Waitemata District Health Board
Best Care for Everyone

2017/18 Annual Plan

Incorporating the Statement of Intent and the Statement of Performance Expectations

Waitemata District Health Board

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004

Mihimihi

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

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

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

The Waitemata District Health Board Annual Plan for 2017/18 is signed for and on behalf of:

Waitemata District Health Board

Dr Lester Levy, CNZM
Chairman

Kylie Clegg
Deputy Chairman

Dr Dale Bramley
Chief Executive

Our Te Tiriti o Waitangi partner
Te Runanga o Ngati Whātua

R Naida Glavish ONZM JP

R Naida Glavish, JP ONZM
Chair, Te Runanga o Ngati Whātua

And signed on behalf of:

The Crown

Hon Dr David Clark
Minister of Health

Date 12/2/18

Hon Dr David Clark

MP for Dunedin North

Minister of Health | Associate Minister of Finance

Lester Levy
Chair
Waitemata District Health Board
Private Bag 93 503
Takapuna
Auckland 0740

21 DEC 2017

Dear Lester

Waitemata District Health Board 2017/18 Annual Plan

To formalise ongoing accountability and to provide surety, I have approved and signed your DHB's 2017/18 Annual Plan.

I would like to thank you, your board, and the DHB's staff for their efforts in developing your Annual Plan for 2017/18. I also appreciate your DHB's significant efforts to provide valuable health services to the public in a challenging environment, and I am confident that we can work together to improve outcomes for the population.

I am pleased that your DHB has planned to break even for 2017/18 and for the following three years. I am signing your plan in the expectation that you will work with the Ministry to resolve the remaining technical issues with your financial templates early in 2018.

As you deliver services for your population, keep in mind that I will shortly be providing a Letter of Expectations to DHBs for the 2018/19 financial year that will provide further clarity on my priorities for DHB planning, such as public provision of health services, improving access to primary care, reducing inequalities and improving mental health services.

Please note that 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.

Please ensure that a copy of this letter is attached to any copies of your signed Annual Plan that are made available to the public. Thank you again for your leadership and efforts to deliver high quality and equitable health outcomes for your population.

I look forward to working with you in the future.

Yours sincerely

Hon Dr David Clark
Minister of Health

Lester,
Thank you for your support early in my time as Minister. I look forward to working with you in your new capacity in the New Year.
Best wishes.
David.

cc Mr Dale Bramley, Chief Executive, Waitemata District Health Board

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Foreword from our Chairman and Chief Executive

We have promised to deliver Best Care for Everyone and our results show we are well on track. The Waitemata district has the highest life expectancy in New Zealand and the lowest rates of cardiovascular disease and infant mortality.

Eighty-six per cent of cancer patients referred to Waitemata DHB in 2016 received their first treatment within 62 days, making us the first DHB in the country to meet and exceed the Faster Cancer Treatment Health Target. Our district is among the national leaders in five-year cancer survival.

We are performing well with compliance across all Health Quality and Safety Commission markers and continue to maintain a keen focus in this area. We are on target with our efforts to tackle childhood obesity and stop people smoking.

We provided nearly 330,000 bed days of care during 2016 and performed more than 22,000 elective surgeries. We saw 123,000 patients in our Emergency Departments, exceeding expectation by admitting, transferring or discharging 97% of them within the Ministry's six-hour target time frame.

The DHB has delivered on a number of major developments over the last 12 months, including:

- The opening of a new state-of-the-art Emergency Department at Waitakere Hospital
- Completion of a sky bridge between North Shore Hospital's main tower building and the Elective Surgical Centre to improve patient transfer flow and allow a higher acuity case mix
- Modern facilities for patients approaching end of life in North Shore Hospital's upgraded Ward 3
- The opening of North Shore Hospital's Hart Department of Medicine
- The opening of a new Child and Adolescent Mental Health Service in Rodney North and the establishment of an Infant Mental Health Service
- The launch of our Early Discharge and Rehabilitation Service to rehabilitate eligible stroke patients in their homes
- Our Health in Mind – a DHB initiative aimed to destigmatise mental illness and provide primary care partners with faster and greater support for patients.

The Leapfrog programme continues to deliver major technological advances to provide an enhanced quality of service. Initiatives including ePrescribing, eVitals and the Winscribe voice-to-text programme put us at the forefront of e-Health as a modern healthcare provider. Further evidence of our digital progress can be found in North Shore Hospital's Ward 7, the first in the country to provide bedside iPads and free DHB-wide wi-fi to improve our patients' experience.

Our focus is firmly on the future with projects like Precision Driven Health – a partnership with Orion Health and the University of Auckland to deliver better outcomes for patients through smarter use of health informatics and analytics.

