COUNTIES MANUKAU HEALTH

Annual Plan 2013/14

Counties Manukau District Health Board Annual Plan 2013/14
Incorporating the Statement of Intent 2013/14 - 2015/16

Counties Manukau District Health Board Annual Plan 2013/14
Published 31 July 2013

The Mangere Community Health Centre pictured on the front cover is owned by the Mangere Health Resources Trust

Annual Plan dated this 3 day of July 2013
(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

between

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

The Honourable Tony Ryall

And

Professor Gregor Coster
Chair of Counties Manukau DHB

Geraint A Martin
Chief Executive of Counties Manukau DHB

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

5 AUG 2013

Professor Gregor Coster
Chair
Counties Manukau District Health Board
Private Bag 94 052
South Auckland Mail Centre
AUCKLAND 2240

Dear Professor Coster

Counties Manukau District Health Board 2013/14 Annual Plan

This letter is to advise you I have approved and signed Counties Manukau District Health Board's (DHB) 2013/14 Annual Plan for three years.

I appreciate the significant work that goes into preparing such a thorough annual planning document and I thank you for your effort. I look forward to seeing your progress over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2013, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Better Public Services (BPS): Results for New Zealanders

The Prime Minister has set ten whole-of-government key result areas. The health service is responsible for leading increased infant immunisation and reduced incidence of rheumatic fever. We are also involved in the key result areas of reducing the number of assaults on children, increasing participation in early childhood education and supporting the implementation of the white paper on vulnerable children.

DHBs are expected to actively engage and invest in these key result areas. Your DHB has included step targets in your Annual Plan to contribute to the Prime Ministerial challenges. Achieving these is not negotiable.

It is important that your board works closely with other social sector organisations and initiatives, including Whānau Ora.

National Health Targets

Your plan includes a good range of actions that will lead to improved or continued performance against the health targets. The target set has remained stable for 2013/14 allowing you to build on the results from the 2012/13 year.

Counties Manukau DHB is performing well in most health target areas. However, in the year ahead I expect Counties Manukau DHB to particularly focus attention on maintaining the recent pattern of improving performance for the primary care component of the Better help for smokers to quit target, and the More heart and diabetes checks target.

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Quality Framework

I recently wrote to DHBs emphasising the need to maintain a focus on the quality and safety of services, both within hospitals and in wider services such as aged residential care and mental health. Ensuring quality will be an on-going focus for us all in the health sector. I expect that DHBs will use the framework that was provided to help shape DHB quality discussions. Also, that DHBs will produce a 'dashboard' of key quality and safety measures to regularly monitor performance and produce Quality Accounts in 2013.

Care Closer to Home

I expect DHBs to increase their focus on integration, particularly with respect to primary care, ensuring the scope of activity is broadened and rate of improvement is increased. I look forward to seeing an integrated approach driving service development, delivery and improved overall system performance; and in preparing to implement integration changes currently under development with the sector.

I am pleased to see an enhanced commitment to tangible actions in your Annual Plan to show how you will achieve real increases in access to diagnostic and treatment services for primary care and service shifts 'closer to home'. I expect DHBs to work in partnership with primary care, using their Alliances to drive service reconfiguration and improved system performance.

I am pleased to see your DHB developed your Annual Plan through the District Alliance Group. It is positive that, in addition to committing to continue meeting the minimum requirements for integration outlined in the Planning Guidance that you have committed to increase your $1 million investment in Health Target performance with an additional $1.2 million to increase a range of community diagnostic tests and extend your 'primary options to acute care' programme to include transient ischemic attacks and renal colic. Implementing notional budgets in 50% of your general practices and assisting 80% of general practice to use electronic decision support will progress integration in your district.

Health of older people

The Government expects DHBs to continue to work with primary and community care to deliver integrated services and improve overall quality of care for older people. I am pleased to see that you have developed an Annual Plan which undertakes to meet the Government's expectations for the coming year. Notably, the implementation of a local dementia pathway that follows the national framework, the management of the risk of variable service quality of home and community support services, and proactive use of your HOP specialists to advise and train health professionals in primary and aged residential care. You have also committed to review your wraparound services, roll out the Comprehensive Clinical Assessments in aged residential care facilities, and to establish a fracture liaison service.

Regional and National Collaboration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities. It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions.

Guidance on national entity priorities was provided to all DHBs in April, for inclusion in final 2013/14 Annual Plans, following the successful completion of the Health Sector Forum lead work between the Ministry, national entities and DHBs. I expect that your DHB will deliver on these commitments, as included in your plan financials. Attached is a summary of National Entity Priority Initiatives that shows your DHB's commitments for 2013/14. I look forward to observing progress on the delivery of these priorities.

Living within our means

DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery. Improvements through national, regional and sub-regional initiatives are expected to continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning surpluses of $3M for 2013/14 and 2014/15 and breakeven result for 2015/16. I will be watching with keen interest your management of financial performance during 2013/14. I look forward to confirmation of your financial template alignment and receiving details of improvement initiatives supporting your planned net results.

Budget 2013

The expectation is that you will deliver on Budget 2013 initiatives. The Ministry of Health will discuss these more fully with you and develop monitoring arrangements during 2013/14.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the NHB. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will be contacting you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

My acceptance of your Annual Plan does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependent on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I would like to thank you, your Board and management 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 2013/14 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

Finally, 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

Tony Ryall

Hon Tony Ryall
Minister of Health

Thankyou for all you, your board, ELT and staff do. Much appreciated.

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Foreword from the Chair and Chief Executive

2013/14 represents year two of a four year whole of health system transformation journey for Counties Manukau Health (CM Health).

This year, CM Health will implement the system integration strategies we planned last year. This is to ensure that we deliver on our promise to be the best healthcare system in Australasia by 2015.

This plan emphasises significant investment and devolution with new models of care in primary and community services (refer Figure 1). We will be spending:

- $7m on service integration and innovation
- $4.5m on devolution of Maaori provider contracts to National Hauora Coalition
- $1.5m on devolution of Pacific provider contracts to Alliance Health Plus
- $5.5m to shift home health care (68 FTE) from secondary care into PHO/DHB jointly governed community based services

This is as a result of establishing in 2012/13 a new platform of locality clinical partnerships of primary and secondary care clinicians to lead delivery of new integrated services. Each of the four localities (Mangere/Otara, East, Franklin and Manukau - and their respective clinical leadership and management governance) now have a 4-year business plan that identifies priorities to deliver better, sooner more convenient services.

In 2013/14, we will deliver year one of the localities plans and move the second tranche of community and allied health services into that structure from 1 July 2013. The locality leadership groups will drive the work of ensuring that community based specialist services are aligned with the population and primary healthcare needs of our local communities.

In 2012/13, our primary care partners established Integrated Family Health Centres that will form the hub of our network of shared services across each locality. During the 2013/14 year, we will proceed with shifting community based specialist services as required by primary care Locality governance with the support of the District Health Board (e.g. school based nursing clinics, diabetes, palliative care, maternity, health of older people services, community mental health).

This year we intend to integrate the Better Sooner More Convenient business cases (BSMC) with the Greater Auckland Integrated Health Network (GAIHN), Alliance Health Plus and the National Hauora Coalition into this structure who will, by 2013/14 be in their final year of "business case" implementation. From 1 July 2013, $4.5m of Maaori health and $1.5m of Pacific health services that improve access to primary healthcare will be shifted to National Hauora Coalition and Alliance Health Plus to align with our desire for whaanau ora/fanau ola implementation.

In 2012/13 we established a first tranche of 8 programmes to reduce our acute inpatient bed demand by 20,000 days. In 2013/14 we will extend this to 13 programmes with additional clinical pathways and improvement initiatives to further reduce our acute growth by an additional 20,000 days. In addition, we expect to reduce Ambulatory Sensitive Hospitalisations (ASH) by 5,000 this year as a consequence of expanded access to Primary Options for Acute Care (POAC), Chronic Care Management (CCM) and other primary care initiatives.

We have set aside $7m service integration and innovation funding to support locality and 20,000 Days campaign of initiatives. We will also begin first year implementation of a "risk and gain" sharing funding model across our healthcare system that reinforces the shared accountability for outcomes such as reducing acute demand between primary and secondary services. While no services will be destabilised by

this introduction by the end of 2013/14, it will set a platform for services to have shared and common incentives on how they work across continuums of care to benefit patient flow.

In 2012/13 we invested an additional $500,000 to increase primary care access to diagnostics. In 2013/14 we extend this programme to provide additional $1.2m investment in additional community diagnostics for spirometry, endoscopy for dyspepsia and will plan ways to increase direct primary care access to CT and MRI.

In 2013/14 we will use the mental health funding carried forward from 2012/13 to significantly invest in the mental health services of children and young people as our contribution to the Prime Minister's Youth Mental Health project and to meet the needs of our very young, mostly Maaori and Pacific populations.

During 2012/13, much was reported publicly about the issues relating to the care and support that is too often disconnected for our vulnerable mothers and their babies. The 2013/14 year will be the year of an increased and focused investment in vulnerable mothers, babies and their whaanau. We will act with concentrated effort on joining up the multitude of services that mothers and babies interact with when planning their families, pregnancy and during the First 2000 Days of baby's life. We believe this is the best opportunity to invest for better population health outcomes in the long term.

In 2013/14, we commit publicly to being a Smokefree DHB by 2025 – we aim to reduce smoking prevalence to less than 5 percent by 2025 with an intermediary goal of 12 percent by 2018 for all ethnic groups - and will be implementing concrete actions to increase access to cessation support. We will also "up the anti" with our intersectoral colleagues to tackle the poor access to warm and safe housing for our most vulnerable people and their whaanau.

We will continue to deliver all our national health targets this year with a focus on reduced waiting times in Emergency Department, diagnostics and cancer services. Our ambition is to exceed expectations. We are committed as a regional player to ensure we do our part in achieving the Northern Region Health Plan. Consequently we will deliver increased access to elective surgery, cancer, cardiac and specialist mental health services in line with the Minister's expectations. We are excited to be opening our Clinical Services Block during the year and utilise the expanded capacity to meet our local health needs.

Importantly, we will move forward to improve the experience of patients and their whaanau when they come into our healthcare system. Year 2 of our First Do No Harm programme will continue our contribution to national and regional campaigns (e.g. CLAB). In 2012/13 we implemented the whaanau as "Partners in Care" that welcomed close whaanau to be with their loved ones in hospital as partners, not as visitors. In 2013/14 we will extend this approach to integrate the experiences of patients in how we design services. Critical to the achievement of our strategic objectives will be the successful development and implementation of a fully integrated patient centred Information and Communication Technologies (ICT).

We aim to be the best. How will we know we are the best? We aim to benchmark ourselves against well researched system level measures that enable our comparison against other systems/jurisdictions over the next 5 years. We will also be testing ourselves against an excellence framework based on the internationally renowned Baldrige Framework for performance success.

We will deliver this within our financial envelope. While 2013/14 will be a challenging year, we will continue our track record of delivering on health needs within our budget. CM Health has had a long term focus on clinical engagement - clinical quality is our highest priority. In this particular year, we aim to bend back our cost growth curve to align more closely with inflation by changing how we work, to provide better care more effectively. We will do this through scrutinising every opportunity and advantage to ensure that we have the optimal mix of people and skills at the front line and that our capital investment focuses on enabling integration through IS/IT. Balancing our budget has been the most difficult for some years and we recognise that this financial challenge will go on for some years. In order to achieve a $3m surplus in 2013/14 and 2014/15 some difficult decisions have had to be made. However, the completion of the System Integration Investment indicative business case, currently being developed jointly by CM Health,

Ministry of Health and Treasury in the spring of 2013, will set the framework as to how we can transform our services to be of the highest quality of care but within a sustainable financial environment. As ever, we are fully committed to regional and national relationships and will continue to be a high performing DHB.

We thank our partners in our local healthcare system – primary care, non-government organisations, communities for your support and ongoing contribution to improving our community's health. This is a responsibility we share with you and we look forward to working together with you this coming year.

Professor Gregor Coster
Chair

Geraint A Martin
Chief Executive

Figure 1: CM Health strategy actions at a glance

	We established in 2012/13	We will implement in 2013/14
Better Outcomes for our Population and intersectoral collaboration	➢ 85 percent of 8 month olds immunised ➢ 95 percent of hospitalised smokers provided with cessation advice ➢ Better Health Outcome for all programme prioritisation of housing, Smokefree and First 2,000 Days of life initiatives ➢ Devolved contract for throat swabs in schools	➢ Immunisation of 90 percent of 8 month olds ➢ Throat swab service in 53 schools ➢ Reduce incidence of rheumatic fever by 10 percent ➢ Improve access to quality housing through increased referrals to retrofit insulation to private/ rental homes ➢ 100 percent school based nursing clinic integration with primary care (targeting at care for risk students) ➢ 1 FTE specialist for community youth alcohol & drug services (contribution to regional plan)
System Integration **with** **Localities Development as a key strategic investment** through hospital and primary/ community care collaboration and whaanau ora service integration	**Incentivise System Integration and Change**	
	➢ District Alliance group ➢ Localities Partnership Agreement and shared performance accountability ➢ Initiative funding for acute demand reduction ➢ Efficiency programme savings over 3 years of approx. $60m ➢ Increase in funding for direct community referred radiology tests (plain film and ultrasound) by $500k	➢ $850k total funding for direct community referred radiology tests (plain film and ultrasound) and scoping of potential expansion to include CT and MRI in 2014/15 ➢ $1m for primary care achievement of health targets ➢ Clinical integration of primary/community health and hospital service structures ➢ Shared risk/gain framework and primary care practice budget holding ➢ Thriving in Difficult Times (efficiencies) programme expanded to the whole system ➢ Whole of system operational information hub ➢ $1.2m investment for increased range of community diagnostic tests for spirometry, endoscopy for dyspepsia, CT/MRI ➢ $6m devolution of Maaori & Pacific contracts to PHOs
	System Infrastructure Development	
	➢ Achieving a Balance Portfolio / Programme Office ➢ Franklin and Eastern locality leadership groups & operational management ➢ Localities Development 3 Year Business Cases ➢ Whaanau Ora Centre Business Case at Manukau ➢ Capacity and production planning systems ➢ Shared Care System pilot ➢ TestSafe Pharmacy to support Medicines Reconciliation	➢ Establish a whole of system strategy planning group of DHB and Primary Health Organisation leaders ➢ Mangere-Otara and Manukau locality leadership groups and operational management ➢ Year 1 of implementation of locality based Integrated Family Healthcare Centres (IFHCs) to deliver service shifts at a cost of $5.5m at: Manukau – Whaanau Ora Centre Otara - Dawson's Rd and Otara Mall Mangere – Community Centre Health Eastern – Botany Community Health Hub Franklin – Franklin Memorial Hospital Health Hub ➢ Information System infrastructure resilience investment through regional shared services ➢ Expansion of Shared Care and CareConnect clinical portal information to more primary/community based health workers
	Care Closer to Home and Service Change	
	➢ 20,000 Days campaign cumulative bed savings of 13,310 by 31 Jan 2013 ➢ Whaanau Ora service development through National Hauora Coalition and related localities business case development ➢ Localities business case proposals for service changes and community based pilot programmes ➢ Improved patient experience (AI2DET programme roll out) ➢ Pulmonary and heart failure rehabilitation programme implementation in localities ➢ High risk patient identification tool in localities ➢ Very High Intensive User team transition to localities ➢ Community Geriatric service expansion to rest homes	➢ $7m service integration and innovation fund ➢ Shift 70 percent (68 FTEs) of home health care workforce from secondary care into PHO/DHB jointly governed community based services ➢ Six more General Practitioner with Special Interest (GPwSI) training programmes - with 3 new GPwSI per locality working in the IFHCs ➢ Direct GP access for specific elective procedures for 850 patients with otitis media, carpal tunnel syndrome and tonsillitis ➢ Pilot expansion of community based cardiac and heart failure rehabilitation group programmes ➢ One credentialed Whaanau Ora network per locality ➢ $4.5m funding to embed the service changes from evaluation of 13 collaborative teams as part of the 20,000 Days Campaign that will save 20,000 bed days ➢ Franklin and Eastern locality wrap around services for older people to reduce acute admissions ➢ Six community midwifery specialist roles and minimum of six LMC midwives in partnership with general practice ➢ At least one Accident and Medical service operating per locality until 10pm ➢ Primary Options for Acute Care (POAC) extension to Transient Ischaemic Attacks (TIAs) and renal colic

1.0 Introduction

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

CMDHB is owned by the Crown and is a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004). Accountability for CMDHB is through the Crown Funding Agreement and Annual Plan which is negotiated and agreed annually between the Minister of Health and the DHB. The Statement of Intent, included in this document, is also a key accountability document.

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

1.1 Treaty of Waitangi

CMDHB aims to fulfil our obligations as agent of the Crown, under the Treaty of Waitangi. Our relationship with the tangata whenua of our District is expressed through a Board to Board relationship with Manawhenua I Taamaki Makaurau. CMDHB has adopted a principles based approach to recognising the contribution that The Treaty of Waitangi can make to better health outcomes for all, inclusive of Maaori.

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

1.2 Governance

CMDHB is governed by a Board of eleven members, seven of whom are elected by the community, and four, including the Chair, whom are appointed by the Minister of Health. The role of the Board is to provide governance and to ensure that CMDHB fulfils is statutory functions in the use of public resources. The current Board governance structure includes three statutory committees and five non-statutory committees (including Advisory Groups) assist the Board to meet its responsibilities. The committees include a mix of Board members, clinicians and community representatives. It is the intention of the incumbent Board to pilot consolidation of the Board subcommittee structure over the May to July 2013 period. Any changes made as a result of this pilot will be reflected in the system performance measurement reporting system.

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

In recognition of the strategic requirement for shared system wide accountability and integration across primary and secondary care providers, CMDHB has established a District Alliance Group and related Agreement with the five Primary Health Organisation (PHO) partners operating within the Counties Manukau district. This includes ProCare, National Hauora Coalition, Alliance Health Plus, Total Healthcare and East Health Trust.

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

1.3 Health profile of Counties Manukau populations

The Counties Manukau population is growing at 2 to 3 percent per year. This rapid growth places a significant load on health service provision and is compounded by an ageing population and relatively high prevalence of diabetes, obesity, smoking and other health issues. The net impact is demand on health services above demographic growth and has significant system capacity implications.

Counties Manukau population and health profile[1,2]

- CM Health provides health and disability services to an estimated 512,000 people who reside in the local authorities of Auckland, Waikato District and Hauraki District
- Our population is growing at a rate of approximately 2 percent per year. Overall, Counties Manukau population is expected to grow by approximately 8,500 residents each year for the next 20 years. From 2006 to 2026 the number of new residents in Counties Manukau is projected to be 169,800 - this is nearly the size of Wellington City in additional growth
- Four geographical locality areas have been defined covering Counties Manukau district: Mangere/Otara, Eastern, Manukau and Franklin. Each locality is diverse in terms of its demographics and health needs
- The Counties Manukau district has a diverse population: 38 percent Pakeha and Other, 23 percent Pacific, 16 percent Maaori, 22 percent Asian. 12 percent of all New Zealand's Maaori live in Counties Manukau and 40 percent of New Zealand's Pacific peoples live in our district
- We are a relatively young population with 24 percent of our population aged 14 years and younger. 14 percent of New Zealand's child population lives in Counties Manukau
- The population aged 65 and over in Counties Manukau is projected to more than double from 35,945 in 2003 (53,610 currently in 2013) to 80,010 by 2023. It is this group who will place the highest demands on health services in the years to come
- Overall, life expectancy (2008-2010 average) at birth in Counties Manukau is similar to that of the New Zealand average at 81 years. However, despite improvement, there are persistent and stark gaps for Maaori and Pacific populations compared with non-Maaori/non-Pacific. The life expectancy gap between Maaori and non-Maaori/non-Pacific remains in excess of 10 years while the gap between Pacific and non-Maaori/non-Pacific is 5 to 7 years
- 34 percent of the Counties Manukau population live in areas classified as being the most socio-economically deprived in New Zealand. 57 percent of Maaori, 79 percent of Pacific and 43 percent of 0-14 year olds in Counties Manukau live in areas with a deprivation index of 9 or 10
- Otara, Mangere and Manurewa are the most socio-economically deprived areas in the Counties Manukau District. The high proportion of the Counties Manukau population living in deprivation has a significant impact on health and health service provision
- In the 2006 census, 28 percent of adults in Counties Manukau had no educational qualifications and 6 percent of households had at least one person receiving an unemployment benefit
- Maaori and Pacific residents of Counties Manukau have relatively higher rates of hospitalisation than the NZ average while Asian and Europeans have a lower rate than the New Zealand average
- 80 percent of deaths, and a substantial proportion of illness and reduced quality of life in our communities are due to a 'package' of conditions – diabetes, cardiovascular disease, chronic respiratory conditions and cancer. There are significant opportunities for prevention of these conditions by addressing the shared risk factors of smoking, obesity, poor nutrition, lack of physical activity and misuse of alcohol

[1] Ministry of Health (2012) DHB Ethnic Group Population Projections, 2007–26 (2006-Base), and various CM Health population health status papers

[2] Counties Manukau Health Maaori Health Plan 2013-2014

1.4 Government focus on Better Sooner More Convenient Services

System integration is central to medium to long term management of our health system demand challenges. Our commitment to this national policy is demonstrable in our implementation of the localities approach. We recognise that the scale and pace of system wide service configuration and integration must be accelerated if we are to meet the rising demand of an ageing and growing population within our available resources. In partnership with primary care, CMDHB is committed to building on the infrastructure and services established in the 2012/13 year, which included:

- Establishment of a District Alliance Group and related agreement with the five PHOs
- Expanding on the range and scope of services delivered in the community
- Shared accountability for health system outcomes and performance and establishment of risk and gain sharing arrangements
- Development of a virtual budget
- Shifting services closer to home
- Continued delivery of government's expectations in national health targets

In the 2013/14 year we will achieve:

- An enhanced role for comprehensive primary health care services, and increased accountability for health system outcomes
- Shifting of some specialist and community based services provided by the DHB to Locality governance and management and, therefore primary care clinical governance
- Development of new models of care that maximise outcomes within the available global budget
- The use of whaanau ora services to support vulnerable families
- Reducing to near as zero as possible growth in unplanned hospital admissions through the provision of enhance primary and community services
- The use of regional service planning to reduce fragmentation and share resources in the metropolitan Auckland community
- Bending back our cost growth curve through initiatives to live within our means

1.5 Key areas of risk and opportunity

The constrained future funding growth forecasts do not match our current health service demand projections. We recognise that the existing service configuration and balance of related funding across the sector is not well designed to meet our population needs within available funding. Figure 2 below outlines the key system risks and related mitigation approaches/opportunities we are implementing to manage these.

The Northern region's triple aim is the framework we have adopted to organise our response and proactively reorganise our collective CM Health capacity and capability to better meet our population needs, deliver service excellence and meet the government's expectations and targets while remaining financially sustainable. Our guiding strategy is to:

- Improve health and equity for all populations
- Improve quality, safety and experience of care
- Ensure best value for public health system resources

Figure 2: CM Health key areas of risk and opportunity

Risk	Opportunities / Mitigations
Increasing demand for health services and infrastructure	▪ Increased focus on preventative measures and early intervention through our Better Health Outcomes for All programme focussed on improved population health outcomes ▪ Patient and whaanau centred care to guide system redesign and fit for purpose services ▪ Driving investment towards improved models of care ▪ System wide service integration ▪ Improving performance through both financial and non-financial incentives ▪ Shared accountability to deliver BSMC services ▪ Intersectoral collaboration to address health and other priorities ▪ Strengthening leadership while supporting front line innovation ▪ Increasing the proportion of community based services
Ongoing fiscal constraints and affordability	▪ Increasing acute services productivity and effectiveness ▪ Reducing unexplained clinical variation ▪ Primary and secondary care shared accountability for financial performance ▪ Improving the way we work regionally and nationally to realise the efficiency benefits of shared services and joint procurement ▪ Sustainable labour cost growth model ▪ More effective utilisation of private and regional capacity/capability
Diverse needs and challenges within local communities	▪ System wide service integration ▪ New models of service delivery and workforce development ▪ Community engagement, patient and whaanau centred care ▪ Strengthening and expanding intersectoral work programmes

1.6 Nature and Scope of Functions / Intended Operations

1.6.1 Whole of system planning

CMDHB has recently reshaped the governance structure to better integrate system wide thinking into short to long term planning. The restructure saw CMDHB move away from being organised along traditional funding and planning functions. Planning functions are now coordinated across strategic prioritisation and related service development planning.

The strategic planning function is supported by a Whole of System Strategy Board that includes PHO and CMDHB executive leadership. Six strategy working groups, some of which are in the process of being established, provide population and service specific strategic advice for this group. As a result, we will be in a better position to consistently focus on a health systems perspective in setting our planning priorities and monitoring progress against agreed outcomes.

Planning involves close collaboration between the Strategic Development and Primary Health and Community Services Directorates. In 2012/13 we worked with our PHO partners through the District Alliance Group to implement locality based infrastructure to support service development closer to where people live. In the coming year we plan to shift community and primary care service functions, which currently sit with the Director of Hospital Services, to the Director of Primary and Community Health. The Whole of System Strategy Board plays a key role in jointly determining the strategic direction of CM Health and resource allocation. Aligned with this is the asset planning functions that are managed by the Business and Corporate Services Directorate.

To better reflect a system approach to health service planning, the collective health resources and associated infrastructures to deliver services for our resident population is referred to as Counties Manukau Health (CM Health). This approach supports a more collaborative approach to planning with the local (primary, community and hospital) and regional care partners. This provides more effective integration of strategic objectives, outcomes and shared implementation planning where there are clear benefits for joined up action plans.

1.6.2 Provider

CM Health is a major provider of both community-based and secondary health services to the estimated 512,130 people residing in the Counties Manukau district.

The PHO associated primary care practices are distributed throughout the district, with more recent investment related Integrated Family Heath Centres with a view to increasing the scale and diversity of services closer to where people live. This will enable integration of primary and secondary services and new models of care as part of our strategic response to the health system challenges. CMDHB operated services are largely delivered from seven inpatient and numerous leased or owned outpatient and community health facilities across the District – the Manukau Health Park and Middlemore Hospital sites contain the largest elective, ambulatory and inpatient facilities.

1.6.3 Funder

As a funder, CMDHB funding responsibilities cover the totality of CM Health services to the people residing in our district. This includes funding for primary care, hospital services, public health services, aged care services, and services provided by other non-government health providers including Maaori and Pacific providers. Some specialist tertiary services and services that are covered by regional contacts are provided by other DHBs. This includes Auckland DHB and Waitemata DHB cardiothoracic, neurosurgery, oncology, forensic mental health and school dental services. Regional public health services are provided by Auckland Regional Public Health Service, under a Ministry of Health contract.

In the 2013/14 year CMDHB will receive $1.3 billion in funding, of this:

- $705.2m is for the provision of services delivered through the DHBs Provider Arm
- $313.4m is for the provision of services delivered through contracts with NGOs
- $268.6m is for the provision of services delivered by providers or contracts that sit outside of Counties Manukau district
- $12.8m is to cover Governance and funding related capability and administration

1.6.4 Owner of Crown Assets

As an owner of Crown Assets, CMDHB is required to operate in a fiscally responsible manner and be accountable for the assets we own and manage. This includes ensuring strong governance and accountability, risk management, audit and performance monitoring and reporting. CMDHB carries out formal asset management planning to determine planned future asset replacement and expected financing arrangements.

We revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. CMDHB land and buildings are revalued every three years. The last revaluation occurred in 2010 on an “Optimised Depreciated Replacement Costs” basis.

2.0 Strategic Direction

2.1 Vision and Values

Our shared vision is *to work in partnership with our communities to improve the health status of all, with particular emphasis on Maaori and Pacific peoples and other communities with health disparities.*

We will do this by:

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

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

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

2.2 Strategic Context

2.2.1 National health sector priorities

The 2013/14 government's Better Public Health Services, six national health targets as indicated in the Minister's Letter of Expectations set the context for our priority setting. We have a particular focus on the integration of health services across the region and between primary and secondary health service providers. CM Health cannot succeed in meeting these challenges without aligning key initiatives with strategic partners including other Northern Region District Health Board's (DHBs), Counties Manukau based Primary Health Organisations (PHO) and related service providers and BSMC business case organisations.

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

2.2.2 Northern region priorities

We are in year 3 of implementation of the Northern Region Health Plan (http://www.ndsa.co.nz) which has been developed by the four DHBs (Auckland, Waitemata, Northland and Counties Manukau) and their primary care partners. For 2013/14, this builds on the region's previous two plans and with an emphasis on longer term planning and the provision of better, sooner, more convenient healthcare for patients and

communities within constrained funding increases. There is a focus on demonstrative collaboration and delivering on regional workforce, IT and capital objectives and more detailed planning across regional priorities. This will include significant changes to our business support systems, and in particular the regional focus around information systems, procurement and the supply chain.

Regional planning focuses on where regional health system collaboration will make a real difference (tangible benefits) and addresses important health issues for the population. Identified new themes for 2013/14 include:

- Health gain for Maaori
- Better integration between services
- Supporting our population to have greater involvement in their care

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

- *First, Do No Harm* - reducing harm and improving patient safety
- *Life and Years* - reducing disparities and achieving longer, healthier and more productive lives
- *The Informed Patient* - ensuring patients and their whaanau get care, information and support appropriate to their context

CM Health's Annual Plan priorities align to the Northern Region goals as shown in the high level Intervention Logic (refer section 2.5).

CM Health is an active participant in the regional governance structure, related clinical networks and programmes of work. In addition to this, examples of key regional leadership roles served by CM Health staff include Lead Chief Executive for the Northern Regional Alliance, Clinical Leader of the Cardiology Network, Chair of the Regional Radiology Network and others.

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

NRA has applied for exemption from producing a Statement of Intent (SOI) for the 2013/14 year as a restructuring process is under way and key outputs and budgets are not able to be set until the new structure is in place. NRA will produce a Business Plan, including budgets and key outputs for 2013/14, and will report both internally and to shareholding DHBs against that Business Plan commencing with a report in October 2013 for the first quarter of 2013/14. The NRA Annual Report for 2013/14 will report actual results against the Business Plan in a similar manner to that which the two amalgamated companies reported against their annual Statements of Intent. The shareholding DHBs will monitor NRA performance against its Business Plan on a quarterly basis throughout 2013/14.

