention: To continue to provide a range of activities focussed around mental health literacy, education, community engagement and mental health promotion with particular focus on Maaori and Pasifika people.					

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
7. Continue to increase the delivery of Mental Health First Aid (MHFA) with a focus on Maaori/Pasifika and Asian populations. **(EOA)**	**7a**. Co-design MHFA workshops with Maaori-focused facilitators to increase provision of MHFA to the community.	End of Q4	**MH04:** Mental Health and Addiction Service Development – FA2: District Suicide Prevention and Postvention 100 MHFA workshops delivered by end of Q4 10% increase in Maaori participants and a 10% increase in Pacific participants for MHFA by end of Q4 4 Asian-focused MHFA workshops completed with50 Asian ethnicity participants in MHFA by end of Q4	We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	7b. Co-design with Pasifika-focused MHFA facilitators for increased provision of MHFA to the community.	End of Q4			
	7c. Co-design with Asian-focused MHFA facilitators for increased provision of MHFA to the community.	End of Q4			
	7d. Widen the reach of MHFA by purchasing the Youth Package.	End of Q4			

Improving crisis response services

The new Mental Health and Addictions Acute Inpatient Unit, when completed, will consist of 2 High Dependency Units (14 beds in each) and 2 Low Dependency Units (24 beds in each). This represents an increase of 24 beds. The new unit is being built in 2 stages. Stage 1 was completed in 2018 and is currently operational. It is anticipated that 6 new low dependency beds will be opened in 2019. The opening of new acute admission beds will improve the service's capacity to provide acute care. When Stage 2 is completed there will be additional High Dependency beds and this will significantly improve the service's capacity to admit without delays, thereby improving our crisis response services.

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
8. Detailed project planning has commenced and dates will be forthcoming.	**8a.** The duration of construction for Stage 2 is estimated to be 15 months; with practical completion date set for June 2020 followed by a contingency of 30 days through July 2020.	End of Q1	**MH01:** Improving the health status of people with severe mental illness through improved access Stage 2 construction commenced by end of Q1	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	8b. It is anticipated that staff training in new building will commence in August 2020, followed by a decant of staff and inpatients in the same month.	End of Q4	Stage 2 construction completed by June 2020		
Cost pressure funding to ensure NGO sustainability. Please refer to action 5 above.					
Work in partnership with workforce centres to strengthen current workforces, including a focus on retention, recruitment and training					
9. Strengthen partnership relationships with the Workforce Centres.	**9a.** Identify specific people to liaise with the workforce centres and provide feedback **9b**. Expand areas in which Peers are employed to include Inpatient Unit		Demonstrate engagement through attendance Peers employed in Inpatient Unit *(target TBC)* Peers employed in ILoC activity *(target TBC)*		

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
CM Health is committed to working collaboratively with a new MH Commission. CM Health's forensic response is through the regional service provided by WDHB.					
Population mental health					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Early Intervention across primary care spectrum: Refer to actions 1-7 under Inquiry activities above					
Increased options for acute responses: Refer to action 8 under Inquiry activities above, and action 1 below					
Suicide Prevention: Refer to action 7 under Inquiry activities above					
Equally Well: Refer to action 6 under Inquiry activities above					
Improving access and wait time: The Child and Adolescent Mental Health Service (CAMHS) has seen an increase in referrals for neuro developmental disorders such as Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder. Delays in neuro developmental assessment and diagnosis in their formative years can lead to major learning and social problems. Delays are commonly due to the quality of relevant information flowing between schools, families and CAMHS. Focus is on better clinical decision making at the front door through a single point of entry for CAMHS Intake (0-19 year olds), so they have access to the right care at the right time.					
1. Develop a single point of entry and a new behavioural neuro-developmental referral pathway for CAMHS; with timely access to an initial assessment and treatment as a result of not having to wait for information flowing back and forth between families, schools and families.	**1a.** Single Point of Entry referral pathway implemented by end of Q2.	End of Q2	**MH03:** Shorter waits for non-urgent mental health and addiction services for 0-19 year olds 20% reduction in referrals to specialist CAMHS services through effective integration with schools and primary	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	1b. Implement trial neuro-developmental referral pathway.	End of Q2			

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	1c. Education session provided to 120 RTLB staff working across Counties Manukau schools.	End of Q3	care by end of Q3 20% Reduction in CAMHS open service records by end of Q4		
	1d. Clear clinical pathways established for Mood Disorders	End of Q4.			
PRIMHD report: CM Health has on-going commitment to maintain high quality reporting to PRIMHD.					
Transitions/discharge and care plans: Refer to action 1 under Improvement activities below					
Supporting Parents, Healthy Children (COPMIA): Supporting parents with mental illness and addiction and their children					
2. All MH&A facilities, including the inpatient facilities have accessible family friendly waiting area. All mental health facilities will plan how they will meet the environment recommendations in SPHC Guideline 2015 p. 24, including funding, resources and processes.	**2a.** A plan documenting how the facility will meet the environment recommendations in SPHC Guideline 2015 p. 24 completed by each facility. Facilities include community centres at Springs Road, Awhinatia, Lambie Drive and Matariki; and inpatient units at Tui, wards 42 and 43, Tamaki Oranga and Tiaho Mai.	End of Q1	**MH04:** Mental Health and Addiction Service Development – FA4: Improve outcomes for Children	We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering
Reduce the rate of Maaori under the Mental Health Act: section 29 community treatment orders The rates of Service Users under the Mental Health Act: section 29 community treatment orders are measured and monitored at a leadership level on a monthly basis via the					

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
monthly DAMHS (Director Area Mental Health Services) Dashboard which breaks down all data by ethnicity to enable easy visual management and analysis of trends. Findings and learnings are fed back directly to SMO's and clinicians; and also to the wider clinical groups through bi-annual presentations at Journal Club; at MH&A Clinical Governance meetings where appropriate; and into the CTO orientation training where appropriate.					
3. Ensure clinical reviews are completed in a timely way.**(EOA)**	**3a.** Audit of SMO consultation with whaanau for s.76 clinical reviews completed.	End of Q2	**MH05**: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders 90% s.76 clinical reviews completed on time by Q4 50% of SMO consultation for s.76 clinical reviews includes whaanau. 50% increase in consultation with Kaupapa Maaori services at the point of CTO application by end of Q4 Number of Service Users receiving funding to support medication	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Connect Service Users and whaanau to NGO for ongoing support. Increased involvement of Kaupapa Maaori services in the persons care; in particular, at consultation before decision is made to put service user on a CTO.	**4a.** Service users who are Maaori for whom an application for CTO is made, will be referred to a consultation with Kaupapa Maaori services.	End of Q4			

Inquiry into mental health and addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	4b. Ensure Service users coming off a CTO and receiving funded medication have ongoing support from an NGO	End of Q4	after coming off CTO will be determined by end of Q4		
Implementation of SACAT is through the regional WDHB specialist addictions services.					

Mental health and addictions improvement activities					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Improving Transitions and Engagement: The Health Quality and Safety Commission (HQSC) Transitions of Care Project Team is focussed on improving service user transitions between primary care and secondary mental health services. From an analysis of data, co-design work with service users and process study we are seeking to identify what is working well and not so well. Obtaining meaningful data has been challenging but has provided useful insights to assist the project. Once the relevant processes have been mapped and the baseline data has been established we will proceed to root cause analysis and verification. We can then move to the 'improve' phase and test hypotheses.					
1. Implement improvements based on the outcomes identified during the Connecting Care (transition) project.	**1a.** Quarterly audit of the quality of transition and wellness plans to meet accepted good practice.	End of Q4	**MH02:** Improving mental health services using wellness and transition (discharge) planning 95% of clients discharged will have a quality transition or wellness plan by end of Q4. This will measure ethnicity. 95% of audited files meet accepted good practice by end of Q4. This will measure ethnicity.	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
Minimising restrictive care (with the aspirational goal of eliminating seclusion by 2020): The HQSC are embarking on a national campaign and quality improvement process to support a national stretch goal of Zero Seclusion by 2020. The CM Health project is titled 'Safe for All' and has a lens focussing on safety and processes that support reduced restrictive practices. Practice changes include admissions where possible occurring via the Whare and with a focus on engagement with whaanau. There is a focus on early identification of behaviours of distress and early intervention with sensory modulation, de-escalation, distraction and one to one therapeutic options. The physical environment is the biggest change with the opening of the new inpatient unit in November 2018 and the physical use of a range of spaces allows much more opportunity for service users to self-manage their distress.					
2. Utilise findings from the HQSC campaign to reduce the utilisation of seclusion in Tiaho Mai - the CM Health Acute Adult inpatient unit	**2a.** Collect data and interpret and discuss statistical significance of ongoing performance.	Before Q1 and ongoing	**MH02:** Improving mental health services using wellness and transition (discharge)	We have improved quality of life (health	Ensure everyone who is able to, is earning, learning, caring or volunteering

Mental health and addictions improvement activities					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	2b. Work with the clinical team to set targets for these key measures and to review the balancing measures for suitability.	Before Q1	planning 50% reduction of people admitted to Tiaho Mai who are secluded by end of Q2 Additional 25% reduction of people admitted to Tiaho Mai who are secluded by end of Q3 Targets will be set for the reduction in average seclusion hours per person to Tiaho Mai and the reduction in average seclusion events per person admitted to Tiaho Mai	maintenance and independence)	

Addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Existing addiction services The Counties Manukau population accesses specialist Alcohol and Other Drug (AOD) services via Waitemata DHB's regional AOD services and a range of contracted NGO services. Seventeen percent of the total NGO contracts are for AOD services, with 14 contracts across nine NGO providers. Services are both residential and community-based, with provision for both youth and adults and specific Maaori and Pacific services.					
New addiction services CM Health is developing a new specialist addictions liaison team as part of its integrated model of care. The resource will complement the regional specialist addiction services provided by Waitemata DHB Community Alcohol and Drug Services (CADS), with a focus on providing a joined-up response to service users with both an addiction and a mental health need. The resource will work across the specialist mental health teams – community and acute – primarily providing consult liaison and capability development, with scope for clinical interventions in complex presentations. The specialist Addictions liaison team work will include a focus on those Service Users engaged by CM Health's Maaori Cultural Clinical Liaison (CLL) team, Rapua Whaioranga, and our Pacific CLL team Faletoa; please refer to the Inquiry into mental health and addiction section of the 2019-2020 Annual Plan for further information on these services.					
1. CADS addiction specialists working actively within CM Health's primary-care facing integrated locality care (ILoC) model.	**1a.** 1 FTE CADS addiction specialist in regular (weekly) attendance at ILoC and primary care MDTs providing specialist liaison advice to primary care.	End of Q1	**MH04:** Mental Health and Addiction Service Development – FA1: Primary Mental Health 10% of Adult Service Users with an open referral have an AOD screening by end of Q4 75% of Service Users accessing Faletoa CCL services have an AOD screening by end of Q4	We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering
2. Specialist addictions liaison team established and fully operational, including engagement with the Cultural Clinical Liaison teams. **(EOA)**	**2a.** Capability development sessions held with all community teams in IC North and IC South.	End of Q4			

Addiction					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	2b. Front-door assessment criteria implemented to enable early intervention and liaison input for those with highest AOD need.		75% of Service Users accessing Rapua Whaioranga CCL services have an AOD screening by end of Q4		

Maternal mental health					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Awhi Rito is a maternal mental health respite facility which offers clinical and non-clinical mental health support to women who are referred either by CM Health Maternal Mental Health team or their primary care practitioner. The team work in partnership with women to meet their mental health needs, enhance their parenting skills and support positive attachment with their infants. Awhi Rito extends the support that can be accessed through Primary Care under the Wellness Support model of care. Wellness Support sees practice nurses and GPs working confidently with people towards their mental health; please refer to the Wellness Support programme detailed in the Population Mental Health section. Current report data shows an inequity in the number of Pacific women accessing the maternal mental health respite facility, Awhi Rito. The number of Maaori women accessing the service reflects the percentage of Maaori women birthing at CM Health, but few Pacific women access the services. The respite facility only has four beds so we intend to work alongside General Practices and the DHB Start Well team to improve equity and access rates during 2019-2020. Unfortunately, it is not possible to open up to all LMCs and Well Child; due to capacity of the service and the referring needs to maintain clinical responsibility and potentially this would not work for LMCs and Well Child.					
1. Increase access to Awhi Rito respite facility for women not under the care of maternal mental health but who require additional support to meet their mental health needs; with a particular focus on Pacific women. **(EOA)**	**1a.** Implement the primary care referral pathway with 3 primary care agencies in the Manukau Locality	End of Q1	**MH06:** Mental Health Annual Plan Update Report Baseline data for teen access to Awhi Rito identified by end of Q2	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering

2. Increase access to Awhi Rito for teenagers	**2a.** Implement policies to ensure teens are appropriately cared for alongside adults as per the UNCROC guideline.	End of Q2	Baseline age and ethnicity data for access to day programmes, workshops and home based supports identified by end of Q3		
3. Monitor access by primary care and teens by ethnicity. Access to day programmes, workshops and home based supports will be monitored by ethnicity to help understand if these models of care are accessed by Pacific women. **(EOA)**	**3a.** Record and monitor teen utilisation of Awhi Rito by age and ethnicity.	End of Q3			
4. The Auckland DHB quality improvement project reviewing Pacific access to and engagement in ADHB maternal mental health services will identify barriers to referrals and engagement in the service. The findings and recommendations of this project will be shared regionally through the Regional Perinatal Clinical Governance Group.	**4a.** Monitor proportion of women accessing maternal mental Health services from all births at CM Health.	End of Q4			

2.4.3 Improving wellbeing through prevention

Preventing ill health and promoting wellness is vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards prevention. This preventive focus includes supporting people to live active and health lives, working with other agencies to address key determinants of health, and to identify and treat health concerns early in the life course and in the life of progress of the disease.

Cross-sectoral collaboration					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Social Wellbeing Board CM Health is a key partner in the South Auckland Social Wellbeing Board (SASWB), originally one of three Cabinet mandated Place-Based Initiatives (PBIs). The SASWB partners, local and national decision-makers from 11 government agencies plus Auckland Council, who jointly fund many of the services and support whaanau receive, are working together to improve health and social outcomes for children and their whaanau in South Auckland. There is a focus on Maaori and Pacific whaanau. CM Health is also the organisational host for the SASWB staff who support the work of the SASWB (e.g. leadership, programme management, and evidence and insights). The SASWB work focuses on five areas/prototypes to identify system-level change and commissioning opportunities that will improve meaningful support for whaanau and children in the early years. From a whaanau perspective, these areas of course overlap and a holistic, coordinated whaanau approach is needed. The five areas are Family Violence and Harm, Early Childhood Education, Mental Health and Substance use, Housing Support and Stability and Start Well, an intensive home visiting programme for young mothers from pregnancy to when their child is aged 5 years					
1. CM Health contributes to a move towards a 'self-sustaining' model based on resource contributions from the SASWB member agencies. This includes elements of resourcing that can become part of collective core business activities of SASWB member agencies, as well as commissioning opportunities. Leveraging the system to improve outcomes for Maaori and Pacific whaanau is an **EOA.**	**1a.** Sustainable SASWB model developed with a plan for next steps.	Q4		We have improved health equity (healthy populations)	Support healthier, safer and more connected communities
2. Ensure that there is an appropriate, sustainable health contribution to the 'One-system Response to Family Harm', led operationally by Police. This includes participation in the daily, cross sector Safety Assessment Meeting (SAM) after acute family harm incidents, and embedded pathways to respond to referrals from the SAM to health services. Maaori and Pacific peoples are disproportionately impacted by family harm; improving social sector responses to family harm is an **EOA.**	**2a.** Sustainable SAM health response.	Q4			

Cross-sectoral collaboration				
DHB activity	**Milestone**	**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
			System outcome	**Government priority outcome**
Other CM Health cross-sectoral activity *Referral support to AWHI (Housing Support Service):* As part of the DHB Rheumatic Fever Prevention programme, the DHB employs referral support to ensure families who are eligible receive referral to AWHI, the housing support service contracted directly by the Ministry of Health with the provider (National Hauora Coalition). *Integration of Social Work Support in pregnancy/early years:* The DHB also has an initiative linking midwives with social work support available through Family Start. *Auckland Regional Public Health Service (ARPHS) cross-sectoral work on behalf of metro-Auckland DHBs:* ARPHS provide policy advice and submissions on public health and social service relevant issues (e.g. the Healthy Homes Standards consultation) on behalf of Metro Auckland DHBs, working closely with DHBs to gain DHB CEOs' signoff where that is deemed particularly useful. ARPHS is also involved in the Regional Homelessness Plan led by Auckland Council. *Providing coordinated local responses to emerging drug threats such as synthetic cannabinoids*: In the event of sudden and serious increases in acute harms associated with synthetic drug use, such as deaths and overdose incidents, CM Health will work with ARPHS, other Auckland region DHBs, and cross sectoral partners in a coordinated way to address the emerging issues. Other cross-sectoral work not specifically related to health and social services integration is described in other parts of this plan (e.g. participation in Healthy Auckland Together – working to improve environments to support healthy nutrition, physical activity and obesity prevention, includes Auckland Council and Auckland Transport, with ARPHS providing a backbone function).				

Climate change					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Energy and water					
1. Continued work with the Energy Efficiency and Conservation Authority (EECA) meeting the Collaborative Agreement with targeted energy savings set at $400,000 per annum for FY19 compared to baseline FY16.	**1a.** Achievement of the savings target.	Q4	$400,000 saved per annum	Transition to a clean, green carbon neutral new Zealand	Grow and share New Zealand's prosperity more fairly

Climate change					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Carbon mitigation and adaptation					
2. Continuation with Certified Emissions Measurement and Reduction Scheme (CEMARS) Certification and all carbon mitigation and adaptation activities.	**2a.** Maintenance of CEMARS Certification.	Ongoing	Carbon reduction of 2%	Transition to a clean, green carbon neutral new Zealand	Grow and share New Zealand's prosperity more fairly
3. Increase the number of emission reduction engagement activities for DHB staff.	**3a.** Implement 10 initiatives.	Q4			
4. Northern Region DHB Supplier Relationship Management Framework: Implementation of active plans including sustainability initiatives.	**4a.** 10 suppliers by June 2020.	Q4			

Waste Disposal					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Recycling and waste reduction: CM Health will continue to recycle cardboard, soft plastic, mixed recycling, non-confidential paper, polystyrene and e-waste. CM Health will also undertake the following recycling and waste reduction activities: • Initiate a trial for single use surgical instrument reprocessing indicated as safe and beneficial • Improve waste segregation and recycling infrastructure	**1a.** Include all clinical areas in scissor and tweezer recycling by June 2020.	Q4	Track monthly waste volumes	Transition to a clean, green carbon neutral new Zealand	Grow and share New Zealand's prosperity more fairly
	1b. Complete trial of single-use instrument reprocessing and identify results.	Q4			
	1c. Evaluate and expand trial.	Q4			

Waste Disposal					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
• Continue to deliver training to reduce preventable medical waste and general waste • Expand on scissor and tweezer recycling					

Drinking Water					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
The Auckland Regional Public Health Service (ARPHS) leads the drinking water activities in the environmental health exemplar across the region, and CM Health will:					
1. Input and review ARPHS Annual Operational Plan and contractual reporting.		Annually/six-monthly	% of network water supplies compliant with the Health Act 1956 (broken down by class) for Metro Auckland DHBs (annual measure) 100% of medium and large suppliers are compliant	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities
2. Work closely with ARPHS where there are drinking water issues that impact on the Counties Manukau DHB population.		As required			
3. Work with ARPHS to implement the Wai Auckland tap water initiative, with a focus on Maori and Pacific populations **(EOA).** The Wai Auckland project aims to decrease intake of sugary drinks and improve the accessibility of tap water.	**3a.** Commence implementation from 1 July 2019.	Q1			

Healthy food and drink					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. CM Health has had a healthy food and drink policy for more than a decade. Since 2016 CM Health has been implementing a policy aligned with the National Healthy Food and Drink Policy.	**1a.** Use most recent monitoring data to give detailed feedback to retailers and work with them to address barriers to increased compliance.	Ongoing	Working with 50% of retail spaces to address compliance barriers with measured improvement in compliance by end of Q2 and working with 60-75% by Q4	We live longer in good health (prevention and early intervention)	Support healthier, safer and more connected communities
2. CM Health has included a clause in 100% of funder arm contracts renewed in the 2017/18 year (from July 2017) outlining the expectation of implementation of a healthy food and drink policy (example clause below), except for those providers who sit under national contracts, i.e. Age Related Residential Care, Combined Dental Agreements and Community Pharmacy Services Agreements. In some instances there are local schedules to national contracts in which the clause has been included (e.g. PHO agreements). ***Healthy Food and Drink Policy*** *DHBs expect you to have a role in promoting the health and wellbeing of your service users, staff and visitors to your service by supporting them to make healthy food and drink choices. From 1 July 2017, you will adopt a Healthy Food and Drink Policy covering all food and drinks sold on*	**2a.** Healthy food and drink policy clause to be included in any new funder arm contracts, unless the Programme Managers have a clear rationale to specifically request that this clause is excluded.	Ongoing	The number of funder arm contracts with a healthy food and drink clause is reported as part of the Regional Childhood Healthy Weight Plan reporting		