The Northern Region DHBs are working together to develop a Long Term Investment Plan (LTIP) to guide medium- to long-term regional investment decisions. Investment priorities are outlined within three asset portfolios: Physical Infrastructure, Clinical Equipment and Information and Communication Technology (ICT). Information systems are key to the Northern Region's ability to deliver a collaborative whole of system approach to health service delivery. As part of the LTIP, a new regional Information Systems Strategic Plan (ISSP) is also being developed. This document will detail the future roadmap and target state architecture of IS investments.

Our 615,000 population is expected to reach nearly 700,000 by 2025 and we have a 10-year plan to redesign and improve our physical environment so it is more comfortable for patients and their whānau, and will accommodate our increasing population. As part of our Waitemata 2025 programme, this year sees:

- The opening of a new Waitakere Hospital Emergency Department paediatric zone
- The opening of two negative pressure rooms; extra singled-bedded rooms; an expanded radiology suite and a new CT scanner at Waitakere Hospital
- A new 15-bed medium secure unit at Mason Clinic
- The opening of a Clinical and Learning Skills Centre at North Shore Hospital
- A modern Medicine and Older Adults outpatient facility in North Shore Hospital's remodelled Building 5
- The development of primary birthing unit options.

We do this for our patients, families and community who all deserve the best care we can provide from the resource we have available to us.

Our hardworking and dedicated staff remain our greatest asset and we look to them with gratitude as we collectively renew our resolve to relieve suffering, reduce inequalities and promote wellness in 2017 and beyond.

Dr Lester Levy CNZM

Chairman Waitemata District Health Board

Dr Dale Bramley

Chief Executive Waitemata District Health Board

Introduction

This Annual Plan articulates Waitemata DHB's commitment to meeting the expectations of the Minister of Health, and our continued commitment to our Board's promise of '**best care for everyone**'.

The Plan also meets the requirements of the New Zealand Public Health and Disability Act (2000), Crown Entities Act (2004), and Public Finance Act (1989).

At the request of the previous Minister, this year's Annual Plan was streamlined compared with previous plans, and focuses on the key activities that the previous Minister identified for delivery in 2017/18. Although an updated Statement of Intent (SOI) was not requested for 2017/18, we have chosen to refresh ours to reflect changes to our performance framework and other strategic updates. Our SOI is presented in Appendix A.

This streamlined Annual Plan is a high level document but still provides a strong focus on improved performance and access, financial viability, health equity and service performance to meet legislative requirements. More detailed reporting, including Financial Performance, our updated Statement of Intent, and Statement of Performance Expectations for 2017/18, is contained in the appendices.

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 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 inequities. 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 DHB 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 practise 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.

Waitemata DHB will continue to develop and deliver on an annual Māori Health Plan in 2017/18. While we are proud of the achievements we have accomplished so far for our Māori population, we see the continuation of an annual Māori Health Plan as an important means of enabling us to remain focused, deliberate and intentional in the pursuit of Māori health gain. It also enables greater and more meaningful collaboration and sharing of intelligence across DHBs in terms of Māori health.

Equity

The Waitemata population overall has the longest life expectancy in New Zealand, and although our Māori and Pacific life expectancies are high compared with the rest of New Zealand, they are still nearly 6 years lower than our population as a whole.

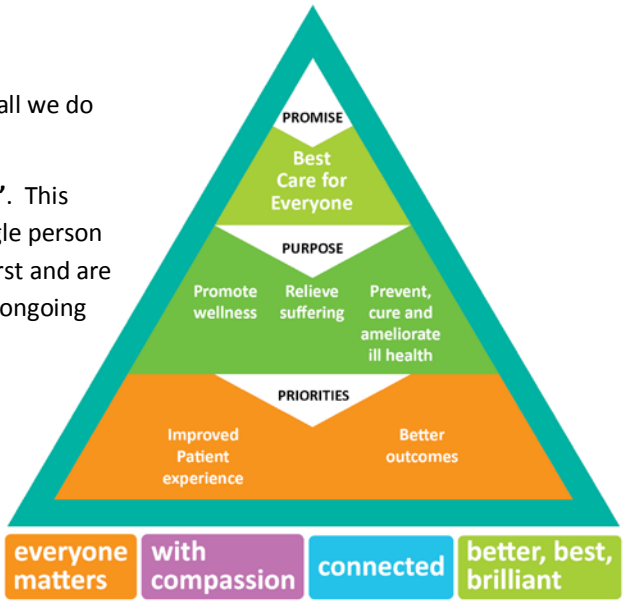
Waitemata DHB is committed to helping all our residents achieve equitable health outcomes. Section 2 of the Annual Plan identifies specific activities designed to help reduce health equity gaps for Māori and other priority groups such as disabled people. We are committed to reducing the health equity gap for Māori; more specific information on targeted deliverables is detailed in our 2017/18 Māori Health Plan.

