Waitemata
District Health Board
Best Care for Everyone

2015/16

Annual Plan

Incorporating the Statement of Intent and the Statement of Performance Expectations

Waitemata District Health Board

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"

Waitemata District Health Board Annual Plan 2015/16

The Waitemata District Health Board Annual Plan for 2015/16 is signed for and on behalf of:

Waitemata District Health Board

Dr Lester Levy, CNZM **Chairman**	Anthony Norman, MNZM **Deputy Chairman**
Dr Dale Bramley **Chief Executive Officer**	

Our Te Tiriti o Waitangi partners

Te Runanga o Ngati Whatua	Te Whānau o Waipareira Trust
ONZM JP	
R Naida Glavish, JP ONZM **Chair, Te Runanga o Ngati Whatua**	John Tamihere **CEO, Te Whānau o Waipareira Trust**

And signed on behalf of:

The Crown

Hon Dr Jonathan Coleman
Minister of Health

Office of Hon Dr Jonathan Coleman

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

25 SEP 2015

Dr Lester Levy
Chairperson
Waitemata District Health Board
Private Bag 93503
Takapuna
Auckland 0740

Dear Dr Levy

Waitemata District Health Board 2015/16 Annual Plan

This letter is to advise you I have approved and signed Waitemata District Health Board's (DHB's) 2015/16 Annual Plan for three years.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

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

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

Living Within our Means
The Government is determined to reach surplus in 2015/16. To assist with this, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning a surplus for 2015/16 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2015/16.

Health Shared Services Programme
DHBs have committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to include cost and benefit impacts for the Finance Procurement and Supply Chain Initiative in Annual Plans where

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

these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

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

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

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

System Integration
As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2015/16. Shifting services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Waitemata DHB plans to maintain current levels of primary care access to radiology and Primary Care Options for Acute Care. It is encouraging that you intend to strengthen integration in 2015/16 by:

- developing a mental health clinical pathway by December 2015 with implementation in March 2016 to reduce acute demand
- developing a diabetes clinical pathway by December 2015 with implementation in March 2016 to reduce acute demand
- improving access to cognitive impairment and infusion services by December 2015 and March 2016 so that more services are provided in the community
- shifting 30 percent of sexual health services into the community.

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

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

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

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

Tackling Obesity
I am pleased to note your Annual Plan includes a focus on obesity, and identified a range of activities to tackle obesity. I have asked Ministry officials to look at what actions can be undertaken to help address childhood obesity, including, advice on a possible obesity target that will be

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meaningful and evidence based. I will be writing to all DHBs in coming months to outline proposed next steps.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. I am aware you have a number of service reviews under way. I have asked the National Health Board to ensure regular updates are provided as these reviews progress. Please ensure that you advise the National Health Board as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2015/16 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

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

The Statement of Intent covers the four year period from 1 July 2015 to 30 June 2019.

Foreword from our Chair and Chief Executive

The Waitemata District Health Board (DHB) is in a phase of significant growth and transformation. We are now the largest DHB in New Zealand and serve a population approaching 600,000. Our population is also the fastest growing in the country and is forecast to reach around 720,000 by the year 2030. Our emergency departments treat more people, faster than ever before, and we have achieved the greatest increase in elective discharges in the country over the last five years.

Our organisational promise – Best Care for Everyone – guides each new decision and development with the aspiration of achieving the best possible health outcomes for the population we serve.

In the past 12 months, we have made considerable inroads to deliver on this promise. The 17,077 elective discharges delivered in the last financial year is one of the clearest demonstrations of how our DHB has made positive interventions to relieve suffering and support our patients to lead active, productive and independent lives. Similarly, Waitemata DHB is now a national leader for the support and advice we provide to help people quit smoking, which translates directly into lives saved in our district.

Our efforts are reflected in the health of our population, with life expectancy in the Waitemata district at 85.1 years, 3 years higher than the national figure and an increase of 2.4 years over the past 5 years. The rest of New Zealand is not expected to achieve this life expectancy until 2040. Our mortality rates from cardiovascular disease (CVD) and cancer, the two biggest causes of death, are the lowest in New Zealand.

Key milestones

In the past year, we invested in new facilities and services with immediate differences to our communities:

- The opening of a North Shore-based $3.6 million, 18-station community dialysis centre Tātari Oranga O Te Raki, 'filtering for wellness – North'
- The opening of a second MRI suite at North Shore Hospital, including a 3-Tesla scanner, allowing faster, more detailed and convenient medical scanning for our patients
- The opening of Ophthalmology Outpatient Services at Waitakere Hospital, providing post-operative cataract care and paediatric orthoptics.
- An extensive inpatient ward quality improvement programme at North Shore Hospital, with completed refurbishments of Wards 4, 5, 9 and 10 and Ward 8 underway
- The first stage of a project giving Waitemata DHB patients and their whānau access to free high-speed wifi.

Our performance

In addition to these developments, our overall performance is strong, ending 2014 leading the nation on many key indicators. We achieved five of the six national health targets during the year and narrowly missed the immunisation target. Most significantly, our DHB continues to exceed the 95 percent target of having all emergency department patients admitted, discharged or transferred in six hours or less – continuing the exceptional performance by our teams at Waitakere and North Shore hospitals.

With growth has come an increased organisation-wide focus on quality to enhance patient safety and optimal health outcomes. We have made excellent progress toward achieving the Health Quality and Safety Commission's Quality Markers, including prevention of falls, healthcare-associated infections, perioperative harm and medication safety. The latest audit results reveal that Waitemata DHB's hand hygiene compliance rate of 80.3 percent is well ahead of the national performance rate of 75.3 percent. Our Hospital Standardised Mortality Ratio (0.78) is the lowest in the country and is decreasing, confirming the ongoing efforts to enhance the safety of the services we provide to our patients.

Working within an increasingly challenging financial landscape has seen us continue to seek new efficiencies in the way we operate. We have met our financial plans for each of the last five years and are on-track to generate a small surplus in 2014/15. We are growing frontline staffing numbers to keep pace with demand. Doctor, nurse and allied health staff FTE positions have increased, with the number of doctors at Waitemata growing 26 percent since 2009/10. Our total organisational workforce is now 7,000.

We are sharpening our focus on improving the patient experience by working hard as an organisation to understand how things look from the perspective of the person receiving care. We continue to expand this focus with innovative initiatives to support improved health outcomes and enable those in our care to better understand their own healthcare journey.

2015 and beyond

2015 will be another exceptionally busy year as we continue our significant programme of investment in state-of-the-art facilities and innovative services and initiatives, including:

- The opening of our new $25 million, 46-bed mental health facility He Puna Waiora – 'a pool of wellness'. The facility, due for completion in April 2015, forms part of our programme to provide better quality care for mental health service users with high and complex needs.
- The expansion of Waitakere Hospital's Emergency Department to continue the provision of high-quality 24-hour emergency care for the people of West Auckland, more than doubling the size of the existing facility.
- Our first-ever dedicated women's inpatient ward – a 15-bed gynaecology facility scheduled to open at North Shore Hospital in mid-2015. At an anticipated cost of $6.2 million, the new facility will see a 30-member specialist gynaecological team providing integrated care alongside the maternity ward.
- Opening of new floor space above the antenatal unit at North Shore Hospital, providing a home for our Division of Medicine as well as a new chapel to further support the spiritual wellbeing of patients and their families.
- A significant upgrade of Waitakere Hospital's maternity wards will see the unit revitalised to improve the experience of west Auckland women and their families using the service.
- A new primary-care based CARE pilot in North Shore and Rodney to reduce hospital admissions and improve the care of people aged 75 and over and Māori/Pacific people aged 65 and over.
- Implementation of the Auckland-Waitemata Health Alliance agreement to strengthen relationships between Mana Whenua, Mataawaka, Primary Health Organisations and the Auckland and Waitemata DHBs creating a strong platform for patient and whānau-determined care.
- The final year of the National Bowel Screening pilot to successfully conclude the four-year programme in our district.

We do not underestimate the considerable challenges ahead as we work to meet the needs to our growing population and continue to sustain our performance improvements. There is still work to be done in realising this organisation's potential in delivering the best care for every single person who uses our services. With the support of our dedicated and focused workforce, we continue to approach each challenge as an opportunity to relieve suffering, reduce inequalities, improve life expectancy, promote wellness and prevent ill health for those in our community. Waitemata DHB is well positioned for continued success and achievement in 2015.

Dr Lester Levy, CNZM Chairman	Dr Dale Bramley Chief Executive Officer

Te Tiriti o Waitangi

The Waitemata DHB recognises 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 active partnerships with mana whenua at a governance level.

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

In practice Te Tiriti o Waitangi is fully expressed in Whānau Ora.

Whānau ora

Whānau ora, in the context of this plan, is concerned with an intra- and intersectorial 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.

About Waitemata DHB

Who we are and what we do

The Waitemata DHB is one of 20 DHBs established under the Health and Disability Act 2000. The Waitemata DHB is the government's funder and provider of health services to the 580,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest and fastest growing DHB in the country. The boundaries of Waitemata DHB extend to Wellsford in the north and as far south as the Auckland Harbour Bridge, incorporating Whangaparaoa in the east and the west coast beaches of Muriwai, Piha and Karekare.

Waitemata DHB receives funding from the government with which to purchase and provide health and disability services to the population within our district. The objectives of DHBs are outlined within the Health and Disability Act 2000. These objectives include:

- 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 people needing personal health services or disability support.

To achieve these objectives, the Waitemata DHB works with consumers, stakeholders, communities and other health and disability organisations to plan and co-ordinate activities, monitor and report on the health status of the population and health system performance, foster health promotion and disease prevention, and ensure the provision of high quality and equitable health and disability services.

DHBs have four key roles to deliver on their objectives under the Health and Disability Act 2000. DHBs act as 'planners', 'funders' and 'providers' of health services as well as owners of Crown assets. Each DHB's Planning, Funding and Outcomes Division is responsible for assessing its population's health need and determining the mix and range of services to be purchased within the available funding and specific financial constraints. Health needs assessment, along with input from key stakeholders, clinical leaders, service providers and the community, establishes the important areas of focus within our district. The identified needs are then balanced alongside national and regional priorities. These processes inform the Northern Region Health Plan, which sets the longer-term priorities for DHBs in the northern region (i.e. the Northland, Waitemata, Counties Manukau and Auckland DHBs), this Annual Plan and the Waitemata DHB's Māori Health Plan.

The Waitemata DHB provides 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. Since 2013, the DHB has been the national provider of hyperbaric oxygen therapy services. We contract other DHBs, particularly Auckland DHB, to provide some tertiary services, e.g. 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.

Our population, services and key achievements

Largest DHB in NZ	Population 580,000
Fastest growing DHB	Population growth of 20.7% (119,000 people is expected by 2030)
Ethnically diverse	9.7% Māori, 7.3% Pacific, 19% Asian and the remainder European/other
Workforce	7,000 staff
Annual budget	$1.5 billion
Major facilities	North Shore Hospital, Waitakere Hospital, Mason Clinic and Wilson Centre
Regional provider of	Child disability, forensic psychiatric, alcohol and drug and school dental services
National provider of	Hyperbaric oxygen therapy services and national bowel screening pilot

Key highlights

Highest life expectancy in NZ	*Life expectancy in Waitemata is 85.1 years, three years higher than the national figure and has increased by 2.4 years over the past five years. The rest of New Zealand is not expected to achieve this rate until 2040. Our mortality rates from CVD and cancer, the two biggest causes of death, are among the lowest in New Zealand.*
Children get the healthiest start to life	*Our infant mortality rate is the lowest in the country and less than half of the national rate (2.3 per 1000 live births versus the national rate of 4.8 per 1,000 live births). Our immunisation rates are very high, as nearly 95% of our 8-month- and 2-year-old children are fully immunised.*
Excellent performance	*Waitemata DHB was the best performing DHB in the country for the smoking target in primary care, achieving 100% for this target. We delivered 17,077 elective discharges in 2013/14 and achieved the largest increase in elective discharges in the country over the last 5 years. Total activity adjusted for casemix has increased by 23% over 5 years compared with population growth of 10%. CT and MRI scans have increased by 58% and 30% respectively.*
Rapid access to services	*Waitemata DHB emergency departments treat and see more people, faster than ever before, with over 95% of patients discharged, admitted or transferred within six hours, a major improvement from the 61% rate from 5 years ago.*
High quality and safe services	*Our Hospital Standardised Mortality Ratio (0.78) is the lowest in the country and is decreasing, indicating that our services are very safe. Similarly, our hospitals perform well on all quality measures, such as hand hygiene and infection rates.*
Fiscal responsibility	*We have met our financial plans for each of the last 5 years and are on track to generate a surplus in 2014/15. We have invested in growing frontline staffing numbers to keep up with demand. Doctor, nurse and allied health staff FTE has grown over the period (with the number of doctors at Waitemata growing 26% since FY2009/10), while efficiencies in back office functions have seen administration staff reduce by 3%.*
Investing in facilities	*We are making significant investments in state-of-the-art, modern facilities and services, such as the 40-bed elective surgical centre, new emergency departments, advanced cardiac units and He Puna Waiora - the new mental health facility at North Shore Hospital. At the same time, refurbishment of our existing facilities is underway.*

Our challenges

Although the majority of our population enjoy very good health and the financial performance of our organisation has been strong, a number of challenges exist as a provider and funder of health services and for the health status of our population.

The DHB completed an assessment of health needs in 2015, which highlighted areas in our district where the DHB is doing well and areas where we would like to see improvement.

- **Changing demographics** - Our district is currently experiencing a period of rapid population growth and change. Population growth will see an additional 100,000 people living in our district within the next 10 years, a large proportion of which will be migrants. Our population is also becoming older, and by 2024 one out of every five people in our district will be aged 60+ years
- **Differences in health status -** Although overall life expectancy is rising for Māori and Pacific people, the increase is smaller than for Europeans and Asians. One in twelve of our population live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. These individuals experience poorer health outcomes than those in more affluent areas
- **Promoting healthy lifestyles** - Everyday choices contribute strongly to health and wellbeing. Although smoking rates are declining within our district, there is still room for improvement, as 12% of our adult population are regular cigarette smokers, with higher rates in the Māori (27%) and Pacific (20%) populations. Nearly one in four of our adults are obese (low by national standards) and over half are overweight. Approximately half of our population is meeting daily exercise recommendations. One in four of our adult men is at risk from hazardous drinking
- **Increasing prevalence of long-term conditions** - Long-term conditions or chronic diseases are ongoing or recurring conditions, such as CVD and cancer, and can significantly impact people's lives. We are currently experiencing a rise in the prevalence of long -term conditions that can be attributed to an increase in lifestyle risk factors, the ageing population, and socioeconomic determinants of health
- **Mental health** - Mental ill health affects one in five people each year, and the New Zealand health survey identified one in eight of our residents (equivalent to around 50,000 people) as suffering from common mental illnesses. Around 3% of our population (17,000 people) are accessing secondary mental health services. Although our suicide rates are the third lowest in New Zealand, approximately 54 lives are lost each year, more must be done to prevent these deaths. Alcohol and drug addiction and dependence also impact our population
- **Meeting future health needs and demand for services –** With significant population growth and an increase in the proportion of our population aged over 65 years living in our district, we are likely to see significant growth in the demand for health services. Ensuring continued development of staff, facilities and capabilities by having a 'whole-of-system' health service with a focus on prevention and good access to primary care will allow us to meet the future health needs of our population
- **Financial sustainability -** In the face of reduced funding growth, continuing to achieve a breakeven financial position will be challenging in the coming years. We must continue to contain costs to affordable levels by providing services in a more efficient and cost-effective way. This will be achieved through business transformation and performance improvement and efficiency initiatives identified and implemented by our staff and savings realised from national and regional initiatives.

Meeting the challenge

Given the aforementioned challenges, we have identified the following risks as being relevant for 2015/16 and opportunities that will enable us to address these challenges.

Risks	Mitigations/opportunities
Ensuring long-term sustainability through fiscal responsibility	• Effective governance and strong clinical leadership • Connecting the health system and working as one system • Delivering the best evidence-based care to avoid financial and system wastage • Ensuring tight cost control to limit the rate of cost growth pressure
Changing population demographics	• Engaging patients, consumers and their families and the community in the development and design of health services and ensuring that our services are responsive to their needs • Assisting people and their families to better manage their own health, supported by specialist services delivered in community settings as well as in hospitals, and increasing our focus on proven preventative measures and earlier intervention
Meeting future health needs and the growing demand for health services	Maintaining momentum, in key areas such as: • A continued focus on upstream interventions that improve the social and economic determinants of health, both within and outside of the health system • Providing evidence-based management of long-term conditions • Working as a whole system to better meet people's needs • Working regionally and across the government and other services to address health and other priorities • A relentless focus on quality improvement in all areas • Ongoing development of services, staff and infrastructure • Involving patients and family in their care to make their personal decisions paramount.

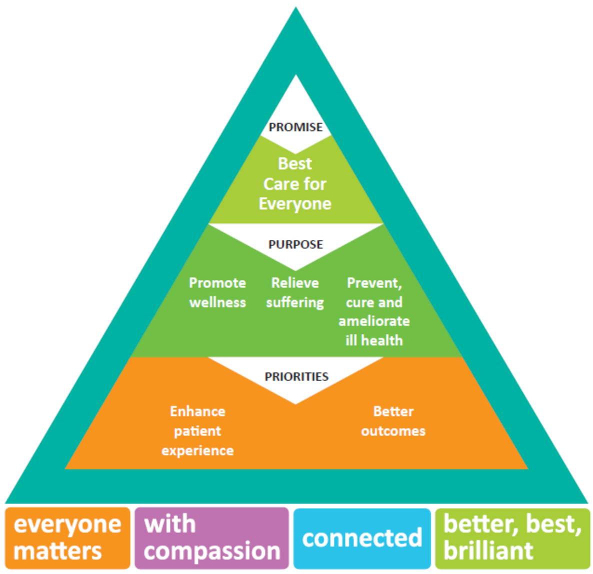
The Waitemata way

Best care for everyone

Our promise, purpose, priorities and values are the foundation for all we do as an organisation.

Our **promise** is that we will ensure we deliver the **'best care for everyone'**. This is our promise to the Waitemata community and the standard for how our staff will work together. For us that means striving to offer the best care possible to every single 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 care, and ongoing improvements that are enhanced by strong clinical leadership.

Our promise, purpose, priorities and values



Our **purpose** defines what we strive to do and achieve, and focuses us on delivering the 'Best Care for Everyone'. Our **purpose** is to:

- Promote wellness
- Prevent, cure and ameliorate ill health, and
- Relieve suffering of those entrusted into our care.

Our two **priorities** which we will focus on for the next 3 years are:

- **Better outcomes** (for patients, whānau, clinicians, our staff, and our population)
- **Enhance patient experience**

Our values and behaviours reflect our purpose and describe the internal culture we strive for. They will shape:

- The way our staff plan and make decisions
- The way our staff behave and interact with patients, service users, whānau and with each other
- How the DHB recruits, inducts, appraises and develops staff
- How the DHB measures and continues to improve everyone's experience

During 2015/16, we will continue to build on our positive progress to date, pursuing a number of initiatives to execute on our promise to provide the 'best care for everyone'. We will maintain our strong focus on research, innovation and development aimed at improving outcomes and processes of care. We will continue our strong momentum towards connecting the whole health system to ensure patients and family receive the right care in the most appropriate place. We have a dedicated team of clinical leaders across primary and hospital care who are responsible for and capable of implementing improved care models in their clinical areas.

Innovation, improvement and clinical leadership

In order to continually improve outcomes and processes of care, innovation capacity and capability need to be developed, encouraged and sustained. Innovation, research and development are an important focus for the Waitemata DHB. The Awhina Health Campus contributes to our promise of 'best care for everyone' by supporting and providing facilities and resources for research and innovation. Awhina collaborates with tertiary education institutes, other DHBs, NGOs and primary health care providers to:

- Create district-wide centres of excellence that reflect population needs and build value for the Waitemata district
- Substantially strengthen and embed best-practice learning, research and knowledge into practice
- Enable innovations oriented to improve patient outcomes
- Build learning, research and innovation capabilities to enhance and improve the quality of service provided to our population

The Centre for Health IT Creative Design – This is a research and development centre targeted at improving patient and whānau experience and outcomes through the adoption of information technology (IT) and evidence-based creative design. Technology adoption sites within the DHB (currently two wards in North Shore Hospital) act as a canvas for the exploration of new ideas – to develop, adapt, implement, evaluate, refine and display new ideas, enabling safe and ethical research and development, and aiming to inspire further ingenuity on which the evolution of our health system depends. This includes innovation partnerships with industry and evaluation partnerships with academic institutions. Adoption within the sites aims to inspire or catalyse subsequent tailored roll out and cross pollination of ideas.

Leapfrog Programme –The Leapfrog programme oversees a number of initiatives that have been identified as likely to have key impacts in the short-to-medium term against the DHB's purpose and priorities, which align with the organisational values. The intention of the programme is to make a step change in these strategic organisation-wide projects, and to assist in instilling the culture of improvement and innovation, demonstrating that Waitemata DHB is prepared to lead in these areas, prepared to learn from international exemplars, and able to implement rapidly. The current Leapfrog project areas include: Best data capture methods; Decision support algorithms in clinical practice; Primary Care Connections; Organisational Mobility Strategy; Best facilities planning; Better outpatient follow-up; and Electronic order entry systems.

Institute of Innovation and Improvement – An Institute for Innovation and Improvement will support data-driven, clinically-led outcomes-based care at Waitemata DHB by providing dedicated resources and expertise for clinical teams to design and implement models of care and best practice care processes that improve health outcomes, and patient and whānau experience. The Institute will support our enhanced care management and clinical leadership model, which involves clinicians at all organisation levels engaging in care process redesign and tracking outcomes, with a group of clinical leaders taking on an enhanced management role with control of, and responsibility for, service design and day-to-day clinical operations.

Clinical Leadership - Waitemata DHB is committed to supporting clinically led care design and delivery. This commitment is evident in our care design and delivery processes, workforce innovations, learning and development opportunities, and governance structures.

Our intention is to increase clinician responsibility for, and control over, service design and day-to-day clinical operations. We seek to move from a situation where clinicians are users of healthcare resources to a situation where clinicians are the stewards of those resources. To support this transition, we are investing in building the networks, processes and capability to deliver the tasks of clinical leadership.

A range of leader, leadership and management development activities are available at Waitemata DHB. These activities are offered across all career levels to both clinical and non-clinical staff, and include a new Fellows Programme. Our clinical leaders and clinical networks will continue to be given strong mandates to shape and deliver services in partnerships with management. This will build on the significant achievements to date and will continue to play a lead role in shaping services to meet future health needs.

Whole of system

Developing a 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 continue our strong momentum and focus on the whole of system. We will continue to develop strong clinical leaders with responsibility for accelerating the rate of system integration through clinical redesign of existing models of care. This will ensure patients and family receive the right care in the most appropriate place.

In 2015/16, the DHB will build upon and complement existing integration developments, with a focus on:

- Embedding strong relationships between the DHB and primary care through the District Alliance and working with PHOs to jointly implement the Integrated Performance and Incentive Framework (IPIF)
- Improving diabetes and CVD outcomes through collaboration with primary and secondary care services by using the intervention logic model
- Piloting and evaluating the Co-ordinated Case, Assessment, Rehabilitation, and Education (CARE) initiative
- Establishing connections with other public and social services to enhance cross-agency collaboration
- Release of expertise within the hospitals to better support primary care and NGOs, to increase the care delivered in community settings
- Building capability and capacity across the healthcare system, particularly primary care
- Improving performance through quality improvement and transparent reporting
- Developing innovative funding models that enable and support sustainable service change
- A focus on Māori, Pacific and other high need populations and identifying their health needs

Strategic outcomes – national, regional and sub-regional

National

The Waitemata DHB operates collectively as part of a national health system. As such, the overall direction and outcomes for the health sector are set by the Minister's expectations.