Healthy food and drink					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
sites, and provided to service users, staff and visitors under your jurisdiction. At a minimum, your Policy is to be written and reflect the principles of the National District Health Boards and Ministry of Health Healthy Food and Drink Policy, which aligns with the Ministry of Health's Eating and Activity Guidelines. A template policy can be found at: *https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations* . This clause is also part of our current Provider Specific Terms and Conditions template and as such will be included in any new funder arm contracts, unless the Programme Managers have a clear rationale to specifically request that this clause is excluded.					
3. Work with ARPHS to evaluate the feasibility and potential method of determining how many Early Learning Settings (ELS) and schools in the CM Health rohe have a current water-only policy and/or healthy food policy which is consistent with the Eating and Activity Guidelines. From current data available to ARPHS and CM Health, determine the number of Early Learning Settings and schools which have a current water-only policy and/or healthy food policy which is consistent with the Eating and Activity Guidelines.	**3a.** Feasibility report complete.	Q2			

Smokefree 2025					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. With a particular focus on Maaori, patient outcomes related to harm from smoking will be improved by: • Continuing to focus on brief advice in primary care. • An increase in referrals to cessation support. • Support for the delivery of medication therapy in primary care. **(EOA)**	**1a.** An increase in primary care referrals to Living Smokefree Service by 6%.	Q4	PH04: Better help for smokers to quit (primary care) SS05: Better Help for smokers to quit in public hospitals CW09: Better help for smokers to quit (maternity)	We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child
	1b. 40% of those supported to stop smoking are Maaori.	Q4			
	1c. An increase people dispensed stop smoking medications in primary care by 12%.	Q4			
2. Improve the quality of data collected on postnatal smoking as an indicator of smoking in pregnancy by active support for WCTO providers to improve the quality of smoking status data, through feedback, education and reporting. A particular focus will be given to waahine Maaori.	**2a.** Increase the proportion of waahine Maaori who smoke who are referred to the Smokefree maternal incentives programme by 10% (180 women referred).	Q1-Q4		We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	2b. 60% of those supported to stop smoking are hapu waahine Maaori.				
3. Explore and develop a Tobacco Free Generation (TFG) approach in Counties Manukau, which will involve **(EOA)**: • Refocusing existing work and prioritising key population groups; • Trialling new initiatives that contribute to TFG; • Building a TFG 'movement' in Counties Manukau.	**3a.** Complete development of the approach.	Q4			
4. Champion innovative approaches for smoking cessation and harm reduction, including supporting people who choose to use vaping products.		Ongoing			

Smokefree 2025					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Please refer to the 2019/20 Metro Auckland SLM Improvement Plan for a number of additional activities, in particular the sections on respiratory admissions in 0-4 year olds and smoking cessation for Maaori and Pacific.					

Breast Screening					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
CM Health is committed to achieving equity in screening coverage. Coverage as at March 2019 by DHB for women aged 50-69 years was: Maaori **65.5%**, Pacific **83.2.** Total **71.8%.** Coverage targets for Pacific and the total population have been met. BreastScreen Counties Manukau and the CM Health Screening Support Services work together on strategies in the Counties Manukau area to increase coverage in priority groups. Activities to improve breast screening coverage for Maaori women specifically include:					
1. Improved data matching to identify Maaori women who are not enrolled and to find new contact details for women who may have moved: • Regular data matching with all primary care practices in the DHB • Data match with DHB patient management system • Auckland Regional Project - *Find 500 Maaori Women* through data matching with PHO enrolment data.	**1a.** DHB data match completed by December 2019.	Q2	Report number of Maaori women screened as a result of data matches: • DHB data match Dec 2019 • *Find 500* project by June 2020	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
	1b. *Find 500 Maaori Women* project completed by June 2020.	Q4			
2. Tailoring and orienting services to support access and engagement, Mana Wahine days are run monthly on one Saturday per month for Maaori women, where both breast and cervical screening is offered.	**2a.** 12 Mana Wahine days held in 2019/20 year.	Q4	Report number of Maaori women screened at Mana Waahine days June 2020 Maaori coverage target achieved by June 2020		

Cervical Screening					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
CM Health is committed to improving cervical screening coverage and achieving equity in screening coverage. Cervical screening coverage is lowest for Maaori and Asian women. CM Health is focused on improving coverage rates for both population groups via primary care and our Support to Screening Service.					
1. With a specific focus on wahine Maaori, the actions to be implemented are: • Support for PHOs to prioritise women by clinical risk and ethnicity using appropriate systems and processes • Provision of smear-taker support for PHOs with high numbers of wahine Maaori • Holding Mana Wahine days • Provide community smear-taking clinics in a number of locations, including at local marae and at the Manukau SuperClinic. At the Manukau SuperClinic this includes the provision of evening and weekend clinics to reduce access barriers. • Provision of a Support to Screening Service to support wahine along the whole screening pathway	**1a.** Each PHO increases number and percentage of enrolled high needs women screened by June 2020 in comparison to July 2019.	Q4	Strong system SS08: Improving Cervical Screening coverage	We have health equity for Maaori and other groups	Support healthier, safer and more connected communities
	1b. 12 Mana Wahine clinics held by June 2020.	Q4			
	1c. 12 evening/weekend community clinics held by June 2020.	Q4			

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

New Zealanders are living longer, but also spending more time in poor health.

This means we can expect strong demand for health services in the community, our hospitals, and other care settings.

Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development, and joined-up service planning to maximise system resources and to improve health and increase equity.

Engagement and obligations as a Treaty partner					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Note: On a quarterly basis, narrative progress reports against each deliverable will be provided to Maaori Health.					
1. Engaging Manawhenua at a governance level, which includes partnership and participation in DHB governance, planning, funding, and monitoring functions through the DHB board-to-board partnership with Manawhenua.	**1a.** Hold Board to Board meetings.	Q1-Q4	Quarterly narrative progress report for each deliverable to Maaori Health	We have improved health equity (healthy populations)	Support healthier, safer and more connected communities
	1b. Review of Annual Plan completed by Manawhenua.	Q3-Q4			
	1c. Te Tiriti o Waitangi co-governance training completed.	Q2			
2. Implementation of the Manawhenua Hauora plan including health equity and hauora measures and whaanau-centred indicators within CM Health services. This will include: • Development of a co-design model in partnership with CM Health services • Trial a Manawhenua evaluation tool with a focus on assessing whaanau experience of health services being delivered to Maaori • Monitoring of Treaty responsiveness and Maaori Health equity measures	**2a.** Development of measures and indicators.	Q2			
	2b. Implementation of evaluation tool.	Q4			
	2c. Development of co-design process completed.	Q3			
3. Implement a Te Reo Maaori Strategy led by Manawhenua to promote the active use of Te Reo Maaori in engaging Maaori and their whaanau. Te Reo Maaori classes will be offered and available for all Counties Manukau DHB staff to attend.	**3a.** Implementation of strategy activities.	Q1-Q4	Number of staff attending Te Reo Maaori classes % of staff confident in Te Reo Maaori		
4. Review then implement a Tikanga capability program of Tikanga best practice principles, Treaty of Waitangi, & cultural competency training programme for all Counties Manukau	**4a.** Implementation of programme activities.	Q4	Number of staff who have completed Tikanga training		

Engagement and obligations as a Treaty partner					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
DHB staff.	**4b.** Review and update CM Health's Tikanga Best Practice Manual.	Q1-Q4			
5. Deliver whaanau-centred integrated services to high needs, hard to reach Maaori and whaanau with complex needs with key CM Health priority health conditions.	**5a.** Delivery of whaanau-centred outcomes-based packages of care.	Q1-Q4	Number of referrals received Number of whaanau referred to the service		

Delivery of Whaanau Ora					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Deliver whaanau-centred integrated services to high needs, hard to reach Maaori and whaanau with complex needs with key CM Health priority health conditions.	**1a.** Delivery of whaanau- centred outcomes-based packages of care.	Q1-Q4	Number of referrals received and packages of care delivered	We have improved health equity	Support healthier, safer and more connected communities
2. Development of a whaanau-centred co-design model in partnership between Manawhenua and CM Health services.	**2a.** Development of co-design process completed.	Q3	Quarterly narrative progress report deliverable to Maaori Health		
3. Develop and implement Whaanau Ora model of care for whaanau-centred services delivered within our hospital.	**3a.** Development of Whaanau Ora model of care completed.	Q1-Q4	Number of whaanau referred and accepted into Whaanau Ora services		
4. Embed the Rapua Whaioranga Clinical Cultural Liaison (CCL) model of care across mental health and addiction (MH&A) specialist services.	**4a.** Roadshows and communications delivered to all MH&A teams and external providers.	End of Q1	Improving the health status of people with severe mental illness		

Care Capacity Demand Management					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Implement the components of the Care Capacity Demand Management (CCDM) programme (Governance, Patient Acuity Tool, Core Data Set, Variance Response Management and FTE Calculations), with an initial focus on Governance and the Patient Acuity Tool components.	**1a.** Patient Acuity Tool – CCDM team & pilot wards training and go-live (ARHOP) by October 2019.	Q2	ARHOP live with TrendCare by October 2019	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	1b. Patient Acuity Tool - Phase 1 training and go live by December 2019.	Q2	Phase 1 TrendCare training and go live by December 2019		
	1c. Patient Acuity Tool – Phase 2 training and go live by January 2020.	Q3	Phase 2 TrendCare training and go live by January 2020		
	1d. Governance - establish Safe Staffing Committees for each ward where TrendCare is implemented as per terms of reference (local data councils) by December 2019.	Q2	TrendCare wards have a Safe Staffing Committee		
	1e. Core Data Set - Health Informatics team to trial Qlik Sense and incrementally add TrendCare data. Develop reporting requirements, test	Q4	Business case presented for inclusion in 2020/21 budget.		

Care Capacity Demand Management					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	environment and present business case for inclusion in 2020/21 budget.				
	1f. Variance Response Management - Smart 5 reallocation guideline and escalation plans will be operationalized. IT requirements for CaaG and VIS to be scoped and business case presented for inclusion in 2020/21 budget.	Q4	Business case presented for inclusion in 2020/21 budget.		

Disability					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Implement CM Health-specific action points from the Regional Disability Strategy Implementation Plan. This will include improving data availability on disability, including establishing if there are inequities for our Maaori and Pacific communities. **(EOA)**	**1a.** Develop and implement the CM Health action plan.	Q2	Action plan implemented	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities
	1b. Measure delivery against action points.	Q3	Measure progress of action points		
2. Increase the percentage of staff undertaking training in disability awareness, by improving uptake of mandatory e-Learning on disability responsiveness and cultural competency training with a focus on disability. **(EOA)**	**2a.** Promote disability training and development activities.	Q1	Increase in % of staff who have undertaken mandatory training and cultural competency training		
	2b. Measure uptake of training activity.	Quarterly			
3. The DHB currently collects and manages information on disability to help staff make decisions on the support that may be required to deliver care to the patient during their care journey. This process is currently sufficient to ensure that relevant information is available to clinicians to guide the care of patients. In 2018/19 we will promote and increase uptake of Health Passport (a physical paper passport that patients can carry with them, acting as a means of recording and communicating support required by the patient for specific disabilities) increasing the awareness of health passport with staff and patients.	**3a.** Promote Health Passport use.	Q2	Increase in staff awareness of Health Passport Increase in patients being offered Health Passport		

Planned Care					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Background: Planned Care is a broader concept than medical and surgical services traditionally known as Electives or Arranged services. Planned Care is patient-centred and includes a range of treatments funded by DHBs delivered in inpatient, outpatient, primary and community settings. It also includes selected early intervention programmes that can prevent or delay the need for more complex healthcare interventions. Over 2019/20 CM Health will continue efforts to achieve Planned Care intervention targets, increase clinical capacity and maintain timeliness and equity of access to Planned Care services (including diagnostics and radiology) in line with the National Planned Care Vision and key principles. In 2019/20 CM Health also plans to refresh our Healthy Together strategy for the 2020 - 2025 years. As part of this process, we will complete a Clinical Services Plan which integrates our plans for our services over the next five years and the associated enablers for service delivery. Included in this Plan will be CM Health's proposal to improve Planned Care services. This will include programmes and actions to address the Ministry of Health's five Planned Care Priorities of: • Gain an improved understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed. • Balance national consistency and the local context • Support consumers to navigate their health journeys • Optimises sector capacity and capability • Ensures the Planned Care systems and supports are designed to be fit for the future As part of this work, CM Health will work with the Consumer Council and a range of other key stakeholders to identify which aspects of the Clinical Services Plan and design would be of the greatest value to the consumer.					
Part One: Current Performance Actions					
1. We will achieve SS07 Planned Care Measures Services by: • Delivery against agreed volumes in Price Volume Schedule (PVS). • Using targeted initiative funding to increase access for Planned Care Initiative Discharges and procedures • Review CM Health performance against regional and national performance.	**1a.** Achieve SS07 Planned Care Measures.	Q1- Q4	SS07: Planned Care Interventions 19,892 Inpatient Surgical Discharges 10,579 Minor Procedures Elective Services Patient Flow Indicator	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities

Planned Care					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. Increase clinical capacity to provide Planned Care services: • Maximise theatre utilisation and productivity. • Use alternative clinical staff to deliver a range of ambulatory interventions appropriate to scope of practice. • Negotiate and utilise external agency capacity to support service delivery.	**2a.** Meet other production and access targets.	Q2- Q4	results Diagnostic waiting times for Angiography, Computerised Tomography(CT), and Magnetic Resonance Imaging (MRI) Ophthalmology Follow-up Waiting Times Acute Readmission rates	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities
3. Maintain timeliness and equity of access to Planned Care services: • 3a. Improve timely and equitable access for new patients referred for specialist services by ensuring management and referral guidelines are available to assist primary care to actively manage. appropriate patients in the community • 3b. Support services to regain compliant ESPI status through performance review and regular monitoring against ESPI recovery plan. • 3c. Implement national electronic clinical prioritisation tools into services as released for use to increase equity of prioritisation. • 3d. Deliver 75% of local anaesthetic skin procedures in procedure unit to create capacity in theatre rooms for elective surgical discharges. • 3e. Prioritise high risk cancer patients and high clinical priority patients for treatment	**3.** Regain Elective Services Patient Flow Indicators compliance (ESPI 2 and 5). 3a. Referral guidelines available for primary care via Health Pathways portal by Q2 3b. ESPI compliance actively monitored across all services Q1 – Q4 3c. Ongoing 3d. 75% of local anaesthetic skin procedures delivered in procedure unit (rather than theatres) by Q4 3e-g. Monthly reporting from population CNCs.	Q4			

Planned Care					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
for treatment within 4 months or sooner if clinically indicated with other patients being treated in turn. • 3f. Ensure equity of access to Cancer services and timely FCT access for Maori patients by utilising input from Cancer Nurse Coordinators (CNC) and Maori Health team to navigate care pathways (EOA) • 3g. Ensure equity of access to Cancer services and timely FCT access for Pacifica patients by utilising input from Cancer Nurse Coordinators and Pacific Health team to navigate care pathways (EOA) • 3h. Continue focus on improving timeliness of Ophthalmology follow-up with additional / locum clinics, seeking opportunity for alternative venues and workforce and use of non face to face opportunities	Reports to include contact volumes, ethnicity, FCT target compliance and qualitative narrative completed by the CNC in conjunction with the Maaori and Pacific Health Gains teams. 3h. Ongoing				
Part 2: Three Year Plan for Planned Care					
4. Develop a Clinical Services Plan which incorporates CM Health's proposal to improve Planned Care services over the next five years.	**4a.** Provide to the MoH a plan for the development of the Clinical Services Plan that outlines the	Q1	Plan for the development of the Clinical Services Plan submitted	We have improved quality of life (health maintenance and	Support healthier, safer and more connected communities

Planned Care					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	intended engagement, analysis and development activities along with a timeline for development of the plan.		Planned Care sections of the Clinical Services Plan submitted	independence)	
5. Work with the Consumer Council to identify which aspects of the Clinical Services Plan and design would be of greatest value to the consumer.	**4b.** Submit to the MoH the relevant sections of the Clinical Services Plan which outline actions to improve Planned Care Services.	Q3			

Acute Demand					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Acute data capturing: CM Health is not part of the five DHBs which are piloting SNOMED coding in Emergency Departments. The National Non-Admitted Patient Collection (NNPAC) has indicated that SNOMED is optional for now while the pilot is being completed. Once the pilot is completed we will work with other DHBs in our region to progress the implementation of SNOMED. CM Health is current doing work with our vendor to prepare for eventual implementation.					
Improving patient flow: CM Health's Every Hour Counts portfolio aims to improve patient flow to optimise the quality of care, the experience of care and the experience of caring whilst improving the efficiency of the system. Please see below for some of the key secondary care-focused activities planned for 2019/20 as part of Every Hour Counts. Please refer to the Primary Care Integration section of the Annual Plan for the primary and community-based acute demand activities.					
1. Redesign the system to optimise patient flow, matching demand to capacity and reducing/shaping demand.	**1a.** Introduction of the SAFER patient bundle in Medicine.	Q1	Number of red to green days Average length of stay	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities
	1b. Match capacity to demand to reduce the wait list in MRI to meet standards.	Q3	Demand for scans in measurement of time vs capacity (people and equipment) in unit of time against actual activity in time		
	1c. Reduce the time that beds are unavailable to be occupied by incoming patients to maximum of 4 hours.	Q4	Time of patient discharge versus request for cleaning and time of new patient admitted		
	1d. Introduction of a discharge complexity tool to reduce delay to discharge for medically cleared patients.	Q4	Number of patients with a Delayed Transfer of Care Length of stay between 'ready to go home' date and actual discharge date		

Acute Demand					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. Implementation of care bundles to facilitate prompt treatment by nursing staff for appropriate patients from entry to ED. CM Health is currently introducing five bundles: cellulitis, neck of femur (NOF), asthma, dental and lower back pain.	**2a.** Three bundles expected to be implemented by end of April 2019 with all bundles to be implemented by December 2019.	Q2	SS10: Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours To be seen time	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities
3. A booking and scheduling review of outpatient appointments was completed in 2019. The did-not-attend (DNA) rate was found to be substantially higher for Maaori and Pacific patients. Interviews with 15 Maaori patients and 15 Pacific patients were conducted to understand the drivers of DNAs. Improvement projects to respond to the recommendations of the review will be developed over 2019/20. This will include a focus on reducing DNAs for Maaori and Pacific people. **(EOA)**	**3a.** Develop improvement projects based on the recommendations of the booking and scheduling review, including a focus on reducing DNA rates for Maaori and Pacific people.	Q1-Q4		We have improved quality of life (health maintenance and independence)	We have improved quality of life (health maintenance and independence)

Acute Demand					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
4. Collect and analyse data to understand the demand for mental health services amongst patients presenting or being referred to ED: • Obtain accurate data on referrals to Acute Psychiatry from ED and wait times to be seen over the past 12 months. • Audit the use of the ED triage app jointly developed with Police to understand how effectively it is being used to divert assessments to locations other than ED.	**3a.** Collect data on referrals.	Q1	Total referrals from police Wait times to be seen by Acute Psychiatry for referred patients % of Police referrals then referred to psychiatric services		
	3b. Audit use of app and referral numbers pre-and post-rollout of the app.	*TBC in Q1*			

Rural Health					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Conduct a review of rural marae-based primary care services to support equity of access (enrolment and utilisation) for Maaori. This is likely to include better ways to support patient/whaanau choice or provider and virtual care options. **(EOA)**	**1a.** Stocktake completed.	Q2	PH03: Improving Maaori enrolment in PHOs to meet the national average of 90%	We have improved health equity (healthy populations)	Support healthier, safer and more connected communities

Healthy Ageing					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Working with ACC, HQSC and the Ministry of Health to promote and increase enrolment in Strength & Balance programs and improvement of osteoporosis management: CM Health will continue to: • Identify older people aged 75 years and over at risk of falls through primary care screening, with referral as appropriate to promote enrolment to Strength and Balance programme. CM Health will continue to screen Maaori with a fall in the previous 12 months at an earlier age of 65 years. **(EOA)** • Provide assessment recommendations to primary care via the Fracture Liaison Service to improve implementation of osteoporosis management.					
1. Continue through local and regional networks to focus on improving stroke outcomes for Maaori and Pacific patients. **(EOA)**	**1a**. Continue to monitor stroke key performance indicators (KPIs) by ethnicity with an equity lens throughout 2019/20.	Quarterly	SS13: Improved management for long term conditions - Focus Area 5: Stroke	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering

Healthy Ageing					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
	1b. Review outcome measures as per AROC data, special attention to Functional Independence Measure (FIM) scores/efficiency for Maori and Pacific stroke patients.	Quarterly			
	1c. Begin to explore an Atrial Fibrillation pathway for secondary prevention of stroke.	Q2			
Identify drivers of acute demand for people 75 plus presenting to ED					
2. Drivers of acute demand for people 75+ presenting to ED will be identified through the Every Hour Counts - Acute Flow programme of work. This includes having a geriatrician work alongside the charge nurse in ED and a focus on the frail elderly. CM Health will report quarterly to the Ministry of Health on the data collected and progress made through this work.	**2a.** Provision of quarterly reports on the Acute Flow work.	Quarterly	SS04: Delivery of actions to improve Wrap Around Services for Older People	We live longer in good health (prevention and early intervention)	Support healthier, safer and more connected communities
Immunisation					
3. Raise awareness and promote pharmacy and other immunisation providers to improve influenza vaccination rates in Maaori, Pacific and Asian people over 65 years of age. **(EOA)**	**3a.** Activity completed Q3 -Q4 (flu season).	Q4			
Aligning local DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS: This framework has not yet been received from the Ministry of Health. Once received, CM Health will review the current model of HCSS services alongside the framework and identify gaps in services. CM Health will provide quarterly narrative updates on progress.					