Waitemata DHB is committed to the principles of the United Nations' Convention on the Rights of Persons with Disabilities and is also guided by a range of national strategies, including: He Korowai Oranga (Māori Health Strategy), Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018, and the Healthy Ageing Strategy.

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, how we measure and continue to improve.

To realise our promise of providing 'best care for everyone' we have identified seven **strategic themes**. These provide an overarching framework for the way our services will be planned, developed and delivered.

Waitemata DHB Strategic Themes

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 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 and investment on treatment and keeping people healthy
We are investing in our people, services and facilities across the spectrum of care, with increasing focus on preventing ill health. Lifestyle and preventative programmes and primary and community-based services will increase wellness and reduce the need for hospital admission. We will direct resources 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.

Emphasis on 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

National, regional and sub-regional strategic direction

Waitemata DHB operates as part of the New Zealand health system. The overall direction is set by the Minister's expectations and the New Zealand Health Strategy. Waitemata DHB is committed to delivering on the Health Strategy's vision of 'all New Zealanders live well, stay well, get well'. The actions detailed in Section 2 of this plan align to the Minister's expectations and the Health Strategy themes.

The Northern Region Health Plan (NRHP) demonstrates how the Government's objectives and the region's priorities will be met. The overall intent of the 2017/18 NRHP is to achieve gains across the Triple Aim Framework (which places simultaneous emphasis on improving outcomes for the individual, population and health system), as well as the themes of the New Zealand Health Strategy, in addition to a strong focus on equity.

Waitemata and Auckland DHBs have a bilateral agreement that joins governance and some activities, and the three Metro Auckland DHBs - Auckland, Waitemata and Counties Manukau - share a Board Chair. This allows for collaboration across the three DHBs and a more integrated and aligned approach to health services planning and delivery across Auckland. By working together the three DHBs intend to increase the focus on health outcomes as well as quality improvement, while providing greater value for money. To ensure we take advantage of this opportunity and extract the full potential from the positive elements we already have, we will need to collectively move away from silo thinking and working. We need to share and adopt the best of each DHB and create the mindset, capacity and will for enduring change.

Improving health outcomes for our population

Waitemata DHB's performance framework reflects the key national and local priorities that inform this 2017/18 Annual Plan, and demonstrate our commitment to an outcome-based approach to measuring performance. We have identified two overall long-term population health outcome goals. These are:

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

The outcome measures are long-term indicators; therefore, the aim is for a measurable change in health status over time, rather than a fixed target.

System level measures (SLMs) and contributory measures that will support achievement of these overall goals were identified. We based the SLMs in our performance framework on those set by the Ministry of Health, which align with the five strategic themes of the New Zealand Health Strategy and other national strategic priorities. SLMs provide an opportunity for DHBs to work with their primary, secondary and community care providers to improve the health outcomes of their local populations.

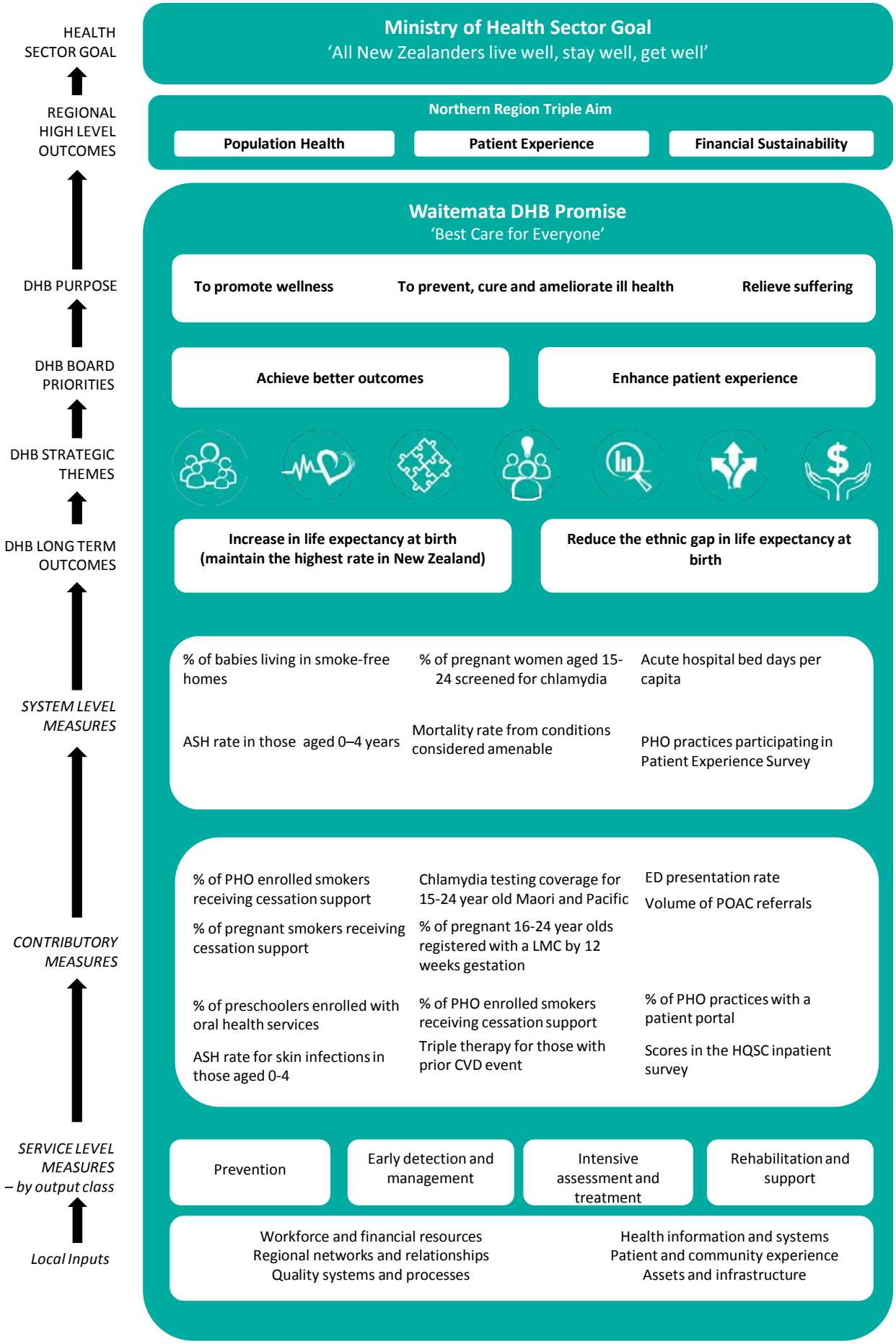
Contributory measures are essential to the achievement of the SLMs and are front-line measurements of specific health processes or activities. The contributory measures included in our performance framework were selected from the set defined by our District Alliance and included in our SLM Improvement Plan.

