Waitemata
District Health Board
Best Care for Everyone

# 2014/15

# Annual Plan

## Incorporating the Statement of Intent and Statement of Performance Expectations

# Mihimihi

E nga mana, e nga reo, e nga karangarangatanga tangata
E mihi atu nei kia koutou
Tena koutou, tena koutou, tena koutou katoa
Ki wa tatou tini mate, kua tangihia, kua mihia kua ea
Ratou, kia ratou, haere, haere, haere
Ko tatou enei nga kanohi ora kia tatou
Ko tenei te kaupapa, 'Oranga Tika', mo te iti me te rahi
Hei huarahi puta hei hapai tahi mo tatou katoa
Hei Oranga mo te Katoa
No reira tena koutou, tena koutou, tena koutou katoa

To the authority, and the voices, of all people within the communities
We send greetings to you all
We acknowledge the spirituality and wisdom of those who have crossed beyond the veil
We farewell them
We of today who continue the aspirations of yesterday to ensure a healthy tomorrow, Greetings
This is the Annual Plan
Embarking on a journey through a pathway that requires your support to ensure success for all
Greetings, greetings, greetings

*"Kaua e mahue tetahi atu ki waho*
*Te Tihi Oranga O Ngati Whatua"*

The Waitemata District Health Board Annual Plan for 2014/15 is signed for and on behalf of:

**Waitemata District Health Board**

Dr Lester Levy, CNZM Date
**Chair**

Anthony Norman MNZM Date
**Deputy Chair**

**Our Te Tiriti o Waitangi partners**

Te Runanga o Ngati Whatua

R Naida Glavish ONZM JP

R Naida Glavish JP Date
**Chair, Te Runanga o Ngati Whatua**

Te Whānau o Waipareira Trust

John Tamihere Date
**CEO, Te Whānau o Waipareira Trust**

And signed on behalf of

**The Crown**

Hon Jonathan Coleman Date 29/4/14.
**Minister of Health**

**Office of Hon Dr Jonathan Coleman**

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

0 1 DEC 2014

Dr Lester Levy
Chair
Waitemata District Health Board
Private Bag 93503
Takapuna
North Shore City 0740

Dear Dr Levy

**Waitemata District Health Board 2014/15 Annual Plan**

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

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

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

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

I am pleased to see that your DHB is planning a surplus for 2014/15 and breakeven for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2014/15.

***Better Public Services (BPS): Results for New Zealanders***
Of the ten whole-of-government key result areas, the health service is leading the following areas:

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

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

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

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

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

***Care Closer to Home***

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

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

***Health of Older People***

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

***Regional and National Collaboration***

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

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

***Budget 2014***

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

***Annual Plan Approval***

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework. The NHB will contact you where change proposals need further engagement. You are reminded that you need to advise the National Health Board of any proposals that may require Ministerial approval as you review services during the year.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2014/15 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr Jonathan Coleman
**Minister of Health**

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# MODULE 1: Introduction and Strategic Intentions (Statement of Intent)

The Statement of Intent covers the four year period: 1 July 2014 to 30 June 2018.

## Foreword from our Chair and Chief Executive

### Growth with integrity

The past year has been one of exponential growth for our DHB. Through this growth, our organisation has used our values and organisational promise – Best Care for Everyone – to guide us.

At the heart of this promise is the need to respect the intrinsic dignity of every single person that enters into our care – a privilege and a responsibility that we strive to keep front of mind through our everyday service delivery.

In the last 12 months, our DHB was privileged to be able to host Robert Francis QC, who is best known in New Zealand for chairing the inquiry into the Mid Staffordshire National Health Service Foundation. His advocacy for a common culture of putting patients first, fundamental standards of quality of care and strong clinical leadership gave us a prime opportunity to reflect as an organisation on our enduring commitment to these principles.

We are now the largest and fastest growing DHB in New Zealand. Population growth, an aging population and the growing prevalence of people with long term conditions will see increased demand for our services in 2014. This has spurred us to look at ways to do more with the resources we have. A substantive business transformation programme underway across the organisation has seen us obtain new efficiencies in the way we operate, while a drive to look at new models of care has seen innovative, fresh ways of delivering high quality health services to our communities. Against an increasingly challenging financial landscape, we strive to not only be sustainable, but to grow and improve the efficiency, safety and quality of the services we provide.

As the organisation rises to this challenge, we aim to meet this demand within a constrained financial environment and keep our organisational promise – Best Care for Everyone – at the heart of everything we do.

### Key milestones

The past year has seen us invest in new facilities and services that have made an immediate and measurable difference to the community we serve. Key milestones include:

- The opening of a 40 bed, 4 theatre, state-of-the-art Elective Surgery Centre – a more efficient, patient-focused service which will significantly reduce waiting times and improve overall patient experience for non-emergency surgery. The new centre will be able to perform up to 5,600 procedures per year
- A $1.7 million advanced Interventional Radiology Suite enabling the DHB to offer minimally invasive treatment options for a wide range of conditions.
- Waitakere Hospital's new endoscopy suite, greatly improving local access to endoscopy services in west Auckland with reduced wait times. The new suite enables the DHB to carry out more than 2000 additional endoscopy procedures, complementing the DHB's Bowel Screening pilot
- The five bed Piri Pono service in Silverdale, the first of several new community mental health facilities planned for our district
- The opening of our first national service with the transfer from the New Zealand Navy of the Slark hyperbaric oxygen therapy service.

## Our performance

In addition to these developments our overall performance is robust, ending 2013 having performed very well against the six national health targets, although we have more work to do to achieve the newest national primary care targets of more heart and diabetes checks as well as the primary care component of providing smoking cessation advice for our population. The DHB remains on a financially sound footing having again produced a small surplus which has been reinvested back into DHB services.

Most significantly, our DHB now consistently exceeds the 95 percent target of having all emergency department patients admitted, discharged or transferred in six hours or less. This exceptional performance at our two emergency departments, Waitakere and North Shore, has been consistently maintained since January 2012 – a result we are immensely proud of.

Our work is reflected in the health of our district, with our population among the healthiest in the country. The Waitemata district has the lowest death rate for its population among all health districts in New Zealand and the lowest mortality rates associated with cancer and heart disease. Our district's population is also the longest living in the country, with an average life expectancy of 84 years.

With growth has come an increased organisation-wide focus on quality to continue to enhance patient safety and experience. Last year saw the publication of Waitemata DHB's first Quality Account – a dedicated report about the quality of our services. The report looks closely at what our DHB is doing well, where improvements can be made and priority areas for improvement. The Quality Account will be released annually through a dedicated website, strengthening our reporting and monitoring systems across the organisation and providing greater public transparency and accountability.

## 2014 and beyond

A number of new developments starting in 2014 include:

- A $25 million, 46-bed mental health facility on the North Shore Hospital site, allowing the current service located in the Taharoto building to migrate to a new state-of-the-art facility
- A new MRI suite at North Shore Hospital, housing significantly faster, more detailed medical scanning equipment, further enhancing our ability to diagnose medical conditions
- New floor space above the antenatal unit at North Shore Hospital, providing additional office and meeting space as well as a new chapel to further support the spiritual wellbeing of patients and their families
- Beginning of the build for the expansion of Waitakere Hospital, future proofing the high quality, around-the-clock emergency care provided to west Auckland's growing population.

We are pleased with the unprecedented progress accomplished at Waitemata DHB over the past year and the progress made towards our organisational goals. There is still much work to do, and we look forward to continuing this in 2014/15.

The past year has been one of considerable achievement only made possible by dedicated staff in every corner of the organisation. As we continue on our path, our staff give us the confidence to continue to deliver positive growth in 2014 and beyond – thank you for all your support.

Dr Lester Levy, CNZM
Chair

Dr Dale Bramley
Chief Executive Officer

# Te Tiriti o Waitangi Statement

Waitemata DHB recognises the Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the relationship between the Crown and Iwi. It provides a framework for Māori development and wellbeing. The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes to enable Māori to participate in, and contribute towards, strategies to improve Māori health outcomes.

Te Tiriti o Waitangi serves as an effective framework for Māori health gain across the health sector and the articles of Te Tiriti provide four domains under which Māori health priorities for Waitemata DHB can be established. The framework recognises an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Article 1 – Kawanatanga (governance) is equated to health systems performance. It covers the structures and systems that are necessary to facilitate Māori health gain and reduce inequalities. It provides for active partnerships with manawhenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is concerned with opportunities for Māori leadership, engagement, and participation in relation to DHB's activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequalities in the determinants of health, health outcomes and health service utilisation.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

## Guiding Principles

The following nine principles underpin the Waitemata DHB work streams and approaches and provide practical direction for the identification of Māori health priority areas and associated activities and indicators.

## Health partnership with manawhenua

This principle is reflected in the memoranda between Waitemata DHB and Te Runanga o Ngati Whatua, which outlines the partnership approach to working together at both governance and operational levels. These memoranda arrangements establish a treaty based health partnership enabling joint collaboration between the Crown and Ngati Whatua in key areas such as funding and planning. To this extent the relationship is designed to ensure the provision of effective health and disability services for Māori resident within the Ngati Whatua tribal rohe (area).

## Commitment to Māori communities

This is reflected in the memoranda between Waitemata DHB and Te Whānau o Waipareira Trust. This arrangement enables joint collaboration in key areas of planning and funding and is designed to ensure provision of effective health and disability services for Māori.

## Whānau ora

Whānau ora, in the context of this plan, is concerned with an intra- and inter-sectoral strength-based approach to supporting whānau to achieve their maximum potential in terms of health and wellbeing. The approach is whānau-centred and involves providing support to strengthen whānau capacities to undertake functions that are necessary for healthy living and contributing to the wellbeing of whānau members and the whānau collective.

## Health equity

Health equity is concerned with eliminating disparities in health outcomes. The concept of health equity acknowledges that different types and levels of resources may be required in order for equitable health outcomes to be achieved for different groups. Improving Māori access to health services will be a key contribution towards achieving health equity.

## Self-determination

This principle is concerned with the right of Māori patients/individuals and collectives to be informed and exert control over their health. This is consistent with full involvement in health care decision-making, increased capacity for self-management, higher levels of autonomy and reduced dependence.

## Indigeneity

Indigeneity is concerned with the status and rights of Māori as indigenous peoples. The value placed on Indigeneity should be reflected in health policies and programmes that support the retention of Māori identity, the participation of Māori in decision-making, and health development based on the aspirations of Māori.

## Ngā kaupapa tuku iho

Ngā kaupapa tuku iho requires acknowledgment and respect for Māori values, beliefs, responsibilities, protocols, and knowledge that are relevant to and may guide health service planning and service delivery for Māori.

## Whole-of-system responsibility

Achieving best health outcomes for whānau and health equity for Māori is a whole-of-system responsibility. Therefore, contributing to Māori health gain and reducing ethnic inequalities in health between Māori and non-Māori is an expectation of all health activities through the whole of the health system.

## Evidence-based approaches

The evidence-based approach is a process through which scientific and other evidence is accessed and assessed for its quality, strength and relevance to local Māori. An understanding of the evidence is then used in combination with good judgement, drawing on a Māori development perspective and social justice ethic, to inform decision-making that maximises the effectiveness and efficiency of Māori health policy, purchasing, service delivery and practice.

# The context of this plan

## Who we are and what we do

Waitemata DHB was established under the New Zealand Public Health and Disability Act (2000) to:

- Improve, promote, and protect the health of communities
- Reduce inequalities in health status
- Integrate health services, especially primary and hospital services
- Promote effective care or support of those in need of personal health services or disability support.

The Waitemata district encompasses North Shore, Waitakere and Rodney. Approximately 574,500 people live in Waitemata DHB and this number is growing due to the inwards migration of people to the Waitemata district. New strategies are being implemented to meet this growing demand. A snapshot of the Waitemata population is provided in the box below.

The next four years will be a period of growth for our DHB guided by our values and promise – Best Care for Everyone. We will continue to roll-out organisational redesign to ensure the optimum arrangement for the most effective and efficient delivery of health services. This will involve clinical leaders taking on the accountability for clinical and financial outcomes for their services.

## Snapshot of Waitemata DHB

- Largest and fastest growing population of all districts – over 574,500 people, with the population expected to grow approximately 20% (111,300 people) over the next 10 years
- Our population is relatively affluent with the third highest proportion of least deprived (deciles one and two) people and the second lowest proportion of highly deprived (decile 10) people of any DHB
- People who live in our district have the highest life expectancy in New Zealand. We also have the highest life expectancy for Māori in the North Island. However, in 2012 there was an 8.8 year gap between Māori and non-Māori non-Pacific and an 8.2 year gap between Pacific and non-Māori non-Pacific ethnic groups
- 20% of the Waitemata population is Asian[1], 10% Māori and 7% Pacific
- 20% of our overall population and 35% of our Māori population are under 15 years of age, 13% of the population are over 65 years, with around 2% over 85 years old
- It is estimated that 7,800 babies will be born to Waitemata residents in 2014/15
- Between 2008 and 2012 we have seen an increase of 37% in the number of people attending our emergency departments with 104,653 attendances in 2012.

Please refer to our website for further information on our population and health needs assessments. http://www.waitematadhb.govt.nz/PlanningConsulting/Healthneedsassessments.aspx

[1] For the purpose of this Annual Plan, the term 'Asian' describes culturally diverse communities with origins from the Asian continent and refers to Chinese, Indian, Southeast Asian and other Asian people excluding people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia. The term 'MELAA' refers to Middle Eastern, Latin American or African ethnicity groupings consisting of extremely diverse cultural, linguistic and religious groups.

## Challenges and Opportunities

Across the overall Auckland region there are similar kinds of challenges and opportunities:

- Population growth and ageing
- Increasingly diverse communities
- Increasing prevalence of long term conditions
- Growing demand for our health services (impacting workforce and infrastructure)
- Inequalities in access to services and health outcomes.

As we grow, our DHB needs to respond while working in a fiscal environment where health spending is expected to be constrained. The challenge is to enhance quality health service delivery against this economic background.

## Key areas of risk and opportunity

| Risks | Mitigations/ opportunities |
|---|---|
| Long-term fiscal sustainability | Clear prioritisation across all areas of the sector. Innovation, integration and regional collaboration to support improved national, regional and local service delivery models of care. Use of evidence-based care to avoid wastage. Tight cost control to limit the rate of cost growth pressure and purchasing and productivity improvement to deliver services more efficiently and effectively across both community and hospital providers. |
| Diversity of need within New Zealand's population, including a growing number of older people with multiple conditions | Engaging patients, consumers and their families and the community in the development and design of health services and ensuring our services are responsive to their needs.<br><br>Assisting people and their families to manage their own health in their own home, supported by specialist services delivered in community settings as well as hospitals and increasing our focus on proven preventative measures and earlier intervention. |
| Growing demand for health services | Accelerating the pace of change, in key areas such as:<br>• Moving intervention upstream<br>• Improved models of care<br>• Better management of long term conditions<br>• Integrating services (the coordination of care, systems and information) to better meet people's needs<br>• Improving performance and implementing evidence based practice<br>• Strengthening leadership while supporting front-line innovation<br>• Integrated contracting<br>• Working regionally and across government to address health and other priorities<br>• Working as a whole of system health service, inclusive of non-government organisations (NGOs), primary care, community, hospitals and funders. |

## Nature and scope of activities

District Health Boards have four key roles to deliver on their objectives. The 'Planner' and 'Funder' roles are undertaken by the same team hosted by Waitemata DHB for both the Auckland and Waitemata DHBs:

- Planner - DHB planning begins with the assessment of population health need. Health needs assessment, along with input from our key stakeholders (including our community), establishes the important areas of focus within our district and these are balanced alongside

national and regional priorities. These inform the Northern Region Health Plan, which sets the longer term priorities for DHBs in the northern region (Northland, Waitemata, Counties Manukau and Auckland DHBs) as well as this annual plan and Māori Health Plan

- Funder - DHB responsibilities include funding the totality of hospital-based and community-based services for our population while delivering both value for money, living within our means and improving health outcomes for our population
- Provider - Waitemata DHB provides predominantly secondary hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. We also provide child disability, forensic psychiatric services, school dental services and alcohol and drug services to the residents of the overall Auckland region on behalf of the other DHBs. We manage the national Hyperbaric Medical Service. We contract other DHBs, particularly Auckland DHB, to provide some tertiary services, eg cardiac surgery and radiation oncology services, and have contracts with approximately 900 other community providers to deliver aged residential care, primary care, mental health, laboratory, pharmacy and oral health services
- Owner of Crown assets - as an owner of Crown assets, we must operate in a fiscally responsible manner and be accountable for the assets we own and manage. We are responsible for ensuring strong governance and accountability, risk management, audit, and performance monitoring and reporting.

## Other interests

The Waitemata DHB group consists of the parent, Waitemata District Health Board, Three Harbours Health Foundation (controlled by Waitemata District Health Board) and the newly formed Well Foundation which replaces two organisations – the North Shore Hospital Foundation and the West Auckland Health Services Foundation. The Well Foundation will operate as a legally-independent charitable entity providing seed funding for new equipment and healthcare innovations and initiatives.

Wilson Home Trust: Waitemata DHB is trustee for this trust, the primary functions of which are: provision and maintenance of building and grounds at the Wilson Home and the funding of equipment and amenities for children with physical disabilities. Waitemata DHB leases from the Trust premises on the Wilson Home site from which the DHB provides services for children with physical disabilities

Joint ventures are healthAlliance N.Z. Limited, New Zealand Health Innovation Hub Limited Partnership and Awhina Waitakere Health Campus. The associate company is Northern Regional Alliance Limited formerly called Northern DHB Support Agency Limited (NDSA).

Waitemata DHB also holds a 20% shareholding in South Kaipara Medical Centre Limited Partnership. This is a joint venture with the Helensville District Health Trust and two local GPs to ensure sustainability of a rural general practice.

Waitemata DHB is a shareholder in a number of Crown entity subsidiaries, namely the New Zealand Health Innovation Hub Management Limited, healthAlliance New Zealand Limited and the Northern Region Alliance Limited, which 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 four equal shares by Waitemata, Auckland, Counties Manukau and Northland DHBs.

Waitemata DHB will seek approval from the Minister of Health to progress any plans to acquire shares or interests in any other company, trusts and/or partnerships.

# Strategic Intentions

## Our DHB's Purpose

Our organisation's purpose is:

- To promote wellness
- To prevent, cure and ameliorate ill health
- To relieve suffering of those entrusted into our care.

Our purpose focuses us on delivering the Best Care for Everyone. For us that means striving to offer the best care possible to every person and their family engaged with our services. This requires us to continue to develop an organisation-wide culture that puts patients first, is relentless in the pursuit of fundamental standards of quality of care and which is enhanced by strong clinical leadership.

Over the past four years we have made substantial gains toward delivering on our purpose. To continue making progress we need to embed those gains and develop new models of care. This requires developing innovation capacity and capability while focusing on our two organisational priorities – relieving suffering and achieving better outcomes.

Relieving suffering requires we act to:

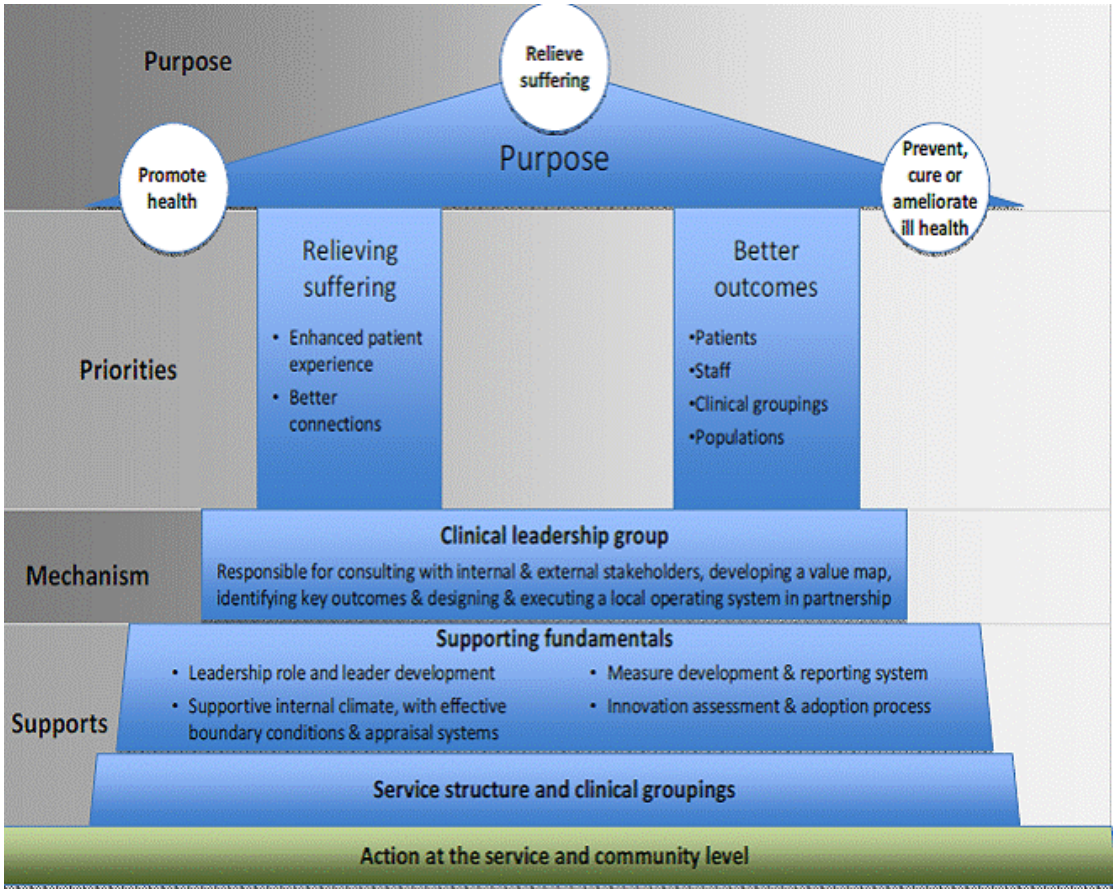
- Enhance patient and whānau experience when they interact with us, be it in the community, as an outpatient or as an inpatient
- Ensure that everything we do is done to relieve physical, psychological/emotional pain in a timely way
- Provide clear and understandable connections and smooth transitions between the various units of the DHB and its many community partners
- Ensure we do nothing to increase suffering, such as commit errors or provide unsafe or inappropriate care.

Achieving better outcomes requires we act to:

- Measure and better manage the outcomes that patients care most about, such as the reduction of pain, return to previous level of functioning, return to work, home and independent living
- Improve the health of the Waitemata population, with a focus on the sub-populations the Board prioritises for action, by timely access to evidence-based treatment and care
- Enhance staff engagement and satisfaction, as this correlates to better patient outcomes.

## Executing on our purpose

We are developing a set of plans and supporting resources in order to execute on this purpose. Primary among these is the development of a group of clinical leaders across primary and hospital care responsible for and capable of implementing improved care models in their clinical areas. As the diagram on the following page outlines, these leaders are being supported by a leadership development programme, a performance measurement system and an innovation assessment and deployment process.




The diagram shows the approach we take at Waitemata DHB to galvanise action at the service level so that we can achieve our purpose. Our purpose and priorities and organisational mechanisms and supports that we have highlighted for attention are based on our current performance and areas for further improvement.

## Innovation and Development

In order to continually improve outcomes and processes of care, innovation capacity and capability need to be developed, encouraged and sustained. We are developing an evolving library of up-to-date information on healthcare innovations nationally and internationally. This sits alongside the clinical leadership programme to support clinical redesign of existing models of care.

We are establishing a Centre for Health IT and Creative Design that will focus on the application and testing of innovations and technologies within the frontline health services. It is a collaborative model, involving partnering with industry and academic institutions as appropriate. This will provide an innovation assessment and prioritisation process and sites for the deployment and testing of new ways of working and new technologies for rapid evaluation by frontline staff. New models of care will be refined before being considered for roll-out across DHB services. Innovations will particularly focus on improving outcomes and the patient and whānau experience of healthcare. The Centre also aims to enhance innovation and research skills in staff, and engage them in a culture of innovation and ideas generation.

## System integration

Developing an effective integrated health care system that meets the needs of our population is central to the delivery of our purpose and priorities. In the coming years we will accelerate progress towards an integrated system to ensure patients and family receive the right care in the most appropriate place.

We will build upon and complement existing integration developments such as the youth hub, the integrated cognitive impairment pathway (previously the dementia care pathway) –led by hospital and community clinicians, integrated diabetes and child health services in west Auckland and the palliative care model of care. We are initiating, with primary care and non-government organisations, our Coordination, Assessment, Rehabilitation, Education (CARE) programme for older people. In collaboration with primary care and non-government organisations we will continue to focus on the Better Public Service targets for health:

- The Prime Minister's Youth Mental Health Project
- The Children's Action Plan
- Increased Immunisation Health Target
- Reduced rates of Rheumatic Fever.

Integration of services is a consistent focus across all our health service delivery areas. We are developing strong clinical leadership with responsibility for accelerating the rate of system integration through clinical redesign of existing models of care. This will be supported by:

- Embedding strong relationships between the DHB and primary care through the district Alliance
- Release of expertise within the hospitals to better support primary care and NGOs allowing more care to be delivered in community settings
- Building capability and capacity across the health care system and particularly primary care
- Improving performance through quality improvement and transparent reporting
- Developing innovative funding models that enable and support sustainable service change
- Organisation culture and norms of behaviour that support redesign processes and clinical leadership
- A focus on Māori, Pacific and other high need populations.

We will also contribute to the achievements of clinically-led regional networks as they progress the objectives of the Northern Region Health Plan. This work places particular emphasis upon:

- Agreement of appropriate standards and the consistency of care delivery across our region
- Development of new models of care to achieve best clinical outcomes and efficient use of our region's health resources
- Use of information technology to enable integrated patient and whānau determined health care; crossing organisational boundaries and extending along the continuum of care.

We will also contribute to the achievement of the Health Quality and Safety Commission, Health Workforce New Zealand, HBL, and National IT Board objectives including:

- Improve the quality and safety of health services and minimising patient harm
- Support implementation of national IT initiatives such as shared care and e-prescription services
- Support workforce development initiatives.

## Strategic outcomes in national and regional context

### National

Collectively, the health sector contributes to government priorities by working towards the Ministry of Health's overarching outcomes:

- New Zealanders living longer, healthier and more independent lives
- The health system is cost-effective and supports a productive economy.

For 2014/15 the Minister of Health requires continuing focus on the following priorities:

- **Better Public Services –** leading the effort to increase immunisation, reduce the incidence of rheumatic fever and reduce violent assaults against children
- **National Health Targets –** committing to achieve the six national health targets
- **Care closer to home –** better integration and coordination of health services between community and hospitals particularly for management of long term conditions and for the health of our older people to support their independence
- **Regional and national collaboration –** to leverage the financial and clinical gains to be derived from working together
- **Living within our means –** to support the Government achieving a surplus.

The DHB will support National Health Committee technology, clinical research and burden of disease work programmes as required during 2014/15. The PHARMAC managed Hospital Medicines List was implemented at Waitemata DHB in July 2013 and nationally is still in the transition phase.

### Regional

The Northern Region Health Plan has been developed by the four Northern Region DHBs. The Plan sets out three priority goals, these are:

- **Goal One** – First, Do No Harm: reducing harm and improving patient safety
- **Goal Two** – Life and Years: reducing disparities and achieving longer, healthier and more productive lives. This year there is a particular emphasis on child health, health of older people and reducing inequalities for Māori, Pacific and other population groups
- **Goal Three** – The Informed Patient: ensuring patients are better informed about care and treatment choices and healthcare providers are better informed about patients' care preferences, particularly around end of life care.

The Northern Regional Health Plan can be located here:
http://www.NDSA.co.nz/FormsDocuments.aspx )

### Sub-regional

Auckland and Waitemata DHBs have a bi-lateral agreement which joins governance and some activities where there is mutual benefit to the planning and delivery of providing enhanced, sustainable health services to over one million Aucklanders. The two DHBs share a Board Chair and have advisory-committees that meet jointly. The merger of a number of teams has increased consistency of relationships across the two DHBs.

## Planning Framework

The following planning framework for Waitemata DHB summarises the key national, regional and local priorities that inform this 2014/15 annual plan and sets the direction for the coming years, including the key measures we monitor to ensure we are achieving our objectives.

| GOVERNMENT OUTCOMES | NEW ZEALANDERS LIVE LONGER, HEALTHIER AND MORE INDEPENDENT LIVES | | THE HEALTH SYSTEM IS COST EFFECTIVE AND SUPPORTS A PRODUCTIVE ECONOMY |
|---|---|---|---|
| **MOH Priorities** | **Minister's Health Targets** | **Better Public Services** | **System Integration** |
| **Northern Region Triple Aim** | Health services are integrated, more convenient and people centered | New Zealanders are healthier and more independent | Future sustainability of health system is assured |

| **WDHB PROMISE** | **Best Care for Everyone** | | |
|---|---|---|---|
| **Board Priorities** | Better Outcomes • Relief of Suffering | | |
| **WDHB Purpose** | Promote Wellness | Prevent, cure and ameliorate ill health | Relieve suffering of those entrusted to our care |
| **Priority Programmes** | • Smoking<br>• Childhood immunisations<br>• Well children<br>• Rheumatic fever | • CVD/Diabetes Checks<br>• Cardiac and Stroke Services<br>• Cancer screening<br>• Faster cancer treatment<br>• Mental health | • Shorter stays in ED<br>• Access to electives<br>• Patient experience<br>• Quality and safety |
| **Priority Populations** | Maori | Pacific | Asian |

| | | | | |
|---|---|---|---|---|
| **Output classes** | Prevention | Early Detection and Management | Intensive Assessment and Treatment | Rehabilitation and Support |
| **Enablers** | Patient and Family empowerment | Workforce | Information and Communication Technology | Financial sustainability |

## Outcomes Framework

Our outcomes framework enables the DHB to ensure it is achieving the best possible outcomes for our population. Based on the three key themes that comprise our purpose statement we have identified two overall outcomes as well as a number of outcome measures and supporting impact measures that will demonstrate whether we are succeeding in delivering our purpose and improving the health and wellbeing of our population. These are presented in the intervention logic diagram on the following page.

Outcomes have been grouped in three sections in line with the DHB's purpose to prevent, cure and ameliorate ill health. Promoting wellness and the relief of suffering are cross cutting outcomes that run across all the DHBs programmes. The outcomes, outputs and programme areas are all interrelated and all contribute to the DHB's overall purpose and priorities as shown by the arrows at the bottom of the table.

Working with our hospital and primary care clinical leaders and MOU partners we will refine this framework and develop metrics and a reporting process to support it. The measures included in our

outcomes framework will be updated through this process. We intend to align this to the Integrated Performance Improvement Framework (IPIF) as it is developed. The Statement of Performance Expectations in module 3 sets out a more detailed set of indicators that contribute to our overall outcomes framework.

