Waitemata
District Health Board
Best Care for Everyone

2016/17

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 2016/17

The Waitemata District Health Board Annual Plan for 2016/17 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

Our Te Tiriti o Waitangi partners

Te Runanga o Ngati Whatua

R Naida Glavish, JP ONZM
Chair, Te Runanga ō Ngati Whatua

Te Whānau o Waipareira Trust

John Tamihere
CEO, Te Whānau o Waipareira Trust

And signed on behalf of:

The Crown

10-4-16.

Hon Dr Jonathan Coleman
Minister of Health

Date

Office of Hon Dr Jonathan Coleman

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

17 NOV 2016

Dr Lester Levy
Chairperson
Waitemata District Health Board
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Takapuna
Auckland 0740

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Dear Dr Levy

Waitemata District Health Board 2016/17 Annual Plan

This letter is to advise you I have approved and signed Waitemata District Health Board's (DHB's) 2016/17 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 make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional $2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year. In order to ensure that the Strategy is informing DHB planning, and in order to ensure value and high performance throughout the health sector, I am considering changes to streamline annual plans in the future and you will be engaged in this process.

Living Within our Means

In order to assist the Government to remain in surplus in 2016/17, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance 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.

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I am pleased to see that your DHB is planning a surplus for 2016/17 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 2016/17.

National Health Targets

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment* health target and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

System Integration including Shifting Services

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift 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 has committed to implement a new after-hours service, increase its investment in clinical pathways over three years, and implement Our Health in Mind priority first-year actions. I look forward to being advised of your progress with this throughout the year. If this activity triggers the service change protocols you will need to follow the normal service change process.

Cross-government Initiatives and Collaboration

Delivery of Better Public Services continues to be a key focus for the Government. 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.

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

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 Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change

that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

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 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

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

cc Dr Dale Bramley
Chief Executive
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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 2016 to 30 June 2020.

Foreword from our Chair and Chief Executive

Waitemata District Health Board (DHB) will experience significant growth in our people, services and facilities in 2016 as we prepare to meet the demands of the largest and fastest growing population of any DHB in New Zealand.

Our Board priorities – to provide *better outcomes* and *enhance patient experience* – guide each new decision and development as we strive to meet our organisational promise of *Best Care for Everyone* in a time of rapid expansion.

In the last 12 months, we have made considerable inroads to deliver on this promise, providing more than 190,000 bed days of care, treatment for 117,000 patients in our Emergency Departments and 18,000 elective surgical procedures. The effect of this is to restore independence, confidence and mobility to many of the thousands of New Zealanders we care for.

The success of our efforts is reflected in the health of our population and the quality and safety of care. The Waitemata district has the highest life expectancy in New Zealand, with the highest survival rates from cancer and the lowest rates of cardiovascular disease and infant mortality. Our hospitals are safe with the lowest standardised mortality rate of any DHB and continued excellent performance across a range of Health Quality and Safety Commission measures.

Key milestones

The past year has seen our DHB invest significantly in new staff, services and facilities:

- The opening of our new $25 million inpatient mental health facility *He Puna Waiora* – 'a pool of wellness' on the North Shore Hospital site
- *Hine Ora*, the DHB's first-ever dedicated women's inpatient ward opened at North Shore Hospital in November
- The DHB's spiritual centre *Ahurewa* to support the spiritual wellbeing of our staff, patients and their families
- An upgrade of Waitakere Hospital's maternity wards improving the experience of West Auckland women and their families using the service
- The establishment of the CARE pilot in North Shore and Rodney to reduce hospital admissions and improve the care of people aged 75 years and over and Māori/Pacific people aged 65 years and over
- An increase in the number of general medical teams at Waitakere Hospital from six to 11, including eight new medical specialists supported by an expanded pool of junior doctors
- A new purpose-built patient discharge lounge on the ground floor of North Shore Hospital.

In addition to these developments, our overall performance remains strong on key health indicators. The DHB achieved the Ministry of Health's *Increased Immunisation* target for the first time in Quarter 2 of 2015, with 95% of all infants in our district completing their primary course of immunisation.

One of the greatest achievements of the past year has been the accelerated rollout of our suite of initiatives to improve the experience of patients in our care. We know from measuring patient feedback that the dignity and respect we demonstrate is recognised and appreciated. We were encouraged to see this work nationally recognised with awards from the Institute of Public Administration New Zealand and the Human Resources Institute of New Zealand. This year will see further development of our patient experience programme with the DHB acknowledging patients as valued partners in their care.

Our focus is firmly on the future with the launch of our Waitemata 2025 programme, which encompasses all our projects to cater for our community a decade from now, when we expect our population to rise to 680,400.

Future focus

Many projects are in progress already to grow our people, services and facilities. These include:

- A major expansion doubling the size of Waitakere Hospital's Emergency Department, providing an entirely fit-for-purpose facility that will meet Waitakere's projected population growth well into the future
- A significant upgrade of Regional Forensic Psychiatric Facilities at the Mason Clinic, with planning underway to develop a new 15-bed unit
- A sky bridge between North Shore Hospital and the Elective Surgical Centre building enabling more complex surgeries to be undertaken at the centre and improved patient transfer flow
- The final two years of the National Bowel Screening pilot successfully bringing the pilot to completion
- A new administrative space for the Division of Medicine at North Shore Hospital, the largest division of its kind in the country
- A significant expansion of child, youth and family mental health services in the Rodney North area, including the development of a new service dedicated to infant mental health
- The development of Primary Birthing unit options in Auckland's North and West.

We expect disciplined financial management will allow us to offer faster access to high quality healthcare without going into financial deficit in the coming year. This is a significant achievement considering the growing demand for our services in an increasingly challenging financial landscape. We will continue to sharpen our focus in 2016 in the knowledge that small changes to our spending and operations can make a significant impact.

There is considerable work ahead to ready our services for the growth projected for our district. We are committed to providing facilities and staffing to meet this need, while continuing to sustain performance improvements and high quality care. As we look ahead to the coming year, we renew our resolve to relieve suffering, reduce inequalities and promote wellness for those in our community. We acknowledge our dedicated workforce for their hard work and commitment to our values as we ready ourselves for another year of significant growth and service to our community.

Dr Lester Levy, CNZM
Chairman
Waitemata District Health Board

Dr Dale Bramley
Chief Executive Officer
Waitemata District Health Board

Te Tiriti o Waitangi

Waitemata DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. In doing so, we commit to the intent of Te Tiriti o Waitangi that established Iwi as equal partners alongside the Crown, with the Articles of Te Tiriti providing the strong foundation upon which our nation was built.

Within a health context, the four Articles of Te Tiriti provide a framework for developing a high performing and efficient health system that honours the beliefs and values of Māori patients, that is responsive to the needs and aspirations of Māori communities, and achieves equitable health outcomes for Māori and other vulnerable members of our communities. We recognise the importance of our Memoranda of Understanding (MOU) partners Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust in the planning and provision of healthcare services in order to achieve this system and Māori health gain.

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 the 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 a collaborative, intersectoral strength-based approach which supports whānau to achieve better health outcomes. The approach places whānau at the centre of service delivery and provides support to empower whānau to lead healthy lives, and contribute to the wellbeing of whānau members and the whānau collective.

About Waitemata DHB

Who we are and what we do

Waitemata DHB is one of 20 DHBs established under the Health and Disability Act 2000. Waitemata DHB is the Government's funder and provider of health services to the 598,000 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.

Did you know? **We are the largest and fastest growing DHB in New Zealand. Waitemata has 598,000 residents and we expect population growth of 18% (90,000 more people) by 2025**

Waitemata DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. We 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 600 other community providers to deliver aged residential care (60 residential care homes offering 3,290 beds), primary care (over 430 GPs), mental health, laboratory (providing more than 3.5 million community lab tests a year), pharmacy (122 pharmacies) and oral health services. Every year, around 80,000 preschool and school aged children are seen at dental clinics.

Did you know? **Over 117,000 people were seen in our Emergency Departments in 2014/15, 42,000 people were seen for the first time by a specialist in an outpatient clinic, and we performed 18,000 elective surgical procedures**

Waitemata DHB receives funding from the Government 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:

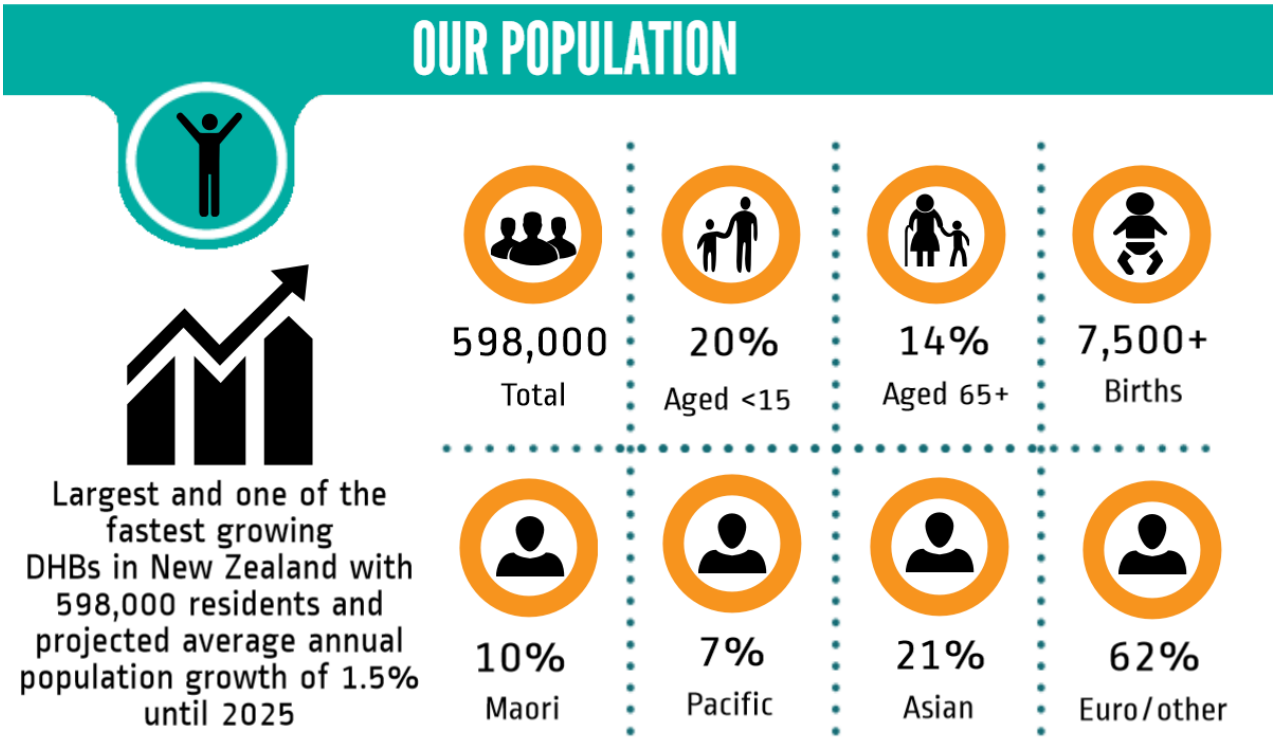
- Improve, promote, and protect the health of communities
- Reduce inequalities in health status
- Integrate health services, especially primary and hospital services
- Promote effective care or support of people needing personal health services or disability support.

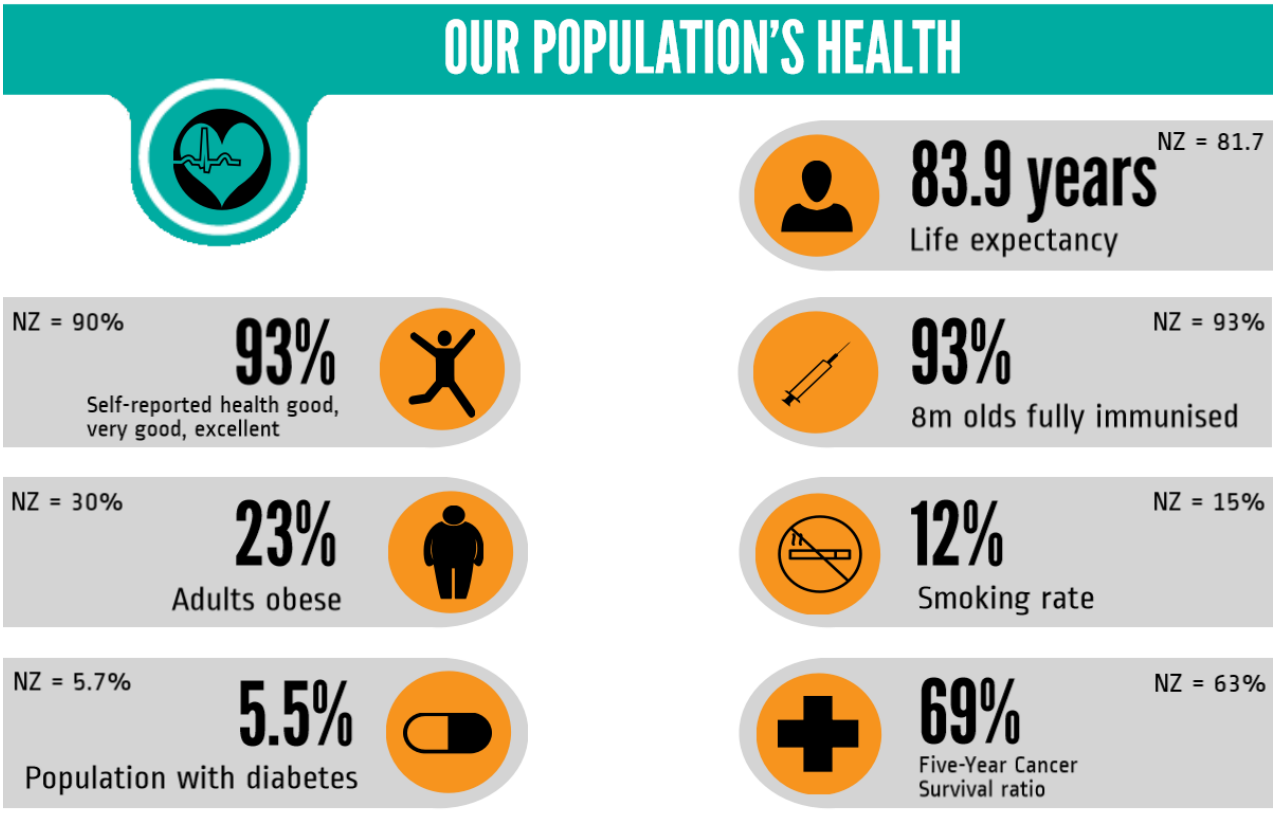
Did you know? **Waitemata DHB employs close to 7,000 people across 31 locations**

DHBs act as 'planners', 'funders' and 'providers' of health services as well as owners of Crown assets. Our 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, this Annual Plan and the Waitemata DHB's Māori Health Plan.

Did you know? **Our budget in 2016/17 is $1.6 billion**

Population Profile





Our achievements

WE ARE HEALTHY We are the healthiest population in New Zealand and our life expectancy is the highest nationwide. Our mortality rates from cardiovascular disease (CVD) and cancer are declining and are among the lowest in New Zealand, as are our rates of smoking. Our five-year survival rate for those diagnosed with cancer is the highest of any DHB	Life expectancy – 83.9 years (2014) CVD mortality – 79/100,000 (NZ = 106) Cancer mortality – 114/100,000 (NZ = 124) Smoking rate – 12% (2013) Cancer survival (5 year) – 69.2%
OUR CHILDREN GET A GREAT START Children in our district are getting the best start to life. We have the lowest infant mortality in New Zealand and we have highly successful health promotion and prevention programmes	Infant mortality – 2.3/1,000 Immunisation at 8 months – 93% Immunisation at 24 months – 92% B4SC rate – 93%
WE ARE TACKLING INEQUALITIES Life expectancy among our Māori and Pacific population is among the highest in New Zealand. Immunisation coverage and cancer screening rates among Māori and Pacific are improving, with Pacific breast screening rates above the overall rate for the DHB	Māori life expectancy – 77.7 years Pacific life expectancy – 79.6 years Cervical screening: Māori – 57% Cervical screening: Pacific – 73% Breast screening: Māori – 59% Breast screening: Pacific – 75%
WE PROVIDE HIGH QUALITY CARE Our hospitals are providing safe, high quality and compassionate care. We achieved excellent results across the Health Quality and Safety Commission (HQSC) markers and our current Hospital Standardised Mortality Ratio is the lowest in the country	HQSC markers: Falls risk assessment – 99% Hand hygiene – 81% Antibiotic given pre-surgery – 98% HSMR – 0.78
WE ARE LIVING WITHIN OUR MEANS We have lived within our means for the past five years and generated a surplus in 2014/15. We have continued to invest in growing our frontline staffing numbers to keep up with demand while creating efficiencies in back office functions	$4.3M surplus forecast in 2015/16 Clinical FTE increased 34% since 2009 Admin staff increase 4%
WE ARE INVESTING IN NEW FACILITIES We are making significant investments in state-of-the-art, modern facilities and services with significant plans in place to continue developing our facilities to meet future demand	He Puna Waiora – new mental health facility – opened in April 2015 Hine Ora – women's inpatient facility – opened in November 2015




The key challenges we are facing

Over the next ten years:

- **Growing and aging population** – the population will increase to approximately 680,400 by 2025 and the 65+ population will double over the next 20 years; combined with growth in demand, this will place considerable pressure on heavily utilised services and facilities, including primary and community health services (older people currently occupy around 45% of beds)
- **Prevention and management of long-term conditions** – the most common causes of death are cancer (32%), cardiovascular disease (28%) and respiratory disease (8%); a large proportion of these are avoidable (27%, or 736 deaths)
- **Health inequalities** – particular populations in our catchment continue to experience inequalities in health outcomes. This is most starkly illustrated by the gap in life expectancy of 6.3 years for Māori and 5.3 years for Pacific compared with other ethnicities
- **Patient-centred care** – patients, whānau and our community are at the centre of our health system. We want people to take greater control of their own health, be active partners in their own care and access relevant information when they need it
- **One system** – we need to ensure healthcare is seamless across the continuum and reduce disconnected and replicated services, as well as fragmentation of data and information between and across hospital, community and other services
- **Financial sustainability** – the financial challenge facing the broader health sector and Waitemata DHB is substantial; the current trajectory of cost growth is estimated to outweigh revenue growth by 2025.

Given the aforementioned challenges, we have identified the following risks as being relevant for 2016/17, as well as 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 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: • Continued focus on upstream interventions to improve the social and economic determinants of health, 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.

Health and Safety

At Waitemata DHB, the health, safety and wellbeing of our people is one of several strategic priorities for the Board. More detail on this and our work-plan for the coming year to increase our level of leadership, commitment and performance can be found in Module 5.

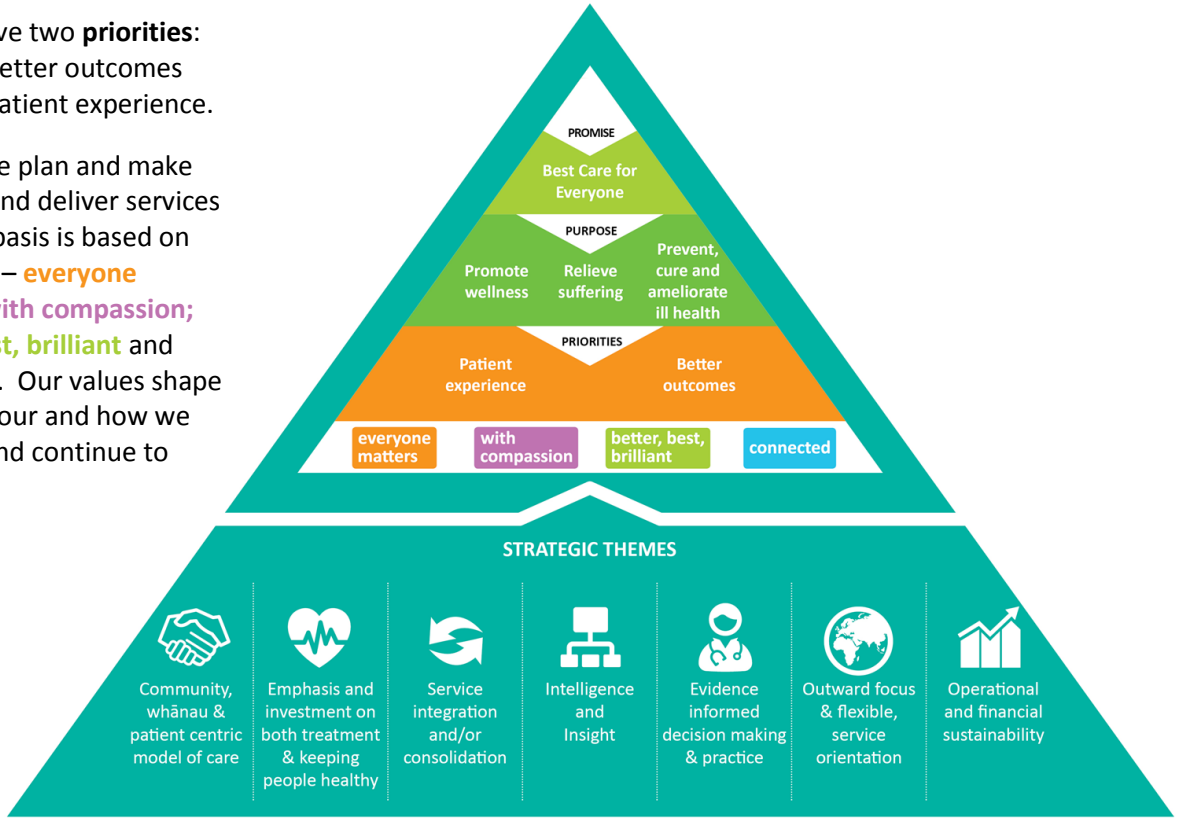
Our strategic direction

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 deliver the **'best care for everyone'**. This means we strive to provide the best care possible to every single person and their family engaged with our services. We put patients first and are relentless in the pursuit of fundamental standards of care and ongoing improvements enhanced by clinical leadership.
- Our **purpose** defines what we strive to achieve, which is to:
  - Promote wellness
  - Prevent, cure and ameliorate ill health
  - Relieve suffering of those entrusted to our care.
- We have two **priorities**:
  - Better outcomes
  - Patient experience.

The way we plan and make decisions and deliver services on a daily basis is based on our **values** – **everyone matters; with compassion; better, best, brilliant** and **connected**. Our values shape our behaviour and how we measure and continue to improve.



Alongside our promise, purpose and priorities sit a number of **strategic mandatories** – essentials that underpin everything we do. These are:

- **Patient safety** and **workplace safety**
- **Equity**
- **Integrity**
- **Cultural awareness**
- **Sustainability**
- **Risk management**.

Strategic Themes

In order to realise our promise of providing '**best care for everyone'** a strategic 'shift' is required from our current state to achieve a system that is focused on the broader management of health. Our strategic themes provide an overarching framework for the way our services will be planned, developed and delivered in the future. They highlight the need for us to organise our efforts in a different way to deliver more for our population.

Community, family/whānau and patient-centred model of care

Patients, whānau and our community are at the centre of our health system. The quality of the patient and whānau experience, and their outcomes, should be the starting point for the way we think, act and invest. Our focus is on empowering people to achieve the health outcomes they want.

Emphasis/investment on treatment and keeping people healthy

We are investing in our people, services and facilities across the spectrum of care, with increasing investment in preventing ill health. Lifestyle and preventative programmes and primary and community based services will increase wellness and reduce the need for hospital admission. Resources will be targeted at high needs communities.

Service integration and/or consolidation

We need to **work collaboratively** to ensure that services are delivered by the best provider in the right place. We will focus on **what we do best** deliver higher standards of care through dedicated centres of excellence, and more local health care.