Improving Quality					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Equity of Outcomes for People with Diabetes The Atlas of Healthcare Variation identifies achieving good glycaemic control and cardiovascular risk management as two key strategies to improving outcomes for people with diabetes. Actions listed under in the Diabetes and Long Term Conditions section include some of the activities that we will undertake in 2019/20 to improve the management of cardiovascular disease (CVD) and diabetes for our Maaori, Pacific and other high risk population groups. Specific activities for diabetes will include:					
1. Utilising the CVD and Diabetes Indicators to identify practices not meeting clinical targets and supporting them to develop a quality improvement plan which will be monitored through monthly progress reports.	**1a.** Improved performance against the five Metro Auckland Diabetes Indicators for the 10 practices requiring additional support.	Q4	SS13: Improved management for long term conditions PH01: Improving system integration and SLMs	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
2. Testing of innovative models of care for Maaori, Pacific and Q5 people with two or more long term conditions following the discovery phase report. **(EOA)**	**2a.** Delivery of innovative models of care which focus on patient engagement and self-management support for Maaori and Pacific populations with two or more long term conditions.	Q2	SS13: Improved management for long term conditions PH01: Improving system integration and SLMs	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	2b. Testing underway.	Q2			
Patient Experience					
3. The lowest domains on the National Survey are Coordination and Communication. The 'In Your Shoes' (IYS) methodology is a powerful tool for jointly building staff competencies and capturing consumer-designed solutions.	**3a.** Hold 3 IYS Sessions.	Q1-Q4	Incremental increase in scores	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities

Healthy Ageing					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
System Level Measures (SLMs)					
4. Implementation of the 2019/20 Metro Auckland System Level Measures Improvement Plan.	**4a.** Successful implementation of the plan.	Q4	PH01: Improving system integration and SLMs	We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
Antimicrobial resistance					
5. In 2019/20 CM Health will focus on those control methods identified by the World Health Organisation as the most important for control of antimicrobial resistance: antimicrobial stewardship, screening and environmental decontamination.	**5a.** Increase compliance from clinical areas for screening as per requests or admission criteria.	Q2	Measured % of eligible patients screened	We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities
	5b. Consult on facilities development to increase ability to manage infectious diseases.	Q4	Increased isolation resources		
6. CM Health Antimicrobial Stewardship Committee continues to meet monthly to discuss issues and strategies relating to antimicrobial usage, infection prevention and control. The committee comprises members from infection control, clinical pharmacists, clinical microbiologists and the infectious diseases team.	**6.** Monthly meetings to discuss issues and strategies including liaison with CM Health laboratory services regarding updates on antimicrobial sensitivity patterns.	Ongoing			
7. Continue and expand the CM Health internal surveillance processes for multidrug-resistant organisms (MDROs) in line with national Carbapenemase-producing Enterobacteriaceae (CPE) management	**7.** Expand surveillance processes to include screening of patients who have spent time in overseas hospitals and	Q1	Documented processes are in place and audit tools developed		

Healthy Ageing					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
guidelines. Activities include screening of patients who have spent time in overseas hospitals and patients who have recently travelled to certain countries.	patients who have recently travelled to certain countries.				
8. Continue membership on National Technical Advisory Group for CPE management	**8.** Provide advice and input as required to the development of national frontline policy and guideline development for CPE management.	Ongoing			
9. Establish an efficient MDRO screening system that is consistent with the New Zealand Antimicrobial Resistant Action Plan.	**9a.** Get adequate compliance from clinical areas for screening as per requests or admission criteria.	Q2	Measured % of eligible patients screened		
	9b. Refine screening protocols according to developing risk.	Q1 (with ongoing refinement based on developing risk)	Revised protocols available		
10. Increase isolation capacity.	**10.** Consult on facilities development to increase ability to manage infectious diseases.	Q4	Increased isolation resources		
11. Primary care and residential care settings will continue to work to ensure that front-line infection prevention and control practices are implemented continuously, effectively and consistently and in alignment with the New	**11.** Improved performance against infection control standards in the	Q4	Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)		

Healthy Ageing					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Zealand Antimicrobial Resistance Action Plan	integrated ARRC audits.				
12. CM Health Senior Infection Control Practitioner continues to provide support and advice to primary care (PHOs and general practices) on an ad hoc basis and as requested. Specific areas of focus include: • Sterilisation in office-based general practices • Hand hygiene – continue to provide information resources to primary care where requested and support with advice on how to best implement these practices in a primary care setting	**12.** Ad hoc advice and support provided to primary care providers.	Ongoing			
13. CM Health Senior Infection Control Practitioner to continue involvement as an invited participant at the South Auckland Aged Residential Care (ARC) forum and cluster groups. This involvement includes providing presentations on requested topics as well as advice and support on management of CPE in aged care settings.	**13.** Presentation on CPE cross-contamination in aged care provided by end of financial year.	Q4			

Cancer Services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway					
1. Currently we report by ethnicity (Maaori, Pacific, Asian and European/Other) and for Quintile 5 patients for each tumour stream. In 2019/20 we will review existing reports to identify opportunities for improving reporting and improving access for patients, with a focus on identifying gaps and areas of unmet need for patients undergoing a cancer pathway from high suspicion to first treatment, that prevent timely access to diagnostics and treatment for patients on the Faster Cancer Treatment (FCT) pathway. The focus will be on responding to gaps to improve access for Maaori, Pacific and Quintile 5 patients. **(EOA)**	**1a.** Reports will be in place to identify areas where KPIs are not met by tumour stream and NHI.	Q1	SS11: Faster cancer treatment	We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	1b. Data will be used to develop action plans per ethnicity and tumour stream.	Q2			
Develop a quality improvement plan for bowel cancer care informed by the Bowel Cancer Quality Improvement Report 2018 and associated data Note: Please also see the Bowel Screening section for detail on implementation of the bowel screening programme.					
2. A quality improvement plan will be developed that focuses on Bowel Quality Indicator 1: Route of diagnosis, Indicator 19: Emergency surgery and Indicator 10: Lymph node yield. The improvement plan will include review of data by ethnicity to identify trends and inequities. CM Health will work with the Regional Bowel Tumour Stream group to undertake additional areas of quality improvement identified as areas of regional focus by the Northern Region Cancer Network.	**2a.** An improvement plan will be in place with actions and timeframes identified.	Q2		We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering

Cancer Services					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Provide people who have completed cancer treatment with services to improve quality of life and to live well beyond cancer					
3. To report on the impact of Cancer Nurse Coordinators (CNC) with a population focus: Maaori & Pacific. Reports to include contact volumes, ethnicity, FCT target compliance and qualitative narrative completed by the Cancer Nurse Coordinator in conjunction with the Maaori and Pacific Health Gains teams. **(EOA)**	**3a.** Monthly reporting from population CNCs.	Q1-Q4		We have improved quality of life (health maintenance and independence)	Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Patient stories will be recorded for Pacific and Maaori patients. These will be utilised as a tool for engaging with patients, to assist with navigation of care on cancer pathways and increasing health literacy. **(EOA)**	**4a.** Stories will be available for patients.	Q4			
5. Maaori patients with complex needs will be identified early in the cancer pathway and support plans developed to ensure they are followed up during and after treatment. This will include reporting on the impact of CNCs as identified in action 3. **(EOA)**	**5a.** Support plans for Maaori with complex needs are in place.	Q2			
CM Health also commits to contributing to the Ministry of Health's development of a national Cancer Plan and working with the Ministry of Health and the Northern Region Cancer Network to implement and deliver local actions from within the Cancer Plan.					

Bowel Screening					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Work with the Ministry of Health, the Bowel Screening Programme (BSP) National Coordination Centre and primary care toward ensuring equitable participation in the National Bowel Screening Programme					
1. Promote the programme to priority populations, Maaori, Pacific and participants living in high socioeconomic deprivation **(EOA)**: • Review and update the programme Communication Plan with a view to ensuring bowel screening promotional activities reach priority populations. • Work with the National Coordination Centre and MoH to improve participation through an active follow-up process. • Carry out outreach activities as resources permit, including text and phone follow-up to encourage participation amongst priority groups. • Work with primary care to encourage opportunistic requests for a test kit for Maaori and Pacific participants and to facilitate GP letters and arrange group presentations to participants who have not returned a kit.	**1a.** Implement the updated Communication Plan.	Q1-Q4	60% participation achieved for eligible Maaori and Pacific in the BSP programme. 95% of BSP patients with a positive faecal immunochemical test (FIT) are offered a colonoscopy or CT colonography within 45 working days of a result on the BSP IT system 70% of P2 diagnostic patients have a colonoscopy within 42 days	We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering
	1b. Analysis of outcomes from the GP opportunistic requests dashboard to evaluate the initiative.	Q3			

Bowel Screening					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. To ensure that symptomatic patients are not adversely affected by the Bowel Screening programme, CM Health will: • Contact private providers as required to ensure that symptomatic patients continue to meet colonoscopy targets. • Increase DHB theatre capacity for colonoscopies by 2021.	**2a.** Private providers to be contracted as required to meet standards.	Ongoing			

Workforce					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Developing a sustainable approach to nursing career pathways: Nurse practitioners (NPs) at CM Health now have a consistent approach to ongoing professional development funding to support their ongoing professional development, which provides an equitable approach across all of our NP roles. Each NP has an annual location of $4000 pro rata. This amount has been regionally agreed and is therefore the same allocation as at Auckland DHB and Waitemata DHB.					
Workforce diversity					
1. Scope an increase in the number of student placements CM Health is able to offer our tertiary providers, through exploring different models of placements and developing interprofessional education opportunities. The focus will be on students who live in the local area and Maaori and Pasifika students. **(EOA).**	**1a.** Scoping to take place.	Q3		We have improved health equity (healthy populations)	Support healthier, safer and more connected communities

Workforce					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
2. Scope increasing the capacity of the Nurse Entry to Practice (NETP) and New Entry to Specialist Practice (NESP) programmes to support additional students.	**2a.** Scope confirmed for NETP & NESP programmes.	Q4			
3. In 2019/20 CM Health will continue to: • Offer an inter-professional allied health new graduate supervision group for graduates in their first year of employment. • Offer trainee placements to anaesthetic technicians, cardiopulmonary technicians, physiology technicians, ultra sonographers and clinical psychology internships through funding from the Health Workforce Directorate, Ministry of Health. There is continued liaison with the Northern Regional Alliance (NRA) on regional workforce strategies.		Ongoing			
Health Literacy					
4. In 2019/20 we aim to achieve our goal of two thirds of health professionals having been trained in health literacy (defined as having been exposed to the three-step	**4a.** Two thirds of Counties Manukau DHB health professionals trained in health literacy by 2020.	Q4	Percentage of health professionals who complete health literacy training	We have improved health equity (healthy populations)	Support healthier, safer and more connected communities

Workforce					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
process for better health literacy).[12] Health literacy, cultural competence and language access are being linked in these training offerings as important aspects of building understanding and as a means towards health equity. **(EOA)**	**4b.** Health literacy training extended to primary care.	Q4	*(Data sources: DHB training records, Ko Awatea LEARN records)*		
5. In 2019/20, we will work to ensure that health literate, culturally competent health education resources for use in patient/whaanau interactions will continue to be available. **(EOA)**	**5b.** Document controllers supporting use of the Ministry of Health's Rauemi Atawhai framework to establish and maintain systems and processes.	Q4	Services have explicit systems and processes for health education resource review and development (ensuring target audience involvement)	We have improved health equity (healthy populations)	Support healthier, safer and more connected communities
Please refer to the Midwifery Workforce section under 2.4.1 Improving Child Wellbeing, the Primary Health Care Integration section – Workforce capacity and capability under 2.4.5. Better population health and equitable outcomes through primary care and sections 4.2.3 Workforce, 4.2.4 Co-operative developments and 4.2.5 Health Literacy for further information on workforce activities.					

[12] https://www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/health-literacy-booklet-3-steps-Dec-2014.pdf

Data and Digital					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Core clinicals: Continue to test & develop systems to support clinical workflow including eVitals and MedChart, which allow the capture of clinical information that can be used to assist in looking at clinical outcomes based on ethnicity and other demographic data (e.g. BMI).	**1a.** Inpatient consultation form implemented.	Q1		We live longer in good health (prevention and early intervention)	Support healthier, safer and more connected communities
	1b. Inpatient task manager referrals implemented.	Q1			
	1c. eVitals system implemented DHB-wide	Q2			
	1d. MedChart implemented DHB-wide.	Q4			
2. Implement smart systems	**2a.** eOrders – Laboratory	Q4			
	2b. Secure communications/pager replacement.	Q4			
3. Data visualisation: We are planning to implement a data visualisation tool which will allow our data to be more readily available to clinicians and managers supporting the planning of care for our population. Ethnicity will be part of the minimum dataset included in every application. **(EOA)**	**3a.** Ensure equity is prioritised in presentation of clinical data through the new data analytics environment.	Q2			
4. Continue to test and scale Telehealth: Our Telehealth programme provides opportunity to look at increasing access to care for patients who may struggle with access to transport or support networks to get them to appointments.		Ongoing			
5. Improve hospital administration	**5a.** TrendCare implemented DHB-wide.	Q4			
Note: CM Health submits a full report of our Healthy Together Technology programme to the MoH Data and Digital team on a quarterly basis.					

Collective Improvement Programme
The Collective Improvement Plan is a district health board Chief Executive programme of work that currently remains under development by the Ministry of Health. CM Health is committed to supporting this work over the 2019/20 year.

Delivery of Regional Service Plan (RSP) priorities					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Hepatitis C: The Northern Regional Alliance (NRA) will support Northern Region DHBs to: • Consistently apply the clinical pathway to ensure patients receive the right care at the right time through the most appropriate care provider ensuring consistency of care and message delivery. • Deliver education, awareness, diagnosis and management/treatment within their Corrections Department and community and alcohol drug service facilities in line with the regional HCV plan and the local services. The following actions will be undertaken in 2019/20:					
1. The NRA will aim to get a clear line of sight on individual patient progress through the pathway from diagnosis to workup, and treatment as well as ongoing management if cirrhotic. This is to be undertaken centrally through the Regional Data Sharing program and HealthSafe protocol. Information on key demographics to ensure consistency of service delivery will be provided.	**1a.** NRA establishes clear line of sight on individual patient progress through the pathway.	Q1		We live longer in good health (prevention and early intervention)	Support healthier, safer and more connected communities
2. The NRA will work with CM Health to develop a pilot project with Wiri Men's prison for micro-elimination of HCV, with key learnings being applied across the Northern Regions Corrections Department facilities. Initiated in Q1 2019/20, outcome review Q3 2019/20.	**2a.** Project initiated.	Q1			
	2b. Outcome review.	Q3			

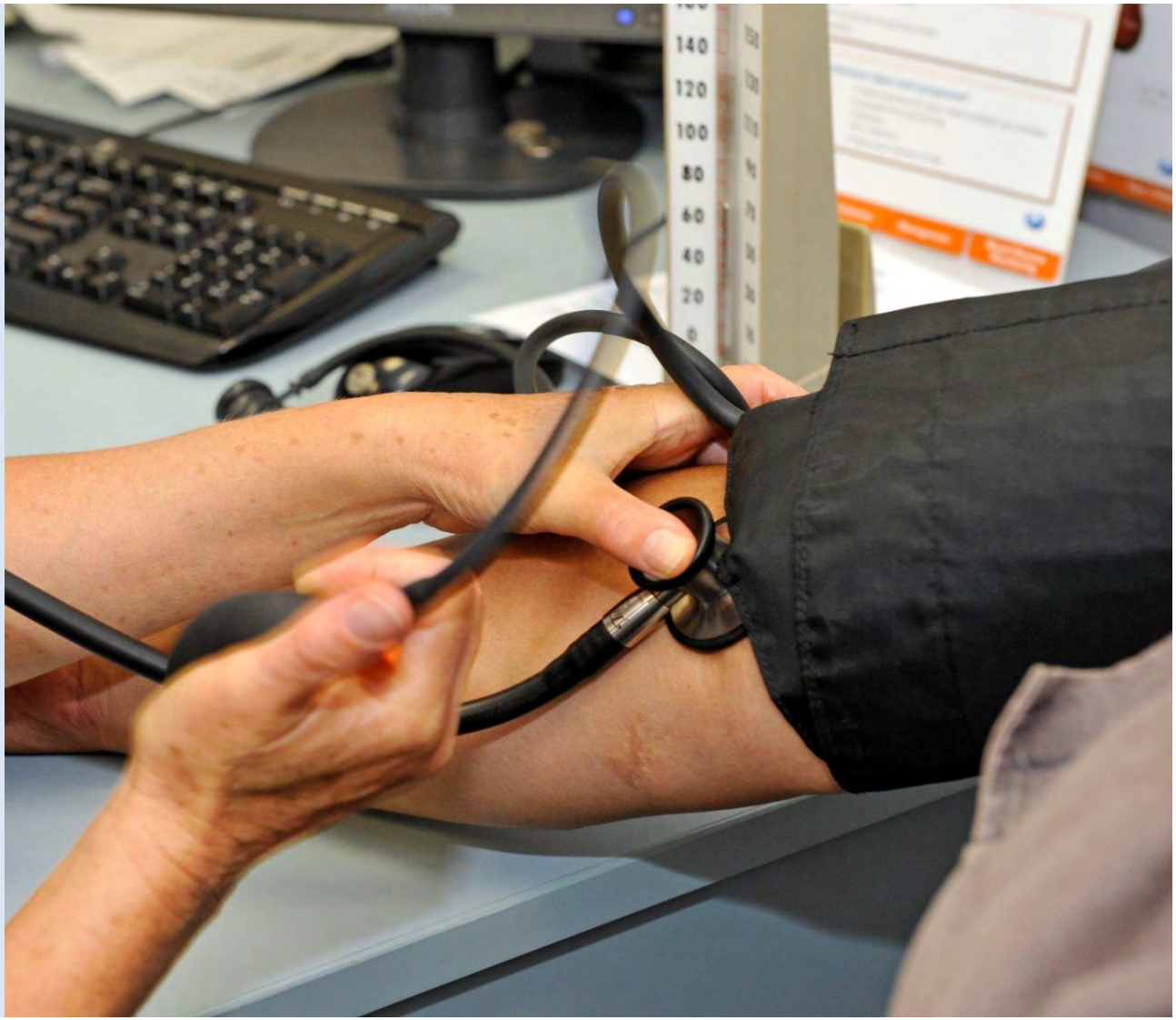
Delivery of Regional Service Plan (RSP) priorities					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Implementation of the New Zealand Framework for Dementia Care					
3. CM Health commits to contributing to the implementation of the NRA's Regional Frailty and Healthy Ageing 2019/20 Action Plan, including through supporting the NRA's work on dementia pathways.	**3a.** Contribute to the NRA's regional stocktake of dementia services and related activity.	Q2		We live longer in good health (prevention and early intervention)	Support healthier, safer and more connected communities
	3b. Support the NRA's work by providing information about the current state of dementia services.	Q3			
	3c. Engage in regional discussions around opportunities for improvement.	Q4			

2.4.5 Better population health outcomes supported by primary health care

Primary health care is a priority work programme for Government, the Ministry of Health and District Health Boards.