## Key to Outcomes Framework

| Acronym/ Term | Definition |
|---|---|
| ABC | **Ask** about smoking status, to give **Brief** advice to all smokers to stop smoking and to provide evidence-based **Cessation** support for those who wish to stop smoking |
| B4 | B4 school check is a nationwide programme offering a free health and development check for four year olds |
| CVD | Cardio-vascular disease |
| DCIP | Diabetes Care Improvement Package |
| HBA1c | HbA1c is a test of blood sugar levels used to indicate how well diabetes is being controlled |
| HBSS | Home-Based Support Service |
| HSMR | Hospital Standardised Mortality Ratio |
| Impact | Means the contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both (Public Finance Act 1989, s2). It normally describes results that are directly attributable to the activity of an agency. For example, the change in the life expectancy of infants at birth and age one as a direct result of the increased uptake of immunisations |
| Outcome | Outcomes are the impacts on or the consequences for, the community of the outputs or activities of government. However in common usage the term 'outcomes' is often used more generally to mean results, regardless of whether they are produced by government action or other means. An intermediate outcome is expected to lead to an end outcome, but in itself, is not the desired result. An end outcome is the final result desired from delivering outputs. An output may have more than one end outcome; or several outputs may contribute to a single end outcome |
| Outputs | Final goods and services, that is, they are supplied to someone outside a Crown Entity. They should not be confused with goods and services produced entirely for consumption within the DHB group (New Crown Entities Act 2004 s136(1)(a – c)) |
| QALYs | Quality-adjusted life years is a measure of disease burden, including both the quality and the quantity of life lived |
| RTT | Referral to treatment. |

## Outcomes Framework and Intervention Logic

| OVERALL OUTCOMES | INCREASE LIFE EXPECTANCY AND IMPROVE QUALITY OF LIFE | | REDUCE INEQUALITIES IN LIFE EXPECTANCY |
|---|---|---|---|
| **Outcome Measures** | • Smoking Prevalence<br>• Obesity Prevalence<br>• Infant + Child Mortality | • CVD Mortality<br>• Cancer Mortality<br>• Suicide rates | • Better Patient Experience<br>• HSMR<br>• Elective QALYs<br>• Staff experience |
| **High Level Impact Measures** | • % Smoking ABC<br>• % immunisation<br>• Rheumatic Fever Cases<br>• Assaults against children | • % CVD Checks<br>• % screened (bowel, breast, cervical)<br>• Access to Mental Health Services | • Net Promoter Score<br>• Elective Discharges<br>• ED waiting times<br>• No. Adverse events |
| **Outputs** | • No. smoking advice given<br>• No. children immunised<br>• No. B4 school checks<br>• No. children swabbed | • No. CVD checks<br>• No. DCIP Annual Reviews<br>• No. People Screened<br>• No. Cardiac procedures<br>• Mental Health contacts | • Outpatient Attendances<br>• Elective Discharges<br>• ED + Inpatient Attendances<br>• HBSS packages of care<br>• Residential placements |
| **Priority Programmes** | • Smoking<br>• Childhood Immunisations<br>• Well Children<br>• Rheumatic Fever | • CVD/Diabetes Checks and Management<br>• Cancer Screening<br>• Faster Cancer Treatment<br>• Mental Health | • Shorter stays in ED<br>• Access to Electives<br>• Patient Experience<br>• Quality and Safety<br>• Health of Older People |
| Priority Populations | Maori | Pacific | Asian |
| **Output Classes** | Prevention | Early Detection and Management | Intensive Assessment and Treatment / Rehabilitation and Support |
| **PURPOSE** | Prevent | Cure | Ameliorate |
| **BOARD PRIORITIES** | *Better Outcomes* | *Relief of Suffering* | |

## Overall Outcomes

The overall outcomes that we want to achieve are to increase life expectancy and quality of life (measured by life expectancy at birth) and to reduce ethnic inequalities (measured by the ethnic gap in life expectancy). Measures for the quality of life are less well developed so we have not currently identified a single overall measure of quality of life. However a number of measures in our outcomes framework will contribute to quality of life. Mental ill health in particular is a major cause of disability and distress that significantly reduces quality of life.

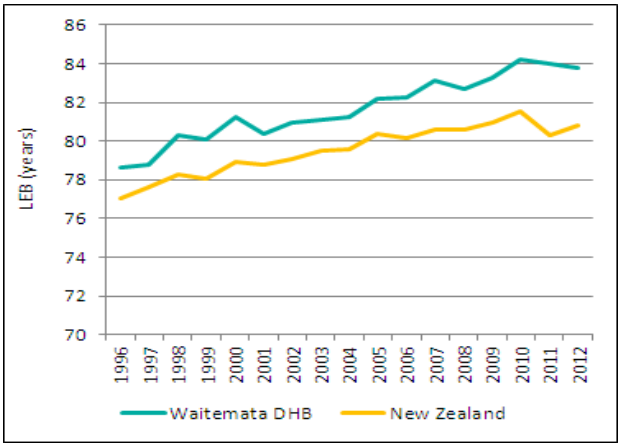
## Key

✔ Indicates an outcome measure has achieved target, or is performing better than the national average. (The absence of a tick does not necessarily indicate poor performance as not all measures have targets or are compared to national rates).

### Overall Outcome – Increase Life Expectancy and Quality of Life

Internationally recognised as a measure of population health status, increased life expectancy continues to be the high level outcome we monitor. For New Zealand as a whole life expectancy has increased by 2.7 years per decade over the last 16 years. In Waitemata life expectancy has increased by 3.3 years per decade. Overall we continue to have the highest life expectancy in the country at around 84 years – almost three years higher than New Zealand as a whole. If the Waitemata district were a country we would have the highest life expectancy in the world (ahead of Japan, Switzerland and San Marino who all had life expectancies at birth in 2011 of 83 years[2]).

**Outcome Measure – Life Expectancy at birth** ✔

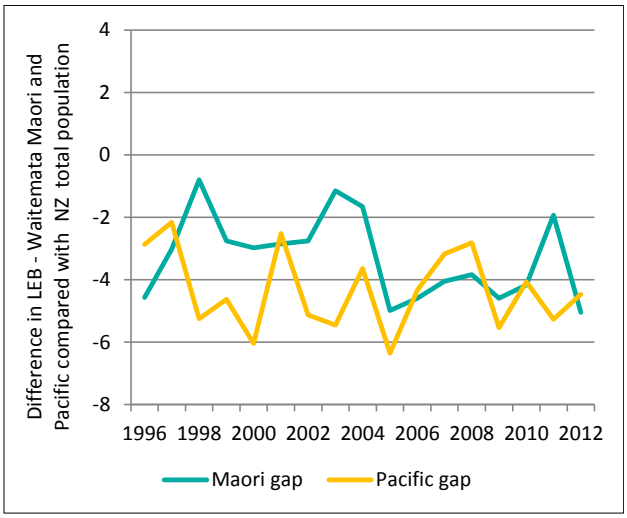



### Overall Outcome – Reduce Inequalities for all populations

There are significant differences in life expectancy rates between ethnic groups within our district. Māori and Pacific people have a lower life expectancy compared to other New Zealanders, with a gap of 5 years for Māori, and 4.5 years for Pacific.

Cardiovascular disease, lung cancer, diabetes and obesity accounted for over half the difference in life expectancy between Māori and Pacific, and European ethnicities in Waitemata. Accidents, chronic obstructive airways disease, prostate cancer and female genital cancer also made significant contributions to the ethnic differences in life expectancy. These findings are reflected in our outcome areas below.

**Outcome Measure – Ethnic gap in life expectancy at birth**




[2] Global Health Observatory (http://apps.who.int/gho/data/node.main.3?lang=en)

## To prevent ill health – people will be supported to be healthier and take greater responsibility for their own health

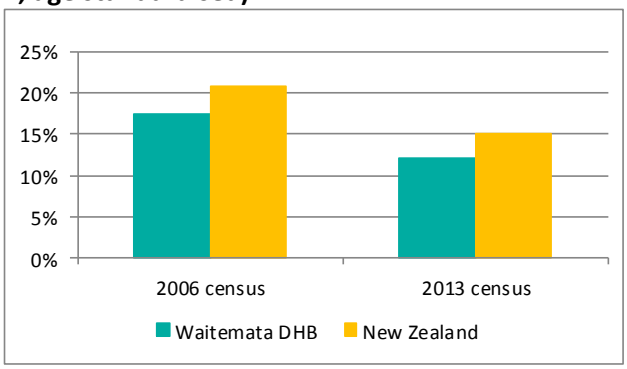
Our focus in this area is on smoking, obesity, and childrens health. In these areas we will ensure people are better protected from harm, informed of the signs and symptoms of ill health, and supported to reduce risk behaviours and modify lifestyles in order to maintain good health. We will create health-promoting physical and social environments which support people to take more responsibility for their own health and make healthier choices. Over the next 4 years our main measures of these activities are as follows.

### Outcome – A Smokefree Aotearoa by 2025

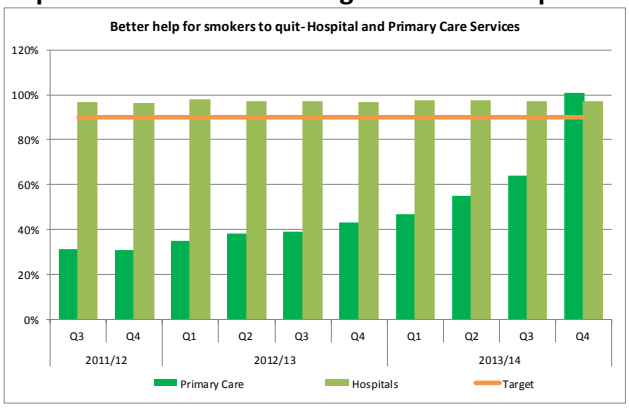
Smoking is the leading modifiable risk factor in New Zealand and contributes to many deaths and hospitalisations in Waitemata. The prevalence of smoking in Waitemata DHB was 12% according to census 2013. This is well below the national average of 15% and has reduced markedly since the previous census.

There are significant ethnic differences in our district with Māori and Pacific people more likely to smoke although these rates are well below the national average (27.1% and 20.7% respectively for Waitemata). We have performed very well providing brief advice to smokers in hospital – 97% of hospitalised smokers received advice on quitting smoking in quarter four 2013/14. However, results for this health target in primary care were particularly impressive – more than 100% of smokers seen by primary care received advice to quit in quarter four 2013/14. In addition to offering advice in primary care settings, some practices also contacted patients who had not recently attended their general practitioner to offer them brief advice and support to quit smoking.

**Outcome measure – Smoking prevalence (15 years +, age standardised)** ✔



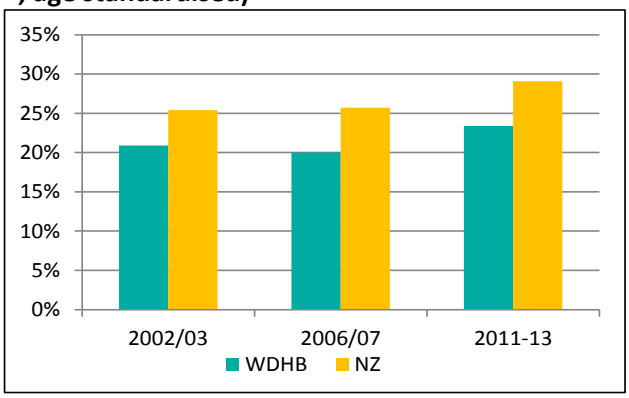

**Impact measure – Smokers given advice to quit**




### Outcome – Halt the rise in Obesity

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand and obesity is the second most important modifiable risk factor. Our community's overall obesity prevalence (22.2%) is less than the New Zealand average. Obesity prevalence is particularly high amongst Māori and Pacific people (30.7% and 48% respectively). The associated costs of obesity have been estimated at 4.4% of healthcare expenditure or $152 million dollars for the overall Auckland region and are rising.

**Outcome Measure – Obesity Prevalence (15 years +, age standardised)** ✔



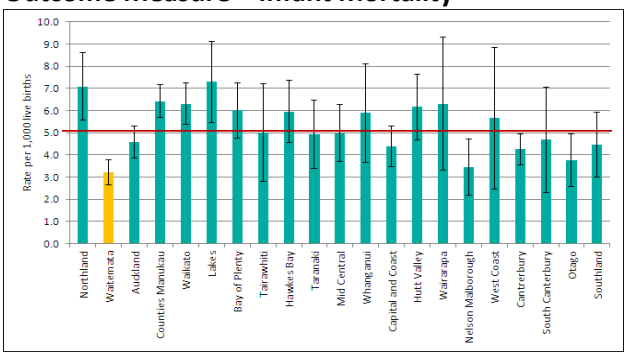
## Outcome – Children get the best possible start in life

The wellbeing of children is critical to the wellbeing of the population as a whole and is both a regional and a national priority. Healthy children are more likely to become healthy adults. Positive health outcomes for children and mothers are essential for this. Waitemata DHB's infant mortality rate of 3.2 per 1000 live births (2006-2010) is the lowest in the country, as is the child mortality rate.

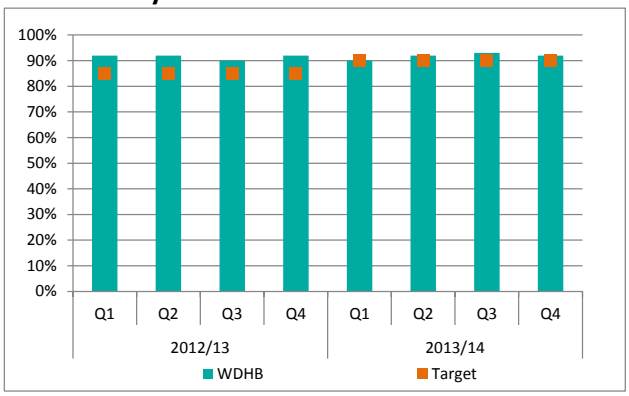
Significant progress has been made in increasing the proportion of children immunised in recent years. 92% of Waitemata children were fully immunised at 8 months at the end of June 2014 and steady gains have been made to reduce the equity gap with an increase of 16% for Māori and 6% for Pacific since July 2012. We want 95% of children to be immunised by December 2014 and to maintain or improve on this level in the coming years.

Reducing the number of assaults and supporting the prevention and early identification of child maltreatment through delivering on the Children's Action Plan (CAP) and aligned initiatives is a national and local priority. Child assault admissions to Waitemata hospitals have declined in recent years – from 21 per 100,000 children in 2010/11 to 13 per 100,000 children in 2012/13.

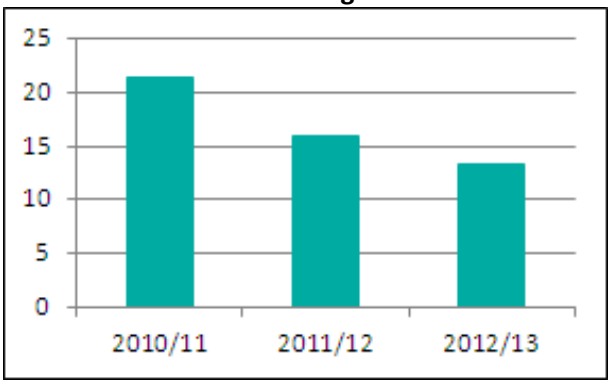
**Outcome Measure – Infant Mortality** ✔

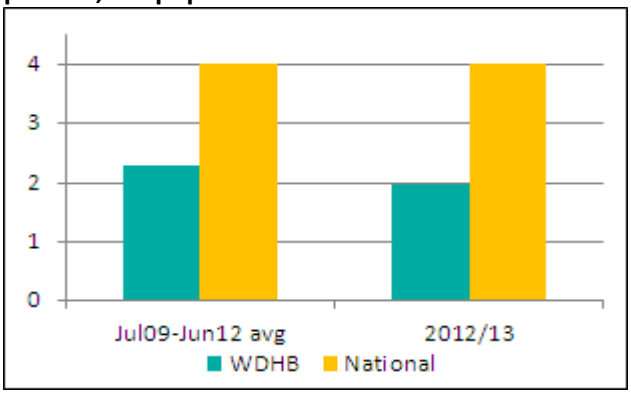



**Impact Measure - Proportion of 8 month old children fully immunised** ✔



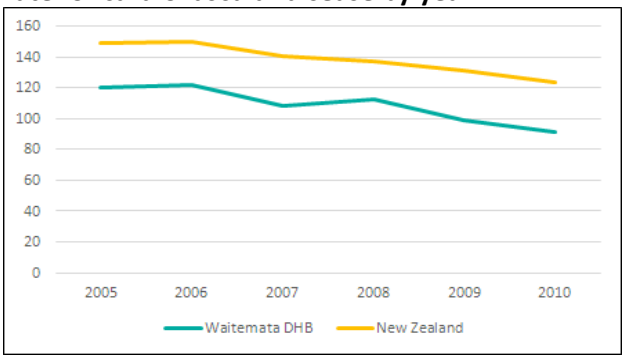
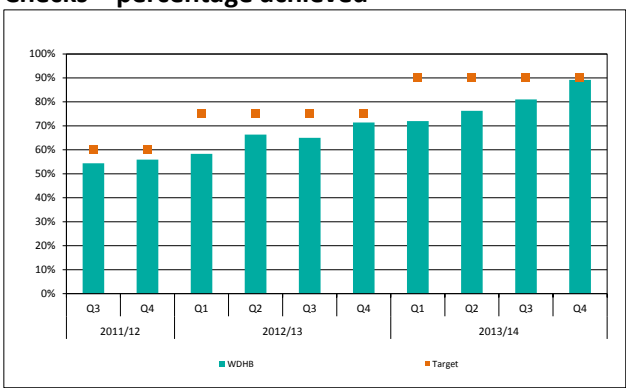

**Impact Measure – Hospital Admission Rates for injuries arising from Assault / Neglect / Maltreatment of Children Aged 0-14 Years** ✔



| Outcome – Children get the best possible start in life | |
|---|---|
| Rheumatic fever rates are unacceptably high in New Zealand and are largely preventable. Waitemata DHB has one of the lowest rates of acute rheumatic fever in the country – our baseline 3 year rate was 2.3/100,000 population (12 cases) as at 2011/12. Our target for 2014/15 is to further reduce the rate in Waitemata to 1.4 per 100,000 population (8 cases), aiming for no more than 0.8 episodes per 100,000 of the population by 2017/18. | **Impact Measure – Acute Rheumatic Fever Cases, per 100,000 population**   |

## To cure ill health – people will be supported to stay well through early detection and effective management of ill health.

Significant progress has been made in improving the management of ill health. This is reflected in our morbidity rates for cardiovascular disease and cancer, which are the lowest in the country. But there is more that can be done to increase life and reduce disability for our patients particularly for Māori and Pacific populations. We need to improve the detection and management of cancer, cardiovascular disease and mental ill health as well as ensuring rapid assessment and treatment for patients when they are ill. Our main measures in this area over the next 4 years are as follows.

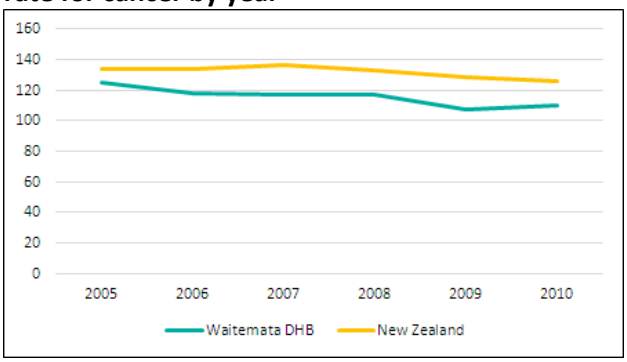
| Outcome - Reduced mortality from Cardiovascular Disease (CVD) | |
|---|---|
| Cardiovascular mortality (92 per 100,000) in Waitemata is the lowest in the country but it remains a leading cause of death and is largely preventable with lifestyle change, early intervention, and effective management. Cardiovascular disease is exacerbated and compounded by diabetes and although the prevalence of diabetes is the lowest in the country, over 26,535 residents live with diabetes and the number is increasing. Ethnic differences persist and long term conditions rarely occur as a single disease.<br><br>A cardiovascular risk assessment programme has been operating in Waitemata for a number of years and steady progress is being made to meet the heart and diabetes check target. Management of blood pressure, cholesterol, blood glucose levels (HBA1c), retinal screening and diabetes patient education can significantly reduce cardiovascular mortality and improve health outcomes. | **Outcome Measure - Age standardised mortality rate for cardiovascular disease by year**   <br>**Impact Measure – More Heart and Diabetes Checks – percentage achieved**   |

## Outcome - Reduced mortality from Cardiovascular Disease (CVD)

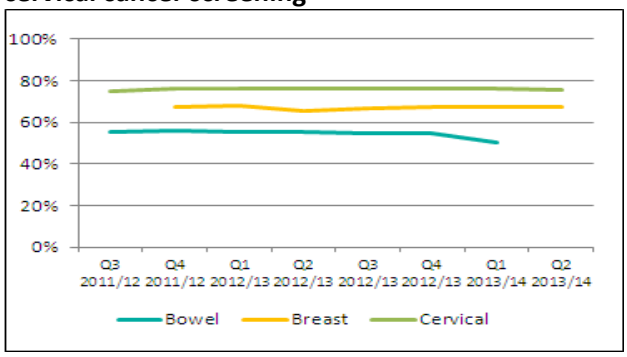
We have the lowest cancer mortality in the country at 110.7 per 100,000 population (128/100,000 nationally) and we have the highest overall one year cancer survival rate in the country at 81.5%. But cancer continues to be the leading cause of death in Waitemata and 2315 people per year were diagnosed with cancer in our district between 2008 and 2010.

Breast, cervical and bowel screening programmes identify cancers in these areas and enable early treatment of disease. Waitemata DHB is a national pilot for the bowel screening programme. Uptake of all three cancer screening programmes has been increasing but can be further improved. Similarly rapid diagnosis and treatment of cancer which is the focus of the 62 day referral to treatment target increase the options for treatment and the chances of survival.

**Outcome Measure - Age standardised mortality rate for cancer by year** ✔



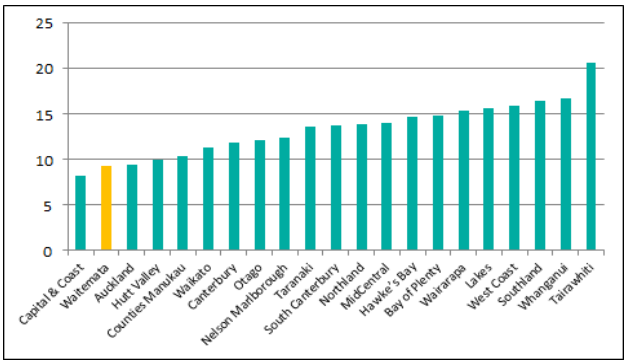

**Impact Measures – Uptake of bowel, breast and cervical cancer screening**



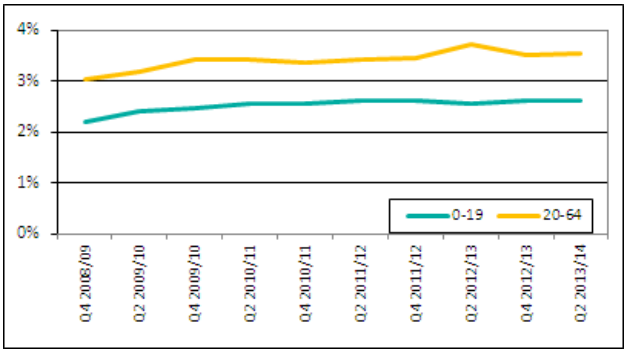

## Outcome – Reduced morbidity and mortality from mental illness

Mental ill health is one of the leading causes of disability and overall health loss. Nationally one in 5 people have suffered some kind of mental illness in the last year and 3% have suffered from a serious mental illness. Approximately 45 -50 people die as a result of suicide each year in the Waitemata DHB district, a disproportionate number of who are young and Māori. Timely access to mental health services in primary care or hospital and effective treatment can reduce the time spent with a mental illness and reduce the associated morbidity and mortality.

**Outcome Measure – Suicide rates (age-standardised, by DHB, 2006-2010)** ✔




**Impact Measure – % of people <19 and 20-64 years with access to mental health services.**



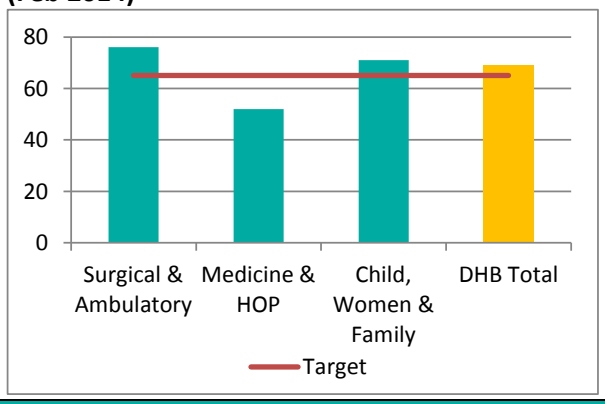
## To ameliorate ill health – people will receive timely, safe, high quality and compassionate services when they need them.

Health services play a major role in providing intensive assessment and treatment when people are ill as well as supporting people to regain their functionality after illness and to remain healthy and independent. There are also a number of services or interventions that focus on patient care such as pain management or palliative services to improve the quality of life. Our focus in this area is on patient experience, timely access to hospital services and the quality and safety of services.

### Outcome – Better Patient Experience

Evidence shows that patient experience is a robust indicator of quality and understanding and enhancing patient/whānau experience is essential to achieving high quality health outcomes. We will improve patient experience through: our Patient and Family-Centred programme; upgrading and improving our facilities; implementing the Family and Friends Test, and reducing time to respond to complaints.

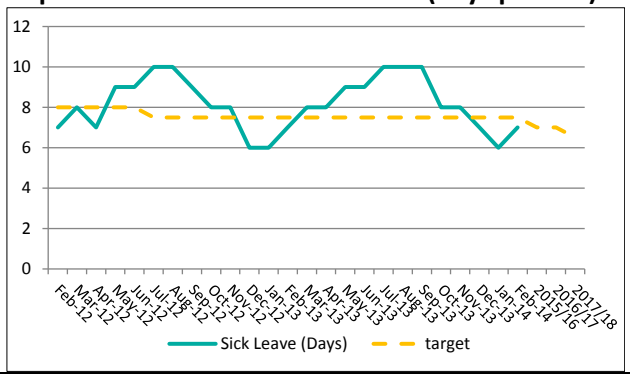
**Outcome Measure – Net Promoter Score (Feb 2014)**




### Outcome – Better Staff Experience

Staff engagement and satisfaction is central to the delivery of high quality and safe services and a significant determinant of outcomes for patients. We are currently in the process of developing a staff survey which will enable us to develop and monitor a staff experience score to track how we are doing in this area.

**Outcome Measure – Staff Experience Score**
**Impact Measure – Sick Leave Rate (days per FTE)**



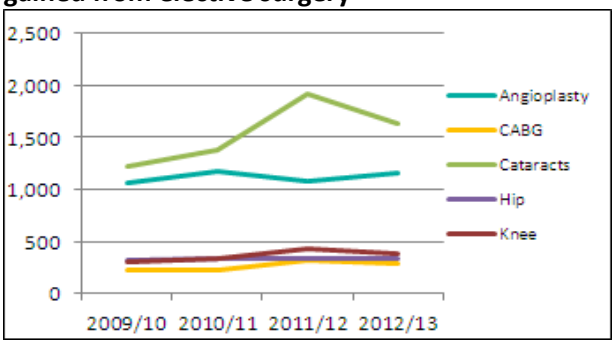
## Outcome – Timely Access to Hospital Services

We want to provide timely access to hospital services to enable people to live longer, healthier and more independent lives. Elective surgery increases quality of life because it remedies or improves disabling conditions.

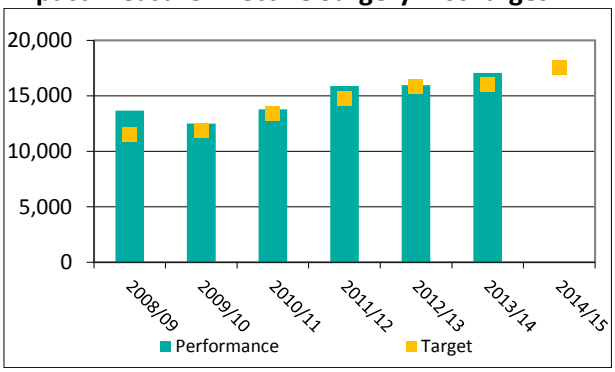
We have achieved the largest increase in elective discharges in the country over the last 3 years. We attained significantly above the surgical intervention rates considered optimum for our population in cataract surgery (to Sep 2013), cardiac surgery, angioplasties and angiographies (to Dec 2013). We also met the surgical intervention rate for major joints for the first time in 2012/13 and continue to achieve against the national target discharge rate

We are consistently admitting, discharging or transferring 95% of patients from our emergency departments within 6 hours. Between 2008 and 2013 we have seen an increase of 37% in the number of people attending our emergency departments with 109,223 attendances in the 2013 calendar year.

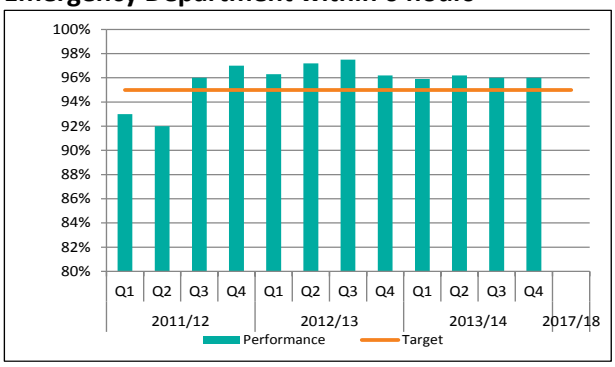
**Outcome Measure - Quality Adjusted Life Years gained from elective surgery**




**Impact Measure- Elective Surgery Discharges** ✔




**Impact Measure - 95% of patients will be admitted, discharged or transferred from the Emergency Department within 6 hours** ✔



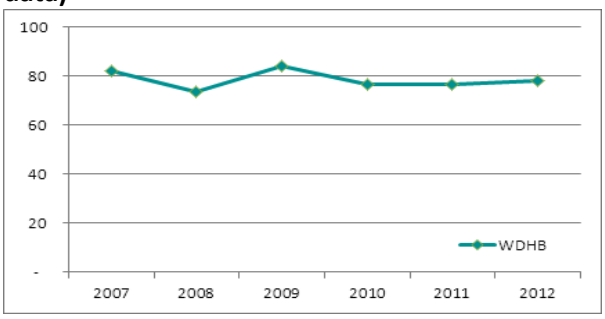
## Outcome – High Quality and Safe Services

To provide the very best care for all our patients, we need to ensure that the care we provide is safe, clinically effective, focused on the needs of our patients, whānau and our community and achieves quality outcomes that are among the best in the world.