Intelligence and insight

The dynamic use of data, information and technology will improve clinical decision making and develop our health insights. Data will be used to support quality improvement, population health management and innovation. Patients will have greater access to information via new technologies.

Consistent evidence informed decision making practice

Delivering safe and high quality care is an integral part of our culture. Evidence from research, clinical expertise, patients and whānau, and other resources will drive our decisions.

Outward focus and flexible service orientation

We put patients first and strive for fundamental standards of care. We must have an openness to change, improve and learn and be outward focused and flexible. Strong clinical leadership is embedded at all levels of the organisation. We are an advocate for the health of our population.

Operational and financial sustainability

Operational and financial sustainability is critical to our ability to deliver on our organisational promise and purpose. We need a longer-term view. To achieve more with the funding we have we will work with others to develop the best service configuration and optimise models of care for efficiency and the best health outcomes. Our workforce must have the highest standard of expertise.

Delivering on our strategic direction

Our focus is on improving our patients' experience while achieving their best possible health outcomes. In the immediate term, our focus is on effectiveness and quality of care. We aim to improve patient outcomes with several initiatives to improve clinical outcomes as determined by our medical staff. This is being achieved by standardising care through clear pathways, implementing evidence-based care and focusing on quality improvement initiatives, such as rapid access to theatres for hip fracture patients.

We want services to be more accessible for patients – we will review our outpatient services with the appropriate use of virtual clinics, telehealth, group and self-booking models. We will promote self-care and prevention by investing in and supporting patient education and remote monitoring and data collection for high impact populations (e.g. patients with cardiovascular disease and diabetes). We will continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services, including shifting services, to ensure patients receive more effective and co-ordinated services closer to home and provided by one team.

Several current Waitemata programmes align well to our strategic direction and are underpinned by our strategic themes, listed below. We expect these strategic themes to be embedded at every organizational level and to drive all decision making and programme development in the future. The themes will help us to determine where to invest our resources and help us identify the most important areas to focus on.

Programme	Description
The Waitemata Experience programme	A co-design programme focused on delivering an excellent experience for patients, whānau and staff
Waitemata 2025	Our programmes to develop the people, services and facilities needed over the next 10 years to meet our anticipated growth
Clinical leadership programme led by Professor Richard Bohmer	Leadership and training programme for health professionals – completed by 120 staff to date
Population health programmes	Including smokefree, obesity, children's health, cardiovascular disease, diabetes, cancer, mental health (e.g. Our Health in Mind), Māori and Pacific health, to deliver the best health outcomes for our population
The Institute of Innovation and Improvement	Design and implementation of new models of care and best practice care processes
Patient Safety and Quality Improvement Programme	Consolidate and embed quality outcome measures within divisions and reporting, and support open and transparent reporting on our performance
LeapFrog programme	Key organisation-wide projects are supported to achieve significant change and instil a culture of improvement and innovation. These include enhancements to our mobile IT devices, WiFi access, transcription and voice-to-text capability, electronic ordering systems, clinical decision support tools, improved outpatient follow-up and data collection and reporting on patient experience
Information systems and business intelligence tools	Commitment to development of the Northern Electronic Health Record, adoption and development of business insight tools to better use our data to inform decision making and improve services for our population
Provider sustainability programme	To improve service efficiency and performance, e.g. Early Discharge Rehabilitation Service for stroke patients, Transitional Care Unit

National, regional and sub-regional strategic direction

National

Waitemata DHB operates collectively as part of a national health system. The overall direction and outcomes for the health sector are set by the Minister's expectations. For 2016/17, these are:

- Refreshed New Zealand Health Strategy
- Living within our means
- Working across Government
- Shifting and integrating services
- National Health Targets
- Tackling obesity
- Health IT programme 2015–2020.

Waitemata DHB is committed to actively working with other agencies to achieve the sector goals related to the Government's Better Public Services initiatives – particularly focusing on vulnerable children and families, and reducing unintended teenage pregnancies. We will continue to work with New Zealand Health Partnerships Limited to progress the 2016/17 initiatives.

Waitemata DHB is working in collaboration with the Paediatric subgroup of the Spinal Cord Impairment (SCI) Governance Group (with national representation on the subgroup) regarding integrated rehabilitation. This subgroup is engaged in the development of pathways and protocols for SCI. The subgroup monitors and reports against the SCI Action Plan.

The New Zealand Health Strategy was published recently. The refreshed strategy provides DHBs with a clear direction and road map to deliver more integrated health services. Waitemata DHB is committed to delivering on the Strategy's over-arching vision of 'All New Zealanders live well, stay well, get well'.

The overarching vision and the five strategic themes are illustrated in the diagram below. Details of the actions we are taking to contribute to the New Zealand Health Strategy are set out in Module 2A.

Regional

The Northern Region Health Plan (NRHP) has been developed by the four Northern Region DHBs and primary care Alliance Partners; it provides an overall framework to demonstrate how the Government's objectives and the region's priorities for regional work will be met during 2016/17 and beyond.

The Northern Regional Alliance (NRA) oversees the NRHP. The NRA continues to ensure regional alignment of plans, and appropriate stakeholder representation and involvement, by having clinical network and workgroup memberships drawn as appropriate from each of our region's DHBs and with representation from across the primary-secondary continuum of care.

The overall direction and strategic intent of the 2016/17 NRHP is to achieve gains across the Triple Aim Framework and reflect the themes of the draft New Zealand Health Strategy.

Sub-regional

Waitemata and Auckland DHBs have a bilateral 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

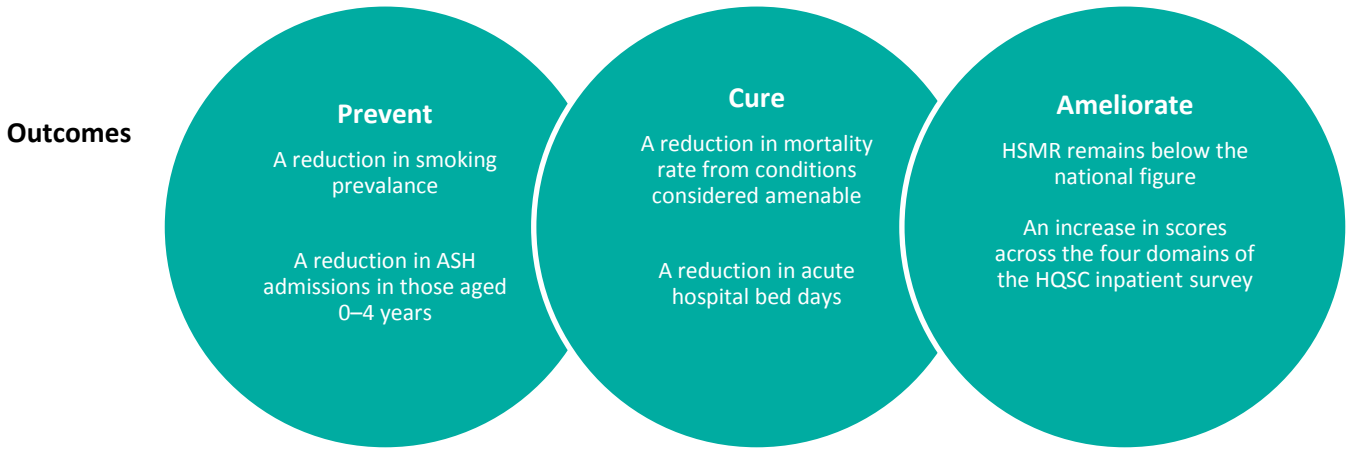
The intervention logic and outcomes framework for Waitemata DHB summarises the key national and local priorities that inform this 2016/17 Annual Plan, and demonstrate our commitment to an outcome-based approach to measuring performance, including the key measures we monitor to ensure that we are achieving our objectives. Our outcomes framework enables the DHB to ensure it is achieving its purpose and delivering the best possible outcomes across the whole system for our population.

We have identified two overall population health outcome goals. These are:

- Highest life expectancy in New Zealand;
- Reduce the difference in health outcomes between ethnic groups.

Outcome measures and supporting impact indicators have been identified that will support achievement of these overall goals. The outcome measures are long-term indicators (up to 10 years in the life of the health system); therefore, the aim is for a measurable change in health status over time, rather than a fixed target. We will report on progress against these measures in the DHB's Annual Report.

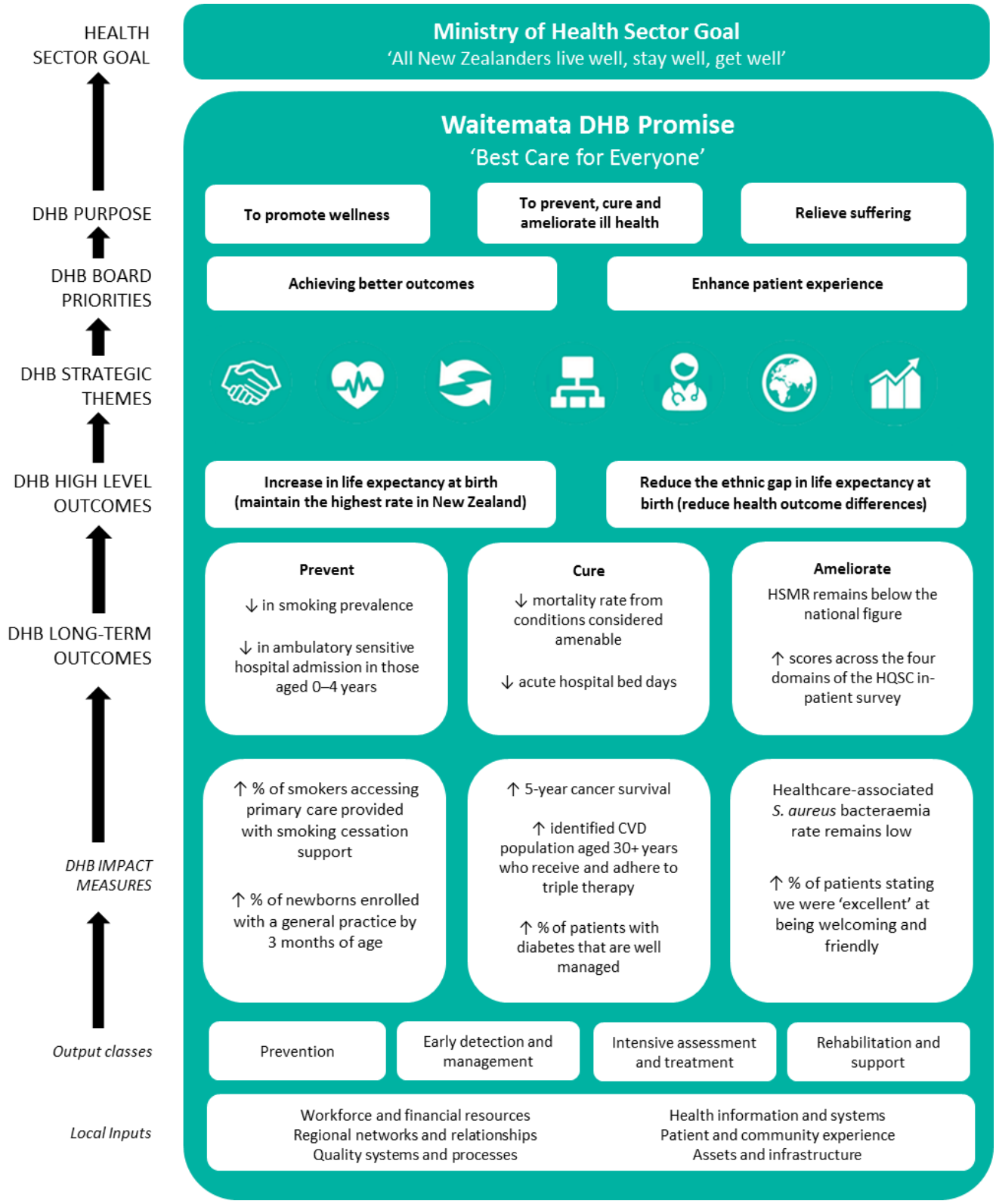
Our outcome and impact measures are summarised below and presented in the intervention logic diagram on the following page. The diagram demonstrates how the services that we choose to fund or provide (outputs) will impact the health of our population and result in the achievement of desired longer-term outcomes and the expectations and priorities of Government. The Statement of Performance Expectations in Module 3 details a set of output indicators that contribute to our overall outcomes framework, and we will report against these in the DHB's Annual Report.



Impact measures

- An increase in smokers accessing primary care provided with smoking cessation support
- An increase in newborns enrolled with a general practice by 3 months of age
- An increase in 5-year cancer survival
- An increase in identified CVD population aged 30+ years receiving triple therapy
- An increase in diabetics that are well managed
- Healthcare-associated *S. aureus* bacteraemia rate remains low
- An increase in the percentage of patients stating we were 'excellent' at being welcoming and friendly

Outcomes framework and intervention logic



Note: two new system level outcome measures will be introduced in 2017/18 – number of babies who live in a smokefree household at 6 weeks post-natal and youth access to and utilisation of youth appropriate health services.

Overall outcomes

The overall outcomes that we want to achieve are an increase in life expectancy (measured by life expectancy at birth) and to reduce ethnic inequalities (measured by the ethnic gap in life expectancy).

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 have the highest life expectancy in the country at 83.9 years (2013–15), which is 2.2 years higher than New Zealand as a whole. Half of this difference in life expectancy between New Zealand and Waitemata is attributed to our lower mortality rates from cardiovascular disease and cancer. In Waitemata, life expectancy has increased by 2.7 years over the last decade, which is 0.4 years more than New Zealand.

Over the longer term, we aim to continue to have the highest life expectancy in the country and maintain a 2.7 year increase in life expectancy over the next decade.

Outcome Measure – An increase in life expectancy at birth

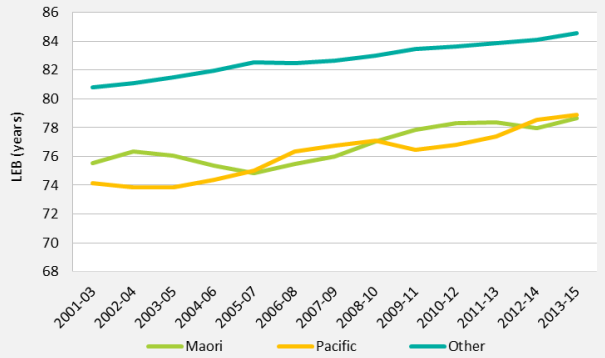
Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used.

Overall outcome – Reduce ethnic differences in health outcomes

Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 5.9 years for Māori and 5.7 years for Pacific (2013–15). Although life expectancy has increased in our Māori (2.6 years) and Pacific (5.0 years) populations over the past decade, the gap has increased slightly for our Māori population and reduced by nearly 2 years in our Pacific population.

Mortality at a younger age from diseases of the circulatory system and cancers account for around 3.1 years of the life expectancy gap (2010–12, compared with European and other) in Māori, and around 3.7 years of the gap in Pacific. We expect a reduction in the gap in life expectancy over the next decade, declining at at least the same rate as observed in the last ten years.

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



Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. 'Other ethnicity' includes non-Māori/non-Pacific ethnicities

Prevent ill health – support people to lead healthier lives

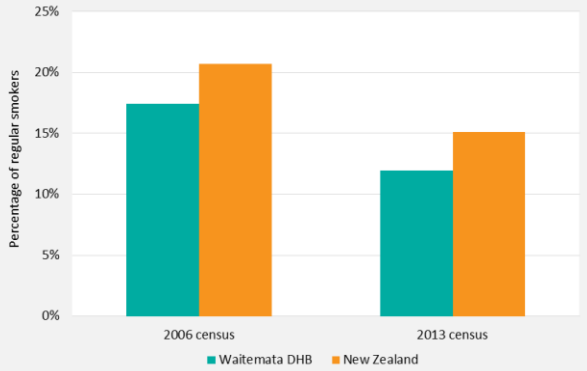
We encourage people to take responsibility for their health by making healthy lifestyle choices and engaging in preventative strategies, such as childhood immunisation programmes and promoting access to primary care services. We are focussing on smoking and ambulatory sensitive admissions in children.

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.

New Zealand Census data shows adult smoking rates in Waitemata have declined from 17.4% in 2006 to 12.0% in 2013, and remain lower than those observed nationally.

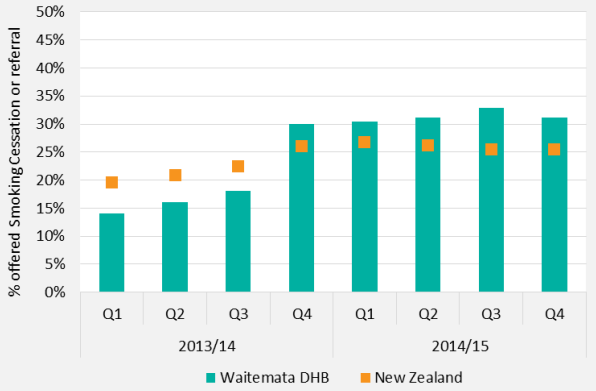
Outcome measure – a reduction in smoking prevalence



Brief advice to stop smoking and an offer of cessation support by a health professional can significantly increase the number of people who attempt to, and succeed in, stopping smoking. Many people who attempt to quit will 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 an increase in the proportion of smokers accessing primary care who are provided with smoking cessation support. Our aim is to continue this trend and ensure we are supporting smokers in their quit attempt.

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



Outcome – Children receive the best start to life

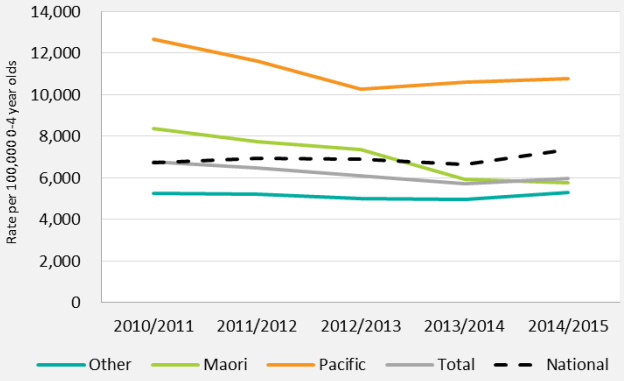
Ensuring that children have the best start to life is crucial to the health and wellbeing of the population. Well integrated, high quality primary and community services can maintain good health, prevent health problems and improve health outcomes.

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital that are considered reducible through preventative or therapeutic interventions delivered in primary care. ASH rates highlight the burden of disease in childhood with a strong emphasis on health equity.

In the 12 months to June 2015, there were 5,964 admissions per 100,000 in our 0–4 year old population (2,338 events) that were considered to be ambulatory sensitive.

Our aim is to reduce this to below the national average and reduce the gap in equity for our Māori and Pacific children.

Outcome Measure – a reduction in ambulatory sensitive hospital admissions in those aged 0–4 years



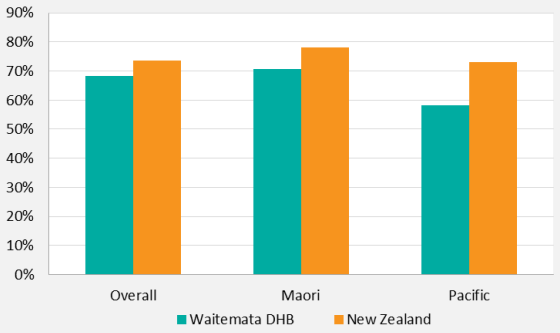
Outcome – Children receive the best start to life

Ensuring babies have been enrolled with a general practice soon after birth means they can receive essential health care, including immunisations and other health checks on time.

Research shows that an established relationship with the primary health care provider is a critical factor in the timely delivery of health care for young children.

The percentage of newborns enrolled with a general practice by three months of age as at Q4 2014/15 was 68%. This is lower than the national rate and among the lowest in the country. Enrolment has increased slightly from 67% in the previous year. Significant inequalities exist, with only 58% of Pacific children enrolled with a general practice by three months of age.

Impact Measure – An increase in newborns enrolled with a general practice by three months of age



Cure ill health – support people to stay well with early detection and effective treatment

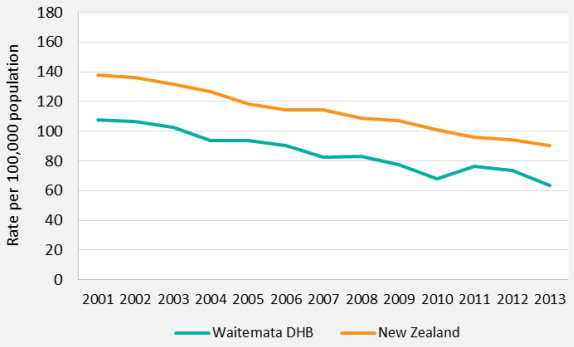
We aim to improve the detection and management of disease as well as providing rapid access to effective treatment for patients when they need it. Significant progress has been made in improving the management and treatment of ill health. This is reflected in our declining rates of mortality from conditions considered amenable to health care intervention. 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 rates of amenable mortality

Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist.

The rate of amenable mortality has steadily decreased over the past decade and is among the lowest in New Zealand at 63.7 per 100,000 population. In 2013, we estimate that 444 deaths (44.4% of all deaths in those aged under 75 years) in Waitemata DHB were amenable. We aim to continue the reduction in amenable mortality at the same rate observed over the past decade.

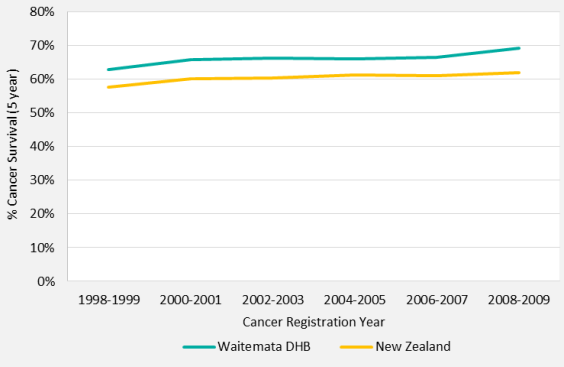
Outcome Measure – A reduction in the mortality rate from conditions considered amenable



Cancer survival is a key indicator of the impact of cancer on society. It is also a valuable way of measuring the success of our 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 2008–2009, the five-year survival ratio was 69.2% (one of the highest in the country), meaning that among those diagnosed with cancer, the cancer reduced the likelihood of surviving five years after diagnosis by 30%. Of 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



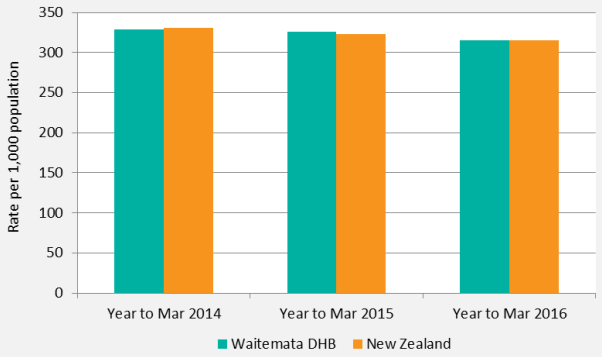
Outcome – A reduction in acute hospital bed days

Acute admissions account for approximately one third of all hospital admissions in New Zealand. The consequences of increasing numbers of acute admissions include: the fiscal challenges, a reduced ability to undertake non-urgent work, increased pressure on staff and difficulties with planning staffing levels.

Our standardised rate of acute bed days has declined slightly since 2014 (329 per 1,000 population to 315 per 1,000 population) and remains similar to the National rate.

A focus on reducing acute hospital admissions will, in the short term, consider the effectiveness of interventions to manage chronic disease and, in the longer term, the importance of preventing the development of these diseases.