An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase use of illness-preventing behaviours and treatments, and thereby increase people's ability to participate in work and education.

Primary health care is earlier, safer, cheaper, and better connected to people's daily routines. However, the primary health care system does not serve all people equitably. Some people are avoiding or delaying engaging with primary care services because of cost. There is also the potential for a different primary care model to better suit people's lives and better integrate across health disciplines and facilities, thereby improving health outcomes.



Primary health care integration					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Strengthening our Alliance			PH03: Improving Maaori enrolment in PHOs to meet the national average of 90% PH01: Improving system integration and SLMs PH02: Improving the quality of data collection in PHO and NHI registers CQ07: Improving newborn enrolment in General Practice SS05: Ambulatory sensitive hospitalisations (ASH adult) SS04: Delivery of actions to improve Wrap Around Services for Older People	We have improved quality of life(health maintenance and independence) We have improved health equity (healthy populations) System outcome We live longer in good health (prevention and early intervention)	Support healthier, safer and more connected communities Make New Zealand the best place in the world to be a child Ensure everyone who is able to, is earning, learning, caring or volunteering
1. Development and implementation of a Regional Flexible Funding Pool (FFP) Application and Governance Framework, in order to improve transparency and increase alignment of priorities and actions, including actions to improve equity. **(EOA)**	**1a.** Establishment of joint governance to develop an FFP Application Framework.	Q1			
	1b. Development and implementation of an FFP Application framework.	Q4			
2. Review of Counties Manukau Alliance Agreement and Alliance Leadership Team (CMALT) Terms of Reference, including membership, principles, and ways of working.	**2a.** CMALT considers Terms of Reference (including membership).	End of Q2			
Workforce capacity and capability					
3. Support general practices involved in the enhancing primary care programme of work to understand their population health needs and workforce requirements, and to consider alternative team members for example peer health coaches, pharmacists and nurse practitioners.	*TBC in Q1*	*TBC in Q1*			

Primary health care integration					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
Improving access					
4. Improve access to and utilisation of reduced-fees general practice visits for Community Services Cardholders (CSC). **(EOA)**	**4a.** Increased utilisation of CSC visits by Q4 (in comparison to Q1), particularly for Maaori and Pacific.	Q4			
5. Conduct a review of rural marae-based primary care services to support equity of access (enrolment and utilisation) for Maaori. This is likely to include better ways to support patient/whaanau choice or provider and virtual care options. This will build on the Long Term Conditions co-design work findings and will be supported by the Rural Service Level Alliance Team (SLAT). **(EOA)**	**5a.** Stocktake completed.	Q2			
6. Reviewing current acute demand management services provided in primary care/community from an equity perspective, in particular considering the objectives and logic model underpinning the current services and investment. **(EOA)**	**6a.** Review completed by the end of the financial year.	Q4			
Please refer to the 2019/20 Metro Auckland SLM Improvement Plan for a number of additional activities, in particular on enablers, respiratory admissions in 0-4 year olds, complex conditions, primary options for acute care and e-portals.					

Pharmacy					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
To support the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA), we will:			PH01: Improving system integration and SLMs SS13: Improved management for long term conditions SS04: Delivery of actions to improve Wrap Around Services for Older People	We have improved quality of life(health maintenance and independence) We have improved health equity (healthy populations)	Support healthier, safer and more connected communities
1. Form a Pharmacy Service Level Alliance (SLA). This SLA will produce a work programme that supports equitable health outcomes. **(EOA)**	**1a.** Alliance formed and operational by December 2019.	Q2			
2. Support the work to enable the separation of dispensing into separate ICPSA schedules (medicine and supply and clinical advice).		Ongoing			
3. Raise awareness and promote pharmacy and other immunisation providers to improve influenza vaccination rates in Maaori, Pacific and Asian people over 65 years of age. **(EOA)**	**3a.** Activity completed Q3 -Q4 (flu season).	Q4			
Please refer to the 2019/20 Metro Auckland SLM Improvement Plan for a number of additional activities, in particular the sections regarding respiratory admissions, smoking cessation and complex conditions.					

Diabetes and other long-term conditions					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
1. Continue the Long Term Conditions (LTC) Model of Care co-design process with the target population (Maaori, Pacific, those living in areas of socioeconomic deprivation with two or more long term conditions) resulting in: • Development of a LTC outcomes framework. • Testing of new and innovative model of care in selected areas. **(EOA)**	**1a.** New Long Term Conditions Outcomes Framework completed.	Q1	SS13: Improved management for long term conditions PH03: Improving Maaori enrolment in PHOs to meet the national average of 90% PH01: Improving system integration and SLMs PH02: Improving the quality of data collection in PHO and NHI registers SS05: Ambulatory sensitive hospitalisations (ASH adult)	We have improved quality of life(health maintenance and independence)	Support healthier, safer and more connected communities
	1b. Testing underway.	Q2			
Diabetes					
2. Focus on public health promotion through the Healthy Auckland Together (HAT) project, which aims to improve environments for children and young people, and the Wai Auckland project which aims to decrease intake of sugary drinks and improve the accessibility of tap water. **(EOA)**	Ongoing	Ongoing		We have improved health equity (healthy populations)	Ensure everyone who is able to, is earning, learning, caring or volunteering

Diabetes and other long-term conditions					
DHB activity	**Milestone**		**Measure**	**Government theme: Improving the wellbeing of New Zealanders and their families**	
				System outcome	**Government priority outcome**
3. Collaboration with primary healthcare providers and specialist secondary care services to deliver group diabetes self-management education (SME) which is culturally sensitive and where possible, delivered by peer facilitators and health coaches. CM Health will continue to use the Health Education and Impact Questionnaire (hei-Q) to evaluate SME impact. This is a user-friendly, relevant, and psychometrically sound instrument which has been translated into several languages and enables comprehensive evaluation of patient education programs, which can be applied across a broad range of chronic conditions. (**EOA)**	**3a.** Provision of culturally appropriate group diabetes SME programmes for people with diabetes.	Q1		We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering
4. Quarterly data and performance discussions with the Long Term Conditions Clinical Governance Group to measure and monitor progress of the 10 practices who are furthest from meeting the agreed diabetes and cardiovascular disease (CVD) targets. Please refer to the 2019/20 SLM Plan for activities targeted toward early risk assessment and risk factor management efforts for people with high and moderate cardiovascular disease risk, which have a focus on supporting the spread of best practice.	**4a.** Improved performance against the five Metro Auckland Diabetes Indicators for the 10 practices requiring additional support.	Q4			
Please refer to the 2019/20 Metro Auckland SLM Improvement Plan for activities related to cardiovascular disease. Additional activities related to long term conditions can be found in the 2019/20 Metro Auckland SLM Improvement Plan.					

2.5 Financial performance summary

The requirement for austerity in 2018/19 and 2019/20 has required the deferral of significant expenditure and investment to outer years. Further work is underway to understand implications for outer year financials together with options to mitigate. In accordance with the statutory requirement to submit forecast financials, the 2019/20 planned deficit has been included as a placeholder for years 2020/21, 2021/22 and 2022/23 pending completion of the work referred above.

The following tables should be viewed with reference to the financial narrative in section 6.0 of the Statement of Performance Expectations.

Statement of comprehensive income

Net Result	2017/18 Audited Actual $000	2018/19 Unaudited Actual $ 000	2019/20 Plan $ 000	2020/21 Plan $ 000	2021/22 Plan $ 000	2022/23 Plan $ 000
Revenue						
Ministry of Health	1,500,497	1,588,449	1,669,448	1,669,448	1,669,448	1,669,448
Other Government	44,549	37,081	36,465	36,465	36,465	36,465
Other	48,317	43,524	40,471	40,471	40,471	40,471
Inter DHB and Internal	81,439	76,863	86,379	86,379	86,379	86,379
Total Revenue	**1,674,802**	**1,745,917**	**1,832,763**	**1,832,763**	**1,832,763**	**1,832,763**
Expenses						
Personnel	627,450	778,616	724,892	724,892	724,892	724,892
Outsourced	90,858	96,118	94,303	94,303	94,303	94,303
Clinical Support	119,556	124,202	123,725	123,725	123,725	123,725
Infrastructure	75,614	81,675	86,688	86,688	86,688	86,688
Personal Health	508,928	523,101	537,694	537,694	537,694	537,694
Mental Health	61,159	63,709	71,657	71,657	71,657	71,657
Disability Support	137,561	148,553	150,430	150,430	150,430	150,430
Public Health	1,317	8,783	7,422	7,422	7,422	7,422
Maaori	1,835	2,776	1,439	1,439	1,439	1,439
Operating Costs	**1,624,278**	**1,827,533**	**1,798,250**	**1,798,250**	**1,798,250**	**1,798,250**
Operating Surplus / (Deficit)	**50,524**	**(81,616)**	**34,513**	**34,513**	**34,513**	**34,513**
Depreciation	32,906	34,779	39,202	39,202	39,202	39,202
Capital Charge	37,421	36,424	33,905	33,905	33,905	33,905
Interest	-	-	-	-	-	-
Net Deficit	**(19,803)**	**(152,819)**	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**
Other Comprehensive Income	7,842	101,984	-	-	-	-
Deficit	**(11,961)**	**(50,835)**	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**

Note: *Included in the 2018/19 unaudited result is an additional provision for the remediation of the areas of non-compliance in terms of the Holiday's Act. This provision may be subject to change during the finalisation of the 30 June 2019 audit.*

2.5.1 Output classes

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

Prevention

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue (includes agency revenue)	**46,722**	**46,722**	**46,722**	**46,722**
Personnel costs	23,944	23,944	23,944	23,944
Outsourced Services	853	853	853	853
Clinical Supplies	4,020	4,020	4,020	4,020
Infrastructure & Non-Clinical Supplies	1,497	1,497	1,497	1,497
Other	16,408	16,408	16,408	16,408
Expenditures (includes agency costs)	**46,722**	**46,722**	**46,722**	**46,722**
Net Surplus (Deficit)	-	-	-	-

Early detection and management

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue (includes agency revenue)	**254,530**	**254,530**	**254,530**	**254,530**
Personnel costs	919	919	919	919
Outsourced Services	33	33	33	33
Clinical Supplies	154	154	154	154
Infrastructure & Non-Clinical Supplies	57	57	57	57
Other	253,367	253,367	253,367	253,367
Expenditures (includes agency costs)	**254,530**	**254,530**	**254,530**	**254,530**
Net Surplus (Deficit)	-	-	-	-

Intensive assessment and treatment

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue (includes agency revenue)	**1,345,873**	**1,345,873**	**1,345,873**	**1,345,873**
Personnel costs	686,582	686,582	686,582	686,582
Outsourced Services	92,938	92,938	92,938	92,938
Clinical Supplies	128,699	128,699	128,699	128,699
Infrastructure & Non-Clinical Supplies	145,994	145,994	145,994	145,994
Other	330,254	330,254	330,254	330,254
Expenditures (includes agency costs)	**1,384,467**	**1,384,467**	**1,384,467**	**1,384,467**
Net Surplus (Deficit)	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**

Rehabilitation and support

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue (includes agency revenue)	**185,636**	**185,636**	**185,636**	**185,636**
Personnel costs	13,447	13,447	13,447	13,447
Outsourced Services	479	479	479	479
Clinical Supplies	2,258	2,258	2,258	2,258
Infrastructure & Non-Clinical Supplies	841	841	841	841
Other	168,611	168,611	168,611	168,611
Expenditures (includes agency costs)	**185,636**	**185,636**	**185,636**	**185,636**
Net Surplus (Deficit)	-	-	-	-

Total

	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Total Revenue (includes agency revenue)	**1,832,763**	**1,832,763**	**1,832,763**	**1,832,763**
Personnel costs	724,892	724,892	724,892	724,892
Outsourced Services	94,303	94,303	94,303	94,303
Clinical Supplies	135,131	135,131	135,131	135,131
Infrastructure & Non-Clinical Supplies	148,388	148,388	148,388	148,388
Other	768,643	768,643	768,643	768,643
Total Expenditures (includes agency costs)	**1,871,357**	**1,871,357**	**1,871,357**	**1,871,357**
Net Surplus (Deficit)	**(38,594)**	**(38,594)**	**(38,594)**	**(38,594)**

3. Service Change

The table below describes all service reviews and service changes that have been approved for implementation in 2019/20.

Service Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Mental Health and Addictions Services in the Community	A substantive amount of NGO mental health and addictions services will be reorganised to develop a more comprehensive suite of services that is locality specific.	This will better support integration and team work across the service user journey. This will enable earlier access to services and interventions in primary care and the community. Services will be more focused around the service user and their whaanau.	Local

4. Stewardship

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

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

4.1 Managing our business

4.1.1 Organisational performance management

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

In 2019/20 we will continue regional work to mature the national System Level Measures reporting processes to reflect greater sharing of accountability for population health outcomes with our primary care alliances.

4.1.2 Funding and financial management

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

Please refer to the Financial Performance Summary in Section 6.0 of CM Health's Statement of Intent 2019-2023 for further information about Counties Manukau DHB's planned financial position for 2019/20 and out years.

4.1.3 Local and regional investment and asset management

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

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

The NRLTIP identifies three investment themes for the Northern Region:

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

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

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

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

4.1.4 Shared service arrangements and ownership interests

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

4.1.5 Risk management

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

4.1.6 Quality assurance and improvement

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

4.2 Building capability

The following sections outline key capabilities and initiatives to support improved capability in 2019/20, across capital and infrastructure investment, information technology and communication systems, workforce and co-operative developments.

4.2.1 Capital and infrastructure development

Regional population health priorities

As part of the work for the NRLTIP, the Northern DHBs have established a Regional Population Health Deep Dive Steering Group to clarify the service delivery intentions and the short, medium and long term investment implications for Public and Population Health in the Northern Region, with a particular focus on addressing inequities in access and outcomes.

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

Regional capital and infrastructure development

The Northern Region continues to develop a more robust working relationship with the Ministry's Capital Investment Committee (CIC). The Northern Region will work to ensure that future capital and infrastructure investment is in line with Cabinet's expectations for the management of investments and assets, as outlined in CO (15) 5: *Investment Management and Asset Performance in the State Services.* Business cases requiring Crown funding and/or >$10m are subject to approval by joint Ministers.

The focus is to ensure a common view of the required programmes of work, projects and phasing of capital funds necessary to deliver the various investments that are critical for the Northern Region.

During 2019/20 the Region is working to strengthen regional governance of capital works and construction processes by improved regional oversight of:

- The implementation of key elements of the capital investment portfolio of work to 'Plan', 'Design', and 'Build' the Region's significant investments
- The 'Approvals' process for Northern Region investments, including ensuring delivery of the business cases
- The procurement processes for capital works.

Immediate priorities include:

- Streamlining regional processes for business case planning and supporting the business case process with standard frameworks, formats, templates and tools
- Strengthening procurement processes to get suppliers to work as a regional, rather than DHB specific, resource pool
- Applying regionally consistent approaches to support the Plan, Design and Build stages of our Region's priority capital works.

CM Health capital and infrastructure development

In 2017/18 CM Health aligned its long-term district investment plan with the agreed NRLTIP priorities. This resulted in a pipeline of investment priorities to progress through to business case development. This requires a balanced district investment portfolio which aligns with regional priorities to manage capacity growth and support whole of system solutions. A review of primary and community services and future investment requirements in light of intersectoral developments and local population health priorities are integral to CM Health's strategy refresh process that started in early 2019.

In 2019/20, this will include continuation of major capital projects in progress (new Acute Mental Health Unit and Scott Building recladding at Middlemore Hospital) and significant development of business cases to address critical facilities infrastructure risks and service capacity challenges.

Intersectoral and regional service and infrastructure planning will focus on community developments. A sustainability focus was adopted in the development of our new Acute Mental Health Unit Tiaho Mai. For each major facilities development, the early concept design processes that inform business case development includes cost benefit assessment of sustainability options.

4.2.2 Information technology (IT) and communications systems

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

- continue to strengthen our shared information service, with a focus on responsiveness and value
- continue to improve access to our health data through Qlik Sense data visualisations
- participate in the Regional ISSP governance forums

- continue to contribute to development and implementation of the Regional Information Services Strategic Plan (ISSP)
- continue to invest regionally in a reliable and sustainable technology infrastructure
- participate in national initiatives, e.g. the National Health Plan and National Health Information Exchange
- continue to improve the maturity of our regional cyber-security capability
- continue investments in electronic support of clinically-led service initiatives

Please refer to the Data and Digital section in Section 2.4.4 for further information about our IT and communication commitments for 2019/20.

4.2.3 Workforce

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

The strong relationships with our strategic tertiary partners will continue to develop in 2019/20 through regular liaison and forums and expansion to additional tertiary partners. There is a focus on scoping an increase in the number of student placements CM Health is able to offer our tertiary providers, through exploring different models of placements and developing interprofessional education opportunities. There is intent to accommodate student placements for students who live in the local area and Maaori and Pasifika students.

Nurse Entry to Practice (NETP) graduates within the Counties Manukau region are supported with the CM Health NETP programme, with intake numbers anticipated to increase in 2019/20. Nursing, occupational therapy and social work graduates are supported through the New Entry to Specialist Practice (NESP) (Mental Health) programme, with an increase likely in graduate numbers. Scoping the capacity of the NETP and NESP programmes to support additional students will take place in 2019/20.

An allied health new graduate supervision group will continue to be offered throughout 2019/20, this is an interprofessional group open to physiotherapy, occupational therapy, social work, dietetic and speech and language therapy graduates in their first year of employment.

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

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

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

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

An intrinsic part of CM Health is the Ko Awatea Education Centre. It is purpose-built to provide an open, social learning space, with lecture theatres, breakout rooms, and a variety of teaching spaces. The Centre was built in 2011 as a joint venture project with the Auckland University of Technology, Manukau Institute of Technology and the University of Auckland, and is a contemporary building with modern capabilities to match. The Centre has a Customer Support and Technology Help office providing service and support to the Centre and its users. In addition

to providing a training venue for our future allied health, medical, and nursing workforce, the centre also hosts a large number of CM Health staff forums and events and local, national and international visitors. The number of Centre bookings has been increasing annually with bookings in 2018 totalling over 12,655.

4.2.4 Co-operative developments

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

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

There is discussion with the Tertiary Education Commission around further development programmes for the Kaiawhina/unregulated workforce to build on the numeracy and literacy training delivered in 2018/19.

4.2.5 Health Literacy

Advancing on being a health literate organisation and system is identified as a key action to achieve CM Health's Healthy Together strategic objective of Healthy People, Whaanau and Communities. Such a system is defined as one in which:

- Everyone in Counties Manukau can find their way into and around the health services they need;
- Every interaction builds understanding between patients, whaanau and staff; and
- Appropriate health education resources are used when needed to build understanding.

The key components identified for such a system are:

1. health literate, culturally competent staff;
2. health literate, culturally competent health education resources; and
3. supportive systems and processes .

In 2019/20 we aim to achieve our goal of two thirds of health professionals having been trained in health literacy (defined as having been exposed to the three-step process for better health literacy). This will be achieved through a combination of online and in-person training, the latter including a range of levels from introductory through expert, ensuring that staff have access to support for health literate practice. Health literacy, cultural competence and language access are being linked in these training offerings as important aspects of building understanding and as a means towards health equity.

In 2019/20, work to ensure that health literate, culturally competent health education resources are available for use in patient/whaanau interactions will continue. The Ministry of Health's Rauemi Atawhai framework will be promoted as the standard for all health education resources used within CM Health services, with quality and risk managers extending their roles as document controllers for health education resources. A key element of this is target audience involvement as a requirement for resource selection or development.

4.3 Workforce

Please refer to the Workforce priority in Section 2.4.4 for details of our planned workforce activities for 2019/20.

5. Performance measures

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

- Child wellbeing
- Mental wellbeing
- Strong and equitable health and disability system
- Primary care and prevention.

The DHB monitoring framework and accountability measures have been updated for 2019/20 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governance.

5.1 2019/20 Performance Measures

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Year 1	51%	
		Year 2	51%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	0.79	
		Year 2	0.79	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled	Year 1	>=95%
			Year 2	>=95%
		Children (0-12) not examined according to planned recall	Year 1	<=10%
			Year 2	<=10%
CW04	Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	Year 1	>=85%	
		Year 2	>=85%	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight month olds fully immunised.		
		95% of five year olds fully immunised.		
		75% of boys and girls fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	55% of newborns enrolled in General Practice by 6 weeks of age.		
		85% of newborns enrolled in General Practice by 3 months of age.		
CW08	Increased immunisation at two years	95% of two year olds have completed al age-appropriate immunisations due between birth and two years.		
CW09	Better help for smokers to quit	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief		

Performance measure		Expectation		
	(maternity)	advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		
CW11	Supporting child wellbeing	Provide report as per measure definition		
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.		
		Initiative 3: Youth Primary Mental Health.		
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.		
CW13	Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever to 4.5 per 100,000		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Maaori, other & total	Total	3.10%
			Maaori	4.25%
		Age (20-64) Maaori, other & total	Total	3.10%
			Maaori	7.50%
		Age (65+) Maaori, other &total	Total	2.60%
			Maaori	2.60%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		
		95% of audited files meet accepted good practice.		
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm	80% of people seen within 3 weeks.	
			95% of people seen within 8 weeks.	
		Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks.	
			95% of people seen within 8 weeks.	