Our SLMs and contributory measures are summarised below and presented in the intervention logic diagram (Appendix A). The diagram demonstrates how the services that we choose to fund or provide will contribute to the health of our population and result in the achievement of our longer-term outcomes and the expectations of Government. The Statement of Performance Expectations (Appendix B) details a list of service level indicators that form part of our overall performance framework. We will report progress against all these measures in our Annual Report.

	Healthy start	Keeping children out of hospital	Youth are healthy, safe and supported	Preventing and detecting disease early	Using health resources effectively	Ensuring patient-centred care
System level measures (SLMs)	**Proportion of babies who live in a smokefree household at 6 weeks postnatal**	**Ambulatory sensitive hospitalisations 0-4 years**	**Sexual and reproductive health - chlamydia testing coverage for 15-24 year-olds, focusing on pregnant women**	**Amenable mortality**	**Acute hospital bed days**	**Patient experience of care - PHO practices participating in the PHC Patient Experience survey**
Key contributory measures	Smoking cessation: PHO-enrolled smokers receiving cessation support Pregnant smokers receiving cessation support	Children fully immunised by 8 months of age Skin infections: ambulatory senstive hospitalisations rate for skin infection 0-4 years	Chlamydia testing coverage for 15-24 year old Māori and Pacific LMC registration at 12 weeks in 16-24 year-olds	CVD management: proportion of those with a prior CVD event receiving triple therapy Smoking cessation: PHO-enrolled smokers receiving cessation support	Emergency department attendance rate Referrals to Primary Options for Acute Care	Hospital inpatient survey: aggregate score pacross all four domains Proportion of practices with patient e-portals

Note: The youth System Level Measure consists of five domains reflecting the complexity and breadth of issues impacting youth health and wellbeing. The Metro Auckland Alliances have chosen to focus on the Sexual and reproductive health domain, selecting chlamydia testing as our improvement milestone.

Performance and intervention framework



SECTION 2: Our Goals and Priorities

Introduction

In December 2016, the Minister of Health wrote to DHBs to set out priorities for 2017/18. This section details our key work programmes to deliver on these priorities. Specific actions are included to help achieve health equity for all population groups, and these equitable outcomes actions are identified as 'EOA'. More information on the performance measures required by the Ministry is provided in Section 5.

Effective implementation of activities to meet these priorities and the achievement of milestones requires coordinated input and effort across multiple stakeholders to achieve real health gain for our communities. Overall leadership and accountability for the priority areas in this section generally sits within the Planning, Funding and Outcomes directorate, except where the focus is provider specific. Responsibility for delivery may sit across multiple stakeholders and collaborative priority setting and accountability is critical.

Several of the priority areas below benefit from or are directly influenced by the connections we share across the northern region. Many actions make sense to progress regionally just once, in a collaborative and consistent manner, rather than independently by each DHB. These have been developed with significant contributions from the Region's clinical networks, clinical governance groups and other regional workgroups and represent the thinking of clinicians and managers from both our hospital and community settings. Our Northern Region Health Plan provides the detail on this regional work.