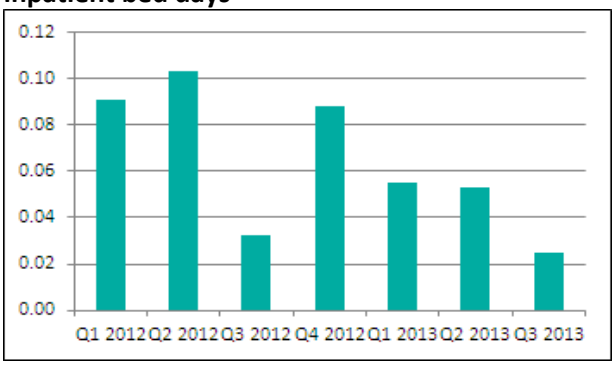
We will improve quality and safety through implementing the First Do No Harm programme, being open and transparent and monitoring the Health Quality and Safety Commission's quality and safety markers (QSMs) and regularly striving to improve in the four areas of harm covered by the campaign:

- Falls
- Healthcare associated infections (hand hygiene, central line associated bacteraemia and surgical site infection)
- Perioperative harm
- Medication safety

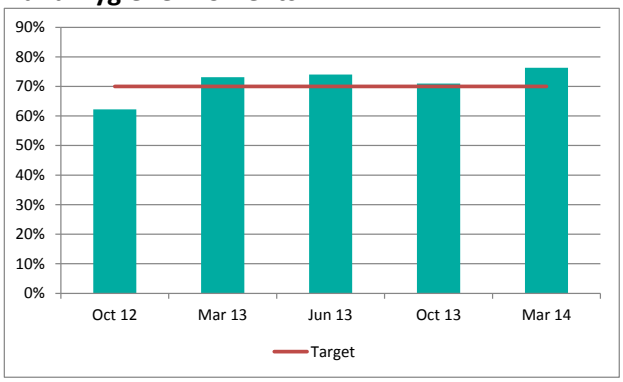
**Outcome Measure – Waitemata DHB Hospital-standardised mortality rate, 2007-2012 (MOH data)**




**Impact Measure – Healthcare associated Staphylococcus aureus bacteremia per 1000 inpatient bed days**

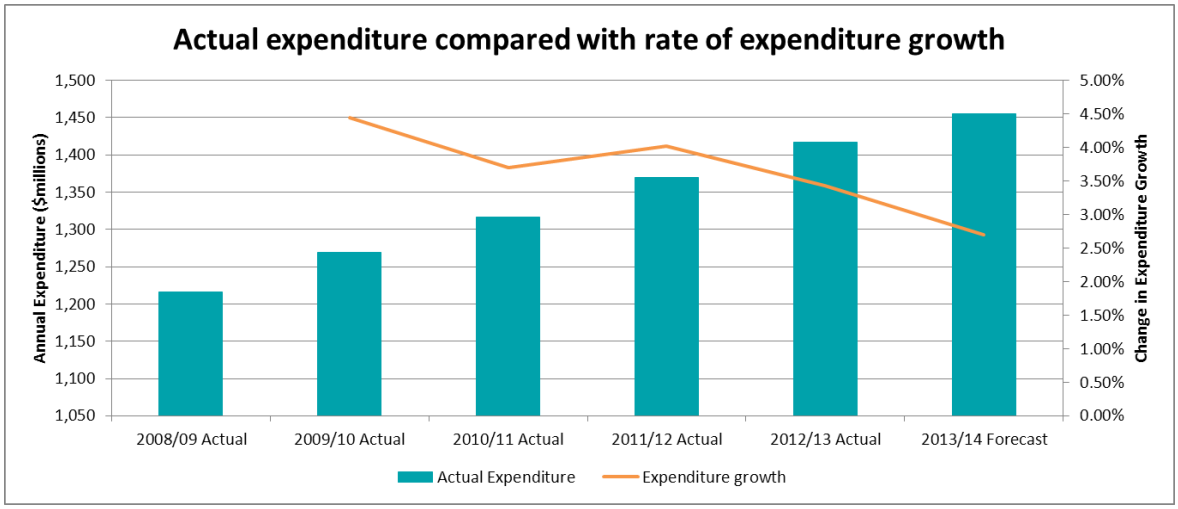



**Impact Measure - % rate of compliance with 5 Hand Hygiene Moments**



## Efficient and Effective Delivery of Health Services

In addition to ensuring we improve the health outcomes for our community we are also focused on the sustainability of our organisation. DHBs are required "to ensure they seek the optimum arrangements for the most effective and efficient delivery of health services in order to meet local, regional, and national needs"[3]. We are also required to operate in a financially responsible manner and must endeavour to cover all our annual costs from our annual income. We will continue to ensure we remain a sustainable organisation which manages its resources efficiently and achieves a break-even position each year. For example our rate of expenditure growth has decreased over the last 5 years (refer graph on the following page).




We have lived within our means for the past five years, achieving year-end financial results better than approved plans and more recently generating surpluses that have been reinvested into programmes to ensure that we continue to meet the health service needs of our growing population. This required providing services in a more efficient and cost effective way and has been achieved through our business transformation programme and involving our clinical staff in our decision-making processes.

## How will we know we have provided the most effective and efficient delivery of health services?

- A surplus was achieved for 2012/13 and we are on track to deliver a surplus in 2013/14. A $1m surplus is presented in this plan. We intend to maintain a breakeven position in the coming years
- Successfully implementing Business Transformation savings
- Successfully implementing agreed collaboration work streams at a national, regional, sub-regional and local and locality level, achieving associated savings. These initiatives include working with other DHBs and our PHO partners reviewing models of care and service configurations to ensure efficient and effective service delivery
- healthAlliance and Health Benefit Limited savings initiatives implemented and savings achieved by each year
- Successfully implementing Performance Improvement and achieving quality and productivity improvements against national benchmarks and against health outcomes
- Fully implementing regional health plan work streams
- Maintaining Capped FTE count at agreed budget levels.

[3] NZPHD Act 2000 Sec 22.1.ba

# MODULE 2: Targets and Priorities

## *Health Targets*

### Shorter Stays in Emergency Departments (ED)(including Major Trauma)

#### What are we trying to do?

Deliver high quality emergency care to our community by exceeding the health target (95% of patients admitted, discharged or transferred from an ED within six hours).

#### Why is this important for community and patients?

Less time spent waiting and then receiving treatment in the ED gives patients a more dignified and convenient experience when they are acutely ill. It also gives rise to better outcomes and enables us to use our resources more effectively and efficiently.

#### Progress to date

We consistently achieve the 95% health target for all ethnic groups. Care bundles, consisting of standardised documentation, quality plans and processes, improved patient information leaflets and patient care pathways have been implemented with interdisciplinary collaboration. These align with international and local best practice and patient preference.

We have increased clinician numbers and enhanced cross-site flexibility. We have improved consistency of practice via better training and development of our clinical nurse specialists. A quality suite of 72 indicators and a quality scorecard have been developed to focus our attention on the quality of care delivered in our EDs. We have worked with primary care through use of primary options and St Johns to divert care to the right settings, thereby preventing unnecessary admissions.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| Enhance linkages between ED and other hospital services, primary care and the community by:<br>• Work with regional and national clinical groups to improve access to diagnostics, particularly MRI, through installation of a new MRI by late 2014<br>• Improve linkages with Accident and Medical, and general practitioner fracture clinics<br>• Orient all new staff to the care bundle clinical pathways during 2014/15<br>• Develop a dedicated transit care team at Waitakere Hospital by late 2014<br>• Collect major trauma data, consistent with the New Zealand Major Trauma Minimum Dataset- on-going<br>• Work with the Medical Officer of Health and Auckland Regional Public Health Service to develop local alcohol policies to reduce excess alcohol consumption in the community – on-going<br>• Support the Medical Officer of Health in | • 95% of patients will be admitted, discharged, or transferred from Emergency Department within six hours – monitored by ethnicity<br>• Reduced number of unexpected return visits to ED within 72 hours (baseline to be determined by analysing retrospective data – by ethnicity)<br>• All staff use the care bundle clinical pathways for managing patients<br>• Implementation of a transit care team at Waitakere Hospital by late 2014<br>• Systems are in place to collect the New Zealand Major Trauma Minimum Dataset with a 50% collection rate by 30 June 2015. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| exercising statutory responsibilities under the Sale and Supply of Alcohol Act 2012 – on-going<br>• Monitor quality indicators - including the mandatory ED Quality Framework Suite of Quality Measures – on-going<br>• Work with the Ministry of Health to implement the ED Quality Framework as appropriate – commenced by 31 March 2015<br>• Review accelerated chest pain pathway currently used in the emergency department to ensure it meets the National Cardiac Network framework by June 2015. | |

## Improved Access to Elective Surgery

### What are we trying to do?

We want to provide our community with timely and equitable access to elective surgery by exceeding the Waitemata health target of 17,545 elective discharges and reducing waiting times.

### Why is this important for community and patients?

Elective surgery increases quality of life because it cures or ameliorates disabling conditions. Patients want certainty regarding access to elective surgery when they need it without having to wait too long for their assessment, diagnostic and treatment services. Patients and their referrers need to understand the process through which they receive surgery and know that it is effective, efficient and fair.

### Progress to date

The increasing elective health target has been consistently met for the last three years. 15,965 surgical procedures were carried out in 2012/13, 16% more than two years ago. We plan to deliver 16,701 in 2013/14. Patients now wait no more than five months for their first specialist appointment or their elective surgery. The new state of the art Elective Surgical Centre (ESC) opened in July 2013 delivering up to 3,800 procedures per year. We now offer more surgical services including breast reconstruction and acute hand orthopaedic services.

We streamlined the patient journey with over 50% of general practices now using electronic referrals; using patient focused bookings to improve referral response times (> 90% of patient referrals now responded to within 10 working days); investigating the reasons why more Māori and Pacific patients do not attend their outpatient appointments; developing a new model of care to reduce the number of visits patients need to make before their surgery (The Shorter Journey); employed perioperative nurse coordinators to case manage more complex patients prior to surgery and commenced an orthopaedic enhanced recovery after surgery (ERAS) project to improve length of stay.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Utilise additional theatre capacity in the ESC to increase the volume of elective surgery over 2014/15<br>• Implement service review changes by 31 July 2014 to ensure full compliance with elective waiting time indicators by 1 December 2014<br>• Prioritise all patients for treatment using nationally recognised tools and treatment in accordance with assigned priority and waiting time - on-going<br>• Complete the Shorter Journey productivity project and roll out where appropriate by 30 November 2014<br>• Encourage primary care to increase electronic referrals to improve referral quality and numbers direct to FSA through promotion via the Primary Care newsletter and individual GP feedback – over 2014/15<br>• Complete the orthopaedic ERAS project by 30 June 2015<br>• Pilot direct primary care access to spinal MRIs by December 2014<br>• Work with private and other DHB radiology partners to implement collaborative sonographer training, increasing trainees from 3 to 5 by December 2014<br>• Complete DNA project to improve DNA rates, particularly for Māori and Pacific by 30 June 2015<br>• Implement National Patient Flow system to collect and report patient-by-patient outpatient waiting times, outcomes of FSAs and diagnostic test and treatment metrics by 30 June 2015<br>• Develop and test a methodology for measuring access to elective surgery by ethnicity, accounting for need for intervention and other demographic factors by 30 June 2015<br>• Adopt regionally consistent CPAC tools across elective surgical services and review of regional DHB thresholds for access to services by 30 June 2015. | • Meeting the health target by delivering a minimum of 17,545 elective discharges by June 2015<br>• 90% of accepted referrals for CT scans and 80% of accepted referrals for MRI scans will be completed within 6 weeks (42 days)<br>• Compliance with four month wait time for FSAs and elective surgery by 31 December 2014<br>• 60% of primary care elective referrals received electronically by 30 June 2015<br>• Maintain expected surgical intervention rates in major joints, cataracts and cardiac surgery. Increased rates in general surgery, gynaecology, plastics, urology and vascular surgery – will be achieved by June 2015<br>• National Patient Flow data – phase 1 – able to be reported from 1 July 2014<br>• National Patient Flow data – phase 2 - able to be reported from 1 July 2015<br>• Percentage of referrals from primary care received electronically will increase from 50% to 60% by June 2015<br>• No more than 5% of total referrals received are returned to primary care with inadequate information by June 2015. |

*Note: regional imperatives will be met from current budget, no additional budget allocations will be made*

## Shorter Waits for Cancer Treatment (Faster Cancer Treatment)

### What are we trying to do?

We want to provide timely cancer treatment ensuring we meet the health target (all patients who are ready-for-treatment wait less than four weeks for radiotherapy or chemotherapy). We also want to ensure that patients wait no more than 62 days between diagnosis and first treatment.

Successful implementation of the national bowel screening pilot is an important focus for us, along with improving colonoscopy waiting times. We will also work locally and regionally to ensure our compliance with nominated national tumour standards and implement prioritised improvements.

### Why is this important for community and patients?

Cancer is the leading cause of death in our district - approximately 943 people die in Waitemata per year from cancer. There are about 7000 new tumours registered nationally each year. Despite significant improvement in recent years, some of our patients still wait too long for their cancer diagnosis and treatment, and some struggle to navigate their way through our health services. Outcomes for Māori and Pacific patients and uptake of bowel screening are not as good as those of other ethnic groups.

### Progress to date

We have the lowest cancer mortality in the country at 110 per 100,000 population (126/100,000 nationally)[4] and none of our patients wait more than four weeks for radiotherapy or chemotherapy. There are no inequalities for Māori or others in these waiting times. We are also improving the waiting time at every stage of the journey.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| We will:<br>• Monitor performance against the radiotherapy and chemotherapy waiting times health target – on-going<br>• Implement the Quality Endoscopy Improvement programme to address productivity and capacity issues over two sites and introduce a daily report which identifies actual capacity used by the provider. Commence this reporting 1 July 2014 and respond to issues as they arise over 2014/15<br>• Establish a five year colonoscopy capacity plan that includes a regional view by 31 December 2014<br>• Implement a nurse endoscopist training programme regionally by late 2014<br>• Use CT colonography as a diagnostic tool instead of colonoscopy in 25% of colonoscopy referrals, where clinically appropriate, which will increase colonoscopy capacity - measured monthly | • Compliance with the faster cancer treatment target of maximum four weeks waiting time for radiotherapy and chemotherapy *(becomes part of indicator reporting from October 2014 – no longer a health target)*<br>• Faster cancer treatment indicators will be routinely measured and reported quarterly; including by ethnic group<br>  ○ All patients with a confirmed diagnosis of cancer receive their first cancer treatment within 31 days of decision to treat<br>  ○ 85% patients referred urgently with a high suspicion of cancer receive their first cancer treatment within 62 days by 1 July 2016 *(becomes health target from October 2014).*<br>• Patient experience survey undertaken by the provider to provide a baseline by 30 June 2015<br>• 75% of people accepted for an urgent diagnostic colonoscopy receive their procedure within two weeks (14 days) |

[4] 2010 age standardised rates (mortality data)

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Review cancer patient pathway within booking and scheduling (referral to FSA) Develop a plan to address bottlenecks by June 2015<br>• Identify and implement improvements to the quality of faster cancer treatment indicator data, including collection by ethnicity<br>• Develop action plans to address ethnic differences in access for our population by 31 December 2014 and implement improvements by 30 June 2015 within available resources<br>• Ensure DHB cancer care coordinators work closely with and involve the Waipareira Trust cancer navigators in cancer care for Māori patients – on-going<br>• Develop MDM meetings to be highly functional locally and regionally. Use tumour stream templates live in cancer MDM meetings from July 2014<br>• Actively participate in regional prostate, bowel and lung tumour group activities facilitated by the Northern Cancer Network (NCN) – on-going<br>• Implement prioritised service improvement locally and regionally arising out of the 2013/14 regional review of tumour standards by 30 June 2015<br>• Review compliance with three additional tumour standards including the breast tumour standards in 2014/15, identify service improvement activity by 30 June 2015<br>• Ensure cancer care coordinators and nurses participate in regional and national training, evaluate the cancer care coordinator roles – on-going<br>• Support activities associated with the Bowel Screening Pilot and address ethnic inequalities in participation - ongoing<br>• Increase cervical screening rates for Māori, Pacific and Asian populations by adopting the successful Auckland DHB model; supporting the development of a pilot kaiawhina role in the community and implementing data matching work with general practices to identify women who need a cervical smear. | • 60% of people accepted for a diagnostic colonoscopy receive their procedure within six weeks (42 days)<br>• 60% of people waiting for a surveillance colonoscopy wait no longer than twelve weeks (84 days) beyond the planned date<br>• Uptake of bowel screening by ethnicity<br>• Cervical screening rates improve for all ethnicities. |

## Increased Immunisation

### What are we trying to do?

We want to achieve the immunisation health target (95% of children fully immunised at 8 months by 31 December 2014), and maintain this.

### Why is this important for community and patients?

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children. This equates to longer and healthier lives. The changes which are required to reach the target immunisation coverage levels will lead to better health services for children because more children will be enrolled with and visit their primary care provider on a regular basis.

### Progress to date

92% of Waitemata children were fully immunised at 8 months at the end of December 2013 and steady gains have been made to reduce the equity gap with an increase of 16% for Māori and 6% for Pacific since July 2012. This has been accomplished through: increasing knowledge and awareness of immunisation guidelines; providing support for midwives and general practice staff; developing robust referral processes to Outreach Immunisation Services (OIS); and development of a strong and experienced steering group.

An ability to consistently identify children overdue for immunisation, including those presenting as inpatients, in a timely manner has also impacted positively on performance. A pathway has been established for rapid referral to outreach and primary care for Māori newborns with no GP.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Work with partners to develop a 6 month Milestone Project to improve timeliness of 3 and 5 month immunisations and reduce the equity gap for Māori children by September 2014<br>• Develop and distribute recommendations for improving early enrolment processes by April 2015<br>• Embed process to improve handover of mother and child through maternity, primary care and Well Child/Tamariki Ora (WCTO) services<br>• Monitor monthly DHB, PHO and practice level coverage and manage service delivery gaps - on-going<br>• Develop systematic early indicators of changes in practice performance by September 2014. Practices identified will be given additional support by the PHOs and NIR<br>• Commence an Immunisation Reference Group based at Whānau House to develop actions on how best to support Māori babies and whānau by Dec 2014 | Measured by –<br>• 95% of 8 month old children are fully immunised by December 2014 and maintained<br>• 88% of newborn children are enrolled with a GP by three months by December 2014 and 98% by June 2016<br>• 85% of 6 week immunisations are completed by December 2014 and maintained<br>• 95% of 2 year immunisations are completed and maintained<br>• 70% of Māori 6 month old children are fully immunised by December 2014 and maintained<br>• Report on DHB and interagency activities to promote immunisation week 2015 completed by February 2015. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Review and implement an immunisation coordination service model across Auckland and Waitemata DHBs by July 2015<br>• Implement Immunisation Schedule changes from July 2014<br>• In collaboration with NGOs and government agencies work across the sector to increase immunisation coverage – on-going<br>• Strengthen primary health care participation in the Auckland and Waitemata DHB immunisation steering and operational groups- on-going<br>• We will continue to present immunisation issues, provide updates and plan local immunisation promotion activities at the bi-monthly Child Health Stakeholder Advisory Group (CHSAG) meeting that includes representatives from Health, Education and Social Services. | |

## Better Help for Smokers to Quit

### What are we trying to do?

We want to support smokers to quit by achieving the following health targets: 95% of hospitalised patients who smoke and are seen by a health practitioner in public hospitals; 90% of enrolled patients who smoke and are seen by a health practitioner in general practice are offered brief advice and support to quit smoking; 90% 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. We also want to reduce smoking prevalence thereby assisting the country in achieving Smokefree Aotearoa in 2025.

### Why is this important for community and patients?

Smoking is the most significant cause of premature and preventable death in New Zealand. Māori and Pacific people are more likely to smoke (27.1% and 20.7% respectively). These population groups, along with pregnant women and those with mental health problems are more likely to experience negative health impacts.

### Progress to date

Our smoking prevalence is one of the lowest in the country at 12%. We have achieved and been a national leader in the performance against the better help for hospitalised smokers to quit health target over the last 3 years. We have also achieved large increases in the percentage of smokers offered advice to quit in primary care, from 55% in December 2013 to 64.1% in April 2014.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| ***Initiatives led by hospital***<br>• The Smokefree Services Team will continue to monitor and audit performance against the health target and provide targeted | • 95% of hospitalised patients who smoke are offered brief advice and support to quit smoking<br>• 90% of patients who smoke and are seen by a |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| support to services that are below 90% - on-going<br>• Follow up Māori and Pacific people seeking post discharge support to quit smoking to ensure they have had every opportunity to engage with a smoking cessation service best suited to their needs - follow up support process in place by December 2014<br>• Develop and maintain a centralised triage and referral system for smokers identified in hospital for on-going support in the community by December 2014<br>• The Smokefree Services Team will continue to embed the ABC approach by providing training, resources and support to the Smokefree Lead in each inpatient hospital service (34 services), so they can provide training and support to their clinical staff in order to maintain the brief advice and cessation support approach – on-going.<br><br>***Initiatives led by primary care***<br>Allocate $220k to primary care activity specifically aimed at meeting the health target:<br>• The DHB will contract with each PHO to have a Smokefree Coordinator that will lead a smokefree plan and activities for that PHO – by October 2014<br>• PHOs will ensure GPs and nurses are trained and supported to ask patients about smoking, offer advice and referrals for support to quit and that these interventions are documented – on-going<br>• PHOs will support practices to have software in place to prompt providing advice to quit and robust data management systems for documentation - on-going<br>• Each PHO will have a clinical champion and provide quarterly feedback to each GP/practice on their relative performance on meeting the health target by September 2014<br>• Each PHO will provide support to practices that miss providing advice and support to quit to patients when they visit the practice – on-going.<br><br>***Initiatives led by Planning and Funding***<br>• Update the DHB's Tobacco Control Plan by | health practitioner in primary care are offered brief advice and support to quit smoking by June 2015<br>• 90% of Māori seeking post discharge support to quit smoking followed up to ensure they have had every opportunity to engage with a smoking cessation service best suited to their needs<br>• 90% of GPs and Practice Nurses trained in brief advice and cessation support<br>• 10 Māori leaders identified as community champions by December 2014<br>• 90% of pregnant women who are smokers at the time of booking with a LMC are offered advice and support to quit<br>• Maternity Health Target Working Group expanded and meeting regularly by August 2014<br>• Supportive and appropriate resources for pregnant women developed and available by December 2014.<br><br>*Note: it is expected that these targets will be equitably met for Māori and Pacific people.* |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| December 2014<br>• Identify and support Māori leaders e.g. 'Aunties' to champion and promote quitting to their communities – implement trial by December 2014.<br>• Facilitate smokefree training for community based health professionals - on-going<br>• Collaborate with and support Auckland Council and the Cancer Society on implementing the new smokefree public places policies, commenced by September 2014<br>• Champion the Ministry of Health Innovation Fund projects (Quit Bus, WINZ training, Hospital Visitors) that are taking place within Waitemata or Auckland DHBs – on-going.<br>***Maternity specific***<br>• Monitor and provide feedback to Lead Maternity Carers on their individual maternity health target result by December 2014<br>• Work with Midwives, Specialist Smokefree Services and Māori Health to collaboratively develop information to be given to women at confirmation of pregnancy to encourage quitting smoking – on-going<br>• Present updates on smoking cessation in pregnancy through the regular lead maternity carer training days and quarterly in the Maternity Quality Newsletter<br>• Work with the local Clinical Link Champion to ensure midwives give consistent messages and referrals to quit smoking services to their clients by December 2014. | |

## More Heart and Diabetes Checks and Long Term Conditions (including Diabetes)

### What are we trying to do?

We want to meet the health target for all ethnic groups – 90% of the eligible population will have had their cardiovascular and diabetes (CVD) risk assessed in the last five years. We also want to improve outcomes for those with cardiovascular disease and diabetes and other long term conditions, especially Māori and Pacific people.

### Why is this important for community and patients?

Despite the declining mortality rates in recent years, cardiovascular disease remains the second largest cause of death in Waitemata causing approximately 840 deaths per year. The disease burden

for people is exacerbated and compounded by diabetes and other long term conditions - the incidence of which is increasing markedly as a consequence of rising obesity. Over 26,535 Waitemata DHB residents live with diabetes and 135,195 people are eligible for a five year CVD risk assessment.

## Progress to date

Our cardiovascular mortality rate (92 per 100,000) is the lowest in the country. Our diabetes prevalence (2.5%) according to the 2011/12 New Zealand Health Survey is also the lowest in the country and significantly lower than the national rate of 4.4%. As at March 2014 113,893 people have had a CVD risk assessment over the last five years achieving 81% coverage for our population.

More Heart and Diabetes check coverage for Māori has improved 4% over the past year and 6% for Pacific. 51% of the eligible population of Waitemata DHB have completed their annual diabetes review and of these, 75% have good diabetes management.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| ***Prevention***<br>• Provide 6,523 people with the opportunity to participate in the Green Prescription programme over the year<br>• Provide 13,372 retinal screening visits for people with diabetes over the year<br>• Provide 3,000 packages of care for people with diabetes and high risk foot disease over the year.<br>***Identification***<br>• Ensure 90% of the eligible population have their cardiovascular and diabetes risk assessment completed every five years through PHO and general practice service agreements and activities – on-going<br>• Work collaboratively with PHOs to ensure plans are in place to meet the health target by 1 September 2014.<br>***Management***<br>• Deliver the Diabetes Care Improvement Package (DCIP) through PHOs and general practice to improve the care of people with diabetes – on-going<br>• Continue annual diabetes checks, including a cardiovascular assessment and care plan with the patient for the next year – on-going<br>• Work with the Alliance and regional networks to identify key indicators for the management of diabetes and cardiovascular disease by 30 December 2014.<br>***Enablers***<br>• Work directly with the Northern Region Cardiac Network and PHOs, using quarterly regional reports as basis for discussion with | • 90% target for more heart and diabetes checks reached and maintained - quarterly<br>• 13,372 retinal screening visits provided for people with diabetes by the end of the year<br>• 75% of people who have had a diabetes annual review have a HbA1c of ≤ 64mmol/mol by 30 June 2015, monitored quarterly<br>• Percentage of people with cardiovascular disease on triple therapy as reported by the Northern Region Cardiac Network maintained (or improved) at June 2014. (12 months rolling report)<br>• Final agreed indicators presented to the primary care Clinical Governance group no later than 30 June 2015<br>• Quarterly performance reports from providers delivering services through DHB contracts. Reports will include total population and ethnicity information. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| the PHOs regarding medical adherence for people with CVD – on-going<br>• Work with the Alliance and regional networks to identify key indicators for the management of diabetes and cardiovascular risk by 30 December 2014<br>• Work with existing services such as Te Whānau o Waipareira Trust and West Fono disease specific primary care nurses to maximise resources and outcomes for Māori and Pacific people – on-going<br>• Implement processes across primary care using a phased plan to maintain health target achievement using the CVDRA funding from 2013 including (all ongoing):<br>o Clinician education programmes<br>o Practice audit tools and dashboards to ensure people are assessed and managed effectively<br>o Use of PHO practice liaison staff to manage quality and service plans with low performing practices<br>o Virtual CVD risk assessments<br>o Regional collaboration for workplace CVD assessments.<br>• The diabetes service will complete the west Auckland locality integrated diabetes service pilot evaluation by December 2014<br>• Quality improvement services will work in conjunction with PHO liaison staff to improve care within practices - monitored quarterly. | |

## *Better Public Services*

## Reducing Rheumatic Fever

### What are we trying to do?

We want to reduce the incidence of rheumatic fever by a further 20% to 1.4 per 100,000 population.

### Why is this important for community and patients?

Rheumatic fever is a preventable disease. Reducing the incidence of acute rheumatic fever will reduce the burden of disease experienced by patients and their families and reduce the morbidity and mortality and the associated costs to the health service.

### Progress to date

Waitemata DHB has one of the lowest rates of acute rheumatic fever in the country – our baseline 3 year rate was 2.3/100,000 population (12 cases) as at 2011/12. We have established 5 school based

throat swabbing and management programmes in the district and identified 11 sentinel general practices who have agreed to provide open access sore throat management services. We have also engaged Te Whānau o Waipereira Trust to provide a community-based outreach swabbing programme in a range of community locations.

We have undertaken reviews of all cases of acute rheumatic fever (ARF) and established a bicillin injection pathway for children with three group A streptococcus (GAS) positive results. We have made significant progress implementing rheumatic fever responses during 2013/14 including: training health professionals; putting systems in place to obtain monitoring data to support on-going analysis; actively working to raise local community awareness and collaborating with stakeholders to support the Pacific Engagement Strategy and begun to develop referral processes to the Auckland-wide Healthy Homes Initiative for the school based programme, bicillin service and hospital.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| In addition to all the commitments made in our rapid response and rheumatic fever programme plans, activities during 2014/15 will be adopted and modified in response to results from full implementation of the programme:<br>• Respond to information from the school based swabbing programme and tailoring services more appropriately if required regarding: frequency of swabbing, follow up with families, health literacy information, access to after-hours services and rapid response general practice (GP) and community based clinics<br>• Continue to educate health professionals regarding guidelines and where possible, monitoring adherence to guidelines - on-going<br>• Further promote awareness of rheumatic fever prevention and treatment options through work with the Ministries of Health and Youth Development focused on youth and by engaging with providers from other sectors working with the rheumatic fever target population over 2014/15<br>• Monitor whether communications are achieving appropriate responses from target communities over 2014/15<br>• Develop systems and processes and provide on-going training to a range of staff to support referrals to the AWHI programme from hospital, the bicillin service and school based sore throat management programme<br>• Undertake systematic case reviews and root cause analysis for every case of acute rheumatic fever in the district. | • A further 20% reduction of the Waitemata DHB 2013/14 target rate of 2.0 per100,000 to 1.4 per 100,000 population (n = 8)<br>• 100% of all new cases of rheumatic fever are reviewed, with a focus on learnings that inform future practice regarding the management of sore throats prior to hospitalisation with ARF. |

## Prime Minister's Youth Mental Health Project

### What are we trying to do?

We want to increase resilience and improve outcomes for young people by intervening early, involving Māori, Pacific and under-served rangatahi in the planning and implementation of the Youth Health Hub service, decreasing waiting times and increasing access to services.

### Why is this important for community and patients?

Mental health and alcohol and drug issues in young people are poorly recognised. Barriers include lack of awareness and reluctance to seek help through conventional health services. Timely access to mental health services in primary or hospital and effective treatment can reduce the time spent with a mental illness and reduce the associated morbidity and mortality. The lack of early intervention increases the risk of adult mental health and addiction problems. Young people also have a higher risk of suicide and Māori and Pacific young people are at comparatively higher risk of mental health issues.

The expansion of access to primary mental health services alleviates the distress, suffering and longer-term poor outcomes for those young people and their families who are not currently eligible for interventions for mild to moderate conditions. It also supports expectations in the Service Development Plan, the Prime Minister's Youth Mental Health Project and Drivers of Crime priority areas in relation to alcohol related crime committed by young people.

### Progress to date

891 young people have received primary mental health packages under the existing model targeting Māori, Pacific and under-served populations since 1 July 2013. 230 young people have received the additional primary mental health packages, under the Prime Minister's additional packages since 1 July 2013. Youth access rates to specialist alcohol and drug (AOD) services have improved. 79% of 0-19 year olds access services within three weeks and 94% access within eight weeks (as at year end September 2013).

School based health services (SBHS) were extended to decile three schools in February 2013 and a review of these services is underway. The district wide Youth Health Hub has trained 50 clinicians in comprehensive wellness checks (HEEADSSS[5] assessment) and also provided training to Marinoto teams and Te Puna Health Team. Weekly complex case review meetings are facilitated by the Hub for all SBHS clinicians and a professional clinician development pathway has been established for these clinicians. Integrated health clinics have been developed with the Hub and secondary mental health services (Marinoto teams, Adult Mental Health services, and Māori Mental Health team). Two NGO family/whānau support services for adults are expanding to also deliver to children.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Provide follow-up care plans for youth aged 12 to 19 discharged from hospital into primary care – to commence once guidelines released by Dec 2014<br>• Ensure a range of psychological services are available to young people, including e- | • Collection of percentage of youth aged 12 to 19 discharged from CAMHS and Youth AOD services into primary care being provided with follow-up care plans<br>• Continuing to reach the waiting time targets for non-urgent mental health and addiction |

[5] Home, Education and Employment, Eating and Exercise, Activities and Peer Relationships, Drug Use/Cigarettes/Alcohol, Sexuality, Suicide and Depression and Safety

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| therapy during 2014/2015<br>• Implement targeted actions identified by the stock take gap analysis in conjunction with relevant stakeholders eg. Youth Health Hub over 2014/15<br>• Implement the recommendations from the SBHS review and link to suicide prevention strategies targeting young Māori (pilot in Kelston Girls High School) – pilot will commence December 2014<br>• Train a further 50 practitioners in HEEADSSS assessment in 2014/15<br>• Target service delivery for young people who don't attend school – linked to the truancy programme by June 2015<br>• Improve access to primary health care for Māori youth through enhancing SBHS and ensuring the model facilitates engagement with primary care beyond the school gates by June 2015<br>• Set bench marks for access and readmission rates for Māori, Pacific and Asian, based on prevalence data by December 2014<br>• Establish a Service Level Alliance Team (SLAT) for youth by June 2015<br>• Further develop services for children of parents with mental illness and addictions – in place by December 2014. | services – 80% seen within 3 weeks, 95% within 8 weeks (including CAMHS and youth AOD services)<br>• Meeting youth access rate (0-18 years) to specialist drug and alcohol services target of 1.5% by June 2015 (regional target). |

## Children's Action Plan Implementation

### What are we trying to do?

We want to reduce the number of assaults and support the prevention and early identification of child maltreatment through delivering on the Children's Action Plan (CAP) and aligned initiatives. We also want to provide services which contribute to infants having the highest attainable standard of health and equity of life expectancy and parents being confident, knowledgeable and supported to nurture.