Performance measure		Expectation		
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified		
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Maaori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.		
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.		
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS02	Ensuring delivery of Regional Service Plans	Provide reports as specified.		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified.		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified.		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	Total 45-64 years		4,681/100,000 population
SS07	Planned Care Measures	Planned Care Measure 1: Planned Care Interventions		19,892 inpatient surgical discharges 10,579 minor procedures 110 non-surgical interventions
SS07	Planned Care Measures	Planned Care Measure 2: Elective Service Patient Flow Indicators	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less).
			ESPI 2	0% - no patients are waiting over four

Performance measure		Expectation		
				months for FSA.
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT).
			ESPI 5	0% - zero patients are waiting over 120 days for treatment.
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised priority tool.
		Planned Care Measure 3: Diagnostics waiting time	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		Planned Care Measure 4: Opthalmology Follow-up Waiting Times	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 6: Acute Readmissions	0-28 days	< or equal to 10.7%
SS08	Planned care three year plan	Provide reports as specified.		
SS09	Improving the quality of identity data within the National Health Index (NHI)	Focus Area 1: Improving the quality of data	Recording of non-specific ethnicity in new NHI	>0.5% and < or equal to

Performance measure		Expectation		
	and data submitted to National Collections	within the NHI	registration	2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	To be confirmed by MOH
			New NHI registration in error (duplication)	Group A >2% to < or equal to 4%
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures	Greater than or equal to 90% and less than 95%
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %
			Assessment of data reported to the NMDS	Greater than or equal to 75%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified		

Performance measure		Expectation	
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified.
		Focus Area 4: Acute heart service	Indicator 1: Door to cath - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram**.**
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and Indicator 2b: ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - - Aspirin*, a 2nd anti-platelet agent*, statin and an ACEI/ARB (4 classes), and - LVEF<40% should also be on a beta-blocker (5-classes). ** An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.*
			Indicator 5: Device Registry Completion - ≥99% of patients who have a pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of

Performance measure		Expectation	
			this procedure.
		Focus Area 5: Stroke services	Indicator 1 ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway
			Indicator 2 Thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.	
SS16	Delivery of collective improvement plan	Deliverable to be confirmed by the MOH.	
SS17	Delivery of Whānau ora	Provide reports as specified	
PH01	Delivery of actions to improve system integration and SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	Provide reports as specified	
PH03	Access to Care (PHO Enrolments)	Meet and/or maintain the national average enrolment rate of 90%.	
PH04	Primary health care :Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	
Annual plan actions – status update reports		Provide reports as specified	

Appendix A: System Level Measures Improvement Plan

System Level Measures Improvement Plan

Auckland, Waitemata &
Counties Manukau Health Alliances

2019 2020

FINANCIAL YEAR

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

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

– Sir James Henare

Photo Credit (cover): John Hettig Westone Productions

1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitemata Alliance Leadership Teams (the Alliances) have jointly developed a 2019/20 System Level Measures Improvement Plan.

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

Extensive consultation was carried out across the sector in the development of the 2018/19 System Level Measures Improvement Plan. This year's plan is a consolidation of the 2018/19 plan. Some activities have been removed as they have been successfully achieved. Some have been found to be impractical or not easily measurable. These too have been removed. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement. New contributory measures have been added where data collection processes have been developed in response to identified clinical priorities. Examples of this include alcohol harm reduction and smoking cessation rates. An extensive stocktake of activity against the 2018/19 plan, across primary and secondary care allowed stakeholders to contribute to the prioritisation of activities in the current plan.

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

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

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

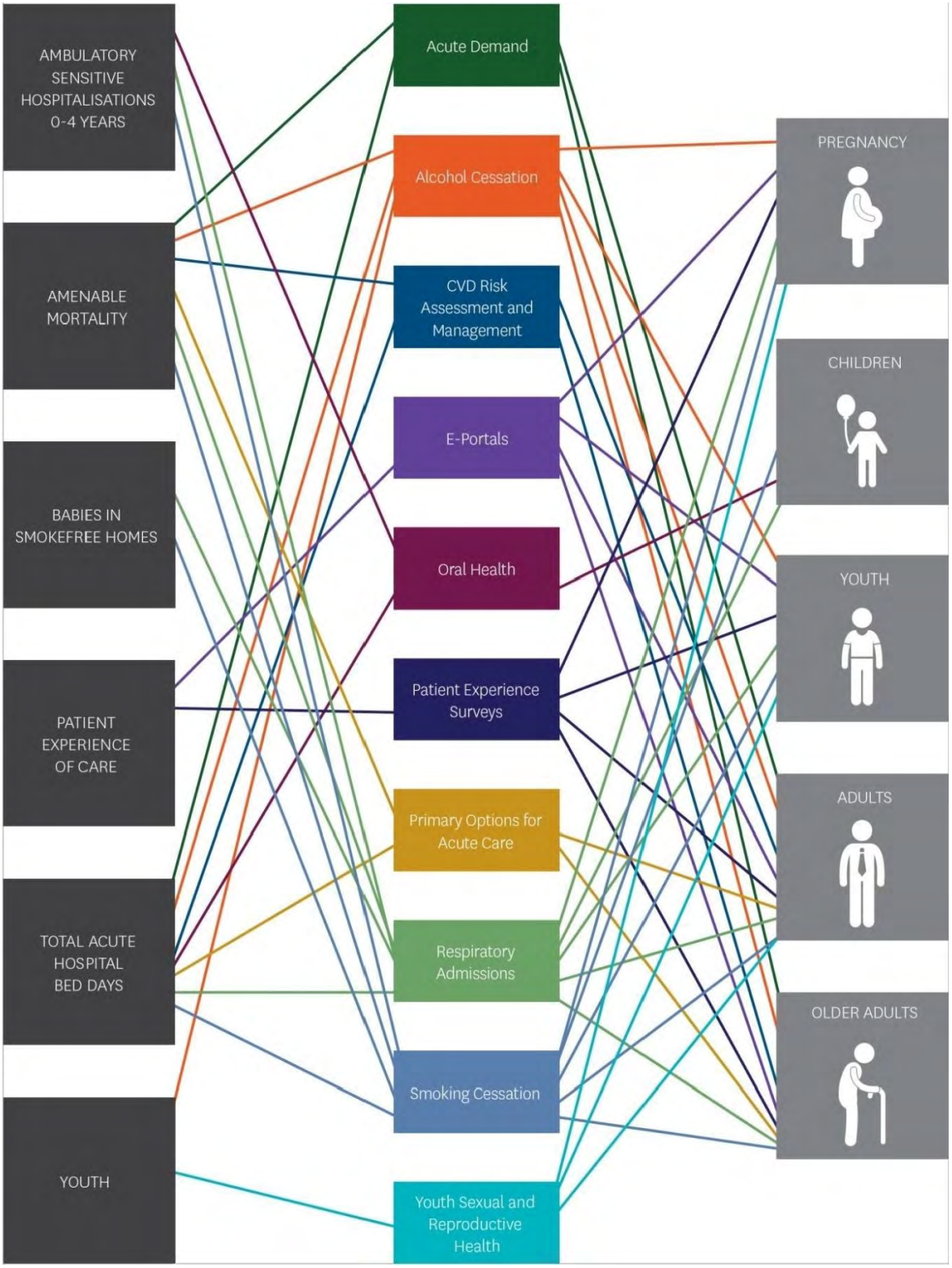
The primary health organisations (PHOs) included in this improvement plan are:

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

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

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

2. INTERRELATED ACTIVITY FOR COLLECTIVE IMPACT



3. PURPOSE

This document outlines how the 2019/20 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the activities that will be fundamental to this improvement. Please note that, as further discussed in section 4, implementation planning is developed annually to sit under this document to provide a higher level of detail.

4. BACKGROUND

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

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

b) For each SLM, an improvement milestone to be achieved in 2019/20. The milestone must be a number that shows improvement (either for Māori, total population, or a specifically identified population to address equity gaps) for each of the six SLMs.

c) A brief description of activities to be undertaken by all alliancing partners (primary, secondary and community) to achieve the SLM milestones.

d) Contributory measures for each of the six SLMs that is chosen by the district alliance based on local needs, demographics and service configurations that enable the alliance to measure local progress against the SLM activities.

e) Signatures of all district alliance partners to demonstrate an integrated and partnership approach to the development and implementation of the improvement plan.

In 2016, the Counties Manukau Health and Auckland Waitemata Alliances agreed to a joint approach to the development of the SLM Improvement Plan. This included the establishment of a Metro Auckland Steering Group and working groups for each SLM. Steering Group membership includes senior clinicians and leaders from the seven PHOs and three DHBs. The Steering Group is accountable to the Alliances and provides oversight of the overall process.

In 2019/20, SLMs continue to be business-as-usual. The governance structure of Alliance Leadership and Steering Group continue to guide improvement processes. The responsibility for implementation sits primarily with the Implementation Group. This group has primary care representation and flexible subject matter expertise dependant on topic and requirements. The Implementation Group meet regularly to further develop key actions (particularly at a local level) and inform implementation planning, monitor data, facilitate systems partnerships, and collaboratively guide the ongoing development of the SLMs with the Steering Group and Alliance Leadership Teams.
The work of the Implementation Group is guided by an Implementation Plan which sits under this plan and contains considerably more detail on activities and timeframes, and how a quality improvement approach will be taken for each area. The distinction between this high level plan and an implementation plan is necessary in a relatively complex environment of seven PHOs spanning three DHBs.

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

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

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

4.1 Equity Approach, Consultation and Partnership

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

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

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

The 2019/20 plan is a consolidation of the 2018/19 plan and therefore continues with a strong focus on equity. There is ongoing engagement and dialog with Māori and Pacific providers with a view to improving service integration.

4.2 Regional Working

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

4.3 2019/20 Priorities for System Level Measures

The 2019/20 plan continues to focus on cross–system activities which have application to multiple milestones as demonstrated in the 'interrelated activity for collective impact' diagram in Section 2. An extensive stocktake was conducted with both primary and secondary care stakeholders to establish the uptake of the SLM activities, identify barriers and focus on the areas for prioritisation for the 2019/20 plan. The results of the stocktake were discussed

with the Implementation Group and clinical leaders before being considered by the Steering Group. The aim was to consolidate the plan.
This year we also recognise those activities which enable achievement of the SLM activities and milestones. This essential work is the foundation for quality improvement activities, and illustrates enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

Overarching priorities for 2019/20 continue to adopt a prevention approach, and focus on improvements in equity of outcome or access. These activities support intervention in high risk populations, and collective impact. They were developed and planned with a population focus that included specific consultation with patients, family and whānau, and community. Some contributory measures aim for improvement in specific populations such as Māori and Pacific, particularly where significant inequity exists. It is expected that activity to improve these measures will also improve results for the total population as the processes are universal with a focus on high risk groups.

5. ENABLERS TO CAPACITY AND CAPABILITY

6. SYSTEM LEVEL MEASURES 2019/20 MILESTONES

Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2020.** **3% reduction for Māori populations by 30 June 2020.** **3% reduction for Pacific populations by 30 June 2020.**

Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori populations by 30 June 2020.** **3% reduction for Pacific populations by 30 June 2020.**

Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 5% improvement on Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' by 30 June 2020.** **Primary care survey: 10% relative improvement on PES question: 'When you ring to make an appointment how quickly do you usually get to see your current GP?' by 30 June 2020.**

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

Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care Young people experience less alcohol and drug related harm and receive appropriate support
Improvement milestone	**Increase coverage of chlamydia testing for males to 6% by 30 June 2020.** **Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2020.**

Babies in Smokefree Homes	
System level outcome	Healthy start
Improvement milestone	**Increase the proportion of babies living in a smokefree homes by 2% by 30 June 2020.**

7. IMPROVEMENT ACTIVITIES AND CONTRIBUTORY MEASURES

The following section outlines the specific improvement activity plan for the six SLMs for 2018/19. Improvement activities create change and work towards improved outcomes in the various SLM milestones. These activities are measured locally by contributory measures which support a continued focus in each area. Activities support the improvement of the system as a whole. For 2018/19, Auckland Metro region are focused on choosing activities which relate to multiple milestones where possible for best collective impact.

7.1 Ambulatory Sensitive Admissions in 0-4 year olds

Activities	Contributory Measure
Increase uptake of children's influenza vaccination to prevent respiratory admissions by: • Improving vaccination rates in primary care of children aged 0-4 years with previous respiratory admissions through the provision of data, practice-level improvement activities, and following up reporting of vaccination uptake provided throughout the season. • Prioritised vaccination of eligible Māori and Pacific children.	Influenza vaccination rates for eligible Māori and Pacific children. Target 15%.
Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness leading to hospital admission by: • Implementing the Early Pregnancy Assessment Tool (EPAT) so it can function as a pregnancy register in primary care. • Identifying pregnant women through booking and set immunisation recalls in primary care. • Opportunistic immunisation at antenatal clinics. • Promotion of pregnancy immunisation especially to Māori and Pacific women, through the use of vouchers, in primary care, pharmacy, LMC, and in other pregnancy service providers.	Influenza and pertussis vaccine coverage rates for pregnant Māori and Pacific. Target 50%.
Support a decrease in respiratory admissions with social determinants by: • Increasing e-referrals rates from primary care to healthy housing programmes by identifying practices with low referral rates and prompting referral using EPAT, with a focus on pregnant low income Māori and Pacific women.	Baseline measurement of referrals to Healthy Housing/AWHI.
• Supporting mothers and whānau of babies to live in smokefree homes by increased referrals from LMCs, primary care, healthy housing programmes, pharmacies and other referrers, to pregnancy smokefree services. • Increase referral of pregnant women who smoke for support to stop smoking when they visit general practice to confirm their pregnancy.	Referrals to maternal incentives smoking cessation programmes, for pregnant women. Target each quarter: 27 for ADHB; 58 for WDHB, and 180 for CMH.
Improve the quality of data collected on post-natal smoking, as an indicator of smoking in pregnancy, by supporting Well Child Tamariki Ora providers to improve the quality of smoking status data, through feedback, education and reporting.	
Support population groups who have inequitable child health outcomes by: • Implementing the National Child Health Information Platform (NCHIP) for ADHB and WDHB to align with Kids Link in CMH. • Promotion of enrolment with WCTO providers opportunistically in primary care, particularly for Māori and Pacific children.	

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

7.2 Youth Sexual and Reproductive Health

Activities	Contributory Measure
Improve chlamydia testing in young people 15-24 years old in particular, and in sexual and reproductive health of youth in general by: • Increasing engagement with young people by working with general practices and other youth healthcare providers to improve the youth friendliness of settings and enrolment rates. • Increasing sexual health screening by improving access to screening (including opportunistic) and screening for pregnant women. • Reporting the rate of chlamydia testing coverage across all youth health specific services, with a view to those with outstanding performance championing best practice in youth healthcare, and services with low testing coverage rates increasing their testing rates. • Implementing chlamydia prevalence reporting to relevant stakeholders, with an expectation that this prevalence will increase as testing improves.	Rate of chlamydia testing (reported by gender and ethnicity) for 15-24 year olds. Target 6% for males.

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

7.3 Alcohol Harm Reduction

Activities	Contributory Measures
Improve data collection and reporting on alcohol harm reduction interventions through: • Establishment of an alcohol ABC baseline in primary care for reporting indicators. • Quality improvement activities focused on implementing Alcohol ABC in practice.	Percentage of the enrolled population aged over 14 years with alcohol status documented. Target 40%.
Quality improvement activities focused on data collection for alcohol-related ED presentations, including youth.	Establish a baseline for alcohol-related ED presentations. Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2020.
Take an integrated approach to alcohol harm reduction by working with other systems partners: • Work with ambulance services and urgent/after-hours services to explore the availability of alcohol-related data and feasibility of adopting/developing alcohol ABC data standard and reporting. • Work with student and other youth health services to explore the availability of alcohol-related data and feasibility of adopting/developing alcohol ABC data standard and reporting.	

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

7.4 Smoking Cessation for Māori and Pacific

Activities	Contributory Measure
Patient outcomes related to harm from smoking will be improved by: • Regularly reporting rates of referrals to cessation support and rates of medication therapy in primary care. • Use of a surveillance report to monitor smoking prevalence by ethnicity and age. The importance of smoking cessation as an intervention will be promoted by: • Continued working with cessation providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services. • Further development of smoking indicators for quality, to inform primary care approaches and interventions from PMS. • Development of a communication plan with regular updates to primary care and other referrers (i.e. LMCs, WCTO) to increase engagement in smoking cessation. Data quality will be improved by continued development of the Metro Auckland smoking indicators.	Rate of referral to smoking cessation providers by PHO. Target 6%. Rate of prescribing of smoking cessation medications by PHO. Target 12%.

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

7.5 Cardiovascular Disease (CVD) Risk Assessment and Management

Activities	Contributory Measure
Primary care and systems partners work together to support equitable CVD Risk Assessment (RA) for Māori by: • Provision of prioritised lists of eligible patients for risk assessment to practices, with Māori and Pacific first. • Referral of highest risk Māori to culturally appropriate providers for self-management and wellness support. Identification of and support to enrol Māori patients who are seen by Māori providers and are not enrolled in primary care. Implement a process to ensure all PHOs will have the ability to calculate and update CVD risk consistent with the National Consensus Statement for Assessment and Management of CVD in Primary Care. Continued reporting of the indicator 'prescribed dual therapy for those with CVD RA greater than 20%', with a view to emphasis of the importance of this intervention, throughout change created by the implementation of the National Consensus Statement for Assessment and Management of CVD in Primary Care.* Where the equity gap for Māori and Pacific has closed, PHOs are to identify other populations with unequitable access and facilitate interventions for those groups Reporting and improvement of clinical management through prescribing is facilitated through: • Continued development of NHI level reporting in secondary prevention. • Comparing dispensing data to prescribing data and identifying any opportunities for improvements.	CVDRA rates for Māori. Target 90%. Percentage of Māori with a previous CVD event who are prescribed triple therapy. Target 70%.
Improved outcomes for patients with a high risk of CVD event are sought by: • Patients who have previously had a CVD event and who are eligible receive the funded influenza vaccination. Monitored by DHB and ethnicity. Coverage will be monitored for the 65 – 74 year age group • Interventions to improve uptake of triple therapy for Māori and Pacific people. Opportunities to improve data collection and quality are advanced through: • Development and baselines for a set of quality indicators to support the implementation of CVD consensus statement (with a focus on coding specified conditions e.g. IHD, AF, CKD, diabetes). ***Note:** We anticipate a disruption in the data for primary prevention with the implementation of the new CVD Consensus Statement therefore this has been removed as a contributory measure for this year, although monitoring will continue.	Influenza vaccination rate for patients with a prior CVD event under 65 years of age. Target 35%.

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

7.6 Complex Conditions and Frail Elderly

Activities	Contributory Measures
Māori and Pacific patients with ASH conditions (e.g. CHF, CVD, COPD, AF/Stroke and Cellulitis) receive appropriate clinical support: • Māori and Pacific patients aged 45-64 with ASH conditions who are eligible receive the funded influenza vaccination. • Māori and Pacific patients who present in primary care with ASH conditions, or comorbidities which contribute to ASH conditions, are referred to appropriate self-management or wellness support services.	ASH rate for both Māori and Pacific adults aged 45-64 years old. Target 2% reduction. Baseline influenza vaccine coverage for patients with an eligible ASH condition and establish an improvement target.
Improve coding in primary care for specified long term and complex conditions (e.g. COPD and CHF) by matching ICD10 codes from secondary care with PHO registers and developing a process to supplement coding as clinically appropriate. Primary care collaborates with Māori providers to identify the Māori primary care population with long term conditions with a view to additional support.	
Increase referral of patients at high risk of falls to an appropriate Strength and Balance Falls Prevention Programme.	Rates of referrals of eligible older people to appropriate Strength and Balance Falls Prevention Programmes.