The key outcomes for the health sector are:

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

For 2015/16, our annual plan reflects the Minister's expectations that we remain within budget and are financially sustainable now and into the future, develop strong leadership, continue working towards a fully 'whole-of-system' health service, and address the key drivers of morbidity within our district with a focus on outcomes for children. The Minister's expectations require a focus on the following priorities:

- **Fiscal discipline/management of the health portfolio** – The DHB needs to budget and work within its allocated funding. Improvements to drive cost savings, productivity, purchasing operations and quality through national, regional and sub-regional initiatives must continue to be a key focus

- **Leadership** – Strong clinical leadership and engagement is to be embedded and utilised in all aspects of our core business. Our governance, senior management and clinical leaders need to work together to drive service improvements
- **Integration between community and hospital care** – Integrating primary care with other parts of the health service is vital for better management of long-term conditions, mental health, the ageing population and patients in general. Pathways to achieve better co-ordinated health and social services need to be developed and supported by clinical leaders in both community and hospital settings
- **National Health Targets** – We must remain focused on achieving and improving performance against the National Health Targets, particularly the primary care targets. We need to work directly with primary health organisations and individual practices to drive performance against the primary care targets
- **Tackling key drivers of morbidity** – The DHB needs to address the major drivers of morbidity within our district and ensure our residents are healthy. A key focus in this area is children's health.

Regional

In delivering its commitment to 'better, sooner, more convenient health services', the government has clear expectations of increased regional collaboration and alignment between DHBs. While each DHB is individually responsible for the provision of services to its own population, working regionally enables us to better address the shared challenges and support improved patient care and more efficient use of resources.

The Northern Region DHBs have a strong history of working together. The Northern Region Health Plan has been developed by the four Northern Region DHBs and primary care Alliance Partners.

Goal One – First, Do No Harm: Patient safety is a priority for the Northern Region. By adopting a regional approach, we aim to achieve a focused effort on improving the quality and safety of the health system.

Goal Two – Life and Years: The objective of this goal is to reduce disparities and achieve longer, healthier and more productive lives for the population. Many of the work areas covered by this goal present the region's greatest opportunities for gain. Priority work areas within this goal include: Child Health, Inequities and Inequalities with an emphasis on health gain in Māori[1], Health of Older People, Cancer Services, CVD, Diabetes, Major Trauma, Mental Health and Addiction Services, Stroke, and Youth Health.

Goal Three – The Informed Patient: The objective of this goal is to achieve greater patient participation and improved health care through patients being better informed across the full health spectrum, from prevention and early diagnosis to better disease treatment. One of the key action areas in achieving this goal involves Advance Care Planning. The primary aim of this is to ensure patients are better informed regarding future care and treatment choices, and healthcare providers are better informed regarding patient's care preferences, particularly end-of-life care.

We will 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 on:

- Agreement of appropriate standards and 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 healthcare, crossing organisational boundaries and extending along the continuum of care.

[1] The Māori Health Plan, a companion document to the Annual Plan, sets out key performance measures for health services. Māori health and reducing inequities are addressed throughout the Annual Plan.

Waitemata DHB supports the regional approach to:

- Expanding the role of nurse practitioners, clinical nurse specialists and palliative care nurses
- Implementing nurse specialist palliative care educator support roles
- Expanding the role of specialist nurses to perform colonoscopies
- Addressing key workforce requirements with regard to the medical physicist workforce

Sub-regional

Auckland and Waitemata DHBs have a bi-lateral agreement that 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, including planning, funding and outcomes, has increased consistency of relationships across the two DHBs.

Improving health outcomes for our population

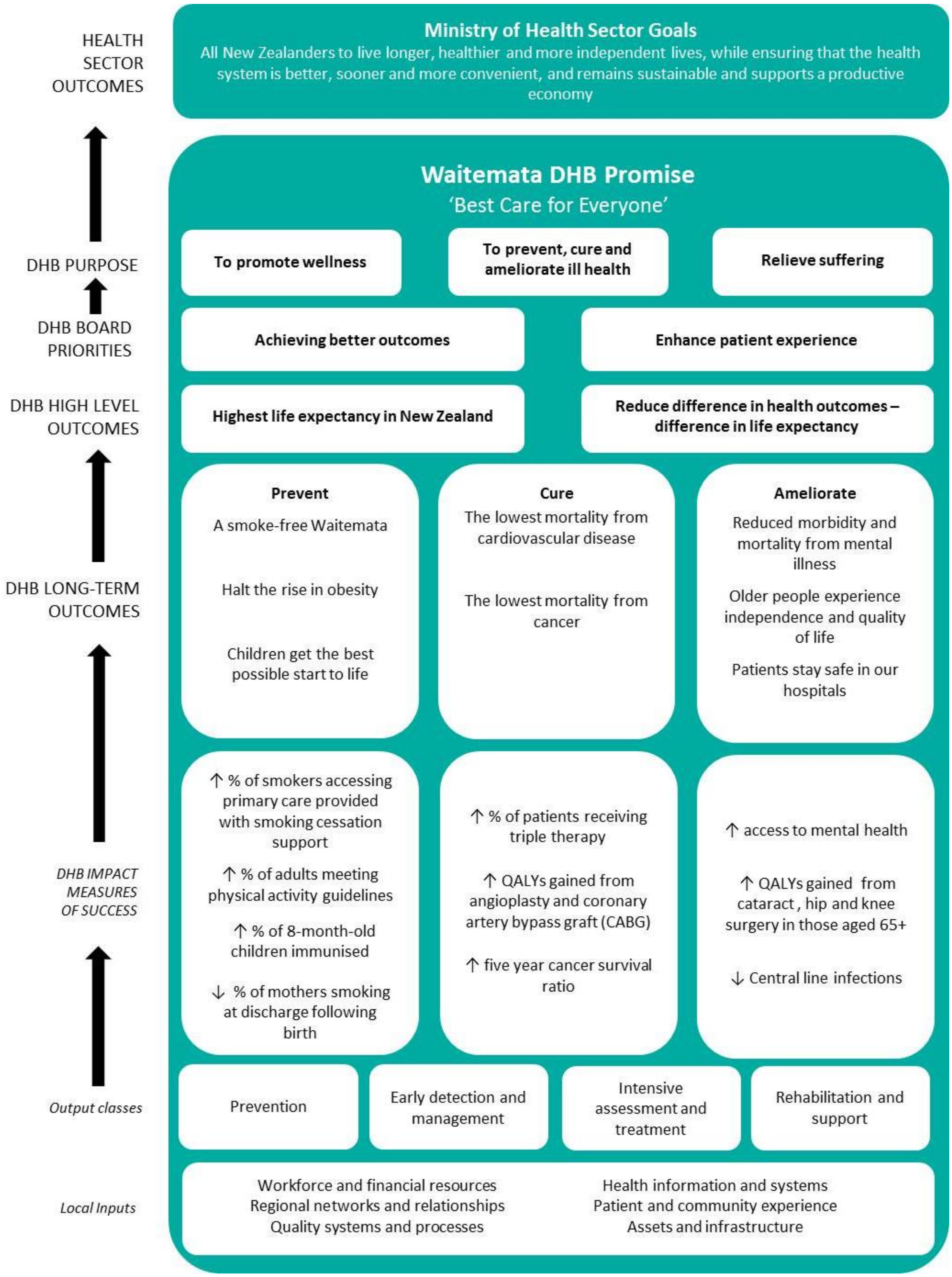
Over the past four years, we have made substantial progress towards delivering on our purpose and have identified a number of key health outcomes (as discussed within our outcomes framework) that will ensure we are providing the 'best care for everyone'. Incorporated in this is ensuring that we move from an outputs or process measure focus towards measuring for outcomes that really make a difference to the people in our district.

Our outcomes framework (below) details the outcomes we are aiming for as well as how we plan to measure our progress towards them. To continue making progress, we need to embed the gains we have made and focus on how we can improve the longer-term health outcomes of our population. This will require our capability and capacity to be innovative, along with strong clinical leadership embedded in all levels of decision making.

We have identified two overall outcomes as well as a number of outcome measures and supporting impact measures that will demonstrate whether we are delivering our purpose and improving the health and wellbeing of our population. Our outcome and impact measures are presented in the intervention logic diagram on the following page.

All of the outcomes and outputs are interrelated and contribute to the DHB's overall purpose and priorities. While we can provide information on our performance against many of our indicators, the nature of health is such that improvements in many outcomes will take years, and sometimes decades, to demonstrate marked change. The Statement of Performance Expectations in Module 3 sets out a set of cornerstone output indicators that contribute to our overall outcomes framework, and we monitor these annually.

Outcomes framework and intervention logic



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). As general measures for the quality of life are less well developed, we have not identified a single overall measure of quality of life. Many of our outcome and impact indicators will contribute to this and can act as proxy indicators for overall health gain, which can be considered as one domain that is likely to contribute to quality of life.

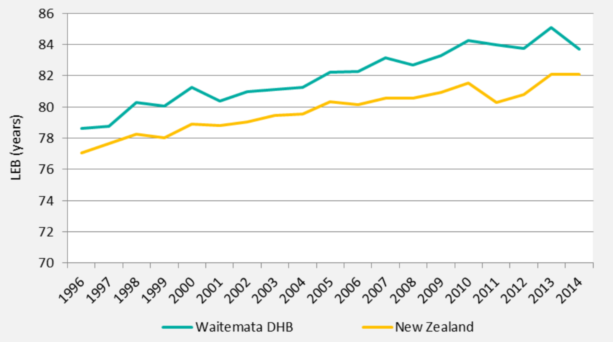
Key

✔ Indicates an outcome measure has achieved its target, trending in the desired direction, 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 with national rates.)

Overall outcome – Highest life expectancy in New Zealand

Life expectancy at birth (LEB) is recognised as a general measure of population health status. Overall, we continue to have the highest life expectancy in the country at around 83.7 years, which is 1.5 years higher than New Zealand as a whole. In Waitemata, life expectancy has increased by 2.4 years over the last decade, a similar increase to that seen in New Zealand as a whole.

Outcome Measure – An increase in life expectancy at birth ✔



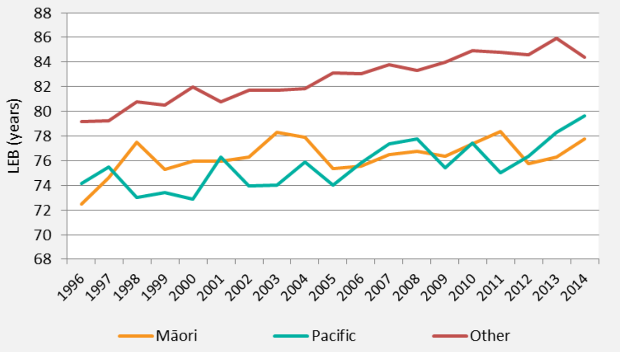
Overall outcome – Reduce difference in health outcomes

There are significant differences in life expectancy between ethnic groups within our district. Māori and Pacific people have a lower life expectancy compared with other ethnicities, with a gap of 8 years for Māori and Pacific; this gap appears to be increasing.

Circulatory system diseases and cancers accounted for half of the difference in life expectancy between Māori or Pacific people versus NZ European/others in Waitemata.

Although life expectancy is increasing in our Maori and Pacific populations, the rate of increase is not as large as that seen in our other population groups.

Outcome Measure – A reduction in the ethnic gap in life expectancy at birth



Prevent ill health – support people to be healthier and take more responsibility

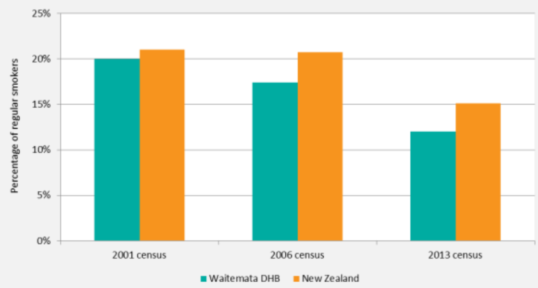
We aim to encourage people to take responsibility for their health through making healthy lifestyle choices and engaging in preventative strategies, such as childhood immunisation programmes and disease risk assessments. Our focus in this area is on smoking, obesity, and children's health. In these areas, we will ensure that people are better protected from harm, informed of the signs and symptoms of ill health, and supported to lead healthy lives. We will create health-promoting physical and social environments, which support people to take more responsibility for their own health and make healthier choices.

Outcome – A smokefree Waitemata by 2025 (<5%)

Smoking is the leading modifiable risk factor for many diseases and contributes to a large number deaths and hospitalisations in Waitemata. Targeting smoking provides us with an opportunity to reduce inequalities and drive improvements in the overall health of our population.

According to the New Zealand Census, adult smoking rates in Waitemata have declined over the past decade, having reduced from 20% in 2001 to 12% in 2013, and remain lower than those observed nationally.

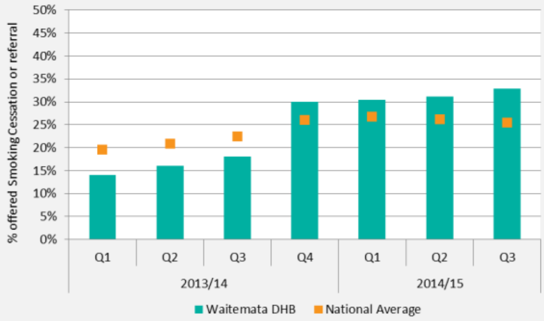
Outcome measure – A reduction in smoking prevalence



Brief advice to stop smoking and, most importantly, an offer of behavioural cessation support by a health professional can significantly increase the number of people who attempt as well as successfully stop smoking. Many people who attempt to quit will likely experience a lapse during their quit attempt. Behavioural support, such as a referral to 'quit smoking' services and pharmacological smoking cessation aids, will help prevent a lapse becoming a return to regular smoking.

We have seen a steady increase in the proportion of smokers accessing primary care that are provided with smoking cessation support either through a referral to 'quit smoking' services or provided with pharmacological smoking cessation aids. Our aim is to continue this trend and ensure we are supporting smokers in their quit attempt.

Impact measure – An increase in the percentage of smokers accessing primary care provided with smoking cessation support

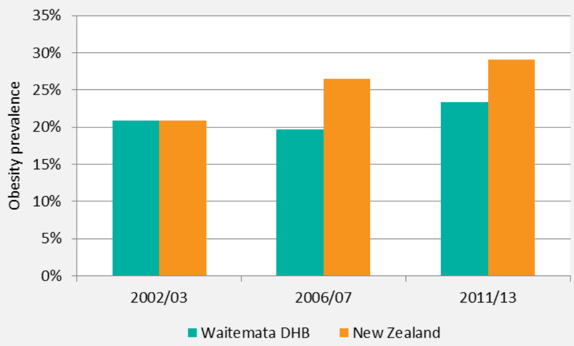


Outcome – Halt the rise in obesity (<23%)

Obesity and the associated effects of poor diet and inactive lifestyles are at epidemic levels in New Zealand. Not only does obesity impact quality of life, but it is a significant risk factor for many chronic diseases, including some cancers and CVD. The associated costs of obesity have been estimated at 4.4% of healthcare expenditure, or $152 million dollars, for the overall Auckland region and this estimate is rising.

Although the prevalence of obesity is lower in Waitemata compared with New Zealand, it is increasing. Nearly one in four of our population aged 15+ years are considered to be obese.

Outcome Measure – Halt the rise in adult (aged 15+ years) obesity

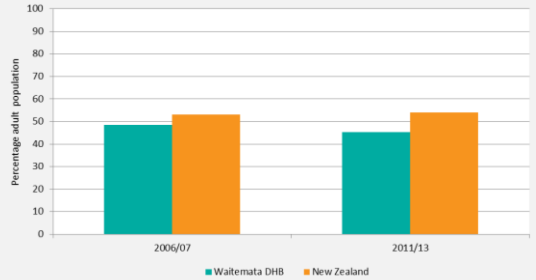


Outcome – Halt the rise in obesity (<23%)

Keeping active can help people stay at a healthy weight or lose weight. It can also lower the risk of heart disease, diabetes, stroke, high blood pressure, osteoporosis, and certain cancers. Inactive (sedentary) lifestyles do just the opposite. Even small increases in physical activity can produce measurable health benefits.

Despite all the health benefits of physical activity, our adult population are exercising less. Current New Zealand guidelines recommend 30 minutes of moderate-intensity physical activity (or equivalent) on at least five out of seven days. Increasing the proportion of our adult population exercising will assist in halting the rise in adult obesity and will have a positive impact on other health outcomes.

Impact Measure – An increase in the percentage of our adult population meeting physical activity guidelines

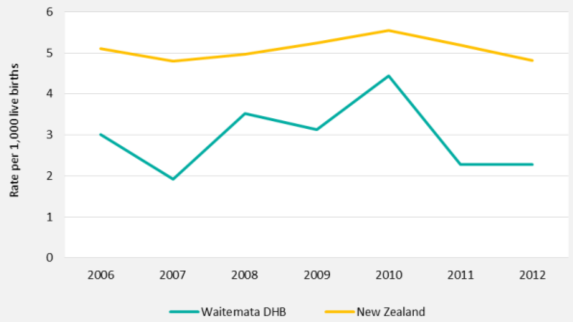


Outcome – Children get the best possible start in life

The health and wellbeing of children, and ensuring that they have the best start to life, are crucial to the health and wellbeing of the population as a whole. Healthy children are more likely to become healthy adults; therefore, positive health outcomes for children and mothers are essential to ensuring that our population is healthy into the future. Infant mortality is an indicator of both child health and the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health, such as economic, social and environmental conditions.

The infant mortality rate within Waitemata is the lowest in the country at 2.3 per 1,000 live births versus the national rate of 4.8 per 1,000 live births in 2012. This rate has consistently remained lower than the national rate.

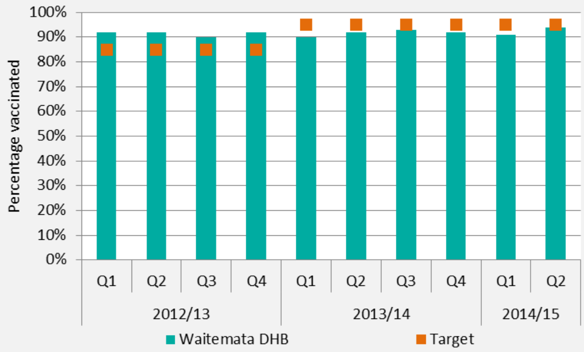
Outcome Measure – A reduction in Infant Mortality



Immunisation is not only an effective intervention to protect children from communicable diseases, it also protects entire populations and can be used as a strategy to reduce inequalities in the delivery of primary health care.

Our 8-month immunisation rates are steadily increasing and we are close to reaching the national 95% target. Our aim is to reach 95% and maintain this level of coverage.

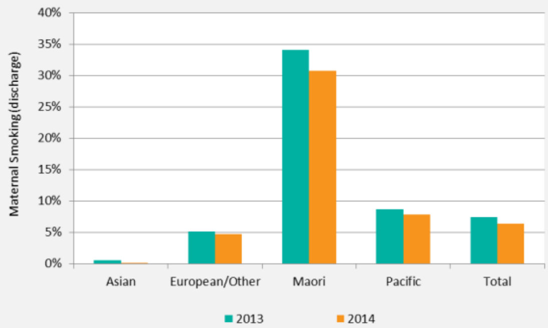
Impact Measure – 95% of 8-month-old children who are fully immunised



Maternal smoking is the main modifiable risk factor affecting foetal and infant health. Smoking during pregnancy is associated with serious complications, including stillbirth, premature delivery and low birth weight. Mothers that continue to smoke following birth may have trouble breastfeeding and place their baby at an increased risk of sudden infant death syndrome.

Significant disparities exist in the proportion of mothers who smoke at the time of discharge following birth. Māori mothers are three to six times more likely to smoke than mothers of other ethnicities.

Impact measure – A reduction in maternal smoking



To cure ill health – support people to stay well with early detection and effective management

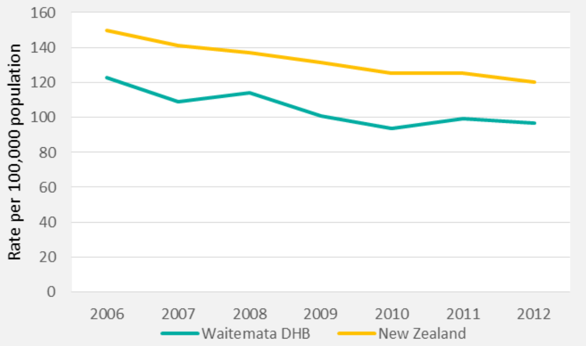
We aim to improve the detection and management of cancer and cardiovascular disease as well as providing rapid assessment and treatment for patients when they are ill. Significant progress has been made in improving the management of ill health. This is reflected in the reduction in the rates of mortality from CVD and cancer. However, more can be done to increase the number of years of healthy life lived and reduce disability for our patients, particularly for our Māori and Pacific populations.

Outcome – The lowest mortality from cardiovascular disease (CVD)

In 2012, CVD was the second leading cause of mortality in Waitemata and it contributes significantly to premature deaths with one in ten CVD deaths occurring in those aged under 65. CVD is largely preventable with lifestyle change, early intervention and effective management. Significant gains have been made over the past decade in the treatment of CVD and improvements in lifestyle, but to ensure a continuous reduction in the rate of mortality from CVD, there needs to be concerted action in both prevention and treatment.

Mortality due to CVD has declined steadily over the years and continues to trend downwards. The rate in Waitemata is consistently lower than the national rate, and remains the lowest in the country.

Outcome Measure – A reduction in the CVD mortality rate



Current New Zealand guidelines recommend that people who experience a heart attack or stroke and where not contraindicated, should be treated with a combination of medication known as triple therapy (defined as taking aspirin or another antiplatelet/anticoagulant agent, a beta blocker and a statin). Although there is no clear clinical evidence to set prescription targets for triple therapy, the National Cardiac Network has agreed that our aspirational target for triple therapy should be 70%.

This indicator does not include patients that started therapy within a year of the most recent reporting month.

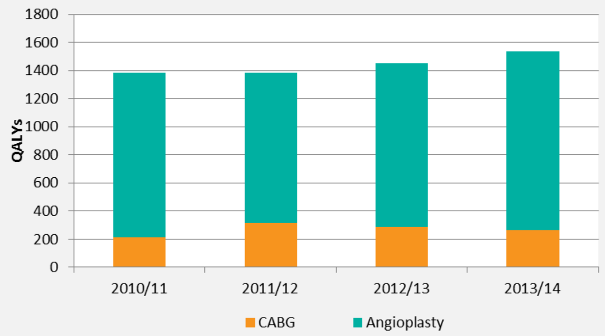
We can make significant progress in ensuring that our patients who have had a CVD event are receiving the best possible care and adhering to their triple therapy medication. Currently, slightly less than 58% of our population that have had a CVD event are on and adhering to their triple therapy medication.

Impact Measure – 70% of identified CVD population aged 30+ years are receiving and adhering to triple therapy

A widely used measure of the impact of medical/surgical interventions is the Quality Adjusted Life Year (QALY). QALYs measure the length and quality of extra years gained by a medical/surgical intervention. QALYs gained from coronary artery by-pass grafting and angioplasty have been estimated. Using these values, we can estimate how many years of quality life are gained by our population through the aforementioned procedures.

In 2013/14, we added over 1,530 QALYs to those having the aforementioned procedures, an 11% increase from 2010/11 and continue to increase yearly.

Impact Measure – An increase in the Quality Adjusted Life Years gained from coronary artery by-pass grafting (CABG) and angioplasty procedures

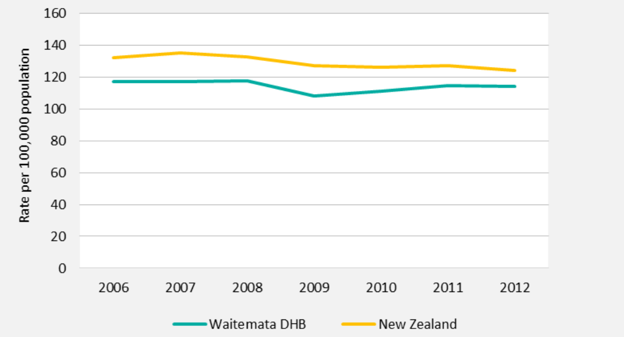


Outcome – The lowest mortality from cancer

In 2012, cancer was the leading cause of mortality in Waitemata DHB and contributes significantly to premature death with over one in four cancer deaths occurring in those aged under 65. To ensure that there continues to be a reduction in mortality from cancer, there needs to be concerted action in both prevention and treatment.

Mortality due to cancer has declined steadily over the years and continues to trend downwards. The rate in Waitemata is consistently lower than the national rate, and remains one of the lowest in the country.