Outcome Measure – A reduction in acute hospital bed days

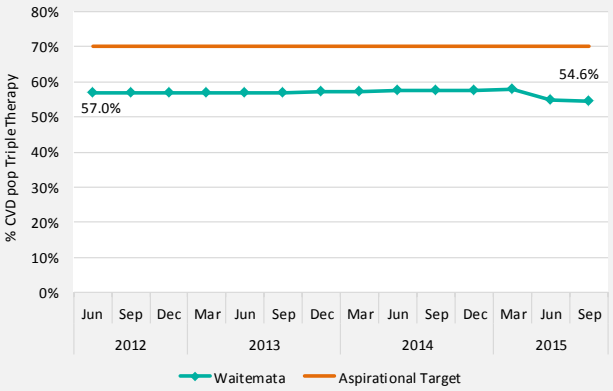


*Age standardised rate

Current New Zealand guidelines recommend that people who experience a heart attack or stroke (where appropriate) should be treated with a combination of medication known as triple therapy (aspirin or another antiplatelet/anticoagulant agent, a beta blocker and a statin). The National Cardiac Network has agreed that our aspirational target should be 70%.

We intend to make sure that our patients who have had a CVD event are receiving the best possible care. Currently, 55% of our population who have had a CVD event are prescribed ongoing triple therapy medication.

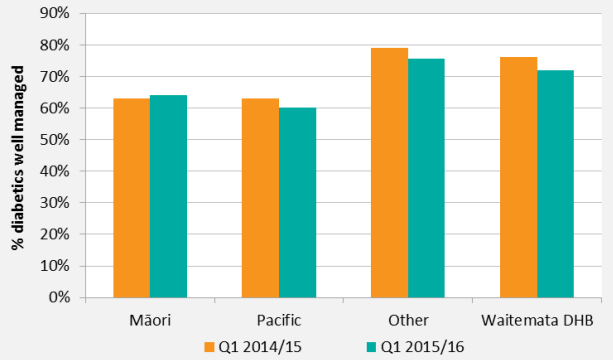
Impact Measure – An increase in the identified CVD population aged 30+ years receiving triple therapy medication



Diabetes is a chronic illness that requires continuous medical care, patient self-management and education to reduce the risk of acute and long-term complications. How well a patient is managing their diabetes can be monitored through assessment of their HbA1c (an indicator of glycaemic control).

In Q1 2015/16, 72% of our patients with diabetes were managing their condition well when checked at their annual review. However, significant inequalities exist within our population. Only 64% of Māori and 60% of Pacific patients with diabetes are well managed. There is significant room for improvement for our Māori and Pacific populations, which will likely lead to a reduction in diabetic complications in these populations.

Impact Measure – An increase in patients with diabetes that are well managed at their annual review



Ameliorate ill health – relieve suffering and enhance quality of life with safe, high quality and compassionate services

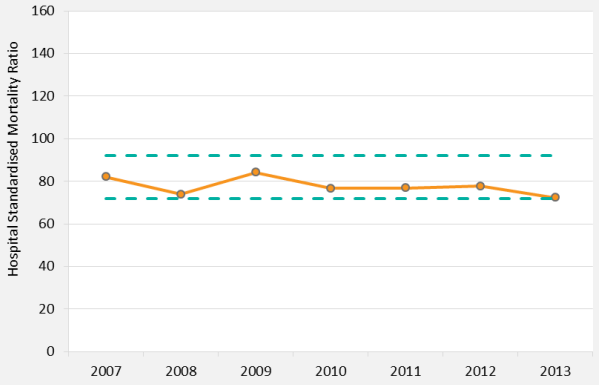
Health services play a major role in providing care and treatment when people are experiencing less than optimal health. The experience patients have when encountering our services is as important as clinical effectiveness and safety. It is vital that the services we provide are of the highest quality, safe and that we meet the physical and emotional needs of the patient.

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 average of all national hospitals is an HSMR of 100, thus an HSMR under 100 indicates a hospital has a lower hospital mortality than the national average. Our HSMR (72, 2013) has consistently been lower than the national figure and remains one of the lowest In the country. This is a significant accomplishment and we aim to maintain this performance in the longer term.

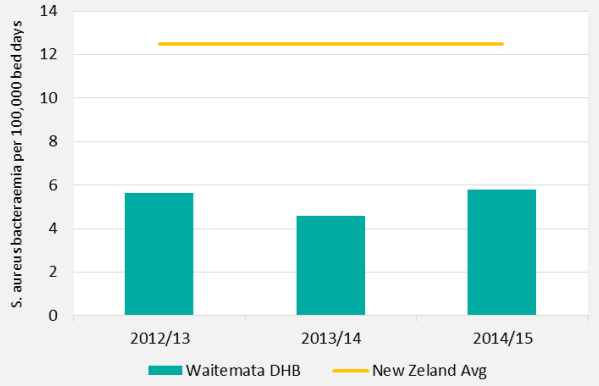
Outcome Measure – A reduction in the Hospital Standardised Mortality Ratio



Healthcare-associated infections can develop either as a direct result of healthcare interventions (such as medical or surgical treatment) or from contact with a healthcare setting. These infections pose a serious risk to patients, staff and visitors. They can incur significant costs for the DHB through treatment and increased length of stay, and cause significant morbidity to those infected.

Our rate of healthcare acquired *Staphylococcus aureus* bacteraemia per 100,000 bed days is among the lowest in the country and has remained well below the national average for the last 3 years.

Impact Measure – Healthcare-associated *S. aureus* bacteraemia rate remains low

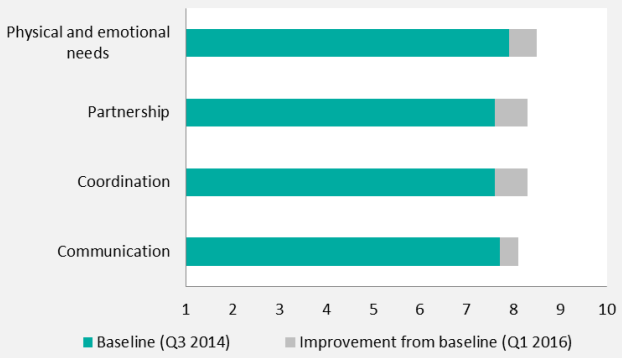


Outcome – Enhanced patient experience

Patient experience is an important indicator in assessing the quality of the care we provide and is strongly linked to overall health outcomes. Our focus is on individualised care, tailoring services to meet patient and whānau needs, and engaging them as partners in their care.

The HQSC inpatient survey rates patient experience across four domains: communication, coordination, partnership, and physical and emotional needs. Our average scores out of ten have steadily improved since the survey was implemented and are similar to New Zealand as a whole. We would like to accelerate improvement in this rating, aiming to consistently reach at least 9.0 in each domain in the intermediate term.

Outcome Measure – An increase in scores across the four domains of the HQSC inpatient survey

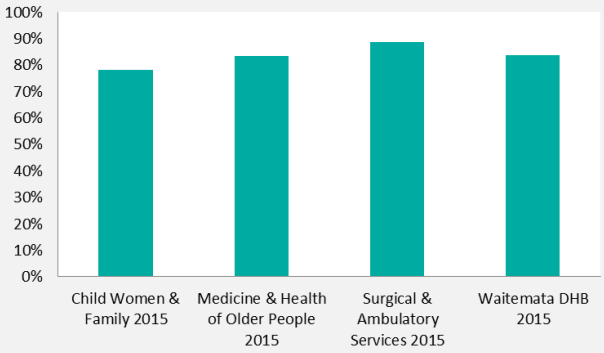


Outcome – Enhanced patient experience

Patient experience involves more than providing world-class clinical care – it requires care that addresses every aspect of a patient's encounter with Waitemata DHB, including the patient's physical comfort, as well as their educational, emotional, and spiritual needs.

Our analysis of Waitemata DHB's internal patient experience survey data has identified that staff being welcoming and friendly was the most significant factor in patients having a positive experience. In 2015, 83.8% of patients surveyed stated we were 'excellent' at being welcoming and friendly. Our aim is to increase this across all divisions.

Impact Measure – An increase in the percentage of patients stating we were 'excellent' at being welcoming and friendly



** data is 11 months February to December as question was only implemented in February 2015

MODULE 2A: Implementation of the New Zealand Health Strategy

The refreshed New Zealand Health Strategy provides DHBs with a clear strategic direction and road map for delivery of more integrated health services into the future. Waitemata DHB is committed to delivering on the Strategy's over-arching vision of 'All New Zealanders live well, stay well, get well'. The current themes of the Strategy provide a focus to drive change:

- People powered
- Care closer to home
- Value and high performance
- One team
- Smart system.

The Strategy's Roadmap of Actions sets out 20 work areas to put the Strategy in place. Although the Strategy has a ten-year horizon, we will begin implementation of the strategy in 2016/17. We are already planning to deliver activities that will contribute to the draft Roadmap Actions, under existing priority areas, and these are identified in the below table.

Health Strategy Action	Priority Area (Module 2B, unless stated)
Theme: People Powered	
1. Inform people about public and personal health services so they can be 'health smart' and have greater control over their health and wellbeing	Module 5 – Building Capability; Healthy lifestyles; Early detection and improved management; Priority Populations
2. Make the health system more responsive to people	Patient Experience and Community Engagement; Priority Populations; Supporting Vulnerable Children; Health of Older People; Mental Health; PM's Youth Mental Health Project
3. Engage the consumer voice by reporting progress against measures important to the public, building local responses and increasing participation of priority groups	Patient Experience and Community Engagement; Priority Populations
4. Promote people-led service design, including for high-need priority populations	Patient Experience and Community Engagement; Priority Populations; Whānau Ora
5. In selected high-need communities, build on, align, clarify and simplify multiple programmes of social investment.	Priority Populations; Whānau Ora; Service Configuration; Healthy lifestyles
Theme: Closer to Home	
6. Ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way	Service Configuration; Priority Populations; Living within Our Means
7. Enable all people working in the health system to add the greatest value by providing the right care at the earliest time, fully utilising their skills and training	Module 5 – Workforce
8. Increase the effort on prevention, early intervention, rehabilitation and wellbeing for long-term conditions and for obesity	Tobacco; Obesity; Priority Populations; Cardiovascular Disease; Living Well with Diabetes; Cancer; Mental Health
9. Collaborate across government agencies, using social investment approaches, to improve the health outcomes and the equity of health and social outcomes for children, families and whānau, particularly those at risk	PM's Youth Mental Health Project; Supporting Vulnerable Children; Whānau Ora; Rheumatic Fever; Increased Immunisation
10. Involve health and other social services in developing shared care for older people with high and complex needs in residential care facilities or those needing support at home	Health of Older People
11. Support clinicians and people in developing advance care plans and advance directives	Module 3 – Statement of Performance Expectations
12. Review adult palliative care services to ensure all those who	Service Configuration

Health Strategy Action	Priority Area (Module 2B, unless stated)
would benefit from palliative care at the end of their life are able to access high quality care and have a seamless experience.	
Theme: Value and High Performance	
13. Enable people to be partners in the search for value by developing measures of service user experience and improving public reporting	Patient Experience and Community Engagement System Level Outcome; Module 1 – Outcomes Framework
14. Implement framework focused on health outcomes to better reflect links between people, their needs, and outcomes of services	Module 1 – Outcomes Framework; Module 3 – Statement of Performance Expectations
15. Work with the system to develop a performance management approach with reporting that makes the whole system publicly transparent	Living within Our Means; Module 5 – Building Capability
16. Maintain the direction set by the Strategy through monitoring and evaluation, and advice from a Strategy Leadership Group	MoH action
17. Align funding across the system to get the best value from health investment	MoH action
18. Continue to develop the application of the social investment approach to health investment with DHBs. Consider using this approach to improve overall outcomes for high-need priority populations, while developing and spreading better practices	MoH action
19. Continuously improve system quality and safety.	Improving Quality
Theme: One Team	
20. Improve governance and decision-making processes across the system in order to improve overall outcomes, , by focusing on capability, innovation and best practice	Improving Quality
21. Clarify roles and responsibilities and accountabilities across the system as part of the process of putting the Strategy into action	MoH action
22. Create a 'one team' approach to health in New Zealand through an annual forum for the whole system to share best practice and help build a culture of trust and partnership	Module 5 – Workforce
23. Put in place a system leadership and talent management programme to enhance capacity, capability, diversity and succession planning throughout the sector	Annual Planning days; Health of Older People; Whānau Ora, Module 5 – Workforce
24. Put in place workforce development initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility.	Whānau Ora, Module 5 – Workforce
Theme: Smart System	
25. Increase New Zealand's national data quality and analytical capability to make the whole health system more transparent and provide useful information for designing and delivering effective services	Module 5 – Building Capability
26. Establish a national electronic health record that is accessed via certified systems including patient portals, health provider portals, and mobile applications	Module 5 – Building Capability
27. Develop capability for effective identifying, developing, prioritising, regulating, and introducing knowledge and technologies.	Module 5 – Building Capability

MODULE 2B: Our Goals and Priorities

To focus our work for the next year, we have developed specific goals to prevent, cure and ameliorate ill health, whilst working towards a sustainable and equitable healthcare system. We will report performance against these deliverables and measures to the Ministry of Health (where required), our Board and Board committees as appropriate.

Prevent ill health – supporting people to lead healthier lives

We focus on preventing ill health at a population level. Our role is to inform and support individuals 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, including children and young people, so that our entire population achieves its full health potential.

Our goal is to:	Support our population to achieve healthier lifestyles and provide the healthiest start to life for our younger population

Healthy lifestyles

Common lifestyle choices, such as smoking, lack of physical activity and poor nutrition, are major contributing factors of long-term diseases, including cardiovascular disease and cancer. Over 300 deaths a year could be avoided through primary prevention strategies, such as adopting healthier lifestyles. Addressing these factors will help to reduce our incidence and impact of preventable chronic disease.

Tobacco

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% in 2006 to 12% in 2013 – one of the lowest smoking rates in the country. However, significant ethnic disparities remain in our district. Our 'Ask, Brief Advice, and Support to Quit' programme provides quit advice to almost all smokers who access our hospital services and nearly 90% of those who access primary care – we want to meet the 90% target in the coming year. We will continue to offer advice and support to quit to 90% of pregnant women.

Tobacco

Health outcome: A smokefree Waitemata by 2025 (<5%)

What are we aiming for in 2016/17? (Our measures)

Key measures

- Achievement of Smokefree 2025: 5% or less of the population (of all ethnic groups) identify as smokers by 2025
- Progress against the health target: 90% of PHO-enrolled patients who smoke are offered help to quit smoking by a health practitioner in the last 15 months
- Progress against the health target: 90% of pregnant women who identify as smokers at registration with a DHB-employed midwife or Lead Maternity Carer are offered quit advice and support.

Other measures

- 95% of Māori women are smokefree at two weeks post-natal (a MoH Māori Health target)
- 80% of Mental Health and Addiction service users have their smoking status recorded and receive advice and an offer of support to quit.

How will we achieve this?

Smokefree 2025

Meet the Government goal of 'Smokefree Aotearoa 2025' through implementation of the Smokefree 2025 roadmap (Ministry's foundation document to guide activity) of:

- Protecting children from exposure to tobacco marketing and promotion – ongoing

Tobacco

- Providing the best possible support for quitting – ongoing
- ARPHS to lead the development of a Smokefree Health Promotion Strategy to reduce smoking uptake, prevalence and inequities – December 2016.

Supporting achievement of the Better Help for Smokers to Quit primary care health target

- Contract with each PHO to lead and coordinate support to General Practices to meet the health target, including setting key performance indicators, regular feedback on performance, training and clinical leadership – ongoing
- Implement initiatives to increase the number of smokers that make supported quit attempts, particularly for Māori, Pacific and pregnant women by June 2017.

Supporting achievement of the hospitals indicator

- Maintain the 'Ask, Brief Advice and Support to Quit' approach by providing training, resources and support to the Smokefree Lead in each inpatient hospital service – ongoing
- Set a hospital target for the percentage of smokers that make a supported quit attempt (prescribed NRT and/or accept a referral to a Stop Smoking Service) by October 2016.

Supporting achievement of the maternity health target

- Plan for implementing the new System Level Measure of 'number of PHO-enrolled babies who live in a smokefree household at the 6-week vaccination' by June 2017.

Support Mental Health and Addiction Services to be smokefree

- Support the DHB and regional Mental Health and Addictions NGO Smokefree project – ongoing
- Make recording of smoking status in the client's medical record mandatory by December 2016
- Northern Regional Alliance to coordinate and complete a mass quit challenge (with incentives) for Mental Health and Addiction Service users and staff by June 2017.

DHB leadership and innovation

- Build relationships and referral pathways with the new Stop Smoking Services that the MoH contracts with in the Waitemata and Auckland DHB areas by December 2016
- Update resources that list the Stop Smoking Support services that are available and promote these services across the districts by December 2016
- Implement a pilot programme of youth-initiated smoking prevention strategies with lessons informed by the work undertaken with schools in 2015–2016 by December 2016
- Pilot an initiative to support staff to stop smoking in ARPHS – June 2017.

Obesity

Low levels of physical activity and poor nutrition affect the health of our population. Nearly 29% of our four year-old children are obese or overweight. Although our obesity rates in children are lower than the national rates, they are increasing. The rate of childhood obesity in our Māori and Pacific populations is high, with 10% of Māori and 23% of Pacific 2- to 14-year-olds considered to be obese (NZHS 2011/13); we will continue to target these populations in 2016/17.

Obesity

Health outcome: Reduce childhood obesity

What are we aiming for in 2016/17? (Our measures)

Key measure

- Progress against the Raising Healthy Kids Health Target: 95% of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017.

Other measures

- 50% of pregnant women of all ethnicities with gestational diabetes are referred to Green Prescription by June 2017

Obesity

- At least 60% of babies of all ethnicities are fully or exclusively breast-fed at three months of age
- At least 78% of four-year-olds are at a healthy weight at the B4SC.

How will we achieve this?

- Implement the Regional Obesity framework and, as part of Healthy Auckland Together (HAT), work collaboratively with key stakeholders across health and other sectors including Auckland Regional Public Health Service (ARPHS), Council and Pacific networks – ongoing
- The Director Health Outcomes will provide senior management representation on the Healthy Families Waitakere (HFW) Governance Group, DHB Communications staff will link with HFW and key team members will work strategically with the local HFW workforce.

Population and Pre-conception: ***Enabling healthy environments, knowledge and skills to support healthy choices***

- Agree a national DHB food and beverage environments policy by August 2016, and work towards compliance with the policy by June 2017
- Map the food environment of ECEs, schools, DHBs and other community settings around schools in collaboration with HAT partners by June 2017
- Collaborate with HAT, Kai Auckland, HFW and the Auckland Social Sector Leadership Group to engage intersectorally with social services and non-health organisations to support healthy food environments from July 2016
- Extend the reach of the Aiga Challenge programme by June 2017
- Survey Pacific adults who have maintained weight loss for 3 years on enablers to weight loss maintenance by December 2016, and utilise findings to develop programme strategies by June 2017
- Collaborate with HFW to co-design initiatives for families and children that address equity, food security, workplace wellness and breastfeeding to support healthy changes and reduce childhood obesity by 30 June 2017
- Develop an adult overweight health pathway, including information resources and a bariatric pathway by June 2017.

Maternal and First Year of Life: ***Supportive environments and best care***

- Strengthen connections with maternity services kohanga reo and Pacific ECE centres to increase access to the Healthy Babies Healthy Futures (HBHF) programme for Māori, Pacific and Asian women and their families by December 2016
- Identify the number of pregnant women engaged with HBHF with healthy weight gain in pregnancy
- Work with primary care, Green Prescription providers, LMCs, DHB maternity services and HBHF to increase Green Prescription referrals and provide tailored advice for pregnant women by June 2017
- Provide culturally appropriate breastfeeding support to women and their families via trained peer support, improved health professional health literacy (primary care, LMCs and community workers) by June 2017
- Increase access to evidence-based nutrition and activity information for pregnant women through the Pregnancy and Parenting app and website by June 2017
- Work with DHB birthing facilities to establish a baseline population measure for monitoring BMI and maternal obesity in the DHB by September 2016.

Childhood: ***Supportive environments and best care for a healthy childhood***

- Resource Plunket as the contracted B4 School Check provider to maintain timely referral processes in line with the health target, and to provide additional advice on nutrition, activity and parenting to parents and caregivers of obese 4-year-old children from June 2016
- In line with the Ministry's service specification, engage providers of services for obese pre-schoolers through an RFP process by June 2017
- Develop and pilot a brief intervention and goal setting resource with B4SC to ensure consistent health promotion messages across community, primary and secondary care by December 2016
- Develop a family-based nutrition, physical activity and parenting programme, and a quantitative indicator to monitor the programme's effectiveness - by June 2017

Obesity

- Through the Regional Child Health Network, ensure regionally consistent pathways of care and a streamlined referral pathway to community programmes for overweight and obese children by December 2016
- The B4SC Governance Group, including Māori and Pacific representatives, will support local implementation of the regional referral pathway and monitor referral rates of 4-year-old children to ensure equity for Māori, Pacific, and children living in high deprivation areas by December 2016
- With Primary Care, community programmes and paediatric outpatients, investigate shared clinical opportunities to provide advice and support for children and families by December 2016.

Children's Health

Generating positive health outcomes for children, young people and mothers is essential in ensuring positive long-term health outcomes. Risk and protective factors and social patterns established in childhood and adolescence have significant long-term impacts on health. 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 children and young people are safe and have the healthiest start to life.

Increased Immunisation

Immunisation is an effective means of protecting children from infectious diseases throughout life and ensures families engage with primary care services early. We achieved the national target of 95% of 8-month-olds being immunised for the first time in Q2 2015. The 8-month-old immunisation rate is 94.1% in our Māori population and 96.8% in our Pacific population. Our current rate of 12-year-old girls completing all doses of their HPV vaccine is 58% (target of 70%).

Increased Immunisation

Health outcome: Children get the best possible start in life

What are we aiming for in 2016/17? (Our measures)

Key measure

- 95% of 8-month-old children of all ethnicities are fully immunised by June 2017.

Other measures

- 95% of 2- and 5-year-old children of all ethnicities are fully immunised by June 2017
- At least 70% of all 12-year-old girls (2003 birth cohort) of all ethnicities have completed all doses of their HPV vaccine by 30 June 2017
- 98% of newborn children are enrolled with a GP by 3 months of age.

How will we achieve this?

- Monitor all immunisation coverage rates weekly, with a focus on achieving equity for Māori, Pacific and high-deprivation populations – ongoing
- Review outcomes and develop recommendations from the Māori Immunisation Reference group to improve uptake and timeliness of immunisation for Māori whānau and babies by December 2016
- Create an action plan based on results of the audit 'From Hospital to General Practice' to drive further alignment of processes across tertiary, secondary and primary care regarding children not fully immunised and those eligible for special immunisations by December 2016
- Maintain the effectiveness of the Joint Auckland DHB and Waitemata DHB Immunisation Steering and Operations Groups and Auckland Metro School Based Immunisation Working Group – ongoing
- In partnership with primary care staff and NIR, review and streamline processes for follow-up and referral to outreach immunisation services (OIS) of children overdue for 4-year-old immunisations by September 2016
- Work with PHOs and NIR/OIS on the Shared Approach Plan to develop a pathway for early enrolment

Increased Immunisation

and B-code enrolment of all newborns with general practices by July 2017
- Develop communication tools including an I-immunise poster and decals on DHB fleet cars to promote on-time immunisations by September 2016
- Provide at least four joint DHB/PHO education workshops for primary and secondary care providers and school-based nurses that address vaccine hesitancy and best practice by June 2017
- Facilitate education workshops for secondary care providers to enable opportunistic immunisation in DHB facilities including renal, ED and maternity services by June 2017
- Provide two funded Midwives Immunisation Education sessions to provide an annual update on Antenatal Immunisation by June 2017
- With Primary Care, B4SC providers and the education sector, develop processes for promotion and information sharing to increase immunisation coverage for all 4-year-olds by December 2016
- Conduct a data-cleansing project with NIR/OIS, PHO and general practices to verify all 4-year-old immunisations given are recorded on the NIR by October 2016
- Review the current school-based immunisation programme to identify areas that could improve coverage by December 2016, and work with PHO Immunisation Coordinators to ensure young people who decline the school-based immunisation programme are recalled by their GP by February 2017
- Review school-based immunisation processes in readiness for potential changes to adolescent immunisation schedule (including HPV immunisation) by December 2016
- Work with ARPHS to develop a plan to promote Immunisation Week 2017 by February 2017.