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

7.7 Primary Options for Acute Care (POAC)

Activities	Contributory Measure
Primary and secondary care will work together with the POAC team to increase utilisation of POAC for high needs populations, particularly Māori and Pacific people aged 45-64 by: • Promotion of POAC and referral pathways within general practice. • Focussing on increasing utilisation of POAC for ASH conditions, particularly, CHF, COPD and cellulitis. • Linking with ambulance services to increase POAC utilisation where patients are able to be best managed in the community, if transport or social requirements are met. • Investigation of options for supportive, early discharge from hospital, such as usage of POAC, interim care, or early discharge services managed by primary, community or secondary care providers.	POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions. Target 3 per 100 for each PHO.

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

7.8 E-portals

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

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

7.9 Patient Experience Surveys in Primary and Secondary Care

Activities	Contributory Measure
Primary care will improve patient experience by: • Working with early adopter practices to champion engagement. • Prioritising feedback from Māori and Pacific patients. • Participating in CQI activity via 'PES to PDSA' or 'You said – We did activity/Kōrero mai'. • Developing a PDSA activity focussed on Māori and Pacific. • PHO to practice support continues in monitoring and managing reports post survey week. • Practices utilise feedback from patients and whānau when making changes in the practice.	Practice participation rate in the PHC PES as at end June 2019. Target: maintain or increase current rates. Percentage of valid email addresses in the PMS for patients invited to participate in the PES.
Secondary care will improve patient experience by: • Focusing on the medication safety question in the National Inpatient Survey with a multidisciplinary approach. • Focussing on culturally appropriate patient centred information • Co-design of patient experience initiatives with a focus on Māori and Pacific people (CMDHB) • Develop an integrated approach to feedback so patient stories can be heard outside of traditional survey collection mechanisms (ADHB and WDHB). • Develop a Māori Patient Experience plan endorsed by Māori Health Equity Committee (WDHB) • Convene Consumer Council to advise on DHB priorities, strategy, health literacy and patient experience (WDHB) • Sharing learnings with primary care through established networks and forums. • Improving visibility of reporting of Māori and Pacific response rates, with a view to encouraging awareness via activities as noted above. Primary and secondary care will work together to explore the underlying data for Māori and Pacific patients enrolled in primary care to identify barriers to participations in the PHC PES.	Average score in Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?'. Target 5% improvement.

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

8. SYSTEM LEVEL MEASURE MILESTONES IN DETAIL

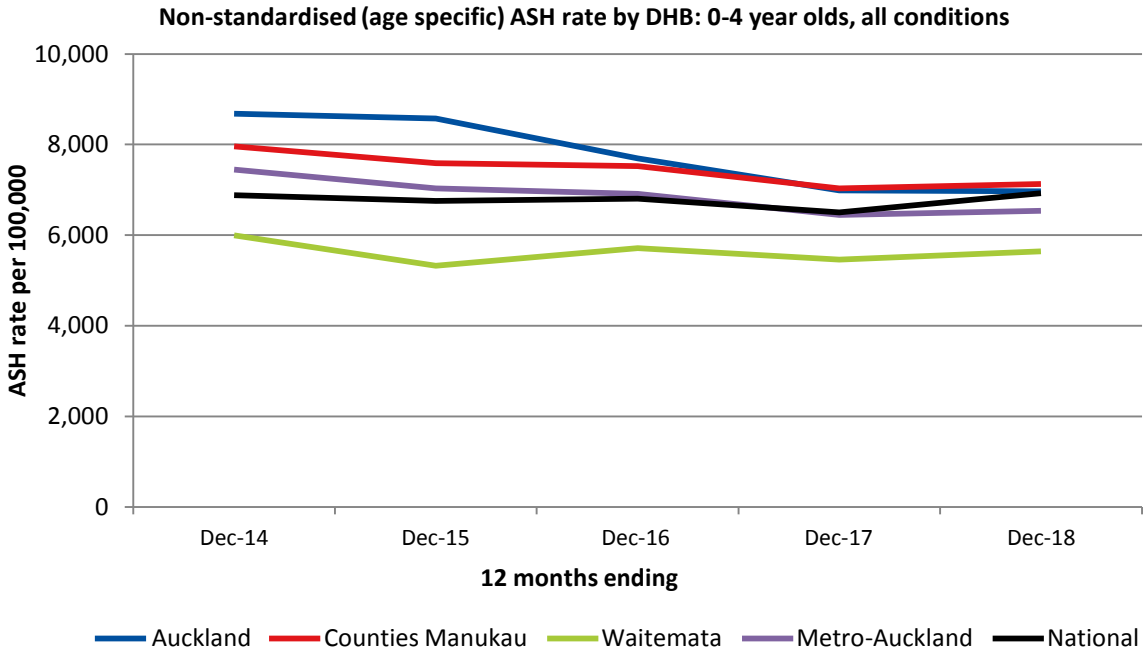
8.1 Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2020.** **3% reduction for Māori populations by 30 June 2020.** **3% reduction for Pacific populations by 30 June 2020.**

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

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

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

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



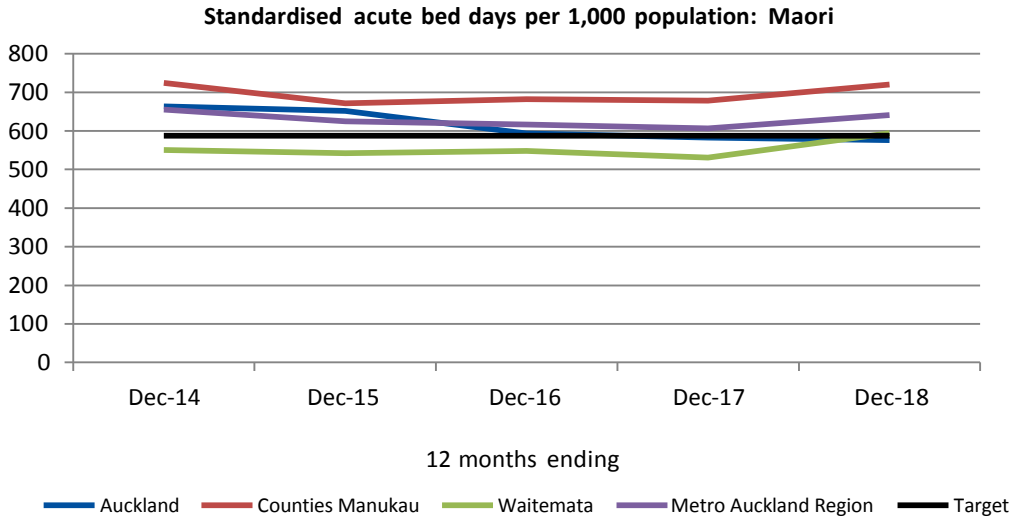
8.2 Total Acute Hospital Bed Days

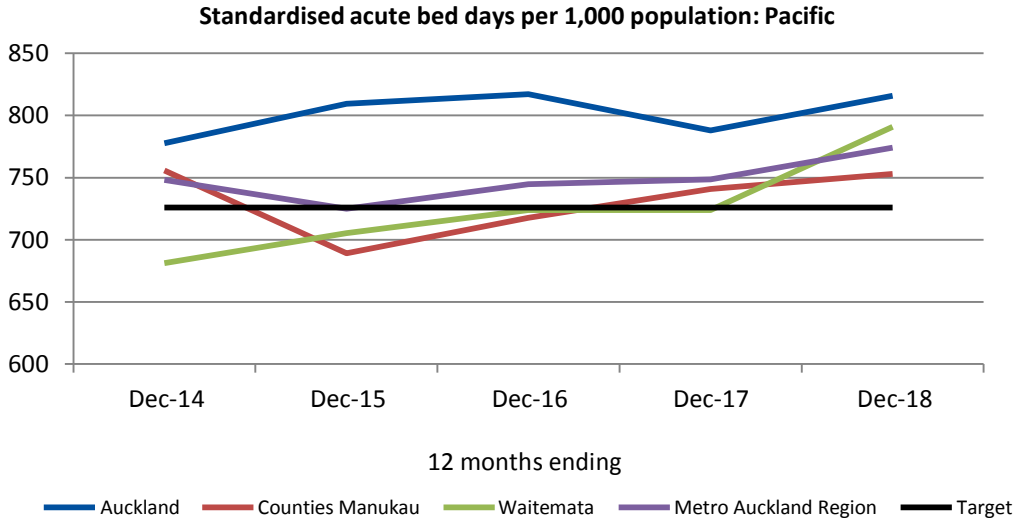
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori population by 30 June 2020.** **3% reduction for Pacific population by 30 June 2020.**

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. The intent of the measure is to reflect integration between community, primary and secondary care, and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. We will achieve a greater reduction in acute bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific targets for these populations are higher due to the inequity when compared to the total population.

We plan to target populations most likely to be admitted or readmitted to hospital, and focus on prevention and treatment of conditions that contribute the most to acute hospital bed days. Priority areas include alcohol harm reduction, CVD management, influenza vaccination for high risk groups and effective use of POAC. Conditions identified as highest priority include congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Coding for these conditions in primary care will be improved so effective interventions can be targeted.

Total acute hospital bed days for 2018/19 for Māori and Pacific identify marked inequities when compared to non-Māori, non-Pacific rates, so we will continue to focus on patients from this population in addition to the prioritised conditions.





8.3 Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 5% improvement on Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' by 30 June 2020.** **Primary care survey: 10% improvement on PES question: . 'When you ring to make an appointment how quickly do you usually get to see your current GP?' by 30 June 2020.**

Patient experience is a good indicator of the quality of health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes. The Health Quality and Safety Commission (HQSC) patient experience survey (PES) domains cover key aspects of a patient's experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs.
The 2019/20 plan reflects a shift from response rates to improvement in low scoring survey questions.

Hospital Inpatient PES: This has been in place since 2014. The milestone for 2019/20 focuses on the knowledge patients have about possible medication side effects when they are discharged from hospital. This will be achieved by multidisciplinary teams focusing on patient empowerment, health literacy, equity, and community awareness. This will be supported by continued work on culturally appropriate communication and health literacy.

Primary Health Care PES: The PHC PES was developed more recently and has continued to be implemented in practices over the 2018/19 year. The focus this year is to increase engagement of patients with the survey and strengthening a culture of quality improvement. This use of patient feedback and PDSA improvement cycles will lead to changes in practices that are important to patients.

8.4 Amenable Mortality

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

Two contributory measures have been consistent in amenable mortality improvement planning to date, those that have the greatest evidence-based impact – cardiovascular disease (CVD) management and smoking cessation. In 2019/20 we aim to build on the work already by continuing to prepare for the new Consensus Statement for Assessment and Management of CVD. We plan to achieve a 2% reduction in our milestone for each DHB to contribute to our 2021 target.

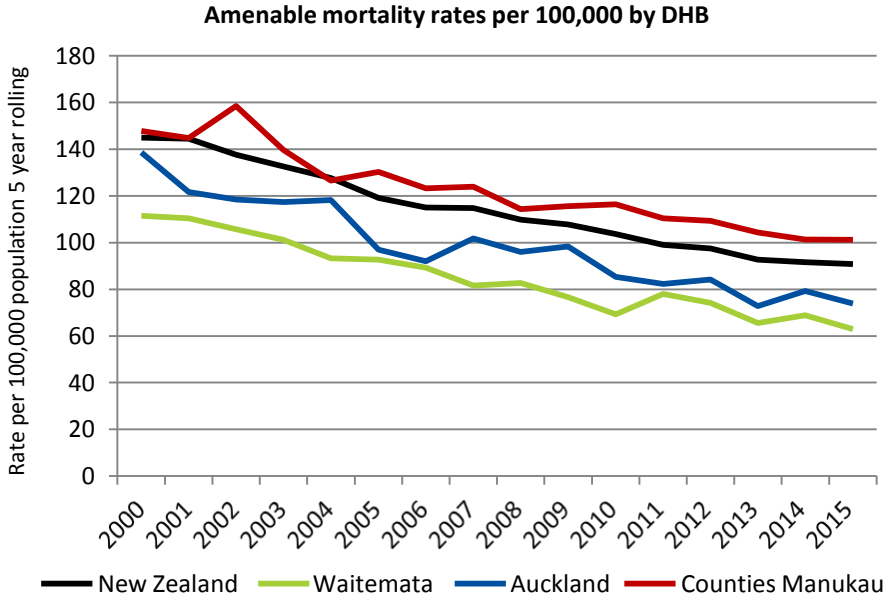
CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed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

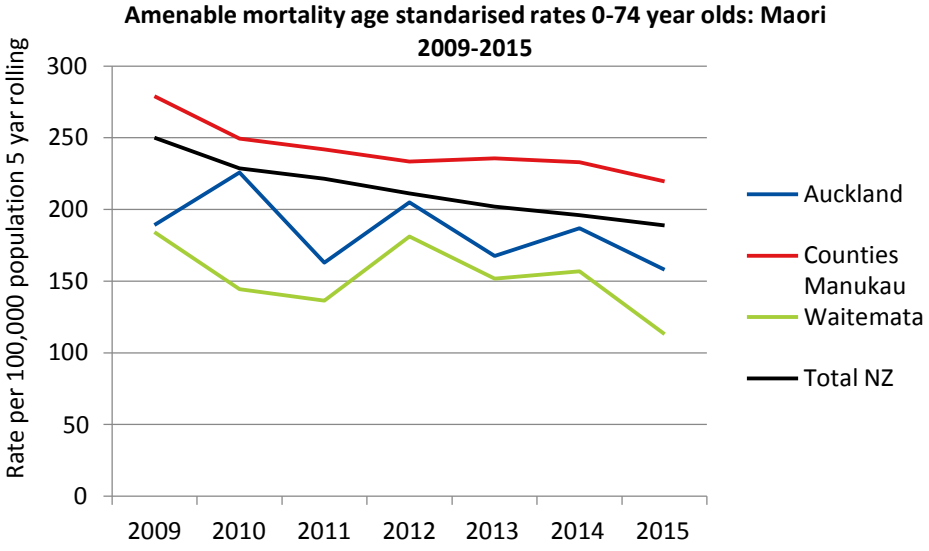
The burden of CVD falls disproportionately on Māori and Pacific populations, and there are well-documented inequities in CVD mortality, case fatality and incidence. Reducing these inequities is a high priority and can be achieved through increased use of evidence-based medical management of high-risk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

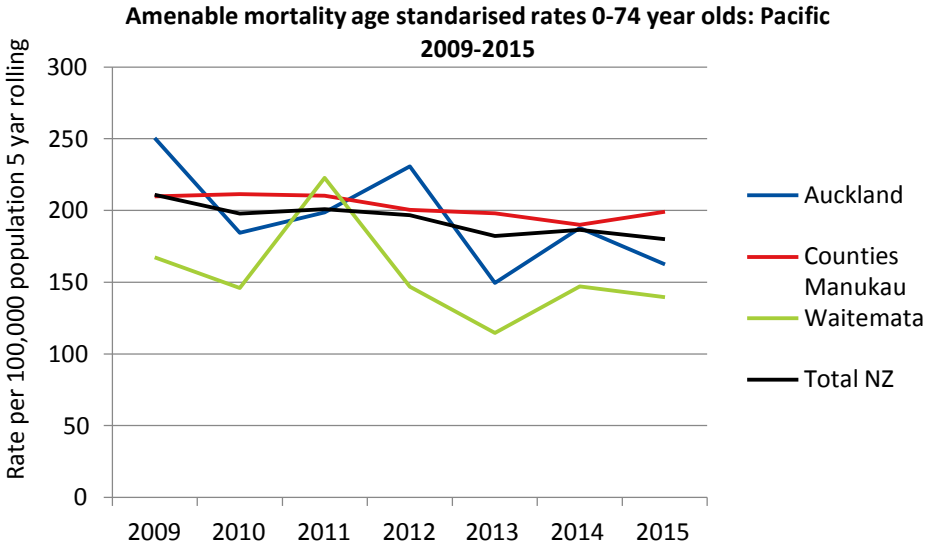
Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and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

We plan to connect this work with the Better Help for Smokers to Quit indicator which will support improved outcomes.

The 2019/20 plan will also focus on implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption




Amenable mortality age standarised rates 0-74 year olds: Maori
2009-2015
Rate per 100,000 population 5 yar rolling
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
Auckland
Counties Manukau
Waitemata
Total NZ


Amenable mortality age standarised rates 0-74 year olds: Pacific
2009-2015
Rate per 100,000 population 5 yar rolling
300
250
200
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2009
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2011
2012
2013
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2015
Auckland
Counties Manukau
Waitemata
Total NZ

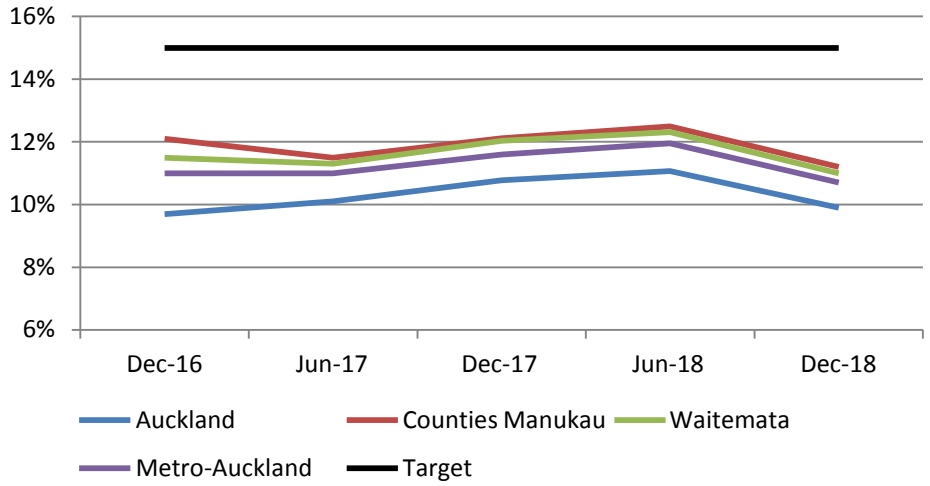
8.5 Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care Young people experience less alcohol and drug related harm and receive appropriate support
Improvement milestone	**Increase coverage of chlamydia testing for males to 6% by 30 June 2020.** **Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2020.**

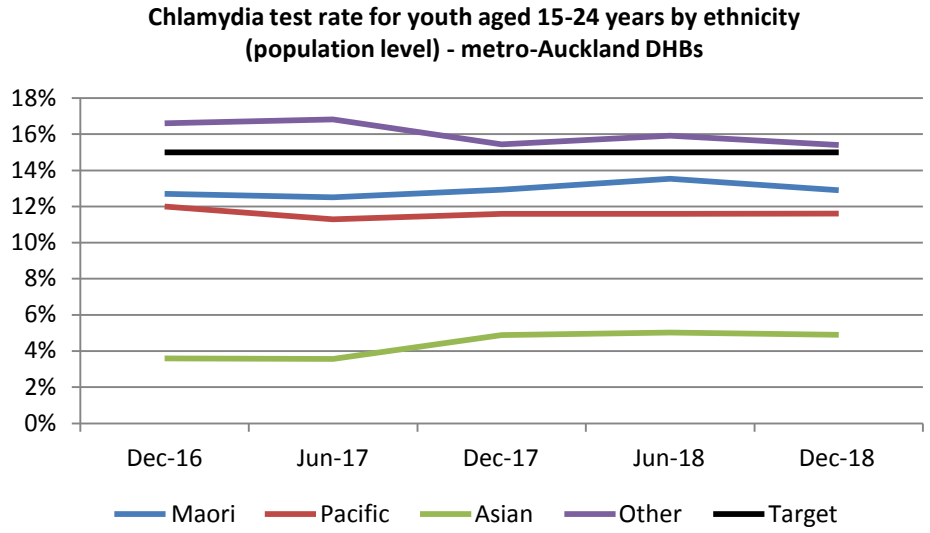
Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows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

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

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

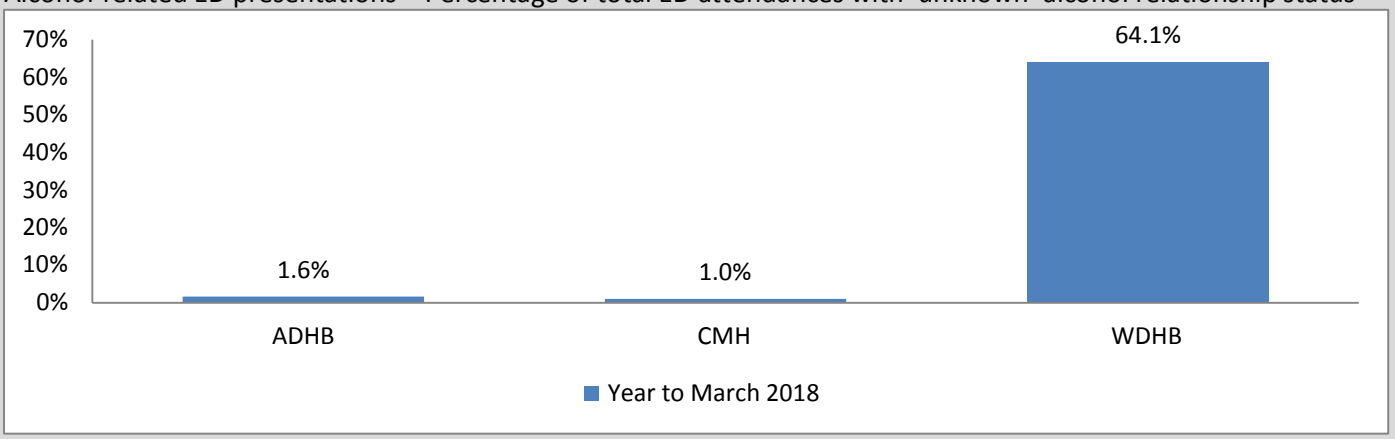
Chlamydia test rate for youth aged 15-24 years (population level)





Alcohol-related ED presentations: Identifying and monitoring alcohol-related ED presentations will enable better understanding of alcohol harm and which populations and communities are most affected. From July 2017, a mandatory data item was added to the National Non-admitted Patient Collection. In some DHBs, full implementation and reporting to the Ministry is not complete. The mandatory question is "Is alcohol associated with this event?" Possible answers are: yes, no, unknown and secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved). It should be noted that the response recorded may be a subjective assessment by healthcare staff and not confirmed by alcohol testing. Data quality is still poor, with significant missing data in some areas, therefore the 2019/20 plan will focus on quality improvement for alcohol data collection across primary care, youth services, and emergency departments.