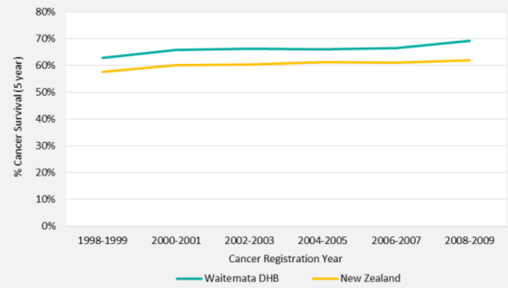
Outcome Measure – A reduction in the cancer mortality rate



Cancer survival is one of the key indicators of the impact of cancer on society. It is a valuable way of measuring the success of cancer control activities including treatment and early detection.

We have seen a steady rise in the five-year survival ratio for people diagnosed with cancer in our district. For all individuals diagnosed with new cancer in 2008-09, the five year survival ratio was 69.2% (one of the highest in the country), meaning that among those diagnosed with cancer, the cancer had reduced the likelihood of surviving five years after diagnosis by 30%. It is important to note the five-year survival ratio varies greatly by cancer type, ranging from 98.2% for prostate cancer, to 14.3% for lung cancer.

Impact measure – An Increase in five year cancer survival ratio



Ameliorate ill health with timely, safe, high quality and compassionate services

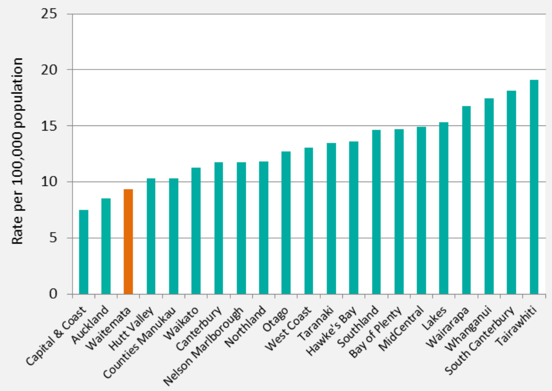
Health services play a major role in providing intensive assessment and treatment when people are experiencing less than optimal health. Services also support people to regain their functionality after experiencing ill health and to remain healthy and independent. Our focus in this area is on ensuring people suffering mental ill health are able to access high quality and timely services and support, our older population experience independence and quality of life, and our patients stay safe when in our hospitals.

Outcome – Reduced morbidity and mortality from mental illness

Good mental health is an important part of living a complete and fulfilling life. Mental illness is one of the leading causes of disability and overall health loss in our population. Nationally, one in five individuals has a mental illness in any given year, and 3% have a serious mental illness.

Our five-year suicide rate (2007–2011) is the third lowest in the country and remains below the national rate. However, approximately 45–50 people die because of suicide each year in the Waitemata DHB region, and a disproportionate number of these individuals are young and Māori.

Outcome Measure – A reduction in suicide rates

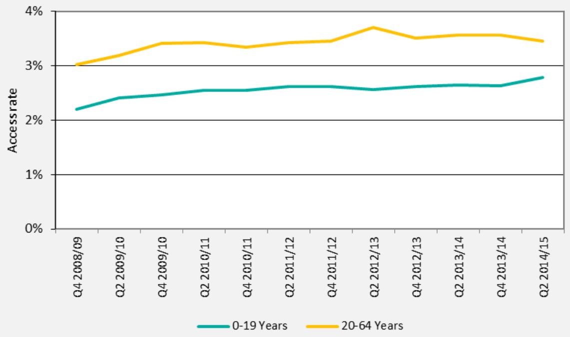


Outcome – Reduced morbidity and mortality from mental illness

People with a serious mental illness require high quality and timely clinical care. Evidence suggests that mental illnesses are less severe, of shorter duration and less likely to recur when identified and treated early. Low treatment rates for people with mental illness and/or addiction may be due to several factors. These may include unavailability of services, a lack of awareness, previous negative experiences and the stigma associated with mental illness. Timely access to mental health services in primary care or hospitals and effective treatment can reduce the time spent with a mental illness and reduce the associated morbidity and mortality.

The percentage of our population who access secondary mental health services has steadily increased. Approximately 2.8% of our 0 to 19 year-olds and 3.5% of our 20 to 64 year-olds accessed mental health services.

Impact Measure – Percentage of individuals aged <19 and 20–64 years with access to mental health services.

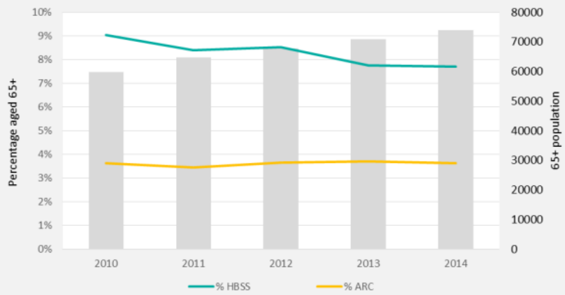


Outcome – Older people experience independence and quality of life

For a number of older people, the care they require can only be provided within an aged residential care (ARC) environment. However, those who are able to live in their own homes and remain connected with their local community generally have better long-term health outcomes. A decrease in the proportion of the 65+ population living in ARC and a decrease in those receiving home-based support services (HBSS) is a potential proxy indicator for the health of the older population and how well the health system is managing age-related long-term conditions.

We have seen a steady decline in the percentage of our 65+ years population receiving funded HBSS and a relatively stable percentage living in funded ARC. This suggests that our older population are gradually becoming healthier and are able to live more independently.

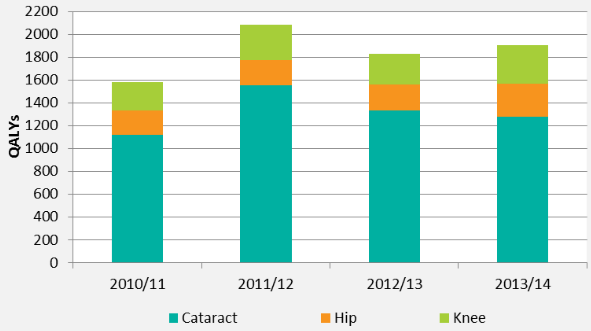
Outcome Measure – A decrease in the proportion of our older population receiving home-based support or living in aged residential care ✓



Cataract surgery as well as knee and hip replacements can significantly improve the independence and overall quality of life for those requiring and receiving them. Using previously estimated QALY values, we can estimate how many years of quality life are gained by our 65+ population through the aforementioned procedures.

In 2013/14 our 65+ population gained over 1900 QALYs from cataract surgery and hip and knee replacements. This represented a 20% increase from 2010/11. The largest number of QALYs were gained through cataract surgery, followed by knee replacements and hip replacements.

Impact Measure – An increase in the QALYs gained from cataract, knee and hip procedures in our 65+ population

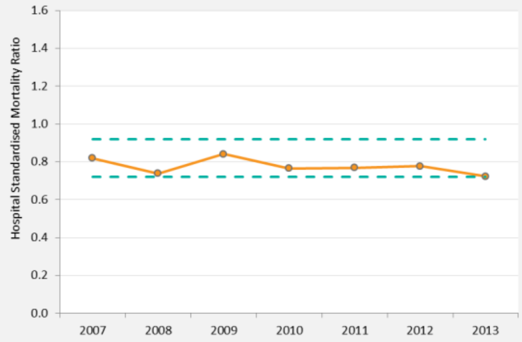


Outcome – Patients stay safe in our hospitals

To provide the very best care to all of 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.

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality and safety that measures whether the death rate at a hospital is higher or lower than would be expected. The rate is adjusted for a variety of factors, such as population size, age profile, level of poverty, range of treatments and operations provided. The average of all national hospitals is an HSMR of 1.00, thus an HSMR under 1.00 indicates a hospital has lower hospital mortality than the national average. Our HSMR (0.78) has consistently been lower than the national figure and remains one of the lowest In the country.

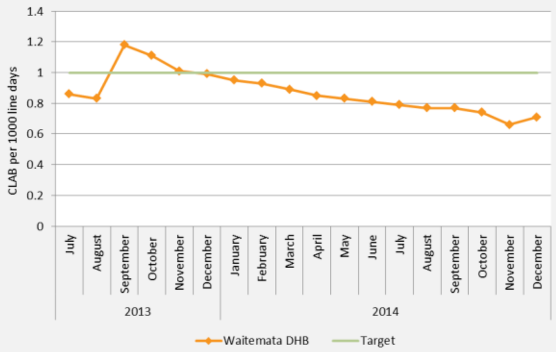
Outcome Measure – A reduction in the Hospital-standardised mortality ratio



Central line-associated bloodstream infections result in increased length of stay and additional cost to the healthcare system, yet these infections are preventable. Hand hygiene programmes and following proper central line maintenance practices can significantly reduce the risk of a central line infection.

We have achieved the national target of less than one central line infection per 1,000 line days for 12 consecutive months.

Impact Measure – Central line infections remain below 1 per 1000 line days



MODULE 2: Targets and Priorities

Promoting wellness

We focus on promoting wellness at a population level. Our role is to inform and support the individuals in our population to make healthier and more responsible choices, and to create environments in which making these choices is the easier option. We will target activities for groups with specific health needs so that our entire population achieves its full health potential.

Healthy lifestyles

Common lifestyle choices, such as smoking, lack of physical activity and poor nutrition, are major contributing factors of long-term chronic diseases, including CVD and cancer. Addressing these factors will help to mitigate the increasing incidence and impact of preventable chronic disease in our population, both now and in the future.

Smoking - Smoking is the largest single cause of preventable ill health and premature death. The smoking rate has declined substantially in our adult population from 17.4% in 2006 to 12% in 2013, and we have one of the lowest smoking rates in the country. However, significant ethnic disparities in smoking rates remain within our district. Our 'Ask, Brief advice, and Support to Quit' programme provides quit advice to over 95% of smokers who access primary care and hospital services; this was the highest rate among all DHBs in 2013/14. Our goal is to achieve a smoke-free Waitemata by 2025. In 2015/16, we will update our tobacco control plan, aim to maintain and improve on the current levels of advice and support offered through our Ask, Brief advice and Support to Quit programme, and strengthen the mechanisms to provide on-going cessation support.

Obesity - Low levels of physical activity and poor nutrition affect the health of our population. One in four adults are obese and over half are overweight. The rate of childhood obesity in our Māori and Pacific populations is high, with 11% of Māori and 23% of Pacific 2- to 14-year-olds considered to be obese. Although our rates are lower than the national rates, there is still room for improvement. In 2015/16, we will support our population to adopt healthy lifestyles through the Healthy Families New Zealand initiative, the Healthy Babies Healthy Futures initiative, improving access to Green Prescriptions and providing timely and efficient access to bariatric surgery. We will also continue to participate in and support Healthy Auckland Together, a intersectoral, regional obesity prevention initiative.

Better Help for Smokers to Quit

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• The Smokefree Services Team will ensure that the Ask, Brief advice and Support to Quit approach becomes self-sustaining by providing training, resources and support to the Smokefree Lead in each inpatient hospital service, so they can in turn support their clinical staff to maintain the Health Target - ongoing • Develop a process to follow-up on patients prescribed NRT in hospital by June 2016 • Refresh the training provided to health professionals (to improve the quality of support to quit and increase the number of support quit attempts, particularly to Māori and Pacific patients) - by December 2015	• 95% of hospitalised patients who smoke are offered brief advice and support to quit smoking by June 2016 • Increase the number of referrals from hospital services to stop smoking services to 80 per month by quarter 4 in 2015/16

Better Help for Smokers to Quit

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Ensure training is available to all health professionals, including community health, mental health and addictions, child health, Māori and Pacific teams in the Ask, Brief advice and Support to Quit approach - by 30 June 2016.	
Supporting achievement of the primary care target: • The DHB will contract with each PHO to lead and coordinate support to General Practices including: setting key performance indicators, regular feedback on performance, IT tools and clinical champions - ongoing • Implement a project to address low referral rates to stop smoking services - by December 2015 • Refresh the training provided to General Practices (to improve the quality of support to quit and increase the number of support quit attempts, particularly to Māori and Pacific patients) - by June 2016.	• 90% of patients who smoke and are seen by a health professional in primary care are offered brief advice and support to quit smoking by June 2016
Supporting achievement of the maternity target: Ensure pregnant women have easy access to appropriate antenatal and postnatal stop smoking services by: • Implementing an incentives scheme – by October 2015 • Develop and implement a communications plan that promotes quitting to pregnant women and their whānau – by December 2015 • Build on the training provided by Innovat8 to ensure all midwives and General Practice staff can support pregnant women to quit - ongoing • Build relationships between Lead Maternity Carers, Maternity Services, Well Child Tamariki Ora providers and all locally available stop smoking services – ongoing.	• 90% of pregnant women who smoke at the time of confirmation of pregnancy are offered brief advice and support to quit
Supporting quit smoking services across the district: • Evaluate the pharmacy stop smoking services – by June 2016 • Support the DHB and regional Mental Health and Addictions NGO smokefree project – ongoing • Facilitate the Ask, Brief advice and Support to Quit programme training to other health professionals (such as dentists and sonographers) – by June 2016.	

Obesity	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

• We will develop a local childhood obesity plan once national advice has been provided, in consultation and agreement with the northern region DHBs and Auckland Regional Public Health Service
• Healthy Families New Zealand initiative lead by Sport Waitakere - participate in the governance arrangements, align existing DHB-led health promotion activities with the initiative, generate awareness in the DHB, and take part in the Prevention Partnership - ongoing
• Support the implementation of the Healthy Babies Healthy Futures project by:
  ○ Providing women with key breastfeeding messages through text messaging, community promotion, and support groups – ongoing
  ○ Continuing to work with our Auckland and Waitemata Collective partners to target specific ethnic groups (Māori, Pacific, Asian, Chinese, Korean and Japanese,) – ongoing
  ○ Developing all stages of the Text Match messages (multi-lingual) by April 2015
  ○ Evaluating the project by June 2016
• Work with the bariatric service to identify and remedy barriers within the triage service to improve acceptance rates of Māori and Pacific people onto the bariatric surgery waiting list – by December 2015
• Collate bariatric surgery figures for 2014/15 by ethnicity to assess procedure rates for Māori and Pacific patients to establish a baseline for 2015/16 – by July 2015
• Implement Healthy Eating Guidelines within Enua Ola church/community groups (guidelines require 15 policies to be implemented to achieve gold accreditation, 7 for silver and 3 for bronze) – by June 2016
• Conduct the Aiga Challenge Programme (an 8-week, church-based, weight loss programme) in October 2015
• Support and participate in the Healthy Auckland Together inter-sectorial group to progress regional actions to improve physical activity and nutrition – ongoing
• Finalise and launch the updated DHB food and beverage guideline by June 2015 and conduct monthly monitoring of DHB outlet compliance.
	Healthy Babies Healthy Futures project
	• Double last year's number of family support members registered (target of 344) by December 2015
	• Double last year's number of staff trained in Healthy Conversational Skills (target of 50) by December 2015
	• 100 bariatric procedures to be performed, with 25 of these for Māori and 25 for Pacific patients, by 30 June, 2016
	• 6500 people to receive a green prescription referral by June 2016
	• All Enua Ola church/community groups to achieve bronze accreditation by June 2016
	• 800 people to register and complete the Aiga Challenge programme by June 2016
	• 100% compliance with updated food and beverage guidelines for all Waitemata DHB-based retail outlets by June 2016

The healthiest start for children and young people

Providing positive health outcomes for children, young people and mothers is essential in ensuring positive long-term health outcomes for our population. Risk and protective factors and social patterns established in childhood and adolescence have a significant long-term impact on health. Furthermore, many common mental health problems, such as depression, anxiety and substance abuse, emerge early in life and have life-long consequences. Our overall aim is to work collaboratively with primary care and other social sector agencies to ensure parents receive the best maternity care, and children and young people are safe and have the healthiest start to life.

Maternal and Children's Health - In recent years we have made substantial progress to ensure pregnant women engage with health services early and children have the healthiest start to life. Our infant mortality rate of 2.3 deaths per 1,000 live births is the lowest in the country. We have a high rate of breastfeeding, with 80% of babies being breastfed at discharge from hospital. PHO and General Practice enrolment rates for three-month-olds have improved to 71%, an increase of 15% from July 2012. Immunisation coverage is now 94% for 8-month-olds and 92% for 2-year-olds. Our rate of rheumatic fever continues to be one of the lowest in the country at 2.3 per 100,000 population. Seventy six percent of infants received all core contacts with their Well Child/Tamariki Ora provider and 92% of four-year-olds received a comprehensive health check before starting school; however, ethnic inequalities exist.

For 2015/16, we have a number of key focus areas in maternal and children's health. We will work with primary care and general practices to promote and support early LMC engagement through a regional pathway for first semester care and support the LMC model of care with direct access to obstetric clinicians. In the area of child health, we will focus on strong governance and integrating services across the child health spectrum. We aim to strengthen the First Year of Life Service Alliance and ensure it improves child health outcomes. We will have a strong focus on the Multi Enrolment Project, whereby new-borns are referred to enrol into all appropriate services through a single entry point. The Rheumatic Fever Programme Plan will be reviewed we will continue to support the Rheumatic Fever Rapid Response clinics established in a number of general practices and pharmacies and enhance our school based screening services in primary and high needs secondary schools. To protect vulnerable children in our district, we will support the prevention and early identification of child maltreatment and neglect by delivering on the New Zealand Children's Action Plan and aligned initiatives. We will support the implementation of regional Children's Teams and enhance interagency capacity and the continuum of care through regional information sharing and strengthening linkages with partner organisations.

Youth Mental Health –Early intervention to appropriate services for those with mental health problems and substance abuse issues will have a positive impact on health outcomes in young people. Access rates to specialist alcohol and drug services are improving, with 70% of those aged 19 years and under accessing services within 3 weeks.

In 2015/16, our focus is on enhancing school-based health services and further developing youth primary mental health and alcohol and drug services. This will ensure these services are accessible and responsive to our young people, with early interventions. We will aim to better understand and address inequalities in mental health service access and outcomes, and develop and implement culturally appropriate service models.

Child Health	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Ensure the Pregnancy and First Year of Life Service Alliance provides effective governance and drives improved outcomes for babies and infants – ongoing. **Enrolment** • Implement the Multi Enrolment Project to refer newborns for enrolment into a range of services (NIR, General Practice, Oral Health, Well Child/Tamariki Ora providers and Newborn Hearing screening) by April 2016 • We will aim to achieve equity of enrolment for Maori, Pacific and Asian through the multi-enrolment project by June 2016. **Well Child/Tamariki Ora (WCTO)** • Make the WCTO Quality Improvement Framework a living plan by adding at least one new PDSA activity every quarter from September 2015. **Breastfeeding** • Work with consumers to analyse the reasons for declining breastfeeding rates for infants aged between 6 weeks and three months (particularly for Māori and Pacific infants), and present recommended actions to the Alliance by October 2015 • Implement the new pregnancy and parenting education smartphone app to encourage all women, particularly Māori, Pacific and Asian, to breastfeed for at least the first 6 months of their baby's life by March 2014 • Implement combined Well Child Tamariki Ora and Midwifery breastfeeding education training for professionals from March 2016 • Implement the Breastfeeding – Beginners Guide (Chinese/Mandarin) across all maternity units in the Auckland DHB region by December 2015. **Oral Health** • Collaborate with oral health clinical leaders and service management to identify areas for further regional collaboration in approaches to oral health data collection, reporting and activities by December 2015 • Collaborate with ARDS to review enrolment pathways for newborns and for children aged under 5 years who are new to New Zealand by August 2015 • ARDS will begin a training programme for WCTO and other child health providers in key messages related to oral health literacy by December 2015 • Work with ARDS to develop and implement at least one action to increase oral health care service utilisation by infants aged less than 1 year, with a particular focus on Māori infants, by June 2016.	• Achieve equity across all targets for Māori, Pacific and Asian groups by June 2016 • 98% of newborns of all ethnicities are enrolled with a PHO, general practice, WCTO provider and ARDS by three months by June 2016 • 95% of Māori pre-school children are enrolled with ARDS by June 2016 • At least two oral health provider education workshops for WCTO, whānau ora workers and community health workers to be held by June 2016 • At least four PDSA activities to improve the quality of the Well Child Tamariki Ora programme are underway by March 2016 • At least 90% of four-year-olds receive a B4 school check, including 90% of Māori and Pacific children and children living in areas of high deprivation

Child Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
B4SC • Engage with Te Kōhanga Reo National Trust Tamaki Makaurau to develop a new approach to the delivery of B4SC in the Kōhanga Reo setting by September 2015 • Pilot an intervention to improve uptake of the B4SC in Te Kōhanga Reo whānau by June 2016 • Investigate opportunities to extend the pilot into Puna Reo and other early childhood centres with high Māori enrolment rates from May 2016.	

Maternal Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Develop and consult on a long-term maternity health-services plan to 2025; report (with service enhancement recommendations) to the Board in November 2015. **Continuity of Care** • Provide continuity of care for women with social complexity by promoting the Te Aka Ora group to LMCs – ongoing • Support the LMC model of care for women with complex needs by ensuring wrap-around care by the DHB obstetric team, thereby keeping the LMC engaged in providing primary maternity care for all women – ongoing. **Registration with LMC** • Work with primary care/general practices to promote and support early LMC registration and implement the regional GP pathway for first trimester care in pregnancy by March 2016 • Implement early engagement communications for women and their families from September 2015 • Align our work stream with the new Primary Care IPIF target – ongoing. **Pregnancy and Parenting** • Rejuvenate pregnancy and parenting education and ensure women, families and whānau have access to a range of meaningful evidence-based information by July 2016, including implementation of a smartphone app from October 2015 • Monitor the implementation of the pregnancy and parenting curriculum and assess whether the new model better engages target populations from December 2015. **Maternity Quality and Safety Programme (MQSP)** • Implement the new national Post-Partum Haemorrhage guideline and review incidence rates by June 2016 • Review the Waitemata DHB induction of labour guidelines by September 2015	• 98% of newborns are enrolled with a PHO by three months • 95% of pregnant women of all ethnicities receive continuity of primary maternity care through a community or DHB LMC • 80% of women of all ethnicities who register with an LMC do so in the first trimester • 30% of Māori, Pacific and teen pregnant women complete DHB-funded pregnancy and parenting education • 90% of pregnant women of all ethnicities who smoke will be offered advice and support to quit smoking.

Maternal Health

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Review episiotomy practices and outcomes by ethnicity by August 2016. **Gestational Diabetes Mellitus** • Implement new guidelines, as appropriate, by June 2016 • Work with regional counterparts to agree a regional approach for women with HbA1C of 41% to 49% in the first trimester by June 2016. **Smoking** • Audit smoking-related data from pregnant women in the Waitemata region by October 2015.	

Increased Immunisation

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Monitor Immunisation coverage rates weekly with particular focus on achieving equity for Māori babies - ongoing • Liaise closely with the Auckland and Waitemata Immunisation Operations Group, PHOs and the NIR for early detection and to action problem-solving measures when required - ongoing • Implement the Shared Approach Plan by September 2015 • Facilitate the development of communication tools and run education workshops for primary care providers regarding immunisation declines and delays – commenced from July 2015 • In conjunction with PHOs and the Department of Corrections, develop health literacy education workshops for parents sentenced to community service by June 2015 • Develop a working group and Project Implementation Plan for the Multi Newborn Enrolment Project by July 2015 • Implement the Shared Approach Plan to increase GP/PHO enrolment, particularly for Māori, by September 2015 • Work with providers and the Immunisation Reference Group based at Whānau House, Henderson, to share information, offer assistance and develop actions to support Māori whānau and babies who have overdue immunisation events by June 2016 • Complete the narrative report summarising annual learnings from the Whānau House Group by June 2016 • Embed the 2015 Immunisation Coordination delivery model by July 2015 • Maintain the effectiveness and engagement of key stakeholders in the Joint Auckland DHB/Waitemata DHB Immunisation Steering Group and Auckland Metro School Based Immunisation Working Group – ongoing • Work with the DHB Immunisation Steering Group to develop a	• 95% of 8-month- and 2-year-old children of all ethnicities are fully immunised • 90% of four-year-olds are fully immunised by age 5 (reported quarterly) by June 2016 (the long-term target is 95%) • 98% of new-born children of all ethnicities are enrolled with a GP by age three months by June 2016 • Narrative report on DHB and interagency activities to promote immunisation week (completed by early 2016) • At least 65% of girls have received HPV dose three, reported annually in quarter 4 (for 2015/16, this is the 2002 birth cohort measured at 30 June 2016)

Increased Immunisation

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
plan to increase the 4-year-old immunisation coverage, particularly for Māori, by August 2015 • Work with Waitemata DHB inpatient services to increase reporting and referral of children identified at admission who require immunisation – extend to paediatric emergency department services by March 2016. Review the feasibility of extending to out-patients services by June 2016 • Develop a plan for Immunisation Week 2016, including the Department of Corrections component, by February 2016 • Develop a promotion plan for use of the online learning tool to improve knowledge of HPV immunisations – by March 2016 • Improve communication with primary care providers to ensure young people who decline the school-based immunisation programme (and who choose to go the their GP) are recalled by June 2016 • Review the current HPV programme to identify areas that could result in improved coverage by December 2015.	