2.3 Our Priorities for 2013/14 and Beyond

In 2012/13 we made significant progress towards our goal to become the best healthcare system in Australasia through implementation of our Triple Aim Strategy objectives:

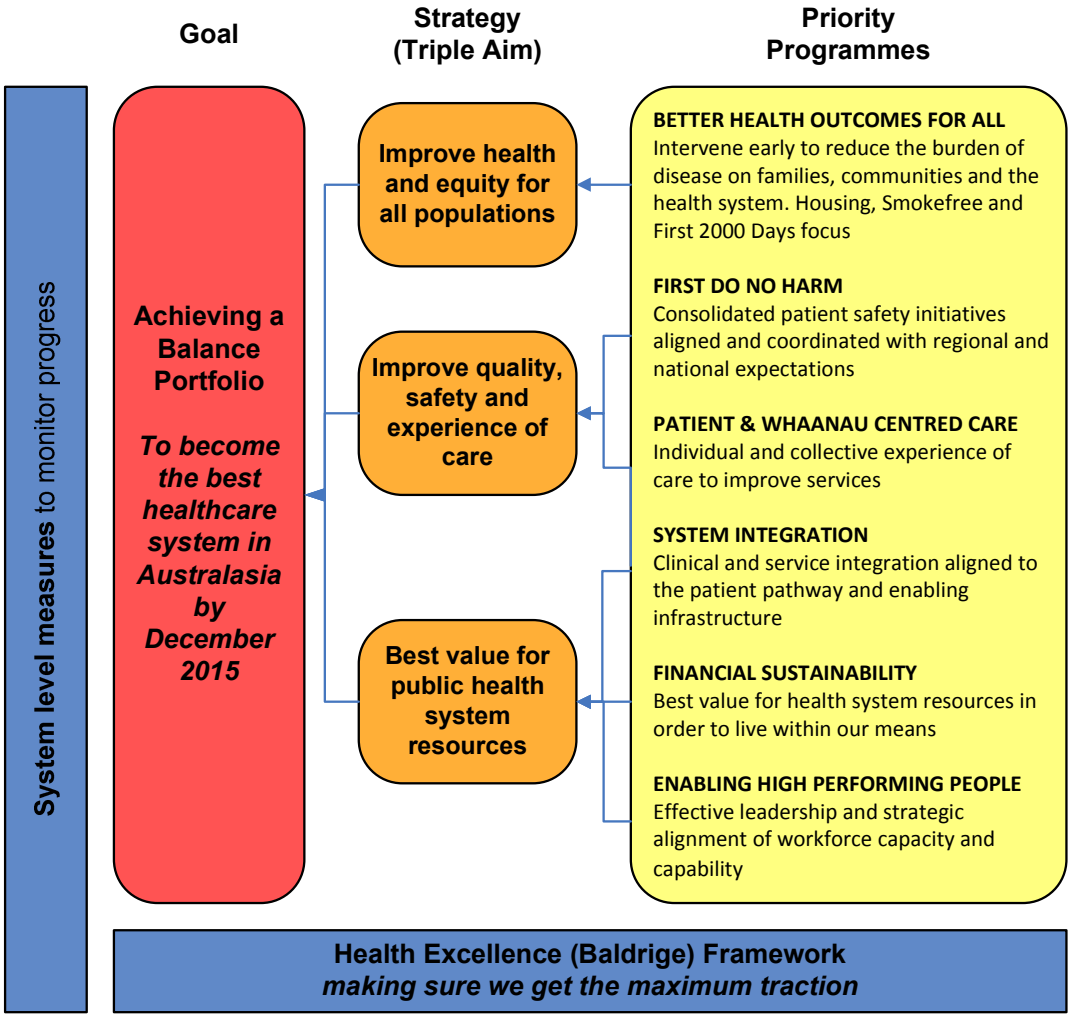
- Improve health and equity for all populations
- Improve quality, safety and experience of care
- Ensure best value for public health system resources

These objectives align with the Northern Region triple aim that simultaneously considers health system decision making in relation to, population health, cost and productivity and quality of patient experience. Each Triple Aim has a programme of change and organisation delivery to enable effective direction of

resources to implement agreed actions plans. This is summarised in Figure 3 and related programme descriptions.

Targeted investment in Information and Communication Technologies (ICT) is critical to achieving our strategic priorities and has been confirmed by our clinical leaders as the highest 3-5 year investment priority (refer section 4.2.1). This will enable us to work smarter through technologies that enable patients and whaanau to take a more central role in their health, integrate and remove duplication of services and associated service delivery efficiencies, and provide end to end clinical integration for our patients (i.e. whole of system).

Figure 3: Achieving a Balance Portfolio: Delivering excellent healthcare while also being sustainable



The practical application of this strategy means that CM Health is working alongside our health system partners to align workstreams where appropriate and utilise our outcomes framework to track how the contributing activities perform against targets. This enables logical links to national health targets and priorities alongside CM Health specific outcomes that references our Maaori Health Plan, Annual Plan and Locality Development Plans.

The identified performance measures associated with this portfolio and Annual Plan are aligned and common across all ethnic groups, with targeted action plans to address health inequalities and integrate with our Maaori Health Plan.

2.4 Key Risks and Opportunities

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

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

The most critical strategic risks and management strategies CM Health faces in 2013/14 are outlined in Figure 4.

Figure 4: CM Health strategic risks and opportunities

Category	Risk/Opportunity	Management Strategy
Clinical	*Whole of system capacity and capability*: To integrate services and to increase the type and scale of primary and community care based services	A *Whole of System Strategy Group* comprising Primary Health Organisation Chief Executives and CM Health Executive Leadership Team to focus on the longer term health system vision to clarify investment (hard and soft) priorities. This will determine the most effective use of resources with a focus on the short, medium and longer term priorities *Prioritised investment in shared information systems* that support health service delivery and decision making in the most effective care setting, i.e. national, regional and local system development *Whaanau ora* promises to bring a greater focus on addressing the issues of employment, housing and educational achievement, as well as working with vulnerable whaanau. This is consistent with a strengthened population health approach *Locality Development* with a service integration and implementation focus for 2013/14
Corporate	*Revenue*: The forecast revenue increase of 2.7 percent is just over half of what is anticipated to maintain operations. This is a longer term forecast constraint that has impacts for the affordability of capacity expansion	This provides an opportunity/stimulus for *increased scale and pace of system wide service integration* and shared accountability (as for whole of system capacity and capability above), to deliver services closer to where people live, intervene earlier for improved health outcomes and resulting reduction in acute service demand *Significantly increased focus on clinical models of care*, reducing clinical variation and improving acute service productivity across the health system (from primary care to hospitalisation). These are seen as critical to further cost containment and clinical leadership is an essential factor for success *Acute system capacity and production planning* capability expansion to inform the most effective use of available resources, e.g. the Peak Workload Plan, daily capacity reporting *System wide value for money review* which is looking systematically at our costs, how we are working, how we are spending across the whole of system and revenue-generating opportunities

Corporate	*Constrained public health capital funding for hard and soft assets*: This has impacts for infrastructure resilience (e.g. IS), facilities and equipment condition and fitness for purpose	*Regional prioritisation of IS infrastructure* to assure business continuity and platform for future system investments, e.g. regional upgrade of Microsoft software upgrades in workspace and infrastructure, Shared Care system implementation *Whole of system strategy priorities* to align facilities investment planning (under review currently) *Reduce reliance on (new) capital* for managing service demand, i.e. different models of care, primary and community care (Locality Development Plans), better leverage regional and private capacity and capability *Collaboration with regional and national partners* (DHBs and Health Benefits Limited) to leverage of aggregated savings and efficiency benefits and local system level accountability for financial and non-financial performance

2.5 Key Counties Manukau Health Outcomes and Impacts

CM Health planning priorities align with national, regional and local planning goals and link to strategic outcomes. Our prioritised goals for the Statement of Intent three year period aligned to the regional triple aim outlined in section 2.3 above.

A more detailed CM Health performance measures output/capability summary is currently in development with a view to providing our intervention logic and integrating system level 'big dot' measures. The working elements of this are represented in our intervention logic (refer Figure 15, page 23), with refinement and implementation expected in the form of a revised reporting scoreboard as part of our performance measurement system review during the 2013/14 year.

2.5.1 Improved health and equity for all populations

Outcome 1: People live healthier, longer, more productive, disease free lives

Given Counties Manukau's high proportion of Maaori and Pacific people, if we are to improve the health status of the population it is important that we focus on reducing some of the disparities in health outcomes. As such, the life expectancy gap between Maaori and Pacific and non-Maaori / non-Pacific is an important point of focus for the DHB as a marker of the impact we are making in lifting Maaori and Pacific health outcomes and reducing health inequalities. Life expectancy at birth is a key long term measure of health status and Counties Manukau resident data highlights large disparities between Maaori, Pacific and non-Maaori/non-Pacific populations[3].

Long Term Impact Measures (5 to 10 years)

We will know when we are succeeding when there is:	
Continued improvement in overall life expectancy and narrowing of ethnic disparity Of principle concern is the persistent wide gap (in excess of 10 years) for Maaori compared to non-Maaori/non-Pacific groups. In addition, Maaori in Counties Manukau are falling behind Maaori nationally. The gap for Pacific, although smaller (6-years), is also of ongoing concern.	**Impact Measure**: The life expectancy gap between Maaori and Pacific and non-Maaori and non-Pacific.

[3] O'Brien B, Winnard D, Wang K, Papa D (2012). Life expectancy update to 2011 for Counties Manukau DHB. Auckland: Counties Manukau District Health Board, unpublished

Figure 5: Life expectancy at birth by ethnicity, 3 year rolling average, 1996-2012

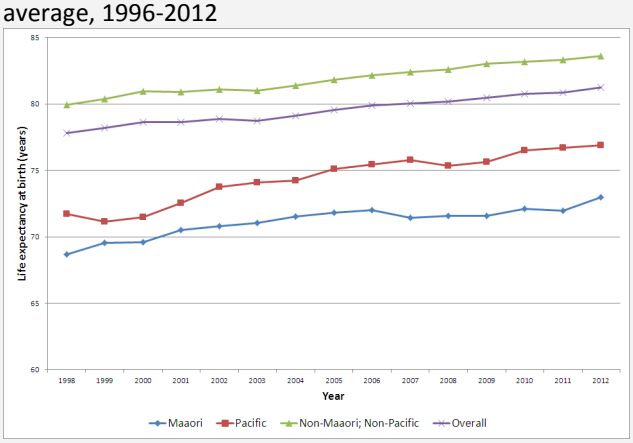


Figure 5 shows that while life expectancy overall has increased, the gaps between Maaori and non-Maaori/non-Pacific, and Pacific and non-Maaori/non-Pacific remain and have not decreased. There is projected to be a significant increase in the percentage of the Counties Manukau Maaori population who will be aged over 65 yrs.

Targeted actions to support the health and wellbeing of the older Maaori population are detailed in the CM Maaori Health Plan 2013/14.

Medium Term Impact Measures (1 to 5 years)

Previous CM Health analysis identified the main causes of death that contribute to differences in life expectancy as:

- Lung diseases related to smoking
- Cardiovascular diseases
- Cancer (non-lung)
- Diabetes
- Infant mortality[4]

Based on our review of current and previous activity, the current policy settings, emerging national priorities, expert advice and international experience, three priority areas of action and related impact measures are housing, Smokefree and the first 2,000 days from peri-conception to 5 years of life. This is the focus of our Better Health Outcomes for All programme that focuses on reducing the impact of long term conditions such as diabetes, heart disease and others.

The selection of these priority areas takes into account that there is significant work which will continue in the other areas, such intersectoral partnership interventions in education, housing, employment and the health system work to improve management of long term conditions, along with the considerable national policy drivers. We will continue public health policy advocacy at national, regional and local levels for increasing smokefree environments, tobacco pricing and ensuring compliance with regulated sales to minors. Our smoke-free initiatives, within both primary care and community services and in the hospital, will support a further reduction in the prevalence of inpatient smokers.

Over the next one to five years we seek to make a positive impact on the health and wellbeing of Counties Manukau population and contribute to the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides will be evaluated using the following impact measures.

[4] Smith J, Jackson G, Sinclair S (2008) Life expectancy in 2005: Contribution to life expectancy gaps of major disease areas in CMDHB. Auckland: CMDHB

We will know when we are succeeding when there is:

A reduction in smoking prevalence

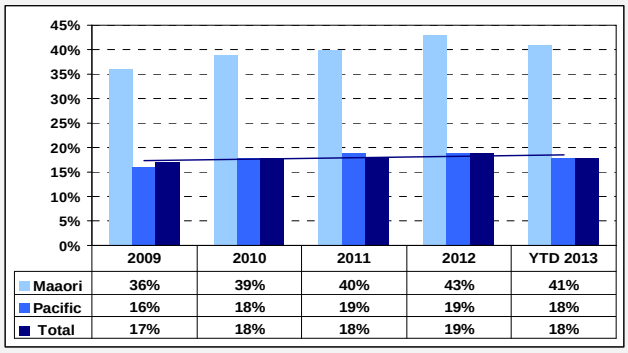
Tobacco smoking is one of the leading causes of death and hospitalisations in Counties Manukau. An estimated 5,000 people in New Zealand die every year due to tobacco smoking and second hand smoke exposure. Smoking is a major contributor to preventable illness and long-term conditions such as cancer, heart disease, stroke and respiratory diseases.

The increase in inpatient smoking prevalence shown in **Figure 6** is likely a reflection of improved data accuracy, and increase in inpatient smoking cessation activity over time. The 2012 New Zealand Health survey, suggests a 2% fall in smoking prevalence in the Counties Manukau community since 2006.

The government health targets related to smoking add to our understanding of success in this area with the related primary care initiatives involving smoking cessation advice and support.

Impact Measure:

Figure 6: Percentage of CM Health inpatients who smoke



	2009	2010	2011	2012	YTD 2013
Maaori	36%	39%	40%	43%	41%
Pacific	16%	18%	19%	19%	18%
Total	17%	18%	18%	19%	18%

A reduction in the incidence of rheumatic fever

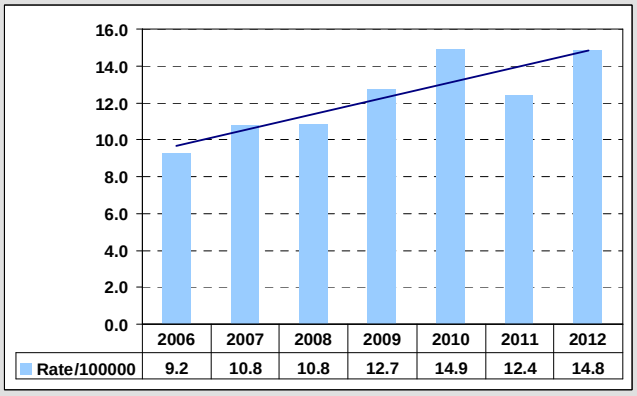
Acute rheumatic fever (ARF) is a preventable, life limiting illness that continues to be diagnosed in children across New Zealand. The potential of ARF to cause damage to the heart is that which is of most concern as this can lead to permanent disability and in severe cases, death. Acute rheumatic fever occurs most commonly in children and young people aged 5-14 years. The long term sequelae results in a considerable burden of disease in the adult population.

Rheumatic heart disease and acute rheumatic fever are potentially preventable conditions if Group A streptococcal throat infections are identified and treated appropriately. CM Health has the highest numbers of rhematic fever notifications and factors such as household overcrowding[5], and poor access to healthcare increase the risk of rheumatic fever.

Rheumatic fever disease (acute and chronic) disproportionally affects Maori and Pacific children and young people. Primary prevention strategies are required if the disease burden is to be reduced.

Impact Measure:

Figure 7: CM Health Admission rates for acute rheumatic fever



	2006	2007	2008	2009	2010	2011	2012
Rate/100000	9.2	10.8	10.8	12.7	14.9	12.4	14.8

Improved diabetes control in our population

Diabetes is one of the leading causes of cardiovascular disease and kidney failure in Counties Manukau. In 2009 there were approximately 29,600 adults identified as having diabetes living in the CM region. The increase in

Impact Measure: Improved access to diabetes support services

[5] At 2006 Census, 25% of residents in former Manukau City were living in housing requiring additional rooms compared with 15.7% for the whole of Auckland.

the number of diabetes annual reviews is a reflection of continued improved access and coverage of diabetes support services over time. The challenge is to provide optimal diabetes management for people with diabetes.

The Chronic Care Management program is currently under review with the aim to increase emphasis on the quality of diabetes management. The diabetes screening coverage is expected to improve further with the progressive increase in the number of cardiovascular risk assessments. More people with less severe form of diabetes are likely to be detected potentially contributing to an average lower HbA1c test measure.

The 2013/14 plan includes actions to improve the outcomes for the at risk population. There are also linkages to the Northern Region Health Plan work plans related to diabetes pre-screening in primary care to assist with earlier intervention for improved outcomes.

Figure 8: Increase in the number of diabetes annual reviews where HbA1C ≤ 64mmol/mol

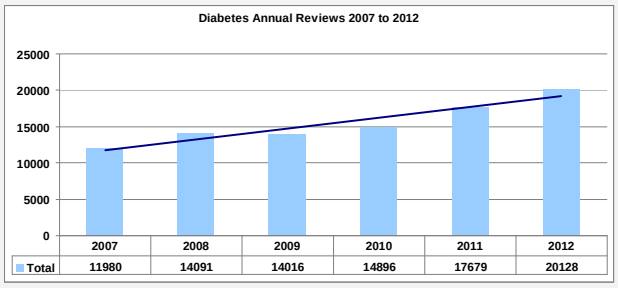
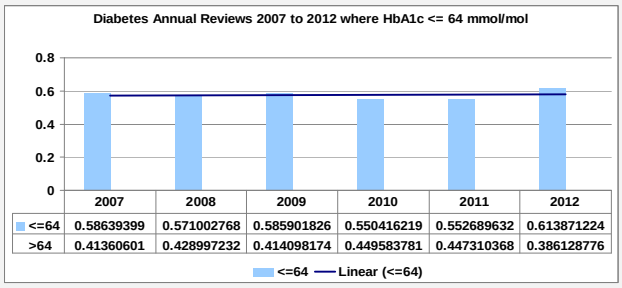


Figure 9: Diabetes annual reviews where HbA1C ≤ 64mmol/mol



2.5.2 Improved quality, safety and experience of care

Being a more patient and whaanau centred health system and working with primary and community partners will be central to the achievement of greater gains in the improvement of health outcomes and sustainability than can be achieved through hospital driven quality improvement initiatives alone. Our First Do No Harm and Patient and Whaanau Centred Care programmes will coordinate related action plans to improve outcomes. The role of consumer participation is particularly important for this strategic objective.

CM Health has a well established structure for consumer representation as part of the governance structure that provides an avenue for information provision and high level information gathering and community input. This currently includes our Community Advisory Panel, Pacific and Maaori advisory committees that provide high level input and identification of other groups and individuals that can contribute to our understanding of issues and options for service development.

Enhancing the consumer voice in our health system development will be supported through a targeted community engagement approach that currently includes community advisory groups to our Executive Leadership Team and other service specific groups, e.g. in mental health, health of older people services and others. In future, this will further leverage off locality based Community Advisory Networks through our localities development. Mental Health services have led the way within CM Health through use of the Health Co-design[6] processes that involves consumers in detailed service feedback and service redesign. The Northern Cancer Network is using this approach for the Cancer Care Coordination project (http://www.northerncancernetwork.org.nz). This is a template for expansion to other health service areas.

Outcome 2: People are at the centre of our health system with earlier access to quality health services

Monitoring and understanding a patient's experience of care is an integral part of positive improvement in care. Rather than measuring overall satisfaction for an episode of care alone, patient experience better reflects the entire continuum of care, from admission to discharge, whilst also identifying components of

[6] Health Service Co-design (Co-design) involves patients, whaanau/family and healthcare providers all working together to identify issues and develop solutions to healthcare issues. One of the key principles of Co-design is the importance of the experience of the journey for patients.

care that are of significant importance to patients and their whaanau. Section 4.0 outlines the high level work plans associated with the Health Quality and Safety Commission's quality safety programmes.

Long Term Impact Measures (5 to 10 years)

We will know when we are succeeding when there is:

Improved patient experience of care

By July 2013 the new CM Health Patient Experience web-based system will be fully functional. This will include a range of tools (e.g. online survey, community portal) that covers a much greater scope than the previously available. This will enable identification of areas that will drive improvement in patient experience. Development of a new suite of measures (and related baseline data) more reflective of patient and whaanau centred care will be completed in 2013/14.

Medium Term Impact Measures (1 to 5 years)

Over the next one to five years we seek to make a positive impact on the health and wellbeing of Counties Manukau population and contribute to the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides will be evaluated using impact measures that focus on improved access to health services to enable timely (and early) intervention, thereby mitigating the potential harm to patients through delayed health assessment and treatment. This supports the government's health targets aimed at improving service access, e.g. elective services (outpatient assessments and elective procedures), Emergency Department care and mental health services.

We will know when we are succeeding when there is:

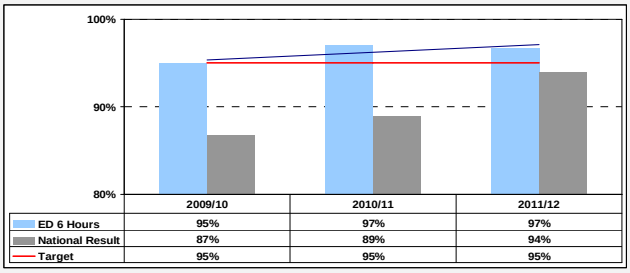
Improved access to emergency care

A whole of system response and good teamwork is essential to ensuring that people needing acute care are seen in a timely manner.

Shorter Stays in Emergency Department have been shown as a proxy measure for timeliness of acute care. Poor performance against this measures reflected in long stays in Emergency Departments are linked to poorly coordinated health systems leading to overcrowding, negative clinical outcomes and compromised standards of privacy and dignity for patients. Reducing this length of stay also improves the public's confidence in being able to access services in a timely manner when they need to, increasing their level of confidence in health services as well as improving the outcomes from those services.

Impact Measure: Percentage of patients presenting at CM Health emergency departments who are admitted, discharged or transferred within 6 hours

Figure 10: Shorter stays in our Emergency Department



	2009/10	2010/11	2011/12
ED 6 Hours	95%	97%	97%
National Result	87%	89%	94%
Target	95%	95%	95%

Improved access to mental health services

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

CM Health's focus is to support community wellbeing and ensure the people of Counties Manukau experience seamless, empowering Mental Health and Addiction services and are able to access them in a timely and appropriate manner.

Mental health service access rates is a proxy measure for determining the impact of CM Health

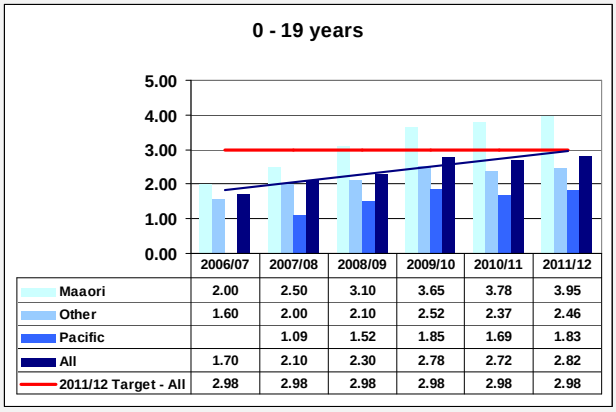
Impact Measures:

mental health services delivery on improving the quality of life for members of our population who are suffering from mental illness or issues with alcohol or drug addiction.

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

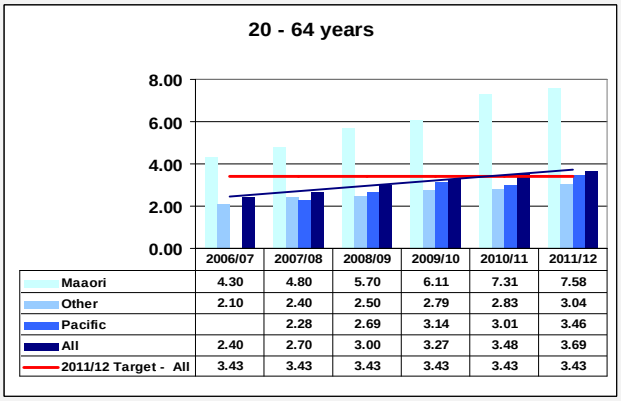
The expanded focus for the next 1 to 5 years relates to those with moderate to severe illness, with a need to look at system wide models of care that further enhance the role of primary care and community based services.

Figure 11: Percentage of people ≤ 19 years with access to mental health services



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Maaori	2.00	2.50	3.10	3.65	3.78	3.95
Other	1.60	2.00	2.10	2.52	2.37	2.46
Pacific		1.09	1.52	1.85	1.69	1.83
All	1.70	2.10	2.30	2.78	2.72	2.82
2011/12 Target - All	2.98	2.98	2.98	2.98	2.98	2.98

Figure 12: Percentage of people 20 to 64 years with access to mental health services



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Maaori	4.30	4.80	5.70	6.11	7.31	7.58
Other	2.10	2.40	2.50	2.79	2.83	3.04
Pacific		2.28	2.69	3.14	3.01	3.46
All	2.40	2.70	3.00	3.27	3.48	3.69
2011/12 Target - All	3.43	3.43	3.43	3.43	3.43	3.43

Improved access to elective services

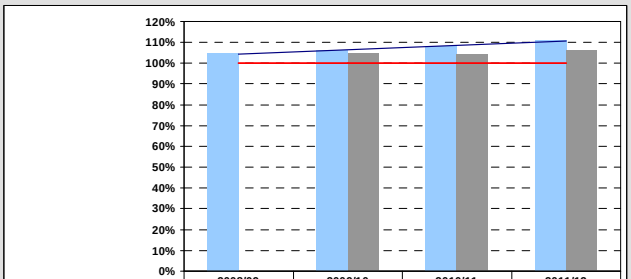
We have chosen the improved access to elective surgery health target of as a proxy medium term measure for our patient centred approach to better assessment and treatment access.

Elective services are an important component of the health care system for the treatment, diagnosis and management of health problems. Timely access to a first specialist assessment or elective surgery will improve quality of life by ensuring early diagnosis, intervention or treatment and therefore reducing pain and discomfort for the patient whilst improving independence and wellbeing.

We are undertaking quality improvement and service development innovations that involve surgical theatre efficiencies, expanded involvement of primary care in looking at ways in which to enhance patient flow through the system so that their waiting times are within acceptable limits and we can continue to meet nationally set service level expectations.

Impact Measure:

Figure 13: Improved access to elective surgery



	2008/09	2009/10	2010/11	2011/12
Delivering agreed Elective discharge volumes	105%	106%	108%	111%
National Result		105%	104%	106%
Target	100%	100%	100%	100%

2.5.3 Achieve the best value from health system resources

This outcome is vital for our long-term clinical and financial sustainability as we face an ever growing demand for health services driven by patient need and expectations that exceed our ability to fund. Although CM Health has lived within its means for the last three years, there are a range of activities needed to be able to meet the Minister's expectations for 2013/14 and following two years.

Outcome 3: Health system clinical and financial sustainability

The overall focus is to concurrently improve the acute health system effectiveness (across all care settings) and deliver more sustainable models of care services that provide care closer to where people live. The related measures for this outcome are financially based in the longer term but are significantly influenced by workforce skill mix requirements in line with model of care changes and overall labour cost growth. Development of related measures is a work in progress over the 2013/14 year.

Long Term Outcome Measures (5 to 10 years)

Work is in progress to develop other measures that will provide CM Health with ability to monitor progress and respond accordingly. This will need to include a balance of measures that monitor the effectiveness of primary and community based service alternatives to hospital settings and related labour cost growth curves.

We will know when we are succeeding when there is:

Reduced rate of annual health expenditure increase per capita

The key financial outcome measure will be CM Health expenditure per head of population as the sector forecasts a tightening of public funding and increasing demand for health services. The assumption is that CM Health will live within its means and Figure 14 below demonstrates how we must reduce the rate of annual cost increases in order to achieve future sustainability.

Figure 14: CM Health financial outcome trends from 2006 – 2012

Factor	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12
Total Revenue ($000's)[7]	$949,226	$1,013,884	$1,138,527	$1,216,356	$1,296,173	$1,352,493
Total Expenditure ($000's)[7]	$948,108	$1,053,385	$1,141,521	$1,216,193	$1,291,311	$1,349,584
Population[8]	459,040	467,210	475,585	484,920	494,465	502,475
CM Health expenditure per capita [7, 9]	$2,065	$2,255	$2,400	$2,508	$2,612	$2,686
Rate of CM Health expenditure increase per capita	-	9.2%	6.4%	4.5%	4.1%	2.8%

[7] Sourced from Counties Manukau District Health Board Annual Reports 2007-2012

8 Statistics New Zealand. (2012). DHB Age-Sex Projections 2006-2026 (2006 Base). Christchurch, New Zealand: Statistics NZ

9 Note that national services provided by CM Health are included in the total revenue and therefore includes services for people living outside our district, but this is a relatively small proportion of the total spend

Figure 15: High level planning priorities intervention logic

National and Regional			
National Goal	All New Zealanders live longer, healthier and more independent lives		
National Policy	Better sooner more convenient care		
Regional Vision	To improve health outcomes and reduce health disparities by delivering better, sooner, more convenient services We will do this in a way that meets future demand whilst living within our means		
TRIPLE AIM	**Population Health**	**Patient Experience**	**Cost/Productivity**
National Priorities	Rheumatic Fever / Clinical Integration / Mental Health / Youth Mental Health / Vulnerable Children / Diagnostics / Cancer / Whaanau Ora / Living Within Our Means		
National Health Targets	Preventative health targets with a focus on: ▪ Increasing immunisation; reducing rheumatic fever ▪ Better help for smokers to quit ▪ More heart and diabetes checks	Improved access to: ▪ Emergency Departments (shorter stays) ▪ Elective services (surgical and outpatients) ▪ Cancer services	Living within our means by: ▪ Lifting productivity ▪ Keeping to budget
Regional Strategic Objectives	Adding to and increasing the productive life of people in the Northern Region	Delivering safe and good quality healthcare which is patient and family centred	The region's health resources are efficiently and sustainably managed to meet present and future health needs
Regional Priorities	Life and Years	First Do No Harm /The Informed Patient	Life and Years
Counties Manukau Health			
Goal	Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015		
Strategy	Improved health and equity for all populations	Improved quality, safety and experience of care	Best value for health system resources
Priorities (3 year)	Better health outcomes for all programme targeting Housing, Smokefree by 2025 and First 2,000 Days Reducing the health impact of long term conditions	First Do No Harm programme Delivering Patient and Whaanau Centred Care programme	System integration (local and regional) programme Ensuring financial sustainability programme Enabling high performing people programme
Outcomes (10+ years)	People live healthier, longer more productive, disease free lives	People are at the centre of our health system with earlier access to quality health services	Health system clinical and financial sustainability
Key Impacts (5-10+ years)	▪ Continued improvement in overall life expectancy and narrowing of ethnic disparity ▪ Reduction in smoking related cancers and respiratory conditions ▪ Reduction in the differences in rates of housing related hospitalisations between ethnic groups and groups with different socioeconomic status	▪ Improved patient experience of care ▪ Increased proportion of whaanau as partners in care	▪ Reduced rate of annual health expenditure increase per capita ▪ Continued improvement in overall life expectancy and narrowing of ethnic disparity ▪ Increased workforce diversity and ethnicity ▪ Reduced labour cost growth
Key Impacts (1-5 years)	▪ Reduction in smoking prevalence ▪ Reduction in the incidence of rheumatic fever ▪ Improved diabetes control in our population	▪ Improved access to emergency care ▪ Improved access to mental health services ▪ Improved access to elective services ▪ Reduced hospital stays in the last 6-mths of life	▪ Increased percentage of total heath service delivery/spend in primary and community care ▪ Improved reliability of care
Output Classes (refer sections 5.0 and 8.0)	**Prevention** Health Promotion & Education, Immunisation, Health Screening, Statutory and Regulatory	**Early Detection and Management** Primary Health Care (GP), Long Term Conditions, Oral Health Diagnostics, Pharmacy	**Intensive Assessment and Treatment** Mental Health, Elective, Acute, Maternity, Additional Patient Safety	**Rehabilitation and Support** NASC, Assessment Treatment & Rehabilitation, Palliative Care, ARRC, Home Based Support

Figure 16: Summarised Strategic Actions for 2013/14

Strategy Action Summary - **Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015**	
Strategy	Improve health and equity for all populations - Improve quality, safety and experience of care - Provide best value for health system resources
Key Areas of Focus	**Key Actions (Annual Plan reference)**
Better Results for NZers:	
▪ **Increase infant immunisation**	▪ Target 8mth old Maaori children immunisation course completion ▪ Joint DHB, primary care, NGO immunisation education / events and seamless cross service handover
▪ **Reduce rheumatic fever incidence**	▪ Pathway for high risk families and children with offer of whaanau ora support community worker ▪ Deliver more throat swabs (registered nurse and whaanau support worker) to reach 53 schools through National Hauora Coalition contract
Service Integration:	
▪ **Establish localities**	▪ Complete establishment of four locality clinical partnership and Integrated Family Health Centres (IFHC)
▪ **Incentivise general practice / PHO for system performance**	▪ Implement Locality Partnership Agreement for shared accountability of population outcomes and health system resource utilisation ▪ Establish risk/gain share framework and budget holding at a practice level to incentivise performance against health system targets ▪ Integrate and devolve Maaori and Pacific Health NGO contracts to National Hauora Coalition / Alliance Health Plus ▪ $7m development fund for new service initiatives, integration pilots, additional clinical resource to reduce acute demand ▪ $1m investment for collective sustainable primary care strategies to achieve health targets ▪ $1.2m investment for increased range of community diagnostic tests
▪ **Direct primary care referrals**	▪ Direct GP referral for specific elective procedures directly to waiting list for patients with: otitis media, carpel tunnel and tonsillitis
▪ **Care closer to home and whaanau ora integration**	▪ 70% (68 FTE) home health care workforce shift from secondary into primary care through localities integration ▪ Implement six more GP with Special Interest (GPwSI) training programmes - with 3 new GPwSI per locality working in the IFHCs ▪ Lead SMO for primary care based Very High Intensive User team to wrap support for patients of high risk of hospital admission ▪ New Chronic Care Management Programme including outcomes based framework to reduce practice variation and improve care ▪ Locality (2) based wrap round services for older people through a Coordination/Rapid response team to reduce acute admissions ▪ Develop six community midwifery specialist roles and increase availability of LMC midwives in partnership with general practice ▪ Pilot expansion of community based cardiac and heart failure rehabilitation group programmes ▪ At least one Accident and Medical services operating per locality until 10pm as an alternative to hospital emergency department presentation ▪ At least one credentialed Whaanau Ora practice in place in each locality care cluster ▪ Reduced wait time for primary care follow up of youth from the secondary Child and Adolescent Mental Health services
Regional Integration	▪ Contribution to the Northern Region Health Plans for targeted areas, e.g. Improve specialist community based alcohol and drug services for youth, improve waiting times for diagnostic related cancer services ▪ Greater Auckland Integrated Health Network expansion of Primary Options for Acute Care to include Transient Ischaemic Attack; renal colic ▪ Increase number of PHO enrolled patients with a shared care record ▪ First Do No Harm regional patient safety campaign extension into Aged Related Residential Care sector (Northern Region Health Plan Appendix A2)
Intersectoral Integration	▪ Improve access to quality housing through increased referrals to retrofit insulation to private and rental homes; supported landlord agreements ▪ Improve access to affordable housing for mental health consumers ▪ Extend school based alcohol and drug services into Alternative Education settings ▪ 100% of school based nursing clinic integrated with primary care to facilitate comprehensive care for high risk students

3.0 Implementing Government Priorities and Targets

This section describes the actions Counties Manukau Health (CM Health) will undertake to implement the government's priorities as expressed in the Minister's Letter of Expectations and related guidance. This section is structured as follows:

3.1	Prime Minister's Key Result Areas – Supporting Vulnerable Children and Youth Mental Health
3.1.1	Prime Minister's Youth Mental Health Project
3.1.2	Better Public Services: Supporting Vulnerable Children
3.2	National Health Targets
3.2.1	Shorter Stays in Emergency Departments
3.2.2	Improved Access to Elective Surgery
3.2.3	Shorter Waits for Cancer Treatment
3.2.4	Increased Immunisation
3.2.5	Better Help for Smokers to Quit
3.2.6	More Heart and Diabetes Checks
3.3	Care closer to home/Service Integration
3.3.1	Primary Care
3.3.2	Maternal and Child Health
3.3.3	Acute and Unplanned Care
3.3.4	General Medicine
3.3.5	Long Term Conditions
3.3.6	Health of Older People
3.3.7	Mental Health and Addictions Service Development
3.4	Service Development
3.4.1	Improved Access to Diagnostic Services
3.4.2	Cardiac Services
3.4.3	Population Health
3.4.4	Whaanau Ora
3.5	Regional and National Collaboration (including Health Sector Agencies)
3.6	Living Within Our Means

3.1 Prime Minister's Key Result Areas - Youth Mental Health and Supporting Vulnerable Children

3.1.1 Prime Minister's Youth Mental Health Project

In Counties Manukau, there are just over 64,000 12-19 year olds (approximately 66,000 if Otahuhu is taken into account as part of the mental health services catchment area); of these 21 percent are Maaori and 30 percent are Pacific. The objectives of the Prime Minister's Youth Mental Health Project are highly relevant for Counties Manukau youth. As 37 percent of our population of this age live in socio-economically deprived areas, our approach to services in this age group needs to be comprehensive. This means taking the services to where young people are including school based and targeted youth specialist services for high needs youth who are not in school.