Alcohol-related ED presentations – Percentage of total ED attendances with 'unknown' alcohol relationship status



8.6 Babies in Smokefree Homes

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

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

The definition of this indicator has recently changed so we only have one data point and cannot compare with older data.

Babies living in smokefree homes at 6 weeks postnatal

Reporting period	DHB of Domicile			
	New Zealand	Auckland	Counties Manukau	Waitemata
Jan 18 - Jun 18	53.8%	66.8%	52.8%	61.9%

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

9. GLOSSARY

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

Appendix B: Public Health Unit Plan Guidance

2019/20 Annual Plan Guidance for Public Health Units

Introduction

This 2019/20 Annual Plan Guidance for Public Health Units (PHUs) (the document) provides **strategic guidance** to support Public Health Unit (PHU) service planning for 2019/20. It includes high level strategic direction for focus/actions and, in most cases, the population targeted under each issues area.

We will provide you with updates if there are any changes or developments in relation to central government priorities.

Strengthening Public Health action

The Director-General of Health letter, dated 14 November 2018, to all PHU service managers (copied to the DHB Chief Executives) acknowledges the value of your work and the importance of your role in supporting greater integration of public health action and effort.

Key messages from the Director-General of Health's letter are highlighted below:

- Increased collaboration and integration are driving strategies across all parts of our health sector and similar approaches with other sectors will help ensure more organised and co-ordinated service delivery, reduce any gaps, overlap or duplication, and strengthen efforts to more effectively address determinants of health and Government priorities to achieve health equity and wellbeing.
- PHUs have an important role to play to address determinants of health and achieve health equity and wellbeing by supporting greater integration of public health action and effort. Accordingly, you should continue to support regional delivery of services where appropriate, build strong and proactive relationships and increase collaboration with other providers, stakeholders, primary care and government agencies.
- We encourage you to continue sharing best-practice innovations with other PHUs through the National Public Health Clinical Network, and your established regional partnerships, such as the South Island Public Health Partnership, and the Midland Region and Central Regional Public Health Clinical Networks.
- The Ministry of Health (Ministry) will be doing its part to support greater integration by working closely with you and your DHBs to ensure that the Ministry's investment in public health services for your communities is better aligned with local and regional efforts.

Results Based Accountability™ Framework

PHUs are encouraged to continue using Results Based Accountability™ (RBA) performance measures to align with the streamlined contracting approach being used across Government to purchase services.

Core Functions approach

The core functions approach was developed by the National Public Health Clinical Network and endorsed by the Ministry for use by the sector from 2012 onwards.

You may group and display the activities within your PHU Annual Plan according to what works best for you: whether in service lines, settings, core functions or their internal service structure groupings. Financial reporting will still be according to service lines or a service lines/core functions matrix.

2019/20 PHU Annual Plan timeline

The 2019/20 Annual Plan timeline is as follows:

- Start the planning process with your DHB(s) after reviewing the total DHB/PHU planning package.
- Submit the draft PHU Annual Plan for 2019/20 to your Ministry Portfolio Manager for the core public health services contract by **31 March 2019**. The Ministry is to provide feedback on your draft PHU Annual Plan within one month of receiving it.
- Incorporate feedback and seek DHB sign-off for your final PHU Annual Plan.
- Submit your final 2019/20 PHU Annual Plan to the Ministry by **31 May 2019** – your DHB(s) will be submitting their DHB District Annual Plan and Regional Services Plan to the Ministry at about the same time.
- Ministry feedback on the final PHU Annual Plan will be sent to you by 14 June 2019.
- Ongoing resolution of issues with PHU Annual Plan (as required) from 14 June 2019.
- Prepare for PHU service delivery from **1 July 2019**.

Reporting to the Ministry

Your service performance will be assessed through performance monitoring reports submitted every six months, to the Ministry, our regular meetings/visits to your premises and any service audits/reviews/evaluations.

There are three different reporting templates:

- Summary Progress Report (due 31 January)
- Whole-of-year Report (due 31 July)
- 'Vital few' RBA Reporting (due 31 January and 31 July).

Reporting requirements, templates and exemplars (Environmental and Border Health and Alcohol) remain the same as in the 2018/19 planning year. There is a new Tobacco Control exemplar, which is currently being reviewed. It will be sent to you when finalised.

Please contact Peter Burt, DDI 03 9742314, email: peter_burt@moh.govt.nz if you require the PHU planning and reporting templates or if you have any queries about the guidance.

How to use the guidance

The Ministry is mindful that not all activities outlined in this document will be relevant or appropriate for your population of coverage and that you may be required to prioritise some activities over others to ensure that existing resources are used most efficiently and effectively.

It is important that you ensure your service delivery is aligned with the strategic priorities of the Government, the Ministry and your DHB(s), and that all regulatory requirements are fulfilled.

As this guidance is high level, not every activity that PHUs carry out on a daily basis is included. For example, Communicable Diseases activities relating to surveillance are not considered here because they are core business-as-usual activities.

Government Priorities:

1. Improving Māori health	
Ministry contact: **Geoffrey Thompson** Email: geoffrey_thompson@moh.govt.nz DDI: 04 4962391 **Cheree Shortland-Nuku** Email: cheree_shortland-nuku@moh.govt.nz DDI: 04 8163587	
ISSUE DIRECTION/FOCUS:	**TARGET POPULATION**
DHBs and their PHUs must implement the principles of the Treaty of Waitangi in their activities, namely: a) **Participation**: requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development, delivery, monitoring and evaluation of health and disability services. b) **Partnership**: involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services. c) **Protection**: involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices. **PHU contribution:** • Māori health is a priority for the Government and the Ministry. Improving Māori health outcomes and addressing long standing inequities is a responsibility for everyone, in the Ministry and across the sectors. This requires focused effort and leadership. • The Ministry expects your planning documents to show how your public health services are aligned with your respective DHB Annual Plans. Your PHU Annual Plan should clearly demonstrate what you are doing to improve health outcomes for Māori, why your chosen approach will succeed and how you will measure your success in contributing towards improving Māori health. This level of information is expected for each service grouping of your PHU Annual Plan. • Please refer to He Korowai Oranga (2014) for the Ministry's overarching framework to achieve health outcomes for Māori. He Korowai Oranga's overarching aim, *Pae Ora – healthy futures* – encourages everyone in the health and disability sector to work collaboratively, to think beyond narrow definitions of health, and to provide high quality and effective services. Actions taken under He Korowai Oranga is one way the health system recognises and respects the principles of the Treaty of Waitangi (2016).	Māori peoples

2. Achieving Equity in Health and Wellness	
Ministry contact: **Geoffrey Thompson** Email: geoffrey_thompson@moh.govt.nz DDI: 04 4962391 **Cheree Shortland-Nuku** Email: cheree_shortland-nuku@moh.govt.nz DDI: 04 8163587	
ISSUE DIRECTION/FOCUS:	**TARGET POPULATION**

A system that delivers the same high-quality health outcomes and wellness for all people to reach their full potential no matter where they live, what they have or who they are.
 	
PHU contribution:
 	
• The current government has made it a priority to improve the health and wellbeing of all New Zealanders. Māori and Pacific peoples, and people living in low socio-economic areas experience significant health inequities across the social determinants of health. Reducing health inequities will require collaboration across the health and other sectors.
• The Ministry expects your planning documents to show how your public health services are aligned with your respective DHB Plans. Your PHU Annual Plan should clearly demonstrate what you are doing to improve health outcomes for Māori and Pacific peoples, and peoples living in low socio-economic areas, why your chosen approach will succeed and how you will measure your success in contributing towards improving their health. This level of information is expected for each service grouping of your PHU Annual Plan.
• Please refer to 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing. This document outlines the strategy for improving the health of Pacific peoples. A central part of the vision of this strategy is achieving equitable health outcomes for Pacific Peoples. It is also of key importance in achieving the goals of the New Zealand Health Strategy 2016-2026.
• Contribute to your DHBs' efforts to achieve equity in health and wellness, as specified in the Operational Policy Framework (section TBC) and the Minister of Health's Letter of Expectations.
• Particular areas of focus include:
  ○ enhancing relationships with other social sector agencies operating in their geographical area of coverage (eg, education, social development, housing, local government) to achieve the best health outcomes for your population
  ○ identifying key areas of unmet need and helping plan initiatives with your DHBs to address those unmet needs, along with methods for measuring the impact of these actions.
• To ensure a strong equity focus in service planning, you are encouraged to use tools that will enable you to assess your service delivery for their current or future impacts on achieving health equity [eg, using the Health Equity Assessment Tool (Ministry of Health June 2008) alongside other strategic, planning, implementation and evaluation tools, such as prioritisation frameworks, Health Impact Assessment, Whānau Ora Health Impact Assessment, and Equity of
	Any defined group in society who are not achieving equitable health outcomes. Priority groups are Māori, Pacific peoples and people living in low socio-economic areas.

Health Care for Māori: A framework (2014)].	
3. Child and Youth Wellbeing	
Ministry contact/s: **Liz Parker** Email: Liz_Parker@moh.govt.nz DDI: 04 8162147 **Pat Tuohy** Email: pat_tuohy@moh.govt.nz DDI: 04 4962373	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
Background information Child and Youth Wellbeing is a priority work programme for Government, the Ministry of Health and District Health Boards. This section identifies annual planning guidance for children and young people that contributes to the development and delivery of New Zealand's first Child and Youth Wellbeing Strategy (the Strategy) and preparing the Health and Disability sector for system transformation over time. Each of the Minister's planning priorities supports delivery of the Government's priorities outcomes (system shift) and is aligned with the Government's theme: Improving the well-being of New Zealanders and their families. Please note the guidance under Equity, Alcohol and Other Drugs, Healthy Families NZ, Immunisation, Injury Prevention, Long Term Conditions, Maternal and Child Health, Nutrition, Physical Activity and Healthy Weight, Sexual Health and Smokefree/Tobacco may be relevant to your work to achieve child and youth wellbeing. Child and Youth Wellbeing is an equitable outcomes action (EOA) focus area for DHBs (equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs). Recognising the influence of the first 1000 days on the subsequent health of a baby during its life time, particular emphasis continues to be on women of child-bearing age, infants, babies and pre-school children, and their families and whānau. Promotion of exclusive breastfeeding until about six months' of age, then introduction of appropriate nutritious complementary foods combined with continued breastfeeding, continue to	Any defined group in society who are not achieving equitable health outcomes. Priority groups are Māori, Pacific peoples and people living in low socio-economic areas.

be a focus. **PHU contribution – please support your DHB(s) in the following:** • There is an expectation that annual plans reflect how DHBs/PHUs are actively working to improve the health and wellbeing of infants, children, young people and their whanau, with a particular focus on improving equity of outcomes. • Annual plans should inform a comprehensive approach to prevention and early intervention services (primary and community health) provided to women of child bearing age, infants, babies, pre-school and school-aged children and youth, and their families/carers. • DHBs should draw on the most relevant information necessary to evidence their approach. ***First 1000 days (conception to around two years of age)*** • Identify the most important focus areas to ensuring the population needs for pregnant women, babies, children and their whānau are well understood, and identify key actions that demonstrate how the DHB will meet these needs, including realising a measurable improvement in equity for your DHB. Actions should include a comprehensive approach to prevention and early intervention services across priorities (see below) via maternity, Well Child Tamariki Ora, National SUDI Prevention Programme, and other services. • Identify what action you will take to identify barriers to achieving well integrated services across the first 1000 days. ***Well Child Tamariki Ora Review*** • Guidance to come. ***Family Violence and Sexual Violence*** • Reducing family violence and sexual violence is an important priority for the Government, and something we want all DHBs to be working on, in partnership with communities and other agencies. Please provide the action(s) for the upcoming year that your DHB considers is the most important contribution to this, including the reasons why the action(s) are important and the impact you expect them to achieve (updates will be provided as required).	
4. Mental Health	
Ministry contact: **Barry Welsh** Email: barry_welsh@moh.govt.nz DDI: 04 8162923	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**

PHU contribution: Provide support to your DHB/s to implement the relevant public health promotion aspects of the Government agreed actions following the Mental Health and Addiction Inquiry Report (further guidance will be provided following Government decisions).	General population but particular focus on Māori and Pacific peoples, children, youth and people with experience of mental illness and their family and whānau.
5. Primary Health Care	
Ministry contact: **Helen Topham** Email: helen_topham@moh.govt.nz DDI: 04 4962439	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
A strong primary health care system is central to improving the health of all New Zealanders and reducing health inequities between different groups. While primary care is working for most people, not all New Zealanders can get the health care they need due to cost and other barriers. Māori adults are 1.5 times more likely than non-Māori to cite cost as a barrier to access. Primary health care covers a broad range of health services including diagnosis and treatment, health education, counselling, disease prevention and screening. High performing primary health care relies on general practice, community providers and iwi providers delivering high quality accessible care in their local communities[13]. Primary care and public health have shared goals in addressing issues of disease prevention, health promotion and equity of health outcomes and access. Achieving these goals requires increased collaboration across the health and social system to address the root causes of illness, prevent disease and to make the default choice a healthy one. It is important to be aware that there are differences in primary health care provision, service models, composition, size, and capacity across New Zealand. An established broad relationship between primary care and public health is an important base for effective integration. Both public health knowledge and clinical experience can achieve better population health outcomes by working together (across organisational levels). For example: • understanding the primary care environment in your district/region, what's already happening that is relevant to population health, and identifying shared values, goals and concerns • enabling primary care's input into public health service planning	

[13] Primary health care is a network of wide ranging organisations and providers planning and delivering services in the community including: DHBs primary care portfolio managers, primary health organisations, general practitioners, primary care nurses, pharmacists, midwives, social workers, physiotherapists, community workers, district nurses etc.

• identifying and acting on relationship building and partnership opportunities:
  ○ supporting implementation of System Level Measures[14] through the District Alliances;
  ○ supporting Primary Health Organisation (PHO) Health Promotion initiatives,
  ○ building on existing formal and informal networks (eg, for emergency management, communicable disease outbreaks and immunisation)
  ○ exploring shared training and professional development opportunities
  ○ working in partnership on social determinants of health and wellbeing issues (eg, via healthy housing programmes, nutrition and physical activity initiatives, Healthy Families NZ)
  ○ improving referral pathways between primary care and public health initiatives
• Sharing data and information to support population health responses
• Exploring opportunities to align health messages, and share resources
• Strengthening networks with relevant primary care based health promotion initiatives (eg, Green Prescription).	

Ministry's immediate system priority (applicable to PHUs):

1. Drinking Water Regulation	
Ministry contacts: **Sally Gilbert** Email: sally_gilbert@moh.govt.nz DDI: 04 8164345 **Sarah Reader** Email: sarah_reader@moh.govt.nz DDI: 04 819 6836	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
PHU contribution: The priorities are those activities identified in the drinking water section of the Environmental Health exemplar.	Water suppliers, local government. All communities at risk and priority groups, such as Māori, Pacific and lower socioeconomic groups.

[14] https://www.health.govt.nz/new-zealand-health-system/system-level-measures-framework

Ministry's priority supporting activity (applicable to PHUs):

1. Long Term Conditions – Prevention, Identification and Management: guidance for DHBs and PHUs
Ministry contact: **Dr Fran McGrath** Email: fran_mcgrath@moh.govt.nz DDI: 04 8162039

Long term conditions are ongoing, long term or recurring conditions. The prevalence of long term conditions is increasing, causing premature mortality and morbidity, which is directly or indirectly linked with the underlying disease. Māori and Pacific people, people living in low socioeconomic circumstances, people with disabilities and people with mental health and addiction issues are disproportionately affected by some long term conditions, with a more significant impact from ill health and earlier mortality.

DHB prevention and treatment services need to adapt to meet this increasing burden of long term conditions, with consideration given to cardiovascular disease, cancer, diabetes, chronic respiratory conditions, mental ill health and musculo-skeletal conditions. Focus needs to be placed on providing evidence-based services that are people-centred and closer to where people live, learn, work and play. Services should focus on wellness and prevention (eg, strategies and environments that help make healthy choices easier), early identification, and integrating management and treatment in community-based services. This can both stop the occurrence, and slow the progression of many long term conditions. DHBs are expected to identify new activity to deal with this rising burden, and identified disparities, while also committing to continue current programmes to deal with the burden of long term conditions (eg, current Chronic Obstructive Pulmonary Disease and Asthma programmes).

DHBs and PHUs should collaborate with their local PHO/s and other local partners (eg, iwi, education providers, local government, government agencies, non-government organisations, and businesses) to develop appropriate actions for the prevention, identification and management of long term conditions to implement integrated programmes. The local partners/key stakeholders for each priority should include any groups that will be involved in the implementation of the specific plan.

Interventions/approaches known to work that must be considered and reflected, as appropriate, in the DHB/PHU Annual Plan follow:

- population based and targeted prevention
- collaborative programmes that make healthy choices easier, and target higher risk populations
- workforce capacity and capability
- IT solutions
- consumer and community co-design

- effective primary care and community/services closer to home
- self-management programmes.

Effective collaborative action and outcomes (as outlined in dot point two above) cross community and primary care organisations to maximise physical activity, good nutrition, quit smoking and reduction in the harmful use of alcohol (including demand reduction and control), and support for mental health promotion programmes. Where DHBs have reflected one of the above approaches, this should be clearly identified within the Annual Plan, as DHB Annual Plans will be assessed against the reflection of the above dot points, particularly how joint participants bring different foci/perspectives from their areas of expertise (eg, physical activity).

Some key areas associated with long term conditions have been chosen by the Whānau Ora Partnership Group (comprising of representatives from the Iwi Chairs Forum and six Ministers representing the Crown) to highlight health sector activity to support Whānau Ora. These are part of a larger set of indicators. Health sector activity will need to focus on progress in five key areas that contribute to Whānau Ora – mental health (reduced rate of Māori committed to compulsory treatment relative to non-Māori), tobacco (better support for pregnant women to quit smoking), asthma (reduced asthma admission rates for Māori and Pacific children), oral health (Māori and Pacific 5 year-old children who are caries free), and obesity (B4 School Check services). These have been chosen to achieve accelerated progress towards health equity for Māori and Pacific, and Whānau Ora in the next four years.

Further guidance on common risk factors

As the six conditions which make the largest contribution to morbidity and mortality due to long term conditions (cardiovascular diseases, cancer, chronic respiratory diseases, diabetes, mental ill health and musculo-skeletal conditions) share four behavioural risk factors (tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol), some guidance for PHUs on the four risks factors are given below (starting with Healthy Families NZ).

Healthy Families NZ
Healthy Families NZ is a large-scale initiative that brings community leadership together in a united effort for better health. It aims to improve people's health where they live, learn, work and play by taking a dynamic systems approach to preventing chronic disease. Currently, the key focus areas for Healthy Families NZ include increased physical activity, improved nutrition, more people smoke-free and reduced alcohol-related harm.