Rheumatic Fever

Better Public Service Target

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Review and revise the Waitemata DHB Rheumatic Fever Programme Plan in line with Ministry expectations by October 2015 • Evaluate the effectiveness of the school-based throat swabbing and management programme, including health literacy, by September 2015 • Monitor and evaluate the effectiveness of the CHW service in three high needs secondary schools to support the rapid response programme by June 2016 • Ensure all eligible referrals for housing-related concerns are sent to the Auckland Wide Healthy Housing Initiative (AWHI) Hub and that systems and relationships support referrers to help keep families informed – ongoing • Train at least 60 non-health front-line staff who interface with the target group from at least 3 geographically distinct organisations on the importance of sore throats and seeking medical help by December 2015 • Maintain the intensive school-based throat swabbing and management programme in 5 primary schools - ongoing • Monitor the effectiveness of the Rapid Response Clinics in general practice and in pharmacy monthly, through the Rheumatic Fever Service Steering Group - ongoing • Report quarterly to the Ministry on the lessons learned and actions taken following the root cause analysis of cases of first episode rheumatic fever hospitalisations and implement	• Reduce rheumatic fever rate to 1.0 per 100,000 or 6 people experiencing a first episode rheumatic fever hospitalisation by June 2016

Rheumatic Fever	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
relevant learnings – ongoing • Development of a lead indicator on acute hospitalisations (with quarterly reports) by August 2015 • Development of a feedback loop-education for clinicians RE: the result of housing referrals by October 2015 • Use the Results-Based Accountability framework to monitor and improve the performance of the DHB – AWHI service system for reducing structural and functional overcrowding – ongoing.	

Children's Action Plan	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

Reducing the number of assaults on children
• Maintain and evaluate the VIP programme, its implementation and continually update the VIP strategic plan based on evaluations, audits and other information - ongoing
• Maintain the National Child Protection Alerts System to tackle child abuse and child vulnerability by placing Child Protection Alerts in clinical records, national health index medical warning system and DHB internal systems on all appropriately identified mothers, infants, children and youth, to be completed by March 2016
• Develop child protection screening tools for use in primary care settings, including A+Ms, by June 2016
• Agree to common Auckland district child protection policy between key stakeholders by December 2015
• Develop care plans following placement of alerts by June 2016
• Ensure intervention pathways for family violence are clear and resourced adequately - ongoing
• Commence process to identify mental health and alcohol and drugs patients who are caring for children – by March 2016
• Ensure all Māori wahine/women and/or their children/tamariki who are admitted to North Shore and Waitakere Hospitals are offered Whānau/Pai Ora assessments, to be implemented from March 2016
• Monitor family violence screening rates in the community, and encourage improvement in rates, particularly through Well Child Tamariki Ora providers - ongoing
• Support primary care with family violence screening tools (including social determinant factors) and more training on child protection – by June 2016
• Ensure all contracted providers have implemented aligned Child Protection policies and comply with the Vulnerable Children Act - ongoing
• Review the configuration of our key workforces and ensure
	• Family violence (FV) screening coverage rates and referrals by key NGOs, primary care and the DHB will be reviewed by the FV governance group at every meeting
	• Reports of concern to CYF across the Auckland district will be discussed with CYF quarterly
	• Exception reports and remedial actions to audit scores less than 80/100 completed for each of the child and partner abuse components of our VIP programme
	• Monitor NCPAS and other child protection information systems by 30 June 2016
	• Internal governance/engagement arrangements and with primary and community partners maintained to provide services for:
	  ○ vulnerable children and their families/whānau
	  ○ pregnant women with complex needs
	  ○ children referred to Gateway.
	• Implementation of Rising to the Challenge (e.g. COPMIA) supported

Children's Action Plan	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
core national competencies are implemented from February 2016. **Support implementation of regional Children's Teams** • Build inter-agency capacity through information sharing with the Child Health Stakeholder Advisory Group, with regional DHB counterparts, social sector agencies and key NGOs - ongoing • Foster stronger connections – through the Pregnancy and First Year of Life Service Alliance - between the DHB, primary care, maternity providers and Well Child Tamariki Ora providers – ongoing. **Continuum of services across primary and referred health services** • Strengthen governance and advisory arrangements and linkages between partner organisations through the development of a shared vision which will be documented in a shared strategic plan by June 2016.	• Support for Healthy Beginnings: Developing perinatal and Infant Mental Health Services in NZ.

Prime Minister's Youth Mental Health Project	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

• Increase access to youth health clinical leadership across WDHB (dependent on funding) through engaging a part-time youth health specialist clinical FTE by June 2016
• Develop an accessible online training resource (moodle module) for general clinicians who engage with young people by June 2016.
Enhanced School Based Health Service (ESBHS)
• Maintain school-based health services in all decile one to three schools, teen parent units and alternative education facilities as per specifications – ongoing
• Enhanced school-based health services nurses are supported to work towards post-graduate qualifications in youth health, undertake HEADSS training and upskill in primary mental health - ongoing
• All ESBHS nurses are working under 'standing-orders' by December 2015.
Improve the responsiveness of primary care to youth
• Auckland DHB Youth SLAT will be broadened to include Waitemata PHO (ProCare is already a member). Specific actions include:
  o Information sharing across the SLAT and the Ranui Social Sector Trial, with options for attendance where appropriate from July 2015
  o Revising the Alliance agreement to align with the District
	• 75% of Year 9 students to receive a HEADSS assessment by December 2015
	• 95% of youths aged 12-19 years discharged from CAMHS and Altered High will have a transition plan in place by December 2015
	• Waiting time targets for non-urgent mental health and addiction services- 80% seen within 3 months, 95% seen within 8 weeks (including child and adolescent mental health services and youth alcohol and drug services) are achieved
	Altered High reporting across the region by June 2016:
	• At least 150 additional young people will be seen by Altered High
	• 15 AOD assessment and brief intervention training sessions

Prime Minister's Youth Mental Health Project	Better Public Service Target
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
Alliance and to review membership by September 2015 o Developing a primary care youth-friendly accreditation tool by June 2016 o Agreeing on how to standardise sexual health services, particularly in relation to access, across primary care by December 2015 • Information from an evaluation of the Youth Health Hub will be used to refine youth health services provided in the district from January 2016 • Maintain a range of psychological services available to young people, including e therapy - ongoing • Identify strategies to increase access to youth-appropriate health services in rural areas by March 2016 **Child and Adolescent Mental Health and Youth Alcohol and Drug Services** • Ensure transition plans are provided for youths aged 12-19 years who are discharged from CAMPHS and Altered High into primary care using MoH/Werry Centre guidelines – ongoing. The transition plans will specify a timeframe for primary care to follow-up each young person • Complete primary care roll-out of e-referrals by December 2015 • Deliver 2015/16 youth-specific actions of the WDHB Suicide Prevention and Postvention Action Plan (2015-17) by June 2016 (please see the Rising to the Challenge section) • Continue to participate in the Ranui Social Sector trial, and evaluation of the pilot project to increase the engagement of Ranui youth in secondary education through supporting the decrease in cannabis use – ongoing • Deliver the 2015/16 actions of the Ranui Social Sector Trial Action Plan (2015-2017) (to be released in June 2015) by June 2016. The plan and actions will be guided by the Advisory Group. Actions include working with the Ranui Social Sector Trial to: o provide training to youth leaders in supporting young people with alcohol and drug issues by December 2015 o develop a youth led campaign to reduce youth substance related harm by June 2016 • Altered High will continue to develop relationships and pathways through training and consult liaison sessions with primary care services (including PHOs, GPs, practice nurses and school-based health services) to improve the provision of alcohol and other drug (AOD) treatment for young people – ongoing • Opportunities for delivering CAMHS and Altered High services locally are fully explored and changes implemented to	provided to GP's, practice nurses, school health services; 300 health professionals will be trained; and 200 consultation/liaison contacts will be provided

Prime Minister's Youth Mental Health Project	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
maximise access (particularly in rural and under-served areas) by June 2016 • CAMHS will review service provision: ○ Develop a configuration plan to allocate resources to meet population demand, projected growth, need in rural areas and underserved populations by December 2015 ○ Ensure dedicated Infant Mental Health FTE are employed by October 2015 • Continue to implement the Choice and Partnership Approach (CAPA) to reduce waiting times for non-urgent mental health and addictions services for young people – ongoing.	

Cure, ameliorate and prevent ill health

We have a significant role to play in improving the management of ill health, in particular ensuring prompt identification, treatment and management of long-term chronic disease. We want to ensure people have access to preventive and supportive services and can readily access prompt diagnosis and treatment with the goal of reducing the burden of disease and improving the health outcomes and the quality of life of our population.

Managing chronic disease and enhancing quality of life

Cardiovascular disease, diabetes and Cancer – Despite having the lowest CVD mortality rate in the country (96.6 per 100,000 individuals) and one of the lowest for cancer (114 per 100,000 individuals), these chronic diseases contribute significantly to the overall burden of disease in our population. Cancer and CVD (including stroke) are responsible for nearly two out of every three deaths and significantly contribute to ethnic differences in health outcomes. Diabetes exacerbates the burden of many diseases, including CVD and with an estimated prevalence of 3.3 % (age-standardised prevalence, NZ Health Survey) and rising, will likely impact significantly on health outcomes into the future.

While 91% of adults have had their CVD risk assessment within the past five years, only 58% of eligible CVD patients are on triple therapy. Evidence suggests that this combination of pharmacological agents can reduce the five year ischaemic event rate by 25-30%. Cancer screening rates are high in our population, however inequalities and access barriers exist.

In 2015/16 our focus is to provide timely cancer identification and treatment and ensure patients with a high suspicion of cancer wait no more than 62 days from the date of referral for their first treatment (currently 82%). We are committed to applying the Equity of Health Care for Māori framework when reviewing or developing cancer pathways. With an extension to 2017, our bowel screening pilot programme will determine the feasibility of a national roll-out. In the area of cardiac and stroke services, our focus is to improve the pathways of care ensuring the provision of clinically appropriate, timely and equitable levels of access, including redesigning rehabilitation programmes. This will include working regionally to manage acute patient flow, to minimise patient wait times and refine transfer processes. Diabetes is a key priority for our District Alliance. Our focus is on identifying at-risk individuals early and improving diabetes management by providing culturally appropriate Healthy Lifestyle Programmes and supporting better self-management.

Mental Health Services – An estimated 20% of our population experience poor mental health in any given year, with 3% severely affected. Approximately 54 people in our district die each year because of suicide, and a large number of these are young Māori men. We have exceeded waiting time targets for Adult Mental Health, with 93% seen within three weeks; patients requiring non-urgent mental health services are seen within eight weeks.

In 2015/16 we will continue to improve outcomes and quality of life for people affected by poor mental health and to ensure our population have timely access to mental health services. We will work with our partners to ensure services reach vulnerable communities and continue our involvement and evaluation of the Ranui social sector trial. Non-government organisations (NGOs) are important partners in the delivery of mental health services within the community and we will enter into a collaborative approach with them to ensure their sustainability. This will include service reviews and redesign to achieve appropriate performance and outcomes along with ensuring value for money and long term NGO sustainability.

Health of Older People - The number of older people in our district is increasing. By 2025, our district will have nearly 115,000 people aged 65+ years, or 17% of the total population. Older people utilise a substantially greater proportion of our healthcare resources than younger individuals. Approximately half our health resources are used to provide care for people aged over 65.

In 2015/16 we will focus on providing older people with accessible, flexible, timely, coordinated and responsive health and disability services. The Co-ordinated Care, Assessment, Rehabilitation pilot (CARE) will contribute significantly to further integration of primary and community care, and we plan to begin patient enrolment and process evaluation this year. A further aim is to improve the outcomes for patients with dementia; we will be developing a business case to deliver the Cognitive Impairment Clinical Pathway to enable timely diagnosis and intervention.

Long-Term Conditions (LTCs)	
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

Prevention
• Fully utilise the Green Prescription programme in 2015/16, especially focusing on high needs individuals (Māori, Pacific, low decile, migrant and refugee populations) by June 2016
• Undertake a review of existing retinal screening services across WDHB and explore options for an improved, accessible patient service for Waitemata DHB by June 2016.
Identification of risk
• General Practices will use appropriate risk assessment, patient management and monitoring tools to identify individuals who are at risk of developing LTCs – ongoing.
Management
• Develop a detailed investment plan supporting the implementation of new models of care and services closer to home for diabetes and CVD (aligned to the ALT work plan) by June 2016
• Fully utilise self-management workshops with particular focus on high needs individuals (e.g. Māori, Pacific, low decile, migrant and refugee populations) by June 2016
• Undertake an evaluation of the Quality Improvement Pilot in West Auckland by June 2016
• Monitor and report on key indicators (by ethnicity) for the management of diabetes and CVD as prioritised by the District Alliance at the PHO level by December 2015 and at the practice level by June 2016
• Provide monitoring of the clinical indicators to the Metro Auckland Clinical Governance Forum – ongoing
• Establish Service Level Alliance (under the ALT) for diabetes and CVD by December 2015.
Enablers
• PHOs to support primary care workforce by providing appropriate education programmes – ongoing
• Support general practice to audit their data and develop
	• Provide 6,500 people with the opportunity to participate in the Green Prescription programme over 2015/16
	ASH rates
	• 0-4 years Total: TBC%
	• 0-4 years Māori: TBC%
	• 0-4 years Pacific: TBC%
	• 45-64 years Total: TBC%
	• 45-64 years Māori: TBC%
	• 45-64 years Pacific: TBC%
	• 0-74 years Total: TBC%
	• 0-74 years Māori: TBC%
	• 0-74 years Pacific: TBC%
	• Number of patients with diabetes (by ethnicity) who successfully complete the self-management workshops
	• Maintain quarterly reporting on key diabetes/CVD indicators:
	  ○ Percentage of people with diabetes who have good or acceptable glycaemic control
	  ○ Percentage of people (with / without diabetes) who have had a CVD event and are on triple therapy

Long-Term Conditions (LTCs)	
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
quality improvement initiatives through the Diabetes Quality Improvement Pilot in West Auckland by June 2016. The outcome will inform quality improvement initiatives across the Waitemata DHB region • Evaluation of the Quality Improvement Pilot in West Auckland to be completed by June 2016 • Implement information technology enablers, i.e. e-shared care and e-referrals - ongoing • Establish quarterly reporting on key diabetes/CVD indicators, implemented by June 2016: ○ Percentage of people with diabetes that have uncontrolled high blood pressure (BP) ○ Percentage of people (with / without diabetes) aged <75 with a 5 year CVD risk >15% and < 20% on dual therapy ○ Percentage of people with diabetes who have appropriate management of micro albuminuria.	

More Heart and Diabetes Checks	
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• PHO and general practice service agreements and activities will reflect the requirement to ensure 90% of the eligible population, particularly at risk populations (Māori, Pacific and Asian men aged between 35 and 44 years) have their cardiovascular and diabetes risk assessment completed every five years – ongoing • General Practices will use appropriate risk assessment, patient management and monitoring IT tools to identify individuals with CVD risk >15% and put in place appropriate management plans – ongoing • Report on key CVD indicators (by ethnicity) as prioritised by the District Alliance and the PHO level by December 2015 and at the practice level by June 2016 • Implement information technology enablers, i.e. e-shared care and e-referrals – ongoing • Support general practices to audit their data and develop quality improvement initiatives through the Diabetes Quality Improvement Pilot in West Auckland by June 2016 • PHOs will support the primary care workforce by providing appropriate education programmes - ongoing • PHO Quarterly Performance Monitoring Returns will include achievement against target and progress on specific actions/issues/risks/mitigation including quality improvement initiatives – ongoing • Commitment of budget 2013 funding for PHO practice	• 90% of the eligible population – of all ethnicities – will have had their cardiovascular risk assessed in the last five years

More Heart and Diabetes Checks	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
support/liaison team who assist practices with: ○ identifying eligible population and provide optimal management, as appropriate, of modifiable risk factors, namely lipid profile and glycaemic control ○ providing continued professional education on the quality standards for best management of patients with diabetes and high cardiovascular risk profiles ○ conduct audit and running practice level reporting to demonstrate improvement in patient care	

Diabetes Care Improvement Packages (DCIP)	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
Prevention • See Long-Term Conditions section above. ***Identification*** • General Practices will use appropriate risk assessment, patient management and monitoring tools to identify individuals who are at risk of developing diabetes and put in place appropriate management plans to delay or prevent the onset of the disease – ongoing • General practice will use tools (as above) to identify individuals with diabetes and put in place appropriate management plans (including care planning) to prevent or delay the onset of diabetes-related complications – ongoing. ***Management*** • Develop a detailed investment plan supporting the implementation of new models of care and services closer to home for diabetes and CVD (aligned to the ALT work plan) by June 2016 • Undertake an evaluation of the Quality Improvement Pilot in west Auckland by June 2016 • Expansion of the Whānau Ora diabetes service in west Auckland with the addition of a nurse specialist FTE to increase the capacity of the DHB to provide a more comprehensive Whānau Ora diabetes service to Māori living in west Auckland by June 2016 • Seek consumer participation and incorporate consumer input into developing quality improvement initiatives (co-design) as part of the West Auckland Quality Improvement Pilot by December 2015 • Provide access to self-management workshops with particular focus on high needs individuals (Māori, Pacific, low decile, migrant and refugee populations) by June 2016	• Reduction in the proportion of patients with HbA1c above 64, 80 and 100 mmol/mol, including those at high risk (e.g. Māori, Pacific, low decide, migrant and refugee populations), to be assessed quarterly • Number of patients with diabetes (by ethnicity who successfully complete the self-management workshops

Diabetes Care Improvement Packages (DCIP)	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Explore ways to improve participation in these workshops, particularly high needs populations and develop a set of recommendations by June 2016 • Staged implementation of the Auckland/Waitemata Alliance Leadership Team (ALT) approved set of 22 diabetes care clinical indicators (based on the MoH 20 quality standards for diabetes care) – first five to be implemented by June 2016 • Provide monitoring of the above clinical indicators (by ethnicity) to the Metro Auckland Clinical Governance Forum – ongoing • Maintain specialist support in primary care – ongoing • Services for our youth population living with type one diabetes are provided by Auckland DHB and will continue to be in the 15/16 year. We will contribute to a review these services, to determine if there is appropriate clinical and educational support for effective identification and management by June 2016 • Providers to demonstrate ongoing proactive management of patients with diabetes and/or CVD, with particular focus on at risk populations through quarterly Performance Monitoring Returns. ***Enablers*** • Implement information technology enablers, i.e. e-shared care and e-referrals – ongoing • Support general practice to audit their data and develop quality improvement initiatives through the Diabetes Quality Improvement Pilot in west Auckland by June 2016 • Support general practice with appropriate clinician education programmes – ongoing.	

Cancer Services/Faster Cancer Treatment	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Identify existing models/processes of investigations and treatment which negatively impact on faster cancer treatment times and implement changes recommended by local and regional cancer round one improvement projects to improve performance by June 2016 • Clinically led implementation of key findings at Waitemata in each tumour stream of the round one MoH service improvement project by UniServices by December 2015 • Support Auckland DHB and the region to plan initiatives for consideration for round two for the MoH service improvement funding • Participate in the IT-led National Patient Flow system and	• 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017 • Less than 10% of the faster cancer treatment records submitted by the DHB are declined • 100% of patients will receive their

Cancer Services/Faster Cancer Treatment

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
track patients undergoing assessment and treatment for cancer in real time and intervene if their journey is delayed at any point, to be implemented by June 2016 • Support Auckland DHB radiotherapy and chemotherapy production plans by giving ample notice and information of Waitemata DHB patients decision-to-treat (DTT) to first treatment dates - ongoing • Work closely with Auckland DHB in all tertiary cancer services to ensure Waitemata patients meet the 62 day FCT target and 31 day indicator - ongoing • We will work with GPs to encourage the use of eReferrals and work regionally to develop guidelines to improve the quality of information provided in referrals where there is a high suspicion of cancer – ongoing • Ensure all tumour streams have high suspicion flags which are used actively by the clinicians by December 2015 • Implement and support the Cancer Health Information Strategy when released nationally by June 2016 • Implement guidance on active surveillance treatment for prostate cancer care (available mid 2015), ensuring clinicians receive information and care pathways and MDM proformas are updated • Continue to contribute to regional work to improve MDM templates for gynaecology, head and neck, sarcoma, lymphoma, lung and neurology - ongoing • Improve local processes to ensure relevant patients with cancer are discussed at MDM in a time frame to facilitate the 62 day target (referral to treatment) - ongoing • Review local MDM terms of reference by December 2015 • Audit local tumour stream MDM volumes and completeness to identify which tumour streams would benefit from more MDM coordination support by December 2015 • Continue with the Bowel Screening Pilot over 2015 (with extension to 2017), share learnings nationally • Undertake annual cancer patient experience survey, commencing in February 2016 and completing in April 2016 • Implement the Ministry-funded Cancer Supportive Care suite of psychological and social services to improve cancer patient support by June 2016 • Support Northern Cancer Network (NCN) conducting at least two additional tumour type reviews against National Tumour Standards by June 2016 • Develop a quarterly cancer equity report which includes ethnicity indicators by December 2015 in accordance with the regional approach	radiotherapy and chemotherapy within four weeks of decision to treat every month throughout the year • At least 75% of patients accepted for an urgent diagnostic colonoscopy will receive their procedure within 14 days, 100% within 120 days, throughout 2015/16 • At least 65% of patients will receive their non-urgent colonoscopy within 42 days throughout 2015/16 • 100% of patients accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 120 days • At least 65% of patients accepted for a surveillance colonoscopy will receive their procedure within 84 days, 100% within 120 days

Cancer Services/Faster Cancer Treatment

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Implement the action points of the endoscopy review undertaken in 2014 by June 2016 • Ongoing participation in regional collaborative activities and the development of a 5-year colonoscopy plan.	

Cardiac Services

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Best practices Cardiac rehab programmes will be established by July 2016 which will be regionally consistent and with a whole-of-system approach that includes primary care • Measure retention rates by ethnicity on current cardiac rehabilitation programme to enable comparison once new programme established – by September 2015 • FSA Chest pain clinic pilot to be established by 1 July 2015, with evaluation on the impact to reduce wait times to within target post implementation by Oct 2015 • Audit of selected patients who have been prioritised for surgery using the CPAC tool to assess correct use of tool – completed by November 2015 • Work with regional colleagues to manage the acute patient flow to minimise patient wait time and refine transfer process using CPAC tool, to be regionally agreed to and applied by June 2016 • Work with the regional, and where appropriate, national, cardiac networks to improve outcomes for patients with heart failure (MoH new priority) • Continue to work on improving systems for data input and recording for cardiac registry data – ongoing.	**Secondary Services** • A minimum of 330 total cardiac surgery discharges for our local population in 2015/16 • Patients will wait no longer than four months for first specialist assessment and treatment • Establish the baseline number of patients going through cardiac rehabilitation • For the elective coronary angiography measureable activity, please see the Improved Access to Diagnostics section *SI4: Standardised Intervention Rates* • Cardiac surgery: 6.5 per 10,000 of population • Percutaneous revascularisation: 12.5 per 10,000 of population • Coronary angiography: 34.7 per 10,000 of population **Acute Coronary Syndrome** • Over 95% of patients presenting with ACS who undergo coronary angiography to complete ANZACS-QI ACS and Cath/PCI registry data collection within 30 days • Meet the requirement that 70% of all ACS patients receive a coronary angiography within 3 days (68.6% at Q2, 2014) • Monitor readmit rates by NHI for heart failure patients to secondary services over a 12-month period

Stroke Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

• Identify Older Adult Service processes that could be integrated into the Stroke Service, which support early engagement with stroke patients' families and their journey from admission to rehabilitation and then back into the community, pending ESD business case approval before end of 2015
• Establish a pathway for MDT family meetings and nurse-led ward rounds within the stroke ward, to commence by June 2015
• Continue to audit the percentage of patients admitted to stroke units across both sites, and take any corrective action required to meet the 80% target – ongoing
• Assess the swallow documentation and review the process for assessment to ensure it reflects best practice – ensure updated documentation available on the stroke and allied health intranet by December 2015
• Work with patients and their families (during inpatient admission) to optimise the number of referrals to the Stroke Foundation (by providing information on the Stroke Foundation) and ensure the opportunity for support from the volunteer stroke service is made available in a timely manner - ongoing
• Investigate the feasibility of developing an early supported discharge service for stroke patients – paper developed by April 2015.
 	