Rheumatic Fever

Reducing the burden of rheumatic fever is a national priority. Our rapid response services and school-based programme make it easier for young people in high incidence areas to get their sore throats checked and treated if necessary. In 2015, 6,627 children were throat swabbed as part of our school-based rheumatic fever programme. Our rate of rheumatic fever was 1.6 cases per 100,000 in 2014/15. This is a 30% decrease from the 2013/14 rate of 2.3 cases per 100,000.

Rheumatic Fever

Health outcome: Children get the best possible start in life

What are we aiming for in 2016/17? (Our measures)

Key measure
- Reduce rheumatic fever rate to 0.7 per 100,000 people by June 2017.

How will we achieve this?

Governance
- Achieve effective programme oversight through the joint Waitemata and Auckland DHBs Rheumatic Fever Steering Group – ongoing
- Monitor the implementation of the endorsed DHB Rheumatic Fever Prevention Plan – ongoing
- Develop a draft Rheumatic fever budget for activities from July 2017, investment plan prepared by January 2017.

Reducing the incidence of first episode rheumatic fever
- Promote rapid response clinics through localised community consultation events – ongoing
- Develop a Rheumatic Fever promotional campaign that utilises existing resources, to specifically engage Māori and Pasifika communities across Auckland and Waitemata DHBs by June 2017
- Support PHOs to lead targeted activity to increase health literacy and access to sore throat clinics by June 2017
- Hold the school-based 'HYPE' event 2016 – a youth health priority event to promote rheumatic fever prevention and support youth rheumatic fever advocates by September 2016
- Collaborate with Plunket/Tamariki Ora Well Child Providers to introduce rheumatic fever health messages within the B4School Checks by December 2016
- Monitor and increase the effectiveness of the Rapid Response Clinics in general practice and in

Rheumatic Fever

pharmacy through the Rheumatic Fever Programme Clinical & Operations Group – ongoing
- Complete analysis and report on the cross-sectional survey of West Auckland caregivers and children at high risk of rheumatic fever by December 2016.

Auckland Wide Healthy Housing Initiative
- Ensure all eligible referrals for housing-related concerns are sent to the AWHI Hub and that systems and relationships support referrals to help keep families informed – ongoing
- Continue to work with the Ministry regarding AWHI and housing-related funding and document this in a plan by December 2016.

School-based programme
- Subject to further evaluation and consideration of the model of care by the Board (decision expected by January 2017), maintain school-based rheumatic fever programmes in five primary schools.

Reporting
- Report quarterly to the Ministry on lessons learned and actions taken following root cause analysis of cases of first episode rheumatic fever hospitalisations and implement relevant learnings – ongoing.

Effective follow-up
- Ensure that all cases of acute and recurrent acute rheumatic fever are notified with complete case information to the Medical Officer of Health within seven days of hospital admission – ongoing
- Ensure patients with a history of rheumatic fever receive monthly antibiotics not more than 5 days after their due date – ongoing
- Undertake an audit of rheumatic fever secondary prophylaxis coverage for children aged 0–15 years, youth aged 15–24 years, and adults aged 25+ years and report by June 2017
- Identify and follow-up known risk factors and system failure points in recurrent cases – ongoing
- Follow-up on any issues identified by the 2015/16 audit of recurrent hospitalisations of acute rheumatic fever and unexpected rheumatic heart disease – ongoing.

Supporting Vulnerable Children

A key focus of the Government is vulnerable families. To protect vulnerable children in our district, we will support the prevention and early identification of child maltreatment. We will support cross-agency work that tackles the complex and long-term issues that some families face, particularly in priority populations, and we will meet the requirements of the Vulnerable Children Act.

Supporting Vulnerable Children

Health outcome: Children get the best possible start in life

What are we aiming for in 2016/17? (Our measures)

Key measure
- Reduce injuries in 0–14 year olds resulting from assault, neglect or maltreatment (baseline 10.4/100,000 2009–2013).

Other measures
- Achieve an increased disclosure rate (from around 1% to at least 2%) in one priority clinical area that focuses on increasing the quality of the routine enquiry into intimate partner violence
- Achieve at least a 50% increase in child protection screening for children aged 0–2 years presenting to the Emergency Department by June 2017 (VIP Snapshot baseline = 4% at June 2015)
- 100% of Gateway assessments completed within 6 weeks of completed referral.

What are we going to do in 2016/17?

Reduce mortality, morbidity and hospitalisations resulting from assault, neglect or maltreatment
- Maintain Te Aka Ora (the vulnerable pregnant women's group) – ongoing
- Establish a benchmark for the number of women referred to Family Start and/or WCTO by TAO antenatally by December 2016

Supporting Vulnerable Children

- Map the information sharing process between health professionals for child and family violence and identify areas of improvement by March 2017
- Take part in the national development process to appropriately share child protection alerts information across primary, secondary and mental health services by June 2017
- 'Sharing information' training is reviewed and strengthened by June 2017
- Review recommendations of the Family Violence Death Review Committee Fifth Report and consider implications for the DHB; the Family Violence Steering Group to report implications to the Executive Leadership Team by March 2017
- Implement the neglect of care medical guidelines by June 2017
- Develop the training on guidelines ready for implementation by June 2017
- Develop and implement an acute paediatric (inclusive of Emergency) care and protection pathway by June 2017
- Implement a monthly internal audit process to monitor implementation of screening for family violence across mental health, addiction, child, maternity and emergency services from October 2016, and report audit results to Family Violence Steering Group at least quarterly
- Support the national development of a training programme for health professionals, including LMCs, primary care and Well Child Tamariki Ora providers to increase the confidence of providers to make routine enquiries regarding intimate partner violence by June 2017
- Establish a working group for perinatal mental health with broad representation to develop population-level preventive approaches, early detection of perinatal mental health issues, develop referral pathways, and develop primary perinatal mental health services by August 2016
- Localise a pathway for key mental health risk factors (such as maternal depression) by June 2017
- Ensure a range of strength-based interventions is identified to support positive parenting and early attachment, with funding (for implementation in 2017/18) approved by February 2017.

Other actions

- Maintain Waitemata DHB's Child Protection Policy and CYF liaison social worker role – ongoing
- Build effective intersectoral working relationships, particularly with MSD and Education – ongoing.

Prime Minister's Youth Mental Health Project (including Reducing Unintended Teenage Pregnancy)

Mental health and alcohol and drug issues in young people have low rates of recognition. Barriers include lack of awareness and reluctance to seek help through conventional health services. Early intervention to appropriate services for those with mental health problems and substance abuse issues will positively impact health outcomes in young people. In 2016/17, our focus is to continue to enhance school-based health services and further develop youth primary mental health and drug and alcohol services.

Prime Minister's Youth Mental Health Project (including Reducing Unintended Teenage Pregnancy)

Health outcome: Children get the best possible start in life

What are we aiming for in 2016/17? (Our measures)

Key measures

- 95% of youths aged 12–19 years discharged from CAMHS and Altered High will have a transition (discharge) plan in place by December 2016
- 80% of 0–19 year olds referred for non-urgent mental health or addiction services are seen within 3 weeks and 95% within 8 weeks
- 85% Home, Education/Employment/Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety (HEEADSSS) coverage in ESBHS.

Other measures

- Altered High service provision by 6 June 2016
  - At least 150 additional young people seen by Altered High

Prime Minister's Youth Mental Health Project (including Reducing Unintended Teenage Pregnancy)

- 15 AOD assessment and brief intervention training sessions provided to GPs, practice nurses and school health services
- 300 health professionals trained
- 200 consultation/liaison contacts provided.

How will we achieve this?

Enhance school-based health service (ESBHS)

- Maintain high functioning school-based health services in all decile 1–3 schools, teen parent units and alternative education facilities – ongoing
- Maintain and apply PDSA skills in each school to continually improve service quality – ongoing
- Nurses to have emergency contraception programme (ECP) endorsement and use Standing Orders – ongoing
- Evaluate whether ESBHS is improving equity by assessing access breakdowns by ethnicity for Māori and Pacific by June 2017.

Improve responsiveness of Primary Care to youth

- Develop a Waitemata DHB-specific Youth SLAT work programme:
  - Agree on how to standardise sexual health services, particularly in relation to access for young people not in education, employment or training (NEET) across primary care by December 2016
  - Begin communicating best practice messages to primary care from Youth CGG by December 2016
  - Obtain feedback from PHOs on the use of the College of GP accredited 'youth friendly' self-auditing tool by July 2017.

Child and Adolescent Mental and Youth Alcohol and Drug Services

- Support the development of a youth peer support framework, to be developed by December 2016
- Ensure early communication and initial transitional engagement and planning for youth aged 12–19 years discharged from CAMHS and Altered High into primary care using MOH/Werry Centre guidelines – ongoing
- Deliver the 2016/17 youth-specific actions of the Waitemata DHB Suicide Prevention and Postvention Action Plan (2015–2017) by June 2017
- 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 – ongoing
- Convene 'Look Up Youth Innovation Forum' by March 2017.

Reducing Unintended Teenage Pregnancy *(Note: other activities related to this priority are included above)*

- Ensure all ESBHS staff are delivering a full range of sexual health services including relationship advice from July 2017
- Evaluate whether ESBHS are reducing unintended teenage pregnancies by January 2017
- Engage Family Planning in the Youth Service Alliance Clinical Governance Group by September 2017
- Provide a Sexual Health education programme for primary, secondary and tertiary care staff, including youth-friendly, culturally competent contraceptive choices, to be implemented from March 2017
- Develop regional clinical standards, protocols and clinical pathways for primary and secondary care and implement from November 2016
- Identify a DHB youth health/sexual health and reproductive health clinical champion by December 2016.

Cure ill health – supporting people to stay well

We have a significant role in improving the management of ill health, in particular ensuring prompt identification, treatment and management of long-term chronic disease. We want to ensure our population has access to preventive and supportive services, with prompt diagnosis and treatment.

Our goal is to:	Improve the detection and management of long-term conditions and provide readily available specialist services when needed

Early detection and improved management

Early detection and improved management of people with long-term conditions is a key priority for Waitemata DHB, with diabetes and CVD identified as the number one priority for our District Alliance. We know that if people with long-term conditions are managed effectively in the community, they should remain relatively stable and enjoy quality of life without needing acute care and other hospital services.

Living Well with Diabetes

An estimated 23,000 people in Waitemata DHB have diabetes and this number is steadily increasing. The presence of diabetes can lead to CVD, blindness, dementia, kidney disease, and foot problems that may lead to amputation. Early detection and good management can delay or avoid the onset of these problems. Currently, 33% of patients with diabetes have poorly controlled HbA1c (Q3 2015/16). In 2014, 16.2% of medical and surgical bed days were used by people with diabetes (HQSC).

Living Well with Diabetes

Health outcome: Reduce premature mortality from cardiovascular disease

What are we aiming for in 2016/17? (Our measures)

Key measure

- 3% reduction in proportion of patients with HbA1c above 64, 80 and 100 mmol/mol at their annual review.

Other measures

- Provide DSME courses to 1,000 people living with diabetes per annum

How will we achieve this?

Diabetes Service Level Alliance Work Programme

- Complete the development of the Work Programme as approved by the Alliance Leadership Team by June 2017, covering these workstreams:
  - Systems Redesign
  - Optimisation of Clinical Management
  - Self-Management Education and Support, including DSME and Care Planning
  - Workforce Development
- Develop a Diabetes Model of Care, guided by the MoH Quality Standards for diabetes care, that is fit for purpose, informed by evidence and patient/provider experience, and adopts a whole-of-systems approach to better align services across the Waitemata and Auckland DHBs by June 2017
- Develop an implementation plan for the Diabetes Model of Care by June 2017.

Enable effective self-management

- Undertake a co-design process involving patients and their family and whānau and providers to identify factors that affect access, utilisation and effectiveness by December 2016
- Develop a DSME Service Delivery Model including a model specific to Māori and Pacific that will improve access and utilisation by June 2017
- Support the implementation of the Northern Region Diabetes Network (NDRN) Standards for DSME including auditing programmes against the standards by June 2017.

Optimise clinical management including care planning to improve quality of services

- Implement systems and processes to measure and monitor the regionally agreed clinical

Living Well with Diabetes

indicators to help improve outcomes by June 2017
- Commence the implementation of the Diabetes Pathway by June 2017
- Develop a Care Planning template to standardise data collection of patient outcome measures across the Northern region DHBs by June 2017
- Evaluate the West Auckland quality improvement pilot by June 2017
- Collect the minimum dataset for people with type 2 diabetes by June 2017
- Develop strategies to improve secondary diabetes services DNA rates, particularly in high needs patients, as part of the Service Alliance Work Programme by June 2017.

Early detection to reduce risk of complications
- Review the retinal screening service and develop an action plan to ensure all patients with diabetes have access to retinal screening, in line with Ministry's guidelines by June 2017
- Review the podiatry service and develop an action plan to ensure that all people with diabetes have a comprehensive foot assessment annually by June 2017
- Track and measure the incidence of diabetes-related amputations, particularly in Māori by June 2017 with a long-term goal of reducing incidence.

Provide integrated care, including workforce development
- Improve primary care providers' access to specialist diabetes service for advice, education and mentoring by June 2017
- Develop standard referral criteria to optimise appropriate referrals and utilisation of specialist service by patients with diabetes by June 2017
- Develop a diabetes/CVD education programme for primary health care nurses, based on the National Diabetes Knowledge and Skills Framework by June 2017.

Budget 2013 funding
- Continue to deliver podiatry services funded through budget 2013 in select practices to agreed volumes (2,699) for 2016/17
- Provide a report to the Ministry on the programme for the 2015/16 year by Q1 2016/17

Note: Deliverables related to Preventing high risk people from developing type 2 diabetes appear in the Obesity, Improved Access to Elective Surgery and Cardiovascular Disease (CVD) sections within this module. Related measures also appear in the CVD section.

Cardiovascular Disease (CVD)

Despite having some of the lowest mortality rates from CVD (96.6 per 100,000 individuals) in the country, CVD is still a leading cause of premature mortality in Waitemata. Early identification of those most at risk, comprehensive lifestyle advice and early treatment can prevent development and/or progression of disease. Currently, 90% of the eligible population have had their CVD risk assessed within 5 years, and 55% of those with existing CVD are on triple therapy; the Northern Region's aspirational target is 70%.

Cardiovascular Disease (CVD)

Health outcome: Reduce premature mortality from cardiovascular disease

What are we aiming for in 2016/17? (Our measures)

Key measure
- 90% of the eligible population will have had their cardiovascular risk assessed in the last five years (by ethnicity – Māori, Pacific, Indian and Asian).

Other measures
- 55% percent of patients with known cardiovascular disease are on triple therapy
- Percentage of patients with 5-year cardiovascular risk ever recorded >20%, who are on dual therapy.

Cardiovascular Disease (CVD)

How will we achieve this?

Prevention

- PHOs to continue working with general practices to ensure practices provide patients with necessary information (e.g. pamphlets) – ongoing
- PHOs to continue working with general practices to ensure patients, especially Māori and Pacific patients, are referred to exercise and nutrition programmes – ongoing.

Early Detection

- Continue to fund primary care to provide More Heart and Diabetes Checks to their eligible populations.

Optimise Clinical Management including Care Planning to Improve Quality of Services

- Report on the regionally agreed diabetes/cardiovascular disease clinical indicators and establish baseline data by June 2017
- Use this information to provide feedback on clinical indicator performance at practice level and support practices to improve CVD management, particularly in high risk populations, by June 2017
- Develop a consistent Care Planning template for use in the Northern region by June 2017.

Note: deliverables related to Prevention and Effective Self-Management appear in the Tobacco, Obesity and Living Well with Diabetes sections within this module.

Cancer

Despite having mortality rates from cancer (114 per 100,000 individuals, 2012) among the lowest in the country, approximately one in every three deaths is attributable to cancer and significantly contributes to ethnic differences in health outcomes. Rapid diagnosis and treatment of cancer increases the options for treatment and the chances of survival; we undertake routine screening for cervical and breast cancer, and a pilot programme is underway to screen for bowel cancer. At present, 70% of our 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 (the national target is 85%).

Cancer

Health outcome: The lowest premature mortality from cancer

What are we aiming for in 2016/17? (Our measures)

Key measure

- Progress against the Health Target: 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.

Other measures

- 90% of patients receive their first cancer treatment (or other management) within 31 days from date of decision to treat by June 2017
- 100% of patients will receive their radiotherapy and chemotherapy within four weeks of decision to treat every month
- 70% of patients waiting for a surveillance colonoscopy will wait no longer than 84 days, 100% within 120 days
- All cancer-related MDMs will use electronic forms to document MDM outcomes live by June 2017
- All urgent diagnostic bowel investigations will be completed within two weeks.

How will we achieve this?

- Audit two tumour specialties for appropriate application of the high suspicion cancer flags (to increase identification of these patients) by December 2016
- Identify the percentage of high suspicion patients who fit the criteria of high suspicion cancer who access their treatment in the private sector by June 2017

Cancer

- Identify the ethnicity-specific high suspicion cancer conversion rate by June 2017
- Localise and implement the prostate pathway in primary care by June 2017 (consistent with the Ministry of Health's Prostate Cancer Management and Referral Guidelines)
- Support the region's developmental stages of a Wellness Centre and local delivery of medical oncology – ongoing
- Continue to contribute to the prevention and early detection of cancer through programmes including healthy lifestyles (in particular obesity, alcohol and tobacco) and screening – ongoing
- Participate in the transition to the national bowel screening programme during 2016/17.

Rapid access and effective treatment

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' 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.

Shorter Stays in Emergency Departments

Approximately one in seven of our population visits a hospital Emergency Department (ED) in any given year, and this demand has risen by 17% since 2011. Currently, 95% of ED patients spend no longer than six hours in the ED. Shorter stays in the ED result in less overcrowding and better health outcomes, enabling us to use our resources more effectively and efficiently.

Shorter Stays in Emergency Departments

Health outcome: Our population live longer, healthier and more independent lives

What are we aiming for in 2016/17? (Our measures)

Key measure

- Progress against the Health Target: 95% of patients will be admitted, discharged, or transferred from an Emergency Department within 6 hours of presentation (including by ethnicity).

How will we achieve this?

Acute demand

- Analyse ED attendance data to build activity profile with options to reduce avoidable attendances – report to inform quality improvement service redesign developments to be compiled by December 2016
- Continue to work closely with urgent care clinics/primary care partners over 2016/17 to improve access for minor ailments and primary care issues and promote access after-hours to reduce low acuity presentations
- Promote health literacy and use of non-ED services available via Health point – by September 2016

Managing acute flow in ED

- Develop and implement specific pathways (such as Renal Colic, Sepsis, Back pain)in 2016
- Provide ongoing support to pathways already in place (e.g. Acute Abdominal Pain pathway)
- Implement the Accelerated Chest Pain Pathway by December 2016, review and audit by June 2017
- Improve timely access to diagnostics and validation (particularly CT scan) working collaboratively with Radiology improvement initiatives by December 2016
- Implement the Quality Framework, including M&Ms, Clinical Audits, Audit schedule, data collection, metrics, and monthly quality report by December 2016

Managing Outflow

- Communicate pathways out of ED (inpatients, community, transitional care) to other stakeholders, including documentation that stating those involved in care provision, particularly for vulnerable groups (e.g. those with no fixed abode, refugees, migrants, and those experiencing severe and

Shorter Stays in Emergency Departments

enduring mental health issues) – ongoing
- Implement recommendations following review for Assessment and Planning Units – December 2016
- Report health target performance by ethnicity from July 2017 to establish baseline performance
- Implementation of the ED Quality Framework by June 2017, including systems in place to enable monitoring of all the mandatory and non-mandatory measures
- Address recommendations made by Target Champion for North Shore and Waitakere Hospitals (December 2015) to improve patient flow during 2016/17.

Improved Access to Elective Surgery

Providing our population with timely and equitable access to elective surgery is a key priority. We continue to meet the increasing elective health target, with 18,185 surgical procedures carried out in 2014/15, 23% more than three years ago. Patients now wait no more than four months for their first specialist appointment or their elective surgery. In 2016/17, we plan to deliver 21,583 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.

Improved Access to Elective Surgery

Health outcome: Our population live longer, healthier and more independent lives

What are we aiming for in 2016/17? (Our measures)

Key measure
- Delivery against the agreed volume schedule, including at least 21,583 elective surgical discharges in 2016/17 towards the Electives Health Target and at least 445 (provisional) elective orthopaedic and general surgery discharges in 2016/17, as part of the Budget 2015 additional investment.

Other measures
- Achieve an elective surgical inpatient standardised ALOS of 1.55 days
- Standardised Intervention Rate targets:
  - Major joint replacement procedures: a target of 21 per 10,000 of population will be achieved
  - Cataract procedures: a target of 27 per 10,000 of population will be achieved
- Elective Services Patient Flow Indicators expectations are met, and patients wait no longer than four months for first specialist assessment and treatment
- All patients are prioritised using the most recent national tool available
- Patient-level data are reported into the NPF collection, in line with specified requirements
- Deliver 100 bariatric surgeries June 2017.

How will we achieve this?

Elective Surgery
- Maintain performance against the Elective health target over 2016/17 through:
  - Recruiting additional specialist workforce, specifically an additional spinal surgeon by October 2016
  - Hold weekly ESPI compliance meetings with the Patient Service Centre Electives Managers, Specialty Operations Managers and Perioperative Nurse Co-ordinators to identify any issues and plan the patients surgical treatment pathway – ongoing
  - Weekly meetings between the General Manager for surgical services and the Director of Hospital Services, specifically to focus on meeting the elective surgical health target volumes – ongoing
  - Participation in the northern regional electives forum to meet KPIs as outlined in the Northern Region Health Plan for electives in 2016/2017
- Improve data capture and utilisation of acute and elective surgical volumes to inform waiting times management by December 2016

Improved Access to Elective Surgery

- Reduce unnecessary follow-up appointments through different strategies, including:
  - develop telehealth platform to manage care options for specific conditions/services/patients – Q4
  - implement standardised regimes involving GPs for conditions where ongoing follow-up is required for access to primary/secondary care/tests etc., e.g. cancer survivorship strategies – Q3
- Implement musculoskeletal pathways in partnership with primary care and community service providers – Q2
- Investigate opportunities to shift more services/procedures from secondary to primary/community care settings (e.g. skin services) – Q2
- Continue involvement in joint Waitemata and Auckland DHB bariatric surgery project to further develop equitable access to bariatric surgery and improve success rates for all Waitemata DHB population with increased Māori and Pacific volumes – by Q4
- Continue surgical clinical excellence programme, including ERAS, falls, surgical checklist in theatres, reduced length of stay (LOS) – ongoing
- Implement national Clinical Prioritisation Access Criteria (CPAC) tools as they become available and explore ways to share information and feedback with primary care regarding referrals and CPAC scoring to increase understanding and improve quality and appropriateness of referrals – ongoing
- Participate in activity relating to all phases of National Patient Flow (NPF), including identification of, and engagement with, local, regional and sector-wide quality improvement opportunities – ongoing.