Planning Priorities

Government planning priority	Link to NZ Health Strategy	Waitemata DHB key response actions to deliver improved performance		Measures
		Activity	Milestones	
Prime Minister's Youth Mental Health Project	**Value and high performance**	Deliver comprehensive health and wellbeing checks (Home, Education/Employment/Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety or HEEADSSS assessments) to all (95%) Year 9 and other high risk students	Ongoing	PP25: Prime Minister's Youth Mental Health Project
		Embed the Service Level Alliance Team (SLAT) as an alliance across Auckland and Waitemata DHBs and monitor progress against an agreed outcome framework endorsed by the Clinical Governance Group	From Jul 2017	
		Begin planning for increasing access to long-acting reversible contraception	Jun 2018	
		Develop and deliver two workshops for youth and parents in Asian, refugee and migrant communities, focused on available mental health services, including evaluation (EOA)	Jun 2018	
		See the Rangatahi (Mental Health) section of our 2017/18 Māori Health Plan for more information		
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	**People powered**	Ensure all Enhanced School Based Health Service staff maintain the delivery of a comprehensive range of sexual health services, including relationship advice	Ongoing	PP38: Delivery of response actions agreed in annual plan
		Promote the Youth Hub as an option for Māori and Pacific youth not at school to access advice and contraception (EOA)	Jun 2018	
		Building on work areas identified in the SLM Plan (chlamydia screening) to increase general practices' understanding of access to sexual health services (including screening) by ethnicity and age	Jun 2018	
		In preparation for the SLM work programme, being to develop a programme of work with primary care, maternity, NGOs and regional partners to introduce more intentional screening and brief interventions for alcohol misuse	Jun 2018	
		Work with the primary care sector to roll out the new youth friendly Audit tool: Audit of Medical Practice Activity	Dec 2017	
		Improve primary care health pathways to align with New Zealand Sexual Health Society Best Practice Guidelines related to chlamydia screening in pregnancy	Mar 2018	

Government planning priority	Link to NZ Health Strategy	Waitemata DHB key response actions to deliver improved performance		Measures
		Activity	Milestones	
Supporting Vulnerable Children BPS Target	One team	Develop tools and pathways to identify and support vulnerable pregnant women and infants, including consistent risk assessment tools and referral pathways for maternal depression, alcohol and other drug issues, housing issues and social work services	Tools by Jun 2018	PP27: Supporting Vulnerable Children
		Increase screening rates for family violence	Ongoing	
		Continue to work with Pacific churches and community groups to implement Triple P parenting programmes (EOA)	Ongoing	
		Implement an enhanced assessment and referral pathway inclusive of mental health and neurodevelopmental assessments as part of the Gateway programme and improve processes to follow up referrals (pending MSD/MoH approvals)	Jun 2018	
		Continue to work with Oranga Tamariki and education staff to monitor delivery and timeliness of services for children who have had a Gateway assessment, as outlined in the Interagency Services Agreement. In partnership with Oranga Tamariki, implement quality improvement actions in areas where access or timeliness is below expectations	Ongoing	
		Participate in MSD direct purchasing pilot		
		See the Matua, Pēpi me Tamariki (Child Health) and Oral Health sections of our 2017/18 Māori Health Plan for more information		
Healthy Mums and Babies BPS Target	One team	Improve information sharing regarding pregnant women and newborn infants between GPs, LMCs, DHB and WCTO providers under the leadership of the Healthy Mums and Babies, including through development of agreed expectations regarding what health information needs to be shared and when	Jun 2018	PP38: Delivery of response actions agreed in annual plan (section 1)
		Develop a programme to support new graduate midwives to enter the self-employed LMC workforce	Jun 2018	
		Formalise a working group to develop initiatives to engage young pregnant women and multiparous Pacific women (those who have given birth to more than one baby) with an LMC earlier in their pregnancies (EOA)	Jun 2018	
		Improve data entry and IT tools to improve reporting of babies living in smoke-free homes	Jun 2018	
		Develop a regional action plan to implement the National SUDI Prevention Programme	Nov 2017	
		Establish consistent distribution mechanisms for safe sleep devices and education to families with identified SUDI risk factors	Jun 2018	
		Continue to improve breastfeeding support for mothers and babies in the community	Ongoing	
		Implement an incentive programme to help pregnant women quit smoking, particularly targeting Māori (EOA)	Jun 2018	
		Obtain baseline data to support the development of strategies to increase access to pregnancy immunisations (Boostrix and influenza)	Jun 2018	
Keeping Kids Healthy BPS Target	One team	Improve information sharing between hospitals and general practices to support identification of children aged less than 5 years eligible for influenza vaccination and support Primary Care to recall and vaccinate soon after discharge from hospital	Jun 2018	PP38: Delivery of response actions agreed in annual plan (section 1)
		Increase oral health promotion and implement a system to deliver fluoride varnish for pre-schoolers	Jun 2018	