24/7 thrombolysis
• Improve existing stroke thrombolysis quality monitoring e.g. door to needle, protocol adherence, and haemorrhagic complications by working with the public health specialist to ensure the accuracy of collected data (the stroke pathway will be explored in a similar way to the cardiac pathway recently developed in ED) by October 2015
• Specific monitoring and analysis of reasons for delays in thrombolysis treatment, including ensuring time of onset recording is improved – ongoing
• Review stroke thrombolysis pathway and identify aspects for improvement that would assist identification of suitable patients at the front door – review completed by December 2015. Identified improvements implemented by June 2016.
 	
MDT education
• Dysphagia training for nursing staff – ongoing
• Operate annual MDT study days – 2 days within 2015/16
• Grand round presentations – twice within 2015/16
• Develop best practice clinical guidelines identifying 'appropriate' patients to be admitted to stroke ward by
	• 6% of potentially eligible stroke patients are thrombolysed
	• 80% of stroke patients are admitted to a stroke unit or organised stroke service with demonstrated stroke pathway
	• 60% of stroke patients are transferred to a rehabilitation facility within 10 days
	• Collect data to establish a baseline for ongoing reporting of:
	  ○ The % of patients admitted with acute stroke referred to community rehabilitation
	  ○ The % of the above patients undergoing face-to-face community assessment within 5 days of discharge from hospital

Stroke Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
June 2016. (This is particularly important for after-hours access) • Work with the NRA to contribute to a National stroke thrombolysis register quarterly reporting commencing January 2015 • Work with the NRA stroke network to develop quality monitoring and support the TIA electronic pathway by June 2016 • Work with regional colleagues and Public Health Physicians to agree a consistent model of care by June 2016.	

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

Rising to the Challenge/Mental Health and Addiction Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
Whole-of-system integration and responsiveness • Primary care development – rollout of e-referrals by December 2015 • Primary health care – further develop stepped care pilot with Totara Health, including NGO support services and evaluate by March 2016 • Build mental health specialist support (both mainstream and Kaupapa Māori) co-located at Whānau House, informed by learnings from the Totara Health pilot, and pilot the use of Kaupapa Māori NGO support for this integration of services by March 2016 • Develop a service navigation tool to describe the range of services available, and the means of access to the services by December 2015 • Develop a plan with Services for Older Adults and primary care to 'share care' for the ageing population by December 2015 • Implement a new model of care in He Puna Waiora (the new adult inpatient unit) to be operational from May 2015, and the new model of care to be fully implemented by December 2015 • Mason clinic stage 1 remedial works programme to be completed by June 2016 (the full programme is expected to take 5–6 years to complete). The design phase of the new 15 bed medium secure unit will be completed by November 2015 and construction will commence in May 2016. The relocation of staff and demolition of the existing Puriri building will occur by April 2016 • Implementation of sustainable community residential services for people with high and complex needs	• Continue to meet mental health and addictions service waiting times: 80% within 3 weeks and 95% within 8 weeks (PP8) with a special focus on 0-19 age group • Continue to meet agreed access rate targets • At least 95% of 12 to 19-year-old clients discharged will have a transition (discharge) plan (PP7) • At least 95% of Māori and Pacific long term clients will have up-to-date relapse prevention plans • Establishment of enhanced acute service based at Waitakere Hospital ED will achieve shorter waiting times and contribute to meeting the 6-hour target by June 2016 • Provider Arm and NGOs will be reliably and consistently collecting social outcome data by June 2016 • All 8 Rising to the Challenge Service Development Plan actions for 15/16 will be achieved

Rising to the Challenge/Mental Health and Addiction Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
completed by June 2016 • Full roll-out of enhanced acute service based at Waitakere Hospital ED by December 2015 • Implementation of a new model of community acute response (Pilot from February 2015 and complete roll out July 2016).Will achieve district wide service consistency, earlier responses, better support to GPs, and increased capacity to deliver services in the home environment. **Intervening early to promote resilience and self-management** • Continued participation in the Ranui Social Sector trial, and evaluation of the pilot project to increase the engagement of Ranui youth in secondary education through supporting the decrease in cannabis use – ongoing • Establishment and implementation of a forum, for all agencies in Ranui by October 2015. **Understanding and addressing inequities** • Facilitate whānau hui with Tagata Whai I te Ora and their whānau who receive mental health treatment from the Waitemata DHB Māori Mental Health Services to gain insights into the negative and positive effects of compulsory community treatment orders by March 2016 • Evaluate clinical/cultural care pathways for Māori receiving Kaupapa Māori services, under compulsory community treatment orders and provide a report with recommendations on the elements of the current care pathway that need changing to better meet the needs of Māori by June 2016 • Monitor and analyse the use of section 29 Mental Health Act treatment orders to identify trends by ethnicity by June 2016 • Ensure reliable collection of data for use of seclusion and restraint for Māori, and analyse the data to understand differential rates of use for Māori, by December 2015 • Māori and Pacific service users have the highest physical health comorbidities. Ensure routine metabolic screening for secondary service users, with priority focus on Māori and Pacific clients by June 2016 • Deliver 2015/16 actions of the WDHB Suicide Prevention and Postvention Action Plan (2015-2017). The plan and actions will be guided by the Advisory Group and the Inter-Agency Working group, and will prioritise at-risk populations, e.g. youth/rural/Māori. Activities in 2015/16 will include workforce development training, to identify, support and refer at-risk people; and cross-agency facilitation in prevention and postvention • The joint WDHB/ADHB Employment Plan to increase access	• Monitor and analyse section 29 Mental Health Act treatment orders for Māori ○ Record the number of CTOs and indefinites by ethnicity - quarterly ○ Record the duration of CTO orders by ethnicity – quarterly ○ Record the number and average length of admission by ethnicity - quarterly • 50% of Māori and Pacific people in secondary services will have metabolic screening by June 2016

Rising to the Challenge/Mental Health and Addiction Services	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
for service-users to employment is to be released in March 2015 – 2015/16 priority actions will be identified from the plan and implemented by June 2016 • Provider Arm will review systems to reliably collect social outcome data (housing, employment and PHO enrolment) using agreed KPI definitions and align with NGO collection approaches and PRIMHD collection protocols. This process is to commence by July 2015 • Ministry COPMIA guidelines (expected in April 2015) will be implemented. All staff will have increased knowledge of available COPMIA resources and increased competencies to promote COPMIA child and family focused practice. **Regional Activity** • Participate in regional plan activity – High and Complex needs/Eating Disorders/implementation of Perinatal and Infant Mental Health continuum/Māori workforce development plan, framework for suicide prevention training, review of child and youth services, offender health, and forensics (youth and adult)- ongoing • Continue implementation of local Infant and Perinatal Mental Health Services – with year two of service development funding: $1,039,726. **NGO sustainability** • Work with Mental Health and Addictions sector NGO representative groups to plan for sustainable services – agree approach, work plan and milestones with NGOs by 31 December 2015.	

Health of Older People	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

• Develop business cases for provision of improved access to community delivered services including cognitive impairment services (based on the model of care developed with general practice) by December 2015
• Co-ordinated Care, assessment, rehabilitation and Education (CARE) pilot enrolling patients by July 2015 – this is also a target for Primary Care
• Implement in-between-travel funding allocation for HBSS Providers as advised by the MoH
• Support implementation of agreed components from the negotiated HBSS in-between travel settlement as advised by the MoH
• Continue implementation of standardised clinical assessments (interRAI) across the Home and Community sector and ARRC sector – ongoing
• Older people referred to NASC for an InterRAI assessment to access publicly funded care services will undergo the assessment in a timely manner – ongoing
• Collaborate with Central TAS to develop – through their new integrated InterRAI service –comparative standardised InterRAI quality reporting measures by June 2016 to compare our performance with other northern region DHBs and identify opportunities for quality improvement
• Develop a quality framework for the ARRC population by December 2015
• Use our Specialists Services for Older People (geriatricians, gerontology nurse specialists) proactively to advise and train health professionals in aged residential care and primary care - ongoing
• Maintain and monitor Fracture Liaison Service - ongoing
• Facilitate implementation of the Regional Health of Older People Plan at a district level – ongoing.
	• Report quarterly on the percentage and number (target =75%) of older people who have received long-term home and community support services in the last 3 months who have had an interRAI Homecare or Contact assessment and completed care plan; 50% having their assessment within a 12-month period
	• Establish a baseline and report on the proportion of ARRC residents who have a second interRAI assessment completed 230 days after admission
	• Report quarterly on the proportion of urgent referrals for an interRAI assessment completed within 5 days and the proportion of non-urgent referrals completed within 15 days
	• Reporting to monitor the Fracture Liaison Service (FLS), including:
	  ○ the total number of patients admitted with a hip fracture
	  ○ the number of patients admitted with a hip fracture not on current therapy
	  ○ the number of patients admitted with a hip fracture assessed by the FLS and commenced on therapy (osteoporosis treatment)
	• Maintain current consult and liaison services to ARRC and primary care by Waitemata DHB gerontology nurse specialists - referral numbers from primary care per quarter will be reported against a baseline average of 186 (range 150 -210) per quarter

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

Timely and efficient access to services

Our aim is to provide timely access to services to enable people to live longer, healthier and more independent lives. Accessing the right care at the right time in the right location is critical to ensuring that patients achieve the best health outcomes possible. Patients want certainty regarding access to healthcare when they need it without long waits for their assessment, diagnosis or treatment. Patients' journeys are improved if they have timely access to services and that those services are well integrated across community, primary and hospital settings and are culturally appropriate.

Emergency Department – Approximately one in seven of our population visits a hospital Emergency Department (ED) in any given year and this demand has risen by 50% in six years. Currently, 95% of ED patients spend no longer than six hours in the ED. Shorter stays in the ED result in less overcrowding, better health outcomes, and shorter stays, enabling us to use our resources more effectively and efficiently. In 2015/16, we will continue to meet the 95% target and focus on improving clinical pathways and expanding our facilities and services within the region and improve access to services during periods of high demand.

Elective Surgery and Diagnostics – Providing our population with timely and equitable access to elective surgery and diagnostic services is a key priority. Waitemata DHB had the largest increase in elective surgeries of any DHB in the country over the last four years. The increasing elective health target has been consistently met with 17,076 surgical procedures carried out in 2013/14, nearly 24% more than three years ago. Patients now wait no more than four months for their first specialist appointment or their elective surgery. Over the previous five years, CT and MRI scans have increased by 58% and 30% respectively, with a further boost in capacity with the opening of a second MRI suite at North Shore Hospital.

In 2015/16, we plan to deliver 20,773 elective procedures and improve the experience of our patients when they contact our services. General Practitioners will have direct access to MRI for patients with back pain prior to specialist referral. We will also deliver on the regional plan for cardiac services, ensuring appropriate access to coronary angiography.

Primary Care – Primary care is central to improving health and reducing inequalities: 90% of our population's interactions with the health system occur in primary care and it is often the point of entry into the health care system. In 2014/15 we performed strongly, achieving many of the primary care targets for the first time and were the best performing DHB in the country in achieving our smoking targets. The Auckland and Waitemata District Alliance is in place with a focus on patient- and whānau-determined care, improved integration, management of long-term conditions and developing capability and capacity in primary care.

In 2015/16, we will continue to develop and strengthen the District Alliance. Our priority this year is on the management of Diabetes and cardiovascular disease. We are committed to working with PHOs to explore opportunities to develop a comprehensive approach to developing the capacity and capability of general practices and to jointly implement the Integrated Performance and Incentive Framework.

Shorter Stays in Emergency Departments

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
• Implement five more clinical pathways/best care bundles: cellulitis, respiratory infections; renal colic gastroenteritis; and dental conditions by 30 June 2016 • Embed existing clinical pathways/best care bundles and audit outcomes as appropriate over 2015/16 • Work with other Emergency Departments to monitor adherence to trauma guidelines and update as needed –	• 95% of our patients will be treated within six hours of presentation through proactive management • A total of five clinical pathways will be implemented by June 2016

Shorter Stays in Emergency Departments

What are we going to do in 2014/15?	How will we know we've achieved it? Measured by
ongoing • Commence the Waitakere ED extension by July 2015 • Fully embed the accelerated chest pain pathway by December 2015: identifying the low to moderate risk patients (with a TIMI score of 0), monitor these patients in ED for two hours rather than admitting • Monitor the use of POAC monthly and maintain high utilisation rates to free up capacity within ED and inpatient services. We will undertake an evidence based review to inform future investment decisions by June 2016 • Establish after hours arrangements with Accident and Medical facilities in the north and west by July 2015 to ensure winter coverage when presentations are higher • Survey three to five patients per 24-hours to identify good and poor feedback regarding patient experience – ongoing • Monitor injury presentations by ethnicity (particularly Māori and Pacific rates), report trends from the regional trauma registry and identify issues for follow-up - ongoing • Operate the acute referral pathway for acute adult spinal cord injury (SCI) patients to CMDHB (as per nationally agreed protocols, systems and processes), including engaging with ambulance and regional providers to implement the hospital and destination pathway - ongoing • Our clinicians will consult CMDHB SCI clinicians regarding the transfer of acute SCI patients to CMDHB – ongoing • Maintain the ED Quality Framework which informs governance and project activity – ongoing • Monitoring of ED quality framework patient journey indicators has identified delays in transfer of patients to wards from ED. We will work with clinical directors to improve the timeliness of review, acceptance and transfer of patients by June 2016 - develop and embed an escalation pathway to improve timeliness of medical and surgical review of ED patients • The ED governance group will initiate projects as necessary to prioritise service improvement activity to solve issues relating to the waiting targets whether internal or external to ED to free capacity. This may include diagnostics and in-patient specialties – ongoing.	• 75% of major trauma will be reported to the region and the Ministry monthly by June 2016 • Re-presentations will remain below 5% of total number of patients seen for both 48 hours and seven days – monitored monthly • 100% of cardiac patients who present with low to moderate risk chest pain (only if clinically indicated and patient is stable) will be referred to general medicine as per the chest pain pathway – process embedded by December 2015 • 100% of patients with low risk chest pain or moderate risk chest pain are treated in ED or referred to general medicine as per chest pain pathway

Improved Access to Elective Surgery/Major Trauma

What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Bariatric surgery – please see the Obesity section • Support the implementation of Phase 2 of the National Patient Flow (NPF) Collection Programme led by the IT team from July 2015, collecting Phase 3 information from July 2016 to enable the Ministry to collect more patient journey data • Support initiatives to regionalise NPF data collection and oversight during 2015/16 • Establish hand surgery and breast reconstruction services locally on eligible and agreed patients who previously would have attended Counties Manukau DHB for these services from July 2015 • Offer non-surgical pain management to appropriate patients with muscular skeletal pain through our chronic pain service from 1 July 2015 and incorporate as business as usual • Include acute arranged surgery and surgery via medical PUCs in our health target measurement and compliance • Ensure triage consistency and equity of access by using national CPHAC tools in all specialties - ongoing • Review regional options for two surgical sub specialty procedures during 2015/16 • Support regional workforce initiatives - ongoing • Monitor surgical intervention rates and increase resource to specialties where the intervention rates are significantly lower than the national average • Continue to embed the learnings over 2015/16 from the elective productivity and Shorter Journey projects into our business as usual e.g. patient-focused bookings.	• Meeting the health target by delivering a minimum of 20,773 elective discharges by June 2016, noting the change to how the MoH will count the elective health target • Compliance with the four-month wait time for FSAs and elective surgery will continue in the 2015/16 year **Standardised Intervention Rate Targets** • Major joint replacement procedures: 21/10,000 of population • Cataract procedures: 27/10,000 of population • Cardiac surgery: 6.5/10,000 of population • Percutaneous revascularisation: 12.5/10,000 of population • Coronary angiography: 34.7/10,000 of population • Elective average length of stay target: 1.59 days • We will improve the national inpatient survey results in all four domains by using the six ward priorities to improve the patient experience by 30 June 2016 • Increase the number of elective referrals (from 2014/15) sent electronically from primary care by 30 June 2016 • Increased uptake of latest national CPAC tools to improve consistency in prioritisation decisions • Patient level data is being reported into the National Patient Flow collection, in line with specified requirements.

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

Improved Access to Diagnostics	
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• We will adapt to the changes in reporting in regards to the implementation of phase three of the National Patient Flow by June 2016 • We will ensure we provide representation, attend and participate in national and regional clinical group activities – ongoing • Participate in the National Radiology Service Improvement Initiative, with the implementation of the WISDOM project (Waitemata Imaging Services Demand OptiMisation) – over 2015/16.	
Angiography • Continue to monitor waiting times for angiography against target and report on a monthly basis to the regional Cardiac Network.	**Angiography** • 95% of accepted referrals for elective coronary angiography will receive their procedure within 90 days
CT and MRI • Two MRT trainee technicians to become proficient at operating the MRI scanners by June 2017 • Identify models of care impacting on diagnostic waiting times e.g. the radiology pathway, and implement changes to improve performance by June 2016.	**CT and MRI** • 95% of accepted referrals for CT scans will receive their scan within 6 weeks • 85% of accepted referrals for MRI scans will receive their scan within 6 weeks
Colonoscopy - see Faster Cancer Treatment section	

Primary Care/Integrated Performance Improvement Framework	
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by

Primary Care
• Review Auckland and Waitemata District Alliance to identify improvement opportunities by 31 December 2015 (this will include alignment of all current Service Level Alliances – Rural, After-Hours, Pregnancy and First Year of Life, Youth and Rheumatic Fever)
• Rural funding will be allocated as per the historical/current arrangements in 2015/16
• The Rural Alliance work programme will consider rural funding allocations:
  ○ review completed by December 2015
  ○ implement updated rural funding allocation plan by March 2016
• Review Metro Auckland Regional Clinical Governance Forum to identify improvement opportunities by 31 December 2015
	• Achievement of the primary care health targets:
	  ○ 90% of the eligible population – of all ethnicities – will have had their cardiovascular risk assessed in the last five years
	  ○ 95% of 8 month old children will be fully immunised
	  ○ 90% of patients who smoke and are seen by a health professional in primary care are offered brief advice and support to quit smoking by June 2016
	• Maintain direct access of at least 31,128 community referrals from GPs to radiology services within 2015/16
	• Achieve a target of 6,519 POAC referrals in 2015/16

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<tr><th>What are we going to do in 2015/16?</th><th>How will we know we've achieved it?
Measured by</th></tr>
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- Work with PHOs to jointly achieve the primary care Health Targets (see relevant sections for specific activities and timeframes)
- Maintain direct access (2014 baseline = 31,128 community referrals) for general practitioners to a full suite of diagnostic imaging including X-rays, ultrasounds, fluoroscopy, mammography, nuclear medicine, CT and MRI, managing to appropriate waiting times – on-going
- Work with PHOs and regional Primary Options for Acute Care (POAC) members to continue to support the services across Auckland – ongoing
- Support the implementation of free under 13's for free general practice visits, prescription co-payments (daytime and after hours)
- Implement information technology enablers:
    - e-shared care - ongoing
    - e-referrals – ongoing
- Implement and support the National Enrolment Service, to be implemented by June 2016
- Ensure GPs implement identified quality improvement activities based on the results of the Ethnicity Data Audit Toolkit - ongoing
- Support the implementation of the Community Pharmacy Services Agreement through engaging primary care prescribers and hospital services with pharmacy. Extension to the existing contract to be finalised 1 July 2015
- Complete pilot of Diabetes Quality Improvement Team by 30 June 2016
- Palliative care model:
    - Agreed Implementation plan by 31 December 2015
    - Implement Medical Hub by June 2016.

System Integration/ Effective and Coordinated Services Closer to Home

- Work with PHOs to investigate supporting the health care homes model in agreed demonstration sites:
    - Present a proposal of jointly-agreed scope to Alliance Leadership Team for consideration by end of Q2 2015/16
    - Explore the opportunity to run a demonstration programme of the Health Care Home concept in at least one area with a high needs population

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- Implementation of free visits and prescriptions for under 13s from 1 July 2015 and After Hours from October 2015 (aligned to the After Hours procurement process)
- 95% of new-borns receive all scheduled immunisations by 8 months of age
- 95% of new-borns receive all scheduled immunisations by 2 years of age

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Primary Care/Integrated Performance Improvement Framework	
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
and where access to primary care is limited – feasibility study initiated by March 2015 o Pending outcome of feasibility study, decision made by ALT by June 2016 • Continue investment in the following areas: o Primary Options for Acute Care (POAC) o After hours services • Clinical pathways: o Mental Health developed by December 2015 and in place by March 2016 o Diabetes developed by June 2016 • Expand the Safety in Practice programme to 10 more general practices in the Waitemata district from July 2015 • Revised service delivery model for sexual health from 1 July 2015 • Up to 30% of the service will move to general practice • Standardisation of access to free services for young people • Develop business cases for provision of improved access to community delivered services: o cognitive impairment services (based on the model of care developed with general practice) by December 2015 o Infusion services such as ferinject by March 2016 • Undertake a feasibility study to establish a renal dialysis unit in the Rodney area – study completed by March 2016 • Review existing resourcing of diabetes services by March 2016 • Develop a plan to maximise the delivery of diabetes services in the community setting – including improved access to community podiatry and retinal screening: o work plan to be finalised by September 2015 o delivery of work plan by June 2016 • Co-ordinated Care, assessment, rehabilitation and Education (CARE) pilot enrolling patients by July 2015 – this is also a target for Health of Older People • Continue the development of clinical pathways	

Primary Care/Integrated Performance Improvement Framework	
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
that include Primary Care direct and easy access to specialist nurse/and or doctor advice in the following services by June 2016: o Mental health o Diabetes (aligned to the ALT workplan) • Work with the Auckland Regional After-Hours Network to implement the new after-hours, over-night, and GP deputising services by 31 December 2015 • Develop a plan for the implementation of the National Access Criteria for Community Referred Diagnostics by June 2016 **Integrated Performance Incentive Framework** • Work with PHOs to jointly implement the Integrated Performance and Incentive Framework - ongoing (see relevant sections for specific activities and timeframes) • Implementation of the Health Quality and Safety Commission Patient Experience Survey (once developed).	

Relieve suffering of those entrusted to our care

We want to relieve suffering for our patients and community. We will achieve this by enhancing the experience of patients/whānau when they interact with us, ensuring everything is done to relieve physical, psychological and emotional pain, deliver care that is culturally and clinically safe and provide clear connections and smooth transitions throughout the health system.

Better quality and experience of care

Patient experience is an important indicator in assessing the quality of care provided and is strongly linked to overall health outcomes. Our focus is on individualised care and tailoring of services to meet patient/whānau needs and engaging them as partners in their care. An enhanced patient experience leads to better emotional health, symptom resolution; less reported pain and more effective self-management.

Patient experience – Patients experience is one of the two priorities of the WDHB Board. We have successfully implemented a local patient experience reporting system through the Friends and Family Test and have begun tracking patient experience around a variety of patient experience metrics. In 2015/16 we will continue to develop our patient experience programme and expand to all DHB services as well as developing systems to engage staff in patient feedback.

Quality and Safety – Waitemata DHB has the lowest Hospital Standardised Mortality Rate of any DHB. We improved our compliance across the HQSM markers including good hand hygiene practice from 62% (July-October 2012) to 95% (July-October 2014) and the rate of central line infection in our intensive care unit is now less than 1 per 1,000 line days. We have decreased the number of patient falls resulting in major harm from 1 per 5,000 bed days to less than 1 per 10,000 bed days. Our results in these areas have been driven by our clinicians working in partnership with patients, their whānau, the community, and our quality improvement team.

In 2015/16 we will continue our collaboration both nationally and regionally on quality improvement programmes and actively participate in the HQSC national patient safety campaign. We are committed to undertaking local and supporting national mortality and morbidity review work. We will continue to roll our electronic medicine reconciliation and electronic prescribing and administration across our hospitals and will aim to remain the lead nationally in the number of wards and beds covered by these electronic systems.