Major Trauma

- Continue to submit data to the National Trauma Registry – ongoing.

Note: Deliverables related to surgical clinical excellence appear in the Improving Quality section within this module.

Improved Access to Diagnostics

Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve DHB demand and capacity management. Currently, 95% of people accepted for an urgent diagnostic colonoscopy receive their procedure within two weeks, 100% of accepted referrals for elective coronary angiography receive their procedure within 3 months and 93% of accepted referrals for CT and MRI scans receive their scan within six weeks (as at December 2015).

Improved Access to Diagnostics

Health outcome: The lowest premature mortality from cancer

What are we aiming for in 2016/17? (Our measures)

Key measure

- Achieve Faster Cancer Treatment-specific targets: 7 days for CT and 10 days for MRI.

Other measures

- CT and MRI – 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within six weeks (42 days)
- Diagnostic colonoscopy
  - 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days
  - 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.
- Surveillance colonoscopy – 70% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100 percent within 120 days.

Note: Measures related to improving radiology services appear in the Service Configuration section within this module.

Improved Access to Diagnostics

How will we achieve this?

Achieve identified waiting time targets by:

- Participate in activity relating to implementation of the National Patient Flow (NPF) system, including adapting data collection and submission to allow reporting to NPF as required – ongoing
- Work with primary care to provide guidance and tools regarding elective surgery pathways to support decision-making for test/referrals for diagnostics – Q3.

Radiology

- Explore future sonography workforce options and present a discussion paper to ELT – Q1
- Work with the Northern Region Radiology Network and WFNZ to support and retain the technical workforce in the public sector
- Continue to work with clinical teams and Facilities and Development to ensure that radiology requirements are included in the master site plan out to 2035.

Colonoscopy/Endoscopy

- Identify and implement ongoing actions to improve waiting times and quality of colonoscopy/endoscopy services, including:
  - Introduce a nursing role to support the selection and allocation of clinically appropriate elective patients to endoscopists
  - Develop a production plan for all endoscopy procedures to enable weekly performance tracking
  - Replace/purchase additional capital equipment to ensure right number and type of scopes/towers to support fully utilised lists
  - Process map the clerical booking processes to ensure they are patient focused and efficient, make changes/enhancements as appropriate
  - Implement business scheduling rules for management of procedural rooms to optimise room utilisation
  - Continue to recruit to the endoscopy fellow roles
  - Develop the nurse endoscopist role
  - Using the Global Rating Scale as part of the National Endoscopy Quality Improvement Programme (NEQIP) – ongoing
  - Ensure appropriate use of the National Referral Criteria for Direct Access Outpatient Colonoscopy – ongoing
  - Regional collaboration to improve access and timeliness to colonoscopy procedures – ongoing
  - Implement regional standardised triage processes for surgical and medical colonoscopy referrals to reduce variation across the region by Q3.

Laboratory/Pathology

- Explore opportunities to develop and implement E-Labs forms for Community Laboratory and Pathology testing in line with local and regional initiatives – Q3
- Implement the regional histology tracking system in the Surgical Pathology laboratory by Q3/4
- Improve turnaround times for Laboratories/Pathology testing in line with regional initiatives – Q4.

Note: Deliverables related to improving radiology services appear in the Service Configuration section within this module.

Cardiac Services

Health outcomes can be improved through ensuring a nationally consistent approach to Acute Coronary Syndrome (ACS) risk stratification and timely access to appropriate intervention for cardiac patients. Currently, 85% of patients receive an angiogram within 3 days of admission (December 2015) and 6.43 cardiac operations are performed per 10,000 of the population (standardised – September 2015). In 2014/15, we added over 1,510 quality-adjusted life years (QALYs) to our population having coronary artery bypass grafts (CABG) and angioplasty procedures, a 10% increase from 2010/11.

Cardiac Services

Health outcome: Reduce premature mortality from cardiovascular disease

What are we aiming for in 2016/17? (Our measures)

Key measure

- Maintain at least 70% of ACS inpatients receiving an angiogram within 3 days of admission ('Day of Admission' being 'Day 0') by ethnicity (baseline = 85%, December 2015).

Other measures

- Deliver 339 total cardiac surgery discharges
- No patients will wait longer than four months for first specialist assessment and treatment
- Improve cardiac rehabilitation programme retention rates to 40% by February 2017
- Reduce SMO follow-up appointments by 20% (1,150 from baseline of 5,781) by February 2017
- 95% of outpatient echocardiograms to be completed within 3 months of referral
- 80% of patients waiting for chest pain FSAs will be seen within 6 weeks
- Establish baseline DNA rate of Māori patient cohort and aim to reduce this by 10% by June 2017
- Standardised Intervention Rates
    - Cardiac surgery: a target intervention rate of 6.5 per 10,000 of population will be achieved
    - Percutaneous revascularisation: a target rate of at least 12.5 per 10,000 of population will be achieved
    - Coronary angiography: a target rate of at least 34.7 per 10,000 of population will be achieved.

How will we achieve this?

Acute Cardiac Services

- FSA chest pain clinics fully established to meet the MoH requirements from July 2016
- Establish Cardiac Rehab programme based on regionally agreed best practice principles by October 2016 (a regionally agreed standardised data collection – using Enigma – will be used to measure referral, participation and completion rates).

Secondary Services

- Complete the model of care change to cardiac follow up appointments by increasing nurse-led clinics for all cardiologists by October 2016
- Identify cohort of Māori patients with DNA history who have co morbidities and implement plan to reduce DNA rate in this cohort by June 2017
- Scope a systematic approach for Mental health screening for those with a cardiac condition, including appropriate tools, when, where, who, how often and treatment options – complete scoping and identify enablers and challenges by June 2017.

Stroke Services

Cardiovascular disease, including heart attacks and strokes, are substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. Patient outcomes are improved when care is provided through an organised acute stroke service as recommended in the New Zealand Clinical Guidelines for Stroke Management. 86% of our stroke patients were admitted to our stroke service and treated via a documented stroke pathway (Q4 2014/15) and 4.8% of our eligible stroke patients were thrombolysed in the 12 months to September 2015.

Stroke Services

Health outcome: Reduce premature mortality from cardiovascular disease

What are we aiming for in 2016/17? (Our measures)

Key measure

- At least 6% of potentially eligible stroke patients are thrombolysed 24/7.

Other measures

- 80% of stroke patients admitted to a stroke unit or organised stroke service

Stroke Services

- 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission (also report percent of acute stroke patients transferred to inpatient rehabilitation).

How will we achieve this?

- Complete work initiated in 2015/16 to establish Waitemata DHB Stroke services plan and implement service improvement in two key areas of the stroke pathway by June 2017
- Develop plan for all ages stroke rehabilitation services for the Waitemata population by June 2017 including a plan specifically targeting Māori and Pacific population rehabilitation needs
- Work regionally to implement locally the MoH-led FAST programme rollout with a particular focus to address Māori and Pacific inequities in access – as per MoH timelines (once finalised)
- Work with regional colleagues to align workforce core competency programmes for staff involved in the management of thrombolysis and acute stroke management and initiate local implementation of the relevant programmes at Waitemata DHB by December 2016
- Work regionally to implement regional hyper acute stroke pathway as agreed in 2015/16 and implement local improvements to enable the successful implementation of the regional clot retrieval service by June 2017.

Ameliorate ill health – 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 responsive and clinically safe and provide clear connections and smooth transitions throughout the health system.

Our goal is to:	Relieve suffering and support independence and enhance quality of life with timely, safe, high quality and compassionate services

Supporting independence and enhancing quality of life

Waitemata DHB has a significant role in supporting and enhancing the quality of life of our older population and those with serious mental ill health. We want to ensure our older population and those with mental ill health are able to live well, with dignity and independence, as part of their community and in a place of their choosing, with the choice of appropriate and affordable support and care services when they need them.

Mental Health – Rising to the Challenge

Mental ill health is one of the leading causes of disability and overall health lost nationally. Our population experiences more positive mental health than New Zealand as a whole. However, one in five people living in our district experiences mental illness and 3% experiences serious mental illness. Māori and Pacific individuals are particularly affected by mental health conditions. Mental illness is associated with reduced life expectancy of 10 or more years as a result of other illnesses, particularly cancer and cardiovascular disease. Not all waiting time targets (80% of people seen within 3 weeks, 95% within 8 weeks) have been met, with results under target for individuals aged 0–19 years and 65+ years. In the 12 months to October 2015, 4.4% of Māori youth, and 3.1% of youth overall, accessed mental health services. Access rates for those aged 65+ years reached 2.1% and 3.4% for those aged 20–64 years.

Rising to the Challenge

Health outcome: Reduce morbidity and mortality for people with mental illness

What are we aiming for in2016/17? (Our measures)

Key measures

- At least 95% of child and youth clients discharged from community mental health and addiction services will have a transition (discharge) plan
- 80% of 0–19 year olds referred for non-urgent mental health or addiction services are seen within three weeks and 95% within 8 weeks.

Other measures

- Access targets for mental health and addiction services: 3.1% (4.4% for Māori) for 0- to 19-year-olds, 3.4% (7.6% for Māori) for 20- to 64-year-olds, and 2.1% for those aged 65+ years
- 95% of older adult service users meeting the criteria will have a current relapse prevention plan.

How will we achieve this?

- Providers will be reliably and consistently collecting social outcome indicators by June 2017.

Actively using our current resources more effectively

- Continue roll-out of a new model of community acute response in Rodney and West Auckland, following the successful North Shore pilot, by June 2017
- Participate in regional plan activity – High and Complex needs, Eating Disorders, Substance Addiction (Compulsory Assessment and Treatment) Bill, Māori workforce development plan, framework for suicide prevention training, review of child and youth services, offender health, and forensics (youth and adult) – ongoing
- Mental Health and Addictions NGO sustainability – with the Mental Health and Addictions sector,

Rising to the Challenge

implement the agreed work plan and complete 2016/17 objectives by June 2017

- Utilising a co-design process, develop a Shifting Services plan across DHB Provider Arm and NGO services to deliver the right care, in the right place, at the right time, by the right people; plan to be completed by June 2017
- Continue to work collaboratively with Police to identify and implement initiatives that will improve the experience of people with mental distress who come to Police attention – ongoing
- Actively participate in the development of the Commissioning Framework and develop an implementation plan once the final Framework is published by June 2017
- Maintain regular meetings and communication with key stakeholders from the Ranui Social Sector Trial to develop, agree and implement a transition plan by 31 July 2017.

Integration between primary and specialist services

- Plan and implement integration of General Practice and NGO support services based on the model(s) developed within the Tamaki Mental Health and Well-being Initiative, prioritising Whānau House and Totara Health, by June 2017
- Further develop primary mental health integration with Totara Health based on the evaluation (evaluation due March 2016) by June 2017
- Improve the interface between the Community Alcohol and Drug Service and primary care – ongoing
- Design and enhance access for primary care clinicians to advice, information and screening from provider arm clinicians by June 2017
- Our Health in Mind actions are implemented with initiatives to build the capability and capacity of primary care to achieve better outcomes for people with mental illness/addiction issues and significant physical health concerns; 2016/17 initiatives include:
    - Improve access to specialist telephone advice for GPs case management enquiries
    - Co-ordinate and publish existing community resources for easy navigation to the most appropriate service quickly and efficiently.

Resilience and recovery

- Develop an Equally Well action plan for the Waitemata and Auckland DHBs to improve the physical health of service users. The initial stages of this plan will include the ability to record physical health status and development of baseline data, to be completed by June 2017
- Evaluate clinical processes around assessment and treatment of Māori under community treatment orders by June 2017
- Monitor and analyse section 29 Mental Health Act treatment orders for Māori – ongoing
- Run focus groups with non-Māori clinical staff to better understand perceived differences in assessment and treatment of Māori under CTOs (Section 29), identify gaps in current service delivery to Māori and recommend steps for improvement by June 2017
- Ensure reliable collection of seclusion and restraint use data for Māori, and analyse the data to understand differential rates of use for Māori by June 2017
- Ensure routine metabolic screening for secondary service users, with priority focus on Māori and Pacific (who have the highest physical health comorbidities) by June 2017
- Deliver 2016/17 actions of the Auckland and Waitemata DHBs' Suicide Prevention and Postvention Action Plan (2015–2017). The plan and the actions will be guided by the Advisory Working Group and Inter-Agency Advisory Group, and will prioritise at-risk populations (e.g. youth/rural/Māori). Activities in 2016/17 will include developing community resources, wellbeing and resiliency; training community members and health providers to identify and support at risk individuals; and develop pathways between primary and secondary care providers – to be completed by June 2017
- Implement the priority actions identified from Everyone's Business: a mental health and employment strategy for the Auckland and Waitemata DHB regions by June 2017
- Support Parents Healthy Children (COPMIA) – all services to develop action plans, and establish routine data collection and service champions by June 2017.

Delivering increased access

- Implement the 2016/17 actions of the Waitemata Stakeholder Network Service development Plan (2015–2020). Actions to be completed by June 2017 include increasing access to Child and Youth

Rising to the Challenge

services in Rodney, delivering the first Incredible Years courses in Chinese and Korean languages, and utilising service user feedback in Older Adult service planning and evaluation
- Continue development of shared care for aging population between Services for Older Adults and primary care by June 2017 – ongoing
- Improve access to alcohol and drug services through improved relationships with education, justice, health and child protection services by June 2017
- Expand delivery of support and care packages in primary care, including access to increased NGO support hours for people with mental illness by June 2017
- Introduce a standardised and universal screening and brief intervention for alcohol harm into primary care to be initially targeting pregnant women by June 2017.

Health of Older People

By 2034 there will be around 153,000 people aged 65+ years living in our district, making up 20% of the total population. Older people are large consumers of health care resources, currently occupying about 45% of our medical and surgical beds. Our aim is to ensure older people receive coordinated and responsive health and disability services that are accessible, flexible and timely. Integrating primary and community care across the health system enables patients to be treated closer to home, and with fewer acute and unplanned admissions to hospital.

Health of Older People

Health outcome: Older people experience independence and quality of life

What are we aiming for in 2016/17? (Our measures)

Key measure
- Reduce the percentage of people aged >75 years living in aged residential care (baseline 6.8% 2013/14)
- Monitor the percentage of people aged >75 years receiving Home Based Support Services (baseline 14.6% 2013/14).

Other measures
- interRAI
  - 95% of older people who have received long-term HBSS in the last three months have had an interRAI Home Care or a Contact assessment and completed care plan
  - Report on the proportion of older people in ARC who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of their previous assessment
  - 98% of LTCF clients admitted to an ARC facility have been assessed using an interRAI Home Care assessment tool in the six months prior to that first LTCF assessment
  - An increase in 1) urgent referrals requiring an interRAI assessment to be completed within 5 days (baseline compliance = 61%) and 2) non-urgent referrals to be completed within 15 days (baseline compliance = 28%)
- Falls Prevention and Fracture Liaison Service
  - total number of patients identified as having a fragility fracture
  - number of patients assessed by the FLS and the number commenced on therapy
  - 350 people receive strength and balance training.
- Cognitive Impairment Pathway
  - number of GPs who have completed the e-learning resource
  - % of PNs per practice who have completed the e-learning resource
  - total number of patients started on the Cognitive Impairment Pathway
  - total number of new dementia diagnoses:<65 years; 65–79 years; 80+ years
  - total number of new mild cognitive impairment diagnosis: <65years; 65–79 years; 80+ years.

Health of Older People

How will we achieve this?

System Integration for older people

- Review processes to ensure the right health information is communicated between providers caring for older people, including transfer of information between hospital and aged residential care (yellow envelope), and Home and Community Support Service providers and primary care and specialist services – provide evidence quarterly that systems are in place to support information flow and improved outcomes for older people.
  - Review completed by December 2016
  - Actions identified and implemented by June 2017.

Falls and Fragility Fracture Prevention

- The joint Auckland and Waitemata DHBs and ACC Falls Working Group will, by 30 September 2016:
  - develop a clinical pathway including: target groups, points of entry and referral processes; a single point of entry to coordinate service delivery; a range of services to meet different needs and follow-up
  - undertake assessment of the capability and capacity of current service provision particularly community group provision of strength and balance training
  - identify and prioritise new service development and funding
- Complete a falls prevention business case by 30 September 2016
- Maintain and monitor operations of the existing Fracture Liaison Service (FLS) – ongoing.

interRAI Comprehensive Clinical Assessment

- Use interRAI assessment tools for all older people receiving long-term Home and Community Support Services (HCSS) or living in aged residential care (ARC) facilities – ongoing
- Older people referred for an interRAI assessment to access publicly funded care services undergo the assessment and have a service allocated/declined in a timely manner – ongoing
- interRAI measures provided by the national data analysis and reporting service are used to compare and benchmark performance with other DHBs and DHB regions (where there is a consistent approach to enable comparisons) to improve outcomes for older people – ongoing.

Home and Community Support Services (HCSS)

- Support Inbetween Settlement agreement outcomes (timeframe dependent on Settlement)
- HCSS procurement plan for new model of care completed by December 2016.

Dementia Care Pathway

- The 'living well with dementia model of care' will be rolled out to GPs who have the electronic version of the Northern Region Cognitive Impairment Pathway; rollout completed with 50% of these GPs by 30 June 2017 and the remaining 50% by 30 June 2018 (dependent on Board approval)
- All participating GPs and Practice Nurses will complete the eLearning Dementia Education Resource before going live with the 'living well with dementia model of care'.

Implement the Kaumatua Action Plan – Investigate the level of whānau carer stress; report and recommendations completed by 30 March 2017.

DHB Health of Older People Strategy – Trial a strategic planning process for Health of Older people by 30 March 2017.

Better quality and experience of care

Patient experience is an important indicator in assessing the quality of care provided, and a positive experience is correlated with improved health outcomes. Our focus is to improve the care our population receives, and to engage people as partners in their care and providing services that are responsive to the individual needs of patients and their whānau.

Patient Experience and Community Engagement

Patient experience is one of our two Board priorities. We implemented an electronic feedback system in 2015/16 and monitor patient experience with several metrics. In 2016/17, we will continue to develop our experience programme across all DHB services, as well as systems to measure and improve staff experience and engagement. We will also implement our recently endorsed engagement strategy to strengthen the partnership with our communities.

Waitemata Experience

Health outcome: Engage patients and communities in the care they receive

What are we aiming for in 2016/17? (Our measures)

Key measure

- Achieve a Net Promoter Score of >70 on the electronic patient and staff experience feedback system by June 2017 (baseline = 62).

Other measures

- 500 members of the Reo Ora Community Voice panel recruited by June 2017 and at least 5 opportunities provided for the panel to provide input into Waitemata DHB activities
- At least 1 'In Your Shoes' session held at each hospital site for volunteers
- Establish the baseline number of volunteers by June 2016 and increase by 100 by June 2017; establish baseline volunteer satisfaction (as measured by a Net Promoter Score of >70) by June 2016 and achieve an increase by June 2017
- 10% increase in the numbers of patients/whānau survey participants (8,500 in 2014/15)
- Quarterly reporting on patient experience.

How will we achieve this?

- Develop an implementation plan for the engagement strategy in partnership with the Community Engagement Forum by December 2016
- Continue to work with collaboratively with the Health Links consumer voice in the DHB's work to plan, develop, deliver and review health and disability services – ongoing
- Exploring options for a Consumer Advisory Committee with diverse community membership as a key governance forum – by June 2017
- Conduct an annual survey to evaluate whether consumer representatives feel valued, listened to and supported to participate in DHB projects or programmes of work during 2016/17
- Establish new Reo Ora Community Voice (online community panel) by September 2016
- Support ongoing engagement and co-design process for the Auckland-Waitemata DHB Maternity Services Collaboration Plan during 2016/17
- Review the volunteer programme and develop systems for recruitment, orientation, support and training by December 2016, with a support package to be in place by June 2017
- Engage the community to implement the Partners in Care programme by June 2017
- Re-develop electronic patient and staff experience feedback system to include all areas in the DHB and values-based reporting by June 2017
- Hold biannual 'listening weeks' to gather community and staff stories during 2016/17
- Pilot bedside entertainment system and develop rollout plan to all inpatient areas by December 2016
- Work in partnership with Waitemata 2025 to ensure adherence to design principles – ongoing
- Run the annual Patient Experience Week with Auckland and Counties Manukau DHBs in March 2017.

Improving Quality

Waitemata DHB has the lowest Hospital Standardised Mortality Rate of any DHB (0.72). We improved our compliance across the HQSM markers, including good hand hygiene practice from 62% (July–October 2012) to 85% (July–October 2015), and the rate of healthcare-acquired *Staphylococcus aureus* bacteraemia has remained well below the national average. Nearly all patients at risk of falling are identified and given an individualised care plan. Electronic medicine reconciliation roll out is now almost

complete across the whole organisation. 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.

Improving Quality

Health outcome: Patients stay safe in our hospitals

What are we aiming for in 2016/17? (Our measures)

Key measure

- >80% compliance with good hand hygiene practice.

Other measures

- >90% of older patients are given a falls risk assessment
- 98% of older patients assessed as at risk of falling will receive an individualised care plan to address identified risks
- All three parts (sign in, time out and sign out) of the surgical safety checklist are used in 100% of audited surgical procedures, with levels of team engagement with the checklist at 5 or above, as measured by the 7-point Likert scale, 95% of the time
- All three parts of the WHO surgical safety checklist (sign in, time out and sign out) being used in a minimum of 90% of operations
- 95% of hip and knee replacement patients receive 1.5 g or more of cefazolin or 1.5 g or more cefuroxime
- 100% of hip and knee replacement patients receive prophylactic antibiotics at 0–60 minutes prior to incision
- 100% of all wards to use the electronic medicine reconciliation (eMR) platform and >50% of clinical areas to use eMR by July 2017
- 20 additional primary care practices to participate in Patient Safety in Primary Care programme by July 2017
- Zero grade 3 and 4 and ungradeable pressure injuries.

How will we achieve this?

Health Quality and Safety Commission (HQSC)

- Performance updates published by the HQSC and included in Waitemata DHB's quality accounts as required, and report regularly to DHB Board Committees – ongoing
- Support the Quality & Safety Markers (QSMs) and the HQSC's associated priority areas by collaborating nationally and regionally on quality improvement programmes and meeting and exceeding the national targets for the QSMs for falls, healthcare associated infections, perioperative care and medications – ongoing
- Implement the HQSC's quality account guidance, promote key messages and the theme of Patient Safety Week 2016 in the 2016/17 quality account and publish online by December 2017.

Safe surgery

- Continue to use paperless surgical safety checklist as a teamwork and communication tool rather than an audit tool – ongoing
- Implement briefing and debriefing for each theatre list in all operating theatres by June 2017
- Sustain achievement above the identified QSM threshold for the clinical interventions specified by the Surgical Site Infection Improvement Programme for all hip and knee operations – ongoing
- Implement local improvement methodology and front-line ownership for all surgical site infection programmes (hip and knee operations) by June 2017
- Results of the surgical site infection programmes will be reviewed regularly to improve quality and safety – ongoing.

Reducing harm from falls

- Undertake weekly audits of falls risk assessments and care planning in all wards and provide real-time falls data to ward teams and managers to monitor and reduce falls incidence – 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

Improving Quality

reporting and investigations – ongoing
- In partnership with Health of Older People services, implement a systematic and integrated community falls prevention programme, including a care pathway for targeted high risk individuals by June 2017
- Integrate in-hospital and community falls prevention programmes with shared membership of falls steering group and alignment of activities, by December 2016.

Pressure injury prevention
- Measure and report to HQSC all pressure injuries grade three and above as serious adverse events – ongoing
- Measure and report pressure injury prevalence regularly and consistently – ongoing
- Improve classification and documentation of pressure injuries by grade in the patient record and ensure they are coded – ongoing
- Consistently use evidence-based structured risk assessment of pressure injury to support clinical judgement and implement effective prevention – ongoing.