Our goal is to intervene early to prevent the development of mental health issues and improve access to specialised treatment when required through working collaboratively with our primary care partners and wider community - wherever our youth are. The objective of this work programme is to:

- Make primary health care more youth friendly and responsive
- Improve the coverage and quality of School Based Health Services
- Improve youth wait times and follow-up care for specialist mental health services

Linkages

Mental Health & Addictions Service Development Plan 2012-2017 - Rising to the Challenge; Northern Region Health Plan (NRHP) - Mental Health & Addiction workstream; Primary Care, NGO Providers and Schools; Other public sector agencies, i.e. Ministry of Social Development, Ministry of Education; CM Health Maaori Health Plan (Indicator 17)

Action to deliver improved performance	Health system success is measured by
Making primary care more youth friendly ▪ Develop strategic objectives to achieve the goals of "Better Mental Health and Wellbeing for Young People in Counties Manukau" and guide where additional investment will be targeted ▪ A Service Development Plan will be completed in consultation with local providers and take into consideration the unique needs of youth, for example cultural, service accessibility, gender, age and developmental stage ▪ Extend delivery of year 9 decile 1-4 HEEADSSS assessments to include primary care settings by extending training to practitioners in primary care settings ▪ Expand Primary mental health service responsiveness to 12 to 19 year age youth and families by establishing stepped care models and building capacity and capability of appropriately trained primary mental	▪ Strategic objectives for Better Mental Health and Wellbeing for Young People in Counties Manukau and Service Development Plan developed and agreed ▪ Increase Psychosocial assessment tools training , including delivery of HEEADSSS assessments to primary level care practitioners (inclusive of primary care and SBHS) from 174 to 250 ▪ A stock take and gap analysis of the CM Health primary and community services will be completed in consultation with local providers and take into consideration the unique needs of youth, for example cultural, service accessibility, gender, age and developmental stage. This will outline actions to address gaps by December 2013 (Q1) ▪ Agree and develop primary mental health interventions based on findings ▪ Increase primary mental health interventions in line with the stepped care model (subject

health providers ▪ Identify points of access in the community and development of referral systems into the primary mental health service (refer Referral Pathways below) and establish interventions ▪ Agreed funding levels from pharmaceutical savings will be directed to support increased access to primary level services	to report findings)
Maintain and expand School Based Health Services (SBHS) ▪ Provide SBHS to all decile 1 - 4 secondary schools, teen parent units and alternative education facilities in Counties Manukau ▪ Through Locality structures, establish referrals and links from SBHS to primary care	▪ All young people in decile 1 – 4 secondary schools, teen parent units and alternative education facilities in Counties Manukau receive a HEEADSSS[10] assessment in Year 9 ▪ Information is captured on and reported from the Pupil Information System (Pupil IS) ▪ Services delivered reflect needs identified in Pupil IS including general practice and school based services
Improving wait times and follow up care ▪ Baseline data is collected to measure the number of youth that have follow-up care plans that are discharged from Child and Adolescent Mental health Services (CAMHS) and Youth Alcohol and Other Drugs (AOD) services into primary care, by end of June 2014 ▪ Improved follow up for youth (12-19 years) who have been discharged from secondary mental health and addiction services ▪ Improve access to CAMHS and Youth AOD services through integrated case management and delivery of agreed targets ▪ Work with primary care to develop process to gather data on follow up of youth discharged from CAMHS and AOD services to primary care	▪ Audit of follow up plans to establish baseline ▪ Reduce wait time for follow up for youth discharged from secondary mental health and addiction services to 3 weeks ▪ Improved wait times phased over a 2 year period for CAMHS and Youth AOD service: ▪ 80 percent of youth to access services within three weeks ▪ 95 percent to access services within eight weeks of contact
Referral pathways ▪ In collaboration with key stakeholders, establish agreed prioritisation pathways for direct access to CAMHS clinical access for: ▪ Primary Health Organisations (PHOs) ▪ School pastoral care teams, Resource Teachers Learning & Behaviour (RTLB) and Teen Pregnancy Units (TPU)	▪ Implementation of a two-way system between School Based Health Services (SBHS) and primary mental health service ▪ Extended primary mental health service access to youth presenting through primary care services outside of PHOs (in line with the strategic objectives) for Better Mental Health and Wellbeing for Young People in Counties Manukau)

[10] HEEADSSS is a psychological assessment of young people. This stands for Home, Education/ Employment, eating, peer group Activities, Drugs, Sexuality, Suicide/depression and Safety.

▪ Child Youth and Family (CYF) ▪ Alcohol & Other Drugs services (AOD) ▪ Alternative education settings	*Reporting requirements (summary actions):* ▪ PP8 Six-monthly Performance Reporting ▪ Quarterly CFA Performance Reporting ▪ Six-monthly Performance Reporting against CMS contracts

3.1.2 Better Public Services: Supporting Vulnerable Children

This section describes the actions CM Health will take to implement the government's Better Public Services targets that cover infant immunisation, rheumatic fever and – through the implementation of the Children's Action Plan – reduce the number of assaults on children. CM Health also intends to support the Better Public Service target relating to improved early childhood enrolments that is led by the education sector.

- *Infant Immunisation Rates* - Increased immunisation rates so that 95 percent of eight month olds are fully immunised by December 2014 and this is maintained through 30 June 2017. This is covered in the Health Target: Increased Immunisation section.
- *Rheumatic Fever* - CM Health has the highest number of rheumatic fever notifications in comparison to all DHBs, and has an overall rheumatic fever rate of 37.1 per 100,000. This is double the national average. CM Health aims to reduce the incidence of rheumatic fever among all tamariki in CM Health. This is also a priority in the CM Health Maaori Health Plan.
- *Children's Action Plan* - Counties Manukau Health supports the conclusions of the White Paper for Vulnerable Children and the Children's Action Plan released on October 2012 by the Minister for Social Development. Although CM Health is not one of the first pilots to develop and implement Children's Action Plan (CAP), we will closely observe learning from Lakes and Northland DHBs to ensure we are prepared for implementation when appropriate.
- *Early Childhood Education Participation* - CM Health also believes that, although not required, we can contribute to the Better Public Service goals to increase early childhood participation. We have been engaged in a joint collaborative planning process with the Auckland City Council's Southern Initiative to increase early childhood participation.

This activity should be read alongside the Health Target: Increased Immunisation and the Child Health section of the Northern Regional Health Plan and CM Health's Maaori Health Plan for 2013/14. The objectives of this activity are to:

- Increase immunisation (health target)
- Ensure we are prepared for the implementation of Children's Teams
- Ensure families with children at high risk of rheumatic fever (defined as Quintile 5, Maaori and Pacific) living in Counties Manukau have free access to a school based primary health care programme
- Support vulnerable children to have increased participation in Early Childhood Education (ECE)
- Be adaptive and agile in responding to evolving evidence and potentially leverage off new government funding streams, e.g. rheumatic fever awareness campaigns, housing referrals and primordial rheumatic fever prevention, in particular housing referral and advice services

Linkages

These include linking with Primary Care Initiatives; the CM Health strategy for Better Health Outcomes for All, specifically the First 2000 Days Programme; CM Health Immunisation Strategy; the Northern Region Health Plan (NRHP) – Child Health Implementation Plan; CM Health Maaori Health Plan (Indicators 11 and 15)

Action to deliver improved performance	Health system success is measured by
Infant immunisation rates	
Refer to Health Target: Increased Immunisation	
Reduce the incidence of Rheumatic Fever	

▪ Develop and implement a rheumatic fever plan by 30 June 2013, with a focus on primary prevention acknowledging the importance of secondary prophylaxis and consideration of access to services for those diagnosed with Rheumatic fever
▪ Implementation of sore throat swabbing services in 53 schools in high risk areas in Counties Manukau
▪ CM Health will work in partnership with the Ministry of Health to agree funding for sore throat swabbing services when contacts end in 2014
▪ Work with the provider arm and primary care to develop systems to identify families with children at high risk of rheumatic fever (defined as Quintile 5, Maaori and Pacific) living in crowded housing
▪ Working collaboratively with primary and community service partners to:
  ▪ develop and implement a rheumatic fever prevention programme within the community
  ▪ develop systems that ensure that people with Group A strep have begun treatment within 7 days
▪ Review current notification processes of acute rheumatic fever to the Medical Officer of Health, secondary care clinicians will review cases of rheumatic fever to identify risk factors and system failure points
▪ Work with the National Hauora Coalition (NHC) to deliver sore throat swabbing services to 53 schools in Counties Manukau until June 2014
▪ A sustainable pathway for the service long term will be agreed by end June 2014. CM Health will reorientate some Public Health Nursing Workforce during 2013/14 to be a significant provider in the Mana Kidz programme and deliver the full suite of services using the same model and principles as the Mana Kidz Programme. This may support sustainability beyond June 2014
	▪ 23,000 children in high risk areas within CM Health have received services from the programme
	▪ Aim to meet the target of 12.4 per 100,000
	▪ Hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 10 percent lower than the average over the last 3 years (measured by National Minimum Data Set)
	▪ A Continuing Medical Education (CME) programme for the implementation of the National Health Foundation (NHF) guidelines is established in Q1 and rolled out with primary care by the end of Q2
	▪ All families with children at high risk of rheumatic fever (defined as Quintile 5, Maaori and Pacific) will be managed on the appropriate pathway as they are discharged from secondary care services by Q3 including being offered a Whaanau ora support worker in community
	▪ Systems and processes in general practice environments for the review of results and treatment plans for families with children at high risk of rheumatic fever will be audited by Q2
	▪ Recommendations following the completion of the audit will be implemented by Q4
	▪ Notification of Rheumatic Fever to the Medical Officer of Health occurs within 7 days
	▪ Review of secondary care processes completed by Q2 and implementation of recommendations of the secondary care review by Q4
	▪ Patients with a past history of rheumatic fever receive monthly antibiotics no more than 5 days after due date by Q3
	▪ Number of injections overdue by more than 5 days is less than 20 percent by Q3
	▪ Number of patients who have annual audit of secondary prophylaxis coverage 90 percent
	▪ Sore throat swabbing services will be

▪ Work with Localities to deliver school based rheumatic fever prevention programme	contracted for and delivered to 53 schools in Counties Manukau by June 2014 *Reporting requirements:* ▪ PP28 Six-monthly Performance Reporting ▪ CFA Performance Reporting
Reduce the number of assaults on children / Implement the Children's Action Plan	
▪ A child admitted to Emergency Care and inpatient services for NAI will receive a 24 hour interagency response whereby CYF, NZ Police and CM Health formally meet to share information and develop a management plan as described within the MoU with Child Youth and Family, Police and DHBs ▪ By the end of 2014 CM Health will complete a stock take of services that support vulnerable children through the Better Public Services intersectoral group ▪ Scope the potential to implement a Shaken Baby Prevention Programme ▪ Work with other sectors to implement the children's action plan in Counties Manukau ▪ Attend Regional Strengthening Families Meetings and ensure health is at the Local Management Group Meetings ▪ Implement changes to information sharing practices that are identified in the Ministry of Health's guidance [*further documentation expected May/ June 2013*] ▪ Implement the National Child Protection Alert System ▪ Design and implement a specific training programme for the recognition of signs of maltreatment ▪ Complete a stock take of the vetting processes used by providers working closely with children ▪ Support initiatives as they are finalised for the implementation of the cross-sector standards, workforce competencies and training requirements ▪ Monitor the implementation of Children's Action Plans in pilot DHBs for application to CM Health	▪ Multi Agency Safety Plan (MASP) is held by the strategy agency (CYF). This is developed after the 24 hour response meeting identifying each agency's responsibility ▪ Violent intervention programme audit (University of Auckland) completed to requested timeframes ▪ Information sharing practices (as identified) will be implemented by Q4 ▪ Attendance at the Better Public Services intersectoral group that meets to coordinate regional activities ▪ CM Health child protection services will implement the National Child Protection Alert System (in conjunction with the local DHB system) by Q2 ▪ Frontline staff working for providers in Counties Manukau will have attended a specific training programme for the recognition of signs of maltreatment by Q4 ▪ Attendance recorded on meeting minutes ▪ CM Health providers working closely with children will use consistent vetting processes by Q4 ▪ The implementation of the cross-sector standards, workforce competencies and training requirements will be completed in CM Health by end of 2014 *Reporting requirements:* ▪ PP27 Quarterly Performance Reporting
Contribute to increased participation in quality Early Childhood Education	
▪ Attend monthly Early Childhood Education (ECE) Implementation Group at the Manukau	▪ Frontline workers routinely provide information about ECE to parents and

Council. Support the council to develop a strategic plan that acknowledges interagency relationships ▪ Early Childhood Education will work innovatively to increase participation in Early Childhood Education. This includes mobile service delivery. The DHB will link in to the ECE planning to promote visibility of the Health access issues relating to these new models of care within the Education sector ▪ Participate in the development of new initiatives to increase the participation in ECE ▪ Support frontline health services working with families with young children with information and resources on the importance of early childhood education and in improving health and wellbeing and education outcomes ▪ Capture the ECE centre information electronically in PiMS when a child accesses DHB services ▪ Monitor referrals to ECE using a mix of education and health sector data, such as Well Child and Before School Check (B4SC) data ▪ B4 School Coordinator will meet with Early Childhood Sector at least 6 monthly to support coordination of service delivery for the B4 school check. We will work with Ohomairangi Trust to implement initiatives that help to locate, engage and retain vulnerable children in quality early childhood education	families ▪ Families know about the importance of accessing ECE and are aware of local health service providers and their entitlements ▪ Increased proportion of vulnerable children access ECE. 90 percent of children in Counties Manukau accessing ECE
▪ Engage and participate in local and regional ECE forums ▪ Participation in the development of the business case for implementation of the Auckland Plan, specifically the Southern Initiative ▪ Ensure that health providers work in collaboration with other sectors to increase participation in ECE	▪ The CM Health Child Health Portfolio Manager is on the Auckland Council Early Childhood Implementation Team ▪ The CM Health Senior Portfolio Manager, and CM Health Public Health Medicine Specialist participate in the Better Business Case development workshops for Improving wellbeing outcomes for 0-5 year olds in the Southern Initiative *Reporting requirements:* ▪ CFA Quarterly Performance Reporting

3.2 National Health Targets

3.2.1 Shorter Stays in Emergency Departments

This target requires that 95 percent of patients will be admitted, discharged or transferred from an ED within six hours. CM Health has the busiest Emergency Department in Australasia seeing and treating more than 100,600 people that present each year. Effective management of wait times in ED requires a whole of system approach that includes planning which involve both managers and clinicians – ensuring appropriate referrals from other health professionals and self-referring patients are appropriate and require ED level intervention, while also ensuring patients are able to be admitted into the hospital where required. CM Health was the first large hospital to achieve this target and continues to sustain its achievement since Q2 2009.

Linkages

System integration expectations and measures; OS 3 (inpatient length of stay) and OS 8 (acute readmissions)

Action to deliver improved performance	Health system success is measured by
▪ Develop and implement an Emergency Care (EC) model of care to manage demand for acute services especially during the winter (June to October) including working with Localities and the GP liaison service to support initiatives to reduce the demand for acute services and improve the provision of community ▪ Contribute to the 20,000 days initiative by implementing the low-risk chest pain pathway in EC in collaboration with Medicine and ambulatory services at CM Health ▪ Redevelop EC front door and fast track area ▪ Open the 42 bed Medical Assessment in May 2014 to develop and implement a model of care for acute medical patients ▪ Reconfigure the paediatric EC model of care ▪ Develop the nurse practitioner role in EC and continue to contribute to the Regional/National EC CNS Nurse Practitioner training and competency programme ▪ Support the development of an acute radiology hub, including direct access to CT in EC ▪ Monitor and improve time critical treatments including analgesia, PCI, sepsis, and time to antibiotics against baselines	▪ 95 percent of patients being admitted, discharged, or transferred from an Emergency Department within six hours (subject to funding to meet growing demand particularly during the winter) *Reporting requirements:* ▪ National Health Target Quarterly Performance Reporting

3.2.2 Improved Access to Elective Surgery

The target is for CM Health to contribute to the national goal to increase the volume of elective surgery by at least 4000 discharges this year. Elective surgery is an important part of our healthcare system. It is important that patients who need surgery are able to access this in a timely way so that disruption to a

patient's life is minimised. Meeting our elective surgery targets requires that we continue to improve how patients flow through our services from First Specialist Assessments (FSA), access to diagnostics, certainty of treatment through to discharge and, where required, follow up. CM Health will commit to seeing and treating patients in the most clinically appropriate timeframe that will involve using recognised prioritisation tools, and begin in accordance with assigned priority and waiting times. We will work with primary care to implement pathways where it is feasible for primary care to support FSAs through GPs with Specialist Interest (GPwSI) training and Follow Ups to facilitate early discharge. CM Health will reduce wait time for elective surgery to meet the government's target of no one waiting more than 5 months, with intention to make early progress to meet this target.

Linkages

Northern Region Health Plan, National Elective Productivity Plans

Action to deliver improved performance	Health system success is measured by
▪ Contribute to the planned national increase in volume of 4000 elective surgical discharges to be provided year on year	▪ Elective discharge rate from Surgical Diagnostic Related Group (DRG) is at least 308 per 10,000 population ▪ S14: Major Joint discharge SIR is at least 21 per 10,000 population ▪ S14: Cataract discharge SIR is at least 27 per 10,000 population ▪ S14: Cardiac Surgery discharge SIR is at least 6.5 per 10,000 population ▪ S14: Angiography SIR is at least 33.9 per 10,000 population ▪ S14: Angioplasty SIR is at least 11.9 per 10,000 population ▪ 155 Bariatric procedures *Reporting requirements:* ▪ National Health Target Performance Reporting
▪ Review and enhance management of referral processes ▪ Greater linkage with primary care to support wider range of service provision in localities and community ▪ Improved access (capacity and timeliness) to diagnostics for primary care ▪ Improve capacity of outpatient clinics – increase available appointments and virtual assessments, eliminate unnecessary visits and Did Not Attend (DNA) ▪ Management of follow-ups - review volumes and criteria for secondary intervention, increase nurse led clinics ▪ Effective screening and preparation	▪ ESPI 2: Zero patients waiting 150 days+ ▪ Demonstrable progress to achieving Zero patients waiting 120 days+ ▪ ESPI 5 : Zero patients waiting 150 days+ ▪ Demonstrable progress to achieving Zero patients waiting 120 days+ *Reporting requirements:* ▪ National Health Target Performance Reporting

processes of patients prior to treatment ▪ Effective scheduling of cases to theatre to maximize theatre utilization and productivity ▪ Employment of right mix and number of clinical staff to support required level of service provision	
▪ Monitor CM Health performance against benchmarks and national standards	▪ Inpatient Length of Stay – 3.21 days *Reporting requirements:* ▪ OS3 Quarterly Performance Reporting
▪ Referral by GPwSI for specific elective procedures directly to waiting list will include the following conditions: otitis media, carpal tunnel syndrome and tonsillitis	▪ 300 patients will be referred directly to waiting list with carpal tunnel syndrome from 1 July 2013 to 30 June 2014 ▪ 350 patients will be referred directly to waiting list with otitis media from 1 July 2013 to 30 June 2014 ▪ 200 children aged 4-15 years old will be referred directly to waiting list with tonsillitis from 1 July 2013 to 30 June 2014 *Reporting requirements:* ▪ PP22 Performance Reporting
Elective Innovations National Health Board funding has been approved for CMDHB to lead an initiative through the following five workstreams: ▪ Improve the primary and secondary service collaboration for elective direct referrals and discharge from secondary surgical services ▪ Redesign of three general clinical pathways for varicose veins, bariatric surgery and PR bleeding ▪ Redesign of plastic clinical pathways for breast reconstruction and hand/carpal tunnel syndrome ▪ Assessment and recommendations for regionalisation of urological surgical services ▪ Supporting other DHBs with Enhanced Recovery After Surgery (ERAS) initiatives implementation and potential model expansion to other surgical specialties	▪ Achievement of elective health targets ▪ Recommendations for potential regionalisation of specified surgical services, i.e. urology and breast reconstruction ▪ Improved patient referral and experience of care ▪ Shared elective innovation successes and support for other DHBs *Reporting requirements* ▪ As per funder expectations

3.2.3 Shorter Waits for Cancer Treatment

This target requires that all patients, ready for treatment, wait less than four weeks for radiotherapy or chemotherapy treatment. Cancer is a leading cause of death, accounting for 30 percent of all deaths. The impact on people diagnosed with cancer and their whaanau can be devastating for months and sometimes

years. A whole of system approach via tumour streams is improving access to services and waiting times for patients, with strong multidisciplinary expertise and standard care pathways. Notwithstanding the success of our approaches to date, cancer remains a significant concern for our population and health services.

Auckland District Health Board (ADHB) provides non-surgical cancer services and some surgical cancer treatment services for CM Health domiciled patients. All chemotherapy for Oncology is provided through ADHB. Chemotherapy for Haematology is provided largely by CM Health. CM Health clinicians from several disciplines participate or lead the development of national and regional cancer pathways.

Linkages

National Cancer Network for the development of national standards for tumour streams; Regional Oncology Operations Group in developing the Northern Region Health Plan and ensuring this is in line with National priorities

Action to deliver improved performance	Health system success is measured by
We will Implement the regional initiatives identified in the National Cancer Programme Work Plan including: ▪ Identify and implement actions to improve faster cancer treatment data collection systems to support service improvements along cancer patient pathway ▪ Improve the functionality and coverage of multidisciplinary meetings (MDMs) across the region, including extending MDMs across additional tumour streams as part of the National Tumour Stream work ▪ Support the implementation of the priority areas identified in National Medical Oncology Models of Care Implementation Plan 2012/13 ▪ Begin implementing the national tumour standards of service provision ▪ Nurse coordinators will track patients through their health system journey and provide weekly reports ▪ Support cancer nurse coordinators to review pathways to reduce system barriers and enable their participation in training and development forums ▪ Patient tracking oversight and system problem identification and resolution through Lead Cancer Nurse Coordinator role ▪ Utilisation of Cancer Tracking information to identify and resolve potential and actual system delays from referral to treatment commencement ▪ Implement priorities identified in the	▪ 100 percent of patients receive care within four weeks for: ▪ Radiation therapy ▪ Chemotherapy treatment ▪ Faster cancer treatment targets including the following are to be base-lined during 2013/14: ▪ DV1: 14 day indicator - proportion of patients referred urgently with a high suspicion of cancer who have their first specialist assessment within 14 days ▪ DV1: 31 day indicator - proportion of patients with a confirmed diagnosis of cancer who receives their first cancer treatment (or other management) within 31 days of decision-to-treat ▪ DV1: 62 day indicator - proportion of patients referred urgently with a high suspicion of cancer who receives their first cancer treatment (or other management) within 62 days ▪ Progress on delivery of the actions and milestones agreed in 2012/13 Annual Plan to support implementation of the faster cancer treatment initiative by funding multi-disciplinary meetings (MDMs) for all main cancer tumour types and increasing the number of cases discussed at MDMs ▪ 100 percent of patients wait 5 months or less for a first specialist appointment from July 2013

Prostate Cancer Quality Improvement Plan ▪ Initial scoping of a non-surgical patient management system to work towards regional clinical data repositories for cancer ▪ Improve access and waiting times for diagnostic services: Colonoscopy (see Diagnostic services) ▪ Support the implementation of the Endoscopy Quality Improvement (EQI) Programme ▪ Northern Region – Support ongoing activities associated with the Waitemata DHB bowel screening pilot ▪ Haematology - implement automated collection of data for the chemotherapy health target within the CM Health Haematology Service ▪ Pilot PREDICT database for enhanced tracking of Lung Cancer patients ▪ Maaori Nurse Co-ordinator and Pacific Nurse Co-ordinator established	*Reporting requirements:* ▪ National Health Target Performance Reporting

3.2.4 Increased Immunisation

This target requires that 85 percent of all eight month olds will have their primary course of immunisation at six weeks (which CM Health has already achieved), 3 months and five months on time, increasing to 90 percent by 30 June 2014 and 95 percent by December 2014. This is also one of the government's Better Public Services targets. The national goal is to reach 95 percent of children fully immunised at eight months by December 2014.

Immunisation is still one of the most cost effective interventions to protect and improve population health. Reaching high coverage rates is important to realise population wide benefits. CM Health has experienced breakthrough of vaccine preventable diseases such as measles and whooping cough. CM Health aims to reach the target for all population groups in our District. Effective interventions requires a whole of system approach – primary care practices and provider vaccinating, outreach information services who seek and contact hard to reach families and information systems that enable the sharing of information to track progress.

Linkages

These include linking with Primary Care Initiatives; the CM Health strategy for Better Health Outcomes for All, specifically the First 2000 Days Programme; CM Health Immunisation Strategy; the Northern Region Health Plan (NRHP) – Child Health Implementation Plan; CM Health Maaori Health Plan (Indicator 11)

Action to deliver improved performance	Health system success is measured by
▪ CM Health representation and attendance immunisation forums ▪ Regional planning occurs with stakeholders and Auckland Regional Public Health Service (ARPHS) in response to planning for pandemic events	▪ Increase infant immunisation rates (85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by 30 June 2013, 90 percent by 30 June 2014 and 95 percent by

▪ DHB immunisation working group will meet monthly. This group includes PHO nurse leaders, Well Child Providers, Nurse Leader Immunisation, Nurse Leader Maaori Health and Pacific Health, and representation from Maternity Services. This group reports to the DHB Strategic Forum ▪ Work with maternity and primary care partners to implement newborn enrolment policy and monitor newborn enrolment rates ▪ Monitor and evaluate immunisation coverage at DHB, PHO and practice level, manage identified service delivery gaps ▪ Targeted immunisation strategies that achieve 85 percent of Maaori and Pacific children aged eight months old will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by 30 June 2013, 90 percent by 30 June 2014 and 95 percent by December 2014) ▪ A standardised PHO reporting system across DHBs will be evident by 30 June 2014 with monthly evaluation of datamart reports at PHO and practice level. Immunisation Nurse Leader will select 10 practices with lowest coverage rates and will meet individually with each practise to improve performance measured by the datamart report in the following month ▪ Immunisation status of all children presenting to Kidz First services will be available and recorded by Q3 ▪ Develop systems for seamless handover of mother and child as they move from: maternity care services to general practice and WCTO services ▪ Requirements within the Tier Two WCTO schedule are implemented ▪ Actively promote Immunisation week ▪ Develop an immunisation education and event calendar jointly with primary care and NGO sectors	December 2014) ▪ 95 percent of newborns enrolled on the National Immunisation Register (NIR) at birth (measure NIR) ▪ 100 percent of newborns enrolled with general practice (measured at 6 weeks, measure B code uptake) ▪ 85 percent of 6 week immunisations are completed (measured through the completed events report at 8 weeks) ▪ CM Health coverage rates for Maaori will equal non Maaori ▪ Seamless handover processes from General Practitioners (GPs), Lead Maternity Carer (LMC) and Well Child/Tamariki Ora (WCTO) providers designed and written up by Q2 ▪ Public Sector Targets are reported on and reviewed ▪ CM Health participates in immunisation week activities ▪ Immunisation education and event calendar available Q1 ▪ Monthly datamart report evaluation *Reporting requirements:* ▪ National Health Target Reporting ▪ Quarterly CFA Performance Reporting

3.2.5 Better Help for Smokers to Quit

This target requires that 95 percent of patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of patients who smoke and are seen by health practitioners in primary care are offered brief advice and support to quit smoking. Within this target, an additional target will be

implemented that focuses on a specialised group – 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

At the last Census, 20 percent of CM Health residents reported that they were smokers. 50 percent of Maaori, however, and 42.4 percent Pacific were reported as smokers. Smoking increases risk of respiratory and lung related disease, lung cancers and other long term conditions such as heart disease and poor oral health. These conditions contribute to the life expectancy difference between Maaori and Pacific and non-Maaori/Pacific people in CM Health.

CM Health will, this year commit to be a Smokefree DHB by 2025. We will achieve this by increasing our emphasis on support for smokers to quit by increasing capacity for cessation services. This is one of three priority population health goals for CM Health. This is a 5-year project aimed at reducing adult smoking prevalence to 12 percent as an intermediate goal towards <5 percent by 2025. Two priority workstreams have been identified - support to quit, and protection of children and youth, and other vulnerable groups. CM Health also identifies this as a priority for the Maaori Health Plan (pg. 26 refers).