Patient Experience	
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Development of a work plan for the next phase of the values programme, including combining the patient and staff experience work streams and engaging staff in continuous quality improvement based on the feedback received - ongoing • Develop the annual work plan for the Patient and Whānau Centred Care Programme by September 2015 and implement it by June 16 • Continue to identify opportunities for improvement, using the national inpatient survey results – ongoing • Redevelop the survey programme technology for areas that currently use the system by December 2015, with expansion to all other areas, including community services, by June 2016, to make the survey available via different modalities, such as smart phones, tablets and online • Engage with Māori, Pacific, Asian and other cultural groups to improve our understanding of patient experience and engagement, cultural safety and cultural responsiveness. Activities include attending existing events and forums, introducing new digital tools for engagement, holding community forums and through two listening weeks each year – ongoing • Continue to involve the community through health literacy groups to review and update a range of communication materials such as patient information sheets, letters, videos and web-based material - ongoing • 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 • Continue to work with Health Links and non-government organisations to identify further opportunities for enhanced community and patient engagement • Continue to remove barriers for whānau, family	• Improve in all four domains (Communication/Coordination/ Partnership/Physical and Emotional Needs) of the national adult inpatient survey by June 2016 • All services to utilise the Friends and Family Test • All wards to demonstrate continuous quality improvement using the IDEAS (Identify, Do, Evaluate, After action review, Share and celebrate) improvement terminology • Achieve a Net Promoter Score for the Friends and Family Test of >70 by June 2015 • Achieve an annual average of <15 days for the time to respond to complaints over the 2015/16 period

Patient Experience	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
and friends by implementing Partners in Care, whereby patients can nominate someone to support them and stay with them at any time • Continue to improve information to patients and the community by reviewing and updating quality boards in all clinical areas • Survey of overall satisfaction with handling of complaints to be completed by June 2015 and any improvements identified from the survey are implemented by July 2016 • Increase electronic responses to patient surveys by offering a variety of survey modalities (online, tablet, apps) through which consumers can provide feedback.	

Quality and Safety	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
HQSC Quality and Safety Markers • 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 • 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 medications • Actively participate in the northern region's 'First Do No Harm' patient safety and quality improvement programme • Sustain achievement in falls risk assessment and care planning – ongoing ○ Continue to undertake weekly audits of fall risk assessments and care planning in all wards and provide real time falls data to senior nurses and managers to monitor and report falls to track and reduce the incidence of falls - ongoing ○ Continue to implement the falls prevention programme including falls champions on each ward; falls risk reporting at each handover; falls education and training days; and standardisation of falls reporting and investigations - ongoing ○ Implement a community falls prevention	• 90% of older patients are given a falls risk assessment • 98% of older patients assessed as at risk of falling receive an individualised care plan addressing these risks • 80% compliance with good hand hygiene practice maintained • Healthcare associated Staphylococcus bacteraemia <0.1 per 1000 bed days rate maintained • All three parts of the surgical safety checklist are used in at least 90% of operations • 95% of hip and knee replacement patients receive cephazolin ≥2g as surgical prophylaxis • 100% hip and knee replacement patients have recommended skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine • 100% hip and knee replacement patients receive prophylactic antibiotic 0-60 minutes before surgical incision • Maintain > 95% compliance with evidence-based central line care bundles in the Intensive Care Unit • Central line associated bacteraemia (CLAB) infections <0.1 per 1000 line days rate maintained

Quality and Safety	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

project, including a care pathway for targeted high risk individuals, by Jan 2016
• Sustain achievement for hand hygiene compliance
  ○ Continue to develop and deliver the staff education and training programme for hand hygiene, including sustained 'bare above the elbow' practise and production of further staff and patient stories - ongoing
  ○ Continue roll out of hand hygiene 'gold auditing' to all wards using local gold auditors in each ward, weekly auditing, and electronic real time reporting for each ward, with full roll out by June 2016
• Sustain achievement of use of all three parts of the WHO surgical safety checklist
  ○ Track and report theatre teams' use of the three parts of the WHO surgical safety checklist - ongoing
  ○ Continue to introduce designated clinical leads for each part of the surgical safety checklist in each operating theatre to ensure all staff are consistently engaged for all phases of the checklist, with roll out completed by December 2015
  ○ Undertake monthly observational audits of the use of the surgical safety checklist by each specialty group to ensure the checklist is being used as a teamwork and communication tool - ongoing
  ○ Introduce team briefing and debriefing for each operating theatre list to improve patient safety, teamwork and communication within the teams by June 2016
  ○ Work with the Commission to implement the new perioperative harm QSM during 2015/16, for public reporting in 2016/17
• Sustain achievement above the identified Quality and Safety Marker threshold for the clinical standards specified by the national Surgical Site Infection Improvement Programme for hip and knee operations - ongoing
• 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 and ward quality boards – ongoing
	• Zero grade 3 or 4 pressure injuries over the 2015/16 financial year
	• 60% of patients discharged from Medical & AT&R wards will have a completed eMR (electronic Medicine Reconciliation)
	• Introduction of a standardised pain scoring system and auditing of consistent use of the scoring system by June 2016
	• >80% patients in the national patient experience survey say staff told them about medication side effects to watch for when they went home from hospital, to be achieved by June 2016
	• Hospital mortality ratio (HSMR) maintained or decreased
	  ○ 5% reduction in weekend admission risk adjusted mortality at North Shore Hospital from 109% to 104%

Quality and Safety	
What are we going to do in 2015/16?	How will we know we've achieved it? Measured by
• Continue to implement electronic prescribing and administration, and electronic medicine reconciliation, to be completed by June 2017 • Implement a quality improvement project co-designed with consumers to improve pain management and the safe prescribing and administration of opiate medication by May 2016 **Mortality reviews** • Implement a quality improvement programme to ensure consistent care in hospital and reduced variation in hospital mortality, across the days of the weeks and across the hours of the day (24/7), with the programme implemented and reported on by June 2016 • Improve mortality and morbidity review systems including standardisation of review processes, case selection, and documentation by June 2016 **Care standards** • Implement care standards in each area within the hospitals overseen by a consumer-led multidisciplinary steering group by June 2016 • Commence implementation and monthly auditing of care standards in each area within the hospitals overseen by a consumer-led multidisciplinary steering group in July 2015 **Planning and reporting** • Continue to develop system level measures and a quality measurement framework to help ensure alignment and reporting of measures across the organisation – by June 2016 • Work with services and clinical groups to develop quality plans with and service-specific quality indicators – ongoing • Annual Quality Accounts produced in 2015/16 will be informed by HQSC guidance and will be focused on whole-of-system performance and continuous quality and safety improvement. **Enhanced care management** • Continue to develop and implement the enhanced care management and clinical leadership model training – ongoing • Commence enhanced care management and clinical leadership model development with integrated chronic disease clinical teams developing clinical pathways and integrated care	

Quality and Safety	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
models by December 2015 • Continue to support the primary care patient safety campaign including quality improvement support for primary care teams – ongoing	

Priority populations

The Waitemata population generally has better access to health services and better health status than the average New Zealander. However, despite improvement in the health status of our ethnic populations, inequalities remain. Our aim is to reduce the impact that known modifiable risk factors, including smoking and obesity, have on the health of these population groups, identify and effectively manage chronic conditions, such as CVD and diabetes and ensure equitable access to culturally appropriate health services.

Māori Health and Pacific health – Waitemata's Māori and Pacific populations have higher rates of diabetes and cardiovascular disease and are over-represented in terms of risk factors, particularly smoking. Differences in health outcomes are best illustrated by the gap in life expectancy. In 2014 Māori lived 6.6 years less on average and Pacific people 4.8 years compared with the total Waitemata population. We have already made positive gains for our Māori and Pacific people. With a collective approach from across the health system, we are determined to make further progress.

In 2015/16, we will establish Whānau Ora networks in West Rodney locality and on the North Shore. Services and programmes to improve outcomes for children including immunisations, health lifestyles initiatives and PHO enrolment, have been prioritised. We will continue to implement the objectives described in the Pacific Health Action Plan.

Asian, New Migrant and Refugee health – The Asian population accounted for 19% of Waitemata's population in 2014 and is projected to increase over the coming years. Although our Asian population experiences the highest life expectancy in the district, Asian and migrant populations are often very diverse and have specific health needs that are not generalisable to the entire Asian and migrant population. Our Asian, new migrant and refugee populations require tailored and targeted health interventions and services. We aim to improve access to health services for these population groups and ensure they are culturally and linguistically responsive. This will assist with ensuring improved access and provide early opportunities for intervention, particularly in the areas of CVD and diabetes.

Māori Health	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
Data quality • Develop ethnicity e-learning module by December 2015 • Pilot and evaluate e-learning module by March 2016 • Implement the e-learning tool nationally in a variety of settings in collaboration with the Ministry of Health, DHBs, primary care by June 2016. **Improving access to primary care** • Analyse the proportion of Māori ASH admissions	By achievement of the following national Māori health targets: • 95% of Māori enrolled in PHOs • 75% of Māori aged ≥65 years receive the seasonal influenza vaccine • 68% of Māori babies are fully or exclusively breastfed at 6 weeks • 54% of Māori babies are fully or exclusively breastfed at 3 months • 59% of Māori babies are receiving

Māori Health	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
without a GP recorded and develop an approach to increase enrolment in this group by December 2015 • Develop and implement an initiative to support prisoners released from prison to enrol with a GP and have a free first visit. **Obesity** • Continue to support the implementation of the Healthy Babies Healthy Futures project: o Provide women with key breastfeeding messages through text messaging, community promotion, and support groups – on-going o Continue to work with our Auckland and Waitemata Collective partners to target specific ethnic groups (Māori, Pacific, Asian, Chinese, Korean and Japanese) – on-going o Evaluate the project by June 2016. **Improving the health of older people** • Work with PHOs on the feasibility of developing and implementing an equity focused incentivised Flu vaccination programme for Māori 65+ based in primary care by June 2016 • Offer vaccinator training to registered nurses working with rest homes and other residential settings so they can offer vaccinations to eligible people - ongoing • Develop the capacity of Māori RN workforce by funding Māori nurses within Māori providers to complete the vaccinator's course by March 2016 • Promote vaccinations and record details of Kaumatua and Kuia not vaccinated who are admitted to hospital in collaboration with the He Kamaka Waiora team by June 2016. **Family violence** • Monitor & support implementation of a kaupapa Māori intervention to support whānau to be violence-free. **Screening** • Complete the Abdominal Aortic Aneurism Pilot targeted at Māori men in Wellsford by March 2016. **Primary Care** • Establish a forum for PHOs to support the maintenance of and improve performance against the Māori Health Plan targets by December 2015.	breast milk at 6 months.

Whānau Ora	Better Public Service Target
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**

• Work with Te Haa Oranga to establish a Whānau Ora Network and model of care in the West Rodney locality by June 2016
• Work with Te Puna Hauora to establish a Whānau Ora Network and model of care in the North Shore area by June 2016
• Participate in processes led by the Ministry of Health to obtain a broader health sector view on Whānau Ora implementation, including supporting any providers seeking to set up the Whānau Ora Information System - ongoing
• Work with Pasifika Futures to ensure effective integration between whānau ora and Waitemata DHB funded family support services as well as identify outcomes for families – ongoing quarterly meetings with West Fono Health Trust (the Pacific whānau ora provider for the DHB)
• Establishment of a Board-approved whānau ora alliancing group which includes the Te Whānau O Waipereira Trust (National Maori Urban Maori Authority Whanau Ora Collective member) by March 2016 to support improved:
    ○ Models of care
    ○ Communication
    ○ Information sharing
    ○ Joint service delivery
• Work with Te Pou Matakana and Te Runanga o Ngati Whatua to identify and implement opportunities for co-investment and service co-design - ongoing
• Collaborate with Te Pou Matakana to contribute to the Tamaki Collective impact initiative - ongoing
• Support Te Whānau o Waipereira Trust to develop a Health Needs Assessment for Whānau house as part of the Collective Impact Initiative (to prioritise next service transition) by June 2016
• Continue to provide a forum for Māori providers to support provider development and input to DHB activities - quarterly
	• Whānau Ora Network in the West Rodney locality established by June 2016
	• Whānau Ora Network in the North Shore area established by June 2016
	• Alliancing group established and approved by the Waitemata DHB Board by March 2016
	• Waitemata DHB contracts and whānau ora contracts are aligned by June 2016

Pacific Health	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Implement five Family Violence Prevention programmes, two by December 2015 and a further three by June 2016 • Implement four Parenting Education programmes, two	• Five Family Violence programmes and four Parenting Education programmes are delivered by June 2016 • 400 staff from WDHB and ADHB will

Pacific Health	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
by December 2015 and a further two by June 2016 • Update the database of smoke-free churches to ensure the smoking status of Enua Ola churches are recorded by August 2015 • Provide training for 30 smoking cessation champions from the Enula Ola churches/community groups by June 2016 • Conduct the WERO competition and record the number of church and community groups that participated in September 2015 • Conduct the Aiga Challenge in October 2015 • West Fono will deliver DSME sessions to 180 people by 30 June 2016 • Three parish nurses work with church and community groups to address health needs as identified by health targets and churches/communities, and to develop and implement the Health Action Plans for at least 10 churches and community groups by June 2016 • Monitor and ensure Pacific cancer patients receive treatment that meets MOH timelines - ongoing • Ongoing participation in housing advocacy forums • Support the establishment of two Pacific Health Science Academies for secondary schools in both Waitemata and Auckland DHBs by June 2016 • Set up Pacific nursing and allied health clinical networks for both Waitemata and Auckland DHBs by June 2016.	go through the Pacific Best Practice competency training by June 2016

Asian, New Migrant and Refugee Health	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
Data Quality • Establish complete and accurate breakdown data on level 2 Asian subgroups to guide planning and monitoring of services by June 2016 **Long-Term Conditions** • Ensure access to More Heart and Diabetes Checks for 90% of the eligible population through general practices by 30 June 2016 • Increase communication to South Asian populations on consistent messaging regarding CVD and diabetes risk assessments and healthy lifestyle behaviours linking with community organisation partner outreach initiatives by 30 June, 2016 • Increase health-promoting messages to Asian communities on preventive and healthy lifestyle	• Asian life expectancy remains high (currently 89 years for all Asian, 91.7 for Asian women) • 90% of the eligible population – of all ethnicities – will have had their cardiovascular risk assessed in the last five years, by 30 June 2015, based on accurate ethnicity data collection and reporting protocols • 51% of Indian people with diabetes in the Waitemata DHB district have an annual review by 30 June 2016 • 75% of Indian people with diabetes and have an HbA1c of <64 mmol/mol by 30 June, 2016

Asian, New Migrant and Refugee Health	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
behaviours at community organisation workshops and partner self-management programmes by June 2016. **Child and Maternal Health** • Increase messaging and community support to Asian women and their families to encourage continuation of breast feeding from six weeks to three months, linking with the Maternal and Infant Nutrition and Physical Activity Collective and implementation of Service Plans by June 2016 • Continue to provide input into and support the promotion of Plunket's National Asian Strategy to Asian communities and health services – ongoing. **Women's Health** • Continue to provide free smears for Asian women not screened in the last 5 years or never screened – ongoing • Establish a baseline for Asian breast screening coverage by December 2015. **Health of Older People** • Seek to increase the registration of the CALD module 1 and Health of Older People module for Home-Based Support Services and Age-Related Residential Care workforce. **Smoking** • Translate Quit Smoking resources into two Asian and/or MELAA languages by June 2016. **Refugee Health** • Provide workforce development training to health professionals on refugee health across the Auckland region by June 2016.	• 70% of eligible Asian women have completed a breast screen by June 2016 • 80% of eligible Asian women have completed a cervical smear by 2020 current rate 65% as at September 2014) • 95% immunisation rate in infants aged 8 months and 2 years by June 2016 • At least 55% of Asian infants are fully breastfed at three months of age • Three refugee forums delivered annually across Auckland DHB and Waitemata DHB, with Counties Manukau DHB engagement by June 2016

Fiscal responsibility

We must be a financially sustainable and productive organisation while improving health outcomes and reducing inequalities for our community. 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 (13% of the national population), and the fastest growing of all DHBs.

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 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, $16.9m in 2013/14 were achieved and savings of $8M in 2014/15 is underway. We are forecasting a surplus of $1M for the 2014/15 financial year as planned.

Fiscal Responsibility	
What are we going to do in 2015/16?	**How will we know we've achieved it? Measured by**
• Continue the Business Transformation programme– ongoing • healthAlliance and NZHPL savings programme from procurement and supply chain – ongoing • Support the work of NZHPL 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 service • Consolidate Waitemata and Auckland DHBs' collaboration work streams (e.g. planning and funding, Māori and Pacific health, child health hospital services, health services planning, corporate services, employee relations, call centre) - ongoing • Inventory management of all supplies – ongoing • Pharmac and healthAlliance to work jointly on the national procurement of medical devices for best health outcomes – ongoing • Infrastructure costs/contracts and energy efficiency reviews and savings - ongoing • Rollout Electronic Prescribing as part of Medication Safety Strategy, phase 3 by June 2016 • Development of further joint work streams where applicable with Auckland DHB over 2015/16 • Review older people services and clinical pathways - ongoing • Pursue additional income opportunities over 2015/16. • Maintain long-term capital asset management plan to meet increased demand - ongoing • Contain the growth of Administration and Management FTEs to focus resources on front line services - ongoing • Deloitte's review of direct savings plans and other operational savings to deliver an estimated $11-18M savings.	• Breakeven financial result achieved for 2015/16 and breakeven financial result achieved for each of the out years • Specific business transformation initiatives implemented in prior years and savings achieved have been carried forward to 2015/16 • Agreed collaboration work streams implemented by year end and savings achieved • healthAlliance and Health Benefit Limited savings initiatives implemented and savings achieved by year end • Capped management and administration FTE count maintained at final agreed budget levels throughout 2015/16

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 2015/16 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 2015/16 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 2015/16 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 outcomes framework and intervention logic in Module 1.

Cost of outputs

Waitemata DHB 2015/16 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 ($'000)	Rehabilitation & Support ($'000)	Total ($'000)
	Plan	Plan	Plan	Plan	Plan
Total Revenue	31,527	364,852	985,485	193,569	**1,575,433**
Expenditure					
Personnel	9,655	67,688	463,302	26,155	566,800
Outsourced Services	1,317	11,972	60,418	5,288	78,995
Clinical Supplies	1,697	11,445	84,076	4,211	101,429
Infrastructure & Non-Clinical Supplies	1,481	8,673	81,023	2,554	93,731
Payments to Providers	17,299	264,087	295,507	154,773	731,666
Total Expenditure	**31,449**	**363,865**	**984,326**	**192,981**	**1,572,621**
Net Surplus / (Deficit)	**78**	**987**	**1,159**	**588**	**2,812**

Targets and achievements

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	
On target or better		Achieved	
95-99.9%	0.1% - 5% away from target	Substantially Achieved	
90-94.9%	5.1% - 10% away from target*	Not achieved, but progress made	
<90%	>10% away from target**	Not Achieved	

*and improvement on previous year
** or 5.1-10% away from target and no improvement on previous year

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 CVD the percentage is much higher. Effective prevention services can therefore have a significant impact on health outcomes. From a financial sustainability perspective a quick and effective response to outbreaks, environmental hazards and other emergencies also reduces downstream demands on DHBs for personal health services.

Output: Health promotion

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
% of patients who smoke and are seen by a health practitioner in public hospitals who are offered brief advice and support to quit smoking.	Q	97.9%	95%	Q2 2014/15
% of enrolled patients who smoke and are seen by a health practitioner in primary care who are offered brief advice and support to quit smoking.	Q	99.8%	90%	Q2 2014/15
Number of people accessing Green Prescriptions	V	6182	7033	Q2 2014/15 extrap.
% of decile 1-4 schools engaged in Health Promoting Schools	Q	48.8%	75%	Nov 2014
Enforcement of the Smokefree Environments Act 1990				
Number of retailer compliance checks conducted	V	302	300	2013/14
Proportion of retailers visited during Controlled Purchase Operations (CPOs) in which tobacco is sold to minors	Q	3% (7 retailers)	Ω	2013/14

Output: Health protection

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline Data
Tuberculosis (TB)				
Number of TB contacts followed up	V	1,080	750	2013/14
Percentage of TB and LTBI (Latent TB Infection) cases who have started treatment and have a recorded start date for treatment	Q	83.6%	≥85%	2013/14
Percentage (and number) of eligible infants vaccinated with a BCG	C	98.3% (4,613)	≥98%	2013/14

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	Baseline	Target 2015/16	Baseline data
Breast Screening				
Coverage rates among eligible groups	C	68%	70%	Sept 2014
Bowel Cancer Screening Programme Pilot				
Percentage of people invited to participate who returned a correctly completed test kit	C	54.2%	60%	Round 1 June 2014
Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 55 working days	T	99%	95%	July-Dec 2014
Children				
Percentage of referred children with a completed referral waiting within the contracted timeframe for a Gateway Assessment	T	new measure	85%	
Percentage of B4 School Checks completed	C	86%	90%	May 2015

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.

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. Early detection and management services also enable patient's to maintain their functional independence and prevent relapse of illness.

Output: Primary health care

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Primary care enrolment rates	C	93.1%	95%	March 2015
Percentage of children fully immunised at 5 years	C	78%	90%	Q2 2014/15
Seasonal influenza immunisation rates – 65+	C	63%	75%	Q1 2014/15
HPV immunisation coverage (dose 3)	C	54%	65%	Dec 2014
Cervical screening coverage	C	76%	80%	Dec 2014
Percentage of diabetes patients receiving retinal screening	C	59%	60%	2014/15
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	C	90.2%	90%	Q2 2014/15

Output: Community-referred testing and diagnostics

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Number of community laboratory tests	V	3,723,168	Ω	Oct 2013-Sept 2014
Number radiological procedures referred by GPs to hospital	V	52,976	Ω	2013/14
Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks	T	CT 99% MRI 58%	CT 95% MRI 85%	Dec 2014

◈ Note the data to support this measure is for all three metro Auckland DHBs

Output: Oral health

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Enrolment rates in children under five	C	83%	87%	Dec 2014
Utilisation rates for adolescents	C	64%	85%	2013 CY
Arrears rates	T	6.6%	7%	2014 CY

Output: Pharmacy

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Number of prescription items subsidised	V	6,470,285	Ω	2013/14

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
- Emergency Department services including triage, diagnostic, therapeutic and disposition services.
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative 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.