Government planning priority	Link to NZ Health Strategy	Waitemata DHB key response actions to deliver improved performance		Measures
		Activity	Milestones	
		Roll out a supported process for high needs children who do not attend dental therapy appointments	Jun 2018	
		Scope and begin to implement a National Child Health Information Platform	Mar 2018	
		Continue to improve the effectiveness of the Kainga Ora Healthy Housing Initiative, with a particular focus on increasing referrals of pregnant women	Ongoing	
		Work with regional partners (including ARDS) to develop and implement the Pre-school Oral Health Strategy to improve engagement and access for Pacific and Māori children (EOA) • Finalise regional preschool oral health strategy • Finalise indicators for regional preschool oral health strategy and collect baseline data • Finalise oral health/obesity key messages • Complete the implementation plan for a fluoride varnish programme	 Sep 2018 Dec 2018 Mar 2018 Jun 2018	
Increased Immunisation Health Target 	**Closer to home**	Work with PHO champions and National Enrolment Service (NES) to develop operational measures and monitoring to increase newborn enrolments for Māori and Pacific (EOA)	Jun 2018	95% of eight months olds will have their primary course of immunisation on time PP21: Immunisation Services
		Develop a set of recommendations to increase immunisation coverage at 5 years of age through the B4SC	Mar 2018	
		Maintain opportunistic vaccination services at Waitakere and develop options to deliver drop in service on Saturdays	Ongoing	
		Apply learnings from the Māori case review group to service refinements across the primary series of immunisation (EOA)	Jun 2018	
		See the Immunisation and Ambulatory Sensitive Hospitalisations (0-4 years) sections of our 2017/18 Māori Health Plan for more information		
Shorter Stays in Emergency Departments Health Target 	**Value and high performance**	Analyse ED mental health (MH) attendances to understand the profile of presentations	Jun 2018	95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours
		Work with MH to develop clinical and shared care pathways for regular and high users of ED with plans developed for known service users of Specialist MH services Implement shared care MH pathways	Mar 2018 Jun 2018	
		Formalise the use of POAC (primary options for acute care) in the ED develop and implement a range of pathways	Mar 2018	
		Implement the OptimisED project in Waitakere ED to effectively utilising new ED areas to maximise patient flow	Jun 2018	
		Continue to work with urgent care/primary care partners to improve access to primary care for primary care issues	Jun 2018	
		Promote access afterhours to reduce low acuity presentations	Dec 2017	
		Develop a pilot in Waitakere ED to more efficiently assess low acuity patients	Jun 2018	
Improved Access to Elective Surgery Health Target 	**Value and high performance**	Reduce unnecessary follow-up appointments through different ongoing strategies, including: • Develop standardised patient care pathways for outpatient clinic follow-up appointments • Implement self-referral of symptoms (SOS) initiative for follow-up appointments in ORL	 Jun 2018 Dec 2017	Elective Health Target: 22,073 procedures SI4: Standardised intervention rates OS3: Inpatient length of stay (electives) Electives and
		Engage with primary care to develop community assessment and undertake minor ORL procedures: • Develop service model of care with GPs for ORL assessment of patients and minor ORL procedures to be delivered from primary/community care settings	Jun 2018	