Linkages

CM Health Maaori Health Plan (Indicators 9 and 10) and targeted primary care support

Action to deliver improved performance	Health system success is measured by
Primary Care Indicator Build links between community based cessation providers and GP practices, including development of easy referral pathways and reliable feedback systems ▪ Work with PHOs, GP practices and cessation providers to ensure that ABC training is available and delivered. Smokefree Coordinator to provide ongoing training and updates as necessary to PHOs, GP practices, community cessation providers ▪ The Smokefree Community Provider Network group will continue to meet monthly to identify and plan strategies to improve performance ▪ Work together with PHOs and GP practices to ensure ABC practices are used and offered to every patient every time and that practice management systems and data quality is robust and reliable. ▪ Smokefree Coordinator to monitor data integrity from data collection, recording, read coding, writing back from advanced forms, data extraction, presenting of information and report league table and feedback for improvement purposes	▪ 90 percent of enrolled patients who smoke and are seen in General Practice are offered brief advice and support to quit smoking by 30 June 2014 ▪ ABC training schedule and implementation plan is developed by Q2 2013/2014 ▪ Implementation of new training schedule throughout 2013/2014 ▪ Monthly Smokefree Community Provider Network meetings ongoing throughout 2013/2014 ▪ Internal audit developed to review ABC practices, practice management systems and data quality by Q2 2013/2014 ▪ Report League Table is developed by Q2 2013/2014
Secondary Care Indicator Provide enhanced training and refresher updates to ensure brief interventions are delivered	▪ 95 percent of hospitalised smokers will be provided with brief advice and support to

competently, and that hospitalised smokers receive the most appropriate smokefree support ▪ Maintain and improve existing referral pathways from secondary care to cessation services ▪ Improve integration of smokefree processes into daily hospital operations	quit by 30 June 2014 ▪ Implementation and review of new referrals processes by Q2 2013/14 ▪ Implementation and review of new training schedule throughout 2013/14 ▪ Daily reporting system transitioned to standard hospital processes by Q2 2013/14
Maternity Services Indicator ▪ Work with LMCs and within maternity services to enable clinicians to support pregnant women who smoke to quit ▪ Establish a working group to ensure implementation of the Maternity Smoking Health Target	▪ 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit by 30 June 2014 ▪ Completed stock take and gap analysis of training and resource requirements by August 2013 ▪ Maternity Smoking Health Target Implementation Plan by August 2013

Smokefree Counties Manukau 2025:
▪ Implementation of Year 1 of the 5-year project according to the following two key workstreams:
  ▪ Support to Quit
  ▪ Protection of Children and Youth, and other Vulnerable Groups
	▪ CM Health adult smoking prevalence of 12 percent by 2018 with halving of current prevalence amongst Maaori and Pacific
	Reporting requirements:
	▪ National Health Target Quarterly Performance Reporting

3.2.6 More Heart and Diabetes Checks

This target requires that 90 percent of the eligible population will have had their cardiovascular risk assessed in the last 5 years to be achieved by 30 June 2014.

Linkages

CM Health Maaori Health Plan (Indicators 5); Northern Region Health Plan; government Health targets

Action to deliver improved performance	Health system success is measured by
Work with PHOs and their practices to: ▪ Implement and use a population health tool to identify eligible populations ▪ Identify and up-skill Practice staff in the use of recall systems, reporting and audit tools ▪ Identify and proactively invite patients who need a CVD risk assessment and send blood test form to patients who do not have a lipid results letter ▪ Develop a Practice Plan outlining how they will achieve and sustain performance against the national health target	▪ 90 percent of the eligible adult population will have had their cardiovascular disease (CVD) risk assessed in the last five years by 30 June 2014 with focus on Maaori & Pacific *Reporting requirements:* ▪ National Health Target Quarterly Performance Reporting

▪ Work in partnership with CM Health clinical staff to develop and deliver targeted education programmes to GPs and Practice Nurses ▪ Upgrade the current electronic decision support tools and utilise audit tools to identify, understand and plan effectively for their practice populations ▪ Employ 2 FTE RN's to undertake CVD risk assessments to patients in secondary care. Refer patients identified as high risk back to primary care following brief intervention (subject to funding) ▪ Fund $250,000 worth of point of care testing or phlebotomy services directly into practices to remove barriers for diagnostic screening	

3.3 Care Closer to Home/Service Integration

This section describes how CM Health will implement the second year of our journey towards an integrated healthcare system. In 2012/13 the Board agreed, and we implemented four Localities with their own General Manager, a lead PHO, locality clinical leadership group that represent clinical primary care leadership in that area. Each Locality has also seen increased primary healthcare facility capacity where an Integrated Family Health Centre (IFHC) is now present in each community to provide a setting for specialist and wider District services to be provided:

Franklin Locality - population are primarily rural, older, non-Maaori/Pacific. ProCare PHO are the local leads, Pukekohe Hospital provides the IFHC facility hub for local specialist services

- *Manukau Locality* - population have a greater proportion of Maaori, lower income and the faster growing part of the District. ProCare is the lead PHO, the DHB has supported the establishment of a Whaanau Ora Centre on the Manukau Health Park site and will be progressing additional A&M clinics as potential IFHC settings
- *Mangere/Otara Locality* - population is more than 80 percent Pacific, low income and urban. Alliance Health Plus is the lead PHO for Mangere and Total Healthcare Otara (THO) is the lead PHO for Otara. The Mangere Community Health Centre provides the local IFHC for specialist services in Mangere and the THO's Dawson Road facility is the Otara IFHC
- *East Locality* - population is urban, older, primarily non-Maaori/Pacific and rapidly growing Asian. East health is the lead PHO, Botany Clinic will provide the IFHC base for local specialist services

Whaanau Ora is a District wide service network that will be led by National Hauora Coalition (NHC). NHC will work with PHOs and Localities to ensure that whaanau ora support is available and accessible to high need and vulnerable families across the District.

From 1 July, the first tranche of community based older people services will be shifted to Localities governance and management. The role of these groups is to better align the demand for specialist and wider community based services with the needs of local populations. This can include further shifting of services or funding responsibilities if appropriate. Further decisions will be confirmed for other community based specialist services to shift to Locality infrastructure during 2013/14.

A significant development is the establishment of two key groups:

- Whole of System Strategy Board where PHO governance and leadership and the DHB Executive Leadership Group will meet quarterly to take a whole of system view to integration
- The District Alliance Group, which consists of DHB and PHO Chairs and CEOs who are responsible for ensuring that the vision of Locality Clinical Partnerships are delivered as agreed

This will steer us to enhanced role for comprehensive primary healthcare services, including moving towards integration of community and primary healthcare services and increased accountability for health system outcomes, enhance capacity and capability in primary care and implement Better Sooner More Convenient (BSMC) philosophy through changes in systems and processes, and delivery of specialist services in primary care settings. As part of this, geriatricians, cardiologists, diabetologists and respiratory physicians will work directly with members of the Locality Clinical Partnerships providing specialist advice to keep people well and at home.

3.3.1 Primary Care

Identification of key objectives to strengthen the role of Primary Care within CM Health has been undertaken with key partners. Evidence of the relationship principles exist within the District Alliance Agreement, and details of locality engagement between the DHB and the nominated PHO partners for each area are clearly described in Section 2. Partners have been instrumental in the development of the key initiatives, and prioritisation of funded initiatives as outlined in the investment strategy have been made in conjunction with PHO partners.

A clear indicator of the high trust environment that exists with Primary care is the shift to outcomes based contracting, evidenced by the Chronic Care Management (CCM) Redesign, Diabetes Care Improvement Package (DCIP) and the ongoing incentivising of key health targets as outlined above.

From 1 July, National Hauora Coalition (NHC) will be responsible for $4.5m of Maaori health services and Alliance Health Plus (AH+) will be responsible for approximately $1.5m of Pacific health services. The integration of these services in NHC and AH+ implements the BSMC business cases. It is likely that 2013/14 will be the final year the BSMC business cases will exist outside CM Health's primary care work programme. Integration of the business cases with our business as usual will be actioned during 2013/14.

CM Health provides primary care with direct access to ultrasound and plain films where there are currently no waiting times. In 2013/14 we will explore GP direct access to CT and MRI scans. CM Health consulted with our primary care partners and have agreed to maintain the National Immunisation Register (NIR) for the 2013/14 year.

Linkages

CM Health 20,000 days campaign, GAIHN - particularly workstream one – Management of High Risk Individuals; CM Health Maaori Health Plan (Indicator 3)

Action to deliver improved performance	Health system success is measured by
National Health Targets ▪ Work with Primary care partners to achieve health targets through collective strategies and incentivisation funding (refer section 3.3.5)	▪ Roll over initial $1m investment strategy for health target outcomes in 2013/14 to ensure sustainable effort to reach key targets *Reporting requirements:* ▪ National Health Target Quarterly Performance Reporting ▪ PP20 Performance Reporting ▪ PP21 Performance Reporting ▪ PP22 Performance Reporting

Localities ▪ Complete the establishment of the four identified localities ▪ Detailed Action Plans are agreed and delivered for the first operational year of the four localities ▪ Whole of system strategy confirmation of additional service shifts from secondary to primary and community services (*additional opportunities to those outlined in the locality plans)* ▪ Investigate and confirm the type, scope and volume of outpatient services to shifted ▪ As part of Localities, geriatricians, cardiologists, diabetologists and respiratory physicians will work directly with members of the Locality Clinical Partnerships providing specialist advice to keep people well and at home ▪ Implementation of three direct referral elective services as outlined in 3.2.2	▪ 70 percent of Home Health workforce is devolved to one of the four localities ▪ An Integrated Family Health Centre is established in Otara Mall and Dawson Road to serve the Otara population within the Otara/Mangere locality by the end of Quarter 1 ▪ An Integrated Family Health Centre is operational within the Mangere Town Centre to serve the Mangere population within the Mangere/Otara locality by the end of Quarter 1 ▪ Pukekoe Hospital site is expanded to become the Health Hub for shared care delivery for the population of Franklin by the end of Quarter 1 ▪ Two existing A&M facilities within the Manukau Locality are reconfigured to become IFHCs within the Manukau locality ▪ 850 patients will be referred directly to waiting list with carpal tunnel syndrome, otitis media and tonsillitis. Refer 3.2.2 *Reporting requirements:* ▪ PP22 Performance Reporting
Shifting School Based Clinics to Localities ▪ Work closely with Primary care partners and schools to ensure that school based nursing clinics are integrated into Primary care, with standing orders and linkages in place to ensure comprehensive care for students most at risk	▪ 50 percent of school based nursing clinics integrated into primary care by the end of Quarter 2 ▪ 100 percent of school based nursing clinics integrated into primary care by the end of Quarter 2 *Reporting requirements:* ▪ PP22 Performance Reporting ▪ CFA School Health Service
Increased funding in Primary Care ▪ Implement the primary care investment strategy to ensure that the right balance between primary and secondary services is achieved in line with integration objectives ▪ Continued commitment to the $7m development fund across Localities and 20,000 days to support new initiatives, integration pilots and additional clinical resource to support Primary Care Teams ▪ 80 percent of $7m committed in 2013/14 to support initiatives directly attributed to supporting primary care and/or	▪ Ensure each PHO meet the national health targets as they relate to Primary Care, particularly CVD Risk Admission and the full suite of smoking related indicators ▪ Deliver an overall reduction in presentations to Emergency Department by 5 percent across enrolled populations ▪ Reduce Ambulatory Sensitive Hospitalisations (ASH) related admissions by 3 percent across all enrolled populations ▪ Contribute to the 20,000 bed days saved in line with the wider organisational strategy to give well days back to the Counties

reducing acute demand ▪ Coordination of CM Health Annual Plans to increase capacity of resources in the primary health setting with ongoing development of District Alliance Agreements ▪ $1.2m investment for increased range of community diagnostic tests for spirometry, endoscopy for dyspepsia, CT & MRI	community *Reporting requirements:* ▪ PP22 Performance Reporting ▪ OS8 Performance Reporting
Primary Care Workforce Development ▪ Explore opportunities to maximise Primary care workforce through model of care redesign and expanded scopes of practice (refer to Elective Services)	▪ Implement a further six GP with Special Interest (GPwSI) training programmes ▪ Explore further the role of Physician Assistant's in conjunction with Health Workforce New Zealand ▪ Reform the current model of Primary Care by introducing Nurse Led clinics within the Mangere/Otara health hub ▪ Continue to up skill GP's through the use of Quality Improvement teams and Clinical champions *Reporting requirements:* ▪ PP22 Performance Reporting
Outcome based Contracting ▪ Increased use of results/outcomes based contract arrangements	▪ A full set of indicators, including current and pipeline are developed and accepted by the District Alliance Group to monitor the impact of integration initiatives on localities
Development of new models of care that maximise outcomes within a global budget: ▪ Work with lead SMO's and the Very High Intensive Users team to support Primary care to provide wrap out services for those identified as highest risk ▪ Increase GPwSI numbers in line with locality population need ▪ Develop a business case in line with Locality development Plans for the delivery of First Specialist Appointment (FSA) and follow up appointments within localities	▪ 20 percent reduction in admissions from practices participating the High Risk Individual programme ▪ A further 3 GPwSI per locality to be trained and working within the designated shared care health hub or Integrated Family Health Centres (IFHC) ▪ 10 percent reduction in outpatients delivered across Middlemore Hospital (MMH) or Manukau Health Park *Reporting requirements:* ▪ PP22 Performance Reporting
Increased investment in primary care IT ▪ Increased use of shared patient records ▪ Continue to support the regional approach to IS initiatives, specifically the sharing of electronic patient records	▪ 20 percent increase in the number of enrolled patients with a shared care record *Reporting requirements:* ▪ PP22 Performance Reporting

BSMC Business Case Implementation Work with Primary care partners (in conjunction with GAIHN workstream one) to establish systems to support, and to enable the direct referral to locality hub or secondary referred services: ▪ Complete design phase in conjunction with clinical reference group to incentivise appropriate interventions for primary care in respect of high risk individuals ▪ Work with PHO partners and regional DHB's to design and procure resource allocation and notional budget setting tool, aligning to the work of the national e-referrals project ▪ Work with primary care to achieve better identification and management of high risk individuals in primary care settings	▪ 50 percent of practices using notional budgets and value added services ▪ 80 percent of participating practices using electronic decision support *Reporting requirements:* ▪ PP22 Performance Reporting ▪ OS8 Performance Reporting
▪ Further extension of Primary Options for Acute Care (POAC) to ensure that acute demand is managed in community settings wherever possible	▪ 20 percent increase in the use of POAC from secondary care for the purpose of reducing length of stay ▪ POAC to support a further increase in community radiology through the adoption of two further clinical pathways – Transient ischemic attack (TIA) and Renal Colic ▪ POAC to expand to support the coordination of at least one GP with Special Interest programme within localities by the end of 2013/14 *Reporting requirements:* ▪ PP22 Performance Reporting ▪ OS8 Performance Reporting
After Hours Continue to support the evolution of the regional After Hours Network to align to localities strategy and ensure equitable and fair access to services out of hours: ▪ Work with regional consortium to ensure further development and sustainability of the after-hours and overnight services	▪ At least one A&M service operating per locality until 10pm by end of Quarter 2 ▪ Universal free access for 100 percent of under 6's across the network ▪ Comprehensive linkages exist between GP's and After Hours providers within the locality as to medical cover and service access, particularly in key times such as public holidays *Reporting requirements:* ▪ PP22 Performance Reporting
Whaanau Ora Implementation	▪ At least one credentialed Whaanau Ora practice is in place within each care cluster by

Work with Primary care partners to implement Whaanau Ora networks in line with localities: ▪ Establish a framework for implementation of Whaanau Ora networks, including credentialing framework for practitioners, eligibility criteria and scope of practice ▪ Fully explore and understand how to rationalise coordination and navigation systems across primary and secondary so as to maximise effectiveness of Whaanau Ora networks ▪ Support non-TPK Whaanau Ora business case providers in developing Maaori Provider Development Scheme (MPDS) three year plans for submission to the MOH ▪ Implement the integrated contracts programme as relates to the Whaanau Ora business cases within the National Hauora Coalition Contracts Integration Programme	end of 2013/14 ▪ All non-Whaanau Ora providers submit and have approved three year development plans by Sept 2013 ▪ NHC complete contract integration process of health contracts for all Whaanau Ora business case providers by June 2014 *Reporting requirements:* ▪ PP22 Performance Reporting
Palliative Care ▪ Work with Hospices in our area, as well as hospital specialists, community and primary care partners to create Local Palliative care Teams that will operate within localities	▪ Ensure end of life care is managed and coordinated from the Medical Home with support, wherever possible and appropriate
Maaori Health Improvement Work closely with Primary care partners to develop and monitor Maaori Health Plans: ▪ Develop a process to receive, feedback, approve and monitor Maaori Health Plans ▪ Ensure Maaori Health Plans include actions to increase accuracy of ethnicity collection and recording and strategies to increase the enrolment of Maaori into primary health organisations	▪ Primary health organisations have submitted Maaori Health Plans ▪ Maaori Health Plans are signed off by General Manager Maaori and Group Manager Primary Care
Advance Care Planning ▪ Participate in Advance Care Planning Maaori Task Team ▪ Participate as the lead DHB for the Pacific Tools Task Team ▪ Continue to deliver Advance Care Planning training, support and leadership to Primary Care across all four localities	▪ Development of an Advance Care Planning process and communication approach that identifies and meets the needs of Maaori and Pacific ▪ Advance Care Planning training, support and leadership provided to Primary Care ▪ 700 Advance Care Planning conversations completed ▪ 120 Advance Care plans completed

3.3.2 Maternal and Child Health

14 percent of all births in New Zealand are to women living in Counties Manukau. Approximately 8,500 babies a year are born in CM Health of whom more than 50 percent are born to Maaori or Pacific mothers and a high proportion who live in areas of high socioeconomic deprivation. Women of childbearing age make up 30.4 percent of the total CM Health population. While our maternity and child health system is well regarded for the quality of care it delivers, CM Health has more women and children with high health needs during pregnancy than any other part of the country. Women with high health needs include obesity, smokers, teenage mothers, older mothers and those whom have had several pregnancies. CM Health wants to see improvements in our overall maternal and child health services that deliver clinically and socially integrated care.

Our challenge in the 2013/14 year is to ensure that the multiple national, regional and local drivers of change in the maternal and child health system are well integrated. CM Health will focus on ensuring that these initiatives are consistent, connected and integrate well for our mothers and babies.

Those drivers include but are not limited to:

- *Nationally* - Better Public Services; Supporting Vulnerable Children and the government's Children's Action Plan, Rheumatic Fever, National Health Target (Immunisations), Maternity Quality Safety Improvement Plan, Prime Minister's Youth Mental Health Plan
- *Regionally* – Northern Regional Health Plan Child Health Plan and Youth Health Plan
- *Locally* – Independent Panel's Review of Maternity Care, Manukau and Mangere/Otara Locality Priorities for mother and baby services, Whaanau Ora implementation

While these initiatives aim to achieve the same objectives, they must work together efficiently and effectively with the mothers and babies of CM Health at their centre

Linkages

Green Paper; White Paper; Children's Action Plan; Primary Care Initiatives; the CM Health strategy for Better Health Outcomes for All, specifically the First 2000 Days Programme; CM Health Immunisation Strategy; the recommendations from the external Maternity Care Review; The Maternity Quality and Safety Programme; and the NRHSP – Child Health Implementation Plan (CHIP); Youth Health Implementation Plan; Minister's Youth Primary Mental Health Initiatives; Whaanau Ora programmes and Mana Kidz; CM Health Maaori Health Plan (Indicator 11)

Action to deliver improved performance	Health system success is measured by
Higher coverage and more equitable access to universal services and primary care	
Maternity Implement the External Maternity Care Review action plan that includes: ▪ increasing access to family planning and contraception services by reviewing available capacity, particularly for at risk women ▪ LMC care for early assessment and continuity of care during pregnancy ▪ Develop strategies to provide appropriate and affordable contraceptive advice in a timely manner ▪ Identifying vulnerable women and	▪ Pregnant women are booked and engaged with a Lead Maternity Carer (LMC) and have accessed Antenatal Care (ANC) by week 12 of their pregnancy whilst maintaining existing relationships with primary care ▪ 50 percent by June 2014 ▪ 70 percent by June 2015 ▪ 85 percent by June 2016 ▪ LMC's and other maternity care providers across the health care continuum will be able to access the same information ▪ Women not enrolled with a PHO remains at

establish the services required to support them ▪ Multi-media tools specific to our Maaori and Pacific Island populations will be developed following consultation with community focus groups. The key message will be to promote early engagement with an LMC ▪ Increase the availability of self employed midwives, with focus on Maaori and Pacific LMC to work closely with GPs and be aligned specifically to a practice ▪ A project will begin in June 2013 to include the development of community midwifery specialist roles, 6 new graduate midwives each working with experienced midwives in partnership with 6 GP practices ▪ Facilitate training and education within localities to ensure that women enrol in maternity care by 12 weeks gestation ▪ Increase resource in GP Liaison role to support linkages with maternity and primary care (.2FTE) ▪ Service delivery of pregnancy and parenting education will include kaupapa Maaori classes and classes specific for teenage mothers	=or < 3 percent ▪ Seamless handover processes from GP, LMC and WC providers designed and written up by Q2 ▪ Seamless handover processes implemented ▪ New graduate midwives are supported to work in partnership with GPs and in localities ▪ The number of self employed midwives in CM Health increases ▪ Education programmes are targeted to ethnic populations; women are ready, empowered to choose, when they want to have children ▪ Women access appropriate advice and affordable contraception in a timely manner ▪ Improve outcomes for women and infants by preventing unwanted pregnancies ▪ Training and education programmes provided quarterly to ensure timely and effective referral processes from GP to LMC ▪ Antenatal care will be provided to support increased access rate for Maaori and Teenage Mums
Maternity Clinical Information System ▪ CM Health's roll-out of the National DHB Maternity Clinical Information System (MCIS): ▪ Operationalise CM Health's business case for implementation and year one roll-out of the MCIS	▪ Maternity Clinical Information System to go 'live' by 1st October 2013 ▪ All clinicians/providers adopt and use the system in clinical and business practice ▪ All women admitted to CM Health Maternity service will have an electronic record that can be shared with primary care
▪ Handover processes and referral guidelines will be reinforced, specifically between GP, LMC and WC providers	▪ Maternity care is seamless and women receive timely access to services ▪ LMC's are profiled with inclusion of ethnicity and information available to support health professionals advise pregnant women about LMC services and their options of care ▪ Pregnant women receive continuity of care by a LMC
Well Child Service Delivery ▪ Well Child/ Tamariki Ora (WCTO) provider forum to discuss and agree the Tier Two WCTO schedule set up and completed Q1	▪ WCTO providers are briefed on the opportunities for service development within the Tier Two Service Schedule ▪ Maternity care providers to engage with WCTO providers for services as specified in Tier Two of the WCTO schedule

	▪ Services are available to meet the needs of vulnerable women
Before School Checks (B4SCs) ▪ Routine contract reviews completed for B4SC providers. These include coverage reports, referral data, and participation in the case review forums	▪ At least 90 percent of all eligible children receive a B4SC, including at least 80 percent of children in most deprived regions ▪ Referrals to services are completed and children access services in a timely manner ▪ Clinical support and supervision is in place for frontline clinical staff
Vulnerable Women ▪ Linked to workstream in the External Review of Maternity Care Action Plan ▪ Pregnancy and Parenting Services will be reviewed and recommendations made for services to be established to meet the needs of vulnerable women. Vulnerable women identified are likely to be teen age women, families where English is a second language, Maaori, Pacific, families in low decile areas	▪ Pregnant woman can access DHB funded parenting and pregnancy education through LMC and GP referrals. Vulnerable families are prioritised *Reporting requirements:* ▪ Quarterly CFA Performance Reporting
More timely access to specialist and referred services	
▪ Demonstrate improved access to maternal/perinatal mental health services for pregnant and postpartum women ▪ Develop pathway for access to the appropriate level of care ▪ Clear definitions of waiting times for wait times for non-urgent referrals and identified and identified targets established	▪ No waiting times for LMCs and DHBs urgent referrals for women to maternal/perinatal mental health services. Maximum of 3 weeks waiting times identified for non-urgent referrals ▪ Pathways for access to appropriate levels of care are developed and implemented
▪ The CM Health Obesity pathway provides information for Primary Care Services about referral processes. This pathway will be implemented by Q3 ▪ Review of current referral pathways to paediatric audiology and ophthalmology ▪ Review of waitlists that exist because proof of eligibility is outstanding ▪ Design a whole of system approach for paediatric outpatient care with a focus on management of follow up care ▪ Complete a service review of paediatric disability services in CM Health. A key goal is sustainability of services and to develop services in particular for children who are Maaori or Pacific	▪ All infants and children identified as requiring referral for specialist advice or care receive timely access to appropriate services ▪ Children referred following a B4SC are seen before their fifth birthday ▪ Processes to support screening of eligibility are implemented by Q3 ▪ Multidisciplinary teams are established in localities to support access to paediatric outpatient care that is better, sooner and more convenient ▪ Quality sustainable Child Development Services for children with disabilities and domiciled in Counties Manukau *Reporting requirements:* ▪ Quarterly CFA Performance Reporting

Quality improvement across all services	
▪ Consolidate the Maternity Quality and Safety programme (MQSP), and identify actions for 2013/14 to embed MQSP as business as usual by June 2015 ▪ The implementation of the Counties Manukau Maternity Quality and Safety 2013/14 Programme actions will all be transitioned to business as usual by June 2015	▪ Improved quality and safety of maternity services including improved access, outcomes and consumer satisfaction ▪ DHBs who are outliers in the New Zealand Maternity Clinical Indicators put programmes in place to review clinical care in these areas and reduce unnecessary variation in clinical practice
▪ The CM Health B4SC Clinical Advisory Group review clinical case notes, data and service quality ▪ DHB funding to have a dedicated B4SC Clinical Coordinator as well as the B4SC Administrator	▪ 5 percent of cases are reviewed monthly ▪ 5 percent of clinical case notes audited monthly ▪ CM Health has funded a Clinical Coordination role across all B4SC Service Providers
▪ Incorporate Quality Improvement Framework (in development 2012/13) across all WCTO services including B4SC	▪ CM Health will implement our WCTO Quality Improvement Plan, building on national and local reviews ▪ Unnecessary variation in the delivery of WCTO is reduced ▪ Access to WCTO and associated services is improved by 20 percent *Reporting requirements:* ▪ Quarterly CFA Performance Reporting
Regional child health	
▪ Work collaboratively with the Northern Region DHBs to achieve the activities outlined in the Northern Region Child Health Implementation Plan	

3.3.3 Acute and Unplanned care

Acute presentations and unplanned care in CM Health is increasing beyond forecast funding, service changes are therefore required to reduce demand on hospital services. The initiatives required to reduce acute demand need to be implemented across the healthcare system from pre-emergency department referral, acute inpatient admissions to reducing unplanned readmissions.

CM Health has multiple initiatives in place to reduce unplanned hospital admissions, readmissions and acute length of stay, including:

- Proactive risk identification and care planning for high risk individuals
- Intensive support and coordination for very high users of acute care, including medication review, ambulance diversion and home monitoring
- Locality Clinical Partnerships which are redesigning care pathways and models of care between primary and secondary care
- Direct primary care access to diagnostics, support and community care through Primary Options for Acute Care (POAC), Access to Diagnostics (ATD), Chronic Care Management (CCM) programmes and Very High Intensive Users (VHIU)

This section describes the actions that aim to bend back the acute demand curve – 20,000 Days campaign to reduce acute presentations by 20,000 days and hospital based acute medicine service improvements. In 2012/13 we established a first tranche of 8 programmes to reduce our acute inpatient bed demand by 20,000 days. In 2013/14 we will extend this programme to 13 with additional clinical pathways and improvement initiatives to further reduce our acute growth by an additional 20,000 days.

This section should be read in conjunction with the Primary Care section that outlines increased access to primary care based initiatives that aim to reduce acute demand such as POAC, CCM, access to after hours and the Health Target: Shorter Stays in Emergency Departments.

Linkages

CM Health Maaori Health Plan (Indicators 5, 11 and 12); Northern Region Health Plan; government health targets

Action to deliver improved performance	Health system success is measured by
Acute Coronary Syndrome	
▪ Continue implementation of the Cardiac ANZACS QI (All NZ Acute Coronary Syndrome Quality Improvement) and Cardiac Surgical registers ▪ CM Health will continue monitor on a monthly basis to ensure we achieve the angiogram risk assessment and Primary PCI targets. Corrective actions will be taken as necessary ▪ Work in partnership with the Regional Clinical Cardiology Network to support and monitor service development within the Northern Region	▪ Monthly KPI monitoring for all targets will continue ▪ Quarterly KPI reporting will continue by the Northern Cardiology Network Team ▪ 70 percent of high-risk patients will receive an angiogram within 3 days of admission ▪ 95 percent of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS Q1 and Cath/PCI registry data ▪ 80 percent of patients presenting with ST elevation myocardial infarctions and referred for Primary Coronary Intervention will be treated within 120 minutes *Reporting requirements:* ▪ National Health Target Performance Reporting
20,000 Days	
New models of care and service integration through the 20,000 Days campaign initiatives - refer to 3.4.4 for the 13 related initiatives.	

3.3.4 General Medicine

Avoidable inpatient admissions and readmissions are a poor health outcome for patients and an inefficient use of costly and strained hospital resources. General Medicine is the filter to medicine sub-specialties and has a key role in determining the direction of a patient's journey. Efficiencies and improvements in General Medicine are expected to generate wider efficiencies and quality improvements reducing the pressure on Middlemore Hospital and improving the care of patients with Long Term Conditions in the community. This stream of work aims to:

- Place patients on their optimal clinical pathway as early as possible in their journey
- Reduce admissions of sub-acute patients
- Admit patients to their home ward

- Ensure that in-patients with long term conditions are discharged in a planned manner that is integrated with primary care providers to improve their health outcomes and reduce readmission rates.

This activity works alongside primary care initiatives outlined in Primary Care Section.