Hand hygiene
- Continue to implement the hand hygiene programme, including training Gold auditors in all clinical areas (to maintain an appropriate number) and monthly auditing, reporting and improvement programmes in all clinical areas, by June 2017
- Hand hygiene audit results will be regularly reviewed, with appropriate actions implemented accordingly to improve quality and safety – ongoing
- Continue staff and patient awareness programme, including a patient and whānau co-designed information resource, promotion of audit results and improvement activities on quality boards in every ward and clinical area, as well as regular hand hygiene awareness activities – ongoing.

Medication safety
- Continue to implement electronic prescribing and administration and eMR, complete implementation by June 2017.

Patient safety
- Develop the primary care patient safety campaign with dedicated quality improvement support for primary care teams – ongoing
- Continue to 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 (hospital 24/7 programme) – ongoing
- Optimise new electronic systems (including eVitals, eLabs, ePrescribing) through integration to improve patient safety and provide better information by June 2017
- Develop and implement a 'time matters' patient safety programme, including the sepsis bundle with integration across community and hospital services by June 2017.

Quality improvement
- Implement ward accreditation programme in every ward with quarterly auditing, frontline ownership and local improvement methodology by June 2017
- Build quality improvement and clinical leadership capability by developing and implementing a tiered enhanced care management and clinical leadership training programme that will support clinician-led care redesign, enhanced care management and patient safety – ongoing
- Promote online quality improvement tools and methodologies to all staff including local e-learning quality improvement modules and IHI/Harvard's Massive Open Online Course (MOOC) by June 2017.

Note: Deliverables related to patient experience appear in the Patient Experience and Community Engagement section within this module.

Sustainable and equitable health system

As our population grows and health service demand increases, it is increasingly important for us to focus on the sustainability of our organisation and the services we fund and provide. We need to ensure health services are delivered from the right locations, are accessible to those who need them the most, and that we make sensible decisions about providing these services now and in the future.

Our goal is to:	Ensure clinical and financial stability and prudent investment to provide patient-focused care

System enablers

We need to ensure we have the right infrastructure and resources in place to build health service capability where it is needed the most and to meet the needs of our diverse and growing population.

Service Configuration including System Level Outcomes

A more integrated system where primary and secondary care clinicians work collaboratively with clear and open lines of communication will ensure that appropriate healthcare services are delivered in the right place at the right time. We will continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services, including shifting services, to ensure patients receive more effective and co-ordinated services closer to home and provided by one team.

Service Configuration including System Level Outcomes

Health outcome: Patients receive more effective and co-ordinated services closer to home and provided by one team

What are we aiming for in 2016/17? (Our measures)

Key measures

- System Level Outcome measures (as set out in the Outcomes Framework in Module 1)
- Maintain direct access (baseline = 30,875 community referrals – CY2015) for general practitioners to a full suite of diagnostic imaging including x-rays, ultrasounds, fluoroscopy, mammography, nuclear medicine, CT and MRI with a focus on managing to appropriate waiting times – ongoing
- Primary Options for Acute Care (POAC) target – 9,500 referrals.

Other measures

- Achieve a 10% increase in access to primary mental health programmes (average increase of 130 people per quarter, where service is commenced or delivered in the quarter)
- Enrol at least four additional general practices into the CARE pilot, to achieve a target final enrolment of 1,250 patients by May 2017.

How will we achieve this?

Collaboration

- Review of Palliative Care Medical Hub to identify improvement opportunities by 30 June 2017
- Continue to work with PHOs to develop the HealthCare Home
    - Progress discussions to define model and level of investment Q1-Q2
    - Determine final model Q3
    - Determine level of investment Q3
- Support National Framework for the Pharmacist Services in the Community by continuing to maintain high quality medicines adherence and optimisation services, such as Long-Term Conditions (LTCs), Community Pharmacy Anticoagulation Services (CPAMS) and Medicine Use Reviews (MUR) – ongoing
- Support the focus areas identified in the Pharmacy Action Plan and making better use of pharmacist expertise by provision of MURs and clinical pharmacist services in residential aged care settings – ongoing
- Development and implementation of an education-based community pharmacy workforce

Service Configuration including System Level Outcomes

development programme to further enhance the capability and capacity of the current Workforce. The programme will enable the Workforce to maximise their potential, and contribute to delivery of integrated high quality care to better meet the population health needs by June 2017

- Participate and contribute towards the national plan of commissioning of pharmacist services in the community via the new Community Pharmacy Services Agreement – ongoing
- Support the development and implementation of a sustainable national solution to pharmaceutical margins and efficient supply chain management via the new Community Pharmacy Services Agreement – ongoing
- Quarterly monitoring of LTC registrations, CPAMS, MUR volumes and workforce development programme completion rates – ongoing
- A new Community Pharmacy Services Agreement in place for the integration of pharmacist services in the community by June 2017
- Implementation of Stage One of the Cognitive Impairment standardised care model completed across both Waitemata and Auckland DHBs by 30 June 2017
- Continue the Co-ordinated Care, Assessment, Rehabilitation, and Education (CARE) pilot – ongoing
- Implement finalised clinical protocol for ferinject in primary and community settings by June 2017.

Service Reconfiguration

- Implement phase one of the Rural Alliance work-plan which will expand services to support increased access to diagnostics and interventions to rural communities by 30 June 2017
    - Complete stocktake of rural GP services Q1
    - Identify which services should be prioritised for investment in rural areas Q2
    - Develop business models and timeline for business case development by Q3
- Work with the PHOs to implement the new after-hours, over-night, and GP deputising services new agreement in place by 1 November 2016.

Quality and Safety of Care

- Expand the Safety in Practice programme with a further 20 general practices participating in Waitemata DHB by 30 June 2017.

Infrastructure and Pathways

- Ongoing rollout of the Clinical Pathways Programme as per the agreed business case – investment over 3 years to expand range of regionally agreed pathways
- Complete POAC and Access to Diagnostics review and report on recommendations Q1
- Implement the recommendations of the POAC and Access to Diagnostics review by 31 March 2017
- Increased commitment and expansion of POAC service to improve primary care response to demand – ongoing
- Work with PHOs and regional POAC members to continue to support the services across Waitemata (target 9,500 referrals) by 30 June 2017.

Primary mental health

- Establish joint governance and leadership group by October 2015
- Implement Our Health in Mind priority first year actions over 2016/17

System Level Outcome Measures

- Waitemata DHB will provide a jointly developed and agreed (with PHOs and district alliances) Improvement Plan to the Ministry by 20 October 2016.

Living within Our Means

We must be a financially sustainable and productive organisation while improving health outcomes and reducing inequities for our community. Like all other DHBs, we operate 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. We have lived within our means for the past five years. We have achieved year-end financial results that are better than approved plans.

Living within our Means

Health outcome: Achieving a financially sustainable health system

What are we aiming for in 2016/17? (Our measures)

Key measure

- Breakeven financial result achieved for 2016/17 and each of the out years.

How will we achieve this?

- healthAlliance and New Zealand Health Partnership Limited (NZHPL) savings programme from procurement – ongoing
- healthAlliance and NZHPL savings initiatives implemented and savings achieved by year end
- Capped management and administration FTE count maintained at final agreed budget levels – ongoing
- Support the work of NZHPL to progress the Food Services, Linen and Laundry Services activities aimed at reducing the costs and improving the overall quality and provision of service
- 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
- Development of further joint work streams where applicable with Auckland DHB over 2016/17
- Pursue additional income opportunities over 2016/17
- 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
- Various model of care reviews to identify more efficiency methods of operating over 2016/17.

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, inequities 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

Waitemata's Māori population has higher rates of diabetes and cardiovascular disease and risk factors are more prevalent, particularly smoking, when compared with the overall Waitemata population. Differences in health outcomes are best illustrated by the gap in life expectancy. In 2012–2014, Māori lived 6.3 years less on average. We have already made positive gains for our Māori population; with a collective approach from across the health system, we are determined to make further progress.

Māori Health

Health outcome: Reduce inequalities in health outcomes

Māori Health

What are we aiming for in 2016/17? (Our measures)

Key measures

- Achieve ASH rate target of <5,567/100,000 population for Māori aged 45–64 years
- 80% of eligible Māori women receive a 3-yearly cervical screen.

Other measures

- At least two Waitemata DHB services implemented in the West Rodney Whānau Ora Network
- At least two new Waitemata DHB outpatient clinics delivered in the Te Puna Hauora Wellness Centre
- At least two new Waitemata DHB services transitioned to Whānau House
- 75% of Māori aged 65+ years of age will have received the seasonal influenza vaccine
- 70% breast screening coverage of eligible Māori women
- 95% Māori enrolment in PHOs
- Achieve ASH rate target of 5,666 to 6,262 per 100,000 population for Māori aged 0–4 years.

How will we achieve this?

Priority areas of focus and performance measures are detailed in the 2016/17 Waitemata DHB Māori Health Plan. These are:

- Data quality
- Access to healthcare
- Child health
- Cancer screening
- Smoking
- Immunisation
- Rheumatic fever
- Oral health
- Mental health
- Workforce
- Obesity
- Cardiovascular disease.

Additional activity:

Provider development and service integration

- Continue to support the implementation and expansion of the Whānau Ora Network and model of care in the West Rodney led by Te Rūnanga o Ngāti Whātua
- Deliver at least two new Waitemata DHB outpatient clinics at the Te Puna Hauora Wellness Centre
- Deliver at least two new services at Whānau House (Te Whānau o Waipereira Trust) based on the findings of the Health Needs Assessment.

Abdominal Aortic Aneurism Screening

- Complete the Abdominal Aortic Aneurism Pilot targeted at Māori men in Wellsford by June 2017.

Family violence

- Support the implementation of the Hohourongo Family Violence Intervention Programme – ongoing.

Whānau Ora

DHBs have a role in contributing to achieving Whānau Ora and health equity across the whole of the health system, actively engaging and collaborating with Commissioning Agencies to benefit the health of whānau. In 2016/17, our focus will be on achieving accelerated progress towards health equity for Māori and Pacific, and Whānau Ora in the next four years in five key areas – mental health, asthma, oral health, obesity and tobacco. More details can be found in our Māori Health Plan.

Whānau Ora

Health outcome: Reduce inequalities in health outcomes

What are we aiming for in 2016/17? (Our measures)

Key measures

- Decrease the rate of Māori treatment orders made under section 29 of the Mental Health Act (73 per 100,000 individuals aged 15+ years, 2013/14 financial year)
- 95% of Māori pre-school children enrolled in the Community Oral Health Service at December 2016.

Other measures

- Increase in the number of Māori children who are caries free at age 5

Whānau Ora

- 80% of all newborns are enrolled with a GP, in NIR, WCTO, Community Oral Health and hearing screening in the first 3 months by Q4 as part of the Single Enrolment Project
- Achieve asthma ASH rate target of <671/100,000 population for Māori aged 0–4 years
- By December 2017, 95 percent of obese Māori children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.
- 95% of all pregnant Māori women smoke free at two weeks post-natal.

How will we achieve this?

Specific deliverables or actions to deliver improved performance include:

- work with Te Pou Matakana and Te Runanga o Ngāti Whātua to identify and implement opportunities for co-investment and service co-design to support improved outcomes in more than one of the key Whānau Ora areas – ongoing
- collaborate with Te Pou Matakana to contribute to the Tamaki Collective Impact initiative with a focus on improving health literacy in whānau to reduce obesity – ongoing
- strengthen our relationship with Te Pou Matakana through quarterly meetings to provide updates on planning and commissioning activities, and to identify opportunities for joint activities that will benefit whānau – ongoing
- identify at least one commissioning priority to support improved outcomes in at least one key Whānau Ora area that Waitemata DHB and Te Pou Matakana can investigate a joint commissioning project that will benefit whānau by December 2016
- present at least one joint commissioning activity to Waitemata DHB Board to support improved outcomes in at least one key Whānau Ora area for consideration by June 2017
- 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 meetings with West Fono Health Trust (the Pacific whānau ora provider for Waitemata DHB) with a focus on improving newborn enrolment rate to support improved outcomes in more than one of the key Whānau Ora areas – ongoing quarterly.

Mental Health

- Audit clinical-cultural care pathway for Māori in Waitemata DHB mainstream services under compulsory community treatment orders and provide a report with recommendations on the elements of the current care pathways that need improvement by June 2017
- Evaluate cultural competency of clinical staff working with Māori and the CTOs (Section 29), identify gaps in current competency levels, and give recommendations of what training is required and who needs it by June 2017
- Run focus groups with non-Māori clinical staff to better understand perceived differences in assessment and treatment of Māori under CTOs (Section 29), identify gaps in current service delivery to Māori and recommend steps for improvement by June 2017.

Asthma

- Audit the primary care component of the asthma care pathway by March 2017, and implement interventions(s) based on the audit findings by June 2017
- Develop a mechanism to monitor if Māori children who are receiving asthma support services are presenting to ED as ASH admissions by June 2017
- Audit the use of the asthma action plan in primary care and secondary care by December 2016 and implement intervention(s) accordingly by June 2017.

Oral Health

- Finalise ARDS Preschool strategy to improve Māori pre-school children enrolment and utilisation in community oral health services by October 2016
- Implement the ARDS preschool and adolescent strategy by December 2016.

Note: related deliverables appear in the Tobacco and Obesity sections within this module.

Pacific Health

Waitemata's Pacific population has higher rates of diabetes and cardiovascular disease and is over-represented in terms of risk factors, particularly smoking, when compared with other ethnicities. Differences in health outcomes are best illustrated by the gap in life expectancy. In 2012–2014, our Pacific population lived 5.3 years less. We have already made positive gains for our Pacific people; with a collective approach from across the health system, we are determined to make further progress.

Pacific Health

Health outcome: Reduce inequalities in health outcomes

What are we aiming for in 2016/17? (Our measures)

Key measure

- Deliver 8 *Living Without Violence* programmes by 30 June 2017
- 85% of Pacific 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.

Other measures

- Deliver 10 *Incredible Years* and/or *PPP* parenting programmes by 30 June 2017
- Implement 2 Pacific-specific WERO quite smoke competitions by 30 June 2017
- Deliver 10 self-management education workshops by 30 June 2017
- 200 staff to participate in the Pacific Best Practice training
- DNA rates will be at 10%.

How will we achieve this?

These deliverables are part of the 2016/17 Pacific Health Plan

Pacific children are safe and well and Pacific families are free of violence

- Participate in intersectoral family violence prevention forums – ongoing
- Engage Pacific women and their families (by holding focus groups) in the co-design of maternity services by December 2016.

Pacific people are smoke-free

- ensure that participating churches in the Enua Ola programme remain smokefree through an audit process by 30 June 2017
- Contribute to improving referrals to quit smoke services – ongoing.

Pacific people eat healthy and stay active

- Deliver nutrition education to the Enua Ola programme with a stronger focus on childhood obesity, by including nutrition information for children by 30 June 2017
- Implement findings from Enua Ola review by 30 June 2017
- Identify *Aiga* Challenge participants who sustain weight loss for 3 years and the causes for the weight loss by 31 December 2016, with analysis and reporting of the findings by 31 March 2017.

Pacific people seek medical and other help early

- In partnership with ARDS, develop and implement the Pacific Oral Health strategy by; plan to be developed by June 2016 and implemented by June 2017
- Review parish community nursing service and refine scope of practice by June 2017.

Pacific people use hospital services when needed

- Produce Pacific video to support 'in your shoes' initiative by 30 June 2017
- Implement recommendations from review of Pacific cancer nursing service by 31 December 2016.

Pacific people live in warm houses that are not overcrowded

- Participate in MBIE-led process seeking responses to the housing needs of Pacific people – ongoing.

Asian, New Migrant and Refugee Health

The Asian population accounts for 21% of Waitemata's population (126,000 people) and is projected to increase to 175,000 by 2025. Although our Asian population experiences the highest life expectancy in the district, Asian, new migrant and refugee populations are diverse and have specific health needs that 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.

Asian, New Migrant and Refugee Health

Health outcome: Reduce inequalities in health outcomes

What are we aiming for in 2016/17? (Our measures)

Key measures

- 90% of eligible Asians have had a heart and diabetes check within the last 5 years by June 2017 based on accurate ethnicity data collection and reporting protocols (Indian rate 82% as at Jan 2016)
- 95% of Asian children are fully immunised at 5 years by 30 June 2017 (85% as at January 2016)
- Increase cervical screening coverage rate to at least 80% by 2020 (64% as at November 2015).

Other measure

- Three refugee forums delivered to primary health professionals annually across Auckland and Waitemata DHBS, with Counties Manukau DHB engagement by June 2017.

How will we achieve this?

Ethnicity Data Quality

- Establish complete and accurate data on level 2 ethnic groups to guide planning and monitoring of services – June 2017.

Long-Term Conditions

- Continue to perform More Heart and Diabetes Checks to Asian populations with a focus on eligible Indian males (aged 35–44 years) – increase culturally appropriate communication to South Asian and other targeted ethnic groups by June 2017
- Collaborate with Healthy Families Waitakere to co-design initiatives for targeted ethnic groups that support healthy change and reduce chronic illness and incorporate priorities from the Healthy Auckland Together Plan by June 2017.

Childhood Obesity

- Design initiatives in partnership with Healthy Families Waitakere that aim to reduce childhood obesity and incorporate priorities from the Health Auckland Together Plan by June 2017
- Work with Asian service providers to monitor the number of pregnant women engaged with the HBHF programme with healthy weight gain in pregnancy by 30 June, 2017
- Provide culturally appropriate Asian & MELAA breastfeeding support in the development of a suite of strategies including peer support training, health professional health literacy (primary care, LMCs and community workers) and increased resourcing of information via the Pregnancy and Parenting App and Website – June 2017.

Immunisation

- Promote awareness of the prevalence of measles and uptake of the 4-year immunisations in Asian communities – by June 2017.

Women's Health

- Continue to provide free smears for Asian women aged 30–69 years who have not been screened or are under screened in the last 5 years – ongoing.

Refugee Health

- Provide workforce development training to primary health professionals on refugee health, and deliver three refugee forums to primary health professionals annually across Auckland and Waitemata DHBs, with Counties Manukau DHB engagement by June 2017.

MODULE 3: Statement of Performance Expectations

Statement of Performance Expectations

The Statement of Performance Expectations is a requirement of the Crown Entities Act 2013 and identifies outputs, measures and performance targets for the 2016/17 year. Recent actual performance data are used as the baseline for targets.

Measures within this Statement of Performance Expectations represent the outputs/activities we deliver to meet our goals and objectives in Modules 1 and 2, and also provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of key indicators. 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 2016/17 is on delivering the key impacts identified in our outcomes framework, which will contribute to the achievement of the long-term outcome measures we have set, and will ultimately result in better health outcomes for our population, measured by our two high level outcomes:

- An increase in life expectancy
- A reduction in the ethnic gap in life expectancy

A description of the impacts and outcomes we expect to see are detailed in our outcomes framework in Module 1. This links the outcomes and impacts of our planned activity with the national, regional and local strategic direction.

Cost of outputs

Waitemata DHB 2016/17 Output Class Reporting – Statement of Service Performance

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	**29,258**	**420,149**	**981,221**	**209,397**	**1,640,025**
Expenditure					
Personnel	10,189	78,586	492,448	27,679	**608,902**
Outsourced Services	1,175	11,168	49,544	4,703	**66,590**
Clinical Supplies	1,836	13,437	91,197	4,469	**110,938**
Infrastructure & Non-Clinical Supplies	1,428	8,483	77,712	2,063	**89,687**
Payments to Providers	14,515	305,922	269,942	169,028	**759,408**
Total Expenditure	**29,143**	**417,596**	**980,843**	**207,942**	**1,635,525**
Net Surplus/(Deficit)	**115**	**2,553**	**378**	**1,455**	**4,500**

Targets and achievements

Targets and comparative baseline data for each of the output measures are included in the following sections. 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
↔	Maintain current 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 and are distinct from treatment services that repair/support health and disability dysfunction. 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. More than one quarter of deaths are preventable (27%), and for CVD, the second leading cause of death, up to 70% can be avoided (HNA, 2015). Effective prevention services can therefore have a significant impact on health outcomes.

Outputs measured by	Notes	Baseline	Target 2016/17	Baseline Data
Health promotion				
Percentage 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	98.0%	95%	Q2 2015/16
Percentage of PHO enrolled patients who smoke have been offered help to quit smoking in the last 15 months	Q	88.2%	90%	Q2 2015/16
Percentage of pregnant women who identify as smokers upon registration with a DHB-midwife or LMC are offered brief advice and support to quit smoking	Q	90%	90%	Q3 2015/16
Raising Healthy Children HT: Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Q	New indicator	95%	
Number of adults referred to Green Prescriptions	V	6,511	7,288	2014/15
Percentage of decile 1–4 schools engaged in Health Promoting Schools	Q	89%	75%	July 2015
Enforcement of the Smokefree Environments Act 1990[1]				
Number of retailer compliance checks conducted	V	284	300	2014/15
Health protection				
Tuberculosis (TB)[1]				
Percentage of TB and LTBI (Latent TB Infection) cases who have started treatment and have a recorded start date for treatment	Q	99.9%	≥85%	2014/15
Population-based screening				
Breast Screening				
Coverage rates among eligible groups	C	68%	70%	Q1 2015/16
Bowel Cancer Screening Programme Pilot				
Percentage of people invited to participate who returned a correctly completed kit	C	53.4%[2]	60%	Jan 2014-Sep 2015
Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 55 working days	T	95%	95%	Dec 2015
Children				
Number of children referred for a Gateway assessment waiting over the contracted timeframe	T	30	0	Mar 2016
Percentage of B4 School Checks completed	C	93%	90%	Q4 2014/15

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.

[1] These services are delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Auckland metro DHBs. The data to support these measures is for all three metro Auckland DHBs.
[2] Round 2 participation

Output class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various settings including general practice, community and Māori health services, pharmacist services and child and adolescent oral health services. 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 patients to maintain their functional independence and prevent relapse of illness.

Outputs measured by	Notes	Baseline	Target 2016/17	Baseline data
Primary health care				
Rate of primary care enrolment	C	93%	95%	Q2 2015/16
Number of referrals to POAC (Primary Options for Acute Care)	V	8489	9500	April 2015 – Mar 2016
Increased immunisation HT: percent of eight months olds will have their primary course of immunisation on time	C	93%	95%	Q3 2015/16
Rate of seasonal influenza immunisation in people aged 65+ years	C	61%	75%	Q1 2015/16
Rate of HPV immunisation coverage (dose 3)	C	58%	70%	Jan 2016
Rate of cervical screening coverage	C	77%	80%	Q2 2015/16
Percentage of people with diabetes whose HbA1c at their annual review was ≤64mmol/mol	Q	67%	69%	Q2 2015/16
Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	C	90%	90%	Q2 2015/16
Percentage of patients with prior CVD who are prescribed triple therapy	Q	54.6%	55%	Oct 2014-Sep 2015
Community-referred testing and diagnostics				
Number radiological procedures referred by GPs to hospital	V	30,875	Ω	CY 2015
Percentage of accepted community referrals for CT and MRI scans receiving their scan within 6 weeks	T	CT 90% MRI 91%	CT 95% MRI 85%	Dec 2015
Oral health				
Mean decayed, missing, filled teeth (DMFT) at year 8 ratio	Q	0.74	0.82 2016 0.72 2017	CY 2015
Children caries free at five years of age	Q	67%	70% 2016 72% 2017	CY 2015

Output class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers. 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 and include:

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

Effective and prompt resolution of medical and surgical emergencies and treatment of significant conditions reduces mortality, restores functional independence and improves health-related quality of life, thereby improving population health.