Output: Acute services

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Number of ED attendances	V	110,989	Ω	2013/14
Acute WIES total (DHB Provider)	V	56,384	56,561	2013/14
Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival.	T	97%	95%	Q2 2014/15
Compliance with Faster Cancer Treatment national health target - 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016 (increasing to 90 percent by June 2017)	T	69.3%	85%	Q3 2014/15
Percentage of eligible stroke patients thrombolysed	T	3.8%	6%	Q2 2014/15
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	Q	81%	80%	Q1 2014/15
Percentage of ACS inpatients receiving coronary angiography within 3 days	T	68.3%	70%	Dec 2014

Output: Maternity

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Number of births	V	6910	Ω	2014
Proportion of all births delivered by caesarean section	Q	30%	↓	2014
Established exclusive breastfeeding at discharge excluding NICU admissions	Q	81%	80%	2014
Third/fourth degree tears for all primiparous vaginal births	Q	3.6%	↓	2013
Admission of term babies to NICU	Q	5.9%	↓	2014
Number of women booking before end of 1st trimester	Q	67%	80%	2013

Output: Elective (inpatient/outpatient)

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Delivery of health target for elective surgical discharges	V	New measure	20,773	2013/14
Surgical intervention rate Joints Cataracts Cardiac PCR Angiogram	C	 25.54 30.54 6.38 15.08 44.66	 21 27 6.5 12.5 34.7	Year ending Sep 2014
Patients waiting longer than 4 months for their first specialist assessment	T	0.18%	0%	Jan 2015
Patients given a commitment to treatment but not treated within 4 months	T	0.38%	0%	Jan 2015

Output: Quality and Patient Safety

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days – HQSC	Q	0.05	↓	2014
Post-operative sepsis and DVT/PE rates - HQSC	Q	8.3 sepsis 6.8 dvt/pe	↓ ↓	2013
Central Line Associated Bacteraemia (CLAB) rate per 1,000 line days	Q	0.70	<1	Jan 2015
In-hospital fractured neck of femur (total) – HQSC	Q	10	↓	CY2013

Output: Assessment treatment and rehabilitation (inpatient)

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
AT&R bed days	V	38,871	Ω	2013/14
% referrals to AT&R seen within 2 working days	T	99.4%	95%	2013/14

Output: Mental health

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Improving the health status of people with severe mental illness				
Access to mental health services Age 0-19 Age 20-64 Age 65+	C	 2.84% 3.43% 2.02%	 3% 3.5% 3.0%	Nov 2013-Oct 2014
Improving mental health services using transition (discharge) planning and employment				
Child and Youth with a Transition (discharge) plan.	Q	26.5	95%	Q2 2014/15
Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.				
% of clients seen within 3 weeks - Mental Health - Addictions % of clients seen within 8 weeks - Mental Health - Addictions	T	83.8% 95.7% 95.6% 99.3%	80% 95%	Oct 2013-Sept 2014

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. 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	Baseline	Target 2015/16	Baseline data
Average number of hours per month of home-based support services for: • Personal care • Household management	V	 64,183 19,001	 Ω Ω	2014/15
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	74%	75%	Q2 2014/15
Percentage of NASC clients assessed within 6 weeks	T	77%	↑	2014/15

Output: Palliative care

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Number of Advance Care Plan conversations recorded in Collaborative Care Management System (CCMS) will increase by 20%	V	1,316	1,579	Target for 14/15
Number completing at least one module of Advance Care training as Level 1 practitioners each year	Q	68	89	Target for 14/15
Number of contacts	V	20,563	Ω	2014/15
Proportion of hospice patient deaths that occur at home	Q	36%	↑	Jul-Dec 2014
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	9%	↓	Jul-Dec 2014

Output: Residential care

Outputs measured by	Notes	Baseline	Target 2015/16	Baseline data
Total number of subsidised aged residential care bed days - Rest homes - Hospitals - Dementia - Psychogeriatric	V	847,743 273,103 451,337 98,059 25,244	Ω	12 months to Sept 2014
Proportion of aged care providers with 4 year audit certification	Q	13%	↑	February 2014

MODULE 4: Financial Performance

Financial management overview

Financial sustainability is critical to our ability to deliver on our organisational promise and purpose. Based on year to date financial performance and expectations for the rest of the 2014/15 financial year, and informed by robust organisational and financial analysis, we are forecasting a surplus of $1m for 2014/15, in line with our 2014/15 Annual Plan. This result reflects continued cost growth containment in our services. Our Business Transformation programme has delivered savings in excess of $80M over the past three years, with savings of $8M planned for the 2014/15 financial year, returning a surplus of $16.7m over the last 4 years. These surpluses have assisted in meeting the growing demand for capital investment to increase our capacity, refurbish our facilities, improve the quality of 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 2015/16 is based on the National Health Board funding envelope advice, with an increase of $31M or 2.4% over the 2014/15 funding envelope.

For the out-years, we have assumed that the funding increase will be 2.0%. Other revenue is based on contractual arrangements in place and reasonable and risk assessed estimates for other income.

Expenditure Growth

Expenditure growth of $32M above the 2014/15 final level is planned for the DHB. 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%). While this has not been expressly stated in the 2015/16 Funding Envelope it is in line with the expectation based on what has been documented in prior year Funding Envelopes. 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)
- A substantial component of Waitemata DHB funded services are provided by other DHBs. On a like for like basis there is a significant increase in Inter District Flow (IDF) expenditure for Waitemata DHB in 2015/16. This expenditure growth is well in excess of equivalent DHB funding and has been budgeted with a five million dollar IDF expenditure savings expectation to be achieved during the year. The budgeted IDF outflow expenditure also includes a reporting reduction of $73M relating to $33M of Community Laboratory expenditure and $40M of Primary Care expenditure now budgeted directly in Waitemata Funder NGO budgets. These services are provided by Auckland DHB for Waitemata DHB in

what is an agency type relationship and are more correctly accounted for directly within Waitemata DHB.

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. These amount to $5.2M in additional savings.

In planning for a breakeven position in 2015/16, 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 Partnership 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 with healthAlliance N.Z. Limited, New Zealand Health Innovation Hub Limited Partnership and Awhina Waitakere Health Campus. The associate companies are Northern Regional Alliance Limited formerly called Northern DHB Support Agency Limited (NDSA) and South Kaipara Medical Centre Limited.

The tables below provide a summary of the consolidated financial statements for the audited result for 2013/14, year-end forecast for 2014/15 and plans for years 2015/16 to 2018/19.

Statement of comprehensive income – parent

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Government and Crown Agency Revenue	1,374,149	1,414,976	1,454,225	1,479,029	1,508,394	1,537,793
Patient Sourced and Other Income	25,552	25,443	28,150	24,990	25,463	25,935
IDFs & Inter DHB Provider Income	76,132	80,880	81,085	82,729	84,374	86,018
Total Funding	**1,475,833**	**1,521,299**	**1,563,460**	**1,586,748**	**1,618,231**	**1,649,746**
Personnel Costs	522,239	552,963	566,801	577,809	589,285	600,755
Outsourced Costs	61,632	74,868	67,023	61,238	62,460	63,681
Clinical Supplies Costs	102,450	108,290	101,429	104,662	106,741	108,819
Infrastructure & Non-Clinical supplies Costs	100,923	106,700	93,731	97,916	99,877	101,835
Payments to Other Providers	686,458	677,478	731,665	742,312	757,057	771,845
Total Expenditure	**1,473,702**	**1,520,299**	**1,560,649**	**1,583,937**	**1,615,420**	**1,646,935**
Net Surplus / (Deficit)	**2,131**	**1,000**	**2,811**	**2,811**	**2,811**	**2,811**
Other Comprehensive Income	**0**	**0**	**0**	**0**	**0**	**0**
Gains/(Losses) on Property Revaluations	38,831	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	40,962	1,000	2,811	2,811	2,811	2,811

Historically, we have performed well financially, with surpluses generated in the past five years and a year-end forecast surplus is 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 2015/16, we are also committed to having a breakeven position.

Statement of comprehensive income – group

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Government and Crown Agency Revenue	1,374,149	1,414,976	1,454,225	1,479,029	1,508,394	1,537,793
Patient Sourced and Other Income	25,875	25,443	28,150	24,990	25,463	25,935
IDFs & Inter DHB Provider Income	76,132	80,880	81,085	82,729	84,374	86,018
Total Funding	**1,476,156**	**1,521,299**	**1,563,460**	**1,586,748**	**1,618,231**	**1,649,746**
Personnel Costs	522,239	552,963	566,801	577,809	589,285	600,755
Outsourced Costs	61,632	74,868	67,023	61,238	62,460	63,681
Clinical Supplies Costs	102,450	108,290	101,429	104,662	106,741	108,819
Infrastructure & Non-Clinical supplies Costs	99,843	106,700	93,731	97,916	99,877	101,835
Payments to Other Providers	686,458	677,478	731,665	742,312	757,057	771,845
Total Expenditure	**1,472,622**	**1,520,299**	**1,560,649**	**1,583,937**	**1,615,420**	**1,646,935**
Net Surplus / (Deficit)	**3,534**	**1,000**	**2,811**	**2,811**	**2,811**	**2,811**
Other Comprehensive Income	**0**	**0**	**0**	**0**	**0**	**0**
Gains/(Losses) on Property Revaluations	38,831	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	42,365	1,000	2,811	2,811	2,811	2,811

Capital costs

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Depreciation	**23,390**	23,899	25,624	26,162	26,680	27,197
Interest Costs	**12,743**	15,329	11,136	14,141	14,422	14,703
Capital Charge	**15,188**	19,032	18,996	18,996	18,996	18,996
Capital Costs	**51,321**	**58,260**	**55,756**	**59,299**	**60,098**	**60,896**

Capital costs are expected to increase with additional capital investments. Increases in depreciation charge are mainly due to our accelerated facilities programme and continued investment in facilities and equipment. 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 on buildings and a full revaluation of land were carried out for the financial year ending 30 June 2014. This is reflected in the increase in Capital Charge in 2014/15 as a result of the full revaluation of land.

Statement of cashflows – parent

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,479,202	1,495,863	1,535,310	1,561,758	1,592,768	1,623,811
Other Income	20,735	19,089	22,140	18,858	19,209	19,560
Interest received	6,281	7,598	6,010	6,132	6,254	6,375
Payments for Personnel	(508,267)	(552,963)	(566,801)	(577,809)	(589,285)	(600,755)
Payments for Supplies	(915,489)	(903,076)	(931,492)	(940,829)	(960,037)	(979,284)
Capital Charge Paid	(15,623)	(19,032)	(18,996)	(18,996)	(18,996)	(18,996)
GST Input Tax	(6,095)	(6,000)	(6,600)	(6,000)	(6,000)	(6,000)
Interest payments	(12,441)	(15,329)	(11,136)	(14,141)	(14,422)	(14,703)
Net cashflow from operating activities	**48,303**	**26,150**	**28,435**	**28,973**	**29,491**	**30,008**
Cashflow from investing activities						
Capital Expenditure (-ve)	(29,825)	(44,468)	(85,652)	(14,000)	(10,500)	(10,500)
Acquisition of investments	0	0	0	0	0	0
Net cashflow from investing activities	**(29,825)**	**(44,468)**	**(85,652)**	**(14,000)**	**(10,500)**	**(10,500)**
Cashflow from financing activities						
Capital contributions from the Crown	0	0	0	0	0	0
Proceeds from borrowings	0	17,300	0	0	0	0
Repayment of borrowings	0	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)
Net cashflow from financing activities	**0**	**16,300**	**(1,000)**	**(1,000)**	**(1,000)**	**(1,000)**
Net cash movements	**18,478**	**(2,018)**	**(58,217)**	**13,973**	**17,991**	**18,508**
Cash and cash equivalents at the start of the year	104,925	123,403	121,385	63,168	77,141	95,132
Cash and cash equivalents at the end of the year	**123,403**	**121,385**	**63,168**	**77,141**	**95,132**	**113,640**

Cashflow forecasts reflect the impact of major capital projects recently completed, under implementation or planned and these include the carpark, Oral Health, Elective Surgery Centre, Taharoto Mental Health Unit, Mason Clinic remedial works, fit-out of the 15 bed gynaecology ward and Waitakere hospital emergency department redevelopment. 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 carpark project loan has been included in the plan.

All Waitemata DHB Crown debt is secured from National Health. As at 1 February 2015, we have debt facility limits of $277.8M, of which $276.7M is drawn. The undrawn facility is the balance on the carpark loan facilities.

Statement of cashflows – group

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,479,202	1,495,863	1,535,310	1,561,758	1,592,768	1,623,811
Other Income	22,091	17,845	22,140	18,858	19,209	19,560
Interest received	6,295	7,598	6,010	6,132	6,254	6,375
Payments for Personnel	(508,267)	(552,963)	(566,801)	(577,809)	(589,285)	(600,755)
Payments for Supplies	(916,105)	(903,076)	(931,492)	(940,829)	(960,037)	(979,284)
Capital Charge Paid	(15,623)	(19,032)	(18,996)	(18,996)	(18,996)	(18,996)
GST Input Tax	(6,095)	(6,000)	(6,600)	(6,000)	(6,000)	(6,000)
Interest payments	(12,441)	(15,329)	(11,136)	(14,141)	(14,422)	(14,703)
Net cashflow from operating activities	**49,057**	**24,906**	**28,435**	**28,973**	**29,491**	**30,008**
Cashflow from investing activities						
Capital Expenditure (-ve)	(29,825)	(44,468)	(85,652)	(14,000)	(10,500)	(10,500)
Acquisition of investments	(370)	0	0	0	0	0
Net cashflow from investing activities	**(30,195)**	**(44,468)**	**(85,652)**	**(14,000)**	**(10,500)**	**(10,500)**
Cashflow from financing activities						
Capital contributions from the Crown	0	0	0	0	0	0
Proceeds from borrowings	0	17,300	0	0	0	0
Repayment of borrowings	0	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)
Net cashflow from financing activities	**0**	**16,300**	**(1,000)**	**(1,000)**	**(1,000)**	**(1,000)**
Net cash movements	**18,862**	**(3,262)**	**(58,217)**	**13,973**	**17,991**	**18,508**
Cash and cash equivalents at the start of the year	105,785	124,647	121,385	63,168	77,141	95,132
Cash and cash equivalents at the end of the year	**124,647**	**121,385**	**63,168**	**77,141**	**95,132**	**113,640**

Statement of financial position – parent

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Current Assets	165,336	165,185	106,968	120,941	138,932	157,440
Non-current assets	592,470	627,318	688,920	677,425	663,917	649,500
Total assets	**757,806**	**792,503**	**795,888**	**798,366**	**802,849**	**806,940**
Current Liabilities	359,588	251,646	252,051	251,648	253,120	254,200
Non-current liabilities	160,321	301,960	302,129	302,199	302,399	302,599
Total liabilities	**519,909**	**553,606**	**554,180**	**553,847**	**555,519**	**556,799**
Net assets	**237,897**	**238,897**	**241,708**	**244,519**	**247,330**	**250,141**
Total equity	**237,897**	**238,897**	**241,708**	**244,519**	**247,330**	**250,141**

A strong asset base is indicated, with total assets planned at $790M by 2014/15 year end reflecting completed capital projects.

Loan portfolio

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Term Loans - Crown (current portion)	(127,198)	(3,710)	(3,710)	(3,710)	(3,710)	(3,710)
Term Loans – Crown (non-current portion)	(132,208)	(272,996)	(271,996)	(270,996)	(269,996)	(268,996)
Total Loans	**(259,406)**	**(276,706)**	**(275,706)**	**(274,706)**	**(273,706)**	**(272,706)**

The size of the loan portfolio has increased by $17.3M in 2014/15 with the new loan for He Puna Waiora – Acute Mental Health Facility being drawn. This loan has been drawn on long term borrowing to maximise the financial impact of the low interest rates and is in line with Waitemata DHB Treasury Policy.

Statement of financial position – group

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Current Assets	168,212	165,185	106,968	120,941	138,932	157,440
Non-current assets	597,287	627,318	688,920	677,425	663,917	649,500
Total assets	**765,499**	**792,503**	**795,888**	**798,366**	**802,849**	**806,940**
Current Liabilities	359,210	251,646	252,051	251,648	253,120	254,200
Non-current liabilities	160,322	301,960	302,129	302,199	302,399	302,599
Total liabilities	**519,532**	**553,606**	**554,180**	**553,847**	**555,519**	**556,799**
Net assets	**245,967**	**238,897**	**241,708**	**244,519**	**247,330**	**250,141**
Total equity	**245,967**	**238,897**	**241,708**	**244,519**	**247,330**	**250,141**

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

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Balance at 1 July	**196,937**	**237,897**	**238,897**	**238,897**	**238,897**	**238,897**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	2,131	1,000	2,811	2,811	2,811	2,811
Other Comprehensive income	38,831	0	0	0	0	0
Total Comprehensive Income	**40,962**	**1,000**	**2,811**	**2,811**	**2,811**	**2,811**
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	**237,899**	**238,897**	**241,708**	**244,519**	**247,330**	**250,141**

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

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Balance at 1 July	**203,602**	**245,967**	**246,967**	**246,967**	**246,967**	**246,967**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	3,534	1,000	2,811	2,811	2,811	2,811
Other Comprehensive income	38,831	0	0	0	0	0
Total Comprehensive Income	**42,365**	**1,000**	**2,811**	**2,811**	**2,811**	**2,811**
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	**245,967**	**246,967**	**249,778**	**252,589**	**255,400**	**258,211**

Additional information

Capital expenditure

	2013/14 Audited $000	2014/15 Forecast $000	2015/16 Plan $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000
Funding Sources:						
Free cashflow from depreciation	23,390	23,899	25,644	25,644	26,162	26,680
External Funding	0	16,300	(1,000)	(1,000)	(1,000)	(1,000)
Cash reserves	73,007	65,572	61,303	295	10,939	25,601
Total Funding	96,397	105,771	85,947	24,939	36,101	51,281
Baseline Capital Expenditure (<$10M)						
Land	0	0	0	0	0	0
Buildings & Plant	(4,892)	(8,591)	(2,844)	(5,000)	(5,000)	(5,000)
Clinical Equipment	(4,189)	(9,621)	(8,185)	(8,000)	(4,500)	(4,500)
Other Equipment	(814)	(672)	(3,399)	(500)	(500)	(500)
Information Technology	(953)	(2,063)	(8,126)	0	0	0
Intangible Assets (Software)	(264)	(226)	(1,150)	0	0	0
Motor Vehicles	(1,464)	(1,151)	(3,330)	(500)	(500)	(500)
Total Baseline Capital Expenditure	(12,576)	(22,324)	(27,034)	(14,000)	(10,500)	(10,500)
Strategic Investments (> $10M)						
Land	0	0	(5,000)	0	0	0
Buildings & Plant	(17,249)	(22,144)	(46,110)	0	0	0
Clinical Equipment	0	0	(1,836)	0	0	0
Other Equipment	0	0	(451)	0	0	0
Information Technology	0	0	(4,693)	0	0	0
Intangible Assets (Software)	0	0	(528)	0	0	0
Motor Vehicles	0	0	0	0	0	0
Total Strategic Capital Expenditure	(17,249)	(22,144)	(58,618)	0	0	0
Total Capital Payments	(29,825)	(44,468)	(85,652)	(14,000)	(10,500)	(10,500)

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

- 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
- Refurbishment of theatres and corridors required to meet current standards for gases and electrical services and updating of consumable store areas
- Detailed planning for the development of a new mini-tower, surgical tower and an ambulatory centre at North Shore hospital and upgrade of the maternity facility at Waitakere hospital
- Extension of the Waitakere hospital Emergency Department is underway, to be completed by April 2016
- First gynaecology ward due to open in October/November 2015 with an additional capacity of 15 beds
- Development of the new Awhina Centre on the North Shore hospital site
- Construction of a bridge between the main North Shore hospital and the Elective Surgery Centre will commence, which will provide easier patient transfer and access to inpatient beds.

Banking facilities and covenants

Term debt facilities

Waitemata DHB has term debt facilities of $277.8M with the National Health Board, of which $276.7M is currently drawn including $17.3M of new Crown debt to finance the He Puna Waiora facility. There are no private sector finance facilities in place for Waitemata DHB.

Shared commercial banking services

Waitemata is in the shared commercial banking arrangements with various other DHBs, Westpac and Health Partnership Limited. Westpac has been selected to provide banking services to the sector. Health Benefits Limited (now Health Partnership Limited) undertook a request for proposal (RFP) process and Westpac was the preferred supplier of banking services. DHBs are no longer required to maintain separate standby facilities for working capital.

Banking covenants

Standard financial covenants put in place by NHB 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 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.

Effective procurement

We will actively work with the Ministry of Business, Innovation and Employment (MBIE) to comply with the government rules for sourcing to undertake procurement efficiently and according to best practice standards. A Strategic Procurement Outlook will be published through MBIE and we will provide an Annual Procurement Plan. This will support achievement of viable and sustainable health services delivered by primary care and other nongovernment organisations, key partners in helping us provide quality healthcare for our population.

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 2015/16 Annual Plan. Input has also been provided for the development of the Northern Region Asset Management Plan (AMP).

We are continuing with the work streams 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. To ensure asset information remains current, it is reviewed as a part of the routine maintenance programme.
- **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 continuing on the development of 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 and implementing a number of options in regards to the affected buildings and the decanting requirements. One occupied earthquake-prone building is to be replaced with the new building that is under construction, scheduled to be completed by April 2015.
- **Motor Vehicles:** The motor vehicle verification and condition assessment exercise was completed and the replacement schedule of vehicles has been reviewed accordingly A coordinated fleet management booking system for Counties Manukau, Auckland and Waitemata DHBs is currently being investigated.
- **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. An updated Health Services Plan will be developed in 2015/16 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:

- 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
- Refurbishment of theatres and corridors required to meet current standards for gases and electrical services and updating of consumable store areas
- Detailed planning for the development of a new mini-tower, surgical tower and an ambulatory centre at North Shore hospital and upgrade of the maternity facility at Waitakere hospital
- Extension of the Waitakere hospital Emergency Department is underway, to be completed by April 2016

- First gynaecology ward due to open in October/November 2015 with an additional capacity of 15 beds
- Development of the new Awhina Centre on the North Shore hospital site
- Construction of a bridge between the main North Shore hospital and the Elective Surgery Centre will commence, which will provide easier patient transfer and access to inpatient beds.

Emergency planning

Waitemata DHB Emergency Systems Planning Team has a comprehensive work plan that meets the requirements of the Operating Policy Framework. The focus is on risk assessment, plans and emergency response processes for the five inpatient and multiple community sites of the provider services as well as planning with the wider DHB agencies and community services. The range of activities ensures the readiness of our DHB to provide a sustainable response whether the emergency situation is clinical or non-clinical. The work plan includes: updated Health Emergency Plans; procedures for managing a range of emergency situations, including evolving infectious diseases and HSNO type emergencies; education/awareness programme for staff and agencies; service specific response plans; and testing of the plans through exercises and table-top reviews with Police, Fire, other DHBs and health provider agencies such as Accident and Medical Centres, residential aged care and primary care.

Waitemata DHB works closely with the northern region DHBs' public health and St John through the Health Coordinating Executive Group to ensure readiness for a regional response. 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. The Waitemata DHB Chief Executive is the regional lead for health in emergency response situations.

Building capability

National and regional programmes

We will contribute to the achievement of the Shared Services Programmes, the Health Promotion Agency, Health Quality and Safety Commission, Health Workforce New Zealand, PHARMAC and National IT Board objectives including:

- Implementation of shared services programmes, e.g. Linen and Laundry and Food Services
- Supporting health promotion agency campaigns, e.g. national health target activities, supporting women to reduce alcohol consumption during pregnancy, alcohol screening and brief intervention
- Continued development of infection control programmes and infection management systems
- Supporting the work of Health Workforce New Zealand, such as expanding the roles of nurse practitioners, clinical nurse specialists and palliative care nurses
- Supporting implementation of national IT initiatives, such as patient and provider portals and the roll out of electronic medicines reconciliation (eMR)
- Supporting National Health Committee strategies to develop improved models of care
- Supporting PHARMAC procurement programmes, e.g. for hospital medical devices.

The DHB will work collaboratively with the NHC to solve sector issues by:

- Engaging with and providing advice on prioritisation and assessments, including through the National Prioritisation Reference Group
- Referring technologies that are driving fast-growing expenditure to the NHC for prioritisation and assessment where appropriate
- Consistently introduce or not introduce emerging technologies, based on NHC recommendations
- Holding technologies, which may be useful, but for which there is insufficient evidence, or which the NHC is assessing for further diffusing or out of business as usual

- Providing clinical and business expertise and research time to design and run field evaluations where possible.

Information communication technology

Information systems are fundamental to our ability to meet the organisation's purpose and priorities. The information vision is to enable clinicians, managers and other information users to provide the best patient care and promote wellness through information systems and access to information. We are committed to improving clinical processes and communication, improving patient experience across the care continuum, improving quality and safety of care, improving accessibility of health information and measuring cost effectiveness of care.

Alignment to the Northern Regional Information Strategy (RIS 2010-20) and the North Region Information Systems Implementation Plan (NRISIP) is important to ensure achievement of these aims. The areas of focus in the NRISIP are infrastructure upgrades, clinical and business system upgrades, improvements in IS processes, capability and capacity, and improved resilience and security of IS systems. Our programmes listed below include regional initiatives from NRISIP.