Action to deliver improved performance	Health system success is measured by
▪ Medical Assessment Unit (MAU) to open November 2013 to provide an efficient service for non-critical medical patients presenting acutely to the hospital via ED or directly from GPs ▪ MAU collaborative (including primary care) to optimally integrate hospital based model of care with locality planning ▪ Develop and implement discharge bundles for better long term care and reduced readmissions	▪ Reduction in the number of patients with LOS<28 hours admitted to an inpatient medical ward ▪ Reducing readmission rates *Reporting requirements:* ▪ OS3 & OS8 Quarterly Performance Reporting

3.3.5 Long Term Conditions

Action to deliver improved performance	Health system success is measured by
Diabetes Care Improvement Packages	

▪ $250,000 has been identified to cover incentive payments targeted to General Practices to deliver more heart and diabetes checks and DCIP for patients not already screened
▪ Improve the skills and knowledge of diabetes clinical workforce in primary care:
  ▪ PHOs practice nurses to complete online NZSSD resource within 12 months
  ▪ Specialist Diabetes service to provide training on foot checks and care
  ▪ Promote the Certificate of Achievement in Diabetes Care and Management to practice nurses
  ▪ Participate and support regional activities around workforce development for diabetes self-management education
▪ Encourage Practices to identify and accurately code patients with diabetes, and stratify according to risk/need. The main focus will initially be on those patients who are not currently well controlled and working with a multi-disciplinary team within a locality setting to prevent future (re)admission to hospital
▪ Reporting
  ▪ Continue to collect data from the PHOs through the electronic Diabetes Annual
	▪ Measurement of improved diabetes outcomes using a set of nationally consistent clinical indicators, phased in over time
	▪ Improve or maintain appropriate management of microalbuminuria in patients with diabetes
	▪ Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control
	Reporting requirements:
	▪ PP22 Six monthly Performance Reporting

Review form ▪ Diabetes review data will be collected by DHBNZ PHO Performance Programme for diabetes detection and diabetes follow up after detection ▪ Diabetes Project Trust to support Practices to improve the provision of care to diabetes patients through audit services and tailored support to practice staff. This service is specifically targeted towards practices with high numbers of Maaori and Pacific patients as well as those with high diabetes prevalence ▪ Practices to utilise audit tools to identify patients who are overdue for retinal screening, foot check or patients who have an HbA1c or blood pressure above recommended value ▪ The Long Term Conditions Clinical Governance Group which includes clinicians from both primary and secondary care and acts as the 'Local Diabetes Team' will continue to provide leadership and governance ▪ This group is Chaired by Dr Campbell Brebner – Chief Medical Advisor – Primary and Integrated Care ▪ PHO performance is monitored and reviewed through monthly DCIP reports ▪ Practice Level Diabetes report will be developed in partnership with primary care and will be sent out as part of the CCM monthly reports ▪ Implement actions recommended from the Retinal Screening Review by Quarter 4 ▪ Complete 11,300 retinal screens in the community ▪ Extend virtual clinics with SMOs running clinics – triaging and discharging patients back to primary care for management ▪ Engage with Localities in long-term management of Maaori & Pacific diabetes patients – education/up-skilling of GPs ▪ Develop Nurse Practitioner capability within the specialist diabetes service ▪ Practices will provide insulin initiation and titration to clinically eligible patients (funded	

by the DHB)
▪ Develop a process for improving the identification and management of the High Risk Foot, including the availability of podiatry services by Quarter 4
▪ PHOs to deliver Diabetes Self Management Education (DSME) for target populations
  ▪ PHOs to deliver both Diabetes SME and the Stanford model of SME
  ▪ Nutrition and exercise advice will be included in all group SME programmes
  ▪ Identify the self-management education needs of the pre-diabetic patient and develop a plan by Quarter 3	

Long Term Conditions with Primary Care	
▪ Provide each locality with timely utilisation data that informs a global budget from which reduced utilisation to key services result in shared savings ▪ Utilise the Patients at Risk of Readmission (PARR) tool to identify patients who are at highest risk of readmission and support primary care teams to provide wrap around services in order to prevent representation to hospital ▪ Significant additional funding to be made available to Primary care to enable extended consults and other value added services to be provided within the broader primary care practice team as an alternative to secondary or outpatient referral ▪ Each practice will continue to work with a lead secondary care SMO and the Very High Intensive User (VHIU) team to collectively provide wrap around support for patients who are identified at highest risk of hospital admission ▪ Extra resource will be targeted to primary care teams for value added services to enable more comprehensive care of these individuals in particular Maaori & Pacific, and notional budgets are being established for closer management of referrals and support ▪ Risk stratification is also a key aspect of the CCM redesign within CM Health, and a prerequisite for participation in the programme ▪ CM Health will continue to play an active role	▪ Acute presentations will reduce in line with the shift in funding to support the development of community services within localities ▪ 5 percent reduction in acute presentations year on year ▪ 3 percent reduction in acute medical and ASH rates ▪ Locality staff will have designated clinical contacts within ED and APU for assistance with ED turn around ▪ The design and management of the new Middlemore APU will be jointly undertaken by secondary and primary clinicians *Reporting requirements:* ▪ PP22 Quarterly Performance Reporting

in the design and implementation of key clinical pathways, which is being managed regionally through the GAIHN clinical pathway. Pathways prioritised for implementation in 2013/14 include: TIA, COPD, Adult Depression, Chronic Kidney Disease. These will be promoted via primary care networks, including PHO staff ▪ PHO will demonstrate access and participation of Maaori & Pacific patients in order to access to additional funding for management of high risk individuals; redesign Chronic Care Management system to incentivise outcomes by Quarter Three ▪ Continue to work with NHC as the lead agent for Whaanau Ora in our district to implement a Whaanau Ora network as part of the broader Localities strategy ▪ Continue to progress with the development of an integrated model of the various self-management education initiatives; prioritise and implement recommendations from stakeholders in collaboration with primary and secondary care by Quarter Four; continue to support the delivery of group courses in the community and be involved in the development of Diabetes self-management education guidelines and standards at a regional level, in partnership with primary care ▪ Implement the new Chronic Care Management Programme, including quality improvement processes and outcomes based funding. Practice plans, including risk stratification of patients with long term conditions, and actions required in order to meet agreed targets will be implemented by Quarter Four. Outcomes based indicators will be focused on Diabetes and CVD management initially and linked to the Diabetes Care Improvement Package. A set of Long Term Conditions Indicators will be reported on regularly including ethnic breakdown	
Stroke Services	
▪ Work with the National Clinical Stroke Network to improve access to specialist stroke services and to achieve consistent practice within the Stroke Service ▪ Review staffing model for Acute Stroke Unit	▪ **Q1:** Education and training provided for EC staff for thrombolysis ▪ TIA Clinic evaluation completed ▪ Process for ensuring stroke patients are reviewed/admitted to stroke unit in place

▪ Develop an acute afterhours thrombolysis service or a pathway to access it ▪ Evaluate the impact of the Transient Ischaemic Attacks (TIA) clinic on TIA admissions and ALOS ▪ Support implementation of regional clinical pathway for TIAs ▪ Dedicated areas for management of people with stroke (rehabilitation services) ▪ Collaborate with acute and primary care services to better co-ordinate the patient journey and outcomes for stroke rehabilitation services ▪ Review benchmarking performance data ▪ 'Best practice' protocols for the assessment and management of stroke are followed including cultural competencies ▪ Structure rehabilitation to provide as much practice as possible within the first six months after stroke ▪ Provide ongoing education for staff, patients and families/caregivers in both acute and rehabilitation settings	▪ 60 percent of stroke patients admitted to stroke unit or organised stroke service with demonstrated stroke pathway ▪ **Q2:** Expansion of TIA clinic (up to 2 per week) ▪ Stroke Ward RN education: 50 percent trained (stage 1-3 stroke education) (baseline 30 percent) ▪ 70 percent of stroke patients admitted to stroke unit or organised stroke service with demonstrated stroke pathway ▪ **Q3:** Stroke Ward RN education: 80% trained (stage 1-3 stroke education) ▪ Afterhours pathway for thrombolysis finalised and implemented ▪ 6 percent of potentially eligible stroke patients thrombolysed ▪ 75 percent of stroke patients admitted to stroke unit or organised stroke service with demonstrated stroke pathway ▪ **Q4:** Stroke Ward RN education: 100 percent trained (stage 1-3 stroke education) ▪ 80 percent of stroke patients admitted to stroke unit or organised stroke service with demonstrated stroke pathway ▪ 75 percent of eligible patients who are discharged from stroke rehabilitation services that are followed up in outpatient clinic within 3 months *Reporting requirements:* ▪ PP20 Quarterly Performance Reporting

3.3.6 Health of Older People

Community support services for older people	
▪ Ensure provider implementation of the revised Home and Community Support Sector Standard NZS 8158:2012 by 1 September 2013 ▪ Use the core quality measures for Home and Community Support Services identified by the DHB HOP Steering Group for each level of management ▪ Formally establish baselines for the core quality measures (once produced by the Ministry of Health and HIQ) and benchmark with other DHBs	▪ Evidence of proactive risk management in relation to the provisions of Home and Community Support services ▪ Monitor and provide support to contracted Home and Community Support Service providers to hold a certificate of conformance with the Home and Community Support Sector Standard NZS 8158:2012 by 1 September 2013 ▪ Evidence that CM Health is utilising core quality measures at each level of management

▪ A recommendations paper from Localities Clinical Partnerships outlining a preferred Home Based Support Services model of care that is culturally responsive to the diverse CM Health population, for endorsement and implementation to deliver improved equitability of service to enable people to continue to live safely in their home as they age, develop long term conditions or following illness or hospitalisation ▪ Development of an accurate database for client numbers and service requirements/ demands ▪ Identification of a preferred HBSS model of care and purchasing framework	▪ Evidence that the DHB has established baselines for core quality measures and benchmarked with other DHBs ▪ Evidence of benchmarking with other DHBs by 30 June 2014 ▪ Recommendation paper completed and submitted to CM Health Board for endorsement ▪ Continue to hold quarterly Home Based Support Services Strategic Forums to provide an opportunity for collaborative discussion between the DHB and providers regarding service model of care, purchasing frameworks and any implications related to implementing the revised Home and Community Support Sector Standards ▪ We will participate in a home-based support services costing exercise through the HoP steering group led by the lead DHB CE for HoP *Reporting requirements:* ▪ PP23 Quarterly Performance Reporting
Wrap Around Services for Older People	

▪ By 30 June 2014 Franklin Locality will have commissioned the Coordination / Rapid Response Service
▪ By 30 June 2014 The Eastern Locality Care Cluster pilot will have rolled out to further Practices in the Eastern Locality
▪ Develop and introduce an acute geriatric inpatient model of care to improve rapid response discharge planning, patient outcomes and bed utilisation efficiency and effectiveness of older people by:
  ▪ Collaborating with general medicine, EC and general practices; integrated level of care locality teams to ensure admission and discharge criteria is appropriate to meet population needs
  ▪ Communicate outcomes / recommendations of delirium, falls, pressure injury care, cognitive screening in care planning and discharge planning
▪ Organise multidisciplinary team care to minimise de-conditioning during the acute episode resulting in increased rate of discharged home
	▪ A reduction in acute admissions from the Franklin Locality and a reduction in the LOS of residents of Franklin Admitted to MMH (Supported Discharge)
	▪ A reduction in acute admissions from the Eastern Locality and reduction in LOS of Eastern Locality residents admitted to MMH (Supported discharge)
	▪ Benchmarked readmission rates for CM Health 75+ population with other DHBs
	▪ A reduction in length of stay for acute geriatric patients by maintaining 5 days for the acute episode of care in AT&R wards
	▪ Decrease in readmission rates of over 65 year old patients back to AT&R within 30 days by 8 percent
	Reporting requirements:
	▪ OS8 Quarterly Performance Reporting

Comprehensive Clinical Assessment in residential care	
▪ Support groups already trained in LTCF interRAI to embed practice ▪ Identify groups that are already going to be trained in LTCF interRAI and work through a pre – checklist of support needs ▪ Work with those groups that have not yet been trained in LTCF interRAI and offer a pre – checklist of what to prepare for ▪ Participate in budget re-forecasting process being led by the LTCF project group	▪ 32 percent of facilities trained in LTCF interRAI by 30 June 2014 ▪ All Age Related Residential Care facilities will be engaged with interRAI by June 2014 *Reporting requirements:* ▪ PP23 Quarterly Performance Reporting
Dementia pathway	
▪ Apply best practice in dementia care into a pathway that provides clarity of access to services across the continuum as set out in the National Dementia Care Pathway Framework (2013) ▪ Complete establishment of dementia team and training ▪ Set up Governance/Expert Group with membership from GP liaison, Clinical Leaders, Alzheimer's Auckland and Senior Management ▪ Provide ongoing engagement with Primary and Community Care promoting the integrated care model and raising awareness for Dementia, both for the development of the pathway phase (completed) and the implementation phase ▪ Provide ongoing awareness programmes for Primary and Community care on the new service model; and key issues for patients and carers (driving, referral process, diagnosis, carer support, legal matters) ▪ Roll out dementia pathway to GP practices and primary care practices ▪ Provide 3 month and 6 month evaluation reports ▪ Undertake a 12 month evaluation by Auckland University	▪ Implementation of best practice pathway by 30 June 2014 ▪ 25 percent of new patients referred with Dementia will be seen by the Dementia Care Service ▪ Additional measures to be further developed by the project team including: ▪ Number of education sessions ▪ Numbers of assessments by practice and source ▪ Delay in placement to residential care ▪ Avoided admissions ▪ Reduced length of stay *Reporting requirements:* ▪ PP23 Quarterly Performance Reporting
Community specialist Health of Older People teams	
▪ Provide proactive support to ARRC and primary care by Gerontology Clinical Nurse Specialists (CNS) and Geriatricians ▪ Provide regular educational sessions to Registered Nurses in ARRC	▪ 50 percent increase in number of Age Related Residential Care Facilities provided proactive advanced nursing practice support programmes (20 facilities provided support) ▪ Maintain attendance rate for nursing

▪ Continue ATTRACT training support ▪ Ensure workforce planning in Geriatricians and Clinical Nurse Specialists supports this objective ▪ Establish a baseline for 'inappropriate' admissions between the community and residential care	education sessions at 500 people per year ▪ Provide 25 hours Geriatrician support per month to 5 primary care practices including clinics and education sessions with GPs ▪ Provide 26 hours Geriatrician support per month to 6 Age Related Residential Care Providers for medication review case conferences ▪ 15 percent decrease in number of inappropriate presentations to Emergency Care from Residential Care ▪ 5 percent decrease in number of presentations to Emergency Care from retirement villages ▪ 25 percent increase in percentage of villages providing nurse-led clinics *Reporting requirements:* ▪ PP23 Quarterly Performance Reporting
Elder Abuse Guidelines	
▪ Implement the Elder Abuse Guidelines through the development and sign off of an Elder Abuse procedure ▪ Recruit and pilot new Elder Abuse and Neglect (EAN) Coordinator role (0.4 FTE) for twelve months to support the implementation of MoH EAN Guidelines (2007) ▪ Review of MoH EAN Guidelines (2007) ▪ Finalise CMDHB EAN Procedure and obtain CMEC approval ▪ Consult and collaborate with MoH / National VIP Programme Manager to ensure national standardisation and compliance ▪ Develop EAN training package ▪ Develop an EAN programme implementation plan for integration into VIP and roll out in designated service areas (AT&R, NASC, HHC and District Nursing services) ▪ Monitoring and evaluation of VIP EAN Programme utilising quality improvement toolkit (to be provided by the MoH)	▪ Elder Abuse procedure to be drafted and presented to the board by 30 June 2014 ▪ Recruitment of EAN Coordinator ▪ Finalised CMDHB EAN Policy and procedure ▪ An approved EAN programme implementation plan ▪ Developed VIP EAN Training Package *Reporting requirements:* ▪ PP23 Quarterly Performance Reporting
Fracture Liaison Service	
▪ Coordination of future care for fragility fracture sufferers to ensure preventative measures are implemented to minimise the	Targets to be established during implementation of fracture liaison service, recommended measures include:

risk of future fractures ▪ Increase identification rate for fragility fractures by establishing a screening process where patients suffering potential fragility fractures are triaged for follow up and assessment by a fracture liaison service ▪ Increase treatment rates for fragility fracture sufferers by better identifying and screening these patients as they pass through secondary care and providing appropriate treatment through a fracture liaison service	▪ The identification rate and treatment rate of fragility fractures in secondary care services ▪ The number of patients provided treatment for the prevention of fragility fractures ▪ Rate of further fractures for patients having suffered a previous fracture *Reporting requirements:* ▪ PP23 Quarterly Performance Reporting

3.3.7 Mental Health and Addiction Service Development

CM Health is committed to achieving the goals of the Service Development Plan (SDP) and ensuring that this document along with Blueprint II is the underpinning framework for our strategic and annual planning processes. We are currently developing a Strategic Action Plan for Mental Health & Addictions (MH&A) in Counties Manukau that will outline our 5 year priorities and actions, and ensure delivery of the goals of the SDP and contribute to the achievement of the organisational goals of CM Health. To develop this plan we are working collaboratively to bring together the views, ideas and priorities of key stakeholders from across the different parts of the sector including the Northern Regional Alliance Network, as well as those who interface with the Mental Health & Addictions sector. The Mental Health & Addictions Advisory Committee has been guiding the development of the plan and consumer leadership has been a key component with representation from the Mental Health Consumer and Alcohol and Other Drugs (AOD) Consumer Networks as part of the leadership group.

We have identified our purpose and key priorities as follows and are now working to develop our objectives and measures. Our purpose is to support community wellbeing and ensure the people of Counties Manukau experience seamless, empowering Mental Health & Addiction services and are able to access them in a timely and appropriate manner.

To achieve this, our priorities are:

- *Improved Integration* - People experience efficient, integrated and connected health services
- *Early Intervention & Increased access* - People can easily access services & information that builds resilience & promotes recovery
- *Building on Gains* - People can access services that enable recovery at any stage of their life journey

Linkages

Prime Minister's Youth Mental Health Project; Northern Region Health Plan (NRHP) – Mental Health and Addiction workstream; CHAMP (NGO DHB Providers Collaborative); CM Health Maaori Health Plan (Indicator 17); ARHOP Dementia Pathway collaboration

Action to deliver improved performance	Health system success is measured by
Make better use of resources/value for money ▪ In conjunction with primary care, undertake a comprehensive gap analysis between the actions identified in the SDP and current service provision model. This will include service mapping to identify the most efficient pathways to ensure better alignment to local	▪ Report on actions already achieved and review service model to identify changes required to meet the actions not achieved (Q1). Develop implementation plan to apply required changes over the next 3 years (6 month milestone) and implement the identified changes for the first year (12 month milestone)

population need. ▪ Develop a plan for older person's acute community options to ensure the provision of efficient and effective services	▪ Data analysis and literature review complete (6 month milestone). Plan developed (12 month milestone)
Improve primary secondary integration ▪ Explore the feasibility of shared care/discharged to general practice for identified people on clozapine ▪ Determine the feasibility of co-location of Te Rawhiti with East Health by January 2014 ▪ Commence implementation of the acute adult services component of the Framework for change by December 2014	▪ Agreed protocols/shared care for general practice for identified people on clozapine (6 month milestone). Pilot implementation of the protocols (12 month milestone) ▪ Lease availability, terms and future options identified (6 month milestone). Options paper (6 month milestone) ▪ Implementation plan documented – June 2013 (6 month milestone). Triage scale implemented – March 2014 (12 month milestone)
▪ Support families of those with MH and/or AOD issues by developing services for Children of Parents with Mental Illness and/or Addiction (COPMIA) ▪ Reduce the use of seclusion and restraint	▪ COPMIA: Identify type of service delivery and amount of service needed for population (6 months); services are contracted and available to the Counties Manukau population (12 month milestone) ▪ Implement sensory profile assessment at admission (6 month milestone) and a reduction in the use of seclusion and restraint compared to baseline (12 month milestone)
Deliver increased access for all age groups ▪ Increase access to mental health services for the most vulnerable infants, children, family and youth to meet target set by the MoH ▪ Facilitate access to sustainable housing through increasing supported landlord services	▪ Staff working two clinic days per week within two different PHO's/localities (6 month milestone). Team locality focus plan completed (12 month milestone) ▪ Identify approach to increase supported landlord services (6 month milestone) ▪ Expand supported landlord services to ensure MH Consumers are able to obtain and sustain safe and comfortable housing (12 month milestone)
Increase access and/or improve outcomes for each of the following government work programmes: Drivers of Crime ▪ Extend school based alcohol and drug services into Alternative Education settings ▪ To deliver the Violence Intervention Programme (VIP) to all mental health clinical staff by July 2015: ▪ Identify service delivery plans and champions by June 2014	**Drivers of Crime** ▪ Expand school based alcohol and drug services into Alternative Education Settings. Reduce harm by alcohol and other drugs and improve access to treatment ▪ Contract for a increased resource (6 month milestone) and increase numbers of youth treated by school based alcohol and drug services (12 month milestone) ▪ Policies and procedures updated to support VIP role (6 month milestone). Identified clinical champions have completed training (12 month milestone)

Implementation of the Suicide Action Plan ▪ Development and implementation of population based resources that increase mental health literacy around depression and drug and alcohol ▪ Appropriate collection and compilation of self harm and suspected suicide data Welfare reforms ▪ Increase Supported Employment services to improve outcomes by enabling more people to gain sustainable employment ▪ Improve access to affordable, appropriate and safe housing for those with mental health and/or addiction issues	**Implementation of the Suicide Action Plan** ▪ Develop Mental Health First Aid package and trainings for Pacific Asian and mainstream; Undertaken training for Mental Health First Aid for Pacific, Maaori, Asian and mainstream communities ▪ 100 percent of suspected suicides will be provided by the coroner's office and disseminated to the appropriate people within 24 hours **Welfare reforms** ▪ Service development informed by review of current employment services with recommendations (6 month milestone) ▪ Contract for increased services in place (12 month milestone). Increased rates of employment for those accessing DHB mental health services by June 2014 ▪ Service development informed by project to understand the volume of unmet housing need and the issues facing consumers (6 month milestone) ▪ Contract for services in place (12 month milestone). Reduced waiting times for appropriate housing and increased support services in place to secure and retain housing by June 2014
▪ Regional Youth Forensic Services model of care implementation including additional community FTE ▪ CM Health's new 1.0 FTE will provide community based specialist services for local youth and contribute to regional development of the model of care	▪ CM Health contribution to regional goals through employment of 1.0 FTE youth forensics worker
▪ Work regionally to improve specialist AOD service access for youth ▪ CM Health has no new FTE resource for these services but will be working with the regional group to enhance service delivery models for the at risk population	▪ CM Health contribution to regional goals through 1.5 percent of 0-19 population in contact with specialist AOD services with a target of 1 percent in 2013/14 *Reporting requirements:* ▪ PP26 Performance Reporting
Integration of whaanau ora and fanau ola approaches for families with complex support needs ▪ Develop integrated approaches for Maaori and Pacific families with mental illness support needs through community based	• Enhanced at risk Maaori and Pacific family support through more two-way referrals between whaanau ora / fanau ora and mental health workers ▪ Review 2013/14 integration approaches to inform 2014/15 service planning action plan

referral of services as part of Locality service developments	priorities

3.4 Service Developments

3.4.1 Improved Access to Diagnostic Services

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

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

Linkages

Northern Region Radiology Network for regional collaboration; BreastScreen Aotearoa (purchaser of screening services); National Breast Cancer Working Group to establish best practice standards for breast cancer care; National Policy and Quality Standards; National Endoscopy Quality Improvement Programme including implementation of the NZ Global Rating Scale; Bowel screening pilot at Waitemata District Health Board (WDHB), CM Health Maaori Health Plan (Indicator 7)

Action to deliver improved performance	Health system success is measured by
Radiology ▪ 'Improving on excellence' – systematic process improvement initiative ▪ Accelerated sonographer training – Northern Region initiative ▪ Develop long term provider partnerships to improve access and capacity, such as outsourcing to ensure patient access is in accordance with assigned priority ▪ Demand management to reduce inappropriate referrals ▪ Increase scheduled operating hours ▪ Work with Greater Auckland Integrated Health Network (GAIHN) Access to Diagnostics project and Clinical Pathways groups and Localities planning to provide easier access to diagnostics by primary health providers including the development of triage criteria and structured GP/Radiology interface which will ensure patients receive their examination within the assigned clinical priority ▪ Regional collaboration (Northern Region Health Plan) through the Northern Region	▪ DV2: CT and MRI – 85 percent of accepted referrals for CT scans will receive their scan within six weeks (42 days); 75 percent of accepted referrals for MRI scans will receive their scan within six weeks (42 days) ▪ DV2: Diagnostic colonoscopy – 50 percent of people accepted as priority one for diagnostic colonoscopy will receive their procedure within two weeks (14 days); and 50 percent of people accepted as priority two for a diagnostic colonoscopy will receive their procedure within six weeks (42 days) ▪ DV2: Surveillance/Follow-up colonoscopy – 50 percent of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date ▪ Coronary angiography – 90 percent of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) (this is a Regional Target and exceeds the National Target of 85 percent) ▪ 70 percent of women in the 50-69 age

Clinical Radiology Network to agree and implement regional reporting and wait list targets and develop regional strategies to reduce waiting times for ultrasound, CT & MRI ▪ Regional collaboration (Northern Region Health Plan) through the Northern Region Clinical Radiology Network to develop a regionally integrated radiology information system platform including the regional roll-out of online teaching image library, and web-based paediatric radiology guidelines **Gastroenterology** ▪ Improve support for referrers via GP liaison, clinical pathway / referral guidance and Improve triage- utilising the national guidelines to ensure appropriate intervention ▪ Increase throughput/capacity of appropriate colonoscopies by increasing productivity in-house through quality improvement processes and production planning and consider further outsourcing ▪ Apply national referral criteria for prioritisation of referrals which determines the wait times for P1 as 14 days and P2 as 42 days and surveillance within 84 days of planned procedure ▪ Implement the national surveillance system to facilitate the collection of data and provide an accurate reporting mechanism ▪ Support the Bowel screening pilot at WDHB through the Regional Oncology Operations Group (ROOG) as a regional partner **Breast** ▪ Imaging: Evaluate initiatives to recruit and retain women to the programme with a focus on priority women; review access to services	group have had a screening mammogram in the past 24-month period *Reporting requirements:* ▪ National Health Target Performance Reporting ▪ DV2 monthly reporting

3.4.2 Cardiac Services

Cardiovascular disease is the leading cause of death for people at CM Health. Mortality rates for heart disease are higher among people with lower incomes. Rates of heart disease and mortality rates are significantly higher for Maaori and Pacific. Approximately 80 percent of cardiovascular issues can be influence by lifestyle changes. Demand for cardiovascular procedures has been growing at over 8 percent per year.

Linkages

Regional Cardiology Group to help ensure equitable and timely access to treatment; CM Health 20,000 Days initiative; CM Health Localities initiative; CM Maaori Health Plan (Indicator 6)

Action to deliver improved performance	Health system success is measured by
Contribute to the National Cardiac Clinical Network cardiac surgery targets by delivering: ▪ Cardiac surgery targets ▪ SIR targets for elective targets and initiatives	▪ 308 cardiac surgery discharges n 2013/14 ▪ S14: Cardiac Surgery SIR is 6.5 per 10,000
Improve access to cardiac diagnostics by: ▪ Meet Regional Cardiology Clinical Network Targets ▪ Continue to train nurse specialists to support roll-out of cardiac rehabilitation in the community and support the 20,000 days and localities initiatives ▪ Run extended lists over the winter period in the Cardiac Catheterisation Laboratory ▪ Employ an additional trainee sonographer to meet wait times target ▪ Continue implementation of coronary angiography scoring system to ensure up-to-data collection to enable accurate reporting	▪ 90 percent of people will receive elective coronary angiograms within 90 days (this is a Regional Target and exceeds the National Target of 85 percent) ▪ ESPI 2: 100 percent of patients will wait five months or less for first specialist assessment from June 2013 ▪ ESPI 5: 100 percent of patients will wait five months or less for treatment from June 2013 ▪ Maaori & Pacific community cardiac rehabilitation service developed and implemented ▪ Percutaneous revascularisation SIR is 11.9 per 10,000 of population ▪ Coronary angiography SIR is 33.9 per 10,000 of population ▪ 80 percent of all outpatients triaged to chest pain clinics will be seen within 6 weeks for cardiology assessment and stress test ▪ 95 percent of outpatient Echo referrals will be seen within 5 months of referral *Reporting requirements:* ▪ National Health Target Performance Reporting ▪ DV2 Monthly Reporting

3.4.3 Population Health

CM Health confirmed 3 population health priorities for the next 5 years. The majority of avoidable deaths (80 percent) and illness, much of the reduced quality of life, and a substantial portion of the health inequalities between Counties Manukau populations are related to conditions which are largely preventable. These conditions (diabetes, CVD, cancer and chronic respiratory disease) share common risk factors, underlying determinants and opportunities for intervention – smoking, unhealthy nutrition/obesity, physical inactivity and harmful use of alcohol.

CM Health communities also experience high rates of infectious diseases related to poverty and poor housing conditions (such as rheumatic fever, cellulitis and respiratory infections). Mental health conditions are also an increasing cause of illness and reduced quality of life.

Based on the review of current and previous activity, the current policy settings, emerging national priorities, expert advice, international experience, and application of a set of prioritisation factors, three

priority areas for CM Health's population health approach were identified and include; Housing, Smoke free and Early Childhood interventions (currently called the First 2000 days).

Linkages

Current government's commitment to Smokefree Aotearoa 2025; Better Public Service Key Result Areas, National Health targets (immunisation, quit smoking, heart checks); White Paper for Vulnerable Children and Children's Action Plan

Action to deliver improved performance	Health system success is measured by
Smokefree DHB by 2025	
▪ [refer to 3.2.5 "Better Help for Smokers to Quit" Health Target]	[Refer to 3.2.5 "Better Help for Smokers to Quit" Health Target] In addition to health target: ▪ Reduce overall smoking prevalence in Counties Manukau to 12 percent by 2018
First 2000 Days	
▪ Integrate services from peri-conception to pre-school age and ensure that these interact better with families, their babies and young children to provide the foundations for all CM Health children to reach their full potential [refer to 3.1.2 and 3.3.2 national and regional Maternal and Child Health actions]	[refer to 3.1.2 and 3.3.2 national and regional Maternal and Child Health actions]
Housing	

Minimise harm from poor quality housing by:
 	
▪ Improving access to quality housing
▪ Work with intersectoral partners to:
  ▪ increase referrals to retrofit insulation into private homes and private rentals
  ▪ continue the Healthy Housing Programme
  ▪ improve access to affordable housing for mental health consumers
▪ Through policy advocacy and engagement improve decision making to increase supply of housing (e.g. social housing, Auckland Council's Draft Housing Action Plan)
▪ Work with communities to mitigate the effects of poor quality housing through advocacy, research and community approaches
	▪ Reduce housing related hospitalisations between ethnic groups and groups with different socioeconomic status by 2040

3.4.4 Whaanau Ora

The Whaanau Ora programme, as promulgated by Te Puni Kokiri, has seen four successful business cases adopted by the three sector partners, i.e. the Kotahitanga business case (members from this district being

Papakura Marae, Turuki Health, Te Kaha o te Rangatahi), Te Ope Koiora business case (the only partner from this district being Raukura Hauora o Tainui), Alliance Health Plus and the National Urban Maaori Authority business cases. The latter does not have a relationship with health in the CM Health area, although we have engaged with this group and will continue to discuss their business case.

The three relevant business cases have progressed through to Plans of Action and Regional Information Plans, with funding allocated from Te Puni Kokiri associated with implementation of those plans. To date the DHB has had engagement at the planning level, with an emphasis on the integrated contracts approach.

For 2013/14 the objectives of CM Health is to support the Te Puni Kokiri Whaanau Ora Collectives to become mature providers through strategic development, capacity and capability development, and continued support for the implementation of their Programmes of Action. As outlined in our 2013/14 Maaori Health Plan, we will also progress implementation of the National Hauora Coalition's (NHC) Better Sooner More Convenient (BSMC) Whaanau Ora programme as the conduit for developing health related Whaanau Ora Integrated contracts.

Linkages

SOI 2011/14 – Integrated, Quality, Mature provider services; Maaori provider development work in association with MoH; CMDHB 2013/14 Maaori Health Plan

Action to deliver improved performance	Health system success is measured by
▪ Support regional health representation and participation to integrate strategic health advice and direction as part of the Regional Leadership Group (RLG) ▪ Work with Whaanau Ora Collectives to achieve 2013/14 priorities and monitor outcomes ▪ Share knowledge and support collectives on outcomes based contracting and alliancing ▪ Primary care collaboration in Whaanau Ora planning and service development to enhance support for whaanau	▪ Full participation by health (and in particular CMDHB) in the Regional Leadership Group's action and decision making processes ▪ Meetings held with Whaanau Ora Collectives on a quarterly basis, convened by TPK/MSD ▪ Identify with collectives priorities and monitoring outcomes for on-going follow-up and monitoring ▪ The outcome of the Whaanau Ora approach in health will be improved health outcomes for whaanau through quality services that are integrated (across social sectors and within health), responsive and patient/whaanau centred *Reporting requirements:* ▪ SI5 Annual Performance Reporting

3.5 Regional and National Collaboration (including Health Sector Agencies)

Counties Manukau DHB is an active partner in the Northern Region planning and governance processes. We are in year three of implementation of the Northern Region Health Plan (http://www.ndsa.co.nz) that has been developed by the four DHBs (Auckland, Waitemata, Northland and Counties Manukau) and their primary care partners. For 2013/14, this builds on the region's previous two plans and with an emphasis on demonstrative collaboration and delivering on regional workforce, IT and capital objectives and more detailed planning across regional priorities. Planned actions include significant changes to our business support systems, and in particular the regional focus around information systems, procurement and the supply chain. A number of our regional priorities are aligned with national agency initiatives, e.g. Health

Quality and Safety Commission First Do No Harm, IT Health Board Maternity Clinical Information System pilot etc.

The following key national health sector agencies have communicated their priorities through a National Health Board. Based on this information, prioritisation, savings and expenditure has been integrated into the Counties Manukau's Annual Plan and related templates. Relevant national health sector agencies include:

- IT Health Board (http://www.ithealthboard.health.nz)
- Health Benefits Limited (http://www.healthbenefits.co.nz)
- Health Quality and Safety Commission (http://www.hqsc.govt.nz)
- Health Workforce New Zealand (http://www.healthworkforce.govt.nz)

Linkages

National Health Board Annual Plan Guidance update on the above agency priorities for 2013/14; Northern Region Health Plan, National Maternity Clinical Information System project (Health IT Board), Maternity Clinical Information System pilot

3.6 Living Within Our Means

The challenge of living within our means cannot be overstated given the forecast revenue increase of 2.7 percent is just over half of what is anticipated to maintain operations. The magnitude of savings required in the next three years requires the Executive Leadership Team commitment to achieve all the recommendations from the Financial Sustainability Taskforce. This is an in-depth review of the entire CM Health cost structure with a commitment to achieving savings while retaining service coverage.