### Why is this important for community and patients?

By working together with communities, community providers, primary health care partners, maternity and midwifery teams, and specialist and hospital health care services we will help improve outcomes for vulnerable children and contribute to a reduction in the number of child assaults.

### Progress to date

Child assault admissions to Waitemata hospitals have declined in recent years – from 21 per 100,000 children in 2010/11 to 13 per 100,000 children in 2012/13. We are a signatory to the Memorandum of Understanding (MOU) with Child, Youth and Family Services, Police and DHBs. We host Child, Youth and Family Services funded liaison social workers and implemented: the National Child

Protection Alert System (NCPAS); the Gateway Assessment programme for children and young people in state care; and a programme to identify, assess and provide interventions to children and families who frequently present to the Emergency Department (ED).

We have policies and reporting systems in place to recognise and report child abuse and neglect, along with Ministry accredited training programmes to support staff to recognise and respond to family violence and child protection issues. Our Violence Intervention Programme (VIP) risk assessment now includes referral to a lead maternity carer if a woman is pregnant and we have a multidisciplinary vulnerable pregnant women's group - Te Aka Ora.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Monitor effectiveness of NCPAS and patient information management (PIMS) alert systems; take action to address any unintended negative consequences – on-going<br>• Implement mental health initiatives including respite beds and support packages for women with maternal mental health issues by June 2015<br>• Establish baseline of women with maternal mental health issues utilising primary mental health services by 31 December 2014<br>• Obtain information from and consider district wide implications associated with Children's Teams demonstration sites over 2014/15<br>• Establish multi-disciplinary Children's Teams, as and when appropriate<br>• Ensure that staffing policies and procedures and contracts entered into align with the Vulnerable Children's Act once passed into law (in June 2014)<br>• Implement relevant responses to Rising to the Challenge (eg. Children of Parents with Mental Illness or Addictions (COPMIA)), and Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand - on-going<br>• Explore options for regional collaboration including governance with Counties Manukau and Auckland DHBs through the Child Health Stakeholder Advisory Group (CHSAG) by June 2015. CHSAG includes social sector partner agencies including Child, Youth and Family (CYF), the Ministry of Education, Council, Plunket and PHOs<br>• Explore options for a programme for vulnerable children aged from birth to 2 years by 30 June 2015 | • Achievement of a minimum audit score of at least 70/100 for each of the child and partner abuse components of our VIP programme<br>• 100% of referred children receive a Gateway Assessment within the targeted time frames<br>• 100% of staff in the following services are trained to recognise and respond to family violence: child and women's health services, emergency department, assessment and diagnostic unit and mental health and alcohol and drug services<br>• 100% of staff carrying out partner abuse screening have completed child protection and partner abuse core training. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Strengthen the work of Te Aka Ora - Vulnerable Families Forum to increase identification during pregnancy; support lead maternity carers (LMCs) and other key workers to implement effective interventions – on-going<br>• Report on the number, ethnicity and issues raised of women referred to vulnerable families groups quarterly<br>• Monitor the number of babies under Maternity Services that are taken into the care of Child, Youth and Family Services over 2014/15<br>• Identify and implement specific actions to increase referrals to the Gateway Assessment Programme by December 2014<br>• Maintain and strengthen existing VIP champion roles within the organisation – on-going<br>• Monitor accuracy of data of staff trained and screening rates in services that have been trained in child protection and partner abuse over 2014/15<br>• Explore options for a Māori provider specific agreement for violence prevention and intervention by 31 September 2014<br>• Establish links with Ministry of Social Development's (MSDs) Pacific Proud campaign – on-going. | |

## Whānau Ora

### What are we trying to do?

We want to support whānau to maximise their health and wellbeing. We will do so by providing the necessary information and support for them to choose the services they want, when they require them. This will require a shift in the way in which we contract for, deliver and monitor health services to ensure an increased focus on achieving outcomes and tangible health gain for Māori families.

### Why is this important for community and patients?

There is a gap of 8.8 years in life expectancy between Māori and non- Māori. There is substantial scope to improve health gain for Māori and we know working with whānau to improve health and wellbeing is important to our Māori community and patients. Access to responsive high quality equitable health services are key components to improving outcomes for whānau.

### Progress to date

We have leased, fitted out and delivered services within Whānau House, Whānau Ora Centre – Te Whānau o Waipareira Trust. A Whānau Ora assessment tool has been implemented in our hospitals and a draft Whānau Ora policy has been developed. We provided support to Whānau Ora collectives in their bid for the North Island non-government organisation (NGO) Whānau Ora Commissioning Agency.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Work with the Whānau Ora collectives to integrate their health contracts, including multi-year contracts by October 2014<br>• Engage MoU partners and wider Māori communities in the development of a Whānau Ora Outcomes Framework - agree on method, milestones and timelines by June 2015<br>• Identify, in partnership with Whānau Ora providers, key outcomes sought from formative/process evaluation by December 2014. | • A localised approach to Whānau Ora by Waitemata DHB and MoU partners approved by Waitemata DHB Board by June 2015<br>• Integrated contracts in place by December 2014<br>• Whānau Ora outcomes framework in place by June 2015. |

## *System Integration*

# Cardiac and Stroke Services – including Acute Coronary Syndrome and Secondary Cardiac Services

### What are we trying to do?

We want to achieve clinically appropriate, timely and equitable levels of access across the region to key cardiac and stroke assessment services. We want to reduce inequalities in access or treatment and reduce disease and premature death in our community caused by cardiac disease and stroke.

### Why is this important for community and patients?

Cardiac disease is a major cause of death, illness and disability in our population and contributes to ethnic differences in life expectancy. Evidence shows variation in the ability to gain timely access to key evidence–based cardiology investigations and treatment in the Northern region. The impact of stroke and TIA can be catastrophic for the individual and family and is resource intensive for health services. Managing these events according to the Stroke Guidelines (2012) is essential for improving and maximising health outcomes for people with a stroke, or those at risk of stroke.

### Progress to date

We have the lowest CVD mortality rate in the country at 92 per 100,000. We have a stroke mortality rate of 7.9 per 10,000 which is lower than New Zealand as a whole at 9.0 per 10,000. In 2013 we had a 30 day Acute Myocardial Infarction case fatality rate of 5.4% which is significantly lower than that of New Zealand as a whole. 74% of stroke patients were admitted to a dedicated stroke unit in the last 12 months and 6%of eligible stroke patients are currently receiving thrombolysis.

We have implemented a new urgency tool for prioritising timely access to cardiac surgery for all Waitemata patients and have sustained standardised intervention rates for cardiac surgery, percutaneous revascularisation and coronary angiography. Referral and waiting list management has been streamlined by separating medical from surgical booking and scheduling to improve waiting times. An agreed regional electrophysiology service (EP) model of care has been developed and regional reporting is underway and has shown improvements in waiting time targets. There are clear pathways for managing suspected stroke and TIA patients who present at the emergency department (ED) or are referred from primary care.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| ***Overall***<br>• Improve access to diagnostics by investigating current delays and developing an action plan to be implemented by July 2014<br>• Identify initiatives to address the causes of ethnic differences in outcomes of cardiovascular disease for Māori and Pacific identified in the work completed in 2013/14 with a specific action plan by February 2015.<br>***Cardiac***<br>• Work with the regional and national cardiac networks to improve outcomes for acute coronary syndrome (ACS) including clinical | • Cardiovascular mortality remaining the lowest in the country<br>• No patient will wait longer than four months for first specialist appointment/treatment by Dec 2014<br>• 100% of inpatients waiting for acute cardiac surgery receive surgery within 10 days of date of wait listing<br>• Standardised intervention rates achieved per 10,000 of population: cardiac surgery – 6.5, percutaneous revascularisation – 12.5, coronary angiography – 34.7<br>• Patients requiring elective cardiac surgery wait no more than 90 days for surgery |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| pathway compliance review, reviewed by Northern Region Clinical Cardiac Network quarterly<br>• Implement regionally agreed protocols for prompt local risk stratification by December 2014<br>• Support and participate in regional cardiac data reporting and monitoring of key cardiology indicators quarterly<br>• Collect all indicator data by ethnicity to help identify and address gaps in equity reported quarterly as KPIs by the Northern Region Cardiac Network by July 2014<br>• Plan and deliver alternative cardiac rehabilitation programmes which meet the needs of Māori, Pacific and Asian populations in collaboration with our DHB and primary care/non-governmental agency partners in a minimum of two localities by June 2015<br>• Ensure a Māori cardiac rehabilitation nurse specialist is supported to work effectively within our community and with all our providers to influence issues relating to access for Māori by July 2014.<br>***Stroke***<br>• Utilise audit data to inform an action plan to identify barriers to thrombolysis and raise the number of eligible patients being thrombolysed – plan developed by October 2014<br>• Active involvement in the National and Regional clinical stroke networks which includes reporting on KPIs for thrombolysis and acute stroke pathways – on-going<br>• Improve collection for both stroke and TIA data - on-going<br>• Review the admission and discharge criteria for North Shore and Waitakere Stroke Units to ensure consistent best practice across the service by June 2015<br>• Review the acute stroke pathway and evaluate the benefit of introducing a dedicated hyper-stroke unit by June 2015<br>• Refinement of the acute stroke pathway to ensure that 80% of stroke patients will be accommodated on the stroke units as best practice business as usual by June 2015 | • 100% outpatients appropriately referred receive an echocardiogram within 150 days of referral. Delays currently being investigated and action plan to be implemented by July 2014<br>• 80% of all outpatients triaged to chest pain clinics seen within six weeks for cardiology assessment and stress test<br>• 90% of outpatient coronary angiograms done within 90 days<br>• >70% of high risk ACS patients accepted for coronary angiography and receive it within 3 days of admission (day of admission being day 0)<br>• >95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days - reported quarterly<br>• 80% of patients presenting with ST elevation myocardial infarction and referred for PCI treated within 120 minutes from time of triage<br>• 45% of Māori, Pacific and Asian patients complete a cardiac rehabilitation programme<br>• 6% of potentially eligible stroke patients are thrombolysed<br>• 100% of patients with stroke have a CT or MRI within 24 hours<br>• 80% of stroke patients are admitted to the stroke unit and all are managed according to the New Zealand Stroke Guidelines. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Continue MDT workforce training to support care pathways as per the NZ Stroke Guidelines – on-going. | |

*Note: regional imperatives will be met from current budget, no additional budget allocations will be made.*

## Primary Care

### What are we trying to do?

We want to develop a high quality and sustainable primary and community health system. We want to increase the integration of community, primary and hospital health services. We want to support earlier identification and better management of long term conditions. We also want to build capability and capacity by increasing the scope of primary care and supporting infrastructure development and drive performance through quality improvement and transparent reporting.

### Why is this important for community and patients?

Primary care is central to improving health and reducing inequalities: 90% of our population's interactions with the health system occur in primary care. There is more that can be done to integrate services, improve the management of long term conditions and increase the involvement of patients, families and whānau in their care. Service integration is important for improving patient outcomes and experience. A more integrated health system where clinicians work together across and within the health system will ensure that appropriate healthcare services are delivered in the right place at the right time.

### Progress to date

We have continued to improve the relationships between the DHB and primary health care. The Auckland and Waitemata District Alliance is in place with a focus on patient and whānau determined care, improved integration, long term conditions and building capability and capacity in primary care. The Alliance Leadership Team (ALT) will be in place by 30 June 2014.

We have increased service integration at Whānau House and New Lynn Integrated Family Health Centre, for diabetes, child health, women's health and district nursing. Clinically led (primary and secondary) new models of care have been developed including:

- Cognitive impairment pathway
- Palliative care
- Co-ordinated Care, Assessment, Rehabilitation, and Education (CARE) pilot
- Mental health integrated Stepped Care model.

A new National Immunisation Register and Outreach Immunisation Services are in place. All after hours network practices are free to under six year olds. A Youth Service Level Alliance has been formed and the Sexual Health Service review has been completed. Rheumatic fever programmes have been developed and implemented with Māori, Pacific and primary care providers.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Implement West Auckland locality – diabetes and child health pathways in all general practices by 30 June 2015<br>• Agree West Rodney locality – work | • All Health Targets achieved each and every quarter<br>• Work programmes reporting through to the Auckland and Waitemata District Alliance |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| programme by 1 October 2014. First priority area scoped and implemented 30 June 2015<br>• Rural Service Alliance team in place with agreed work plan by 1 October 2014<br>• Develop a plan for the distribution of rural funding by June 2015 for implementation in 2015/16<br>• We will work with practices in the region that are excluded from rural funding to develop a plan of support when the SLAT is in place by October 2014<br>• Integrated models of care:<br>  ○ Cognitive impairment pathway evaluated by January 2015<br>  ○ Mental Health stepped care pilots complete with approved roll out plans by 30 June 2015<br>  ○ Palliative care model agreed and implementation initiated by 1 April 2015<br>• Maintain direct access (baseline = 39,000 community referrals – 2013) for general practitioners to a full suite of diagnostic imaging including X-rays, ultrasounds, fluoroscopy, mammography, nuclear medicine, CT and MRI with a focus on managing to appropriate waiting times – on-going<br>• Improve direct GP access to elective surgical lists through enabling specialists in the hospitals to respond directly to GPs about the appropriateness or not of their e-referrals and of any additional work up required, enabling faster surgery confirmation for the patient - ongoing<br>• Maintain on-going direct access for general practitioners to:<br>  ○ E-referral for specific care and treatment of secondary level complications of diabetes<br>  ○ Direct advice from nurse specialists and secondary doctors through dedicated phones. Nurses will cover a specific area within the DHB to increase integration of care<br>  ○ Carpel tunnel and vasectomy elective surgical lists<br>  ○ Co-location of nurse specialist led clinics at Integrated Family Health Care centre | and to the Metropolitan Auckland Clinical Governance and Leadership forum quarterly from Sept 2014<br>• Patient and whānau determined care programmes in place, June 2015<br>• After Hours contract in place, June 2015<br>• Integrated models of care: cognitive Impairment and Mental Health Stepped Care pilots evaluated, June 2015<br>• Primary care led sexual health service in place, March 2015<br>• 50% of IFHCs / GPs provide an after-hours summary to ED via the self-care portal by December 2014<br>• 90% of the PHO eligible population have access to a self-care portal by December 2014<br>• 10% of the PHO eligible population have accessed a self-care portal by December 2014<br>• Community radiology referral waiting times met:<br>  ○ 100% of all routine plain x-ray referrals completed within 6 weeks<br>  ○ 80% of all routine ultrasound referral completed within 6 weeks<br>  ○ 90% of all routine CT referrals completed within 6 weeks<br>  ○ 80% of all routine MRI referrals completed within 6 weeks. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| (IFHC)(New Lynn)<br>○ Integrated care project (diabetes) with specialist doctor and practice (New Lynn)<br>○ Educational opportunities with specialist participation in Clinical Medicine Education, Clinical Nurse Education and NZQA level 7 Diabetes course<br>○ Key contact points between primary and hospital to provide ready access to education, guidance and advice under the cognitive impairment pathway.<br>• Implement direct access to ring pessary elective list:<br>○ Recruit to the nurse specialist role by September 2014<br>○ Implement changes required by February 2015<br>○ Direct referrals by June 2015<br>• Work with PHOs and regional Primary Options for Acute Care (POAC) members to continue to support the services across Waitemata (Target=6,519 referrals by June 2015)<br>• Work with PHOs to jointly implement the Integrated Performance and Incentive Framework locally from July 2014<br>• Continue projects to improve PHO enrolment and data accuracy especially among high need individuals, specifically:<br>○ Primary Care Ethnicity Data Audit Toolkit project – commenced July 2014<br>○ Newborn enrolment projects – three work streams – completed by June 2015.<br>• Complete implementation of primary care led sexual health service by 30 June 2015<br>• Support the implementation of Phase 4 of the Community Pharmacy Services Agreement through engaging primary care prescribers and hospital services with pharmacy in accordance with nationally agreed timelines (to be agreed)<br>• Implement information technology enablers, such as e-shared care and e-referrals<br>• Revise the primary health care nursing strategy by December 2014<br>• DHBs and PHOs will support the availability of patient portals to PHO enrolled populations in 2014 | |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Support the availability of provider portals to enable health providers to access a primary care summary record in 2014<br>• Support emergency departments to be able to access a primary care summary record in 2014. | |

## Health of Older People

### What are we trying to do?

We want to improve outcomes for older people and maximise years of life and quality of life. In order to do this we want to:

- Support and enable older people to participate to their fullest ability in decisions about their health and well-being
- Streamline access for them to all aspects of health services ensuring a 'right place, right time' experience
- Support them to stay at home when it is safe and cost effective
- Provide care that maximises independence and grow integrated services to avoid hospital readmissions.

### Why is this important for community and patients?

Our 65+ population is increasing and is projected to be 15% of the total population by 2021, using a substantially greater proportion of our services than other age groups. Older people should receive coordinated and responsive health and disability services, ie services that are accessible, flexible and timely. Integrating primary and community care across the health system enables patients to be treated closer to home with fewer acute and unplanned admissions into hospital. For those that require a hospital admission or other secondary or tertiary care, the services need to be responsive and connected. We need to ensure these services are structured and provided to make the best use of health funding in order to meet increasing demands.

### Progress to date

We have the longest life expectancy of any DHB in the country at 84 years. An Aged Related Residential Care (ARRC) InterRAI Provider Forum was established and over 95% of ARRC facilities are engaged in interRAI (comprehensive clinical assessment) training. An ARRC model has been established for collaborative management of falls and pressure injuries. Our Residential Aged Care Integration Programme (RACIP) proactively supports ARRC with on and off-site education sessions and best-practice and evidence based resources. ARRC nurses receive Immunisation Advisory Centre (IMAC) training on adult immunisations and have access to a clinical pharmacist. The 'yellow envelope' has been implemented to improve transfer of clinical information between acute care and ARRC. Also, an ARRC psychogeriatric review has been completed.

We have also developed a procurement plan for a new Home Based Support Service (HBSS) model that will maximise patient independence. The Cognitive Impairment Clinical Pathway pilot commenced on 4 November 2013. The pathway focuses on earlier recognition, assessment, diagnosis and management of mild cognitive impairment and uncomplicated dementia in primary care.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Develop a system to analyse the interRAI data set for HBSS clients using core quality measures (once produced by DHB Shared Services and the Ministry of Health) to identify and then manage any quality of service issues with our home and community support services providers<br>• Use additional funding allocated for HBSS to increase support for high and complex clients – on-going funding over 2014/15<br>• Establish baseline data and benchmark our performance with other DHBs using core quality measures for HBSS (once produced by DHB Shared Services and the Ministry of Health)<br>• Support the national interRAI training programme within ARRC<br>  ○ Establish a regional Governance Group for interRAI<br>  ○ Facilitate bi-monthly ARRC provider interRAI forums by July 2014.<br>• Use our Specialist Services for Older People (geriatricians, gerontology nurse specialists, nurse practitioners and pharmacist proactively to advise and support health professionals in primary care and ARRC - on-going<br>• Continue to develop the model of care for the delivery of secondary preventative care for fragility sufferers (through identification, investigation and intervention) to prevent hip fractures by June 2015<br>• Continue the home based support services redesign. The implementation process will progress through 2014/15<br>• Implement the Cognitive Impairment Clinical Pathway:<br>  ○ Evaluate pilot to determine suitability and roll out plan for all DHB general practices July – Dec 2014<br>  ○ Approved roll out plan by June 2015<br>• Pilot and implement CARE: a package of interventions within primary care for older people at high risk of hospital admissions and aged residential care placement which includes pro-active post discharge follow up by primary care - CARE Pilot completed and service implementation commenced by June | • 65% of older people receiving long-term home based support have a comprehensive clinical assessment and individual care plan; 50% have their assessment within twelve months<br>• An additional 22 high and complex clients are funded through additional HBSS funding<br>• All ARRC facilities are using interRAI as their primary assessment tool by 30 June 2015<br>• The Fracture Liaison Service is operational and the following measures are recorded:<br>  ○ Total number of patients admitted with a hip fracture<br>  ○ Number of patients admitted with hip fracture not on current therapy (Current estimate 20%)<br>  ○ Number of patients admitted with hip fracture assessed by the Fracture Liaison Service and commenced on therapy.<br>• The Cognitive Impairment Clinical Pathway roll out plan to all GPs is approved by 30 June 2015<br>• CARE is implemented by 30 June 2015<br>• Current consult and liaison services to ARRC and primary care by Waitemata DHB gerontology nurse specialists are maintained. Referral numbers from primary care per quarter will be reported against a baseline average of 186 (range 150 -210) per quarter<br>• MHSOA achieve agreed waiting time targets (80% within 3 weeks, 95% within 8 weeks)<br>• MHSOA are delivering services in the New Lynn Integrated Family Health Care Centre pilot by June 2015<br>• Three or more priority recommendations from the Kaumatua Action Plan are progressed<br>• Targets in the Regional Health of Older People Plan are achieved. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| 2015<br>• Enhance the delivery and flexibility of specialist mental health services for older adults (MHSOA) through improving waiting times and increasing referrals seen by June 2015<br>• Implement the Kaumatua Action Plan developed during 2013/14 to improve the way in which services we purchase and provide engage with Māori patients and their whānau by June 2015<br>• Facilitate implementation of the Regional Health of Older People Plan at a district level through the regional Health of Older People (HOP) Forum and the HOP Clinical Network by 30 June 2015<br>• Maintain attendances by nurses and health care assistants from ARRC at Health of Older People specialist study days at current level (500) – on-going. | |

*Note: regional imperatives will be met from current budget, no additional budget allocations will be made.*

## Mental Health (Service Development Plan)

### What are we trying to do?

We want to improve outcomes for people affected by mental health issues. We will do this by providing early and effective best practice interventions, increasing access to integrated Mental Health and Alcohol and Drug (AOD) responses across the continuum (primary, secondary and tertiary care and non-government organisation (NGO) services) and contributing to a reduction in suicides.

### Why is this important for community and patients?

Mental ill health is a major cause of health loss. 20% of the population have experienced some form of mental illness over the last year and 3% are severely affected by mental illness. Approximately 53 people in Waitemata district die each year as a result of suicide. A disproportionate number of these deaths are amongst young Māori men.

Families/whānau and individuals are better able to build resilience if information, assessment or treatment is available when mental health or addiction problems emerge. Multi-agency responsiveness ensures different needs are met for the most complex problems and addressing inequalities and increasing access to services produces better mental health and addiction outcomes for everyone. Delivering improved mental health services supports expectations in Blueprint II and Rising to the Challenge (Service Development Plan-SDP) and addresses government strategies (Drivers of Crime, Suicide Action Plan, welfare reforms).

### Progress to date

Waiting time targets have been met or exceeded for adults and older adults across all services – mental health, CADS and forensic mental health. Building of the new $25 million, 46 bed, state of the art Tahoroto mental health facility is underway with the opening planned for early 2015. A

business case has been approved for more beds to complete the building of Tahoroto. The 5 bed Piri Pono service opened in Silverdale. A Short Term Acute Residential (STAR) peer-led acute alternative service was opened in September 2013.

The Hua Oranga (outcome and evaluation) tool is being implemented in the Māori Health team. A stock take and gap analysis against our SDP was completed and actions for 2014/15 have been identified. Secondary Mental Health Services are working out of Whānau House, led by the Māori mental health team. We are running a collaborative project with Auckland DHB looking at employment services (across sectors); a stock-take has been completed.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Review of duration of service use to ensure that people are engaged at the right level of service at the right time (using resources effectively/links to Stepped Care) by June 2015<br>• Improve collection and utilisation of HONOS data, and complete roll out of Hua Oranga by June 2015<br>• Integrate HONOS data into clinical pathways across adult services by June 2015<br>• Build system and clinical integration with primary, secondary and NGO services, building on progress and learnings from the collaborative Stepped Care model and pilot in the New Lynn Integrated Family Health Care Centre. Participate in next Waitemata DHB roll out (e.g. Helensville) over 2014/15<br>• Develop a collaborative plan with PHOs to support mental health workforce capability in primary care by June 2015<br>• Increase the focus of the mental health partnership with Whānau House on Whānau Ora by operating specialist mental health sessions at Whānau House by June 2015<br>• Set bench marks for access and readmission rates for Māori, Pacific and Asian, and aim to reduce late access to service, i.e. first presentation to service resulting in acute admission to an in-patient unit, with a focus on early access for youth by December 2014<br>• Plan to develop mental health focus contracted employment specialists (links to welfare reforms) by March 2015<br>• Maintain the mental health ring fence, (the calculation will include demographic and cost pressure increases). Any additional funding allocation will be prioritised to gaps in the SDP and Prime Minister's Youth Mental Health stock takes - on-going | • Mental health and addictions service waiting times continue to be met: 80% within 3 weeks and 95% within 8 weeks (PP8) with a special focus on 0-19 age group<br>• At least 95% of child and youth clients discharged have a transition (discharge) plan (PP7)<br>• At least 95% of Māori and Pacific long term clients have a up-to-date relapse prevention plans<br>• Establishment of baseline data for mental health access rates for Asian and set targets for 2015/16<br>• PRIMHD file success rate and data quality (OS10) meet or better ministry targets<br>• A minimum of eight actions from across the four goal areas in Rising to the Challenge identified in the Annual Plan are delivered as a policy priority deliverable in 2014/15 (PP26)<br>• Consult Liaison sessions are collected: Targets set in June 2014 are met in the 2014/15 year<br>• 200 structured AOD assessments delivered for each of the Auckland and Waitakere Drug Courts<br>• New local Infant and Perinatal Mental Health Services are fully implemented by March 2015 – service development funding: $1,039,600.75<br>• Maintain or increase the percentage of mentally unwell prisoner admissions to Forensic Inpatient Services that meet the agreed Prison Model of Care acute and sub-acute targets. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Participate in regional work (Eating Disorders, Infant and Peri-Natal Mental Health (additional new operational funding $1.039m), High and Complex needs, Māori workforce development and Youth Forensics), as included in the regional plan - on-going<br>• Roll out training to improve risk assessment/intervention for suicidality, to secondary clinical services and NGOs by December 2014<br>• Complete a staff training programme, roll out of psychosis relapse planning, and participate in IT initiatives to develop relevant self-management tools, to improve self-management by March 2015<br>• Develop Children of Parents with Mental Illness or Addictions (COPMIA) services across provider arm and NGO services by March 2015<br>• Integrate AOD interventions across the continuum with a focus on the integrated pathways between the Waitakere District Court , Community Alcohol and Drugs Services (CADS) and NGOs for the Waitakere Drug Court ( links to Drivers of Crime) by December 2014<br>• Establish AOD outcome measures for youth, as part of the Ranui Social Sector trial by June 2015<br>• Complete a cross DHB/cross agency local suicide prevention/postvention action plan by December 2014<br>• Link school based health services to suicide prevention strategies targeting young Māori (pilot Kelston Girls High School) – pilot to commence December 2014<br>• Continue to implement the WAVES programme (post suicide support and education course to provide group support to people bereaved by suicide) – fully implemented by June 2015<br>• Complete a cross DHB/cross agency local suicide prevention/postvention action plan by December 2014. | |

## Maternal and Child Health

### What are we trying to do?

We want to improve access, quality and outcomes and reduce inequalities for women, babies and infants in Waitemata DHB through the delivery of effective, integrated, evidence-based maternity and children's services.

### Why is this important for community and patients?

The wellbeing of children is critical to the wellbeing of the population as a whole and is both a regional and a national priority. Healthy children are more likely to become healthy adults. Positive health outcomes for children and mothers are essential for this. Disparities in outcomes for pregnant women and children are associated with later engagement with health professionals, higher smoking rates during pregnancy and higher rates of obesity, amongst other factors.

Earlier access to a range of health advice, information and interventions can improve health outcomes for pregnant women and their children. An effective interface between maternity carers and other primary healthcare professionals needs to support these aims. While many families living in Waitemata have better health than their national counterparts, some remain significantly disadvantaged with Māori and Pacific children having poorer health status than other groups.

### Progress to date

Waitemata DHB's infant mortality rate of 3.2 per 1000 live births (2006-2010) is the lowest in the country. Between 2008 and 2010, Waitemata DHB had 0.5 deaths per 1000 live births as the result of sudden unexplained death of an infant (SUDI), significantly less than the national rate. The most recent data suggests that deaths from SUDI are decreasing. 57% of women are breastfeeding at 3 months, 70% of children with high needs and 68% of all children received B4 school checks and 65% of women were enrolled with a lead maternity carer (LMC) at 12 weeks of pregnancy (2012).