Outputs measured by	Notes	Baseline	Target 2016/17	Baseline data
Acute services				
Number of Emergency Department (ED) attendances	V	117,291	Ω	CY2015
Total acute WIES provided	V	56,704	56,561	Q2 2015/16
Shorter stays in Emergency Departments HT: percentage of ED patients discharged admitted or transferred within six hours of arrival	T	95%	95%	Q2 2015/16
Faster Cancer Treatment HT: percentage of patients who 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	T	68%	85%	Q2 2015/16
Percentage of potentially eligible stroke patients thrombolysed	Q	2.9%	6%	Q1 2015/16
Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	Q	82%	80%	Q1 2015/16
Percentage of ACS inpatients receiving coronary angiography within 3 days	T	85%	70%	Dec 2015
Maternity				
Number of births in Waitemata DHB hospitals	V	6,712	Ω	2015
Percentage of patients with third/fourth degree tears for all primiparous vaginal births	Q	3.14%	↓	2015
Proportion of women booking before end of 1st trimester	Q	64%	80%	2015
Elective (inpatient/outpatient)				
Improved access to elective surgery HT: number of elective surgical discharges	V	20,687	21,583	2014/15
Surgical intervention rate - Joints - Cataracts - Cardiac - PCR - Angiogram	C	 18.34 38.15 5.73 10.87 29.69	 21 27 6.5 12.5 34.7	Year ending Sep 2015
Percentage of people receiving urgent diagnostic colonoscopy in 14 days Percentage of people receiving non-urgent diagnostic colonoscopy in 42 days	T	85% 70%	85% 60%	Mar 2016
Percentage of patients waiting longer than 4 months for their first specialist assessment	T	0%	0%	Dec 15
Percentage of patients given a commitment to treatment but not treated within 4 months	T	0.4%	0%	Dec 15
Quality and patient safety				
Percentage of opportunities for hand hygiene taken	Q	80%	85%	Q2 2015/16
Percentage of older patients assessed for risk of falling	Q	99%	90%	Q2 2015/16
Percentage of operations[3] where antibiotic given in hour before incision	Q	98%	100%	Q2 2015/16
Rate of healthcare associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.06	↓	2014/15
Net Promoter Score on patient and staff experience feedback system	Q	70	63	May 2016
% of falls risk patients who received an individualised care plan	Q	99%	90%	Q1 2016/17
Rate of falls with major harm	Q	0.1	<2	Q1 2016/17
% of hip and knee procedures given right antibiotic in right dose	Q	94%	95%	Q3 2015/16
% hip/knee procedures given appropriate skin preparation	Q	100%	100%	Q3 2015/16
Surgical site infections per 100 hip and knee operations	Q	0.29	1.2-1.3	Q4 2015/16
Number of pressure injuries grade 3 & 4 - Provider Arm	Q	0	0	Q1 2016/17
Number of patients with pressure injuries per 100 patients	Q	0	0	July 2016

[3] Hip and knee arthroplasties

Outputs measured by	Notes	Baseline	Target 2016/17	Baseline data
Mental health				
Percentage of population who access mental health services: Age 0–19 years Age 20–64 years Age 65+ years	C	 3.14% 3.50% 2.13%	 3.10% 3.40% 2.10%	Nov 2014 to Oct 2015
Percentage of 0-19 year old clients seen within 3 weeks: - Mental Health - Addictions Percentage of 0-19 year old clients seen within 8 weeks: - Mental Health - Addictions	T	 80% 96% 92% 99%	 80% 95%	Oct 2014 to Sep 2015

Output class 4: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination provided by the Needs Assessment and Service Coordination (NASC) Service for a range of services, including palliative care services, home-based support services and residential care services.

Rehabilitation and support services are provided by the DHB and non-DHB sector, for example residential care providers, hospice and community groups. Effective support services restore function and help people to live at home for longer, therefore improving quality of life and reducing the burden of institutional care costs on the health system.

Outputs measured by	Notes	Baseline	Target 2016/17	Baseline data
Home-based support				
Average number of hours per month of home-based support services for: • Personal care • Household management	V	 67,505 16,331	 Ω Ω	Sep 2015
Proportion of people aged 65+ years receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan (InterRAI)	Q	82%	75%	Q1 2015/16
% of urgent interRAI referrals assessed within 5 working days % of non-urgent interRAI referrals assessed within 15 working days	T	61% 28%	↑	Q1 2016/17
Palliative care				
Number of contacts	V	22,181	Ω	2015/16
Proportion of hospice patient deaths that occur at home	Q	40%	↑	Jul–Dec 2015
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	13%	↓	Jul–Dec 2015
Residential care				
Proportion of aged care providers with 4 year audit certification	Q	15%	↑	2014/15

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 2015/16 financial year, and informed by robust organisational and financial analysis, we are forecasting a surplus of $4.311M for 2015/16 against a budgeted surplus of $2.811M. This result reflects continued cost growth containment in our services. Our Business Transformation programme has delivered savings in excess of $84M over the past four years, with savings of $4.1M planned for the 2015/16 financial year, returning a surplus of $19.7m over the last 5 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 2016/17 is based on the Ministry of Health funding envelope advice, with an increase of $37M or 2.7% over the 2015/16 funding envelope. Overall, the increase in Funding Envelope revenue is $46.9M above the 2015/16 budget (in addition to the Funding Envelope increase, the DHB has received ongoing additional revenue of $7.4M for capital charge on land and building revaluation as at 30 June 2015).

For the out-years, we have assumed that the funding increase will be 2.5%. Other revenue is based on contractual arrangements in place and reasonable and risk assessed estimates for other income.

Expenditure Growth

Expenditure growth of $61.4M above the 2015/16 budget 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 – cost of capital on the revaluation of land and buildings at 30 June 2015) 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 and are mitigated by the impact of procurement cost savings initiatives.

In planning for a surplus of $4.5M for the financial year, we will be forecasting the benefits of savings initiatives that will be delivered through programmes being undertaken by shared services (such as healthAlliance) and national agency entities (such as Health Partnerships Limited, National Health IT Board), as well as internally generated savings initiatives.

Forecast Financial Statements

The Board of Directors of the Waitemata DHB are responsible for the issue of the forecast financial statements, including the appropriateness of the assumptions underlying the forecast financial statements.

The forecast financial statements are authorised by the Board of directors for issue on 26 May 2016.

The forecast financial statements have been prepared to comply with the requirements of Section 139 of the Crown Entities Act. The forecast financial statements may not be appropriate for use for any other purpose. It is not intended for the forecast financial statements to be updated within the next 12 months.

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 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 2014/15, year-end forecast for 2015/16 and plans for years 2016/17 to 2019/20. The financial statements have been prepared on the basis of the *Key Assumptions for Financial Forecasts* and the significant accounting policies summarised in *Appendix 2: Statement of Accounting Policies*. The actual financial results achieved for the period covered are likely to vary from the forecast/plan financial results presented. Such variations may be material.

Forecast Statement of comprehensive income – parent

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Government and Crown Agency Revenue	1,431,771	1,462,465	1,516,950	1,547,740	1,578,536	1,609,313
Patient Sourced and Other Income	27,075	25,826	39,612	40,410	41,209	42,006
IDFs & Inter DHB Provider Income	81,500	81,409	83,463	85,156	86,850	88,543
Total Funding	**1,540,346**	**1,569,700**	**1,640,025**	**1,673,306**	**1,706,595**	**1,739,862**
Personnel Costs	568,097	577,090	609,360	617,660	629,989	642,311
Outsourced Costs	74,014	72,701	66,589	66,234	67,548	68,860
Clinical Supplies Costs	105,924	109,015	110,936	112,858	115,117	117,373
Infrastructure & Non-Clinical supplies Costs	109,255	107,483	89,232	97,141	99,019	100,897
Payments to Other Providers	680,969	699,100	759,408	774,913	790,922	807,421
Total Expenditure	**1,538,259**	**1,565,389**	**1,635,525**	**1,668,806**	**1,702,595**	**1,736,862**
Net Surplus/(Deficit)	**2,087**	**4,311**	**4,500**	**4,500**	**4,000**	**3,000**
Other Comprehensive Income	**0**					
Gains/(Losses) on Property Revaluations	54,245	29,322	0	0	0	0
TOTAL COMPREHENSIVE INCOME	56,332	**33,633**	**4,500**	**4,500**	**4,000**	**3,000**

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 2016/17, we are also committed to delivering a surplus of $4.5M.

Forecast Statement of comprehensive income – group

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Government and Crown Agency Revenue	1,431,771	1,462,465	1,516,950	1,547,740	1,578,536	1,609,313
Patient Sourced and Other Income	27,433	25,826	39,612	40,410	41,209	42,006
IDFs & Inter DHB Provider Income	81,500	81,409	83,463	85,156	86,850	88,543
Total Funding	**1,540,704**	**1,569,700**	**1,640,025**	**1,673,306**	**1,706,595**	**1,739,862**
Personnel Costs	568,097	577,090	609,360	617,660	629,989	642,311
Outsourced Costs	74,014	72,701	66,589	66,234	67,548	68,860
Clinical Supplies Costs	105,924	109,015	110,936	112,858	115,117	117,373
Infrastructure & Non-Clinical supplies Costs	108,682	107,483	89,232	97,141	99,019	100,897
Payments to Other Providers	680,969	699,100	759,408	774,913	790,922	807,421
Total Expenditure	**1,537,686**	**1,565,389**	**1,635,525**	**1,668,806**	**1,702,595**	**1,736,862**
Net Surplus/(Deficit)	**3,018**	**4,311**	**4,500**	**4,500**	**4,000**	**3,000**
Other Comprehensive Income	**0**					
Gains/(Losses) on Property Revaluations	54,245	29,322	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**57,263**	**33,633**	**4,500**	**4,500**	**4,000**	**3,000**

Forecast capital costs

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Depreciation	**23,517**	27,039	28,200	28,771	29,342	29,913
Interest Costs	**12,492**	10,716	11,136	11,362	11,588	11,813
Capital Charge	**18,618**	24,378	24,526	25,443	25,763	26,003
Capital Costs	**54,627**	**62,133**	**63,862**	**65,576**	**66,693**	**67,729**

Capital costs are expected to increase with additional capital investments. The increase in depreciation charge is 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 and revaluation of land and buildings; 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 was on 30 June 2015. A full revaluation on land and buildings were carried out for the financial year ending 30 June 2015. This is reflected in the increase in Capital Charge in 2015/16 as a result of the full revaluation of land and buildings.

Forecast statement of cashflows – parent

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Cashflow from operating activities						
MoH and other Government/Crown	1,519,457	1,614,488	1,633,375	1,666,586	1,699,739	1,732,871
Other Income	39,554	47,071	706	588	602	616
Interest received	7,528	5,082	6,010	6,132	6,254	6,375
Payments for Personnel	(540,677)	(575,929)	(609,360)	(617,660)	(629,989)	(642,311)
Payments for Supplies	(941,263)	(1,041,841)	(962,303)	(983,225)	(1,003,568)	(1,024,477)
Capital Charge Paid	(18,919)	(24,299)	(24,526)	(27,788)	(28,108)	(28,348)
GST Input Tax	(1,190)	(3,536)	0	0	0	0
Interest payments	(15,605)	(10,630)	(11,136)	(11,362)	(11,588)	(11,813)
Net cashflow from operating activities	**48,885**	**10,406**	**32,766**	**33,271**	**33,342**	**32,913**
Cashflow from investing activities						
Sale of fixed assets	0	0	0	19,500	0	0
Capital Expenditure (negative)	(44,619)	(71,624)	(74,926)	(46,899)	(31,413)	(27,542)
Acquisition of investments	(1,576)	0	0	0	0	0
Net cashflow from investing activities	**(46,195)**	**(71,624)**	**(74,926)**	**(27,399)**	**(31,413)**	**(27,542)**
Cashflow from financing activities						
Capital contributions from the Crown	0	0	0	0	0	0
Proceeds from borrowings	17,300	0	0	0	0	0
Repayment of borrowings	0	0	(1,000)	(1,000)	(1,000)	(1,000)
Net cashflow from financing activities	**17,300**	**0**	**(1,000)**	**(1,000)**	**(1,000)**	**(1,000)**
Net cash movements	**19,990**	**(61,218)**	**(43,160)**	**4,872**	**929**	**4,371**
Cash and cash equivalents at the start of the year	123,403	143,393	82,175	39,015	43,887	44,816
Cash and cash equivalents at the end of the year	**143,393**	**82,175**	**39,015**	**43,887**	**44,816**	**49,187**

Cashflow forecasts reflect the impact of major capital projects recently completed, under implementation or planned, and these include Department of Medicine, new Emergency Department at Waitakere, additional wards at North Shore and Waitakere, Mason Clinic remedial works 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 car park project loan has been included in the plan.

As at 1 May 2016, we have debt facility limits of $277.8M, of which $276.7M is drawn. The undrawn facility is the balance on the car park loan facilities.

Forecast statement of cashflows – group

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Cashflow from operating activities						
MoH and other Government/Crown	1,519,457	1,614,488	1,633,374	1,666,586	1,699,739	1,732,871
Other Income	40,658	47,071	706	588	602	616
Interest received	7,562	5,082	6,010	6,132	6,254	6,375
Payments for Personnel	(540,677)	(575,929)	(608,902)	(617,660)	(629,989)	(642,311)
Payments for Supplies	(941,893)	(1,041,841)	(962,760)	(983,225)	(1,003,568)	(1,024,477)
Capital Charge Paid	(18,919)	(24,299)	(24,526)	(27,788)	(28,108)	(28,348)
GST Input Tax	(1,190)	(3,536)	0	0	0	0
Interest payments	(15,605)	(10,630)	(11,136)	(11,362)	(11,588)	(11,813)
Net cashflow from operating activities	**49,393**	**10,406**	**32,766**	**33,271**	**33,342**	**32,913**
Cashflow from investing activities						
Sale of fixed assets	0	0	0	19,500	0	0
Capital Expenditure (negative)	(44,619)	(71,624)	(74,926)	(46,899)	(31,413)	(27,542)
Acquisition of investments	(1,821)	0	0	0	0	0
Net cashflow from investing activities	**(46,440)**	**(71,624)**	**(74,926)**	**(27,399)**	**(31,413)**	**(27,542)**
Cashflow from financing activities						
Capital contributions from the Crown	0	0	0	0	0	0
Proceeds from borrowings	17,300	0	0	0	0	0
Repayment of borrowings	0	0	(1,000)	(1,000)	(1,000)	(1,000)
Net cashflow from financing activities	**17,300**	**0**	**(1,000)**	**(1,000)**	**(1,000)**	**(1,000)**
Net cash movements	**20,253**	**(61,218)**	**(43,160)**	**4,872**	**929**	**4,371**
Cash and cash equivalents at the start of the year	124,647	144,900	83,682	40,522	45,394	46,323
Cash and cash equivalents at the end of the year	**144,900**	**83,682**	**40,522**	**45,394**	**46,323**	**50,694**

Forecast statement of financial position – parent

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Current Assets	189,338	142,049	100,487	107,359	111,288	118,659
Non-current assets	668,151	755,787	800,229	798,341	798,912	795,041
Total assets	**857,489**	**897,836**	**900,716**	**905,700**	**910,200**	**913,700**
Current Liabilities	266,512	256,079	255,459	256,943	258,443	259,943
Non-current liabilities	286,254	303,403	302,403	301,403	300,403	299,403
Total liabilities	**552,766**	**559,482**	**557,862**	**558,346**	**558,846**	**559,346**
Net assets	**304,723**	**338,354**	**342,854**	**347,354**	**351,354**	**354,354**
Total equity	**304,723**	**338,354**	**342,854**	**347,354**	**351,354**	**354,354**

A strong asset base is indicated, with total assets planned at $897M by 2015/16 year end reflecting completed capital projects.

Loan portfolio

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Term Loans – Crown (current portion)	(25,710)	(25,710)	(25,710)	(25,710)	(25,710)	(25,710)
Term Loans – Crown (non-current portion)	(250,996)	(249,996)	(248,996)	(247,996)	(246,996)	(245,996)
Total Loans	**(276,706)**	**(275,706)**	**(274,706)**	**(273,706)**	**(272,706)**	**(271,706)**

The non-current loans have 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.

Forecast statement of financial position – group

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Current Assets	193,134	142,049	100,487	107,359	111,288	118,659
Non-current assets	673,321	755,787	800,229	798,341	798,912	795,041
Total assets	**866,455**	**897,836**	**900,716**	**905,700**	**910,200**	**913,700**
Current Liabilities	266,479	256,079	255,459	256,943	258,443	259,943
Non-current liabilities	286,254	303,403	302,403	301,403	300,403	299,403
Total liabilities	**552,733**	**559,482**	**557,862**	**558,346**	**558,846**	**559,346**
Net assets	**313,722**	**338,354**	**342,854**	**347,354**	**351,354**	**354,354**
Total equity	**313,722**	**338,354**	**342,854**	**347,354**	**351,354**	**354,354**

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 Te Tiriti o 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

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Balance at 1 July	**248,391**	**304,723**	**338,356**	**342,856**	**347,356**	**351,356**
Comprehensive Income/(Expense)						
Surplus/(deficit) for the year	2,087	4,311	4,500	4,500	4,000	3,000
Other Comprehensive income	54,245	29,322	0	0	0	0
Total Comprehensive Income	**56,332**	**33,633**	**4,500**	**4,500**	**4,000**	**3,000**
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	**304,723**	**338,356**	**342,856**	**347,356**	**351,356**	**354,356**

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

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Balance at 1 July	**256,459**	**313,722**	**347,355**	**351,855**	**356,355**	**360,355**
Comprehensive Income/(Expense)						
Surplus/(deficit) for the year	3,018	4,311	4,500	4,500	4,000	3,000
Other Comprehensive income	54,245	29,322	0	0	0	0
Total Comprehensive Income	**57,263**	**33,633**	**4,500**	**4,500**	**4,000**	**3,000**
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	**313,722**	**347,355**	**351,855**	**356,355**	**360,355**	**363,355**

Additional information

Capital expenditure

	2014/15 Audited $000	2015/16 Forecast $000	2016/17 Plan $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000
Funding Sources						
Free cashflow from depreciation	23,517	27,039	28,200	28,200	28,771	29,342
External Funding	17,300	0	(1,000)	(1,000)	(1,000)	(1,000)
Cash reserves	127,665	126,676	82,523	39,297	23,598	22,956
Total Funding	**168,482**	**153,715**	**109,723**	**66,497**	**51,369**	**51,298**
Baseline Capital Expenditure						
Land	0	0	0	0	0	0
Buildings & Plant	(10,865)	(6,205)	(14,735)	(13,755)	(10,479)	(11,194)
Clinical Equipment	(9,709)	(5,685)	(6,194)	(7,773)	(7,906)	(8,039)
Other Equipment	(707)	(1,175)	(2,869)	(1,637)	(1,563)	(1,689)
Information Technology	(2,190)	(1,229)	(2,661)	(1,832)	(1,779)	(1,870)
Intangible Assets (Software)	(919)	(721)	(1,000)	(750)	(750)	(750)
Motor Vehicles	(226)	(612)	(2,087)	(1,480)	0	0
Total Baseline Capital Expenditure	(24,616)	(15,627)	(29,546)	(27,227)	(22,477)	(23,542)
Strategic Investments						
Land	0	0	0	0	0	0
Buildings & Plant	(20,001)	(11,634)	(31,398)	(14,491)	(7,728)	(3,320)
Clinical Equipment	0	(734)	(2,470)	(1,110)	(573)	(400)
Other Equipment	0	(423)	(1,419)	(707)	(420)	(200)
Information Technology	0	(1,448)	(3,853)	(1,533)	(215)	(80)
Intangible Assets (Software)	0	(2,581)	(6,240)	(1,831)	0	0
Motor Vehicles	0	0	0	0	0	0
Total Strategic Capital Expenditure	(20,001)	(16,820)	(45,380)	(19,672)	**(8,936)**	**(4,000)**
Total Capital Payments	(44,617)	(32,447)	(74,926)	(46,899)	**(31,413)**	**(27,542)**

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

Project	Indicative cost ($M)
Complete the construction of a bridge connecting the existing North Shore tower block with the Elective Surgery Centre (ESC) to provide access additional beds within the ESC and easier patient transfer	5.4
Construction of the new Awhina Learning Centre	9.8
Construction of a new 15-bed unit at the Mason Clinic, which is required to facilitate the remediation of the existing facilities and will provide additional inpatient capacity once complete	14.4
Extension of the Waitakere hospital Emergency Department	9.8
Commence the expansion of the ESC building to provide additional theatres, endoscopy suites and inpatient beds	40
Development of options to replace the existing tower which is no longer fit for purpose	200

Banking facilities and covenants

Term debt facilities

Waitemata DHB has term debt facilities of $277.8M with the Ministry of Health, of which $276.7M is currently drawn. 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 Partnerships Limited. Westpac has been selected to provide banking services to the sector. Health Partnerships 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 Ministry of Health 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 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 that links our high-level outcomes framework with day-to-day activity. The organisational performance monitoring processes in place include: our Annual Report; 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 ongoing 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 that 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 are meeting our obligations as a Crown Entity, including compliance with the risk standard AS/NZS 31000: 2009 Standard for Risk Management. The revised Risk Management Strategy was approved by the Board in 2015. The Corporate Risk Register is reviewed by the Board quarterly, providing assurance on the management of the most significant risks faced by Waitemata DHB.

Asset management

Asset management plan development

Waitemata DHB is committed to improving maturity in asset management and our goal is to achieve an advanced level of maturity over the next six years, in accordance with Treasury expectations set out in Circular CO(15)5. To this end, we have developed an asset management improvement plan, which is being incorporated into the latest revision of our Asset Management Plan (AMP) and Long Term Investment Plan. This will be audited as part of the Investor Confidence Rating (ICR) process.

Waitemata DHB understands that mature asset management is the role of everybody in the organisation. Therefore, the foundation project is the review and redevelopment of our organisational Asset Management System. This will redefine our asset management policies, processes and procedures that will set the behaviours needed to deliver long-term improvement. The project will determine the organisational asset information requirements and identify the resource requirements and associated roles and responsibilities needed to deliver these. It will also integrate our asset management information systems to provider greater visibility of asset utilisation and performance to enable us to further optimise the use of our assets and provide improved information to support asset investment decisions that balance cost and risk, and improve the level of service to our patients.

The major focus of this project will be the organisational change management needed to embed the resources, skills, behaviours and ongoing support throughout the organisation.

Facilities modernisation

The Chief Executive Officer launched Waitemata 2025 in June 2015 to enable modernisation of our facilities in order to improve the quality of services, expand capacity and meet service demand. The Waitemata 2025 Programme has been included in Waitemata DHB's capital planning process, including within the regional capital plan.

The Waitemata 2025 programme of works includes:

- Significant strategic build projects required to address not-fit-for-purpose facilities and meet future population needs. These projects are generally high-cost, high-risk and subject to Ministerial approval following submission of a business case.
- A number of short-term facility development and refurbishment projects where rapid upgrades of staff and patient facilities are required to meet immediate and short-term needs.

A number of strategic projects are complete, including:

- A new Mental Health Unit – He Puna Waiora
- A new 15 bed Women's ward – Hine Ora
- Interim Discharge Lounge
- Front of House Refurbishment
- Ward 8 modernisation.

A number of strategic projects are currently underway, including:

- Operating Theatre modernisation
- Clinical and Learning skills Centre
- Department of Medicine offices
- Bridge linking the Elective Surgery Centre to the Main Building
- Ward 3 modernisation
- Waitakere Hospital Emergency Department Redevelopment
- Day room refurbishment.

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, primary care and PHOs.

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 and National IT Board objectives, including:

- 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 participation in regional IT advisory groups.

Waitemata DHB commits to work with the Ministry of Health on the work programme of the former National Health Committee (once this is finalised).

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.