Aligned to and parallel with this, the 2013/14 Annual Plan outlines year two of our system transformation investment through an increase in scale and pace of integration that delivers best value for public health system resources and continued focus on acute care system efficiencies.

- Tight cost control through budget management, shared system performance accountability and effective workforce skill mix specifically through the well established and successful Thriving In Difficult Times programme (Phase 3 of 4) now significantly enhanced beyond pure cost efficiency to modules of care, pathways and integration opportunities
- Localities development of new models of care and integrated service delivery that maximise outcomes and provides care in lower cost settings closer to where people live
- The use of regional and national service planning to reduce fragmentation and share resources through all clinical area opportunities, a regional capital production process and shared regional support services for these areas
- Purchasing improvement through regional and national shared procurement and supply services
- Productivity improvement through more effective service delivery and efficiencies
- A 'whole of system' approach to Living Within Our Means and working with hospital, government/funder, NGOs, PHOs to integrate to seek solutions

Linkages

- Intervention logic and Achieving a Balance portfolio of strategic programmes (section 2); Northern Region Health Plan; HBL collective actions

Action to deliver improved performance	Health system success is measured by
▪ Evaluate recommendations from the Financial Sustainability Taskforce that identify	▪ Implementation of recommendations from

revenue and saving opportunities across the organisation to achieve cost sustainability and a $3m surplus in 2013/14 and 2014/14 ▪ Localities development (refer section 3.3.1 through integrated and service shifts from secondary to primary care ▪ Direct referrals from primary care for elective procedures (refer section 3.2.2) ▪ Regional Elective Service Performance Indicator (ESPI) initiative to increase theatre productivity ▪ Collaborating with private providers and regional colleagues to identify effective outsourcing models e.g. Renal Haemodialysis ▪ Cap the level of allowable and fundable growth within provider and funder groups ▪ Analyse staffing costs and set expectations on the number of full-time employees by skill mix appropriate for acuity level ▪ New models of care and service integration through the 20,000 Days campaign initiatives: ▪ Healthy hearts (community rehabilitation) ▪ Better breathing (community rehabilitation) ▪ Rapid response and supported discharge ▪ Delirium care and management ▪ Hip fracture management ▪ Cellulitis and skin infection ▪ Enhanced Recovery After Surgery (ERAS) ▪ Transitions of Care ▪ Helping high risk people ▪ Safer Medicines Outcomes On Transfers Home (SMOOTH) ▪ Very High Intensive users (VHIU) ▪ Community Geriatric Service expansion into Aged Related Residential Care (ARRC)	the Financial Sustainability Taskforce ▪ Refer Localities development (3.3.1) ▪ Implementing the 20,000 Days initiatives that will save 20,000 bed days and deliver care in a more cost effective setting ▪ Reduced elective waiting times and related acute complications ▪ Comparative baseline data and cost tracking utilising finance systems and “Org Plus” establishment

4.0 Stewardship

4.1 Managing our Business

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

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

4.1.1 Governance

Our Board and Chief Executive hold overall responsibility for the performance, operation and management of the DHB and are supported at all levels of strategic or operational decision making by the Executive Leadership Team of clinical and managerial leaders, clinical forums and networks and advisory committees. All newly appointed Board members are provided with training on what their responsibilities are in relation to performance management and in accordance with the NZ Public Health and Disability Act 2000 (NZPHD Act 2000) every member of the Board must receive Tikanga Maaori training.

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

At a local level, our health system governance and accountability structure for performance management has been expanded from more traditional DHB planning and funding structures to better integrate primary/community care and hospital based services. The restructure has included introduction of the following governance groups:

- District Alliance of Primary Health Organisation (PHO) and CM Health Chief Executives
- Geographically based Locality[11] Clinical Partnerships (and related community advisory networks)
- A Whole of System Strategy Group (and related expert working groups) combining our PHO Executives and CM Health Executive Leadership Team including clinical and managerial leaders; and
- Change to the traditional Planning and Funding roles with establishment of the Strategic Planning and Primary and Community Health Services Directorates to support system level organisational change

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

[11] For Counties Manukau Health purposes, there are 4 localities and infrastructure being established to enable integration of health services within that geographical area. A locality typically contains a resident population of greater than 80,000 people. The four Localities include the Franklin, Eastern, Mangere/Otara and Manukau areas.

4.1.2 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 through operational and clinical management forums and to the Board and related sub-committees, i.e. the Hospital Advisory Committee (HAC) and Community and Public Health Advisory Committee (CPHAC) and others. Accountability for reporting is now better integrated with primary care as we seek to improve understanding of overall health system performance through shared accountability for population outcomes.

CM Health is in the process of extending this performance management process through development of 'System Level' and related impact and outcome measures to enable monitoring and evaluation of quality and service performance across the complete continuum of health care. This forms part of our commitment to system integration and we are currently working towards adoption of the Healthcare Excellence Framework in 2013/14, based on the Baldrige criteria for performance excellence.

Quality assurance is embedded within our quality and safety framework. We also have strategic partnerships with the Institute for Healthcare Improvement (IHI) to establish robust methods (e.g. Collaborative methodology) of system and service level analyses, innovation identification and implementation.

4.1.3 Financial management

The Minister for Health and National Health Board has indicated constrained funding increases from 2013/14 and this will require a highly effective financial planning and management system. Due to combined impacts of increased health service demand and reduced revenue increase of 2.7 percent that is just over half of what is anticipated to maintain operations, the financial management challenges over the next three years represent a significant and unprecedented challenge for CM Health.

The major driver of cost increases continues to be the total clinical wages cost, which inclusive of the automatic step function, is 3 to 4 times our funded cost growth. The 2013/14 plan is submitted with a $3m surplus and a commitment to achieve our national health targets.

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

CM Health utilises industry and public sector standard practices that ensure best practice financial management at both the macro and micro level. At a macro level there are robust budget, forecasting and reporting processes that link in all levels of management in a structured framework accountable to the Chief Executive and Board. At a micro level, funding providers requires a commercial approach to ensure our non-government organisation (NGO) providers remain viable.

Within this plan, CM Health financial projections are fully reconciled to the latest information from Health Benefits Limited (HBL) but are noted as having very little net benefit during the planned period. Of greater benefit to the Northern Region over the next three years would be for enhanced procurement benefits arising from the Northern Region ownership of healthAlliance.

Refer to section 7.0 for details of how the funding envelope will be allocated and related service volumes managed.

4.1.4 Risk management

Organisation level corporate and clinical risks are managed centrally through established policy and procedures that enables consistent risk identification, mitigation/actions reporting and management. Organisation risks are reviewed by operational divisions for local management are presented to Counties Manukau DHB's Board monthly, and at Audit, Risk & Finance Committee quarterly to ensure effective escalation, appropriate and timely attention to enable effective risk management.

4.2 Building Capability

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

Building capability in an environment of transformational change requires more than alignment of typical enablers. It needs a strategic approach to change management and transparency of investment prioritisation to optimise outcomes. Based on our strategic priorities, capability building is centred on the following systems, each benefiting from local, regional and national initiative alignment.

Figure 17: High level summary of capability drivers and related plans

Capability	Capability Contribution	High Level Plan Linkages
*Workforce**	Alignment to capacity management and emerging models of care See section 4.4 for the CM Health approach to implementation	CM Health: ▪ Enabling High Performing People programme with deliverables examples: Leadership Academy; Integrated HR framework; Workforce planning and modelling; Performance development framework Regional: ▪ Northern Region Training Hub (NoRTH) ▪ Engage the Workforce ▪ Change Leadership ▪ Integrated Care Models ▪ Grow a workforce that reflects communities National (Health Workforce NZ): ▪ Regional Training Hubs ▪ Supporting new roles/ways of working
*Quality and Safety**	Delivering excellence while being sustainable requires integration of quality safety from the campaign/initiative stages into business as usual See section 4.4 for the CM Health approach to implementation	CM Health: ▪ First, Do No Harm (combines quality & safety initiatives) Regional: ▪ First, Do No Harm National (Health Quality & Safety Commission & others): ▪ Improving medication safety ▪ Infection prevention and control (preventing healthcare-associated infections) ▪ Reducing harm from falls in healthcare settings ▪ Making surgery safer ▪ Target CLAB Zero (locally lead for NZ)
*Service Innovation**	Essential requirement for health system transformation and building capability in non-traditional service	CM Health: ▪ System Integration Programme including initiatives such as 20,000 Days campaign, Localities Development and others ▪ Innovation Hub

Capability	Capability Contribution	High Level Plan Linkages
	approaches in order to enable future health system sustainability	Regional: ▪ Better Sooner More Convenient (BSMC) business cases, e.g. Care Pathways, Primary Options for Acute Care etc, Whaanau Ora National: ▪ Innovation Hub (joint venture with Counties Manukau, Auckland, Waitemata and Canterbury DHBs) ▪ Shared services, supply chain and procurement (HBL)
*Information Technology& Information Intelligence**	How and where health information is accessed, data analyses and health scenarios modelling combined with hard infrastructure – these are critical clinical and service enablers	CM Health: ▪ Locality information systems Regional: ▪ Refer section 4.3.8 below National (Health IT Board & Others): ▪ eMedicines programme ▪ National Solutions ▪ Regional (DHB) Information Platforms ▪ Integrated (Shared) Care Initiatives ▪ Maternity Shared Care
Capital investment	An integrated asset management plan (equipment, hard infrastructure) that links service requirements (maintenance and developmental) with fixed and non-fixed investments	CM Health ▪ Investment Strategy (10 year – in development) ▪ Facilities Masterplan - Towards 20/20 aligned with; ▪ Enterprise Asset Management System Regional: ▪ Regional Capital Group National (Health Benefits Limited): ▪ Procurement and Supply Chain

*Note: Our Centre for Health Services Innovation (Ko Awatea) supports system level growth and continuous improvement through the Centres of Excellence, strategic partnerships with education organisations[12] and the Institute for Healthcare Improvement. This directorate is central to system transformation in collaboration with CM Health and PHO leadership.

4.2.1 Capital and infrastructure development

Towards 20/20 is our major long-term investment in building and refurbishment of CM Health facilities and services to support the growing needs of our community into the future. We have currently completed two phases of our three-phase development master plan based on a 20 year Health Services Plan (2008). Of significant capacity expansion and improved models of care are our acute surgical theatres and medical assessment and planning facility. The commissioning of our new Clinical Services Block in 2013/14 will support this.

The national economic and local health policy direction changes since that time has required an in-depth reassessment of our planning assumptions. In regard to our longer term asset plan, developing health system integration and Localities are cornerstone strategies to reduce long term acute demand through integrated non-acute and elective services (including a Whaanau Ora Centre, Integrated Family Health Care Centres).

[12] Our educational partners include the University of Auckland, Manukau Institute of Technology and Auckland University of Technology. Each day, over 300 students visit the centre and utilise lecture space. Our strategic partners are the Institute for Healthcare Improvement (IHI), Better Value Healthcare, Ltd. and NHS Wales.

Work completed in 2012 in collaboration with Treasury and the National Health Board, using the Better business case process (http://www.infrastructure.govt.nz), modelled a range of non-acute service and procurement model options against a forecast revenue assumption of 2.7 percent growth (compared to historically an excess of 5 percent growth). The outcomes of this process highlighted the need to revisit investment assumption affordability in light of the probable reduced funding growth scenarios.

Critical work planned for 2013/14 to identify and implement best 'value for money' solutions and aligned investment priorities include the following deliverables:

- *Whole of System Strategy formation* – utilising an integrated governance structure of PHO and CMDHB clinical and managerial leaders. This is critical to implementing the scale and pace of change required to be sustainable. This group will re-define the 'look' of the health system in 10 years and re-define our 5-year investment/development priorities to achieve this. This will then inform our investment strategy
- *Development of a 10 Year Health System Integration Investment Strategy* – that reviews, aligns and prioritises critical enabler programmes of work to align to Strategy priorities, i.e. realignment of related plan priorities for Asset Management, Workforce and Information Systems programmes that integrates related national and regional capacity and capability developments
- *Development of a System Integration Investment Programme Business Case* – with continued collaboration with Treasury and the National Health Board based on agreed strategic health system priorities

The Programme business case was initiated in 2013 with our clinical leaders from across the health system evaluating CM Health's 10 year investment (i.e. services) priorities. When we refer to 'investment' this is not only capital expenditure, but recognises that some initiatives require significant operational investment, (including borrowing costs for any new facilities) over coming years to sustainably create the capacity and capability to meet the health. Criteria to rate relative service area investment priority were based on the regional asset prioritisation approach and locally agreed importance weightings. Consistent with the clinical approach to this prioritisation, 50 percent of the criteria weighting related to 'health gain' and 'clinical risk'.

Although specific investment projects cannot be confirmed until the Programme business case is approved by the CMDHB Board for submission to the National Capital Investment Committee later in September/October 2013, our options evaluation is based on the clinical investment priorities. The top five areas over the next 3 to 5 years for the programme business case to evaluate options includes:

- Information Communication Technologies
- Acute adult mental health
- Radiology services
- Outpatient services – that are locality based
- Rehabilitation, Health of Older People and Spinal services

The CM Health major capital projects provided as part of the northern region capital intentions summary is outlined in section 7.4.9 will be confirmed subject to outcomes of local, regional and national approvals of the Programme business case in late 2013.

In the interim period, with the constraints on government supported capital investment, it will be critical for CM Health to be able to utilise locally available capital funds in a flexible manner in order to achieve best value for money.

4.2.2 Asset management

CM Health collaborates regionally with Northern Regional Alliance (NRA) and our partner DHBs to coordinate capital intentions and priorities for major project investments (refer section 4.2.1 above). In addition to major projects, there are two major areas of asset management of concern to the region:

- Financial burden for a large 'fleet' of clinical equipment (hospital and community based) that requires regular replacement to support delivery of services
- Historic under investment in information systems and technology (refer section 4.3.8 for agreed regional investment priorities)

CM Health has a long standing Asset and Capital committee and annual processes for prioritising capital investments, but recognises that more is needed to maximise our management, planning and renewals prioritisation systems.

Asset management is now recognised as more than a term for maintenance management. Asset management practiced correctly will help us realise the organisation-wide impact and interdependencies within operations, design, asset performance, personnel productivity and lifecycle costs. Enterprise Asset Management is the business process and enabling information systems that support management of an organisation's assets. "Enterprise" refers to the management of the assets across departments, locations, facilities and, in some cases, business units. This enables organisations to maximise value by improving utilisation and performance, reduce capital costs, reduce asset-related operating costs and extend asset life. Further, by aligning these systems across a region, optimal selection and use of some assets can be enabled over and above that within an individual DHB.

CM Health has taken the initiative to investigate a suitable system and have engaged with Canterbury, Capital and Coast and Northern Region DHBs. We are seeking Health Benefit Limited's endorsement and CM Health's Board approval to progress this project in 2013/14. We will work with the clinical engineering groups (local and national) to prioritise roll out this system due to the high value/high risk nature of this group of assets.

4.3 Strengthening our Workforce

4.3.1 Local context

As at 30 June 2011, CM Health employed a headcount of 6553 people, who worked an equivalent of 5183 FTEs. Nursing is by far the largest clinical workforce comprising 46 percent of staff, medical 17 percent, allied health 13 percent and care and support workers 11 percent. A further 9 percent make up technical and scientific workforce groups and 4 percent in the midwifery occupation group. Over a third of CM Health's workforce are on casual and part time contracts.

In the last five years from 2008 to 2012 Counties Manukau DHB Full Time Equivalent (FTE) workforce numbers have increased by approximately 22 percent overall. Capacity expansion has focused clinical health professional resource and reduction in administration and clerical staff (3.4 percent) in line with Ministry of Health expectations. Refer to Figure 18 below for a five year summary by workforce group.

Figure 18: CM Health FTE by Workforce Group

Group	Year as at 31 December				
	2008	2009	2010	2011	2012
Nursing	2,131	2,250	2,299	2,470	2,577
Allied	778	968	940	1,040	1,096
Medical	539	649	659	720	679
Admin/Clerical	601	577	564	597	580

Support	360	368	385	397	431
Management	144	212	197	203	202
Grand Total	**4,553**	**5,025**	**5,044**	**5,429**	**5,566**

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

Figure 19: CM Health workforce representation by ethnicity

Ethnicity	All Staff	Clinical	CM Population	CM Health Patient Discharge
Asian	25 %	28 %	19 %	11 %
Maaori	6 %	6 %	17 %	17 %
Pakeha & Other	59 %	58 %	42 %	44 %
Pacific	10 %	8 %	23 %	27 %

CM Health's 2011 workforce report highlighted several issues that continue to guide our workforce development for 2013/14:

- 15 percent of CM Health's clinical staff that make up 34 percent of our organisation experience in length of service is likely to retire by 2021. Career development and succession management is critical to support this transition in our capability
- A large proportion of our workforce work part time or casual hours – 34 percent of women in clinical roles work part time. CM Health needs to consider ways of getting the best out of a workforce who require flexibility in their work schedules. Generation changes in our workforce mean that lifestyle balance is increasingly important to our staff. This means creative approaches to role development and scope of practice changes are important
- Increasing the diversity of our workforce to better reflect the community and patient populations we serve requires more effort, in particular in highly skilled clinical roles
- Although we will continue to invest in workforce supply from our local community through scholarship and training support, we must step up service changes to ensure that we get the best out of our current workforce mixes

A strategic approach needs to be taken to ensure our workforce is ready to provide services in the way we need them now, and in the future. It is crucial that our workforce capabilities and competencies resonate with health system needs. One of our Enabling High Performing People programme objectives is to ensure that our workforce supply meets immediate and emergent workforce needs, i.e. how to better match workforce supply and skills with service demand across the health system. Workforce planning and modelling is a core part of this programme and work is currently underway to merge workforce and financial models. This will enable us to scenario test the impact of different service models on forecast capacity and capability requirements within expected budget constraints to inform our planning.

4.3.2 Whole of system collaboration is needed

In order to be able to transform our health system, we need to ensure that we have the right people with the right skills in the right place. Some of the challenges facing us, and the wider health sector in New

Zealand, are the ability to attract, retain and motivate key performers, those with high potential or sought after skills.

The Northern Regional Health Plan (http://www.ndsa.co.nz) provides integrated planning for capacity and capability needs for identified government priority areas and targets. CM Health supports regional workforce initiatives in addition to CM Health specific developments and national workforce development direction. With the establishment of the Northern Region Training Hub (NoRTH), our postgraduate education and clinical placement activity will be more coordinated and with heightened clinical leaders engagement.

CM Health supports the Regional Directors of Training in the development of the regional workforce planning with our Human Resources General Manager and Director of Nursing contributing to the Clinical Leads Group that develops the regional workforce plans. An example of CM Health contribution to regional workforce plan implementation is the development of Community Youth Forensics workers and related model of care implementation.

Our workforce strategy follows the domains contained in the State Services Commission workforce strategy framework. The approach we take to workforce development is underpinned by our workforce pipeline concept that engages key stakeholders, e.g. education and primary care providers, to look at key points where people enter training, the workforce and ongoing development and retention.

The following sets out the four dimensions of Capability, Capacity, Culture and Change Leadership that are core to our workforce strategy.

4.3.3 Capability

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

- Competency and performance development framework (in pilot phase) that aligns individual work plans with organisational strategy and priorities and development plans
- Workforce scope of practice and role changes to support integrated models of care, new clinical pathways and future service design
- Career development through a dedicated consultant to guide career planning for staff. This process has been adopted by Health Workforce New Zealand
- Implement the NoRTH regional training hub requirements (see section 4.3.7 below)

4.3.4 Capacity

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

- Expand and retain local Maaori and Pacific people into a health career pathway, e.g. Maaori and Pacific Recruitment Strategy, high school programmes, Health Could B 4 U and health science academies, tertiary health scholarships)
- Work regionally to find vulnerable workforce solutions to recruit and retain, e.g. sonographers, rehabilitation consultants
- Strengthen training capacity through strategic partnerships with tertiary education providers and undergraduate inter-professional trainee placements
- Implement new models of employment, e.g. Bachelor of Nursing Pacific students at MIT

- Workforce planning and modelling (establish workforce requirements for new models of integrated care and pipeline approach to growth the workforce)

4.3.5 Culture

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

- Staff Satisfaction Survey – the baseline completed in October 2012, will allow us to compare our 2013/14 progress against previous results and identify and ongoing or new 'hotspots'. We will work with employee representative groups to identify actions to respond to key improvement areas identified and monitor progress against these over the next twelve to eighteen months
- Organisational values review to ensure we have a set of values that fit with the CM Health vision and are meaningful to staff when working with our community, stakeholders and each other
- Strategies which increase opportunities for engagement from employees and their representative groups e.g. 2013/14 whole of system strategy forming process
- Effective staff communication to keep our people informed regarding key strategies, projects and initiatives through a range of forums including our local intranet (SouthNet sites about our key programmes, CEO Blog and others), consolidated email information (Daily Dose) and participation in workstreams and projects

4.3.6 Change leadership

Our goal is to become the best healthcare provider in Australasia by 2015. This requires us to achieve a balance between the delivery of excellent health care and maintaining sustainability. This will require significant clinical leadership and consumer participation to redesign services, supported by the Strategic Programme Management Office, to structure agreed Achieving a Balance Portfolio. This will include:

- An integrated change management framework that maps out how we will get from our current state to the future vision
- Develop the capacity for change leadership at all levels of the organisation including implementation of a Leadership Academy
- Strategic Programme Management Office to support processes and resources to assist managers and staff respond to changes in the way they do their work
- Build organisational resilience and capability to respond proactively to meet changing demands with innovation support from the Innovation Hub
- Engage patients and whaanau in specific service feedback and involvement in service redesign

4.3.7 Regional training hub (NoRTH)

The activities and governance of the training hub, for the 2013/2014 year, will be more closely aligned with the Northern Region Health Plan as the former NoRTH and NDSA organisations have been amalgamated into the Northern Regional Alliance (NRA). NRA, and in particular the training hub, will work closely with the DHBs, Health Workforce New Zealand (HWNZ), tertiary education providers and the Northern Region Clinical Leaders Forum to implement its work plan.

The training hub will collaborate with the other three regional training hubs and HWNZ to share ideas and initiatives that can be rolled out to other professional groups and hubs. This will be achieved by participating in the monthly national teleconference and quarterly meetings organised by HWNZ.

The Northern Region Health Plan has detailed regional action plans (http://www.ndsa.co.nz) through the following initiatives:

- Strengthen systems and processes to support placement and workforce development activity
- Align recruitment and workforce planning with capacity and model of care requirements
- Delivery of key element s of workforce training and development for professional groups with an initial focus on RMOs and specialist nursing and allied health roles
- Broaden NoRTH clinical and managerial governance

We are aware of the 70/20/10 model for the allocation of postgraduate medical education funds, and our regional service plan takes account of this. Some of the metrics still need to be defined, and as such we endeavour to work collaboratively as a region with the training hubs and HWNZ to achieve these targets. This 70/20/10 model means that we receive 70% of the funds through monthly payments, with the remaining 30 percent paid periodically subject to:

- Meeting HWNZ education expectations such as career planning for RMOs; and
- Having RMO positions in disciplines which HWNZ feel need additional financial support

4.3.8 Regional information systems

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

In 2013/14 the focus will be on infrastructure upgrades and improving system resilience to address the continuity risk for IS services in the region. IS investment will be reprioritised to address these underlying service risks in the following areas:

- Microsoft software upgrades in workspace and infrastructure to keep licensing at formally supported levels
- Clinical and business systems upgrades to ensure systems can operate in these upgraded workspace and infrastructure environments
- Ongoing improvement of IS process, capability and capacity to cope with the levels of complexity and volume of IS service requirements
- Improve resilience of (existing) IS systems to improve system availability, access, data integrity and security

Consistent with the direction set by the National Health IT Board, nine workstreams are identified to progress over the 3-year time period of the plan. These are outlined below with some examples (with the top 5 in prioritised order):

- Safe Sharing Foundations – major focus with infrastructure and electronic system upgrades
- Safe Medication Management – progress ePrescribing, Medicines Reconciliation, eMedicines
- Shared Care - operationalise Regional Shared Care platform and agree patient portal strategy
- Patient Administration Systems – select regional system
- Business Support – national and regional Finance Procurement and Supply Chain systems
- Quality information for primary healthcare - Implementation Clinical Pathways Stage 1
- Continuum of care - eReferrals phase 2; e Discharge Summaries upgrade
- Clinical Support – range of national and DHB system developments and roll-outs
- Population Health – regional dataset and reporting capability development

Further information is available in the Northern Regional Information Strategy 2010 to 2020 (http://www.healthalliance.co.nz) and the related Northern Region Information Systems Implementation Plan.

4.4 Quality and Safety

If CM Health is to be the best healthcare system in Australasia by December 2015, we must put in place a quality and safety programme which not only sets high standards for patient care and minimises harm in hospital, but also addresses those issues wherever patients are receiving care, be that in hospital, at home, in an age-related, residential care facility or in a general practice setting.

Our First Do No Harm programme (aligned to the regional programme) consolidates the governance of all CM Health patient safety initiatives into one group to provide the alignment and coordination of national (Health Quality and Safety Commission), regional and local programmes. It will provide support for implementing and maintaining existing initiatives. CM Health has now extended the patient safety initiatives to Primary Care and Aged Related Residential Care with a focus on falls, pressure injuries and vitamin D prescribing. Our programmes extend to national leadership in quality and safety with a focus on sharing lessons learnt with the rest of the sector.

In October 2012 CM Health partnered with the Health Quality and Safety Commission to lead the national Target CLAB Zero programme aimed at preventing central line associated bacteraemia (CLAB) in public hospital Intensive Care Units throughout the country.

Our Centre for Quality Improvement provides a focus on both the quality improvement knowledge and technical skills needed to ensure healthcare is reliable in practice; and the knowledge and skills needed to appraise and evaluate scientific evidence, the development of proven healthcare interventions, leading to improvements in patient care. This will include driving a large and diverse range of quality improvement and quality assurance programmes and initiatives across CM Health in the following areas:

- Reducing CM Health's prevalence of falls, pressure Injuries, venous thomboembolism (VTEs)
- Improving Patient Identification to prevent 'never events' from patient misidentification
- Reducing healthcare associated Infections such as CLAB and Surgical Site Infections (SSI)
- Reducing perioperative harm, for example Surgical Safety Checklist initiative[13], health screening questions for elective surgery, medical and anaesthetic preadmission for surgery
- Improving hand hygiene and environmental cleaning practices
- Improving the Dignified and Safe Handling of patients

Our surgical services have a number of programmes in place aimed at improving patient safety through improved clinical practice as identified above. The SSI initiatives noted above highlight a focus on procedures most at risk of post operative infection, e.g. prosthetic joint infections, surgical site infection surveillance programme pre- and post hospital discharge, caesarean and gastrointestinal surgery.

Other quality and safety improvement initiatives include areas of operational effectiveness such as Capacity Management and Beds across the hospital system, improving 'Did Not Attend' (DNA) rates, supporting and developing work in relation to family / whaanau as partners in care.

4.4.1 Improving medication safety

The national medication chart has been adopted across Middlemore Hospital and the long stay chart has been piloted in several long stay wards. We will continue our work on:

[13] Including prophylactic antibiotics before knife to skin; VTE risk assessment and prophylaxis, 2 person check before regional blocks; check - is Blood available; Ask - is there other risks we need to know about

- Roll out of electronic medicines reconciliation[14] (eMR) across the services and divisions in the 2013/14 year
- IHI Adverse Drug Event (ADE) Trigger Tool in conjunction with Canterbury and Capital & Coast DHBs
- Medication safety campaign work including the Dirty Dozen (identifying the top 12 medicines associated with harm) and 5 Rights in relation to safe medicines administration

4.4.2 Preventing healthcare-associated infection

- Compliance with Hand Hygiene by participating in the national gold audit, promoting the importance of Hand Hygiene and related initiatives/activities
- Working actively with the wards and other clinical areas to identify improvements to hand hygiene practices
- Central Line Associated Bacteraemia (CLAB) prevention collaborative at a local and national level

4.4.3 Making surgery safer

Our Centre for Quality Improvement has advanced planning towards the implementation of a Surgical Site Infection surveillance database and monitoring system and will contribute its learning on this to the lead agency appointed by the Health Quality and Safety Commission (HQ&SC) for the national SSI system. Reducing perioperative harm initiatives also includes implementation of a Surgical Safety Checklist, i.e. checking that everyone knows each other at the outset of a procedure, checking that we have the right patient and are carrying out the correct operation. Refer to section 4.4 above.

4.5 Organisational Health

As a Good Employer, we promote equity, fairness and safe and healthy workplaces. CM Health discharges its Good Employer obligations by operating under a Human Resources policy containing provisions generally accepted as necessary for the fair and proper treatment of employees in all aspects of their employment and the provision of a safe and healthy workplace. CM Health is committed to this principle and will actively seek to uphold any legislative requirements in this regard.

4.5.1 Maaori participation in decision making

We will strengthen this aspect of our governance in 2013/14 to ensure that Maaori are engaged and participate in decision making and the development of plans and strategies to improve health outcomes for Maaori. CM Health has two types of relationships and two governance forums with Maaori:

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

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

4.5.2 Pacific leadership

We are home to the largest Pacific population in New Zealand and many of our Pasifika communities bear a disproportionate burden in terms of non communicable disease and poorer health outcomes. We recognise that engagement with our Pasifika communities is essential to improving their health outcomes and we are

[14] Refer http://www.hqsc.govt.nz for further information

currently working with them to determine how we can best develop and enhance Pacific leadership across the DHB.

4.6 Reporting and Consultation

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

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

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

4.7 Associate and Subsidiary Companies

4.7.1 HealthAlliance NZ Limited

CM Health together with Waitemata DHB established healthAlliance NZ Limited, a non clinical shared services agency some ten years ago as an early commitment to ensuring a value for money approach to health. This has been extremely successful in all areas of activity in both consistently achieving considerable savings and ensuring a standardisation of approach wherever possible. It was expanded in April 2011 to include Auckland DHB and Northland DHB and will be working in close alignment with HBL to build on these gains for both local and national benefit.

4.7.2 Innovation Hub

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

4.7.3 Locality Clinical Partnerships

We are finalising a collaborative agreement with PHOs for the delivery of locality clinical partnerships.

4.7.4 Integrated Family Health Centres/ Whaanau Ora Centres

Possible establishment of a special purposes vehicle for Integrated Family Health Care / Whaanau Ora Centre, in conjunction with Tainui on land owned by CM Health at the Manukau Health Park.

5.0 Forecast Service Performance

5.1 Statement of Forecast Service Performance

Counties Manukau Health (CM Health) is required under Section 142 of the Crown Entities Act 2004 to provide a statement of forecast service Performance. The measures in the Statement of Forecast Service Performance are non financial measures and consist of key outputs which CM Health plan to deliver through its planned activities and actions for 2013/14.

Our intervention logic in section 2.5 shows how our strategic outcomes guide our decisions around what level of resources (inputs) and mix of services (outputs) best meets our population's health needs, how they are delivered and to what level. The mix of services delivered are expected to contribute towards measurable impacts on our population's health, improvement of which will provide good indication that CM Health is on track to deliver on its high level outcomes.

Outputs are measured against six dimensions of quality[15]

Figure 20: Dimensions of quality

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

Past performance (baseline data or current performance) is included where possible along with performance targets. A number of key measures of output and impact for each output class which best reflect activities that make the largest contribution to CM Health's achievement of key strategic objectives have been included. Actual results of service performance against what was forecast here will be published in our 2013/14 Annual Report.

5.2 Input Levels Against Output Classes

Prevention	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**17,738**	**18,887**	**20,127**	**21,133**	**22,190**
Personnel costs	3,177	4,637	4,760	4,998	5,248
Outsourced Services	1,368	1,261	1,881	1,975	2,074
Clinical Supplies	1,482	1,441	1,926	2,022	2,123
Infrastructure & Non-Clinical Supplies	14	907	1,464	1,537	1,614
Other	11,697	10,641	10,096	10,601	11,131
Total costs	**17,738**	**18,887**	**20,127**	**21,133**	**22,190**
Surplus (Deficit)	-	-	-	-	-

[15] Institute of Medicine Committee on Quality of Health care in America, Crossing the quality chasm: a new health system for the 21st century. 2001, Washington D.C.: National Academy Press.