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| Complete the Auckland and Waitemata DHB maternity review and commence implementation planning.<br><br>***Actions to improve access will include:***<br>• Target strategies to facilitate early registration with a LMC (by 12 weeks pregnant); strategies may include awareness raising and working with GPs and LMCs by June 2015<br>• Work closely with the Immunisation Team and with a GP/PHO workstream to identify current gaps and examine maternity specific actions relating to new born early enrolment by June 2015<br>• Work with Well Child Tamaki Ora (WCTO) providers and other community providers to plan and implement targeted strategies to improve early WCTO enrolment and support Māori, Pacific and young mothers to attend all core WCTO checks in the first year of life by June 2015 | Presentation to the Boards of an agreed plan across Auckland and Waitemata DHBs for the configuration of maternity services by March 2015.<br><br>***Access***<br>• At least 80% of pregnant women are registered with a lead maternity carer by week 12 of their pregnancy<br>• 88% of new born children are enrolled with a GP by three months by December 2014 and 98% by June 2016<br>• 86% of Māori and of Pacific infants receive all WCTO core contacts through their first year<br>• 95% of preschool children are enrolled with Auckland Regional Dental Service<br>• 93% of enrolled children are seen for their oral health assessments on time<br>• 90% of four year olds receive a B4 School Check, including 90% of children living in high deprivation areas |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Provide patient-centred appointments, confirming attendance either by texting or telephoning and by extending clinic hours to suit parents/caregivers to reduce preschool dental non-attendance (DNAs) by March 2015<br>• Monitor engagement of Māori infants with community oral health providers, and work on whānau engagement with community oral health services –on-going<br>• Implement the revised Ministry of Health Pregnancy and Parenting service specifications through a request for proposals process to provide more effectively targeted pregnancy and parenting education and information services by 31 January 2015<br>• Following implementation of the service specification, establish baseline data on engagement in pregnancy and parenting education services by ethnicity 31 July 2015<br>• Communicate up to date key messages and information about well child provider options through the redevelopment of a brief information brochure for pregnant women by March 2015.<br>***Actions to improve quality will include:***<br>• Improve B4 School Check coverage, quality and service referral pathways through the implementation of the B4 School Check Quality Framework by June 2015<br>• Progress specific identified projects under the Maternity Quality and Safety Plans, including:<br>  ○ Promoting the Normal Birth project, and<br>  ○ Promoting increasing early engagement with a LMC by June 2015<br>• Identify quality improvement priorities from the Maternity Quality and Safety plan. This will include reporting on the New Zealand Maternity Clinical Indicators to identify outliers. Programmes will then be implemented to reduce variation in service and practice – on-going<br>• Implement the national guideline for the screening, diagnosis and management of gestational diabetes once available<br>• Work on improvements to the collection | • Baseline data collected for pregnant women who are engaged in quality antenatal education, by ethnicity.<br>***Quality***<br>• Of the children who complete a B4 School check, at least 85% have their check started before they are 4 ½ years of age<br>• An assessment of progress using the New Zealand Maternity Clinical Indicators and the development of specific activities around indicators of concern<br>• Improved quality and safety of maternity services, as measured by improved consumer satisfaction and through a range of indicators in the Annual Clinical Report.<br>***Outcomes***<br>• At least 55% of all infants and particularly Māori, Pacific and Asian infants are fully breastfed at three months of age. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| and reporting of needs to identify system for collecting consumer satisfaction data by February 2015.<br><br>***Actions to improve outcomes will include*:**<br>• Maintain breast feeding friendly hospital initiative accreditation (on-going) and investigate opportunities to extend the concept into primary care settings by April 2015<br>• Increase messaging and community support to Māori, Pacific and Asian women and their families and whānau to encourage continuation of breast feeding from six weeks to three months, linking with the Maternal and Infant Nutrition Project by March 2015<br>• Work with Well Child Providers and LMCs to develop activities identified by the WCTO Quality Framework breastfeeding workstream from August 2014 on-going<br>• Support the Health Promotion Agency work programme toward the prevention of children being born with Foetal Alcohol Spectrum Disorder (FASD) on-going. | |

# Priority Populations

## Māori Health

### What are we trying to do?

We want to ensure that Māori achieve their best possible health outcomes. Specifically we aim to reduce the impact of modifiable risk factors known to impact on Māori health including smoking and obesity and we want to identify and effectively manage chronic conditions such as cardiovascular disease and diabetes. We also seek to ensure Māori wellbeing is maximised by working with Māori partners, including iwi and local Māori providers, in a framework which is responsive to Māori health needs. We aim to ensure full access to our services, equitable treatment through our services and the elimination of health outcome inequalities.

### Why is this important for community and patients?

There is a gap of 8.8 years in life expectancy between Māori and non- Māori. Coronary heart disease, lung cancer, diabetes, obesity and stroke account for over half of this difference. There is substantial scope to improve health gain for Māori. By focusing on risk factors as well as better management of existing conditions, we can improve health outcomes. By ensuring we use a framework that is responsive to Māori and aligned to tikanga best practice we ensure our services are culturally appropriate.

### Progress to date

Māori life expectancy in Waitemata DHB is 76 years, 3 years above the national average for Māori across New Zealand (73 years) at birth (2012). Smoking prevalence has declined more than 10% for Māori between the 2006 and 2013 census to 27.1%. The emergency department health target of 95% was reached as well as the advice to quit smoking health target in hospital services. Heart and diabetes checks (as at December 2013) have increased from 67.9% to 72.3% (2013/14). Immunisation uptake has improved by 16% since July 2012 and breast screening rates have also climbed - 64.5% as at January 2014. Cervical screening rates have improved from 47% to 53% over the last 3 years. The development of Māori nurse specialist roles in key health gain areas (Cancer, Gerontology, Diabetes and Respiratory Services (pending)) is expected to also impact on equity of access and health gain overall.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| ***Access to primary care***<br>• Work closely with PHOs to ensure Māori Health Plan targets are met by all PHOs by June 2015<br>• Collaborate with PHOs to implement all three stages of the Ministry of Health Ethnicity Data Audit Toolkit in general practices by June 2015<br>• Work with PHOs to ensure the quality of ethnicity data at PHO level is high. (i.e. address issues with Datalink) – on-going<br>• Collect and analyse information about the conditions driving ambulatory sensitive hospitalisation (ASH) rates for Māori across all age bands by June 2015 | Achievement of the following national Māori health targets:<br>• PHO enrolment (Māori): 95%<br>• More heart and diabetes checks: 90%<br>• Breast screening: 70%<br>• Cervical screening: 80%<br>• Better help for smokers to quit (hospital): 95%<br>• Better help for smokers to quit (primary care): 90%<br>• Māori fully immunised at 8 months: 90%<br>• Influenza vaccinations for Māori aged 65+: 70%<br>• Rheumatic fever rates: Waitemata DHB 1.4<br>• At least 2 Whānau Ora centres in place across the Waitemata district. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Promote and transfer the learnings from effective targeted community based partnership responses to increase access (Sentinel practices for rheumatic fever swabbing and 65+ Kaumatua community based seasonal influenza vaccination clinics are examples) by June 2015<br>• Support development and implementation of Whānau Ora models of care and delivery, via the development of further business cases and future programme modelling by June 2015.<br>***Chronic conditions***<br>• Continue to analyse care pathways to identify, isolate and address the inequalities gap through development of strategies with appropriate service groups by June 2015<br>• Identify opportunities to increase access in community settings where appropriate by June 2015.<br>***Smoking cessation***<br>• 95% of Māori seeking post discharge support to quit smoking will be followed up to ensure they have had every opportunity to engage with a Smoking Cessation Service best suited to their needs by June 2015<br>• Identify best practice approaches to encourage 15-24 year olds to be smokefree by June 2015<br>• The Maternity Plan will be updated with new activities to encourage pregnant Māori women to quit smoking by June 2015<br>• Identify Māori leaders/champions in the community (eg Aunties) to work with whānau to promote smoke free by June 2015<br>• Provide training to all Māori Health Service/He Kamaka Waiora registered staff to be smoking cessation leads with on-going support through the Waitemata DHB Smokefree Team by June 2015.<br>***Health of older people***<br>• Identify and progress options to support Kaumatua residential care<br>• Identify eligible patients who have not had 'flu' vaccination and offer vaccination. | |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| ***Child health***<br>• Development of a strategy to increase enrolment (GP, Wellchild and oral health), immunisation and before schools checks in collaboration with primary care, Māori providers and non-governmental organisations by June 2015<br>• Support the implementation of the Waitemata DHB acute rheumatic fever programmes by June 2015.<br>***Māori workforce development***<br>• Develop a clinical leadership governance structure for Māori by June 2015<br>• Develop five specific Māori clinical positions by June 2015<br>• Support the Kia Ora Hauora initiative to support young Māori into careers in health through the Rangatahi Programme by June 2015.<br>***Womens health***<br>• Review the quality of ethnicity data within the breast screening programme by June 2015<br>• Support the implementation of the work programme of the Metro Auckland Cervical Screening Steering Group by June 2015. | |

## Pacific Health

### What are we trying to do?

We want to improve Pacific health outcomes by reducing the prevalence of modifiable risk factors such as smoking and improve the identification and management of long term conditions. We also need more people engaged in this effort. We want Pacific people to have good health literacy; communities and churches active in solving health problems; culturally competent clinicians and more Pacific people training for careers in health.

### Why is this important for community and patients?

There is a difference of eight years in life expectancy between Pacific people and non-Pacific non-Māori in our community. Coronary heart disease, lung cancer, diabetes, obesity and stroke account for over half of this difference. In order to reduce the inequalities experienced by our Pacific population, it is important that we work towards meeting the health targets across the board for all our population groups. All health services, at every point in the continuum of care, need to engage with expertise with their Pacific patients and their families, and make sure that health care experiences are always positive.

## Progress to date

Pacific life expectancy in Waitemata DHB is the same as the national average for Pacific across New Zealand (76 years) at birth (2012). The national health target for immunisation of 90% at 8 months was exceeded at 94% and the better help for hospitalised smokers to quit target of 95% was also reached. Breast screening targets were met at 78% and the more heart and diabetes checks health target improved, reaching 72% against a target of 90%. 60% of people with diabetes who had an annual review had satisfactory diabetes management. A joint Auckland/Waitemata DHB Pacific Strategic/Action Plan has been developed with extensive community wide consultation to build on and extend improvements.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Implement the Pacific Action Plan priority areas. This includes:<br>  ○ Family violence prevention – trial programme on at least two church communities by June 2015<br>  ○ Smokefree – train smoke free champions for Enua Ola churches by June 2015<br>  ○ Diet and exercise – continue regular physical activity groups and nutrition education sessions with Enua Ola – on-going.<br>• West Fono will deliver Diabetes Self-Management Education (DSME) workshops for 140 patients within the 2014/15 financial year<br>• ProCare will facilitate and deliver 10 self-management of chronic conditions workshops with a minimum of 10 patients participating in each workshop within the 2014/15 financial year<br>• Maintain health education / promotion and support services to engage with breast, cervical and bowel screening programmes – on-going<br>• Youth Hub services will engage with more Pacific youth in Waitemata over 2014/15<br>• Continue Enua Ola and programmes nurses– annual weight loss competitions and group quit smoke competitions and nutrition training - on-going<br>• Waitemata DHB Child and Family Services will work with West Fono to identify and follow-up children enrolled with West Fono but who did not attend (DNA) their specialist appointments; apply learnings from this process to other children if appropriate by June 2015. | • 90% of Pacific children are up-to-date with their immunisation at 8 months by June 2015<br>• 95% of Pacific children are up-to-date with their immunisation at 24 months by June 2015<br>• Heart and diabetes check completed for 90% of the eligible Pacific population by 30 June 2015<br>• 75% of eligible Pacific population will achieve good diabetes management by June 2015<br>• 90% of enrolled Pacific patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking by June 2015<br>• Increased Pacific participation in bowel screening programme<br>• Continue to meet or exceed Pacific participation in breast screening programme at 70% or higher<br>• Increased Pacific participation in cervical screening to 80%<br>• 33% of Enua Ola church halls and grounds will become smoke free by June 2015. |

## Asians, Migrants and Refugees

### What are we trying to do?

We want to improve the overall health status of Asians, new migrant and refugee populations living in the Waitemata district, with continued focus on identified areas of high need, and strategies to overcome barriers such as access to health services, language and staff cultural competency.

### Why is this important for community and patients?

The Asian population now accounts for 19% of Waitemata's population and is increasing. It is expected that all New Zealanders, regardless of ethnicity, receive an equitable level of health service access, care and outcomes. The Asian and MELAA populations living in the Waitemata region are high and rapidly increasing. These groups have specific health needs. There remain some inequalities in access particularly in relation to PHO enrolment, cervical screening, mental health, and chronic disease (including diabetes and cardiovascular disease).

### Progress to date

Asian life expectancy is higher than other ethnicities in Waitemata at 89 years (2009-2011), with very low rates of mortality for cancer and cardiovascular disease. In the Waitemata DHB district as at April 2014 we achieved:

- 77% Asian PHO enrolment rate
- 63% three year coverage rate for Asian women cervical cancer screening
- Childhood immunisation rates at 8 months exceeding national target of 90%
- Childhood immunisation rates at 2 years exceeding national target of 95%.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Communicate regularly (six monthly) with MoH and other Health and Disability organisations to follow the Ethnicity Data Protocols to report on level 1 'Asian' and 2 categories subgroups ('Other Asian', 'Chinese', 'Indian', 'South East Asian' and 'Asian NFD') by 30 June, 2015<br>• Establish complete and accurate data on level 2 Asian subgroups to guide planning and monitoring of services by 30 June, 2015<br>• Reflect expectations for achievement of 90% access to cardiovascular and diabetes risk assessment services through general practice and inpatient services in PHO contracts and Provider Arm Service Level Agreements by 30 June, 2015<br>• Utilise Northern Regional Diabetes Network indicators as measurement tools by 30 June, 2015<br>• Continue to provide free smears for Asian women not screened in the last 5 years or never screened (on-going)<br>• Increase messaging and community support to Asian women and their families to encourage continuation of breast feeding | • 90% of eligible Asian people have had a heart and diabetes check within the last five years by 30 June, 2015 based on accurate ethnicity data collection and reporting protocols<br>• Northern Region Diabetes Network indication outcomes consistent for Asian people and all other people<br>• A minimum 51% of Indian people in Waitemata DHB district, with diabetes, have an annual review by 30 June, 2015<br>• 75% of Indian people who have had a diabetes annual review have an HbA1c of <64mmol/mol by 30 June, 2015<br>• 75% of eligible Asian people receive the Diabetes Care Improvement Package over the year to 30 June, 2015<br>• Increase breast screening rate to 70% by 30 June, 2015<br>• Work towards increasing cervical screening coverage rate to at least 80% by 2020<br>• Achieve 95% of the Asian immunisation rate of 8 month and 2 year olds by 30 June, 2015<br>• At least 55% of Asian infants are fully |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| from six weeks to three months, linking with the Maternal and Infant Nutrition and Physical Activity Collective and implementation of Service Plans by 30 June, 2015<br>• Provide workforce development training to health professionals on refugee health across Waitemata DHB by 30 June 2015<br>• Set benchmarks for mental health access rates for Asian, and aim to reduce late access to service i.e. first presentation to service resulting in acute admission to an in-patient unit, with a focus on early access for youth by 31 December 2014. | breastfed at three months of age<br>• Three refugee forums delivered annually across Auckland DHB and Waitemata DHB by 30 June 2015<br>• Mental health measure: Establish baseline data for mental health access rates for Asian and set targets for 2015/16. |

# Patient Experience and Quality

## Patient Experience

### What are we trying to do?

We want to relieve suffering and achieve better health outcomes for our patients and community by: enhancing patient/whānau experience when they interact with us; ensuring everything is done to relieve physical, psychological and emotional pain; ensuring patient/whānau care is culturally safe and responsive; and providing clear connections and smooth transitions between units and teams across our organisation. Empowering our patients, whānau and community so they are engaged in healthcare helps us work together in partnership to redesign healthcare services.

### Why is this important for community and patients?

Evidence shows that patient experience is a robust indicator of quality and understanding. Enhancing patient/whānau experience is essential to achieving high quality health outcomes. An enhanced patient experience leads to better emotional health, symptom resolution; less reported pain and more effective self-management.

### Progress to date

We have successfully implemented a patient experience reporting system: the Friends and Family Test, to help us understand the views of our patients and identify areas for improvement. The Friends and Family Test net promoter score is 69 (February 2014) against a target of 65. We have also engaged patients and the community to improve services, including involvement in locality planning and participation in co-design programmes and in service planning.

We have undertaken work to become a values-led organisation, holding patient and staff listening events, analysing compliments and complaints, and surveying our staff. We have established a steering group to lead a Patient and Family Centred Care Programme and continued to remove barriers for whānau, family and friends though extended visiting hours, improved patient information, daily rounds by ward leaders, and hourly rounds by our ward nursing staff.

We continue to tell patient stories at the beginning of every Board meeting and undertake executive leadership rounds. We are committed to prompt complaint resolution through directly engaging our clinical staff with patients and whānau. We have continued to support our Healthy Workplace initiatives to help ensure staff are supported to provide improved patient experience.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Continue to develop a patient experience reporting system to include all DHB services, and an expanded set of survey questions including national patient experience measures and local measures<br>• Expand the friends and family test to all inpatient clinical services. Pilot an expanded set of experience questions in Mental Health services by June 2015<br>• Develop a work plan for the Patient and Family Centred Care programme by July 2014<br>• Engage with Māori, Pacific, Asian and other cultural groups to improve measurement and monitoring of patient experience and engagement, cultural safety and cultural responsiveness<br>• Identify areas for improving patient experience, cultural safety and cultural responsiveness<br>• Engage Māori, Pacific and Asian people in the Patient and Family Centred Steering Group<br>• Continue to identify and utilise opportunities to engage patients, whānau and the community at all levels of the organisation, including governance, service planning and design and care management<br>• Develop a work plan for the next phase of the values-led organisation programme, including further engagement of clinical staff with patient feedback and listening events, identifying improvement actions and building values in the enhanced care management and clinical leadership programme<br>• Continue to work with Health Links and non-government organisations to identify further opportunities for enhanced community and patient engagement<br>• Continue to remove barriers for whānau, family and friends though extended visiting hours, improved patient information and signage. Complete a review of visitation by | • Each service has a workplan for completing the 'Patient Based Care Challenge', identified priorities for improving experience and has undertaken quality improvement activity to improve patient experience and engagement by June 2015<br>• >70% of patients rating 'staff showed care and respect' as 'Good' or 'Excellent' by June 2015<br>• Net Promoter Score for the Friends and Family Test >70 by June 2015<br>• Survey of overall satisfaction with handling of complaints completed by June 2014 and improvements identified from the survey implemented by July 2015<br>• Service standards and priorities for improving patient and staff experience are developed and a 'leading our values' week is held by June 2015<br>• <15 days average time to respond to complaints. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| June 2014 and develop plan for implementing open access by June 2015<br>• Complete implementation of the Quality Review recommendations by June 2015<br>• Continue to increase transparency of information for patients, whānau and the community including the introduction of a Waitemata DHB information booklet for inpatients and publication of a quality account in partnership with our patients, whānau and community. | |

## Quality

### What are we trying to do?

To provide the very best care for all our patients, we need to ensure that the care we provide is safe, clinically effective, focused on the needs of our patients, whānau and our community, and achieves quality outcomes that are among the best in the world.

### Why is this important for community and patients?

Our patients, whānau and the community deserve to receive the best care every time. They need to be confident of the quality and safety of the care they will receive; know that the care they receive is best practice and evidence-based and that they are engaged and involved in the design and the delivery of their care. The greater the trust and engagement our patients, whānau and community have in their care, the greater the safety, effectiveness and the quality outcomes of that care.

### Progress to date

We have collaborated nationally and regionally in quality improvement programmes to reduce harm. We have improved our rates of compliance with good hand hygiene practice from 62.2% (July-October 2012) to 71.3% (July-October 2013) and decreased the number of patients falling (105 falls in January 2013, 91 falls in January 2014). We have also improved the numbers of elderly patients who are assessed for their risk of falling (63.9% March 2013 to 96.1% September 2013), ensuring those patients have a falls care plan to try and prevent falls from occurring. We have also improved the rates of compliance with the use of the surgical safety checklist (from 80% March 2013 to 97.3% September 2013).

The number of patients suffering serious pressure injuries (grade 3 and 4) has reduced to zero and the rate of central lines infections in our intensive care unit is now fewer than 1 infection per 1000 line days. The recommendations from Professor Ron Paterson's Waitemata DHB Quality Review have been implemented and we have commenced a care management and clinical leadership model training programme to enhance the role of clinical managers and engage our clinical staff in the design and management of front line care. We have commenced an 'essentials of care' programme to help ensure our patients receive the basics of care well, at the right time and every time.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Continue to collaborate nationally and regionally on quality improvement programmes and continue to improve by meeting and exceeding the national targets for the quality and safety markers<br>• Actively participate in the Health Quality and Safety Commission's (HQSC) national patient safety campaign (Open for Better Care) to reduce harm from falls, healthcare associated infections, perioperative care and medication<br>• Implement a ward falls champion training programme<br>• Review the process and documentation of falls incidents by July 2014<br>• Undertake weekly audits of fall risk assessments and care planning and provide real time falls data to senior nurses and managers to monitor and report falls to track and reduce the incidence of falls<br>• Further develop a staff education and training programme for hand hygiene including orientation of new staff<br>• Measure and track staff hand hygiene education and training<br>• Continue Gold Auditor training to provide a gold auditor and each ward to undertake regular hand hygiene gold audits and provide real time reporting of hand hygiene practise<br>• Continue to promote the 'bare below elbow' protocol<br>• Track and report theatre teams' use of the three parts of the surgical safety checklist<br>• Identify a surgical safety checklist clinical champion for each surgical subspecialty and work with the clinical champions to improve the effective use of the checklist<br>• Implement patient safety 'never events' and 'always events' to help promote the effective use of the surgical safety checklist<br>• Work with surgical teams to use the Stop/Start/Improve Huddle and Theatre Team Briefing to improve patient safety, teamwork and communication within the teams<br>• Continue to work with the orthopaedic theatre teams to promote the use of cefazolin antibiotic and appropriate skin | • 90% of elderly patients are given a falls risk assessment and patients at high risk of falling have a falls care plan in place by June 2014<br>• Working towards 80% compliance with good hand hygiene practice by June 2015<br>• All three parts of the surgical safety checklist are used >90% of the time by June 2015<br>• 95% of non-allergic hip and knee replacement patients receive cephazolin ≥2g as surgical prophylaxis by December 2014<br>• 100% hip and knee replacement patients have appropriate skin preparation by December 2014<br>• Rate of central line associated bacteraemia (CLAB) infections <0.1 per 1000 line days by June 2014<br>• Zero grade 3 or 4 pressure injuries by June 2014<br>• 60% of patients discharged from Medical & AT&R wards will have a completed eMR (electronic Medicine Reconciliation)<br>• 100% clinical areas using medicines are using Pyxis Medstations for storing medicines by June 2015<br>• 100% serious and sentinel events are investigated and responded to within 70 working days by June 2015<br>• Quality improvement initiatives are documented in response to complaints and reportable events – on- going. |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| preparation for hip and knee replacement surgery<br>• Continue to audit the appropriate dose and timing of the administration cefazolin antibiotic, and appropriate skin preparation, for hip and knee surgery and track and report the results on theatre quality boards<br>• Develop a pain management strategy and quality improvement programme by September 2014, which will include the safe prescribing and administration of opiate medication<br>• Continue to implement a quality improvement programme to reduce the incidence of constipation and nausea and vomiting resulting from opiate medication administration<br>• Actively participate in the northern region's 'First Do No Harm" project to reduce falls causing major harm to a rate less than 0.07 per 1000 patient days, prevent grade 3 and 4 pressure injuries and reduce the rate of central line infections in the intensive care unit<br>• Continue to implement and monitor a programme of quality improvement projects to address issues identified by complaints, incidents and patient and whānau feedback<br>• Complete the implementation of the Quality Review recommendations<br>• Develop system level measures and a quality measurement framework to help ensure alignment and reporting of measures across the organisation<br>• Work with services and clinical groups to develop quality plans with outcome measures<br>• Continue to develop and implement the enhanced care management and clinical leadership model training<br>• Partner with primary and community care when opportunities for improvement exist, including improved diabetes management, enhanced patient safety and improved care and management for elderly people<br>• Continue to promote and improve transparency of quality information, including public reporting of serious and | |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| sentinel incidents, quality indicators and outcomes.<br>• Continue to implement e-prescribing and e-medicine reconciliation<br>• Implement recommendations from a review of palliative care services in relation to end of life processes and staff training<br>• Continue to implement the Advance Care Planning Programme<br>• Quality Accounts produced in 2014/15 will be informed by HQSC guidance once this is provided. | |

## Living within our Means

### What are we trying to do?

We want to be a financially sustainable and productive organisation while improving health outcomes and reducing inequalities for our community.

### Why is this important for community and patients

Like all other DHBs, we are operating in a financially constrained environment, where health expenditure is growing at a faster rate than health funding and where demand for health services is growing. Health service demand growth is particularly an issue for our DHB being the largest DHB in New Zealand (12% of the national population), and the fastest growing of all DHBs.

### Progress to date

We have lived within our means for the past four years. We have achieved year-end financial results better than approved plans and more recently generated surpluses that have been reinvested into capital programmes to ensure that we continue to meet the health services needs of our growing population. Surpluses have been achieved through the successful business transformation programme which commenced in 2010/11 and assisted in generating savings of $45M in that initial year. Further savings of $23M in 2011/12 and $12m in 2012/13 were achieved and savings of $16.9M in 2013/14 is underway. We are forecasting a surplus of $1M for the 2013/14 financial year as planned.

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| • Continue the Business Transformation programme through to 2014/15 and beyond – on-going<br>• healthAlliance savings programme from procurement and supply chain – on-going<br>• Health Benefits Limited (HBL) savings programme for the Finance, Procurement and Supply chain shared services, shared banking arrangements, information services and other initiatives underway. The DHB will work with HBL to identify and quantify | • A surplus of $1M achieved for 2014/15 and breakeven financial result achieved for each of the out years<br>• Specific business transformation initiatives implemented in prior years and savings achieved have been carried forward to 2014/15<br>• Agreed collaboration work streams implemented by year end and savings achieved<br>• healthAlliance and Health Benefit Limited |

| What are we going to do in 2014/15? | How will we know we've achieved it? Measured by |
|---|---|
| savings opportunities. Savings that are sustainable will be embedded into the services by June 2015<br>• Support the work of HBL to progress the Food Services, Linen and Laundry Services and National Infrastructure Platform business cases aimed at reducing the costs and improving the overall quality and provision of services by October 2014<br>• Implement the new model of care for elective services delivery at the new surgery centre by December 2014<br>• Consolidate Waitemata and Auckland DHBs' collaboration work streams (eg planning and funding, Māori health, child health hospital services, health services planning, corporate services, Pacific health, employee relations, telephonists/call centre, etc) by June 2015<br>• Inventory management for clinical and non-clinical supplies – on -going<br>• Pharmac and healthAlliance are working jointly on the national procurement of medical devices for best health outcomes – on-going<br>• Laboratory testing review and cost savings<br>• Funder contracts review and value for money on-going<br>• Provider arm services reviews on-going<br>• Infrastructure costs/contracts and energy efficiency reviews and savings on-going<br>• Rollout Electronic Prescribing as part of Medication Safety Strategy, phase 1 by June 2015<br>• Development of further joint work streams where applicable with Auckland DHB over 2014/15<br>• Review older people services and clinical pathways on-going<br>• Pursue additional income opportunities over 2014/15. | savings initiatives implemented and savings achieved by year end<br>• Capped FTE count maintained at final agreed budget levels throughout 2014/15<br>• Improvements to key measures including - improved inpatient length of stay and reduced acute readmissions to hospital by June 2015. |

# MODULE 3: Statement of Performance Expectations

## Statement of Performance Expectations

The statement of performance expectations is a requirement of the New Crown Entities Act 2013 and identifies outputs, measures, and performance targets for the 2014/15 year. Recent actual performance data is used as the baseline for targets.

We use only a few cornerstone measures here to cover what is a vast scope of business as usual activity. Those included here provide a reasonable representation of the services provided by a District Health Board. Measures within this Statement of Performance Expectations represent those activities we do to deliver our goals and objectives in modules 1 and 2. Service Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures will be reported in the DHB's Annual Report, and audited at year end by the DHB's auditors, AuditNZ.

## Outcomes Measurement Framework

Our focus for 2014/15 is based on the three key outcomes that comprise our purpose statement:

- To promote wellness
- To prevent, ameliorate and cure ill health
- To relieve suffering of those entrusted to our care.

A description of the impacts we expect to see contribute to these outcomes is described in Module 1 which links the outcomes and impacts with the national, regional and local strategic direction. It is important that the actions we take during 2014/15 link to the expected impacts and outcomes sought in the future. The output classes, which are described more fully later in the section, provide an overview of the quantity, quality and cost of activities undertaken by the DHB. Please also refer to the detailed planning framework in Module 1.

Within each output class section, a series of relevant time trend graphs are included. It is intended that these give a broad overview of relevant outputs and impacts, where time trend information is relevant and useful.

## Cost of Outputs

**Waitemata DHB 2014/15 Output Class Reporting / Statement of Service Performance**

| Old Output Class Name | Public | Primary | Hospital | Support | Total |
|---|---|---|---|---|---|
| New Output Class Name | Prevention Services ($'000) | Early Detection & Management ($'000) | Intensive Assessment & Treatment ($'000) | Rehabilitation and Support ($'000) | Total ($'000) |
| | Plan | Plan | Plan | Plan | Plan |
| **Total Revenue** | **26,720** | **394,800** | **880,615** | **224,961** | **1,527,096** |
| **Expenditure** | | | | | |
| Personnel | 8,040 | 55,498 | 442,683 | 33,933 | **540,154** |
| Outsourced Services | 823 | 5,682 | 45,326 | 9,629 | **61,461** |
| Clinical Supplies | 1,532 | 10,572 | 84,328 | 4,628 | **101,059** |
| Infrastructure & Non-Clinical Supplie | 1,553 | 10,717 | 85,487 | 327 | **97,430** |
| Payments to Providers | 14,772 | 311,330 | 222,792 | 177,098 | **725,992** |
| **Total Expenditure** | **26,720** | **393,800** | **880,615** | **224,961** | **1,526,096** |
| **Net Surplus / (Deficit)** | **-** | **1,000** | **-** | **-** | **1,000** |

## Targets and Achievement

The rationale and targets for each of the output measures is included in the following sections. It is important to note, that while there are disparities in health service access and health outcome between ethnic groups, the health sector does not have differential targets for different ethnic groups compared to Others. We have an expectation that all New Zealanders should receive the same level of care and service regardless of ethnicity and we should all enjoy the same health outcomes.

When assessing achievement against each measure we use a grading system to rate performance. This helps to identify those measures where performance was very close to target versus those where under-performance was more significant. The criteria used to allocate these grades are as follows:

| Criteria | Rating | |
|---|---|---|
| > 20% away from target | Not Achieved | |
| 9-20% away from target | Partly Achieved | |
| 0.01-9% away from target | Substantially Achieved | |
| On target or better | Achieved | |

## Key to Output Tables

| Symbol | Definition |
|---|---|
| Ω | Measure is demand driven – not appropriate to set target |
| ↓ | A decreased number indicates improved performance |
| ↑ | An increased number indicates improved performance |
| Q | Measure of quality |
| V | Measure of volume |
| T | Measure of timeliness |
| C | Measure of coverage |

# Output Class 1: Prevention Services

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations. These services are 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.

Approximately a third of the burden of ill health is preventable and for some diseases such as cardiovascular disease the percentage is much higher. Effective prevention services can therefore have a significant impact on health outcomes. From a financial sustainability or efficiency perspective a quick and effective response to outbreaks, environmental hazards and other emergencies also reduces downstream expenditure on the consequences of uncontrolled health threats. Other public health services, such as health promotion and healthy public policy, also help to reduce downstream demands on DHBs for personal health services though influencing medium and long - term health outcomes.

## Output: Health Promotion

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline Data |
|---|---|---|---|---|---|
| Percentage of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking. | Q | By encouraging and supporting more smokers to make quit attempts there will be an increase in successful quit attempts, leading to a reduction in smoking rates and in the risk of the individuals contracting smoking related diseases | 97.7% | 95% | Q2 2013/14 |
| Percentage of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered advice and help to quit | Q | | 55.2% | 90% | Q2 2013/14 |
| Number of people accessing Green Prescriptions | V | A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active, as part of the patient's health management. GRx research confirms this is a cost-effective way to help people stay healthy. | 4953 est. | 6523 | 90% of 2013/14 target est. |
| *Enforcement of the Smokefree Environments Act 1990* | | | | | |
| Number of retailer compliance checks conducted | V | Compliance checks are conducted with tobacco retailers to ensure they are meeting their obligations under the Smokefree Environments Act 1990. | 457 | 300 | 2012/13 |
| Number of retailers visited where Controlled Purchase Operations (CPOs) were conducted | V | Preventing minors from accessing tobacco products contributes towards the prevention of smoking initiation. These are output and impact measures. | 498 | 300 | 2012/13 |
| *Enforcement of alcohol legislation* | | | | | |
| Number of license applications (on[6], off club and special) risk assessed | V | ARPHS works to reduce the proportion of premises which sell alcohol that are of high or extreme risk. All license applications in Auckland region | 1235[7] | 1200 est | 2012/13 |

[6] an 'on- licence' authorises the holder to sell and supply liquor for consumption **on** the premises (e.g. pub) as opposed to off- licences (e.g. liquor stores)

[7] Currently ARPHS risk assesses all license applications received. From July 2013, under the Sale and Supply of Alcohol Act 2012, the Medical Officer of Health is required to inquire into all types of licensing applications (on, off, club and special). The number included here represents the number of license applications (on and club only) processed and risk assessed in the year 2012/13 as a base to estimate the number of licenses that may be processed and risk assessed in the year 2014/15. A more accurate baseline data can only be provided based on the financial year 2013/14.