Government planning priority	Link to NZ Health Strategy	Waitemata DHB key response actions to deliver improved performance		Measures
		Activity	Milestones	
		• Train GPs to assess patients and perform minor ORL procedures	Jun 2018	ambulatory initiative
		Complete roll out of E-triage process in all surgical specialties	Jun 2018	Bariatric initiative
		Continue to implement and appropriately use national Clinical Prioritisation Access Criteria (CPAC) tools to improve referral quality and appropriateness, and ensure fair and equitable access (EOA)	Ongoing	Additional Orthopaedic and General Surgery initiative
		Develop surgical pathways for: • Abscess • Acute appendicectomy	Jun 2018	Elective Services Patient Flow Indicators
Faster Cancer Treatment Health Target 	**One team**	We will implement sustainable service improvement activities to improve access, timeliness and quality of cancer services: • Confirm a process to ensure all tumour streams appropriately apply the High Suspicion of Cancer flags • Work with Māori Health to (EOA): o appoint a Māori Cancer Nurse Coordinator o develop and implement a work plan to ensure equitable health outcomes for Māori patients • Document a clear pathway for all external and internal HSC P1 (high priority) gastroenterology patients, in conjunction with the Gastroenterology Service • Design a process to ensure all cancer follow-up patients are identified and receive follow-up at the correct time • Contribute to the development of plans for local delivery of medical oncology • All cancer-related MDMs will use electronic forms to document meeting outcomes	Dec 2017 Sep 2017 Sep 2017 Sep 2017 Dec 2017 Developed by Dec 2017 In place by Jun 2018	90% of patients to receive their first cancer treatment within 62 days of being referred PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT and MRI
		Improve waiting times for diagnostic CT and MRI by reviewing options to increase capacity and implement changes to service model of care and delivery to improve planned patient access	Dec 2017	
Better Help for Smokers to Quit Health Target 	**Value and high performance**	Plan and implement activities in our priority healthcare settings (Hospital, Primary Care, Maternity, Mental Health and Addiction Services) to increase prescription stop smoking medication and/or referred to a Stop Smoking Service	Jun 2018	90% of PHO-enrolled patients who smoke have been offered help to quit 90% of pregnant women smokers are offered brief advice and support to quit PP31: Better Help for Smokers to Quit in Public Hospitals
		Develop and implement a midwifery role to train and enable maternity providers to deliver advice and complete referrals to Stop Smoking Services for pregnant women and whānau	Oct 2017	
		Support to NGO Mental Health and Addictions Services to deliver stop smoking support to service users	Oct 2017	
		Produce reporting by ethnicity for Smoking Status, Brief Advice and Cessation Support for priority healthcare settings	Jan 2018	
		Improve data entry and IT tools to improve reporting of Brief Advice and Cessation Support in priority healthcare settings	Jun 2018	
		Implement the pregnancy incentives programme if approved by the Board in 2017/18	Jun 2018	
		See the Tobacco section of our 2017/18 Māori Health Plan for more information		
Raising Healthy Kids Health Target 	**Closer to home**	Enhance the training plan for GPs, nurses and other relevant health professionals to increase their confidence in having culturally appropriate conversations about child weight and healthy lifestyle with families	Sep 2017	By Dec 2017, 95% of obese children will be offered a referral to a health professional
		Define and implement an outcomes-based evaluation of the engagement of families and health professionals with the referral process with specific focus on Māori/Pacific outcomes	Dec 2017	

Government planning priority	Link to NZ Health Strategy	Waitemata DHB key response actions to deliver improved performance		Measures
		Activity	Milestones	
		(EOA)		SI5: Delivery of Whānau Ora
		Design and implement a multi-component whānau-focused parenting and active lifestyles programme for pre-school children, including a psychological component and development of specific approaches for Māori and Pacific populations (EOA) • Community-based programme with links to existing programmes in Pacific churches, Māori health providers, and Asian churches and health providers	Mar 2018	
		Maintain access to Healthy Babies, Healthy Futures (HBHF) by increasing referrals from maternity services and partnering with community groups that are engaged with pregnant mothers and mothers of toddlers i.e. Kōhanga Reo, Women's Sports organisations, Cultural groups, Religious communities, Pacific, Asian and South Asian ECEs	Jun 2018	
		See the Childhood Obesity Plan section below and the Metro-Auckland Childhood Healthy Weight Action Plan for more information		
Bowel Screening	Value and high performance	**National Bowel Screening Programme** Provide bowel screening coordination centre services to Hutt and Wairarapa DHBs	Jul to Dec 2017	National Bowel Screening quality, equity and performance indicators
		Meet the bowel screening quality standards for the Waitemata DHB programme	Ongoing	
		Continue to meet the waiting time standard for bowel screening colonoscopies	Ongoing	
		Separate coordination centre functions (currently delivered by Waitemata DHB for the pilot) from our provider functions • National coordination centre provider selected and transition of function completed • Waitemata DHB bowel screening programme structure and staffing in place to join the national programme	Dec 2017 Jan 2018	
		Access across all endoscopy services • Recruit two nurses with full 5-day week coverage to ensure timely access for high priority (P1) patients • Develop an annual production plan for all endoscopy procedures to enable weekly performance tracking • Recruit to the two endoscopy fellow roles • CNS endoscopist role in place	Sep 2017 In place by Jul 2017 Dec 2017 Dec 2017	PP29: Improving waiting times for diagnostic services – Colonoscopy
		Regional collaboration, through a contractual arrangement, to improve access and timeliness to colonoscopy procedures. Work with Auckland DHB through an outsourcing arrangement to do weekly lists for Waitemata DHB patients	Jul 2017	
Mental Health	People powered	**Reduce Māori under community treatment orders (CTO) rate** Work collaboratively with the MoH to agree and document a robust definition for the CTO indicator	Jun 2018	PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders SI5: Delivery of Whānau Ora
		Undertake analysis of underlying data to understand pathways, gaps and opportunities for improvement	Jun 2018	
		Develop recommendations for evidenced-based interventions to address the disease and health burden	Jun 2018	
		See the Mental Health – CTO section of our 2017/18 Māori Health Plan for more information		
	Value and high performance	**Closer to home** • Complete Alternatives to Acute Admissions Service review and develop implementation plan including developing business cases for funding • Review Mental Health workforce roles and functions to	Dec 2017	PP38: Delivery of response actions agreed in Annual Plan