Early Detection	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**212,199**	**212,793**	**208,287**	**218,701**	**229,636**
Personnel costs	-	-	-	-	-
Outsourced Services	-	-	-	-	-
Clinical Supplies	-	-	-	-	-
Infrastructure & Non-Clinical Supplies	-	-	-	-	-
Other	212,199	212,793	208,287	218,701	229,636
Total costs	**212,199**	**212,793**	**208,287**	**218,701**	**229,636**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Intensive	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**1,048,921**	**1,074,866**	**1,101,079**	**1,126,517**	**1,149,157**
Personnel costs	478,066	502,709	525,221	543,786	557,646
Outsourced Services	56,665	56,269	56,487	56,977	61,967
Clinical Supplies	105,662	105,181	102,571	103,521	105,474
Infrastructure & Non-Clinical Supplies	100,586	100,569	107,466	112,765	114,832
Other	302,532	307,113	306,302	306,450	309,220
Total costs	**1,043,511**	**1,071,841**	**1,098,047**	**1,123499**	**1,149,139**
Surplus (Deficit)	**5,410**	**3,025**	**3,032**	**3,018**	**18**

Rehabilitation	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**101,572**	**107,994**	**113,441**	**119,113**	**125,069**
Personnel costs					
Outsourced Services					
Clinical Supplies					
Infrastructure & Non-Clinical Supplies					
Other	101,572	107,994	113,441	119,113	125,069
Total costs	**101,572**	**107,994**	**113,441**	**119,113**	**125,069**
Surplus (Deficit)	**-**	**-**	**-**	**-**	**-**

Total	2011/12 ($000s)	2012/13 ($000s)	2013/14 ($000s)	2014/15 ($000s)	2015/16 ($000s)
Revenue	**1,380,430**	**1,414,540**	**1,442,934**	**1,485,464**	**1,526,052**
Personnel costs	481,243	507,346	529,981	548,784	562,894
Outsourced Services	58,033	57,530	58,368	58,952	64,041
Clinical Supplies	107,144	106,622	104,497	105,543	107,597
Infrastructure & Non-Clinical Supplies	100,600	101,476	108,930	114,302	116,446
Other	628,000	638,541	638,126	654,865	675,056
Total costs	**1,375,020**	**1,411,515**	**1,439,902**	**1,482,446**	**1,526,034**
Surplus (Deficit)	**5,410**	**3,025**	**3,032**	**3,018**	**18**

Output Classes

This section is structured as follows.

5.3	Output class: Prevention Services
5.3.1	Health Promotion and Education Services ▪ Smoking cessation ▪ Healthy environments ▪ Family violence prevention
5.3.2	Immunisation Services
5.3.3	Health Screening ▪ Breast screening ▪ Cervical screening ▪ Well child/ Tamariki Ora
5.3.4	Statutory and Regulatory Services
5.4	Output class: Early Detection and Management Services
5.4.1	Primary Health Care Services (GP)
5.4.2	Long Term Conditions Management
5.4.3	Oral Health Services
5.4.4	Diagnostics
5.5	Output class: Intensive Treatment and Assessment Services
5.5.1	Mental Health
5.5.2	Elective Services
5.5.3	Acute Services ▪ Emergency department ▪ Cancer services ▪ Cardiac services
5.5.4	Maternity Services
5.5.5	Additional Patient Safety Measures for our Hospital Services
5.6	Output class: Rehabilitation and Support Services
5.6.1	NASC
5.6.2	Assessment, Treatment and Rehabilitation Services
5.6.3	Aged Related Residential Care (ARRC)
5.6.4	Home Based Support

Reference Key			
NHT	National Health Target (MoH accountability)	**C**	Coverage
PP	Policy Priority measure	**V**	Volume
OS	Ownership measure	**S**	Safe
SI	System Integration measure	**P**	Patient Centred
DV	Developmental measure	**W**	Efficient
NRHP	Regional target (Northern Region Health Plan)	**T**	Timely
DD	Demand driven measure	**E**	Equitable
		F	Effective

5.3 Output class: Prevention Services

Prevention services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.

5.3.1 Health Promotion and Education Services

Outputs and Related Measures	Forecast Performance		Reference
Smoking Cessation			
▪ We deliver smoking cessation advice and support in secondary and primary care ▪ We fund community based programmes to support people living Smokefree			
Proportion of hospitalised smokers provided with advice and help to quit	Baseline (Q3 2012/13) 95 %	June 2014 95 %	NHT C
Proportion of enrolled primary care patients who are smokers and are seen in General Practice are provided with advice and help to quit	Baseline (Q2 2012/13) 42.96 %	June 2014 90 %	NHT C
Proportion of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Care are offered advice and support to quit	Baseline To be established	June 2014 90 %	NHT C
Healthy Environments			
▪ We work with Housing New Zealand and other non-governmental agencies to improve the housing conditions in the community. This includes the ongoing implementation of the healthy housing programme in Counties Manukau conjunction with Housing New Zealand and other participating District Health Boards (DHBs) which includes a holistic health and housing assessment as its central plank ▪ We are also retrofitting insulation for low income families/ households to reduce the high levels of chronic respiratory conditions arising from poorly insulated and damp homes			
Completed health and housing assessments	Baseline (2011/12) 328	June 2014 320	V
Number of homes insulated	Programme Warm Up CM	June 2014 1000	V
Family Violence Prevention			
▪ We deliver coordination of the Violence Intervention Programme which includes training staff in Adult and Children's Emergency Care, and Children's Surgical and Medical wards in family violence intervention and screening for partner and child abuse and neglect			
Hospital Responsiveness to Family Violence, Child and Partner Abuse Programmes Audit Score (self audit using AUT tool): *The audit score is a measure of the quality of the integrated family violence and child and partner abuse programmes implemented within health services like routine enquiry and child assessments in Emergency Departments and health professional training methods*	 Partner Abuse Child Abuse and Neglect	Baseline (March 2012) 92 / 100 91 / 100	June 2014 90 / 100 90/ 100	F

5.3.2 Immunisation Services

Outputs and Related Measures	Forecast Performance			Reference
▪ We work in collaboration with immunisation providers (including general practice, outreach, school and other community settings) to deliver immunisation service				
Proportion of 8 month olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time Note: Target will increase to 95 percent by Dec 2014		Baseline Q3, 2012/13	June 2014	NRHP NHT
	Maaori	76 %	90 %	
	Pacific	88 %		
	Total	86 %		
Proportion of older people (65+) who have had their flu vaccinations	Baseline (Dec 2012)		Dec 2013	
	61.9 %		75 %	

5.3.3 Health Screening

Outputs and Related Measures	Forecast Performance			Reference
Breast Screening				
▪ We provide free breast screening services for women aged 45 to 69 years old through the BreastScreen Aotearoa programme				
Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months		Baseline (December2012)	June 2014	C
	Maaori	66.5 %	70 %	
	Pacific	67.9 %		
	Total	67.6 %		
Cervical Screening				
▪ We fund primary care providers to deliver free cervical screening for women aged 20 – 70 years				
Proportion of women aged 20 - 70 years who have had a cervical smear in the last three years		Baseline (Dec 2012)	June 2014	C
	Total	70.42 %	80 %	
Well Child/ Tamariki Ora				
▪ We fund Well Child/ Tamariki Ora providers to deliver services to support new mothers and their infants. This includes Well Child Checks, home visits and Before School Checks (B4SC) ▪ The B4 School Check includes hearing and vision, oral health, weight and height checks. It is the final core Well Child/ Tamariki Ora check which ensures that any health problems are identified early and children are ready for learning and to reach their full potential				
Proportion of the eligible population who have had their B4 School Checks		Baseline (FY2012/13)	June 2014	C E
	Vision and Hearing (2 components)	80% 7,022 (including 3,058 of high dep)	90 % of eligible population 8,058 (including 3612 of high dep)	
	Nurse (Well child – core 8			

5.3.4 Statutory and Regulatory Services

Outputs and Related Measures	Forecast Performance		Reference
▪ The Auckland Regional Public Health Service is managed by Auckland DHB and provides regional public health services to Auckland DHB, Counties Manukau DHB and Waitemata DHB under a contract with the Ministry of Health. The service provides statutory and regulatory public health services including responding to outbreaks, environmental hazards and other emergencies. They also deliver health promotion services and advise and/or advocate for healthy public policy ▪ The following baselines and targets are regional and relate to all 3 metro-Auckland DHBs			
Number of license premises risk assessed by Auckland Regional Public Health Service (ARPHS).	Baseline (12/13)	2013/2014	C
	1269	1200	

Number of license premises assessed as high risk. Compliance of liquor retailers with protocol and current legislation is seen as a measure of the quality of information, training and advice services provided to retailers	Baseline (12/13) 608	Estimate 2013/14 400	F
Numbers of joint Controlled Purchase Operations conducted	Baseline (2012/13) 237	Estimate 2013/14 200	V

5.4 Output Class: Early Detection and Management Services

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. These include general practice, community and Maaori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

5.4.1 Primary Health Care Services (GP)

Outputs and Related Measures	Forecast Performance		Reference
▪ We fund PHOs to deliver primary care services to improve, maintain or restore people's health			
Number of bed days saved through our Saving 20,000 Days Campaign initiatives Note: Achievement of this target will give our community 20,000 healthy and well days and it is also a measure of the effectiveness of improved processes and systems within the suite of initiatives that make up our 20,000 Days campaign	Baseline (Jul 2011-Dec 2012) 11,565	June 2014 20,000 days	F

5.4.2 Long Term Conditions Management

Outputs and Related Measures	Forecast Performance			Reference
▪ In conjunction with our primary care and community partners we fund the delivery of targeted programmes aimed at people with high health needs due to long term conditions to reduce the incidence and impact of their conditions through early detection and intervention and better management in primary care and community care settings These include: ▪ Early detection and intervention services like diabetes checks and minor skin lesions surgery provided by GPs ▪ Education programmes to support patients' self-management of long term conditions ▪ Structured primary care programmes aimed at better management of individuals with chronic conditions like the Diabetes Care Improvement Package, Chronic Care Management (CCM) and the Very High Intensive User Programme				
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c of equal to or less than 64 mmol/mol)		Baseline (Q3, 2012/13)	June 2014	PP20 F
	Maaori	57%	66 %	
	Pacific	52%		
	Total	62%		
Number of additional patients enrolled in Self Management (SM) programmes	Baseline 2011/12 551		June 2014 700	V
Percentage of all primary care practices engaged in Chronic Care Management (CCM) programme Note: CCM programmes allow for those with Chronic Conditions to actively manage their health in primary care in the community. This in turn leads	Baseline New measure - to be established		June 2014 70 %	V DD

to decreased acute admissions and avoidable mortality.			
Total number of new patients enrolled in the Very High Intensive User (VHIU) programme (with minimum 200 primary care enrolled)	Baseline (Jan – Dec 2012) 358/(36 primary enrolled)	June 2014 411 (72 primary enrolled)	V
Provide VHIU community based care where possible to avoid hospital admissions	Baseline (Dec 2012) 20 % bed days for identified high risk individuals (350 bed days saved)	June 2014 25 % saving in bed days for identified high risk individuals (438 bed days saved)	V
Number of enrolments/referrals in Primary Options for Acute Care (POAC) Note: POAC contributes to the regional work we are doing to decrease hospital admissions that can be avoided through primary care intervention for conditions like cellulitis	Baseline (Jan-Dec 2012) 9,429	June 2014 12,261	V

5.4.3 Oral Health Services

Outputs and Related Measures	Forecast Performance			Reference
▪ We contract the Auckland Regional Dental Service to deliver free oral health services for children aged 0 to 12 years old at our community and DHB based clinics and mobile dental facilities ▪ We contract with private dentists and ARDS to deliver free oral health services for our adolescents aged 13 up and including to 17 years old ▪ We deliver targeted preschool oral health promotion and brushing programmes with our partners in the Kohanga reo, Language nest and Early Childhood Education sector				
Proportion of children under 5 years enrolled in DHB-funded oral health services	Baseline (Dec 2012) 71 %	By Dec 2013 75 %	By Dec 2014 85 %	PP13a C
Proportion of enrolled preschool and school children who have not been examined (within 30 days of their recall date)	Baseline (Dec 2012) 19 %	By Dec 2013 12 %	By Dec 2014 7 %	PP13b T
Proportion of Year 8 children who have their treatment completed and are transferred to the Adolescent dental service	Baseline (December 2012) 100 %	June 2014 100 %		PP12 C
Proportion of adolescents from school year 9 up to and including 17 years of age utilising free oral health services	Baseline (Interim Dec 2012) 66 %	Dec 2013 80%	Dec 2014 85 %	PP12 C

5.4.4 Diagnostics

Outputs and Related Measures	Forecast Performance			Reference
Proportion of accepted referrals for CT and MRI scans will receive their scan within 6 weeks	Baseline (Q2 2012/13) CT 84 % MRI 63 %	Dec 2013 75 % 75 %	June 2014 85 % 75 %	NRHT DV2 T
Proportion of patients accepted as priority 1 for diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Baseline (Dec 2012) 39 %	Dec 2013 50 %	June 2014 50 %	NRHT DV2 T
Proportion of patients accepted as priority 2 for diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Baseline(Dec 2012) 29 %	Dec 2013 50 %	June 2014 50 %	NRHT DV2 T
Proportion of people waiting for surveillance or follow-up colonoscopy who wait no longer than 12 weeks (84 days) beyond the planned date	Baseline (Dec 2012) 73 %	Dec 2013 50 %	June 2014 50 %	NRHT DV2 T

5.5 Output Class: Intensive Treatment and Assessment Services

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital' or surgery centre. These services are generally complex and provided by health care professionals that work closely together. They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services

On a continuum of care these services are at the complex end of treatment services and focussed on individuals.

5.5.1 Mental Health

<table>
<tr><th>Outputs and Related Measures</th><th>Forecast Performance</th><th>Reference</th></tr>
<tr><td colspan="3">▪ We provide and/or contract a matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health & Addiction services covering Child, Adolescent & Youth; Adult; and Older Adult Age bands
▪ The matrix of services comprise:
▪ Acute and intensive services
▪ Community based clinical treatment and therapy services
▪ Services to promote resilience, recovery and connectedness</td></tr>
<tr><td>Proportion of long term clients with Relapse Prevention Plan (RPP)</td><td><table><tr><td></td><td></td><td>Baseline (Q2, Dec 2012)</td><td>June 2014</td></tr><tr><td>Child and Youth</td><td>Maaori</td><td>91.2 %</td><td rowspan="2">95 %</td></tr><tr><td></td><td>Total</td><td>96.7 %</td></tr><tr><td>Adult (20+)</td><td>Maaori</td><td>89 %</td><td></td></tr><tr><td></td><td>Total</td><td>90.4 %</td><td></td></tr></table></td><td>PP7
P</td></tr>
<tr><td>Proportion of people referred for non-urgent mental health or addiction services seen within three weeks and 8 weeks</td><td><table><tr><td></td><td>Baseline (Q2, 2012/13)</td><td>July 2013</td><td>June 2014</td></tr><tr><td>3 weeks</td><td>83 %</td><td>75 %</td><td>80 %</td></tr><tr><td>8 weeks</td><td>97 %</td><td>85 %</td><td>95 %</td></tr></table></td><td>PP8
T</td></tr>
</table>

5.5.2 Elective Services

<table>
<tr><th>Outputs and Related Measures</th><th>Forecast Performance</th><th>Reference</th></tr>
<tr><td colspan="3">▪ We provide and purchase elective inpatient and outpatient services</td></tr>
<tr><td>ESPI 2: Patients waiting longer than four months for their first specialist assessment (FSA) by December 2014</td><td><table><tr><td>Baseline (Dec 2012)</td><td>Dec 2014</td></tr><tr><td>26.9 %</td><td>0.0 %</td></tr></table></td><td>T</td></tr>
<tr><td>ESPI 5: Patients given a commitment to treatment but not treated within four months by December 2014</td><td><table><tr><td>Baseline (Dec 2012)</td><td>Dec 2014</td></tr><tr><td>0.1 %</td><td>0.0 %</td></tr></table></td><td>T</td></tr>
<tr><td>Number Elective Surgical Discharges</td><td><table><tr><td>Q2, 2012/13</td><td>July 2013</td><td>June 2014</td></tr><tr><td>8,326</td><td>15,381</td><td>15,635</td></tr></table></td><td>NHT2</td></tr>
<tr><td>Elective Services Standardised Intervention Rates (SIRs) per 10,000 of population
The SIRs target rates reflect equitable levels of access to elective surgery</td><td><table><tr><td></td><td>Current Rate (Q2 2012/13)</td><td>June 2014</td></tr><tr><td>Major joints</td><td>21.6</td><td>21.00</td></tr><tr><td>Cardiac</td><td>7.18</td><td>6.50</td></tr><tr><td>Cataracts</td><td>39.91</td><td>27.00</td></tr></table></td><td>SI 4
E</td></tr>
<tr><td>Outpatient Did Not Attend (DNA) rates for Maaori and Pacific</td><td><table><tr><td></td><td>Baseline (April 2013)</td><td>June 2014</td></tr></table></td><td>P</td></tr>
</table>

	Maaori	18.3 %	< 10 %	
	Pacific	16.8 %	< 10 %	

5.5.3 Acute Services

Outputs and Related Measures	Forecast Performance	Reference
Emergency Department		
We provide an emergency and acute care service with the following characteristics: ▪ Timely access to all service components (including diagnostics) and appropriate timely discharge ▪ Capacity to meet needs ▪ Right treatment in the right place ▪ Timely patient transfer to appropriate services from Emergency Department ▪ Good access to support services in the community or primary care level to support patient recovery		
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours	Q3, 2012/13: 97 % June 2014: 95 %	NHT1
Cancer Services		
▪ We work in collaboration with the Northern Region Cancer Network to improve cancer wait times and access to diagnosis and treatment to ensure cancer patients and their families have access to good information about support services available		
All Medical Oncology and Haematology patients needing Radiation Therapy or Chemotherapy treatment (and are ready to start treatment) will have this within four weeks from decision to treat	Radiotherapy Q3, 2012/13: Maaori 100 %; Pacific 100 %; Total 100 % June 2014: 100 % Chemotherapy Q3, 2012/13: Maaori 100 %; Pacific 100 %; Total 100 % June 2014: 100 %	NHT3 NRHP T NHT3 NRHP T
Proportion of patients referred urgently with high suspicion of Lung cancer to first cancer treatment (62 days)	Baseline: 54 % June 2014: Not established	NRHP DV1 T
Proportion of patients referred urgently with high suspicion of lung cancer to first specialist appointment (all treatment types) within 14 days	Dec 2012/13: Radiation oncology 59 %; Medical oncology 60 % June 2014: Not established	
Proportion of patients with confirmed lung cancer diagnosis who receive first cancer treatment within 31 days of decision of treat (all treatment types)	Baseline: 54 % June 2014: Not established	NRHP DV1 T
Cardiac Services		
▪ We provide intensive treatment and assessment services for patients with cardiovascular disease		
Proportion of all outpatients triaged to chest pain clinics who are seen within 6 weeks for cardiology assessment and stress test	Q3, 2012/13: 79 % June 2014: 80 %	NRHP T
Proportion of outpatient coronary angiograms with a waiting time of < 3 months	Q3, 2012/13: 95 % (National Target): (85 %) Regional Target June 2014: 90 %	NRHP DV2 T
Proportion of patients presenting with an acute coronary syndrome who are referred for angiography and receive it within 3 days of admission	Q3, 2012/13: 82 % June 2014: 70 %	NRHP T
Proportion of patients presenting with ST elevation Myocardial Infarction and are referred for Percutaneous Coronary Interventions (PCI) who receive this within 120 mins	Q3, 2012/13: 74 % June 2014: 80 %	NRHP T

5.5.4 Maternity Services

Outputs and Related Measures	Forecast Performance		Reference
▪ We provide readily accessible maternity, obstetric and neonatal care services			
Proportion of CM Health newborns screened within 4 weeks of birth All CM Health maternity facilities to have newborn hearing screening facilities including a mop-up programme for those babies discharged before screening has been completed	Baseline To be confirmed	June 2014 90 %	T

5.5.5 Additional Patient Safety Measures for our Hospital Services

Outputs and Related Measures	Forecast Performance			Reference
Acute readmissions to hospital Unplanned acute readmissions to hospital can occur as a result of the care provided by the health system, related to inadequate length of stay, and puts pressure on hospital resources. Reducing unplanned hospital readmissions can be interpreted as an indication of improving quality of acute care in our health system		Baseline Q3 12/13	June 2014	OS8 S F
	Total	9.66	<= 8.0%	
	75+	11 %	<= 11.8%	
Inpatient Average Length of Stay As stated above, inadequate length of stay can lead to increased readmission. Optimal inpatient LOS ensures patients receive sufficient care to avoid readmission	Baseline (Dec 2012) 3.93		June 2014 3.21 days	OS3 S F
Wards (excluding Mental Health) that have electronic medication reconciliation systems in place	Baseline (FY 2012) Implemented in 5 wards		June 2014 100 %	S
Average rate of Central Line Associated Bacteraemia (CLAB) in the Intensive Care Unit	Baseline (FY 2012) 2.3 / 1000 line days		June 2014 0	S
Number of in-hospital falls per bed-day	Baseline (April 2013) 2.7/1000 bed-days		Dec 2013 <3.5 / 1000 bed-day	S
Number of pressure Injuries hospital wide	Baseline (FY 2012) 3 % to 5 % per 100 patients		Dec 2013 3.5 % per 100 patients	S
Hand hygiene compliance rate (based on Gold Audit)	Baseline (Mar 2013) 69 %		June 2014 80%	S

5.6 Output Class: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum of care these services provide support for individuals

5.6.1 NASC

Outputs and Related Measures	Forecast Performance		Reference
▪ We provide timely access to assessment, treatment and support services for older people with complex health needs ▪ We provide information and support to older people and their carers about community support options			
Proportion of CM Health NASC staff who have participated in interRAI training and can deliver	Baseline (Dec 2012) 100 %	June 2014 100 %	C

appropriate assessments in the community and allocate support using CM Health contracted HBSS		

5.6.2 Assessment, Treatment and Rehabilitation Services

Outputs and Related Measures	Forecast Performance		Reference
▪ We provide readily accessible AT & R services both within the hospital and in the community.			
Community Services Provision of AT & R services for the Franklin locality through Pukekohe hospital	Baseline (Dec 2012) 53 % occupancy of 10 AT&R beds at Pukekohe Hospital	June 2014 80 % occupancy of 10 AT&R beds at Pukekohe Hospital	W
Hospital Services Average length of stay in AT & R (Pukekohe hospital beds)	Baseline (Dec 2012) 17.7 days	June 2014 < 16 days	F
Average length of stay for patients included in acute geriatric pilot at Middlemore Hospital	Baseline (Dec 2012) Average of 5 days acute episode across all MMH medical wards	June 2014 5 days	F

5.6.3 Age Related Residential Care (ARRC)

Outputs and Related Measures	Forecast Performance		Reference
▪ We provide access to subsidised beds based on assessed need ▪ We fund a sufficient supply of contracted beds available to people assessed as requiring long term residential care			
Proportion of residential care service providers who are trained in Long Term Care Facility interRAI	Baseline (Dec 2012) 14 %	June 2014 32 %	C
Number of avoidable EC presentations from ARC *Fewer EC presentations from ARC should result from effective services put in place to support ARRC like specialist input into ARRC, enhanced access to assessment and intervention within ARRC, including diagnostics and point of care testing, and consistent access to in and after hours acute assessment and treatment*	Baseline (Dec 2012) Average of 22 low acuity presentations per month	June 2014 Decrease by 15 % (19 avoidable presentations	F
Number of emergency care presentations from retirement villages	Baseline (Dec 2012) 11 mean presentations per 100 residents	June 2014 Decrease by 5 %	

5.6.4 Home Based Support

Outputs and Related Measures	Forecast Performance		Reference
We improve Home Based Support by: ▪ Promoting the use of the InterRAI tool to ensure people who need home based support services receive them in a consistent way ▪ Providing Home and Clinic based specialist Nursing Services and Allied Health Services to support community care			
Proportion of CM Health NASC clients receiving Home Base Support Services who have a comprehensive interRAI assessment completed in the last 12 months	Baseline (2012) 34 %	June 2014 50 %	S F

6.0 Service Configuration

6.1 Service Coverage

There are no identified significant service coverage exceptions identified for the 2013/14 year.

6.2 Service Change

13/14 will be the third year of implementation of the Better Sooner More Convenient business cases for Alliance Health Plus (AH+) and National Hauora Coalition (NHC). One of the components of both business cases as accepted by Counties Manukau Health (CM Health) and Ministry of Health in 2010/11 is the integration of Maaori and Pacific health agreements under both PHOs to give effect to whaanau ora commissioning. CM Health has adopted Fanau Ola to describe whaanau ora implementation for Pacific populations.

From 1 July, CM Health will have transferred those relevant agreements to NHC and AH+. This represents the first tranche of funding changes.

For AH+, this represents approximately $1.5m of services that aim to improve access to primary health care e.g. community based nursing, school based health clinics. The providers of those services are currently already members of the AH+ PHO. This simplifies the process as those providers will, instead be contracted by AH+ rather than the DHB from 1 July 2013. For National Hauora Coalition, this represents approximately $4.5m of services that aim to improve access to primary health care e.g. community based nursing, well child outreach immunisation, Marae based health services and whaanau ora co-ordinators.

For both PHOs, CM Health aims to agree a three year agreement with an outcomes monitoring framework and reporting against that framework. CM Health and NHC are also agreeing a developmental pathway to support providers make the necessary changes to services to better integrate whaanau ora (and fanau ola) delivery with core primary health care. CM Health will also be expecting a greater alignment of those services with the Localities programme. In practice, it means that:

2013/14 year, the contracts will transition to NHC/AH+ management with no change to current provider service specifications and/or funding. NHC/AH+ will agree a change management programme with providers to align with whaanau ora/fanau ola and localities planning.

2014/15 year, the CM Health agreement with NHC will aggregate the funding and services specifications to focus on outcomes. This means that NHC/AH+ will have flexibility to shift funding and services as agreed with the DHB. NHC/AH+ will implement a change programme with providers to align with whaanau ora/fanau ola to deliver and integrate contracts to providers as agreed in 2013/14.

2015/16 year, we expect full implementation of whaanau ora/fanau ola service delivery and networks. This may occur sooner depending on how quickly providers are able to implement change.

An evaluation of the process will occur during 2016 to inform renewal of both agreements for the 2016/17 and 2017/18 year.

Providers were consulted during 2012 and formally notified of the service changes in 2013 as required in contracts.

7.0 Financial Performance

7.1 Introduction

7.1.1 Tightening Financial Position

Counties Manukau Health (CM Health) and its Primary Health Organisation (PHO) partners remain fully committed to achieving the Government's priorities despite the fiscal constraints the health sector is facing. Clear indications from the Minister and Ministry of Health are of a very significant tightening of fiscal position from 2013/14 onwards. Despite capital and operational constraints, demand on CM Health system services is expected to grow at fiscally unsustainable levels unless significant change and related innovations are implemented. This changing funding forecast has accelerated the scale and pace of health system change needed for future sustainability.

The next major step in how we will address this challenge will come when the indicative business case for System Integration Investment is finalised in the spring of 2013. This joint piece of work between CM Health, Ministry of Health and Treasury will establish the framework for our future financial and service sustainability. This will set the context for our strategic change programmes related to the integration of services through our Localities Development Programme, expanded acute care system efficiencies/model of care changes and an in-depth challenge to existing cost structure, service delivery models, care settings and health system performance accountabilities (Financial Sustainability Taskforce).

Acknowledging significant fiscal challenges the health sector is facing, we are committed to achieving a $3m surplus in 2013/14 and 2014/15. While the outer years are anticipated to be increasingly challenging, CM Health is focused on continuous improvement and innovation as a way of living within our means.

7.1.2 Cost Structure Change to Effect Integration

The 2012/13 year was a transitional year for CM Health as we established essential infrastructure and organisational changes to effect health system wide integration. Our cornerstone investments were establishment of the following:

- District Alliance Group comprising the CM Health Board and CM PHO Chairs and Chief Executives
- Two of our four Locality Clinical Partnerships (LCP) and related Leadership Groups; with the final two to be established in 2013/14
- Locality Clinical Partnership Agreement to provide primary health care providers with greater opportunities to share system resources, and accountability to collectively ensure the best use of those resources
- Framework for global budget holding to incentivise general practice to take shared accountability and increased flexibility to best manage population health needs

These include operational (management) and health service programme budgets that integrates primary health, community, CM Health (shared accountability services[16]) and third party provided services accessed within each locality. We recognise that elements of these changes are leading edge 'risk/gain' share models to incentivise general practice and any potential financial risk will managed through a 2013/14 focus on careful monitoring and evaluation of pilot implementation.