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline Data |
|---|---|---|---|---|---|
| | | are risk assessed | | | |
| Number of premises visited where joint Controlled Purchase Operations (CPOs) were conducted (alcohol) | V | Controlled purchase operations monitor and enforce compliance with legislation. This indicator, by measuring compliance, offers a proxy for the likely impact of legislation and its enforcement on harmful alcohol consumption. These are output and impact measures. | 325 | 400 | 2012/13 |
| *Legislation advocacy and advice* | | | | | |
| Numbers of submissions made (demand driven) | V | Submissions make up a high proportion of the policy work. The number reflects the volume of output although some involve more work than others | 26 | 25 est. | 2012/13 |

## Output: Health Protection

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline Data |
|---|---|---|---|---|---|
| *Communicable disease surveillance and control activities* | | | | | |
| Total number of communicable disease notifications per reporting period | V | Notifiable disease identification and investigation is an important component of the work of ARPHS and plays a major role in communicable disease control. These are indicators of the volume of output in this output class. | 5,597 | 5,500 est. | 2012/13 |
| Number of notifications investigated and found to be a confirmed or probable case | V | | 4,706 | 4,500 est. | 2012/13 |
| *Tuberculosis (TB)* | | | | | |
| Number of TB contacts followed up | V | Investigating and following up TB contacts minimises morbidity and transmission of TB. | 795 | 750 est. | 2012/13 |
| Percentage of TB and LTBI (Latent TB Infection) cases who have started treatment and have a recorded start date for treatment | Q | ARPHS ensures that an appropriate medication regimen is prescribed to TB and LTBI patients that require medication. | 81% | ≥85% | 2012/13 |
| Percentage (and number) of eligible infants vaccinated with a BCG | C | Preventable TB continues to occur among New Zealand children in high risk groups. Vaccination is delivered by ARPHS through hospital and community-based programmes. | 98.4% (total 4,811) | ≥99% total (4,800 est.) | 2012/13 |

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline Data |
|---|---|---|---|---|---|
| *Refugee health screening service* | | | | | |
| Number of quota refugees screened | C | The medical screening aims to protect the New Zealand population via prevention of the spread of communicable diseases and to protect and promote the health of refugees | 848 (750 + 13%) | 750[8] | 2012/13 |
| Percentage of quota refugees commencing a vaccination programme as per NZ immunisation schedule | C | Assessing immunisation status forms part of the refugee screening process. This supports the increase of infant and adult immunisation rates. | 98% | 98% | 2012/13 |
| *Drinking water quality* | | | | | |
| Percentage of the population that received drinking-water from fully compliant supplies | Q | High compliance with the standards will indicate that ARPHS is helping reduce population exposure to water-borne pathogens. This is a measure of impact. | 97% | ≥95% | 2012/13 |

**Note** the services described in the above tables are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. The data to support all above measures is for all three metro Auckland DHBs.

## Output: Population Based Screening

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| *Breast Screening* | | | | | |
| Coverage rates among eligible groups | C | Coverage is a standard measure of output from screening programmes. | 68% | 70% | 2 years to Sept 2013 |
| Proportion of women screened who report that their privacy was respected | Q | Reflects the quality of the service | 99.7% | 95% | 2013 |
| Proportion of women screened who receive their results within 10 working days | T | A timely service provides test results promptly | 97.8% | 95% | 2013 |
| *Bowel Cancer Screening Programme Pilot* | | | | | |
| Percentage of people invited to participate who returned a correctly completed test kit | C | Coverage is a standard measure of output from screening programmes. | 55% | 60% | As at Sept13 |
| Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure/any other investigations.[9] | Q | This indicates whether patients felt that they were able to make an informed decision about colonoscopy and therefore reflects the quality of the service | 93.5% | 95% | Annual survey 2013 |

[8] The New Zealand Government, in agreement with the United Nations High Commissioner for Refugees, has a refugee quota programme which offers 750 places per year (+/- 10%).

[9] Those who rated preparation as good or very good

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 11 weeks | T | Prompt diagnostics is a timeliness indicator that ensures that screening is performed in a timely way. | 98% | 95% | Jan 2012 – June 2013 |
| *Gateway Assessment Service* | | | | | |
| Number of referred children waiting over the contracted timeframe for a Gateway Assessment. | T | Timely assessment results in services being put in place sooner for vulnerable children. | 4 | 0 | As at May 2014 |

**Note** Outputs and Activities provided by General Practice Teams (including cervical screening and immunisation) are covered under Primary Care in the Early Detection and Assessment Output class. A significant portion of the work of Primary Care is preventive in nature.

## Output Class 2: Early Detection and Management

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 Māori 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.

We work with the district's Primary Health Organisations (PHOs), their general practitioners and other community based providers, including community pharmacists and child and adolescent dental services, to deliver a range of services to our population.

### Contribution to outcomes

Ensuring good access to early detection and management services for all population groups, including prompt diagnosis of acute and chronic conditions, management and cure of treatable conditions, contributes to preventing, ameliorating and curing ill health. Giving consideration to health disparities in the prioritisation of service mix helps to reduce those disparities and improve population health. Early detection and management services also enable patient's to maintain their functional independence and prevent relapse of illness.

Our patients' experience is improved and relief of suffering reduced through timely access to services, reassurance in the case of negative results and prompt management of complaints and incidents. Ensuring services undertake clinical audit also provides patients and their family / whānau confidence in the quality of the health system. Effective early detection and management of patients reduces demand on more costly secondary and tertiary care services and can lower per capita out of pocket and total expenditure on pharmaceuticals.

## Output: Primary Health Care

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Primary care enrolment rates | C | Primary care enrolment rates give an indication of access to primary care health services. | 94% | 95% | Q2 2013/14 |
| Immunisation health target achievement - 95% of eight month olds fully immunised by December 2014☑ | C | Preventive health services comprise an important and high impact component of primary care. A high immunisation rate therefore gives an indication of how well our primary care services are providing preventive health care and the impact of our services in achieving heart immunity. | 92% | 95% | Q2 2013/14 |
| Cervical screening coverage | C | As with immunisation, cervical screening coverage is a good indicator of the preventive service output from primary care. | 75.8% | 80% | 3 year coverage as at Sept 2013 |
| Percentage of B4 School Checks completed | C | Coverage is a standard measure of output from screening programmes | 68% | 90% (year-end) | As at Q3 2013/14 |
| Percentage of diabetes patients with satisfactory or better diabetes management (HbA1c ≤64mmol/mol) | Q | Ensuring long-term conditions are identified early and managed appropriately, will help improve the health and disability services people receive and aid in the promotion and protection of good health and independence | 77% | 75% | Q2 2013/14 |
| Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years | C | | 74.7% | 90% | Q2 2013/14 |
| GMS claims from after-hours providers per 10,000 of population | T | The utilisation of primary care during weekends provides an indicator of the timeliness of the services available. If availability is low or costs too high then this will be reflected in the utilisation rate | 446 per 10,000 | Ω | 2012/13 |
| Proportion of practices with cornerstone accreditation | Q | Cornerstone is an accreditation system run by the Royal New Zealand College of General Practice. In order to be accredited practices must accurately assess their level of performance in relation to established standards | 51% | ↑ | As at December 2013 |

## Output: Community Referred Testing & Diagnostics

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Number of community laboratory tests by provider | V | The no. of laboratory tests is a direct indicator of the volume of output of community laboratory diagnostic services | DML= 373,809<br>LTA= 3,214,963 | Ω<br>Ω | Oct 2012-Sep 2013 |
| Number radiological procedures referred by GPs to hospital | V | The no. of community referred radiological procedures is a direct indicator of the volume of output of community radiology diagnostic services | 52,888 | Ω | 2012/13 (PU code CS01001) |
| Number of complaints by community laboratory provider ◈ | Q | A high quality community laboratory diagnostic service will receive only a small number of complaints. | LTA = 60<br>DML=29 | ↓ | Oct 2012-Sep 2013 |
| Average waiting time in minutes for a sample of patients attending collection centres between 7am and 11am | T | A high quality service will process patients quickly and efficiently, thereby avoiding long waiting times. | 8.9 mins (LTA) | < 30 mins | Oct-Dec 2013 |
| Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks | T | Timely access to diagnostic testing makes an important contribution to good patient outcomes. | CT 90%<br>MRI 32% | CT 90%<br>MRI 80% | Dec 2013 |

◈ Note the data to support this measure is for all three metro Auckland DHB's

## Output: Oral Health

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Enrolment rates in children under five by ethnicity:<br>• Māori<br>• Pacific<br>• Other<br>• Total population | C | Output is directly related to the proportion of children enrolled in the service | 4,846 - 64%<br>3,222-64%<br>17,897-97%<br>31,690-82% | 84% | 2013 calendar year |
| Utilisation rates for adolescents | C | This is an indication of the volume of service in relation to the target population | 64% | 85% | 2013 calendar year |
| Number of visits of preschool and school children to oral health services (including adolescents) | V | Provides an indication of the volume of service. | 114,096 | n/a | 2013 calendar year |
| Number of complaints in the financial year | Q | A high quality service will receive low numbers of complaints | 13 | ↓ | 2013 calendar year |
| Arrears rates by ethncity:<br>• Māori<br>• Pacific<br>• Other<br>• Total population | T | A timely oral health service will have low arrears rates | 8.6%<br>8.3%<br>8.6%<br>8.6% | Overall 7% | 2013 calendar year |

## Output: Pharmacy

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Total value of subsidy provided. | V | This indicates the total DHB contribution towards patients' community drug costs. | 110,094,642 | Ω | 2012/13 |
| Number of prescription items subsidised | V | Another indicator of overall volume of community pharmacy subsidy to our population. | 6,430,920 | Ω | 2012/13 |
| Number of Medicine Use Reviews conducted by community pharmacy (WAITEMATA DHB only) | Q | Represents the extent to which MUR Services are being utilised to improve medicines adherence in at-risk groups | 192 | ↑ | 2012/13 initial consults |

## Output Class 3: Intensive Assessment and Treatment

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 focused on individuals.

Effective and prompt resolution of medical and surgical emergencies and acute conditions prevents, ameliorates and cures ill health and relieves suffering. It also reduces mortality, restores functional independence in the case of elective surgery and improves the health-related quality of life in older adults, thereby improving population health.

Ensuring good access to intensive assessment and treatment for all population groups, and giving consideration to health disparities in the prioritisation of service mix helps to reduce those disparities. The overall patient experience, both as an outpatient and as an inpatient, is improved and suffering relieved with prompt service delivery, caring and courteous staff and comfortable, easily accessed facilities catering for all patients' needs.

## Output: Acute Services

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Number of ED attendances | V | An indicator of the volume of emergency care provided to our population | 110,449 | Ω | 2013 |
| Acute WIES total (DHB Provider) | V | An indicator of the volume of acute hospital service provided to our population | 54,260 | 55,132 | 2013 |
| Readmission rates – acute readmissions within 28 days | Q | Although some readmissions are inevitable a high standardised readmission rate compared to other providers is indicative of poor quality care | 7.75% | 7.75% | 2013 |
| Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival. | Q | Emergency care is urgent by definition, long stays cause overcrowding, negative clinical outcomes and compromised standards of privacy and dignity | 96% | 95% | Q4 2012/13 |
| Compliance with shorter waits for cancer treatment national health target of all patients, ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy<br>*(becomes part of indicator reporting from October 2014 – no longer a health target)* | T | Ensuring timely access to cancer treatment for everyone needing it will support public trust in the health and disability system; and that these services can be used with confidence | Chemo 100%<br>Radiation 100% | 100% | Q4 2012/13 |
| Percentage of stroke patients thrombolysed | T | Ensuring patients are treated promptly and appropriately improves health outcomes after stroke. | 6.3% | 6% | Q2 2013/14 |

## Output: Maternity

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Number of births | V | An indicator of volume of service provide to our population | 6730 | Ω | 2013 |
| Number of first obstetric consultations | V | An indicator of volume of service provide to our population | 3904 | Ω | 2013 |
| Number of subsequent obstetric consults | V | An indicator of volume of service provide to our population | 3899 | Ω | 2013 |
| Proportion of all births delivered by caesarean section | Q | An indicator of volume of service provide to our population | 29.3% | ↓ | 2013 |
| Established exclusive breastfeeding at discharge excluding NICU admissions | Q | A good quality maternity service is 'baby-friendly' and will have high rates of established breastfeeding by the point of discharge | 81.3% | 75% | 2013 |

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Third/fourth degree tears for all primiparous vaginal births | Q | Women's Hospital Australasia (WHA) core maternity indicator: 3rd/4th degree tears major complication of vaginal delivery; significant impact on quality of life | 3.8% | ↓ | 2013 |
| Admission of term babies to NICU | Q | An indicator of intra-partum care | 3.0% | ↓ | 2013 |
| Number of women booking before end of 1st trimester | T | An indicator of the degree to which services are accessible and equitably available.<br>Early booking is associated with better maternal and fetal health outcomes | 30% | ↑ | 2013 |

## Output: Elective (Inpatient/Outpatient)

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Delivery of health target for elective surgical discharges | V | Elective surgery has a major impact on the health status of New Zealanders by reducing disability (e.g. cataract surgery and arthroplasty) and by reducing mortality (e.g. PCI) | 15,965 | 17,545 | 2012/13 |
| Surgical intervention rate | C | The need for elective surgery varies according to the population composition (e.g. older people require more elective surgery). By standardising our surgical output for our population composition we can assess whether our output is high or low compared to the national norm | Joints 19.91<br>Cataracts 32.28<br>Cardiac 7.24<br>PCR 15.04<br>Angio 43.60 | 21<br>27<br>6.5<br>12.5<br>34.7 | Year ending Sep 2013<br>Year ending Dec 2013 |
| Number of first specialist assessment (FSA) outpatient consultations | V | FSA consultations are important component of our elective services output and the total number is a good indicator of the volume of our output | 38,655 | Ω | 2012/13 |
| Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC | Q | Health Quality and Safety Commission (HQSC) defined | 0.06 | ↓ | 2012/13 |
| Post-operative sepsis and DVT/PE rates - HQSC | Q | Health Quality and Safety Commission (HQSC) defined | 8.5<br>7.8 | ↓<br>↓ | 2012<br>2012 |
| Patients waiting longer than four months for their first specialist assessment (FSA) | T | Long waiting times for first specialist assessment causes people to suffer conditions longer than necessary, and therefore reflects poor timeliness of the services | 8.19% | 0% | March 2014 |

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Patients given a commitment to treatment but not treated within four months | T | If a decision to treat has been made then it can be assumed that the treatment will lead to health gain. The longer a patient waits for this the less benefit s/he will get from the treatment | 8.18% | 0% | March 2014 |
| Central Line Associated Bacteraemia (CLAB) | Q | Health Quality and Safety Commission (HQSC) defined | 0.95 | <1 / 1000 line days | Jan 14 |

## Output: Assessment Treatment and Rehabilitation (Inpatient)

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| AT&R bed days | V | Bed-days are a standard measure of the total output from this activity | 37,808 | Ω | 2012/13 |
| No. of AT&R inpatient events | V | A standard measure of the total output from this activity | 2,000 | Ω | 2012/13 |
| In-hospital fractured neck of femur (FNOF) (total) – HQSC | Q | A high quality AT&R service will rehabilitate their patients so that they fall less, this would indicate a high quality service | 11 | ↓ | 2012/13 |
| Proportion waiting 4 days or less from waitlist date to admission to AT&R service. | T | This is an indicator of the timeliness of our AT&R service | 50% | 90% | |

## Output: Mental Health

| Outputs measured by | Notes | Rationale | | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|---|
| *Improving the health status of people with severe mental illness* | | | | | | |
| Access to mental health services | C | This indicator demonstrates the utilisation of our mental health services in relation to our population size. Low "Access" rates would indicate that our services may not be reaching a high proportion of those who need them | | | | |
| | | **Age 0-19** | Māori | 3.6% | 3.6% | Feb 2013/ Mar 2014 |
| | | | Total | 2.6% | 3% | |
| | | **Age 20-64** | Māori | 7.92% | 8% | Feb 2013/ Mar 2014 |
| | | | Total | 3.54% | 3.5% | |
| | | **Age 65+** | Total | 2.11% | 3% | Feb 2013/ Mar 2014 |

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| *Improving mental health services using transition (discharge) planning and employment* | | | | | |
| Child and Youth with a Transition (discharge) plan. | Q | Youth discharge planning is directly linked to Rising to the Challenge, Drivers of Crime Initiative and the Youth Mental Health initiative. | New measure | 95% | |
| *Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.* | | | | | |
| % of clients seen within 3 weeks<br>- Mental Health<br>- Addictions<br><br>% of clients seen within 8 weeks<br>- Mental Health<br>- Addictions | T | Waiting times for service are an indicator of timeliness. | 80.7%<br>95.5%<br><br>94.2%<br>98.7% | 80%<br><br>95% | 2013 calendar year |

## Output Class 4: Rehabilitation and Support Services

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

We aim to have a fully inclusive community, where people are supported to live with independence and can participate in their communities. To achieve this aim, following their needs being assessed, support services are delivered to people with long-term disabilities, people with mental health problems and people who have age-related disabilities. These services encompass home-based support services, residential care support services, day services and palliative care services. Rehabilitation and support services are provided by the DHB and non-DHB sector, for example residential care providers, hospice and community groups.

By helping to restore function and independent living the main contribution of rehabilitation and support services to health is in improving health-related quality of life. There is evidence this may also improve length of life. Ensuring rehabilitation and support services are targeted to those most in need helps to reduce health inequalities. In addition to its contribution to health related quality of life, high quality and timely rehabilitation and support services provide patients with a positive experience and a sense of confidence and trust in the health system. Effective support services make a major contribution to enabling people to live at home for longer, thereby not only improving their well-being but also reducing the burden of institutional care costs to the health system.

### Output: Home Based Support

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Average number of hours per month of home based support services for:<br>• Personal care<br>• Household management | V | | <br><br>61,741<br>20,624 | <br><br>Ω<br>Ω | 2012/13 |
| The proportion of people aged 65 and older receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan | Q | Good quality, comprehensive and regular assessments will reduce numbers going into residential care and for older people, services in their own home are much more convenient | 42% | 65% | 2013 |

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Percentage of NASC clients assessed within 6 weeks | T | Long waiting times indicate poor timeliness of this service | 89.7% | ↑ | 2012/13 |

## Output: Palliative Care

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Number of contacts | V | | 20,563 | Ω | 2012/13 |
| Proportion of cancer patients admitted to hospice against proportion of cancer deaths, by ethnicity.<br>- Māori<br>- Pacific | C | Indicator of access equality. The percentage of cancer patients admitted to hospice care should reflect the percentage of cancer deaths by ethnicity. | Admits/ Deaths<br>M 8% 5%<br>P 5% 3% | 1:1 | Admissions = 2012/13<br><br>2010 cancer death data |
| Proportion of patients acutely referred who waited >48 hours for a hospice bed | T | Well-functioning service should provide timely access for acute patients. | 13.56% | ↓ | 2012/13 |

## Output: Residential Care

| Outputs measured by | Notes | Rationale | Baseline | Target 2014/15 | Baseline data |
|---|---|---|---|---|---|
| Total number of subsidised aged residential care bed days | V | Bed days are a standard measure of the volume of aged residential care service. | 821,953 | Ω | 12 months to Sept 2013 |
| Proportion of aged care providers with 4 year audit certification | Q | The granting of 4 year audit certification is a good indicator of on-going confidence in the quality of care delivered by the facility. | 13% | ↑ | February 2014 |
| Percentage of NASC clients assessed within 6 weeks | T | Long waiting times indicate poor timeliness of this service | 89.7% | ↑ | 2012/13 |

# MODULE 4: Financial Performance

## Financial Management Overview

Our organisational values are embodied in our promise of "best care for everyone" to the community we serve. Critical to the long term ability to deliver on this promise is our commitment to remaining financially sustainable well into the future. This means that we have to continue to meet the growing demand for health service needs of our communities by ensuring that resources and infrastructure for service delivery are appropriately provided for within our means.

Our organisational financial goal is therefore to ensure that we continue to improve the health outcomes for our community in a financially sustainable manner. To achieve this, we are committed to continued development and implementation of strategies and initiatives to manage or curtail cost growth pressures facing the DHB in the face of slower funding growth for the DHB sector.

We will continue to:

- Embed our new values that recognise that "everyone matters", require us to be "connected" to our community and colleagues within the DHB and externally, across disciplines and sectors (primary/secondary interface) to ensure that we deliver quality, cost effective and patient focused services "with compassion". We will seek continuous improvement in our processes, policies, systems and procedures to ensure that our services get "better, best and brilliant" for the benefit of our communities
- Foster a culture of financial accountability and discipline underpinned by a Business Transformation programme that seeks to continuously identify and implement cost effectiveness strategies
- Identify and implement smarter ways of delivering quality health services more efficiently, more cost effectively and reducing any waste. We will do this in partnership with our Auckland DHB colleagues, also regionally through mechanisms such as healthAlliance and the Northern Region Alliance, and nationally through participation in processes such as national contract reviews and Health Benefits Limited (HBL) initiatives. We will deliver on national entity priorities that align with our agreed budget commitments (as outlined in our national priority initiative template).

Based on year to date financial performance and expectations for the rest of the 2013/14 financial year, and informed by robust organisational and financial analysis, we are forecasting a surplus of $1.12M for 2013/14. This positive result reflects continued cost growth containment mostly in our funder arm services. Our Business Transformation programme has delivered savings in excess of $80M over the past three years, with savings of $16.9M planned for this financial year, returning a surplus of $14.8m over the last 3 years. These surpluses have assisted in meeting the growing demand for capital investment to increase our capacity, refurbish our facilities, improve the quality and reconfigure our services, invest in new technology and transfer services locally.

## Key Assumptions for Financial Projections

### Revenue Growth

Growth in Population Based Funding Formula (PBFF) revenue for 2014/15 is based on the National Health Board funding envelope advice, with an increase of $46.3M or 3.68% over the 2013/14 funding envelope. This is comprised of a 0.61% ($7.7M) increase to fund cost pressures and 3.07% ($38.6M) for demographic growth.

Total Government and Crown Agency revenue has increased by $60.5M over the 2013/14 full year forecast. This increase includes $46.3m Funding Envelope increase (as detailed above), $4.5m of

additional service purchased by the crown for the 2014/15 financial year and receipts from other Crown Agencies.

For the out-years, we have assumed that the funding increase will be 2.99%, the nominal value that has been signalled for 2014/15 by the National Health Board. Other revenue is based on contractual arrangements in place and reasonable and risk assessed estimates for other income.

### Expenditure Growth

Expenditure growth of $69.3M above the 2013/14 forecast level is planned. This is driven by demographic growth related cost pressure on the services we provide; demographic growth impact on demand driven third party contracts; clinical staff volume growth to meet service growth requirements; costs for staff employment contract agreements and step increases; costs for national initiatives; cost of capital for new facility developments (interest, depreciation and capital charge) and inflationary pressure on clinical and non-clinical supplies and service contracts. Key expenditure assumptions include:

- Impact on personnel costs of all settled employment agreements, automatic step increases and new FTEs, risk provisions for expired employment contracts and of employment agreements expiring during the planning period
- Clinical supplies cost growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. Costs also reflect the impact of volume growth in services provided by us plus impact of procurement cost savings as advised by healthAlliance
- Third party contracts have a planned increase in the price for Aged Care subsidies (1.0%) and for General Practice First Contact Services (1.0%). This is in line with the expectation documented in the Funding Envelope. Price increases agreed in previous years will also be upheld including those agreed as part of sector wide processes (Community Pharmacy and Oral Health are examples)
- We are experiencing significant demand based utilisation growth in Aged Residential Care Private Hospital and Residential Dementia Services as well as in Aged Care Home Based Support Services. The related expenditure growth is in excess of associated demographic revenue and the shortfall will be covered out of planned cost efficiencies across all services.

The Business Transformation initiative first implemented in 2010/11 is a key tool being used by the DHB to manage cost pressures by identifying savings to ensure the DHB lives within its means. Brief descriptions of savings sources, savings amounts and timing of these are provided in the financial templates for the 2014/15 Annual Plan and amount to $9.813M additional savings.

To deliver a surplus of $1M in 2014/15, we will be relying on savings initiatives that will be delivered through programmes being undertaken by shared services (such as healthAlliance) and national agency entities (such as Health Benefits Limited, National Health IT Board).

## Forecast Financial Statements

In line with requirements of Section 139(2) of the Crown Entities Act 2004, we provide both the financial statements of Waitemata DHB and its subsidiaries (together referred to as “Group”) and Waitemata DHB’s interest in associates and jointly controlled entities.

The Waitemata DHB group consists of the parent, Waitemata District Health Board and Three Harbours Health Foundation (controlled by Waitemata District Health Board). Joint ventures are healthAlliance N.Z. Limited, New Zealand Health Innovation Hub Limited Partnership and Awhina Waitakere Health Campus. The associate company is Northern Regional Alliance Limited formerly called Northern DHB Support Agency Limited (NDSA).

The tables below provide a summary of the consolidated financial statements for the audited result for 2012/13, year-end forecast for 2013/14 and plans for years 2014/15 to 2016/17.

## Statement of Comprehensive Income – Parent

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| Government and Crown Agency Revenue | 1,321,555 | 1,358,228 | 1,418,718 | 1,461,287 | 1,505,129 | 1,550,283 |
| Patient Sourced and Other Income | 22,505 | 25,607 | 28,795 | 29,507 | 30,241 | 30,997 |
| IDFs & Inter DHB Provider Income | 77,623 | 74,977 | 79,584 | 81,963 | 84,413 | 86,937 |
| **Total Funding** | **1,421,683** | **1,458,812** | **1,527,097** | **1,572,757** | **1,619,783** | **1,668,217** |
| Personnel Costs | 498,197 | 515,014 | 540,152 | 556,299 | 572,932 | 590,061 |
| Outsourced Costs | 56,406 | 59,139 | 61,462 | 63,300 | 65,191 | 67,140 |
| Clinical Supplies Costs | 92,695 | 99,029 | 101,061 | 104,082 | 107,195 | 110,403 |
| Infrastructure & Non-Clinical supplies Costs | 97,375 | 95,912 | 97,430 | 100,347 | 103,349 | 106,440 |
| Payments to Other Providers | 671,014 | 688,718 | 725,992 | 748,729 | 771,116 | 794,173 |
| **Total Expenditure** | **1,415,687** | **1,457,812** | **1,526,097** | **1,572,757** | **1,619,783** | **1,668,217** |
| **Net Surplus / (Deficit)** | **5,996** | **1,000** | **1,000** | **0** | **0** | **0** |
| **Other Comprehensive Income** | **0** | | | | | |
| **Gains/(Losses) on Property Revaluations** | 24,176 | 0 | 0 | 0 | 0 | 0 |
| TOTAL COMPREHENSIVE INCOME | 30,172 | 1,000 | 1,000 | 0 | 0 | 0 |

The reduction in Infrastructure and Non-Clinical supply costs from the forecast for 2013/14 financial year to the 2014/15 plan reflects a recovery of cost from Auckland District Health Board of approximately $10m for the provision of the Funder Administration function from 1 July 2014. The costs of the provision of this service are budgeted in the 2014/15 plan in staff and other costs.

Historically, we have performed well financially, with surpluses generated in the past two years and a year-end forecast surplus also expected for this financial year. The business transformation programme implemented in 2010/11 has contributed significantly to achievement of the surpluses in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures. For 2014/15, we are also committed to delivering a surplus of $1M.

## Statement of Comprehensive Income - Group

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| Government and Crown Agency Revenue | 1,321,555 | 1,358,228 | 1,418,718 | 1,461,287 | 1,505,129 | 1,550,283 |
| Patient Sourced and Other Income | 24,211 | 25,607 | 28,795 | 29,507 | 30,241 | 30,997 |
| IDFs & Inter DHB Provider Income | 77,623 | 74,977 | 79,584 | 81,963 | 84,413 | 86,937 |
| **Total Funding** | **1,423,389** | **1,458,812** | **1,527,097** | **1,572,757** | **1,619,783** | **1,668,217** |
| Personnel Costs | 498,197 | 515,014 | 540,152 | 556,299 | 572,932 | 590,061 |
| Outsourced Costs | 56,406 | 59,139 | 61,462 | 63,300 | 65,191 | 67,140 |
| Clinical Supplies Costs | 92,695 | 99,029 | 101,061 | 104,082 | 107,195 | 110,403 |
| Infrastructure & Non-Clinical supplies Costs | 98,242 | 95,912 | 97,430 | 100,347 | 103,349 | 106,440 |
| Payments to Other Providers | 671,014 | 688,718 | 725,992 | 748,729 | 771,116 | 794,173 |
| **Total Expenditure** | **1,416,554** | **1,457,812** | **1,526,097** | **1,572,757** | **1,619,783** | **1,668,217** |
| **Net Surplus / (Deficit)** | **6,835** | **1,000** | **1,000** | **0** | **0** | **0** |
| **Other Comprehensive Income** | **0** | | | | | |
| **Gains/(Losses) on Property Revaluations** | 24,176 | 0 | 0 | 0 | 0 | 0 |
| TOTAL COMPREHENSIVE INCOME | 31,011 | 1,000 | 1,000 | 0 | 0 | 0 |

## Capital costs

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| Depreciation | **21,150** | 23,101 | 25,308 | 26,723 | 27,522 | 28,345 |
| Interest Costs | **11,500** | 12,721 | 13,860 | 14,275 | 14,702 | 15,142 |
| Capital Charge | **13,664** | 13,597 | 15,768 | 16,245 | 16,245 | 16,245 |
| **Capital Costs** | **46,314** | **49,419** | **54,936** | **57,243** | **58,469** | **59,732** |

Capital Costs are expected to increase with additional capital investments and loan drawdowns for Waitakere Emergency department refurbishment. Increases in depreciation charge is mainly contributed by migration to Windows 7, this cost cannot be mitigated as we are required to change our operating systems due to licensing issues. The capital charge has increased as a result of revaluation of the underground infrastructure; however this will be offset against additional income.

Waitemata DHB is required to revalue its land and building assets in accordance with the NZ Equivalent to International Accounting Standard 16 Land and Buildings, Plant and Equipment (NZIAS 16) every three to five years. The three year cycle for detailed revaluation exercises for Waitemata DHB falls on 30 June 2015. A desktop revaluation will be carried out for the financial year ending 30 June 2014. The last detailed revaluation was carried out in 30 June 2012.