Healthy Families NZ
Ministry contacts: **Melanie Turner** Email: melanie_turner@moh.govt.nz DDI: 09 5809008 **Holly Novis** Email: holly_novis@moh.govt.nz DDI: 04 816 2210

ISSUE DIRECTION/FOCUS	TARGET POPULATION
For your general information: • Healthy Families NZ is focused on enabling communities to make good food choices, be physically active, smoke-free, and reduce alcohol-related harm. Healthy Families NZ is a move away from disconnected, small-scale and time-limited projects and programmes, towards a whole-of-community approach that makes changes to the systems and settings that influence the health and wellbeing of communities. • The Healthy Families NZ approach is underpinned by a set of principles, including an explicit focus on equity, improving Māori health and reducing inequalities for groups at increased risk of chronic diseases. • Healthy Families NZ is supporting communities to think differently about the underlying causes of poor health and to make changes in key settings within their community (ie, schools, early childhood education settings, workplaces, food outlets, sports clubs, marae, businesses, places of worship, local governments, and more to create healthier environments for all). • Healthy Families NZ aims to build on existing action underway in the community to create an integrated, community-wide "prevention system" for good health. • For further background information, please see: www.healthyfamilies.govt.nz **PHU contribution:** • DHBs and their PHUs have a key role to play in Healthy Families NZ. If you have a Healthy Families NZ community in your region, work strategically with the Lead Provider to support the initiative, including re-aligning your activities, where appropriate. • Workplace settings: The number of PHUs collaborating with Toi Te Ora and Healthy Families NZ locations to support a nationally coordinated approach to workplace wellbeing is increasing. In 2017/18 and 2018/19, the Ministry anticipates these activities will contribute to an increased number of organisations implementing WorkWell and Good4Work as an outcome of strengthened partnerships between PHUs and Healthy Families NZ locations. • Increase your focus on supporting settings-based health promotion. In particular, support action targeted towards workplaces, education settings, marae, sports clubs, and other key community settings. • If there is a Healthy Families NZ community in your area, support Healthy Families NZ workforce, the Strategic Leadership Group and Prevention Partnership networks in the planning, implementation and evaluation of strategic aligned initiatives. • Where appropriate, support the professional development of the Healthy Families NZ workforce, and proactively share learnings and data from current and previous local health promotion activities. The Healthy Families NZ Interim Evaluation Report and Supplementary Report (2017) http://www.health.govt.nz/publication/interim-evaluation-report-	Communities in the ten localities as follows: • Far North District • Waitakere Ward • Manukau Ward • Manurewa-Papakura Ward • Rotorua District • East Cape • Whanganui District • Lower Hutt City • Christchurch City • Invercargill City.

healthy-families-nz is recommended as a source of useful information to help this work.	
Alcohol and Other Drugs (refer also to the Alcohol Exemplar)	
Ministry contacts: **Rebecca Kemp** Email: rebecca_kemp@moh.govt.nz DDI: 03 974 2313 **Emma Solomon** Email: emma_solomon@moh.govt.nz DDI: 09 580 9031 **Jo Muschamp** Email: jo_muschamp@moh.govt.nz DDI: 09 580 9013	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
The National Drug Policy 2015–2020 (NDP) seeks to minimise alcohol and other drug (AOD) related harm, and promote and protect health and wellbeing. The objectives of the policy are: • delayed uptake of AOD by young people • reduced AOD-related illness and injury • reduced hazardous drinking of alcohol • a shift in attitudes towards AOD. *'Taking Action on Foetal Alcohol Spectrum Disorder (: 2016-2019'* (FASD) identifies priority actions for preventing FASD and supporting people with FASD and their family/whānau to live the best possible lives. **PHU contribution:** • PHUs will demonstrate in their Annual Plan how they contribute to the goals and objectives of the NDP and the FASD action plan through evidenced-based demand reduction, problem limitation and supply control strategies. This includes the regulatory responsibilities of Medical Officers of Health under the Sale and Supply of Alcohol Act 2012 as per the Alcohol exemplar. • Multi-faceted health promotion efforts to minimise AOD harm should be based on community need and focused on reducing inequities, including giving children the best start. This should include involvement in the adoption of healthy public policy, such as Local Alcohol Policies and other health promotion initiatives, as per the Alcohol exemplar.	General population but particular focus on Māori and Pacific peoples, youth, pregnant women and their families/whānau, women of childbearing age and parents of young children.
Nutrition, Physical Activity and Healthy Weight	

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ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
Good nutrition and regular physical activity (including sufficient sleep, and reducing sedentary time) are important for all age groups and for supporting healthy weight. They are essential for healthy growth and development of children and young people, essential for reducing the risk of poor health and maintaining overall health and wellbeing of adults. It is also vital for maintaining overall health and wellbeing, and reducing health loss in older adults. The focus this year is on creating supportive environments, particularly through encouraging and supporting organisations to adopt and implement a Healthy Food and Drink Policy such as the National Policy for DHBs or the Organisational Policy In your annual plans, please provide your top three priorities for improving nutrition and top three priorities for increasing physical activity in your area. Overall, your PHU Annual Plan 2018/19 will demonstrate how you will: • ensure activities support priority populations • ensure activities link to the wider outcomes to improve health for all population groups, reduce long term conditions and the burden of public expenditure on health and social services • support relevant local initiatives, such as with local government, businesses, schools, iwi, Māori and Pacific services, NGOs, and others. **PHU contribution:** • Ensure work undertaken is consistent with Ministry of Health policy positions, guidelines (including the *Eating and Activity Guidelines for Adults* and other documents on nutrition and physical activity, and these are reflected in the services provided to local communities. • Encourage and support schools (primary, intermediate and secondary) and early learning settings to adopt and implement water (and plain milk) and healthy food policies in line with Ministry of Health and Ministry of Education guidance, including where appropriate, working with food providers, and other school-	Māori, Pacific, lower socio-economic groups and other vulnerable groups.

based health services and providers (eg, oral health, Health Promoting Schools, Heart Foundation). • Promote and support other health providers (eg, PHOs, local councils, government agencies, non-government organisations, sports clubs and facilities and businesses) to adopt and implement the Ministry's *Healthy Food and Drink Policy for Organisations,* and WorkWell. • Continue to strengthen strategic alliances and interagency networks at local, regional and national levels to promote breastfeeding, healthy food choices and increased physical activity. Work collaboratively with other organisations in your region, such as central and local government agencies, NGOs, Māori and Pacific and other ethnic health and health promotion services, and strengthen alliances between prevention and primary care. • Link into and support other organisations' programmes and promotions, where appropriate including the New Zealand Transport Agency's Urban Cycleways Programme, Health Promotion Agency nutrition and physical activity promotions, National Heart Foundation programmes, workplace wellness and productivity programmes, such as WorkWell, Health Promoting Schools and Fruit in Schools. • Report any issues concerning compliance of the WHO Code of Marketing of Breastmilk Substitutes. Note: The Well Child Tamariki Ora Quality Improvement Framework[15] has four breastfeeding and two healthy weight health indicators, which will be reported against by DHBs every six months.	
Tobacco (exemplar is under development)	
Ministry contacts: **Jane Chambers** Email: jane_chambers@moh.govt.nz DDI: 04 8164420 **Jo Muschamp** Email: jo_muschamp@moh.govt.nz DDI: 09 580 9013	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
PHU contribution: • Please continue to deliver core activities and fulfil your statutory obligations, according to the Smokefree Enforcement Manual and any guidelines or advice provided by the Ministry of Health. • Maintain sufficient numbers of statutory officers to fulfil your statutory obligations and ensure adequate capacity to carry out statutory services. • Outline in your DHB Annual Plan, Tobacco Control Plan and Regional Service Plan, as appropriate, the role you play and the activities that contribute to the achievement of the Smoke-free 2025 target.	Priority populations include Māori and Pacific populations, low socio-economic (ie, deprivation index 7 – 10), other ethnic minority groups, and pregnant women. Any health promotion

[15] http://www.health.govt.nz/publication/well-child-tamariki-ora-quality-improvement-framework

Note: The Well Child Tamariki Ora Quality Improvement Framework[16] has two smoke-free indicators, which will be reported against by DHBs every six months.	or education should be geared towards these priority populations, in particular young pregnant women.

Other Issue Areas: in alphabetical order

1. Communicable Diseases (refer also to Appendix 6C Communicable Diseases Exemplar)	
Ministry contacts: **Communicable Diseases core activities:** **Laurence Holding** Email: laurence_holding@moh.govt.nz DDI: 021 195 1424 **Sarah Reader** Email: sarah_reader@moh.govt.nz DDI: 04 819 6836 **Needle and Syringe Exchange Services: Anne Collis** Email: anne_collis@moh.govt.nz DDI: 04 816 2249 **Immunisation: Rachel Webber** Email: rachel_webber@moh.govt.nz DDI: 04 816 2664	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
Communicable Diseases core activities **PHU contribution:** • Continue to deliver core activities, including health assessment and surveillance, public health capacity development, health protection and health promotion. • Fulfil regulatory reporting, including updating of EpiSurv, as per legislative requirements and according to the Communicable Diseases Control Manual 2012. Ensure that cases of notifiable diseases are entered and updated in EpiSurv in a timely manner and all fields in the case report form are completed accurately. • Maintain ongoing capability and capacity to detect, investigate, assess and respond to cases and outbreaks of infectious diseases, pandemics, emergencies or other significant events with public health implications.	All
Needle and Syringe Exchange Services **PHU contribution:** • Authorise dedicated needle and syringe exchange service	Needle and syringe exchange services in the PHU's region of coverage (including

[16] http://www.health.govt.nz/publication/well-child-tamariki-ora-quality-improvement-framework

providers (ie, premises [physical place], managers [representative] and mobile services [vehicle]), as required. An 'X' in the following link identifies the dedicated needle exchanges in your region, including the New Zealand Prostitutes' Collective that operate Alternative Outlets 'A2'. http://www.needle.co.nz/new/fastpage/fpengine.php/outlet_summary.html/15 Contact the needle exchange national office (+64 3 366 9403) for the authorisation form and guidance. • Undertake observation visits (minimum one per annum if capacity allows) to support needle and syringe exchange services (X, A2) to operate in accordance to best practice, regulatory provisions (Health [Needle and Syringe] Regulations 1998 and Misuse of Drugs Act 1975) and other relevant legislation.	those delivered by the New Zealand Prostitutes' Collective).
Immunisation While increasing childhood immunisations is a priority, it is important that other publicly-funded immunisation programmes also achieve high coverage, for example, antenatal immunisation, HPV immunisation for both girls and boys, measles, mumps and rubella vaccinations in the 12 to 32 year age-group, and the annual influenza programme. It is also a priority to facilitate vulnerable groups in our population to be vaccinated. For example, less than 50% of Māori people aged 65 years and over received influenza vaccination in 2018. **PHU contribution:** • Continue to support your respective DHBs/PHOs towards achieving increased immunisation, in particular with regards to achieving equitable coverage for Māori children and adults. • Work alongside your respective DHBs/PHOs, as required, to provide a collaborative and comprehensive response to vaccine-preventable disease outbreaks. • Ensure the regulatory responsibilities of the Medical Officers of Health are carried out in accordance with the Medicines Regulations 1984, clause 44a. Your role, in terms of the support/advice you give to immunisation promotion, will be as agreed with your DHB(s) and Immunisation Steering Committees. Note: The Well Child Tamariki Ora Quality Improvement Framework[17] has one immunisation health indicator (immunisation at age 5 years), which will be reported against by DHBs every six months.	Children and adults eligible for vaccines as recorded on the National Immunisation Schedule (including childhood vaccines, HPV, influenza vaccine, zoster vaccine, adult boosters [Td] and those eligible for high risk programmes). Parents, guardians, whānau and community (including refugee and migrants) for promotion of immunisation campaigns. Specific health provider groups (eg, Lead Maternity Carers, authorised vaccinators, Primary Care providers and vaccinators, BCG vaccinators).

[17] http://www.health.govt.nz/publication/well-child-tamariki-ora-quality-improvement-framework

2. Environmental and Border Health (excluding drinking water which is covered above)	
Ministry contacts: **Sally Gilbert** Email: sally_gilbert@moh.govt.nz DDI: 04 816 4345 **Sarah Reader** Email: sarah_reader@moh.govt.nz DDI: 04 819 6836	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
PHU contribution: **General:** • The priorities are those activities identified in the Environmental and Border Health exemplar. • Continue to deliver core activities and fulfil your statutory obligations, according to the Environmental Health Protection Manual and any guidelines or advice provided by the Ministry of Health. • Maintain sufficient numbers of statutory officers to fulfil your statutory obligations and ensure adequate capacity to carry out services and respond to incident and emergent issues 24 hours per day.	All communities at risk in geographical area of coverage and priority groups, such as Māori and lower socioeconomic groups.
Climate Change and Waste Disposal: In the DHB Annual Planning Priorities Guidance for 2019/20, your DHB/s have been asked to: **Climate Change** • Identify further areas for action (for example, via gaps identified in the 2018/19 stocktake of climate change actions) to positively mitigate or adapt to the effects of climate change • As appropriate, identify actions that improve the use of environmental sustainability criteria in procurement processes. **Waste Disposal** • Identify further areas for action (for example, via gaps identified in the 2018/19 stocktake of waste disposal actions) to support the environmental disposal of hospital and community (eg, pharmacy) waste products (including cytotoxic waste). Please support your DHB/s to implement the above.	Your DHB/s
3. Healthy Housing	

Ministry contacts: **Natalie Burton** Email: natalie_burton@moh.govt.nz DDI: 09 580 9028 **Bronwyn Petrie** Email: bronwyn_petrie@moh.govt.nz DDI: 09 580 9035	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
PHU contribution: • Monitor the impact of housing-related conditions in your region through engagement, where appropriate, with DHB ambulatory sensitive hospitalisation (ASH) programmes, DHB Community Primary Care programmes and Territorial Authorities (TAs) housing improvement programmes • Assist with the establishment, planning, implementation, integration and evaluation of housing improvement programmes in your region • Undertake health promotion activity regarding healthy housing across your region to improve current and future housing conditions and healthy living practices. • Report back on good-practice outcomes for use in national planning.	All communities at risk of housing-related conditions including: • Children 0-14 years • Adults over 65 years • Those with past episodes of rheumatic fever • Known housing areas of public health concern.
4. Injury Prevention (Unintentional)	
Ministry contact: **Natalie Burton** Email: natalie_burton@moh.govt.nz DDI: 09 580 9028	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
PHU contribution: • Influence and collaborate with your Territorial Authorities (TAs) to encourage and assist them to implement the Pan Pacific Safe Communities model. In those TAs where the model has already been implemented, collaborate with the TAs and wider injury prevention sector to support the sustainability of the model.	Children aged 0-14 years that are Māori, Pacific and/or living in areas of high deprivation.
5. Maternal and Child Health Promotion	
Ministry contacts: **Oral Health**: **Barbara Burt** Email: barbara_burt@moh.govt.nz DDI: 04 816 2834 **Positive Parenting: Helen Fraser** Email: helen_fraser@moh.govt.nz DDI: 07 929 3647 **SUDI: Gavin Koroi** Email: gavin_koroi@moh.govt.nz DDI: 07 929 3629	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**

Oral Health **PHU contribution:** • Promote community water fluoridation (CWF) so that water fluoridation coverage is extended to un-fluoridated areas, especially in areas of high deprivation, and retained in areas where it already exists. • Promote the use of regular strength fluoride toothpaste twice daily for all family/whānau members. Note: Two of the oral health policy priority measures, PP10 (average number of decayed, missing and filled teeth (DMFT) per child at school year 8) and PP11 (percentage of children caries-free at age 5), reported annually by DHBs, are relevant to the above PHU objectives.	Areas without fluoridation, especially with a high proportion of children, and/or high levels of deprivation. Areas with fluoridation where there is pressure to have it removed.
Positive Parenting Programmes **PHU contribution:** • Undertake health promotion activities to promote positive parenting in communities. • Promote or contribute to activities and opportunities that support the primary prevention programme Power to Protect – *'Coping Strategies for a Crying Baby'* (formally Shaken Baby Prevention Programme).	Māori, Pacific and lower socio-economic groups.
Prevention of Sudden Unexpected Death in Infancy (SUDI) **PHU contribution:** The National Sudden Unexpected Death in Infancy (SUDI) Prevention Programme (NSPP), implemented from 1 July 2017, builds on the campaign to 'make every sleep a safe sleep' for babies, through a multi-agency, system-based approach to reduce the SUDI rate to 0.1 in every 1,000 births by 2025. The NSPP will address a range of SUDI risk and protective factors but will target the two key modifiable risk factors for SUDI, which are exposure to tobacco smoke and bed sharing with a baby. The NSPP includes a national SUDI Prevention Coordination Service, four regional SUDI prevention coordinators and funding for all 20 DHBs via Crown Funding Agreements to deliver on local SUDI prevention plans, which outline how they will deliver SUDI prevention services, particularly to babies at high risk of SUDI.	Māori, Pacific and lower socio-economic groups.

6. Public Health Workforce Development	
Ministry contact: **Sene Kerisiano** Email: sene_kerisiano@moh.govt.nz DDI: 04 816 2649	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
PHU contribution: • Ensure your activities and outcomes are consistent with *Te Uru Kahikatea: The Public Health Workforce Development Plan 2007–16* (TUK), noting that a review of TUK is in progress. A TUK version II is planned to become available soon. • Continue to support and encourage staff to attain appropriate qualifications in public health, to meet the Ministry's 75% aspirational goal. • Develop Health Protection staff workforce development plans to address recruitment and retention issues, including for Drinking Water Assessors.	All staff in public health roles delivering public health services. Public health staff who have no formal qualifications in public health (eg, health promoters). Staff who hold formal tertiary education qualifications in the wider health and social sectors who are in public health roles.
7. Refugee and Migrant Health	
Ministry contact: **Jennifer Lamm** Email: jennifer_lamm@moh.govt.nz DDI: 09 580 9077	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
PHU contribution: • Services for refugee and migrant health will be aligned with the New Zealand Refugee Resettlement Strategy and the New Zealand Migrant Settlement and Integration Strategy, where specific targets/indicators will be monitored regularly by a cross-agency group to ensure better refugee and migrant resettlement outcomes. Specific Health outcomes for **refugees** are: o increased Quota Refugee children receiving age-appropriate immunisations (6 and 12 months after arrival) o increased utilisation of general practitioner services	Refugee and New Migrant families/communities, and relevant services/agencies.

○ increased access to mental health services. Specific health outcomes for **migrants** are: ○ increased proportion of recent migrants enrolled with primary health organisations. • Determine if refugee and new migrant communities are a key priority population within your area of coverage and focus activities towards meeting the needs of these individuals, families and communities in collaboration with other agencies and providers to support settlement outcomes and access/transition into primary and secondary healthcare. Include budget and personnel allocated to refugee and new migrant Health, if applicable.	
8. Sexual Health	
Ministry contact: **Jo Elvidge** Email: jo_elvidge@moh.govt.nz DDI: 09 5809099 **Jo Muschamp** Email: jo_muschamp@moh.govt.nz DDI: 09 580 9013	
ISSUE DIRECTION/FOCUS	**TARGET POPULATION**
PHU contribution: The Ministry has been working with PHUs and sexual health clinicians to develop a national Syphilis Action Plan to address the rapidly increasing incidence of syphilis. Two thirds of cases were found in gay and bi sexual men, one third are in heterosexual communities with women of reproductive age being most at risk. There has been a small number of still births caused by congenital syphilis. The general public and most health professionals are largely unaware of the resurgence of syphilis or the health risk (still birth, stroke, dementia, vision and hearing problems) of undiagnosed syphilis. PHUs should collaborate with midwives, primary care, youth health, and sexual health, to raise awareness of the need to use condoms especially with casual sexual partners and encourage testing for those who have had unprotected sex. Podcasts are available for clinicians to learn how to diagnose and manage syphilis at https://www.goodfellowunit.org/podcast. From 1 April 2019, funding will be made available for free or very low cost contraception, including Jadelle and intra-uterine device (IUD	Māori, Pacific, women and young people on low incomes.

procedures for low income women (that are holding community services cards, living on a welfare benefit or in Quintile 5 areas). PHUs, particularly those with health promoters focused on sexual health, can offer support with women's and youth's engagement through their existing networks with Māori and Pacific providers, NGOs and youth health providers. In addition, some DHBs have been working on Youth system level measures focusing on reduction of chlamydia in under 25s. https://nsfl.health.govt.nz/dhb-planning-package/system-level-measures-framework/data-support-system-level-measures/youth-slm-0 Rates of chlamydia for Māori, Pacific, women and young people are three times the rate of others. The Ministry would like to see a joined-up approach between PHUs, primary care, youth health and women's health funders, planners and clinicians in the DHB/s (e.g., through input into the Youth Service Level Alliance Team). The Ministry sees public health input and health promotion strategies as providing valuable input into the planning and implementation of these plans. To ensure services are well targeted and accessed, collaboration with sexuality focused non-governmental organisations (NGOs), Māori and Pacific providers, youth health providers, Youth One Stop Shop and school-based health services is needed.	