The principle programmes of work planned for initiation or completion in the 2015/16 year are:

Programme	2015/16 priorities	Components
LeapFrog Programme	This programme will fast-track a set of high priority IT projects, likely to have the greatest impact on enabling the DHB to deliver against its purpose	- Radiology eOrders - Laboratory eOrders - Voice to Text software for clinician recording of clinical documents - eVitals – Decision support tool for recording patients' vital signs
Mobility adoption (also included in LeapFrog suite)	Waitemata DHB will continue to lead the implementation of the regional mobility strategy	This includes wifi infrastructure, Mobile Policy to mitigate the security and privacy risks, and a platform to enable rollout of applications and forms for patients and clinicians
Other new clinical applications and upgrades	These systems and upgrades aim to improve clinical effectiveness and safety, and improve regional alignment	- Regional RIS/PACS Upgrade - Clinical Communication Tool Selection and Implementation - Infection Prevention and Control Software Implementation (regional) - Electronic Ward Whiteboard upgrade and support infrastructure
Infrastructure investment	G2012 Microsoft License Compliance	Includes updated of servers to Microsoft Windows 2008, extended support for MS 2003 and compliance with the Department of Internal Affairs mandate on use of supported software
Primary/ Secondary Care Pathway Improvement under CareConnect	CareConnect is a programme of work to enable clinical partnerships across the health continuum, increase the range of electronic information available through Concerto, and allow patients access to their own health information	- eReferrals. Completion of phases II and III which include triaging, and intra- and inter- DHB referring - Clinical Pathways (Nexxt) - Shared Care Planning (CCMS) - Patient Portal

Programme	2015/16 priorities	Components
Business Intelligence – Tool Implementation and Infrastructure	The aim of the BI Strategy is to improve information access and user experience	- Data warehouse redesign (due for completion 2015/16) - Data discovery BI tool implementation
Compliance with National Programmes, Targets and Collections	Compliance programme	- National Patient Flow Phase III. System and process changes are required in the 2015/16 year to enable compliance with mandatory reporting in the 2016/17 year - iPM upgrade, essential for compliance with National Patient Flow Phase III - Regional Faster Cancer Treatment Phase II compliance. - Public Records Act Compliance. The Enterprise Content Management System (ECMS) implementation will address this compliance
Electronic Health Record Development	The aim of the EHR strategy is to move Waitemata DHB along a logical pathway to a full electronic healthcare record, accessed from a single sign-on. The Implementation Planning Study will be undertaken by the Northern Electronic Health Record (NEHR) Project, a regional group with representation from all four Auckland region DHBs and healthAlliance. The purpose of an IPS is to understand a vendor and their solution in sufficient detail to be able to accurately estimate the scope, cost, time and resource requirements to implement their solution. NEHR will work in partnership with the vendor for several months. The DHBs are not obliged to proceed to implementation, but serve to benefit either way from clear definition of system and process changes required to implement a regional Electronic Health Record.	

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 Ministry of Health as per established protocols. We are supportive of national engagement process through the Health Sector Relationship Agreement and the National Bipartite Action Group. We meet regularly with various unions to discuss issues of mutual interest via joint consultation committees.

We have a standalone recruitment service wholly owned by the DHB providing capability to support best practice recruitment strategies and processes. This enables cost effective recruitment of staff that enhance the organisations ability to improve health outcomes 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 underway or planned.

The DHB has identified ten work streams to progress the key workforce strategy elements related to culture, capacity, capability, change leadership, including achievement of the Regional Health Plan objectives.

The ten work streams are:

1. Planning our future workforce - priority workforces, workforce planning and intelligence, work re-design
2. Culture, values and behaviours - continuation of our values and patient experience programmes
3. Growing our Māori workforce, including implementing Rangatahi Programme cadetships from July 2015
4. Growing our Pasifika workforce
5. Leadership and Management – care re-design, leadership capacity, capability and value
6. Attraction and retention – health, safety and wellbeing, standard safety checks, health science academies and other Rangatahi-based programmes and scholarships
7. Support for our Kaiawhina workforce
8. Learning technologies – e-learning and learning technology solutions
9. Capacity and Capability – cultural competency, working with youth, shared training across the region
10. Regional Workforce planning which includes:
    - Development of clinical leadership through the Leadership Development Programme hosted by Professor Richard Bohmer – further cohorts will be invited to participate
    - Support for initiatives from the medical (including community placements for RMOs), nursing and allied health, technical and scientific workforce taskforce groups facilitated by Health Workforce New Zealand
    - Growing the capacity and capability of our Māori and Pacific Workforce
    - Increasing access to education, training pathways and support for our Kaiawhina workforce
    - Continuing to link closely with our local education partners
    - Jointly working to strengthen priority workforces, such as sonographers, medical physicists and midwives
    - Working together on regional initiatives for education, cultural competency, leadership and management development and health and safety.

Waitemata DHB will work with our regional partners to develop and implement regional workforce strategies with a focus on Government priority areas and targets. We will work with the Regional Training Hub Director to develop and deliver a workforce plan as part of the 2015/16 Regional Service Plan. The workforce plan will outline regional actions and key milestones. Progress towards achieving this by July 2015 will be reported through the Regional Services Plan.

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	657	10	20	688
Nursing Personnel	2,253	88	75	2,416
Allied Health Personnel	1,297	75	98	1,470
Support Personnel	221	47	20	287
Management /Admin Personnel	739	34	40	812
Grand Total	**5,166**	**254**	**253**	**5,674**

Headcount	Other	Pacific	Māori	TOTAL
Medical Personnel	736	11	23	770
Nursing Personnel	2,673	95	80	2,848
Allied Health Personnel	1,521	80	104	1,705
Support Personnel	249	50	21	320
Management/Admin Personnel	842	37	45	924
Grand Total	**6,021**	**273**	**273**	**6,567**

Headcount excludes casual staff
Sourced from Leader, accurate as at 31 December 2014

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. Activity related to implementation of the policy will be reported in our Annual Report.

Checking of the safety of children's workers

The Vulnerable Children's Act 2014 introduces worker safety checks from 1 July 2015 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. In line with expectations of the regulations, we are working with the Ministry of Health on health specific safety checking guidelines.

We have a robust recruitment and selection policy with processes well embedded. Our standard recruitment process includes police 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.

As required by the Vulnerable Children's Act 2014 we will introduce three yearly reassessments for existing employees within two years.

Organisational health

Health and safety

Occupational and workplace safety is important to Waitemata DHB and we have invested in significant audit, process improvement, reporting frameworks and risk management actions over the last year. This year we plan to increase our level of commitment and performance by:

1. Dealing with key health and safety risks promptly, using contemporary approaches in a way that sustains positive and progressive outcomes
2. Developing an organisation-wide health and safety governance body to oversee all health and safety issues in the DHB
3. Refining our process to select, train and give time to our health and safety representatives
4. Benchmarking our key leading and lagging indicators with others in the health sector and those in other sectors considered the 'best of the best'
5. Working collaboratively with the Northern region on a regional Health and Safety strategy, which will include public health promotion strategies in relation to smoking, drug and alcohol, obesity and chronic disease
6. Working with organisations that are the 'best in class' to ensure we continue to aspire to our Health and Safety promise: "To have a safe environment for our people, patients, visitors and contractors, where our health and safety obligations, risks and harms are understood, regularly discussed, assessed and addressed."

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 building a reputation that 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 (including ageing workforce).

In addition, we provide and support a wide variety of programmes on management and leadership development, professional development and healthy workplaces (including resilience, de-escalation, bullying and harassment, health and safety, fire awareness and managing patients during a fire, moving and handling, resuscitation and customer service).

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 and 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;
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 Mana whenua, Te Runanga o Ngati Whatua, and with Te Whānau o Waipareira Trust.

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
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 – may increase primary care access to support hours
Change in model of service delivery	Auckland DHB Waitemata DHB	Mental Health Services and NGO – Eating Disorders Service	Revised funding model will result in adjustments to the model of care
Level and configuration of services	Waitemata DHB	Mental Health Services	Implementation of community residential services for high and complex needs service users
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
Configuration of services	Auckland DHB Waitemata DHB	Mental Health Services	Full implementation of Mother and Baby respite beds and support hours
Change in model of service delivery	One or both DHBs	Home and Community Support Services (HCSS)	Work is underway to achieve an aligned HCSS model at Auckland and Waitemata DHBs; this will result in changes to existing HCSS models at both DHBs. A RFP for this service will be undertaken in 2015/16
Level, location and configuration of services	Auckland DHB Waitemata DHB	Maternity services	Changes and/or enhancements to maternity care under the guidance of the ADHB/WDHB women's health collaboration including to maternity facilities in the district, as determined by both the Auckland and Waitemata Boards in October 15
Change in service provider/s and configuration of services	Waitemata DHB Auckland DHB	Oral health – relief of pain services	Reviewing current service configuration to ensure geographically equitable access to services. Likely to tender for new service provider/s at end of current contract term.
Change in model of service delivery and possible change in service provider	Waitemata DHB Auckland DHB	Pregnancy and Parenting Education service	New or renewed provider/s and/or provider model to be implemented following RFP during 2015/16
Possible change in service provider and/or model of	Waitemata DHB	Youth services	Potential change to provider/s and or service model following evaluation to be conducted in 2015, with any implementation of

Type of service change	DHB	Area impacted by service change	Description of service change
service delivery			recommended changes likely to commence during 2015/16
Change in model of service delivery	Auckland DHB Waitemata DHB	Cervical screening	Subject to decisions taken by the Ministry of Health regarding devolving funding, potential changes to independent service provider model of service delivery across the district – likely to commence during 2015/16.
Change in model of service delivery	Regional	Sexual Health Services	Implementation of new model of care with service specifications established for the regional sexual health services, including priority population groups and increased access to primary care options for all populations
Review model of service delivery	Waitemata DHB – for metropolitan Auckland	Out of Home Respite Services (based at the Wilson Centre, Takapuna)	Waitemata DHB is aware that there are other models of care that could better meet the respite needs of children and families and are seeking to identify an improved model of respite service delivery for the Auckland metropolitan area in partnership with key stakeholders (including families, the Ministry of Health and NGO providers)
Change in location of service delivery	Waitemata DHB	Medical Oncology	Development of a locally delivered medical oncology service as part of the wider regional service.

MODULE 7: Performance Measures

Monitoring framework performance measures

Performance measure	2015/16 National performance expectation/target			DHB target	
PP6 Improving the health status of people with severe mental illness through improved access	**Age 0-19 years**	Māori		3.6%	
		Total		3%	
	Age 20-64 years	Māori		8%	
		Total		3.5%	
	Age 65+ years	Māori		3%	
		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 years	80%	95%	80%	95%
	Addictions (Provider Arm and NGO)				
	Age	≤3 weeks	≤8 weeks	≤3 weeks	≤8 weeks
	0-19 years	80%	95%	80%	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1			0.85	
	Ratio year 2			0.82	
PP11: Children caries-free at five years of age	Ratio year 1			69%	
	Ratio year 2			70%	
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			87%	
	0-4 years - % year 2			95%	
	Children aged 0-12 years who are not examined % year 1			7%	
	Children aged 0-12 years who are not examined % year 2			6%	
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				
Focus area 2: Diabetes Management (HbA1c) - improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control	Narrative quarterly report on DHB progress towards meeting its deliverables for Diabetes Care Improvement Packages (DCIP) identified in the 2015/16 annual plans 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	

Performance measure	2015/16 National performance expectation/target	DHB target
Focus area 3: Acute coronary syndrome services	70% of high risk patients will receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0')	70%
	Over 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	95%
	Over 95% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge	95%
	Report on delivery of the actions and milestones identified in the Annual Plan, including actions and progress in quality improvement initiatives to support the improvement of ACS indicators as reported in ANZACS-QI	
Focus area 4: Stroke Services	6% of potentially eligible stroke patients thrombolysed	6%
	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
	Report on delivery of the actions and milestones identified in the Annual Plan	
PP21: Immunisation coverage (previous health target)	Percentage of two-year-olds fully immunised	95%
	Percentage of five-year-olds fully immunised	90% by end 2015/16; 95% by end 2016/17
	Percentage of eligible girls who have received dose three of HPV vaccine	65% for dose 3
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	
	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care 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	Quarterly narrative progress reports on the following initiatives: • Initiative 1: School-Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities • Initiative 3: Youth Primary Mental Health • Initiative 5: Improve the responsiveness of primary care to youth	
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	
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 are 55% lower than the average over the last 3 years	1.0 per 100,000
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)	95%
	CT and MRI: a. 95% of accepted referrals for CT scans b. 85% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)	 95% 85%
	Diagnostic colonoscopy:	

Performance measure	2015/16 National performance expectation/target		DHB target
	a. 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days) and b. 65% of people accepted for a diagnostic colonoscopy will receive their procedure within six weeks (42 days)		75% 65%
	Surveillance colonoscopy: 65% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date		65%
PP30: Faster cancer treatment	Part A: Faster cancer treatment – 31 day indicator		<10% of the records submitted by the DHB are declined
	Part B: Shorter waits for cancer treatment – radiotherapy and chemotherapy		All patients who are ready for treatment receive treatment within four weeks from decision to treat
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age 0-4 years		To be advised
	Age 45-64 years		
	Age 0-74 years		
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		21 per 10,000
	Cataract procedures		27 per 10,000
	Cardiac surgery		6.5 per 10,000
	Percutaneous revascularisation		12.5 per 10,000
	Coronary angiography services		34.7 per 10,000
SI5: Delivery of Whānau Ora	Provision of a qualitative report identifying progress within the year that shows that the DHB has delivered on its planned Whānau Ora activity and what the impact of the activity has been		
SI6: IPIF Healthy Adult - Cervical Screening	Enrolled women 25 – 69 years who have received a cervical smear in the past three years		80%
OS3: Inpatient Length of Stay	Elective LOS	The suggested target is 1.59 days, which represents the 75th centile of national performance	1.59 days
	Acute LOS	Maintenance of, or improvement on 2013 baseline performance	3.08
OS8: Reducing Acute Readmissions to Hospital	Total population		Improve against baseline
	Individuals aged 75+ years		Improve against baseline
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections Focus area 1: Improving the quality of identity data	New NHI registration in error A. Greater than 2% and less than or equal to 4% B. Greater than 1% and less than or equal to 3% C. Greater than 1.5% and less than or equal to 6%		Greater than 2% and less than or equal to 4%
	Recording of non-specific ethnicity		Greater than 0.5% and

Performance measure	2015/16 National performance expectation/target	DHB target
	Greater than 0.5% and less than or equal to 2%	less than or equal to 2%
	Update of specific ethnicity value in existing NHI record with a non-specific value Greater than 0.5% and less than or equal to 2%	Greater than 0.5% and less than or equal to 2%
	Invalid NHI data updates	Pending
Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS Greater than or equal to 97% and less than 99.5%	Greater than or equal to 97% and less than 99.5%
	National collections file load success Greater than or equal to 98% and less than 99.5%	Greater than or equal to 98% to less than 99.5%
	Standard vs. edited descriptors Greater than or equal to 75% and less than 90%	Greater than or equal to 75% and less than 90%
	NNPAC timeliness Greater than or equal to 95% and less than 98%	Greater than or equal to 95% and less than 98%
Focus area 3: Improving the quality of the programme for Integration of mental health data (PRIMHD)	PRIMHD 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: a. 5% variance (+/-) of planned volumes for services measured by FTE b. 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and 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

Appendix 1: 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
	Cath Cronin	Director of Hospital Services
	Stuart Bloomfield	Chief Information Officer
	Jenny Parr	Acting 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
	TBC	GM Surgical and Ambulatory Services
	Debbie Eastwood	GM Medicine and Health of Older People
	Linda Harun	GM Child, Women and Family Services
	Ian McKenzie	GM Mental Health Services
	Fiona McCarthy	GM Human Resources
	Naida Glavish	Chief Advisor Tikanga (Auckland DHB/Waitemata DHB)

Appendix 2: statement of accounting policies for the year ending 30 June 2016

The following is a summarised description of the accounting policies used in the preparation of this Annual Plan. A full description of accounting policies used by Waitemata DHB as a first time adopter of the new Public Benefit Entity accounting standards for financial reporting, budgeting and forecasting will be provided in the 2014/15 Annual Report that will be published on the website:

http://www.waitematadhb.govt.nz/AboutUs/AnnualReport.aspx

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).

Basis of Preparation

The financial statements have been prepared on a going concern basis, and all the accounting policies have been applied consistently throughout the period.

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 have been prepared in accordance with Tier 1 PBE accounting standards and comply with PBE accounting standards.

The 2014/15 financial statements are the first financial statements presented in accordance with the new PBE accounting standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

Effect of first-time adoption of PBE standards on accounting policies and disclosures

This is the first set of financial statements of the DHB and group that is presented in accordance with PBE standards. The DHB and group have previously reported in accordance with NZ IFRS (PBE).

The accounting policies adopted in these financial statements are consistent with those of the previous financial year, except for instances when the accounting or reporting requirements of a PBE standard are different to requirements under NZ IFRS (PBE) as outlined below.

The changes to accounting policies and disclosures caused by first time application of PBE accounting standards are as follows:

PBE IPSAS 1: Presentation of Financial Statements
There are minor differences between PBE IPSAS 1 and the equivalent NZ IFRS (PBE) standard. These differences have an effect on disclosure only. The main changes in disclosure resulting from the application of PBE IPSAS 1 are the following:

Receivables from exchange and non-exchange transactions
In the financial statements of the previous financial year, receivables were presented as a single total in the statement of financial position. However, PBE IPSAS 1 requires receivables from non- exchange transactions and receivables from exchange transactions to be presented separately in the statement of financial position. This requirement affected the presentation of both current and comparative receivables figures.

PBE IPSAS 23: Revenue from Non-Exchange Transactions
PBE IPSAS 23 prescribes the financial reporting requirements for revenue arising from non exchange transactions. There is no equivalent financial reporting standard under NZ IFRS. The application of this standard affected the Group's accounting for patient care related revenue and research grants. This requirement affected the presentation of both current and comparative receivables figures.

Standards issued that are not yet effective and not early adopted
In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on and after 1 Jul 2014. The DHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting statements was updated to incorporate requirements and guidance for the not-for-profit sector. These updated statements apply to PBEs with reporting periods beginning on or after 1 April 2015. The DHB will apply these updated standards in preparing its 30 June 2016 financial statements. The DHB expects there will be minimal or no change in applying these updated accounting standards.

Summary of 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. These 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 controlled entity 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 Waitakere 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.

The second joint venture is healthAlliance N.Z. Limited, which is a jointly controlled entity. Any contribution of cash or other resources to the joint venture is recognised in the financial statements as an investment in the joint venture entity. The value of the investment in healthAlliance Joint Venture is reviewed annually for any impairment losses. The investment in healthAlliance Joint Venture is accounted for using the equity method.

The third joint venture is New Zealand Health Innovation Hub Limited Partnership, which is a jointly controlled entity. The interest in this joint venture is not accounted for as it is not material to Waitemata District Health Board.

Partnership

Waitemata DHB is party to a Limited Partnership agreement, with 20% share of initial capital contributed to the South Kaipara Medical Centre Limited Partnership established 1 November 2013.

Associate

An associate is an entity over which the DHB has significant influence and that is neither a controlled entity nor an interest in a joint venture. The interests in Northern Regional Alliance Limited (formerly Northern DHB Support Agency Ltd) are not accounted for as they are not material to Waitemata DHB.

Revenue

The specific accounting policies for significant revenue items are explained below:

MOH revenue

The DHB is primarily funded through revenue received from the Ministry of Health (MoH). This funding is restricted in its use being for the purposes of the DHB to meet the objectives specified in its founding legislation and the scope of the relevant appropriations of the funder.

The DHB considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

The fair value of revenue from the MoH has been determined to be equivalent to the amounts due in the funding arrangements.

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 DHB. An annual wash up occurs at year-end to reflect the actual non-Waitemata patients treated at Waitemata DHB.

Donated services

Certain operations of the DHB are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by the DHB.

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Lease receipts under an operating sublease are recognised as revenue on a straight-line basis over the lease term.

Provision of services

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at 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.

Borrowing costs
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 where the DHB is the lessee 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 reasonable 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 to the lessee.

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 as a reduction of rental expense over the lease term.

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 spot exchange rates 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.

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.

Receivables
Short-term receivables are recorded at their face value, less any provision for impairment.

A receivable is considered impaired when there is evidence that the DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

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

Derivative financial instruments
Derivative financial instruments are used to manage exposure to foreign exchange risk and interest rate risks arising from the DHB's operational, financing and investment activities. The DHB has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into and are subsequently re-measured at their face value at each balance date with the resulting gain or loss recognised in the surplus or deficit.

The full fair value of a derivative is classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, the derivatives are classified as non-current.

Bond forward rate agreement (Bond FRA)
Bond Forward Rate Agreement (FRA) is initially recognised at fair value on the date a contract is entered into and is subsequently re-measured at the fair value at each balance date, with the resulting gain or loss recognised in the surplus or deficit.

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.

Inventories acquired through non –exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of costs (using the FIFO method) and net realisable value.

The amount of any write-down for the loss of service potential or from cost to net realisable value 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 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 (including fit outs and underground infrastructure)
- Fixed Dental Clinics and Pads
- Clinical Equipment
- Other Equipment and Motor Vehicles

Land is measured at fair value, and buildings (including, fixed dental clinics and pads) are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings, underground infrastructure, fixed dental clinics and pads are revalued with sufficient regularity to ensure the carrying amount does not differ materially from fair value, and at least every three years.

The carrying values of revalued assets are assessed annually to ensure they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes will be revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense 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 revenue and expense 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 revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or 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 through a non-exchange transaction 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 general funds.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or 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 property, plant and equipment have been estimated as follows:

- Buildings (including components) 6 to 60 years (1.67%-16.67%)
- Underground Infrastructure 35 to 43 years (2.33% to 2.86%)
- Fixed dental clinics and pads (including fit out) 19 to 35 years (2.86% to 5.26%)
- 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%)

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

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

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

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 is 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 3 to 5 years (20% - 33%)

Indefinite life intangible assets are not amortised.

FPSC rights
The FPSC rights represent the DHB’s right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by Health Partnership Limited (NZHPL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Impairment of property, plant, and equipment and intangible assets

Non-cash generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. 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 determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information

If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Payables

Short-term payables 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

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.

A liability and an expense are recognised for bonuses where there is a contractual obligation, or where there is a past practice that has created a contractual obligation and a reliable estimate of the obligation can be made.

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 the:

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

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

Superannuation schemes

Defined contribution schemes
These cover employer contributions to KiwiSaver, the Government Superannuation Fund and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes
The DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis of allocation. The scheme is therefore accounted for as a defined contribution scheme.

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 an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

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 Accredited Employers Programme
The DHB belongs to the ACC Accredited Employers Programme (the Full Self Cover Plan") whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, the DHB is liable for all its claims costs for a period of two years after the end of the cover period in which injury occurred. 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 Accredited 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:

- contributed capital;
- accumulated surplus/(deficit);
- property revaluation reserves; and
- trust funds.

Property Revaluation reserve

This reserve is related to the revaluation of land and buildings to fair value.

Trust funds

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

Goods and services tax

All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense.

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

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.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Glossary

ACC	Accident Compensation Commission
ADHB	Auckland District Health Board
Aiga Challenge	Aiga is Samoan for family. This programme is an 8-week weight loss challenge across Pacific churches/groups within the Enua Ola (Waitemata DHB) and HVAZ (Auckland DHB) Programmes
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
ED	Emergency department
ENT	Ear, Nose and Throat specialty
Enua Ola	A Pacific Church and Communities Health Programme funded by the Waitemata DHB
ESPI	Elective Services Patient Flow Indicators
FSA	First Specialist Assessment (outpatients)
FTE	Full Time Equivalent
GNS	Gerontology Nurse Specialist
GP	General Practitioner
He Kāmaka Waiora	A spiritual foundation of wellness
He Puna Waiora	A pool of wellness
HEADSS assessment tool	A child and youth health assessment tool that considers: home environment, education/employment/eating and exercise, activities and peer relationships, drug use/depression/mood, sexuality/safety and spirituality
HOP	Health of Older People
ICU	Intensive Care Unit
Iwi	Tribe
Kaiāwhina	Support person
Kaumātua	Male elder
Kaupapa	Agenda
Kōhanga Reo	Māori language nest
Kuia	Female elder
LMC	Lead Maternity Carer
LTC	Long-term Conditions

Mana whenua	People who have authority over the land
Mataawaka	Māori living in the Auckland region whose ancestral links lie outside of the Tāmaki Makaurau region
MHP	Māori Health Plan
Mihimihi	Acknowledgement
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)
Pai ora	Healthy futures
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, i.e. by 30 September, 31 December, 31 March or 30 June
RACIP	Residential Aged Care Integration Programme
Rangatahi	Youth
RFP	Request for proposal
SIA	Services To Improve Access
SME	Self Management Education
Tāngata Whai i te Ora	People seeking wellness, mental health service users
Tamiriki ora	Child services
Te Pou Matakana	North Island Whānau Ora Commissioning Agency
Te Runanga o Ngāti Whātua	Ngāti Whātua Tribal Council
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 hui	Meeting with extended family or family group
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