The direction on information management, systems and services in the Northern Region is set by the Northern Regional Information Strategy (RIS 2010–20). This year, the governance focus with our regional partners will be on:

- continuing to strengthen our shared information service, with a focus on responsiveness and value
- participating in national initiatives, including planning for the National Health Plan, National Infrastructure Platform and National Electronic Health Record
- developing the business case for a regional electronic health record in parallel with a refresh of the RIS10–20
- continuing investments in electronic support of clinically-led service initiatives.

Regional CWS (including MedMan), Regional CDR, Regional PAS – commitment to work regionally to ensure each region has completed the implementation of the regional applications. These systems need to include: SNOMED CT as the standard system of clinical terminology for all point-of-care applications; the captures of all sources of hospital information; ED and theatres; nursing observations and eReferrals triage; single access by clinicians to all sources of information. We also need to provide data to the National Electronic Health Record (EHR), and to ensure each region has developed a roadmap for delivery of each capability.

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 2016/17 year are:

Programme	2016/17 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	- Completing eOrders for Radiology and Laboratory - Completing Voice to Text software for clinician recording of clinical documents - Complete decision support tool for recording patients' vital signs - Complete ePA (Inpatient ePrescribing) implementation in the remaining 400 beds - PERSy – Implement electronic survey platform for staff and patient experience, and values-based reporting
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
Maternity Information System (MISP-NZ)	Initiating implementation of the national Maternity Information System – complete business case	- Implement the New Born Hearing Clinical Information System module of the MISP - Integrating to National Child Health Information Platform
Other new clinical applications and upgrades	These systems and upgrades aim to improve clinical effectiveness and safety, and improve regional alignment	- Completing Regional RIS/PACS Upgrade - Completing Infection Prevention and Control Software (ICNET) Implementation in collaboration with Canterbury
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 phase III, which include triaging, and intra- and inter-DHB referring - Clinical Pathways (Nexxt) - Shared Care Planning (CCMS) - Patient Portal
Business Intelligence – Tool Implementation and Infrastructure	The aim of the BI Strategy is to improve information access and user experience	- Data warehouse redesign Phase II - Complete the data discovery BI tool implementation
Compliance with National Programmes, Targets and Collections	Compliance programme	- National Patient Flow Phase III - Regional Faster Cancer Treatment 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 Northern Electronic Health Record (NEHR) Project will gain regional agreement on an EHR plan dependent on the outcome of the Implementation Planning Study (due to be completed late 2015/16)	

Workforce

Managing our workforce within fiscal constraints

We actively participate in the national Employment Relations Strategy Group, which establishes the parameters to ensure bargaining will deliver organisational and sector expectations, and appropriate recognition structures to support the achievement of health performance and personal development targets. Any agreements negotiated nationally, regionally, or locally are approved by the Ministry of Health in accordance with established protocols. We are supportive of the national engagement process through the Health Sector Relationship Agreement and the National Bipartite Action Group, and we meet regularly with our unions to discuss issues of mutual interest via joint consultation committees.

We have recently undertaken an analysis of recruitment and have plans in place to address these and our future recruitment and retention challenges generally. These plans include:

- ensuring our workforce planning is aligned with our Health Services Plan
- ensuring we are using contemporary, best practice recruitment practices
- investing in excellent systems, processes and reporting technologies
- collaborating regionally and nationally on recruiting and training key workforces
- increasing the pipeline of Māori and Pacific employees through our 'grow our own' programmes
- promoting our plans for organizational growth, sustainability and wellbeing.

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 via Patient Experience and better connections. There is a strong commitment to the ongoing building and maintenance of a performance- and patient-focused culture, which underpins a range of organisational programmes underway or planned.

The DHB has recently used the workforce intelligence and planning framework to identify several focus areas for building and strengthening our workforce over the next 3–5 years, as follows:

1. Planning our future workforce in alignment with our Health Services Plan and Waitemata 2025 facility building programme
2. Health, safety and wellbeing – alignment with new Health and Safety at Work legislation, healthy workplaces strategy 2016–19
3. Retention, culture, values and behaviours – integrating our staff and patient experience programmes
4. Leadership and Management – programme and activity aligned to the national leadership domains framework, care re-design programme for senior leaders, performance feedback succession planning, and professional development
5. Growing our Māori workforce – scholarships, Rangatahi Programme cadetships programme, and developing focused strategies with our MOU partners
6. Growing our Pasifika workforce – health science academies and mentoring
7. Gaining an increasingly diverse workforce – support for ageing workforce, cultural diversity, transport needs
8. Integrated and mobile technologies to support new ways for working and learning
9. Regional Workforce planning, which includes:
    - support for leaders and mangers developed through a regional programme of works, which includes management graduates and a middle-manager development programme
    - support for initiatives from the medical (including community placements for pre-vocational RMOs), nursing, kaiawhina, 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
    - jointly working to strengthen priority workforces, such as sonographers, medical physicists, nurses, midwives, and specialist palliative care educators
    - providing palliative care education and support for staff across aged residential care, GP practices and home-based support services

- the investment will be consistent with HWNZ's current investment in postgraduate nurse training. Government policy commitment September 2014: $7M to create 60 nurse specialist palliative care educators and support roles at hospices
- 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 Workforce Director to develop and deliver a workforce plan as part of the 2016/17 Regional Service Plan. The workforce plan will outline regional actions and key milestones. Progress towards achieving the plan will be reported through the Regional Services Plan.

Our current workforce

FTE	Other	Pacific	Māori	Total
Medical personnel	697	14	19	730
Nursing personnel	2,317	94	80	2,491
Allied Health personnel	1,321	78	98	1,497
Support personnel	240	43	17	300
Management/administrative personnel	773	35	42	850
Grand total	5,348	264	256	5,868

Headcount	Other	Pacific	Māori	Total
Medical personnel	772	14	23	809
Nursing personnel	2,747	104	89	2,940
Allied Health personnel	1,558	84	104	1,746
Support personnel	284	46	18	348
Management/administrative personnel	871	39	49	959
Grand total	6,232	273	283	6,802

Headcount excludes casual staff
Sourced from Leader, accurate as at 31 December 2015

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

Organisational health

Health and safety

At Waitemata DHB, the health, safety and wellbeing of our people is one of the strategic mandatories for the Board. Our health, safety and wellbeing aspiration is expressed in a promise to our staff:

To have a safe environment for our people, patients and visitors, contractors, where our health and safety obligations, risk and harm is understood, regularly discussed, assessed, and addressed.

This year we plan to increase our level of leadership, commitment and performance by:

1. implementing and educating the changes of the new Health and Safety at Work Act 2015 across Waitemata DHB
2. dealing with key health and safety and wellbeing risks promptly, using contemporary approaches in a way that sustains positive and progressive outcomes
3. developing an organisation-wide health and safety governance body to oversee all health and safety issues in the DHB

4. refining our process to select, train and give time to our health and safety representatives to meet the new legislative requirements
5. implementing a new Board report and reviewing our key leading and lagging indicators to be able to continually improve our reporting mechanism
6. working collaboratively with the Northern region on appropriate regional Health and Safety risks, which will include procurement, public health promotion and employee strategies
7. continuing to review our current health and safety systems and processes through internal and external auditing
8. progressing the work streams identified in the security review and implementing the recommended outcomes
9. release the Healthy Workplaces Strategy 2016–2019
10. developing improved health and safety visibility in building project design and pre-occupation inspection
11. embedding Health and Safety into our workplace culture and applying learnings across the organisation.

Equal employment opportunities

We strive to be a good employer at all ages and stages of our employees' careers. Good employment practises are a critical aid to building a healthy, values-based organisation that attracts and retains top health professionals who share our patient-centred culture in their practise and contribution to organisational life.

Through our Good Employer policy, the DHB provides:

- good and safe working conditions
- an equal employment opportunities programme (via our workforce and healthy workplaces plan) with a range of actions focussed on preventing discrimination related to gender identity, ethnicity, disability, sexual orientation, age or other factors and providing opportunities for all employees to achieve their potential
- recognition of the aims, aspirations and employment requirements of female, male and transgender persons
- recognition of the aims, aspirations and 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 to enhance 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 care redesign, 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 Report 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:

- Negotiate and enter into service agreements containing any terms and conditions that may be agreed;
- 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 Te Rūnanga o Ngāti Whātua and with Te Whānau o Waipareira Trust.

MODULE 6: Service Configuration

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

Service coverage and service change

Regional Service Change

Health services are continually evolving. Having a strong regional focus has successfully reduced the number of services identified as 'vulnerable' in terms of workforce, capacity and demand. We are changing the focus toward service planning and development to reflect the support given by DHB Chairs, clinical leaders and management to shape how services are structured and delivered in an environment of greater regional co-operation.

The key regional service change that has been signalled in prior years is the implementation of a Supra Regional Eating Disorders Services (EDS) Hub. Key changes that will be implemented in 2016/17 include:

- Auckland DHB will progress co-location of services comprising the fully integrated Auckland DHB-managed EDS Hub which will result in seamless transitions for clients between services
- A comprehensive training and support schedule will support supra regional workforce development and enhance local service delivery
- Exploring the use of technology to enhance client access to specialist support
- Extending the range of services where there is evidence of effectiveness (e.g. the introduction of multi-family therapy).

We will continue to work in the direction set by the DHB Chairs that our region will promote rational regional service distribution to:

- Strengthen the region overall
- Create the opportunity for certain services to be delivered locally
- Not destabilise any particular DHB.

The moratorium on service repatriation will continue. In the place of service repatriation, we will ensure a service distribution process that is rational, collaborative, enabling and able to be achieved in as short a time as possible.

The vision is that the current service providers will continue to hold the funding (through IDFs) and the key staff for the service mix currently being delivered for different DHB populations but will provide the service in an appropriately agreed and distributed way for each of our DHBs.

In line with the national initiative and recent guidelines to maximise the wellbeing of our population living with hepatitis C, we will support the design and implementation of a single clinical pathway for hepatitis C across the Northern Region to provide consistent services. This includes data capture of the key performance measures of patients diagnosed with hepatitis C and those having a fibroscan within the last year. At a DHB level, we will: work with our District Alliance and other stakeholders to ensure a whole-of-system approach and strong clinical leadership to implement integrated services; raise community and GP awareness and education; provide quality and accessible identification, assessment and management; and support the involvement of clinical nurse specialists in care delivery.

Local oncology service delivery is being considered for change, where we will investigate the options for transitioning some high volume Medical Oncology service elements away from the Northern Region Tertiary centre (Auckland DHB), and into regional secondary and community based delivery. Locations/facilities to be considered are within Northland, Waitemata and Counties Manukau DHBs.

Local Service Change

Type of service change	DHB	Area impacted by service change	Description of service change
Gap in service delivery	Auckland DHB Waitemata DHB	Smoking cessation services: • Pacific Quit Service (delivered by ARPHs) • Elective service (delivered by Waitemata DHB provider-arm) • Pregnancy Smoking Cessation Service (delivered by Auckland DHB provider-arm) • Waitemata DHB Community Pharmacy Smoking Cessation services (19 community pharmacies) • Smokefree Whānau service (delivered by Waitemata PHO)	The Ministry of Health (MOH) is undertaking a realignment of stop smoking services and all current stop smoking services (except Quitline) are ending on 30 June 2016. The MoH are appointing new providers and implement a new service delivery model. This means that the DHB will be required to align Tabaco control contracts with the new model of provision.
Change in model of service delivery	Auckland DHB Waitemata DHB	Home and Community Support Services (HCSS)	Procurement for this service will commence within 2016/17
Potential change in model of service delivery	Auckland DHB Waitemata DHB	Community Pharmacy	DHBs will work towards different contracts for the provision of community pharmacist services by working with consumers and other stakeholders to develop service options, including potential options for pharmacist service delivery
Potential change of provider	Auckland DHB Waitemata DHB	Active Families	Contracts will be re-tendered prior to their expiry on 30 June 2017 as the current providers have held these contracts since the late 1990s
Level, location and configuration of services	Auckland DHB Waitemata DHB	Maternity services	Subject to consultation feedback in Waitemata DHB and Board decisions, additional primary maternity facilities may be commissioned. Changes may be made to maternity facilities in Auckland DHB to increase primary births, following Board decisions. Subject to Board approvals, an RFP process may be run to include existing facilities in Auckland DHB
Change in service provider/s and configuration of services	Waitemata DHB Auckland DHB	Oral health – relief of pain services	New contracts expected to be entered into during 2016/17, following RFP process Also, explore the possibility of shifting relief of pain services for adults out of the hospital service to community dental providers based in high needs locations
Change in model of service delivery/possible change in service provider	Waitemata DHB	Pregnancy and Parenting Education service	New or renewed provider/s and/or provider model may be implemented in Waitemata during 2016/17, subject to Board approvals
Review model of	Waitemata DHB	Out of Home Respite Services	Waitemata DHB is aware that there are

Type of service change	DHB	Area impacted by service change	Description of service change
service delivery	– for metropolitan Auckland	(based at the Wilson Centre, Takapuna)	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 model of service delivery/possible change in service provider	Waitemata DHB	Youth Health Services	May alter model and/or service provider following an RFP to be undertaken in 2016/17
Change in configuration of services/possible change in service provider(s)	Auckland DHB Waitemata DHB	Immunisation and Outreach Services	Review of the configuration of immunisation and outreach services during 2016/17 and possible changes to the configuration of service and/or the provider/s of services from 17/18
Potential changes of providers and configuration of services	Auckland DHB Waitemata DHB	Community Services	In line with the Government's Rules of Sourcing, the DHBs will be undertaking open procurement processes as contracts expire. This has the potential to affect providers of services listed above plus a range of other service providers/services including (but not limited): - National Immunisation and Outreach Services - B4 School Checks

MODULE 7: Performance Measures

Monitoring framework performance measures

The following table presents the full suite of Ministry of Health 2016/17 non-financial reporting indicators, excluding health targets. This section is a Ministry requirement, but many of these measures appear elsewhere in the Annual Plan, as much of our work is centred on government priorities and these measures are a useful way of monitoring progress and achievement.

Performance measure	2016/17 Performance expectation/target			DHB target	
PP6: Improving the health status of people with severe mental illness through improved access	**Age 0-19**			3.1%	
	Age 20-64			3.4%	
	Age 65+			2.1%	
PP7: Improving mental health services using transition (discharge) planning	Long-term clients	Provide a report each quarter as specified in the measure definition			
	Child and youth with a transition (discharge) plan	At lease 95% of clients discharged will have a transition (discharge) plan		≥95%	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm				
	Age	≤3 weeks	≤8 weeks	≤3 weeks	≤8 weeks
	0-19	80%	95%	80%	95%
	Addictions (Provider Arm and NGO)				
	Age	≤3 weeks	≤8 weeks	≤3 weeks	≤8 weeks
	0-19	80%	95%	80%	95%
PP10: Oral Health - Mean DMFT score at Year 8	Ratio year 1			0.82	
	Ratio year 2			0.72	
PP11: Children caries-free at five years of age	Ratio year 1			70%	
	Ratio year 2			72%	
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			95%	
	0-4 years - % year 2			95%	
	Children not examined 0-12 years - % year 1			6%	
	Children not examined 0-12 years - % year 2			6%	
PP20: Improved management for long term conditions (CVD, acute heart health, 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 services	Reporting on implementation of actions in the Diabetes plan "Living Well with Diabetes" Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c indicator)				
Focus area 3: Cardiovascular (CVD) health	Indicator 1: 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years			90%	
	Indicator 2: 90 percent of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years			90%	
	Report on delivery of the actions and milestones identified in the Annual Plan				
Focus area 4: Acute heart service	70 percent of high risk patients will receive an angiogram within 3 days of admission ('Day of Admission' being 'Day 0') by ethnicity			70%	
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days			95%	
	Over 95 percent of patients undergoing cardiac			95%	

Performance measure	2016/17 Performance expectation/target	DHB target
	surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge	
	Report on deliverables for acute heart services identified in Annual Plan and actions and progress in quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI	
Focus area 5: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed	6%
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
	80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%
	Report on delivery of the actions and milestones identified in the Annual Plan	
PP21: Immunisation coverage	Percentage of two year olds fully immunised	95%
	Percentage of five year olds fully immunised	95% by June 2017
	Percentage of eligible girls fully immunised - HPV vaccine	70% for dose 3 (2003 birth cohort at June 2017)
PP22: Improving system integration and SLMs	Report on delivery of the actions and milestones identified in the Annual Plan In relation to SLM measures - a jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17	
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	95%
	Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long-term care facility (LTCF) assessment completed within 230 days of the previous assessment	75%
	The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long-term care facility (LTCF) assessment	98%
PP25: Prime Minister's youth mental health project	*Initiative 1*: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities 1. Provide quarterly quantitative reports on the implementation of SBHS, as per the template provided 2. Provide quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: a framework for continuous quality improvement in each school (or group of schools) with SBHS *Initiative 3:* Youth Primary Mental Health 1. Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: • early identification of mental health and/or addiction issues • better access to timely and appropriate treatment and follow up • equitable access for Māori, Pacific and low decile youth populations 2. Provide quantitative reports using the template provided under PP26 *Initiative 5*: Improve the responsiveness of primary care to youth 1. Provide quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or	

Performance measure	2016/17 Performance expectation/target		DHB target
	equivalent) in your local alliancing arrangements 2. Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme		
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for each focus area: • Primary Mental Health • District Suicide Prevention and Postvention • Improving Crisis Response Services • Improve outcomes for children • Improving employment and physical health needs of people with low prevalence conditions		
PP27: Supporting vulnerable children	Report on delivery of the actions and milestones identified in the Annual Plan		
PP28: Reducing Rheumatic fever	Provide a progress report against DHB's rheumatic fever prevention plan		
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic		0.7 per 100,000
	Report on progress in following-up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever		
PP29: Improving waiting times for diagnostic services	1. Coronary angiography: 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)		95%
	2. CT and MRI – 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days)		95% for CT scans 85% for MRI scans
	3. Diagnostic colonoscopy a. 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 days, inclusive), 100% within 30 days b. 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days		85% within 14 days 100% within 30 days 70% within 42 days 100% within 90 days
	Surveillance colonoscopy c. 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days		70% within 84 days 100% within 120 days
PP30: Faster cancer treatment	Part A: Faster cancer treatment – 31 day indicator	85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat	85%
	Part B: Shorter waits for cancer treatment – radiotherapy and chemotherapy	All patients ready-for-treatment receive treatment within four weeks from decision-to-treat	100%
PP31: Better help for smokers to quit in public hospitals	95 percent of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking		95%
SI1: Ambulatory sensitive (avoidable) hospital admissions (SLM age group 0-4 years)	Age group 0-4 years (SLM measure)	A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones and target, will be provided at the end of quarter one 2016/17 via measure PP22	

Performance measure	2016/17 Performance expectation/target		DHB target
	Age group 45-64 years	3,968/100,000	
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region		
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 (as identified by the DHB or by the Ministry)		
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement	An intervention rate of 21.0 per 10,000 of population	21.0 per 10,000
	Cataract procedures	An intervention rate of 27.0 per 10,000 of population	27.0 per 10,000
	Cardiac surgery	A target intervention rate of 6.5 per 10,000 of population DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate	6.5 per 10,000
	Percutaneous revascularisation	A target rate of at least 12.5 per 10,000 of population	12.5 per 10,000
	Coronary angiography services	A target rate of at least 34.7 per 10,000 of population	34.7 per 10,000
SI5: Delivery of Whānau Ora	Performance expectations are met across all the measures associated with the five priority areas: • Mental health • Asthma • Oral health • Obesity • Tobacco and narrative reports cover all areas indicated		
SI7: SLM total acute hospital bed days per capita	A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22		
SI8: SLM patient experience of care	Hospital	Provide a report each quarter as specified in the measure definition A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22	
	Primary care	A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22	
SI9: SLM amenable mortality	A jointly agreed (by District Alliance) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22		
OS3: Inpatient Length of Stay	Elective LOS	The suggested target is 1.55 days, which represents the 75th centile of national performance	1.55 days
	Acute LOS	The suggested target is 2.35 days, which represents the 75th centile of national performance	2.8 days

Performance measure	2016/17 Performance expectation/target	DHB target
OS8: Reducing Acute Readmissions to Hospital	TBA – indicator definition under review	MoH TBC
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%	 >2% and ≤4% >1% and ≤3% >1.5% and ≤6%
	Recording of non-specific ethnicity Greater than 0.5% and less than or equal to 2%	>0.5% and ≤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%	>0.5% and ≤2%
	Validated addresses unknown Greater than 76% and less than or equal to 85%	>76% and ≤85%
	Invalid NHI data updates (no confirmed target)	MoH TBC
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%	≥97% and <99.5%
	National collections file load success Greater than or equal to 98% and less than 99.5%	≥98% to <99.5%
	Assessment of data reported to the NMDS Greater than or equal to 75%	≥75%
	NNPAC timeliness Greater than or equal to 95% and less than 98%	≥95% and <98%
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a. 5 percent variance (+/−) of planned volumes for services measured by FTE b. 5 percent 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 DV6: SLM youth access to and utilisation of youth appropriate health services	No performance target/expectation set	
Developmental measure DV7: SLM number of babies who live in a smokefree household at six weeks postnatal	No performance target/expectation 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)
	Kylie Clegg	(appointed)
	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
	Tamzin Brott	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
	Michelle Sutherland	GM Surgical and Ambulatory Services
	Debbie Eastwood	GM Medicine and Health of Older People
	Linda Harun	GM Child, Women and Family Services
	Alex Craig	Acting GM Mental Health Services
	Fiona McCarthy	GM Human Resources
	Naida Glavish	Chief Advisor Tikanga (Waitemata and Auckland DHBs)

Appendix 2: statement of accounting policies

The prospective financial statements have been prepared on the basis of the significant accounting policies which are expected to be used in the future for reporting historical financial statements. This Appendix sets out the significant accounting policies used in the preparation of financial statements included in this Annual Plan. A full description of accounting policies used by Waitemata DHB 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 DHB and Three Harbours Health Foundation (controlled by Waitemata DHB). Joint ventures are healthAlliance N.Z. Limited (25%), Health Innovation Hub Limited (25%), Awhina Health Campus. 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 financial reporting purposes.

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 forecast financial statements have been prepared in accordance with *PBE-FRS 42: Prospective Financial Statements*.

Presentation currency and rounding

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

Forecast Information

In preparation of the financial statements, the DHB has made estimates and assumptions concerning future events. The assumptions and estimates are based on historical factors and other factors including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions may differ from subsequent actual results. Factors which could lead to a material difference between the information in the forecast/plan financial results and the actual financial results prepared in future reporting periods include:

- Collective employment contract agreements settling at factors materially different from the assumptions
- Actual cost growth factors being materially different from the cost growth factors assumptions in the forecast financial information
- A re-estimate of the useful life or residual value of property, plant and equipment. The DHB minimises the risk of re-estimate uncertainty by such activities as physical inspection of assets, and asset replacement programmes
- The revenue growth assumed for forecast financial results in financial years beyond June 2017/18, being greater or less than the assumed growth on 2%.

The forecast financial statements for the year ended 30 June 2016, incorporate the unaudited results of the 6 month period to 30 April 2016.

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.

Revenue items	Explanation
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.

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) 6–60 years (1.67–16.67%)
- Underground Infrastructure 35–43 years (2.33–2.86%)
- Fixed dental clinics and pads (including fit out) 19–35 years (2.86–5.26%)
- Clinical equipment 3–20 years (5–33%)
- Other equipment and motor vehicles 3–15 years (6.67–33%)
- IT Equipment 5–15 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 3–5 years (20–33%)
- Internally developed software 3–5 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 New Zealand 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 and 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
- likelihood that staff will reach the point of entitlement and contractual entitlement information;
- 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 ongoing 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.

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
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
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
QALY	Quality-adjusted life years
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