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

7.2 Forecast Financial Statements

7.2.1 Summary by Funding Arm

Net Result	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Forecast 000's	2015/16 Plan 000's
Provider	(6,539)	(5,482)	(7,929)	(8,310)	(8,675)
Governance	1,210	(629)	221	220	220
Funder	10,739	9,136	10,740	11,108	8,473
Operating Surplus	5,410	3,025	3,032	3,018	18
Other Comprehensive Income	(2,500)	-	-	-	-
Surplus (deficit)	2,910	3,025	3,032	3,018	18

7.2.2 Statement of Comprehensive Income

Net Result	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Forecast 000's	2015/16 Plan 000's
Revenue					
Crown *	1,338,039	1,378,401	1,412,652	1,454,431	1,494,247
Other	42,391	36,139	30,282	31,033	31,805
Total Revenue	**1,380,430**	**1,414,540**	**1,442,934**	**1,485,464**	**1,526,052**
Expenses					
Personnel	481,243	507,346	529,981	548,784	562,894
Outsourced	58,033	57,530	58,368	58,952	64,041
Clinical Sup.	99,531	99,039	93,913	94,459	95,513
Infrastructure	66,037	63,268	62,552	61,130	62,007
Personal Health	472,116	473,993	468,840	481,279	494,057
Mental Health	54,502	56,987	57,906	59,310	63,752
Disability Support	97,055	103,675	109,107	111,943	114,854
Public Health	2,908	1,661	946	971	996
Maaori	1,419	2,225	1,327	1,362	1,397
Operating Costs	**1,332,844**	**1,365,724**	**1,382,940**	**1,418,190**	**1,459,511**
Operating surplus	**47,586**	**48,816**	**59,994**	**67,274**	**66,541**
Depn.	20,109	22,106	30,516	37,545	39,545
Capital Chg.	12,441	12,648	12,996	13,126	13,257
Interest	9,626	11,037	13,450	13,585	13,721
Operating Surplus	**5,410**	**3,025**	**3,032**	**3,018**	**18**
Other Comprehensive Income	(2,500)	-	-	-	-
Surplus (Deficit)	**2,910**	**3,025**	**3,032**	**3,018**	**18**

Funder Revenue	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Crown	1,285,061	1,329,353	1,360,587	1,395,963	1,432,261
Other	7,606	5,148	2,734	2,805	2,878
Total	**1,292,667**	**1,334,501**	**1,363,321**	**1,398,768**	**1,435,139**
Personal Health	1,013,881	1,045,074	1,05,781	1,083,478	1,111,912
Mental Health	131,122	135,240	137,772	141,253	147,826
Disability Support	121,689	128,375	142,034	145,727	149,516
Public Health	2,990	1,661	946	971	996
Maaori	1,419	2,225	1,327	1,362	1,397
Governance	10,827	12,790	14,721	14,868	15,017
Total Expenditure	**1,281,928**	**1,325,365**	**1,352,581**	**1,387,659**	**1,426,664**
Net Surplus	**10,739**	**9,136**	**10,740**	**11,109**	**8,475**

Eliminations Revenue	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Crown	(653,928)	(686,824)	(714,455)	(732,795)	(751,610)
Other	-				
Total	**(653,928)**	**(686,824)**	**(714,455)**	**(732,795)**	**(751,610)**
Personal Health	(541,765)	(571,081)	(586,941)	(602,200)	(617,857)
Mental Health	(76,620)	(78,253)	(79,866)	(81,943)	(84,074)
Disability Support	(24,634)	(24,700)	(32,927)	(33,784)	(34,662)
Public Health	(82)	-	-	-	-
Maaori	-	-	-	-	-
Governance	(10,827)	(12,790)	(14,721)	(14,868)	(15,017)
Total Expenditure	**(653,928)**	**(686,824)**	**(714,455)**	**(732,795)**	**(751,610)**
Net Surplus	**-**	**-**	**-**	**-**	**-**

Provider Revenue	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Crown	696,079	719,419	749,639	774,180	796,308
Other	34,397	34,389	29,344	30,075	30,826
Total	**730,476**	**753,808**	**778,983**	**804,255**	**827,134**
Personnel	476,110	499,536	520,082	538,785	552,794
Outsourced	57,340	56,424	57,636	58,212	63,293
Clinical Sup.	99,531	98,955	93,797	94,342	95,395
Infrastructure	61,858	58,584	58,435	56,970	57,084
Operating Costs	**694,839**	**713,499**	**729,950**	**748,309**	**769,286**
Operating surplus	**35,637**	**40,309**	**49,033**	**55,946**	**57,848**
Depreciation	20,109	22,106	30,516	37,545	39,545
Capital Charge	12,441	12,648	12,996	13,126	13,257
Interest	9,626	11,037	13,450	13,585	13,721
Total Expenditure	**737,015**	**759,290**	**786,912**	**812,565**	**835,809**
Net Surplus	**(6,539)**	**(5,482)**	**(7,929)**	**(8,310)**	**(8,675)**
Other Comprehensive Income	(2,500)	-	-	-	-
Surplus (Deficit)	**(9,039)**	**(5,482)**	**(7,929)**	**(8,310)**	**(8,675)**

Governance Revenue	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Crown	10,827	12,790	14,805	14,953	15,103
Other	388	265	280	283	286
Total	**11,215**	**13,055**	**15,085**	**15,236**	**15,389**
Personnel	5,133	7,810	9,899	9,999	10,100
Outsourced	693	1,106	732	740	748
Clinical Sup.	-	84	116	117	118
Infrastructure	4,179	4,684	4,117	4,160	4,203
Total Expenditure	**10,005**	**13,684**	**14,864**	**15,016**	**15,169**
Net Surplus	**1,210**	**(629)**	**221**	**220**	**220**

Balance Sheet Current Assets	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Cash and Bank	6,165	1,104	886	890	890
Debtors	32,166	37,002	29,597	39,150	39,550
Inventory	835	1,990	3,990	3,990	3,990
Assets Held for Sale	-	-	-	-	-
Current Assets total	**39,166**	**40,096**	**34,473**	**44,030**	**44,430**
Non-Current Assets	533,815	608,297	649,896	653,471	646,416
Total Assets	**572,981**	**648,393**	**684,369**	**697,501**	**690,846**
Current Liabilities					
Creditors	85,377	90,055	89,880	73,971	74,507
Loans	30,000	5,000	5,000	-	25,000
Employee Provisions	107,087	113,269	126,414	128,605	121,065
Total Current Liabilities	**222,464**	**208,324**	**221,294**	**202,575**	**220,572**
Working capital	**(183,298)**	**(168,228)**	**(186,821)**	**(158,545)**	**(176,142)**
Net Funds Employed	**350,517**	**440,069**	**463,075**	**494,926**	**470,274**
Non-Current Liabilities					
Employee Provision	16,563	16,357	16,600	16,700	15,300
Term Loans	167,600	252,600	270,600	297,600	272,600
Restricted funds	848	853	856	860	860
Total Non-Current Liabilities	**185,011**	**269,810**	**288,056**	**315,160**	**288,760**
Crown Equity	**165,506**	**170,259**	**175,019**	**179,766**	**181,514**
Net Funds Employed	**350,517**	**440,049**	**463,075**	**494,926**	**470,274**

Movement of Equity	2011/12 Audited Actual 000's	2012/13 Forecast 000's	2013/14 Plan 000's	2014/15 Plan 000's	2015/16 Plan 000's
Total Equity at beginning of period	**160,868**	**165,506**	**170,259**	**175,019**	**179,766**
Surplus / (Loss) for period	5,410	3,025	3,032	3,019	20
Crown Equity injection	2,148	2,148	2,148	2,148	2,148
Crown Equity withdrawal	(420)	(420)	(420)	(420)	(420)
Revaluation Reserve	(2,500)	-	-	-	-
Total Equity at beginning of period	**165,506**	**170,259**	**175,019**	**179,766**	**181,514**

7.3 Accounting Policies

The CM Health financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP).

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

The accounting policies applied in the projected financial statements are set out in 7.6.

7.4 Significant Assumptions

7.4.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2013/14 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing unutilised/approved debt facilities. To ensure we achieve a $3m surplus where cost growth is higher than forecast revenue, CM Health will cap the level of allowable and fundable growth within provider and funder arms

Where previously there appeared to be significant opportunity to continue to improve efficiencies and limit the cost impact of growth, the current outlook provides much more limited opportunities in the historical areas.

In response, CM Health has commissioned an internal Financial Sustainability Taskforce to undertake an in-depth review of additional savings. Agreed 'savings' actions resulting from this work will be confirmed in mid 2013, with implementation planned for the 2013/14 year.

7.4.2 Personnel Costs

Despite the international economic position, the anticipated relatively high level of clinical wage settlements will continue to be an ongoing challenge in relation to the mismatch of health worker wage/salary expectations and affordability. The average national Agreement have settled between 0.7 percent to 1.5 percent for 2013/14, overall personnel cost increase is about 3.5 percent – 4.5 percent due to automatic ongoing step functions, on-cost implications and increasing entitlements. Combined, these largely nationally set Agreement costs are greater than the Crown Funding growth and will be absorbed by internal efficiencies and other initiative savings.

We continue to reduce management and administration FTEs. Despite this, we have prioritised personnel costs to support acceleration of essential health system integration and related activities. This requires commitment to project, programme, analytical and change management resource to be successful.

7.4.3 Third Party and Shared Services Provision

The System Integration Investment programme remains a core enabler of system level change. Our focus for 2013/14 will be alignment of localities development and related primary care/community based capital investment (e.g. whaanau ora centre, integrated family healthcare centres). The form that this programme will take is still evolving and there is an expectation of increased third party participation and provision of public services integrated with core/essential CM Health services.

Capital investment constraints and increasing health target expectations (notably radiology and elective wait time) are likely to require a closer look at third party and shared regional capacity expansion. This will

include a strong direction regarding increased provision of shared services, through healthAlliance and Health Benefits Ltd (HBL); with heightened reliance around realisation of tangible savings.

7.4.4 Supplies

CM Health is working very closely with and contributing to, the national procurement and supply chain efficiency objectives through HBL although the estimated savings expectations are yet to be formalised through NHB advice to the DHBs (as at 8 March 2013).

Regional efficiencies through shared services provided by healthAlliance will be included in our local Thriving in Difficult Time programme.

7.4.5 Services by Other DHBs and Regional Providers

There is a significant commitment to regional cooperation and alignment of service provision to reduce wastage from unnecessary variation. CM Health contributes to the regional Better Sooner More Convenient business cases through an expanded investment in Primary Options for Acute Care (POAC) and Access to Diagnostics to better manage significant volume pressures through more effective service access in the community

Agreement has been reached to invest $250,000 for (operational funding of) point of care testing services in primary care settings to effect improved performance in health targets.

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

7.4.6 Other Funder Contracts

There is a forecast 2012/13 ‘surplus’ within the ring fenced Mental Health spend which is essentially a timing issue rather than a permanent under-spend. These benefits offset the demand driven cost increases occurring within the Funder Arm, particularly Health of Older People, and Pharmaceutical costs.

Publicly ACC has indicated a tighter fiscal affordability envelope and as well, a tightening of their payment parameters. While this is difficult to quantify currently, CM Health expects to offset any downside by further opportunities or enhancement of existing contracts.

CM Health is integrating its Whaanau Ora contracts with Maaori and Pacific providers through funding devolvement to the National Hauora Coalition and Alliance Health Plus.

7.4.7 IS Infrastructure

Prioritised Information System (IS) infrastructure investment has been agreed regional (refer section 2.2.2) and is essential for health system business continuity and effective implementation of integration models of care between secondary and primary/community care settings. The capital commitment for the regional DHBs collectively is significant and has been endorsed as a strategic priority by the CM Health Board. This investment will target IS infrastructure resilience that will provide a sound foundation for shared clinical and business information systems. Refer to section 4.3.8 for an outline of regional IS investments.

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

7.4.8 Capital Servicing

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

This will have a material valuation change to Land and Buildings from when the building is handed over from the main contractor to CM Health in late September 2013.

7.4.9 Capital Investment

The CSB Stage 1 [$208m] is now progressing to schedule with building completion and commissioning scheduled to start in September 2013, with approved service migrations staggered over 7 months. Despite planned efficiencies as a result of more effective department floor layouts, building flows and models of care, this will materially impact on our operating financial position, notably due to service functions such as gas, power and non-clinical support services.

Figure 21: Major capital investment projects – Current

Project	Budgeted Approval	Project Finish Date	Value	Status
Middlemore Hospital, Clinical Services Block Stage 1	Late May 2009	Nov 2014	$208m	Underway ($108m internally funded)

CM Health recognises the need to move away from reliance on physical brick and mortar solutions to manage capacity growth and adopt whole of organisation solutions with a focus on community based service expansion. In line with this, forecast inpatient bed capacity expansion investments will be deferred to prioritise investment in primary and community services integration and expansion to mitigate forecast requirements. In order to manage risks due to potential lag time, likely future requirement for (reduced scale) inpatient hospital bed expansion will be managed as a contingency investment in order to maintain the focus and prioritisation on health system change.

The changing Crown funding forecasts from 2013/14 have required a reassessment of local capital investment prioritisation. Figure 22 below outlined likely major capital investment projects, recognising that this is subject to confirmation by the CM Health Board, NHB and Treasury through submission of a 10 Year System Integration Investment business case and related regional capital planning processes.

Figure 22: Major capital investment projects – Future

Project	Budgeted Approval	Project Finish Date	Value	Status
IS Strategic (healthAlliance)	2013/14	2014-2023	$25m	Local/Regional Capital Intentions planning (indicative only[17])
System Integration Investment Programme (1st tranche)	2013/14	2014-2019	$201m	Programme business case in development (indicative only[17])
System Integration Investment Programme – including women's health, elective services and others (2nd tranche)	2013/14	2016-2023	-	Business case to be developed
Radiology (replacement upgrades)	2013/14	2014-2023	$9m	Local/Regional Capital Intentions planning
Southern Car Park	2013/14	2016	$19m	PPP or equivalent
Regional Food Service/Kitchen	-	-	-	Pending HBL business case outcomes
Grand Total			**$254m**	

Note: The above does not include the cash flow impact and initial operating expense impacts of unapproved business cases

[17] Subject to Programme Business case

7.4.10 Capital Investment Funding

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

7.4.11 Banking Covenant

CM Health operates under one banking covenant, with all its term debt facilities transitioned fully across to Ministry of Health (MoH). The Board maintains a working capital facility with HBL via Westpac which is the only relationship falling under this remaining covenant, together with lease/finance facilities with both Commonwealth Bank and Westpac.

Figure 23: Banking facilities

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

7.4.12 Pharmaceutical Budget

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

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

7.4.13 Property, Plant and Equipment

We revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. CM Health land and buildings are revalued every three years. The last revaluation occurred in 2010 on an "Optimised Depreciated Replacement Costs" basis.

There are currently no specifically identified asset sales within the time period of this Annual Plan. As part of the long term 10 Year System Integration Strategic Investment programme, we will be identifying any potential surplus assets that may be disposed of to assist in funding future developments.

There is recognition of the rising burden of clinical equipment replacement and this has accelerated CM Health's commitment to an enterprise Asset Management System; with roll out scheduled for 2013/14 (refer 2.2 for more detail).

7.5 Additional Information and Explanations

7.5.1 Disposal of Land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, CM Health will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. CM Health will comply with the relevant protection mechanism that addresses the Crown's obligations under the Treaty of Waitangi and any processes related to the Crown's good governance obligations in relation to Maaori sites of significance.

7.6 Significant Accounting Policies

7.6.1 Subsidiaries

Subsidiaries are entities controlled by the Group. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

7.6.2 Loss of control

On the loss of control, the Group derecognises the assets and liabilities of the subsidiary, any non-controlling interests and the other components of equity related to the subsidiary. Any surplus or deficit arising on the loss of control is recognised in profit or loss. If the Group retains any interest in the previous subsidiary, then such interest is measured at fair value at the date that control is lost. Subsequently it is accounted for as an equity-accounted investee or as an available-for-sale financial asset depending on the level of influence retained.

7.6.3 Investments in associates and jointly controlled entities (equity accounted investees)

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

7.6.4 Jointly controlled operations

A jointly controlled operation is a joint venture carried on by each venturer using its own assets in pursuit of the joint operations. The consolidated financial statements include the assets that the Group controls and the liabilities that it incurs in the course of pursuing the joint operation and the expenses that the Group incurs and its share of the income that it earns from the joint operation.

7.6.5 Transactions eliminated on consolidation

Intra-group balances and transactions, and any unrealised income and expenses arising from intra-group transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with equity accounted investees are eliminated against the investment to the extent of the Group's interest in the investee.3 Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

7.6.6 Revenue

Revenue is measured at the fair value of consideration received or receivable.

Crown funding
Funding is provided by the MoH through a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the Appropriation equally throughout the year.

ACC contract revenue is recognised as revenue when eligible services are provided and contract conditions have been fulfilled

Rental income
Rental income is recognised as revenue on a straight-line basis over the term of the lease.

Revenue relating to service contracts

Revenue from services rendered is recognised in profit or loss in proportion to the stage of completion of the transaction at the reporting date. The stage of completion is assessed by reference to surveys of work performed.

7.6.7 Interest income

Interest income is recognised using the effective interest method.

7.6.8 Donations and bequests

Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/(deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

7.6.9 Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

7.6.10 Interest expense

The DHB has elected to defer the adoption of the revised NZ IAS 23 *Borrowing Costs (Revised 2007)* in accordance with the transitional provisions of NZ IAS 23 that are applicable to public benefit entities. Therefore, all borrowing costs are recognised as an expense in the financial year in which they are incurred.

7.6.11 Leases

Finance leases
A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty that the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

7.6.12 Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.

Bank overdrafts are shown as borrowings in current liabilities in the statement of financial position.

7.6.13 Debtors and other receivables

Debtors and other receivables are recorded at their face value, less provision for impairment.

A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired.

The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

7.6.14 Investments

Bank deposits
Investments in bank deposits are initially measured at fair value.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

A bank deposit is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the bank, probability that the bank will enter into receivership or liquidation, and default in payments are considered indicators that the deposit is impaired.

7.6.15 Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. The loss of service potential of inventories held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the lower of cost or replacement cost at the date of acquisition.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit in the period of the write-down.

7.6.16 Non-Current assets held for sale

Non-Current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-Current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of Non-Current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-Current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

7.6.17 Property, plant, and equipment

Property, plant, and equipment consist of the following asset classes:

- Land

- Buildings and plant
- Clinical equipment
- IT and motor vehicles
- Other equipment
- Work in progress

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

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

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

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

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

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

Work in progress is recognised at cost, less impairment, and is not depreciated.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

Disposals
Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses.

Subsequent costs
Costs incurred subsequent to initial acquisition are capitalised only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation
Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their

useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Class of Asset	Estimated Life	Depreciation Rate
Buildings		
Structure/Envelope	10 – 50 years	2% - 10%
Electrical Services	10 – 15 years	6% - 10%
Other Services	15 – 25 years]	4% - 6%
Fit Out	5 – 10 years	10% - 20%
Plant and Equipment	5 – 10 years	10% - 20%
Clinical Equipment	3 – 25 years	4% - 33%
Information Technology	3 – 5 years	20% - 33%
Vehicles	3 – 5 years	20% - 33%
Other Equipment	3 – 25 years	4% - 33%

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

7.6.18 Intangible assets

Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

- Acquired computer software 2-5 years (20% - 50%)

7.6.19 Impairment of Property, Plant & Equipment and Intangible Assets

Property, Plant & Equipment and Intangible Assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

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

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

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

The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

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

7.6.20 Creditors and other payables

Creditors and other payables are generally settled within 30 days so are recorded at their face value.

7.6.21 Borrowings

Borrowings are initially recognised at their fair value. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

7.6.22 Employee entitlements

Short-term employee entitlements
Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

Long-term entitlements
Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as sabbatical leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- Likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- The present value of the estimated future cash flows

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows for entitlements. The inflation factor is based on the expected long-term increase in remuneration for employees.

Presentation of employee entitlements
Sick leave, continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, sabbatical leave, and retirement gratuities expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

7.6.23 Superannuation schemes

Defined contribution schemes
Employer contributions to KiwiSaver, the government Superannuation Fund, and the State Sector Retirement

Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

7.6.24 Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditure will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are not recognised for future operating losses.

Restructuring
A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Partnership Programme
The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of two years up to a specified maximum amount. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date.

Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

7.6.25 Revaluation reserves

These reserves are related to the revaluation of land and buildings to fair value.

Trust funds
This reserve records the unspent amount of donations and bequests provided to the DHB.

7.6.26 Goods and services tax

All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense. The GST (net) component of cash flows from operating activities reflects the net GST paid to and received from the IRD. The GST (net)

component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes and to be consistent with the presentation basis of the other primary financial statements.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

7.6.27 Income tax

The DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

7.6.28 Budget figures

The budget figures are derived from the statement of intent as approved by the Board at the beginning of the financial year. The budget figures have been prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the Board in preparing these financial statements.

Cost Allocation
CM Health has arrived at the net cost of service for each significant activity using the cost allocation system outlined below uses the following.

Cost Allocation Policy
Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Criteria for Direct and Indirect Costs
Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Cost Drivers for Allocation of Indirect Costs
The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

7.6.29 Use of estimates and judgements

The preparation of the financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of accounting policies and the reported amounts of assets, liabilities, income and expenses. Actual results may differ from these estimates.

Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimates are revised and in any future periods affected.

Information about critical judgements in applying accounting policies that have the most significant effect on the amounts recognised in the financial statements is included in the following notes:

- Note 9 – business combinations, acquisition of subsidiary
- Note 10 – commission revenue, determination of whether the Group acts as an agent in the transaction rather than as the principal

- Note 19 – classification of investment property
- Note 28 – accounting for an arrangement containing a lease
- Note 35 – lease classification

Information about assumptions and estimation uncertainties that have a significant risk of resulting in a material adjustment within the next financial year are included in the following notes:

- Note 17 – key assumptions used in discounted cash flow projections
- Note 17 – measurement of defined benefit obligations
- Notes 32 and 37 – provisions and contingencies

7.6.30 Property, plant and equipment

Recognition and measurement

Items of plant and equipment are measured at cost less accumulated depreciation and accumulated impairment losses.

Land and buildings are measured at fair value, less accumulated depreciation on buildings and accumulated impairment losses recognised after the date of the revaluation. Valuations are performed with sufficient frequency to ensure that the fair value of a revalued asset does not differ materially from its carrying amount.

Cost includes expenditure that is directly attributable to the acquisition of the asset. The cost of self-constructed assets includes the following:

- The cost of materials and direct labour
- Any other costs directly attributable to bringing the assets to a working condition for their intended use
- When the group has an obligation to remove the asset or restore the site, an estimate of the costs of dismantling and removing the items and restoring the site on which they are located
- Capitalised borrowing costs

Cost also includes transfers from equity of any gain or loss on qualifying cash flow hedges of foreign currency purchases of property, plant and equipment. Purchased software that is integral to the functionality of the related equipment is capitalised as part of that equipment.

When parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

Any gain or loss on disposal of an item of property, plant and equipment (calculated as the difference between the net proceeds from disposal and the carrying amount of the item) is recognised in profit or loss.

7.6.31 Reclassification to investment property

When the use of a property changes from owner-occupied to investment property, the property is remeasured to fair value and reclassified as investment property. Any gain arising on re-measurement is recognised in profit or loss to the extent that it reverses a previous impairment loss on the specific property, with any remaining gain recognised in other comprehensive income and presented in the revaluation reserve in equity. Any loss is recognised immediately in profit or loss.

7.6.32 Subsequent costs

Subsequent expenditure is capitalised only when it is probable that the future economic benefits associated with the expenditure will flow to the Group. Ongoing repairs and maintenance is expensed as incurred.

7.6.33 Depreciation

For plant and equipment, depreciation is based on the cost of an asset less its residual value,

CM Health has adopted the following revisions to accounting standards during the financial year, which have had only a presentational or disclosure effect:

- Amendments to NZ IAS 1 Presentation of Financial Statements. The amendments introduce a requirement to present, either in the statement of changes in equity or the notes, for each component of equity, an analysis of other comprehensive income by item. The DHB has decided to present this analysis in note 19
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – The purpose of the new standard and amendments is to harmonise Australian and New Zealand accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The main effect of the amendments on the DHB is that certain information about property valuations is no longer required to be disclosed. Note 13 has been updated for these changes.

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

- NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1: Classification and Measurement, Phase 2: Impairment Methodology, and Phase 3: Hedge Accounting. Phase 1: Has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial assets (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standard Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

8.0 Performance Measures

Policy Priorities Dimension

Performance Measure and description			2013/14 Target	National Target	Frequency
PP1 Workforce – improving clinical leadership **Report progress of DHB work to improve clinical leadership and engagement across all levels of the DHB and the Regional Training Hubs**			No quantitative target qualitative deliverable required	NA	Annual
PP6 Improving the health status of people with severe mental illness through improved access	**Age 0-19**	Maaori	4.45 %	NA	Six-Monthly
		Total	3.07 %		
	Age 20-64	Maaori	7.75 %		
		Total	3.07 %		
	Age 65+	Total	2.80 %		
PP7 Improving mental health services using relapse prevention planning		**Adult (20+)**	95%	**95%**	Six-Monthly
		Child & Youth	95%	**95%**	

Policy Priorities Dimension

Performance Measure and description			2013/14 Target		National Target	Frequency
			MH	Addict *		
PP8 Shorter waits for non-urgent mental health and addiction services **Addictions should be NGO only as the Provider Arm regional contract is held by Waitemata DHB*	0-19 years	3 weeks	75 %	75 %	**Within 3 years 80%** of people referred for non-urgent mental health or addiction services are seen within three weeks and **95%** of people are seen within 8 weeks	Six-Monthly
		8 weeks	95%	95%		
	20-64 years	3 weeks	80%	80%		
		8 weeks	95%	95%		
	65+ years	3 weeks	80%	80%		
		8 weeks	95%	95%		
	Total	3 weeks	80%	80%		
		8 weeks	95%	95%		
PP10 Oral Health DMFT Score at year 8			year 1: 1.09 year 2: 1.08		NA	Annual
PP11 Children caries free at 5 years of age			year 1: 52% year 2: 53%		NA	Annual
PP12 Utilisation of DHB funded dental services by adolescents (School Year 9 up to and including age 17 years)			Year 1: 80% Year 2: 85%		**85%**	Annual

Performance Measure and description	2013/14 Target	National Target	Frequency
PP13 Improving the number of children enrolled in DHB funded dental services		NA	Annual
Children Enrolled **0-4 years**	Year 1: 75% Year 2: 85%		
Children not examined **0-12 years**	Year 1: 12% Year 2: 7%		
PP18 Improving community support to maintain the independence of older people The percentage of older people who have received long-term home-support in the last three months who have a Comprehensive Clinical Assessment and a completed individual care plan	95 %	95%+	Quarterly

Policy Priorities Dimension

Performance Measure and description		2013/14 Target	National Target	Frequency
PP 20 improved management for long term conditions (CVD, diabetes and Stroke)				
Focus area 1: Cardiovascular disease	70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')	70%	70%	Quarterly
	80 percent of ACS patients receiving a risk assessment and classification within 24 hours of presenting	80%	80%	Quarterly
	80 percent of non-high risk ACS patients undergoing further risk stratification tests within 2 days of admission.	80%	80%	Quarterly
Focus area 2: Stroke services	6 percent of potentially eligible stroke patients thrombolysed	6%	6%	Quarterly
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%	80%	Quarterly
Focus area 3: Diabetes Management (Microalbuminuria and on an ACEi or ARB and HbA1c)	Maintain or improve appropriate management of microalbuminuria in patients with diabetes	Maintain or improve	NA	Quarterly
	Maintain or improve the proportion of patients with good or acceptable glycaemic control	66%	NA	Quarterly
PP 21 Immunisation coverage	95 per cent of two year olds are fully immunised	95%	95%	Quarterly
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan			Quarterly
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan			Quarterly

Performance Measure and description		2013/14 Target	National Target	Frequency
PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Report on delivery of the actions and milestones identified in the Annual Plan			Quarterly
PP25: Prime Minister's youth mental health project	Provide a written stocktake, gaps analysis and actions being considered			Quarters 1 & 2
PP26: The Mental Health & Addiction Service Development Plan	Provide gaps analysis and report against SDP milestones			Quarters 1,2 & 4
PP27: Delivery of the children's action plan	Report on delivery of the actions and milestones identified in the Annual Plan			Quarterly
PP28: Reducing Rheumatic fever	Provide a progress report against DHBs' rheumatic fever prevention plan			Six-monthly
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 10% lower than the average over the last 3 years	12.4 per 100,000	12.4 per 100,000	

Performance Measure and description		2013/14 Target	National Target	Frequency
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4	84 %		Six-monthly
	Age 45-64	147 %		
	Age 0-74	116 %		
SI2 Delivery of Regional Service Plans	A single progress report on behalf of the region agreed by all DHBs within that region			Quarterly
SI3 Ensuring delivery of Service coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage			Six-monthly
SI4 Elective services standardised intervention rates	**Major joint replacement procedures**	21 per 10,000	21.0 per 10,000	
	Cataract Procedures	27 per 10,000	27.0 per 10,000	
	Cardiac surgery (a target intervention rate 6.5 per 10,000 of population) If previous rate of 6.5 per 10,000 or above -maintain this rate	6.5 per 10,000	6.5 per 10,000	
	Percutaneous revascularization (a target rate of at least 11.9 per 10,000 of population)	11.9 per 10,000	11.9 per 10,000	
	Coronary angiography services (a target rate of at least 32.3 per 10,000 of population)	33.9 per 10,000	33.9 per 10,000	
SI5 Delivery of Whaanau Ora	Report progress on planned activities with providers to improve service delivery and develop mature providers			Annual

Ownership Dimension

Performance Measure and description		2013/14 Target	National Target	Frequency
OS3 Inpatient length of stay	Elective LOS	3.21 days	The year-end target to be stated. The ministry will assume a 25 percent improvement towards target can be made each quarter unless otherwise specified.	Quarterly
	Acute LOS	4.31 days		
OS8 Reducing acute readmissions to hospital	Total Population	<=8.0 %	The year-end target to be stated. The ministry will assume a 25 percent improvement towards target can be made each quarter unless otherwise specified.	Quarterly
	75 plus	<=11.8 %		
OS10 Improving the quality of data provided to national collection systems				
National Health Index (NHI) duplications		Greater than 3.00% and less than or equal to 6.00%	Greater than 3.00% and less than or equal to 6.00%	Quarterly
Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI Numerator: Total number of NHI records created with ethnicity of 'Not Stated' or 'Response Unidentifiable' per DHB per quarter Denominator: Total number of NHI records created per DHB per quarter		Greater than 0.50% and less than or equal to 2%	Greater than 0.50% and less than or equal to 2%	
Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS)		Greater than or equal to 75.00% and less than 90.00%	Greater than or equal to 75.00% and less than 90.00%	
Timeliness of NMDS data		Greater than 2.00% and less than or equal to 5.00% late	Greater than 2.00% and less than or equal to 5.00% late	
NNPAC Emergency Department admitted events have a matched NMDS event		Greater than or equal to 97.00% and less than 99.50%	Greater than or equal to 97.00% and less than 99.50%	

Performance Measure and description	2013/14 Target	National Target	Frequency
PRIMHD File Success Rate	Greater than or equal to 98.0% and less than 99.5%	Greater than or equal to 98.0% and less than 99.5%	

Output Dimension

Performance Measure and description	2013/14 Target	National Target	Frequency
OP1 Mental health output delivery against plan	Within 5%	Volume delivery is within five percent of plan	Quarterly
	Within 5%	Clinically safe occupancy rate of 85 percent for inpatient services is within five percent variance	
	Within 5%	Actual expenditure on delivery of programmes is within five percent of year-to-date plan	

9.0 Appendices

Appendix 1: PHO Letters of Support

ProCARE

28 May 2013

Geraint Martin
Chief Executive Officer
Counties Manukau District Health Board
Private Bag 94052
South Auckland Mail Centre

Dear Geraint

RE: Endorsement for Counties Manukau Health 2013/14 Annual Plan

Thank you for the ongoing engagement and opportunity to contribute to the Counties Manukau Health 2013/14 Annual Plan. As a District Alliance group of Primary Health, we acknowledge and value the purposeful inclusion of primary health care and PHOs as partners in planning, delivery and accountability. We support and endorse the overall direction outlined in the Annual Plan and in particular the service integration and primary care commitments.

We look forward to working in partnership with you in 2013/14 to achieve the goals outlined in the Annual Plan and to improve health and equity for Counties Manukau population.

Yours sincerely,

Steve Boomert
Chief Executive Officer
ProCare Health Limited

Level 2, 110 Stanley Street, Grafton
PO Box 105 346, Auckland 1143
telephone +64 9 377 7827
facsimile +64 9 377 7826
www.procare.co.nz

28 May 2013

Dear Geraint

RE: Endorsement for Counties Manukau Health 2013/14 Annual Plan

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Yours sincerely,

Mark Vella
Chief Executive Officer
Total Healthcare Charitable Trust

Alliance Health Plus Trust
Level 1, 15b Vestey Drive, Mt Wellington
PO Box 132366, Sylvia Park, Auckland 1644
Phone: (09) 588 4260 Fax: (09) 588 4270
admin@alliancehealth.org.nz **www.alliancehealth.org.nz**

31 May 2013

Geraint Martin
Chief Executive
Counties Manukau DHB

Dear Geraint

RE: Endorsement for Counties Manukau Health 2013/14 Annual Plan

Thank you for the ongoing engagement and opportunity to contribute to the Counties Manukau Health 2013/14 Annual Plan. We acknowledge and value the purposeful inclusion of primary health care and PHOs as partners in planning, delivery and accountability. We support and endorse the overall direction outlined in the Annual Plan and in particular the service integration and primary care commitments.

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Yours sincerely,

Alan Wilson
Chief Executive
Alliance Health Plus

cc: Siro Fuata'i – Chairman, AH+

www.nhc.maori.nz

Unit 1 485B | Rosebank Road
Avondale | Auckland 1026

P O Box 104221 | Lincoln North
Auckland 0654

P | 09 950 3325

National
Hauora Coalition

22 May 2013

Lisa Gestro
Group Manager – Primary Care & Service Development
Counties Manukau Health
CMDHB Board Office
Private Bag 94052
AUCKLAND 2241

Lisa.Gestro@middlemore.co.nz

Tēnā koe

DISTRICT ANNUAL PLAN (DAP) – 2013/14

The National Hauora Coalition (NHC) is pleased to confirm engagement by Counties Manukau District Health Board regarding its District Annual Plan (DAP) approaches, content and finalisation for the 2013-14 year.

The NHC is supportive of the content of the primary care sections and is committed to working with the Counties Manukau DHB on health targets and integration initiatives.

Noho ora mai,

Simon Royal
Chief Executive

cc: Benedict Hefford
Director Primary Health & Community Services
Counties Manukau Health
benedict.hefford@cmdhb.org.nz

EAST HEALTH TRUST
primary health organisation

18 June 2013

Geraint Martin
Chief Executive Officer
Counties Manukau Health

Dear Geraint

RE: Endorsement for Counties Manukau Health 2013/14 Annual Plan

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We look forward to working in partnership with you in 2013/14 to achieve the goals outlined in the Annual Plan and to improve health and equity for Counties Manukau population.

Yours sincerely

L. L. C. Hansen.

Loretta Hansen
Chief Executive Officer

East Health Trust
P.O. Box 38248, Auckland 2145
Telephone: 09 538 0599. Telefax: 09 535 5908. Email: health@easthealth.co.nz

COUNTIES
MANUKAU
HEALTH