## Statement of Cashflows – Parent

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| **Cashflow from operating activities** | | | | | | |
| MoH and other Government / Crown | 1,359,438 | 1,433,205 | 1,503,301 | 1,548,249 | 1,594,541 | 1,642,219 |
| Other Income | 44,256 | 19,264 | 17,786 | 18,317 | 18,866 | 19,431 |
| Interest received | 4,277 | 6,343 | 6,010 | 6,190 | 6,375 | 6,566 |
| Payments for Personnel | (482,318) | (515,014) | (540,152) | (556,299) | (572,932) | (590,061) |
| Payments for Supplies | (841,929) | (889,379) | (927,009) | (955,214) | (984,381) | (1,014,423) |
| Capital Charge Paid | (13,398) | (13,597) | (15,768) | (16,245) | (16,245) | (16,245) |
| GST Input Tax | (3,586) | (4,000) | (4,000) | (4,000) | (4,000) | (4,000) |
| Interest payments | (11,538) | (12,721) | (13,860) | (14,275) | (14,702) | (15,142) |
| **Net cashflow from operating activities** | **55,202** | **24,101** | **26,308** | **26,723** | **27,522** | **28,345** |
| **Cashflow from investing activities** | | | | | | |
| Capital Expenditure (-ve) | (56,508) | (56,233) | (51,662) | (28,372) | (17,909) | (13,284) |
| Acquisition of investments | (926) | 0 | 0 | 0 | 0 | 0 |
| **Net cashflow from investing activities** | **(57,434)** | **(56,233)** | **(51,662)** | **(28,372)** | **(17,909)** | **(13,284)** |
| **Cashflow from financing activities** | | | | | | |
| Capital contributions from the Crown | 0 | 0 | 0 | 0 | 0 | 0 |
| Proceeds from borrowings | 38,480 | 5,000 | 9,000 | 0 | 0 | 0 |
| Repayment of borrowings | 0 | 0 | (1,000) | (1,000) | (1,000) | (1,000) |
| **Net cashflow from financing activities** | **38,480** | **5,000** | **8,000** | **(1,000)** | **(1,000)** | **(1,000)** |
| **Net cash movements** | **36,248** | **(27,132)** | **(17,354)** | **(2,649)** | **8,613** | **14,061** |
| Cash and cash equivalents at the start of the year | 68,677 | 105,785 | 78,653 | 61,299 | 58,650 | 67,263 |
| **Cash and cash equivalents at the end of the year** | **104,925** | **78,653** | **61,299** | **58,650** | **67,263** | **81,324** |

Cashflow forecasts reflect the impact of major capital projects recently completed, under implementation or planned and these include the Lakeview Extension, Car Park, Oral Health, Elective Surgery Centre, Taharoto Mental Health Unit and Mason Clinic Remedial Works. Our cash contribution is mainly from depreciation free cashflow and cash reserves accumulated over the past few years (including surpluses) and this is supplemented by Crown debt for projects approved by the Minister. Debt repayment for the Car Park project loan has been included in the plan.

All Waitemata DHB Crown debt secured through the Crown Health Financing Agency (CHFA) has been transferred to the National Health Board (following disestablishment of the CHFA). As at 1 February 2014, we have debt facility limits of $280.1M, of which $259.4M is drawn. The undrawn facilities are balance on the Car Park and Taharoto Mental Health Unit loan facilities.

## Statement of Cashflows – Group

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| **Cashflow from operating activities** | | | | | | |
| MoH and other Government / Crown | 1,359,438 | 1,433,205 | 1,503,301 | 1,548,249 | 1,594,541 | 1,642,219 |
| Other Income | 46,815 | 19,264 | 17,786 | 18,317 | 18,866 | 19,431 |
| Interest received | 4,615 | 6,343 | 6,010 | 6,190 | 6,375 | 6,566 |
| Payments for Personnel | (482,318) | (515,014) | (540,152) | (556,299) | (572,932) | (590,061) |
| Payments for Supplies | (843,897) | (889,379) | (927,009) | (955,214) | (984,381) | (1,014,423) |
| Capital Charge Paid | (13,398) | (13,597) | (15,768) | (16,245) | (16,245) | (16,245) |
| GST Input Tax | (3,586) | (4,000) | (4,000) | (4,000) | (4,000) | (4,000) |
| Interest payments | (11,538) | (12,721) | (13,860) | (14,275) | (14,702) | (15,142) |
| **Net cashflow from operating activities** | **56,131** | **24,101** | **26,308** | **26,723** | **27,522** | **28,345** |
| **Cashflow from investing activities** | | | | | | |
| Capital Expenditure (-ve) | (56,508) | (56,233) | (51,662) | (28,372) | (17,909) | (13,284) |
| | (1,791) | 0 | 0 | 0 | 0 | 0 |
| **Net cashflow from investing activities** | **(58,299)** | **(56,233)** | **(51,662)** | **(28,372)** | **(17,909)** | **(13,284)** |
| **Cashflow from financing activities** | | | | | | |
| Capital contributions from the Crown | 0 | 0 | 0 | 0 | 0 | 0 |
| Proceeds from borrowings | 38,480 | 5,000 | 9,000 | 0 | 0 | 0 |
| Repayment of borrowings | 0 | 0 | (1,000) | (1,000) | (1,000) | (1,000) |
| **Net cashflow from financing activities** | **38,480** | **5,000** | **8,000** | **(1,000)** | **(1,000)** | **(1,000)** |
| **Net cash movements** | **36,312** | **(27,132)** | **(17,354)** | **(2,649)** | **8,613** | **14,061** |
| Cash and cash equivalents at the start of the year | 69,473 | 105,785 | 78,653 | 61,299 | 58,650 | 67,263 |
| **Cash and cash equivalents at the end of the year** | **105,785** | **78,653** | **61,299** | **58,650** | **67,263** | **81,324** |

## Statement of Financial Position – Parent

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| Current Assets | 139,202 | 110,753 | 93,399 | 90,650 | 99,163 | 113,124 |
| Non-current assets | 538,210 | 574,496 | 603,160 | 606,886 | 599,458 | 586,407 |
| **Total assets** | **677,412** | **685,249** | **696,559** | **697,536** | **698,621** | **699,531** |
| Current Liabilities | 270,324 | 268,641 | 278,951 | 280,003 | 281,088 | 281,998 |
| Non-current liabilities | 210,151 | 218,671 | 218,671 | 218,596 | 218,596 | 218,596 |
| **Total liabilities** | **480,475** | **487,312** | **497,622** | **498,599** | **499,684** | **500,594** |
| **Net assets** | **196,937** | **197,937** | **198,937** | **198,937** | **198,937** | **198,937** |
| **Total equity** | **196,937** | **197,937** | **198,937** | **198,937** | **198,937** | **198,937** |

A strong asset base is indicated, with total assets planned at $685M by 2013/14 year end reflecting completed capital projects.

### Loan Portfolio

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| Term Loans - Crown (current portion) | (70,810) | (75,810) | (83,810) | (82,810) | (81,810) | (80,810) |
| Term Loans – Crown (non-current portion) | (188,596) | (188,596) | (188,596) | (188,596) | (188,596) | (188,596) |
| **Total Loans** | **(259,406)** | **(264,406)** | **(272,406)** | **(271,406)** | **(270,406)** | **(269,406)** |

The size of the loan portfolio is expected to increase as the loan for the new Mental Health inpatient unit are drawn. We are expecting to draw this loan on short term borrowing to maximise the financial impact of the low interest rates. However, these will be in line with Waitemata DHB Treasury Policy. The Waitemata DHB Treasury Policy requires that in any 12 month period, interest rate risk should not exceed the greater of 20% of total net debt or $40M. The Treasury Policy also allows for "short-term borrowings" (i.e. floating rate loans and fixed rate loans maturing within 12 months) to be offset against short term investments in the HBL sweep account.

## Statement of Financial Position – Group

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| Current Assets | 141,107 | 110,753 | 93,399 | 90,650 | 99,163 | 113,124 |
| Non-current assets | 542,824 | 574,496 | 603,160 | 606,886 | 599,458 | 586,407 |
| **Total assets** | **683,931** | **685,249** | **696,559** | **697,536** | **698,621** | **699,531** |
| Current Liabilities | 270,178 | 268,641 | 278,951 | 280,003 | 281,088 | 281,998 |
| Non-current liabilities | 210,151 | 218,671 | 218,671 | 218,596 | 218,596 | 218,596 |
| **Total liabilities** | **480,329** | **487,312** | **497,622** | **498,599** | **499,684** | **500,594** |
| **Net assets** | **203,602** | **197,937** | **198,937** | **198,937** | **198,937** | **198,937** |
| **Total equity** | **203,602** | **197,937** | **198,937** | **198,937** | **198,937** | **198,937** |

### Disposal of Land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, Waitemata DHB will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. Waitemata DHB 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 Māori sites of significance.

## Statement of Movement in Equity – Parent

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| **Balance at 1 July** | **166,765** | **196,937** | **197,937** | **198,937** | **198,937** | **198,937** |
| Comprehensive Income/(Expense) | | | | | | |
| Surplus / (deficit) for the year | 5,996 | 1,000 | 1,000 | 0 | 0 | 0 |
| Other Comprehensive income | 24,176 | 0 | 0 | 0 | 0 | 0 |
| **Total Comprehensive Income** | **30,172** | **1,000** | **1,000** | **0** | **0** | **0** |
| **Owner transactions** | | | | | | |
| Capital contributions from the Crown | 0 | 0 | 0 | 0 | 0 | 0 |
| Repayments of capital to the Crown | 0 | 0 | 0 | 0 | 0 | 0 |
| **Balance at 30 June** | **196,937** | **197,937** | **198,937** | **198,937** | **198,937** | **198,937** |

The shareholder's equity position improved due to the surpluses generated in prior years and gains on movement in Buildings/Land assets.

## Statement of Movement in Equity – Group

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| **Balance at 1 July** | **172,592** | **203,603** | **204,603** | **205,603** | **205,603** | **205,603** |
| Comprehensive Income/(Expense) | | | | | | |
| Surplus / (deficit) for the year | 6,835 | 1,000 | 1,000 | 0 | 0 | 0 |
| Other Comprehensive income | 24,176 | 0 | 0 | 0 | 0 | 0 |
| **Total Comprehensive Income** | **31,011** | **1,000** | **1,000** | **0** | **0** | **0** |
| **Owner transactions** | | | | | | |
| Capital contributions from the Crown | 0 | 0 | 0 | 0 | 0 | 0 |
| Repayments of capital to the Crown | 0 | 0 | 0 | 0 | 0 | 0 |
| **Balance at 30 June** | **203,603** | **204,603** | **205,603** | **205,603** | **205,603** | **205,603** |

## Additional Information

Financial performance for each of the DHB arms is summarised in the tables below:

### Provider Arm Financial Performance

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| **Income** | | | | | | |
| MoH via Funder | 654,885 | 684,524 | 705,334 | 726,423 | 748,143 | 770,512 |
| MoH Direct | 36,551 | 37,120 | 44,773 | 46,112 | 47,491 | 48,912 |
| Other | 36,699 | 39,713 | 38,238 | 39,381 | 40,559 | 41,773 |
| **Total Income** | **728,135** | **761,357** | **788,345** | **811,916** | **836,193** | **861,197** |
| **Expenditure** | | | | | | |
| Personnel | 492,225 | 509,507 | 530,516 | 546,377 | 562,716 | 579,541 |
| Outsourced services | 52,956 | 56,524 | 54,320 | 55,945 | 57,616 | 59,338 |
| Clinical supplies | 92,695 | 99,029 | 101,059 | 104,080 | 107,193 | 110,401 |
| Infrastructure & non clinical supplies | 96,945 | 95,297 | 102,450 | 105,514 | 108,668 | 111,917 |
| **Total expenditure** | **734,821** | **760,357** | **788,345** | **811,916** | **836,193** | **861,197** |
| **Surplus / (Deficit)** | **(6,686)** | **1,000** | **0** | **0** | **0** | **0** |

An operating deficit of $6.6M was realised in 2012/13 and planned surplus of $1m in line with 2013/14 budgets. The deficit in 2012/13 reflects cost pressures from a combination of volume growth and price factors for Provider Arm services. The Provider arm has achieved some savings in prior years. However, some of these savings have not been sustainable and overall have not been sufficient to fully offset Provider arm cost growth pressures.

For 2014/15, 68% of Provider arm costs are in personnel (employed and outsourced staff) and the balance are in clinical/non clinical supplies, infrastructure (including financing costs) and outsourced services. Productivity improvements, efficiencies and cost effective operating models are being explored to enable the Provider arm to live within its means.

## Governance and Funding Administration Arm Financial Performance

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| Revenue | 10,490 | 8,737 | 11,760 | 12,112 | 12,474 | 12,847 |
| **Expenditure** | | | | | | |
| Personnel | 5,972 | 5,507 | 9,636 | 9,922 | 10,216 | 10,520 |
| Outsourced services | 3,450 | 2,615 | 7,142 | 7,355 | 7,575 | 7,802 |
| Clinical supplies | 0 | 0 | 2 | 2 | 2 | 2 |
| Infrastructure & non clinical supplies | 1,297 | 615 | (5,020) | (5,167) | (5,319) | (5,477) |
| Total Expenditure | 10,719 | 8,737 | 11,760 | 12,112 | 12,474 | 12,847 |
| Surplus/(Deficit) | (229) | 0 | 0 | 0 | 0 | 0 |

The Governance and Funding Administration arm continues to perform within the funding allocated with a breakeven result forecast for 2013/14.

## Funding Arm Financial Performance

| **Funding** | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| Revenue | 1,349,833 | 1,381,774 | 1,444,086 | 1,487,264 | 1,531,733 | 1,577,532 |
| **Expenditure** | | | | | | |
| Personal Health | 966,440 | 1,018,256 | 1,066,786 | 1,099,713 | 1,132,595 | 1,166,459 |
| Mental Health | 198,153 | 197,579 | 199,137 | 205,090 | 211,221 | 217,537 |
| DSS | 155,193 | 146,183 | 153,981 | 158,584 | 163,326 | 168,208 |
| Public Health | 4,058 | 9,070 | 9,267 | 9,545 | 9,831 | 10,126 |
| Maori Health | 2,055 | 2,154 | 2,155 | 2,220 | 2,286 | 2,355 |
| Governance | 10,184 | 8,532 | 11,760 | 12,112 | 12,474 | 12,847 |
| Total Expenditure | 1,336,083 | 1,381,774 | 1,443,086 | 1,487,264 | 1,531,733 | 1,577,532 |
| Surplus/(Deficit) | 13,750 | 0 | 1,000 | 0 | 0 | 0 |

The Funder generated a surplus of $13.8M in 2012/13 and is forecasting a breakeven position for 2013/14. The Funder is facing cost growth pressures and cost containment is expected to be a challenge moving forward. The Funder is planning a surplus of $1M in 2014/15 and breakeven position in each of the planning years thereafter.

## Capital Expenditure

| | 2012/13 Audited $000 | 2013/14 Forecast $000 | 2014/15 Plan $000 | 2015/16 Plan $000 | 2016/17 Plan $000 | 2017/18 Plan $000 |
|---|---|---|---|---|---|---|
| **Funding Sources:** | | | | | | |
| Free cashflow from depreciation | 21,150 | 23,101 | 25,308 | 26,723 | 27,522 | 28,345 |
| External Funding | 38,480 | 5,000 | 8,000 | (1,000) | (1,000) | (1,000) |
| Cash reserves | 76,308 | 106,785 | 78,653 | 60,999 | 58,350 | 66,963 |
| **Total Funding** | 135,938 | 134,886 | 111,961 | 86,722 | 84,872 | 94,308 |
| **Baseline Capital Expenditure** | | | | | | |
| Land | 0 | 0 | 0 | 0 | 0 | 0 |
| Buildings & Plant | (10,786) | (9,472) | (3,000) | (5,000) | (5,000) | (5,000) |
| Clinical Equipment | (4,675) | (4,500) | (3,000) | (8,000) | (8,000) | (4,500) |
| Other Equipment | (578) | (205) | (500) | (600) | (500) | (500) |
| Information Technology | (2,390) | (600) | 0 | 0 | 0 | 0 |
| Intangible Assets (Software) | (859) | 0 | 0 | 0 | 0 | 0 |
| Motor Vehicles | 0 | (133) | (700) | (1,000) | (500) | (500) |
| **Total Baseline Capital Expenditure** | (19,288) | (14,910) | (7,200) | (14,600) | (14,000) | (10,500) |
| **Strategic Investments** | | | | | | |
| Land | 0 | 0 | 0 | 0 | 0 | 0 |
| Buildings & Plant | (34,091) | (20,897) | (37,782) | (11,272) | (1,409) | (284) |
| Clinical Equipment | 0 | (11,561) | (3,254) | 0 | 0 | 0 |
| Other Equipment | 0 | 0 | 0 | 0 | 0 | 0 |
| Information Technology | 0 | (7,401) | (2,500) | (1,000) | (1,000) | (1,000) |
| Intangible Assets (Software) | (3,129) | (1,464) | (226) | (1,500) | (1,500) | (1,500) |
| Motor Vehicles | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Strategic Capital Expenditure** | (37,220) | (41,323) | (43,762) | (13,772) | (3,909) | (2,784) |
| **Total Capital Payments** | (56,508) | (56,233) | (50,962) | (28,372) | (17,909) | (13,284) |

Major capital projects included in the strategic capital expenditure summarised above include:

- Car Park: Project completed on time and within the approved budget of $24.544M
- Elective Surgery Centre: Project has been completed on time and within the approved budget of $39.4M

- Taharoto Mental Health Unit: Project has an approved budget of $25M and with expected completion of February 2015
- Mason Clinic Remedial Works: Project has an approved budget of $9.9M and will take four to five years to complete
- Remodelling of wards to improve quality and health outcomes, improve patient safety, reduce patient and family stress, help reduce staff stress and fatigue and increase effectiveness in delivering care, anticipated capital cost $3M per ward
- Refurbishment of Waitakere hospital emergency department, capital cost $9.8M
- Refurbishment of theatres and corridors required to meet current standards for gases and electrical services and updating of consumable store areas.

## Banking Facilities and Covenants

### Term Debt Facilities

Waitemata DHB has term debt facilities of $280.1M with the National Health Board, of which $259.4M is currently drawn. The Debt portfolio will increase by $17.3M to $276.8M due to new Crown debt to finance the Taharoto Mental Health Unit.

### Shared Commercial Banking Services

Waitemata is in the shared commercial banking arrangements with various other DHBs, Westpac and Health Benefits Limited. Westpac has been selected to provide banking services to the sector. Health Benefits Limited undertook a Request for Proposal process and Westpac was the preferred supplier of banking services. This arrangement is expected to generate savings of around $4.5M in the sector.

### Banking Covenants

Standard financial covenants put in place by CHFA are currently waived.

# MODULE 5: Stewardship

## Managing our Business

In order to manage our business effectively and efficiently to deliver on the priorities and activities described in modules 1 and 2, we must translate our high level strategic planning into action in an organisational sense within the DHB and have in place supportive infrastructure requirements to achieve this. We must operate in a fiscally responsible manner and be accountable for the assets we own and manage. We must also ensure that every public dollar spent is spent wisely with the overall intention of improving, promoting and protecting the health of our population.

### Organisational performance management

We have developed an organisational performance framework which links our high-level outcomes framework with day to day activity. The organisational performance monitoring processes in place include: annual reporting; quarterly and monthly Board and Committee reporting of health targets and key performance measures; monthly reporting against annual plan deliverables; weekly health target reporting and on-going analysis of inter-district flow performance; monitoring of responsibility centre performance and services analysis.

We also have performance monitoring built into our human resource processes. All staff are expected to have key performance indicators which are linked to overall organisational performance and these are reviewed at least annually.

### Risk management

We continue to monitor our risk management practices to ensure we were meeting our obligations as a Crown Entity, including compliance with the risk standard AS/NZS 31000: 2009 Standard for Risk Management. We have developed a joint risk management framework with Auckland DHB. This enables both DHBs to be consistent in the approach to managing and controlling risks particularly where risks are similar and also in consideration of risks that may arise from the collaboration work underway.

### Asset Management

#### Asset Management Plan Development

Waitemata DHB provided asset management information to the National Health Board as part of the first draft of the financial templates for the 2014/15 Annual Plan. Input has also been provided for the development of the Northern Region Asset Management Plan (AMP).

We are continuing with the workstreams around the updated Asset Management Plan. The Asset Management Plan outlines our current physical asset base used in delivering health services, the condition of the assets, refurbishment, upgrades and replacement requirements over the long term. This plan also outlines the key strategic projects planned for the medium term. Overall, the plan supports investment decisions by providing asset replacement profiles to facilitate management and on-going maintenance of the current asset base and identifying future asset requirements to continue to meet the growing demand for health services provided by our DHB.

To inform the Asset Management Plan development, we have completed a number of asset management improvement initiatives including the following:

- **Clinical Equipment Asset Verification and Cataloguing:** We have reviewed, verified and created a catalogue for high value clinical equipment assets with a value of $10,000 or more (these represent 80% of total clinical equipment assets). Phase 2 of the verification work is now underway and includes the completion of dental and breast screening along with our new

Elective Surgical Centre equipment and updating the catalogue for general additions and disposals

- **Buildings Condition Assessments:** We have completed condition assessments for all buildings owned by Waitemata DHB with assessments completed up to building room level. The output of this is useful for establishing building maintenance and replacement programmes. Training on SPM Assets has been undertaken and the database has been updated with the maintenance work performed in the past year. Work is underway on developing the maintenance programmes required to inform the Asset Management Plan
- **Seismic Compliance Assessment:** Waitemata DHB buildings have been assessed for seismic compliance to inform facility modernisation and upgrade programmes. We are reviewing a number of options in regards to the affected buildings and the decanting requirements
- **Motor Vehicles:** The motor vehicle verification and condition assessment exercise was completed. The next step is to review the option of outsourcing fleet purchasing and management to a specialist fleet manager
- **Site Master Planning**: Work is on-going around key strategic capital projects and timing of these in the medium to long term, including consideration of financing options for these. These will be discussed in the Asset Management Plan
- **Health Services Planning**: Health Services Planning remains a key outstanding work stream to inform the overall longer term asset requirements. A Director of Health Outcomes was appointed to the DHB in 2013 and we are awaiting the outcome of this work to inform the Asset Management Plan in terms of our on-going requirements
- **Asset Management Plan Improvement Projects**: Key local Asset Management Plan improvement projects and regional considerations will be discussed in detail in the updated Asset Management Plan.

## Facilities Modernisation

We are rapidly progressing our facilities modernisation in order to improve the quality of services, expand capacity and meet service demand, enable service transfers from other DHBs (mainly Auckland DHB), improve productivity and efficiency and meet legislative compliance. This includes the following strategic capital projects:

- Construction works for a new Mental Health Unit to replace Taharoto have commenced at the re-named He Puna Wairoa with practical completion estimated to be February 2015, followed by operational commissioning
- The lease with Unitec for decant of the Mason Clinic building has been executed and a design-build solution is being progressed for this facility. Once this is completed and service users are transferred, the first leaky building will be remediated along with internal security upgrades
- Operational commissioning of the building to implement the second phase of the transfer of Renal Services' patients from Auckland DHB will occur once the internal clinical fit out is completed (scheduled for April 2014)
- Construction for a new MRI machine commenced in February with practical completion due in November 2014. The displaced chaplaincy service has been relocated to existing facilities. The displaced Māori Health team still needs to be accommodated on the North Shore campus with many options being considered
- Refurbishment of theatres and corridors required to meet current standards for gases and electrical services and updating of consumable store areas
- Upgrade and replacements of lifts to meet current Health and Safety standards and compliance with New Zealand Building Code requirements. This will ensure lifts are more reliable, using modern and durable materials that are fit for purpose within a hospital environment

- Remodelling of wards - innovative ward design can improve quality and health outcomes, improve patient safety, reduce patient and family stress, help reduce staff stress and fatigue and increase effectiveness in delivering care
- Podium – additional North Shore hospital tower
- Extension of the Waitakere hospital Emergency Department.

### Emergency planning

The Waitemata DHB Emergency Planning and Response Team have a DHB-wide work plan that meets the requirements of the Operating Policy Framework and ensures the readiness of our DHB to provide a sustainable response if an emergency arises. The work plan includes an up to date Health Emergency Plan, education/awareness programme with staff, update of service by service response plans and exercise programmes that include the wider health sector, ie residential aged care and primary care, beyond our provider arm services.

Waitemata DHB works closely with the Auckland region Health Coordinating Executive Group on the priority work plan supporting regional emergency planning and management and participates in regional and national exercises. There is also a link with the regional Civil Defence and emergency services activities in the district and regionally to ensure timely notification and accurate communication and liaison in the event of an emergency.

## Building Capability

### Information Communication Technology

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

The Northern Regional Information Strategy (RIS 2010-20), and the Northern Region Information Systems Implementation Plan set the direction on information management, systems and services in the Northern Region. They align with national and regional information strategies and are a key enabler for us to achieve our clinical and business objectives. Fundamental to the achievement of these objectives is the performance of our shared services support agency, healthAlliance NZ Ltd.

Historic underinvestment in IT infrastructure has resulted in an inherent service continuity risk for IS services and a bow wave of infrastructure upgrade and system resilience requirements in the Northern Region. The Northern Region DHBs began to address this in 13/14 and this will continue in 14/15, with investment in the following areas:

- Microsoft software upgrades in infrastructure
- Clinical and business systems upgrades to ensure systems can realise the potential available only in later versions
- On-going improvement of IS process, capability and capacity to cope with the levels of complexity and volume of IS service requirements
- Improved resilience and security of IS systems to improve system availability, access and data integrity.

Prioritisation of the above areas is a fundamental pre-requisite for maintenance of current IS services and investment in our future systems. The regional plan also supports a five yearly computer replacement cycle to ensure these are regularly updated and fit for purpose.

In addition to the investment in core infrastructure and IS support processes, Auckland DHB and Waitemata DHB, as part of the Northern Region, will undertake the following activities with respect to key national and regional projects:

- G2012 Microsoft License Compliance
  - Upgrade of servers to Microsoft Windows 2008
  - Compliance with Department of Internal Affairs mandate around use of supported software
- NZ ePrescription Service (NZePS)/ CPSA
  - Implementation of the GP scripting service to access community pharmacies
- Maternity Clinical Information System
  - Regional support for Counties Manukau DHB as the lead Northern Region DHB to implement
- Hospital ePharmacy
  - Upgrade of the AUCKLAND DHB ePharmacy system to enable multi-DHB use of the system and integration with the nationally mandated NZ Universal List of Medicines (NZULM) and NZ Formulary (NZF)
- Legacy Patient Administration System (PAS) Replacement ($193K)
  - Auckland DHB will take the regional lead on implementing a Northern Region PAS (plus EMR) with vendor selection and development and approval of the business case to be completed in this period
- eDischarge
  - the new national standard for eDischarge will be implemented across Auckland DHB and Waitemata DHB hospital services
- eMedicines Reconciliation (eMR) ($100k)
  - Auckland DHB will implement the Orion Health eMR module, and Waitemata DHB will upgrade their current system to enable implementation of eMedicines Reconciliation to hospital services within both DHBs
- Care Connect Development Programme (initial focus - $62k)
  - eReferrals phases 2 and 3 ($160k)
    - Auckland DHB and Waitemata DHB will complete implementation of the eReferrals solution (including triage, intra and inter DHB referral functionality)
  - Shared Care Planning
    - Auckland DHB and Waitemata DHB will continue implementation of the national shared care planning tool to support the management of complex, long term conditions and the localities joint initiative with the PHOs
  - Clinical Pathways ($406k)
    - Auckland DHB and Waitemata DHB will continue implementation of dynamic clinical pathways, and will also undertake static pathway development
- Mobility Adoption
  - Auckland DHB and Waitemata DHB will contribute to the development of a regional mobility strategy to guide our investment decisions, and we will install WiFi infrastructure to provide coverage across key clinical and patient areas
- Regional RIS/PACS ($190K).

## Quality and Safety

Our quality vision is to provide the very best care for all our patients - to be recognised as an organisation that provides safe, clinically effective care that is focused on the needs of the patient, their family and our community and achieves quality outcomes that are among the best in the world. We are committed to: placing the quality of patient care, especially patient safety, above all other aims; engaging, empowering, and hearing patients and carers at all times. We are also committed to fostering whole-heartedly the growth and development of all staff, including their

ability and support to improve the processes in which they work embracing transparency unequivocally and everywhere in the service of accountability, trust and the growth of knowledge.

Key foundations for achieving our purpose and vision are a custom designed enhanced care management and clinical leadership programme. We have developed this to equip our clinical leaders with the skill and resources needed to lead the delivery of our quality vision and organisation purpose. It also supports our undertaking to become a values-led organisation using patient and staff listening events, compliments and complaints analysis and staff surveys to connect our patients views and experience with our values. This will enable us to better understand what matters most to patients and their whānau and better understand the links between staff engagement and patient experience.

In 2013 we presented our first Quality Account setting out our commitment to achieving our quality vision and the four national priority areas of patient safety set by the Health Quality and Safety Commission. We are also working regionally with the three other northern region DHBs in a campaign, 'First Do No Harm' to make patient safety a top priority and to focus on no avoidable harm. In 2014/15 we plan to continue to demonstrate this commitment. Specific actions are included in Module 2 ‘Patient Experience’ and ‘Quality’.

# Workforce

## Managing our workforce within fiscal constraints

Living within our means is central to our success as an organisation. We actively participate in the national Employment Relations Strategy Group which establishes the parameters to ensure bargaining will deliver organisational and sector expectations. Any agreements negotiated nationally or locally are approved by the MOH as per established protocols. We have an employee engagement document signed by all the major unions. The intent of this document is central to the relationship development we wish to foster with our current workforce via a strong and effective union relationship in order to achieve a high level of staff engagement with the organisations objectives of achieving better outcomes and the relief of suffering.

We have a standalone recruitment service wholly owned by the DHB providing capability to support best practice recruitment strategies and processes. This enables recruitment of staff who will enhance the organisations ability to improve performance and work in an environment where their professional aspirations are supported and nurtured in order to retain those people within the organisation and the sector.

*Note: regional imperatives will be met from current budget, no additional budget allocations will be made*

## Building and Strengthening our Workforce

Our workforce is central to the delivery of the key organisational priorities of Better Outcomes for patients/ whānau, our staff, our population and Relief of Suffering via better patient experience and better connections. There is a strong commitment to the on-going building and maintenance of a performance and patient focused culture which underpins a range of organisational programmes which have and are being implemented.

Waitemata DHB will work with our regional partners to develop and implement regional workforce strategies with a focus on Government priority areas and targets and in our organisation to strengthen our workforce in relation to Culture, Capability, Capacity and Change Leadership. We will work with the Regional Training Hub Director to develop and deliver a workforce plan as part of the 2014/15 Regional Service Plan. The workforce plan will outline regional actions and key milestones, which include General Practice Education Programme GPEP2) requirements. On a case by case basis

the DHB will work to develop placements to match individual GPEP2 trainee requirements. We will also work in partnership with professional leaders, primary care, professional bodies and unions to support and train increased numbers of diabetes nurse prescribers in the 2014/15 year. Waitemata DHB currently does not currently have nurse prescribers but will actively support at least 2 nurses with the training required to prescribe. We will also be supporting implementation of the Health Workforce New Zealand Implementation of the new the 70/20/10 funding criteria for post-entry training in medical disciplines. Progress towards achieving this by July 2015 will be reported through the Regional Services Plan.

The work streams associated with each of the four workforce strategy elements are detailed in the DHB Workforce Strategy 2012-2016 document in line with regional priorities established to support the achievement of the Regional Health Plan objectives as well as local priorities and requirements. Awhina Education, Workforce Development and Human Resource department lead activity will support the implementation of the strategies as identified in the relevant regional plans.

**Our Current Workforce**

| FTE | Other | Pacific | Māori | TOTAL |
|---|---|---|---|---|
| Medical Personnel | 630.9 | 9.0 | 13.2 | 653.1 |
| Nursing Personnel | 2,181.4 | 91.4 | 72.9 | 2,345.6 |
| Allied Health Personnel | 1,300.9 | 67.4 | 91.9 | 1,460.1 |
| Support Personnel | 203.5 | 46.4 | 18.8 | 268.6 |
| Management /Admin Personnel | 699.1 | 32.7 | 34.8 | 766.5 |
| Grand Total | 5,016 | 247 | 231 | 5,494 |

| Headcount | Other | Pacific | Māori | TOTAL |
|---|---|---|---|---|
| Medical Personnel | 706 | 9 | 15 | 730 |
| Nursing Personnel | 2,590 | 97 | 77 | 2,764 |
| Allied Health Personnel | 1,511 | 72 | 99 | 1,682 |
| Support Personnel | 233 | 49 | 20 | 302 |
| Management/Admin Personnel | 804 | 35 | 38 | 877 |
| Grand Total | 5,844 | 262 | 249 | 6,355 |

Headcount excludes casual staff
Sourced from Leader, accurate as at 31 December 2013

*Note: some services are jointly provided for both DHBs, though hosted and employed by Waitemata DHB.*

## Safe and competent workforce

### *Child protection policies*

We have recently undertaken a review of our child protection policy, which is a single corporate policy that applies to all services. We review our policy every two years and a link to the policy is available on our internet site. This policy provides Waitemata DHB community and hospital based staff with a framework to identify and manage actual and/or suspected child abuse and neglect. We have also been developing service level protocols that are applied in conjunction with the corporate policy. All child health services are going to move to a set of protocols for 'Community' and 'Inpatient'. We are working with Waitemata PHO to start a child protection policy trial with seven general practices and then rolling it out to all their practices. We will ensure that activity related to implementation of the policy is reported in our Annual Report.

### *Children's worker safety checking*

The Vulnerable Children's Bill is introducing worker safety checks to reduce the risk of harm to children by requiring people employed or engaged in work that involves regular or overnight contact with children to be safety checked.

We have a robust recruitment and selection policy with processes well embedded. Our standard recruitment process includes robust criminal vetting with all applicants being required to consent to a police check and reference checks. Applicants are required to provide proof of identity and any qualifications or professional registration or certification necessary for the role they have applied for. Offers of employment are made conditional upon meeting the requirements of the above checks. We require current employees to disclose any changes to their circumstances that may impact on their employment.

Where roles are identified as having unchaperoned care of children additional checks are implemented. Selection panels conduct a thorough risk assessment in any situations where there may be red flags and candidates will not be employed if convicted of one of the specified offences in the Act.

As required by the Vulnerable Children's Bill, we will introduce three yearly reassessments for existing employees within two years. The safety checking information about people employed or engaged by Waitemata DHB in work that involves regular or overnight contact with children is available for provision to the Director-General of Health, as required under Section 38.

# Organisational Health

## Equal Employment Opportunities

We strive to be a good employer at all ages and stages of our employees' careers. We are aware of our legal and ethical obligations in this regard. We are equally aware that good employment practises are a critical aid in the building of a reputation which attracts and retains top health professionals who embody our values and patient centred culture in their practice and contribution to organisational life.

Our Good Employer policy makes clear that we will provide:

- Good and safe working conditions
- An equal employment opportunities programme
- Recognition of the employment requirements of women
- Recognition of the employment requirements of men
- Recognition of the employment requirements of people with disabilities
- The impartial selection of suitably qualified persons for employment

- Recognition of the aims, aspirations, cultural differences and employment requirements of Māori
- Recognition of the aims, aspirations, cultural differences and employment requirements of Pacific people and people from other ethnic or minority groups
- Opportunities for the enhancement of the abilities of individual employees.

We have an on-going Health Scholarship programme which supports Māori and Pacific residents of the district to undertake health-specific tertiary study with an accredited New Zealand education provider. As well as providing students with financial support to achieve their goals, an all-important link to our DHB is established so recipients can access practical placement opportunities and get help to begin a rewarding career after completing study. We are working with local schools to provide a pathway for students from school to studies relevant to health careers. This assists students particularly from Māori and Pacific groups to achieve qualifications at school with an emphasis on mathematics and science so entry to and success in health related qualifications is possible.

Staying On is an innovative development programme designed to assist us and our people adapt to the age wave. It is a strategic whole of organisation approach aimed at creating an engaged culture and supports our desire to be an employer of choice at all ages and stages of a health professional's career. Staying On is built on three pillars: staying engaged, staying healthy and staying connected. It is a specific intervention designed to assist us to creatively and in the spirit of our purpose and values meet the requirements of our Good Employer policy.

## Reporting and Consultation

We will provide the Ministry of Health with information that enables monitoring of performance against any agreement between the parties, and providing advice to the Minister in respect to this. This includes routine monitoring against the funding, DHB service delivery, and DHB ownership performance objectives. We will provide the Minister and the Director-General of Health with the following reports during the year:

- Annual reports and audited financial statements
- Quarterly reports
- Monthly reports
- Any ad hoc information that the Minister or Ministry requires.

## Ability to Enter into Service Agreements

In accordance with section 25 of the New Zealand Public Health and Disability Act, Waitemata DHB is permitted by this annual plan to:

a) Negotiate and enter into service agreements containing any terms and conditions that may be agreed; and

b) Negotiate and enter into agreements to amend service agreements.

## Memoranda of Understanding

We hold a number of Memoranda of Understanding (MoUs) with other groups and agencies which outline the principles, processes and protocols for working together at governance and operational levels to deliver better health care outcomes to the people of the district. These include the MoUs currently held with Manawhenua, Te Runanga o Ngati Whatua, and with Te Whānau o Waipareira Trust.

Through the Awhina Health Campus we have, or expect to create, MoUs with a number of partners, focusing on areas of opportunity and mutual interest. These MoUs relate to various areas including clinical placements and teaching spaces. They enable us to build capacity for developing our existing and future workforce.

# MODULE 6: Service Configuration

Service coverage exceptions and service changes must be formally approved by the National Health Board prior to being undertaken. In this section we signal emerging issues.

## Service Coverage and Service Change

| Type of service change | DHB | Area impacted by service change | Description of service change |
|---|---|---|---|
| Regional changes being trialled to improve early access to Alcohol and Other Drugs (AOD) services | Regional | Mental health and alcohol and other drug services | As a region we are piloting a new configuration of service at one of our AOD providers so that the focus is on working directly with youth in the community where they are. This early intervention approach will improve access to and exit from services. This is a two year pilot, with a formal review in June 2014 and March 2015 which may result in further reconfiguration. |
| Change in model of service delivery | Auckland DHB<br>Waitemata DHB | Mental Health NGO | We will continue our reconfiguration of residential rehabilitation services, from a residential model to a support hours model, where this will better meet client needs |
| Change in model of service delivery | Auckland DHB<br>Waitemata DHB | Mental Health NGO | A regional review of youth residential services for metro Auckland, may result in a reconfiguration of the current regional service, in to locally delivered services |
| Change in model of service delivery | Waitemata DHB | Mental Health Services, PHOs and NGO | Increased interface and integration with primary care, Whānau Ora and schools. |
| Change in model of service delivery | Auckland DHB<br>Waitemata DHB | Mental Health Services and NGO | A regional review of the model of care for the regional Eating Disorders Service (contract holder Auckland DHB) |
| Level and configuration of services | Auckland DHB<br>Waitemata DHB | Mental Health Services | Implementation of the recommendations from the regional review of both forensic high and complex service users and 'acute' high and complex service users, that might result in service changes to meet specific needs, including reconfiguration of regional rehabilitation beds. |
| Level and configuration of services | Auckland DHB<br>Waitemata DHB | Mental Health Services and NGO | Completion of the Service Development Plan and Prime Ministers Youth Mental Health stocktakes and gap analyses, may result in plans to reconfigure services to meet identified gaps |
| Level and configuration of services | Waitemata DHB | Mental Health Services | A review of the acute continuum of service may impact the level and configuration of services |

| Type of service change | DHB | Area impacted by service change | Description of service change |
|---|---|---|---|
| Change in model of service delivery | Waitemata DHB | Palliative Care | Development of model of care now completed. 2014/15 will focus on plan for implementation and new funding models to ensure care is provided equitably, effectively and efficiently across the district. |
| Funding change | Auckland DHB<br>Waitemata DHB | Community Pharmacy | There will be changes in July regarding how DHBs pay Core Service Fees to pharmacy. However, this relates to funding rather than a service delivery change. Service users should not notice a change in care provision |
| Change in model of service delivery | Waitemata DHB | Home Based Support Services | Home Based Support Services redesign aimed at ensuring that the right level of service is provided continues through the approval process. The implementation process will progress through 2014/15. |
| Configuration of services | Auckland DHB<br>Waitemata DHB | Maternity Services | Consultation with the community and stakeholders will be undertaken regarding configuration of maternity services across the two DHBs and an implementation plan developed. |
| Change in model of service delivery | Waitemata DHB – delivered for region | Auckland Regional Dental Service | Regional service delivery models are being reviewed |
| Change in model of service delivery | Waitemata DHB<br>Auckland DHB | Gynaecology service | Review of gynaecology service – as part of the Auckland DHB/Waitemata DHB collaboration |
| Change in model and level of service delivery | Waitemata DHB | Neurology Services | Review of Auckland DHB support for Waitakere Hospital Neurology Services – both inpatient and outpatient – may result in changes to current service delivery to improve local access |
| Change in model of service delivery | Waitemata DHB | Respiratory Services | Review primarily of 'sleep' service may result in changes to service delivery to increase the number of people able to access this service |
| Configuration of services | Waitemata DHB | Paediatric Services to Adult Services - transfer | Review of the way in which paediatric patients are transferred between paediatric services (either from Starship or Waitemata Paediatric Services) to adult services. Findings may result in changes to service configuration to ensure more seamless, coordinated transitioning for patients |

| Type of service change | DHB | Area impacted by service change | Description of service change |
|---|---|---|---|
| Change in service location | Auckland DHB<br>Waitemata DHB | Ophthalmology Services | Local service delivery in Waitemata district, by Auckland DHB, as a hub and spoke model, is planned to commence at Waitakere hospital as an outpatient and minor procedure service from July 2014. Further options for local service delivery to the Rodney area are being explored for commencement in the 2014/15 year |
| Level and configuration of services | Regional | Tertiary services | Auckland DHB will be reviewing the specification and costing of tertiary services. Findings may impact on the configuration and scope of some services for the northern region. |

# MODULE 7: Performance Measures

## Monitoring Framework Performance Measures

| Performance measure | 2014/15 National performance expectation/target | | | DHB Target | |
|---|---|---|---|---|---|
| **PP6 Improving the health status of people with severe mental illness through improved access** | **Age 0-19** | Māori | | 3.6% | |
| | | Total | | 3% | |
| | **Age 20-64** | Māori | | 8% | |
| | | Total | | 3.5% | |
| | **Age 65+** | Total | | 3% | |
| **PP7: Improving mental health services using transition (discharge) planning and employment** | Long term clients | Provide a report as specified | | | |
| | Child and Youth with a Transition (discharge) plan | At least 95% of clients discharged will have a transition (discharge) plan. | | 95% | |
| **PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds** | Mental Health Provider Arm | | | | |
| | Age | <= 3 weeks | <=8 weeks | <= 3 weeks | <=8 weeks |
| | 0-19 | 80% | 95% | 80% | 95% |
| | Addictions (Provider Arm and NGO) | | | | |
| | Age | <= 3 weeks | <=8 weeks | <= 3 weeks | <=8 weeks |
| | 0-19 | 80% | 95% | 80% | 95% |
| **PP10: Oral Health- Mean DMFT score at Year 8** | Ratio year 1 | | | 0.9 | |
| | Ratio year 2 | | | 0.85 | |
| **PP11: Children caries-free at five years of age** | Ratio year 1 | | | 68% | |
| | Ratio year 2 | | | 69% | |
| **PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)** | % year 1 | | | 85% | |
| | % year 2 | | | 85% | |
| **PP13: Improving the number of children enrolled in DHB funded dental services** | 0-4 years - % year 1 | | | 84% | |
| | 0-4 years - % year 2 | | | 87% | |
| | Children not examined 0-12 years % year 1 | | | 7% | |
| | Children not examined 0-12 years % year 2 | | | 7% | |
| **PP18: Improving community support to maintain the independence of older people** | The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan | | | 65% | |
| **PP20: Improved management for long term conditions (CVD, diabetes and Stroke)** | | | | | |
| Focus area 1: Long term conditions | Report on delivery of the actions and milestones identified in the Annual Plan. | | | | |

| Performance measure | 2014/15 National performance expectation/target | DHB Target |
|---|---|---|
| Focus area 2:<br>Diabetes Management (HbA1c) - improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control | Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control | Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control |
| Focus area 3:<br>Acute coronary syndrome services | 70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') | 70% |
| | Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days. | 95% |
| Focus area 4: Stroke Services | 6 percent of potentially eligible stroke patients thrombolysed | 6% |
| | 80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway | 80% |
| **PP21: Immunisation coverage (previous health target)** | Percentage of two year olds fully immunised | 95% |
| **PP22: Improving system integration** | Report on delivery of the actions and milestones identified in the Annual Plan. | |
| **PP23: Improving Wrap Around Services – Health of Older People** | Report on delivery of the actions and milestones identified in the Annual Plan. | |
| **PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings** | Report on delivery of the actions and milestones identified in the Annual Plan. | |
| **PP25: Prime Minister's youth mental health project** | Provide quarterly narrative progress reports against the local alliance Service Level Agreement plan to implement named initiatives/actions to improve primary care responsiveness to youth. Include progress on named actions, milestones and measures. | |
| **PP26: The Mental Health & Addiction Service Development Plan** | Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2014/15 and for any actions which are in progress/on-going in 2014/15. | |
| **PP27: Delivery of the children's action plan** | Report on delivery of the actions and milestones identified in the Annual Plan. | |
| **PP28: Reducing Rheumatic fever** | Provide a progress report against DHBs' rheumatic fever prevention plan | |
| | Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 40% lower than the average over the last 3 years | 1.4 per 100,000 |
| | Provide a quarterly report to the Ministry of Health with a root cause analysis of rheumatic fever cases and lessons learned | |
| **PP29: Improving waiting times for diagnostic services** | Coronary angiography – 90% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days) | 90% |
| | CT and MRI –<br>a. 90% of accepted referrals for CT scans and<br>b. 80% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days) | 90%<br><br>80% |
| | <u>Diagnostic colonoscopy –</u><br>a. 75% of people accepted for an urgent diagnostic colonoscopy will receive their | 75% |

| Performance measure | 2014/15 National performance expectation/target | | DHB Target |
|---|---|---|---|
| | b. procedure within two weeks (14 days) and 60% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days) | | 60% |
| | Surveillance colonoscopy<br>60% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date | | 60% |
| **PP30: Faster cancer treatment** | Proportion of patients referred urgently with a high suspicion of cancer who receive their first cancer treatment (or other management) within 62 days | | 85% (note becomes part of health target from Q2) |
| | Proportion of patients with a confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision to treat | | 100% |
| | All patients ready-for-treatment who wait less than four weeks for radiotherapy or chemotherapy | | 100% (note: becomes part of PP30 reporting from Q2) |
| **SI1: Ambulatory sensitive (avoidable) hospital admissions** | Age 0-4 | | 95% |
| | Age 45-64 | | 110% |
| | Age 0-74 | | 96% |
| **SI2: Delivery of Regional Service Plans** | Provision of a single progress report on behalf of the region agreed by all DHBs within that region ( the report includes local DHB actions that support delivery of regional objectives | | |
| **SI3: Ensuring delivery of Service Coverage** | Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long term exceptions, and any other gaps in service coverage | | |
| **SI4: Standardised Intervention Rates (SIRs)** | Major joint replacement | An intervention rate of 21.0 per 10,000 of population | 21 per 10,000 |
| | Cataract procedures | An intervention rate of 27.0 per 10,000 | 27 per 10,000 |
| | Cardiac surgery | DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate. | 6.5 per 10,000 |
| | Percutaneous revascularisation | A target rate of at least 12.5 per 10,000 of population | 12.5 per 10,000 |
| | Coronary angiography services | A target rate of at least 34.7 per 10,000 of population | 34.7 per 10,000 |
| **SI5: Delivery of Whānau Ora** | Report progress on planned activities with providers to improve service delivery and develop mature providers. | | |
| **OS3: Inpatient Length of Stay** | Elective LOS | The suggested target is 3.18 days, which represents the 75th centile of national performance. | 3.18 days |
| | Acute LOS | Maintenance of, or improvement on 2013 baseline performance | 4 days |

| Performance measure | 2014/15 National performance expectation/target | | DHB Target |
|---|---|---|---|
| **OS8: Reducing Acute Readmissions to Hospital** | Total pop | 7.9% | 7.75% |
| | 75 plus | 10.8% | 11.29% |
| **OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections**<br>Focus area 1: Improving the quality of identity data | New NHI registration in error<br>A. Greater than 2% and less than or equal to 4%<br>B. Greater than 1% and less than or equal to 3%<br>C. Greater than 1.5% and less than or equal to 6% | | Greater than 1% and less than or equal to 3% |
| | Recording of non-specific ethnicity<br>Greater than 0.5% and less than or equal to 2% | | Greater than 0.5% and less than or equal to 2% |
| | Update of specific ethnicity value in existing NHI record with a non-specific value<br>Greater than 0.5% and less than or equal to 2% | | Greater than 0.5% and less than or equal to 2% |
| | Validated addresses unknown<br>Greater than 76% and less than or equal to 85% | | Greater than 76% and less than or equal to 85% |
| | Invalid NHI data updates causing identity confusion | | Still to be confirmed NOTE: this indicator will not be measured for at least Q1 and Q2 2014-15 |
| Focus area 2: Improving the quality of data submitted to National Collections | NBRS links to NNPAC and NMDS<br>Greater than or equal to 97% and less than 99.5% | | Greater than or equal to 97% and less than 99.5% |
| | National collections file load success<br>Greater than or equal to 98% and less than 99.5% | | Greater than or equal to 98% and less than 99.5% |
| | Standard vs edited descriptors<br>Greater than or equal to 75% and less than 90% | | Greater than or equal to 75% and less than 90% |
| | NNPAC timeliness<br>Greater than or equal to 95% and less than 98% | | Greater than or equal to 95% and less than 98% |
| Focus area 3: Improving the quality of the programme for Integration of mental health data (PRIMHD) | PRIMHD File Success Rate- Greater than 95% | | Greater than 95% |
| | PRIMHD data quality | Routine audits undertaken with appropriate actions where required | |
| **Output 1: Mental health output Delivery Against Plan** | Volume delivery for specialist Mental Health and Addiction services is within:<br>a. Five percent variance (+/-) of planned volumes for services measured by FTE<br>b. Five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and<br>**c.** Actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan | | |
| **Developmental measure DV4: Improving patient experience** | No performance target set | | |

# MODULE 8: Appendices

## DHB Board and Management

Governance for our DHBs is provided by a Board each of eleven people, seven of whom are elected and four of whom are appointed by the Minister of Health. Members provide strategic oversight for the DHB, taking into account the Government's vision for the health sector and its current priorities.

| | | |
|---|---|---|
| **Board members** | Dr Lester Levy, Chair | (appointed) |
| | Tony Norman, Deputy Chair | (appointed) |
| | Professor Max Abbott | (elected) |
| | Pat Booth | (elected) |
| | Sandra Coney | (elected) |
| | Warren Flaunty | (elected) |
| | James Le Fevre | (elected) |
| | Morris Pita | (appointed) |
| | Christine Rankin | (elected) |
| | Allison Roe | (elected) |
| | Gwen Tepania-Palmer | (appointed) |

| | | |
|---|---|---|
| **Senior Leadership Team for Waitemata DHB** | Dr Dale Bramley | Chief Executive |
| | Robert Paine | Chief Financial Officer |
| | Dr Debbie Holdsworth | Director – Funding |
| | Simon Bowen | Director – Health Outcomes |
| | Dr Andrew Brant | Chief Medical Officer |
| | Dr Jocelyn Peach | Director of Nursing and Midwifery |
| | Jenny Parr | Associate Director of Nursing and Director of Infection Prevention and Control |
| | Stuart Bloomfield | Chief Information Officer |
| | Phil Barnes | Director Allied Health |
| | Dr Jonathon Christiansen | Head of Division (HOD) Medicine and Health of Older People |
| | Michael Rodgers | HOD Surgical and Ambulatory Services |
| | Peter Van de Weijer | HOD (Acting) Child, Women and Family Services |
| | Dr Murray Patton | HOD Mental Health Services |
| | Cath Cronin | GM Surgical and Ambulatory Services |
| | Debbie Eastwood | GM Medicine and Health of Older People |
| | Linda Harun | GM Child, Women and Family Services |
| | Helen Wood | GM Mental Health Services |
| | Sam Bartrum | GM Human Resources |
| | Naida Glavish | Chief Advisor Tikanga (Auckland DHB/Waitemata DHB) |

# Statement of accounting policies for the year ending 30 June 2015

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, Waitemata 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 have now been developed by the XRB based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is for reporting periods beginning on or after 1 July 2014. This means Waitemata DHB transitions to the new standards in preparing its 30 June 2015 financial statements. As the PAS have recently been developed, Waitemata DHB has not yet fully worked through the implications of the new standards at this time.

These prospective financial statements have therefore been prepared under NZ IFRS. The DHB will work through the implications of the new standards during 2014/15. Due to the change in the Accounting Standards Framework for public benefit entities, all new NZ IFRS and amendments to existing NZ IFRS are not applicable to public benefit entities. The XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

## REPORTING ENTITY

The Waitemata District Health Board (the DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown.

The consolidated financial statements of Waitemata DHB comprise Waitemata DHB and its subsidiaries (together referred to as "Group") and Waitemata DHB's interest in associates and jointly controlled entities. The Waitemata DHB group consists of the parent, Waitemata District Health Board and Three Harbours Health Foundation (controlled by Waitemata District Health Board), joint ventures are healthAlliance N.Z. Limited (20%), Health Innovation Hub Limited (25%), Awhina Health Campus and associate companies are Northern Regional Training Hub Ltd (33%) (Formerly Auckland Regional RMO Service Limited) and Northern DHB Support Agency (34%). The DHB's subsidiary, associates and joint venture are incorporated and domiciled in New Zealand.

The DHB's primary objective is to deliver health, disability, and mental health services to the community within its district. Accordingly, the DHB has designated itself and the group as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

Waitemata DHB's Corporate Address is:

Level 2, 15 Shea Terrace

Takapuna

AUCKLAND 1332

## BASIS OF PREPARATION

### Statement of compliance

The financial statements of the DHB 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 IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

### Measurement base

The financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land and buildings.

### Functional and presentation currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000). The functional currency of the DHB, its subsidiary, associates and joint ventures is New Zealand dollars (NZ$).

### Changes in accounting policies

There have been no changes in accounting policies during the financial year.

### Early adopted amendments to standards

The following amendments to standards have been early adopted:

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.

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.

### Standards, amendments, and interpretations issued that are not yet effective and have not been early adopted

NZ IFRS 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.

### Compliance with the Crown Entities Act

Section 139(2) of the Crown Entities Act 2004 requires Waitemata DHB in its Statement of Intent to include two forecast financial statements, the first for the parent and the second for the group. The 2013/14 Statement of Intent provides both the Parent and Group Forecast Financial Statements.

## SIGNIFICANT ACCOUNTING POLICIES

### Subsidiaries

Subsidiaries are entities in which Waitemata DHB has the capacity to determine the financing and operating policies and from which it has entitlement to significant ownership benefits. The financial statements include Waitemata DHB and its subsidiaries, the acquisition of which are accounted for using the purchase method. The effects of all significant intercompany transactions between entities are eliminated on consolidation. In Waitemata DHB's financial statements, investments in subsidiaries are recognised at cost less any impairment losses.

The DHB does not consolidate its subsidiary Milford Secure Properties as it is dormant and is not material.

### Joint ventures

A joint venture is a contractual arrangement whereby two or more parties undertake an economic activity that is subject to joint control. Waitemata DHB is party to three joint ventures arrangements:

One is a jointly controlled operation; Awhina Health Campus. The DHB recognises in its financial statements the assets it controls, the revenue that it earns, the liabilities and expenses that it incurs from this joint operation

healthAlliance N.Z. Limited is a joint venture company with Health Benefits Limited, Counties Manaukau, Auckland and Northland DHBs that exists to provide a shared services agency to the four Northern DHBs in respect to information technology, procurement and financial processing

The third joint venture is Health Innovation Hub Limited. The four largest District Health Boards (Waitemata, Counties Manaukau, Auckland and Canterbury) have established a national Health Innovation Hub. The Hub will engage with the DHBs, clinicians and industry to collaboratively realise and commercialise products and services that can make a material impact on health care in NEW ZEALAND and internationally. The Hub has been structured as a limited partnership, with the four foundation DHBs each having 25% shareholding in the limited partnership and the general partner, NZ Health innovation Hub Management Limited.

### Associate

An associate is an entity over which the DHB has significant influence and that is neither a subsidiary nor an interest in a joint venture. The interests in Northern DHB Support Agency and Northern Regional Training Hub Ltd (formerly Auckland Regional RMO Service Limited) are not accounted for as they are not material to Waitemata District Health Board.

### Revenue

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

*MOH revenue*

The DHB is primarily funded through revenue received from the MoH, which is restricted in its use

for the purpose of the DHB meeting its objectives. Revenue from the MoH is recognised as revenue when earned.

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

*Revenue from other DHBs*
Inter district patient inflow revenue occurs when a patient treated within the Waitemata DHB region is domiciled outside of Waitemata. The MoH credits Waitemata DHB with a monthly amount based on estimated patient treatment for non Waitemata residents within Waitemata. An annual wash up occurs at year end to reflect the actual non Waitemata patients treated at Waitemata DHB.

*Interest income*
Interest income is recognised using the effective interest method.

*Rental income*
Lease income under an operating lease is recognised as revenue on a straight-line basis over the lease term.

*Provision of services*
Revenue derived through the provision of services to third parties is recognised in proportion to the stage of completion at the balance date.

*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).

## Expenses

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

### *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.

### *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 as to whether 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.

## Financial instruments

### Non-derivative financial instruments

Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

Non-derivative financial instruments are recognised initially at fair value plus, for instruments not at fair value through profit or loss, any directly attributable transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.

A financial instrument is recognised if the DHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if the DHB's contractual rights to the cash flows from the financial assets expire or if the DHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Regular way purchases and sales of financial assets are accounted for at trade date, i.e., the date that the DHB commits itself to purchase or sell the asset. Financial liabilities are derecognised if the DHB's obligations specified in the contract expire or are discharged or cancelled.

### 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 within borrowings in current liabilities in the statement of financial position.

### Foreign currency transactions

Foreign currency transactions (including those for which forward foreign exchange contracts are held) are translated into NZ$ (the functional currency) using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions and from the translation at year-end exchange rates of monetary assets and liabilities denominated in foreign currencies are recognised in the surplus or deficit.

### Derivative financial instruments

Waitemata DHB uses interest swap contracts to economically hedge its exposure to interest rate risks arising from operational, financing and investment activities. Derivatives that do not qualify for hedge accounting are accounted for as held for trading financial instruments. Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are stated at fair value. The gain or loss on re-measurement to fair value is recognised immediately in the income statement.

The fair value of interest rate swaps is the estimated amount that Waitemata DHB would receive or pay to terminate the swap at the balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparties.

### Debtors and other receivables

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

A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the

surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

### Investments

*Bank deposits*

Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

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

### Inventories

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

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

### Non-current assets held for sale

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

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised. Non-current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

### Property, plant, and equipment

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

- land;
- buildings;
- clinical equipment;
- IT equipment; and
- other equipment and motor vehicles.

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

In most instances, an item of property, plant, and equipment is initially recognised at its cost. 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:

- Buildings (including components) 6 to 60 years (1.67%-16.67%)
- Clinical equipment 3 to 20 years (5%-33%)
- Other equipment and motor vehicles 3 to 15 years (6.67%-33%)
- IT Equipment 5 to 15 years (6.67%-20%)

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

## Intangible assets

*Software acquisition and development*
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred.

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

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

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

- Acquired software 3 to 5 years (20% - 33%)
- Internally developed software (20% - 33%)

### Impairment of property, plant, and equipment and intangible assets

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

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

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

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit. For assets not carried at a revalued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

### Creditors and other payables

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

### Borrowings

Borrowings are initially recognised at their fair value plus transaction costs. 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. Borrowings where the DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date are classified as current liabilities if the DHB expects to settle the liability within 12 months of the balance date.

### Employee entitlements

*Short-term employee entitlements*
Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay. These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, and sick leave.

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

*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 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

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.

## Superannuation schemes

*Defined contribution schemes*
Employer contributions to Kiwi Saver, the Government Superannuation Fund, and the State Sector Retirement. Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

## Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditure will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. Provisions are not recognised for future operating losses.

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

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

### Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- Crown equity;
- Accumulated surpluses;
- Revaluation reserves; and
- Trust funds.

*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 Three Harbours Health Foundation.

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

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

### Income tax

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

### Budget figures

The budget figures are per the Waitemata DHB 2013/14 District Annual Plan. 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

The DHB has determined the cost of outputs using the cost allocation system outlined below.

- Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner, with a specific output.
- Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.
- The cost allocation methodology is currently under review. It is possible that the methodology may be modified from that applied to the last audited financial statements.

## Glossary

| | |
|---|---|
| ACC | Accident Compensation Commission |
| ADHB | Auckland District Health Board |
| ALOS | Average Length of Stay |
| AOD | Alcohol Other Drugs |
| ARDS | Auckland Regional Dental Service |
| ASH | Ambulatory Sensitive Hospitalisations |
| BSA | Breast Screen Aotearoa |
| CADS | Community Alcohol, Drug and Addictions Service |
| CAMHS | Child, Adolescent Mental Health Service |
| COPD | Chronic Obstructive Pulmonary Disorder |
| CT | Computerised Tomography |
| CVD | Cardiovascular disease |
| DNA | Did Not Attend |
| DSME | Diabetes Self Management and Education |
| EBI | Effective Brief Intervention |
| ENT | Ear, Nose and Throat specialty |
| ESPI | Elective Services Performance Indicators |
| FSA | First Specialist Assessment (outpatients) |
| FTE | Full Time Equivalent |
| GNS | Gerontology Nurse Specialist |
| GP | General Practitioner |
| HOP | Health of Older People |
| ICU | Intensive Care Unit |
| LMC | Lead Maternity Carer |
| LTC | Long Term Conditions |
| Manawhenua | Iwi of the region with Trusteeship of Land |
| MHP | Māori Health Plan |
| MoH | Ministry of Health |
| MOU | Memorandum of Understanding |
| NCSP | National Cervical Screening Programme |
| NIR | National Immunisation Register |
| NRA | Northern Region Alliance (NoRTH and Northern Region DHB support Agency) |
| NSH | North Shore Hospital |
| OIS | Outreach Immunisation Service |
| ORL | Otorhinolaryngology (ear, nose, and throat) |
| PAM | Potentially Avoidable Hospital Admissions |
| PHO | Primary Healthcare Organisation |
| POAC | Primary Options Acute Care |
| PPP | PHO Performance Programme |
| Q1 Q2 Q3 Q4 | Quarters 1-4, ie by 30 September, 31 December. 31 March or 30 June |
| RACIP | Residential Aged Care Integration Programme |
| RFP | Request for proposal |

| | |
|---|---|
| SIA | Services To Improve Access |
| SME | Self Management Education |
| Te Tiriti o Waitangi | Treaty of Waitangi |
| Tikanga | Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention. |
| WCTO | Well Child / Tamariki Ora |
| Whānau | Extended family |
| Whānau Ora | Families supported to achieve their maximum health and wellbeing |
| WTK | Waitakere Hospital |
| YTD | Year To Date |

Waitemata
District Health Board

Best Care for Everyone