Government planning priority	Link to NZ Health Strategy	Waitemata DHB key response actions to deliver improved performance		Measures
		Activity	Milestones	
		identify opportunities to create peer roles within service delivery model	Dec 2017	(section 2)
		Range of Services • Develop SACAT clinical and service pathways including a business case to develop SACAT response within DHB • Develop business case to expand Community Alcohol and Drugs Services and Pregnancy and Parental Services into community and primary care sector	Feb 2018 Jun 2018	
		Physical health outcomes • Establish metabolic screening and primary care services protocols for people with serious mental illness >12 months, including reporting • Establish baseline volumes of physical health screening	Jun 2018	
		Suicide prevention and postvention • Pilot and evaluate Kaupapa Māori Suicide prevention trainings (EOA)	Jun 2018	
		See the Rangatahi (Mental Health) section of our 2017/18 Māori Health Plan for more information		
Healthy Ageing	**Closer to home**	Implement outcomes of the Inbetween Travel Settlement Agreement and equal pay negotiations	By required dates	PP23: Implementing the Healthy Ageing Strategy
		Review Interim Care Scheme and Respite Care; complete contracting processes	Jan 2018	
		Complete procurement for Home and Community Support Services	Jun 2018	
		Continue implementing Falls Prevention Programme	Ongoing	
		Establish community falls prevention group programmes for areas/population groups not covered to ensure equitable access to the service (EOA)	Jun 2018	
		Compare and benchmark performance with other DHBs using international Resident Assessment Instrument (interRAI) measures provided by the national data analysis to improve outcomes for older people	Ongoing	
		Develop an integrated clinical and shared care pathway for Specialist Mental Health and Addictions Service users to receive appropriate services and support Implement pathway	Dec 2017 Mar 2018	
		Implement relevant actions (some detailed above) to deliver on Regional Health Plan objectives to: • Strengthen dementia pathways • Proactively use InterRAI data, including ethnicity data to drive service improvement • Work collaboratively to implement workforce activities in the Healthy Ageing Strategy 2016	Jun 2018	
		See the Immunisation (65+ years) section of our 2017/18 Māori Health Plan for more information		
Living Well with Diabetes	**Closer to home**	Complete the development of the diabetes care improvement framework and gain approval to implement (EOA) Implement framework based on approval (EOA)	Dec 2017 Jun 2018	PP20: Improved management for long-term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes
		Implement the recommendations from the retinal screening review consistently across Waitemata and Auckland DHBs • Complete procurement of community-based retinal screening services across both DHBs, centred on high volume, high need areas with a specific focus on Māori and Pacific (EOA) • Implement community-based services, screening at least 85% of patients (EOA)	Mar 2018 Jun 2018	

Government planning priority	Link to NZ Health Strategy	Waitemata DHB key response actions to deliver improved performance		Measures
		Activity	Milestones	
		Implement the recommendations from the podiatry review consistently across both DHBs • Complete contracting process with PHOs and DHBs, which incorporate requirements for more patient-centred, effective and efficient service delivery aimed at reducing inequalities in health outcomes (EOA)	Jun 2018	services
		Develop and implement the CVD improvement framework, which specifically targets improving CVD management for Māori and Pacific people to achieve the regionally agreed clinical targets (EOA): • Complete development of the framework • Gain approval to implement framework • Implement framework (subject to approval)	 Sep 2017 Dec 2017 Jun 2018	
		See the Long-Term Conditions section of our 2017/18 Māori Health Plan for more information		
Childhood Obesity Plan	**Closer to home**	Work with provider(s) selected by RFP, to: • roll out expanded Active Families programme for school children and adolescents, including Māori and Pacific (EOA) • contract for and monitor target volumes for Māori at two times and Pacific children at 2.5 times their percentage of the population (EOA) • establish a baseline and increase referrals of pregnant women into Green Prescriptions for healthy weight management	Dec 2017 Ongoing Mar 2018	PP38: Delivery of response actions agreed in annual plan (section 2)
		In collaboration with Healthy Auckland Together (HAT) and Healthy Families Waitakere, support a stocktake and gap analysis of healthy food environments in and around Kōhanga Reo, Pacific Language nests, and ECE	Dec 2017	
		Work with the northern region DHBs (including ARDS) to develop consistent health promotion messages using the common risk factor approach for obesity and oral health	Mar 2018	
		Implement the National DHB healthy food and drinks policy	Jun 2018	
		See the Raising Healthy Kids section above, the Oral Health section of our 2017/18 Māori Health Plan, and the Metro-Auckland Childhood Healthy Weight Action Plan for more information		
Disability Support Services	**One team**	Implement updated Disability Responsiveness e-learning module for staff, plus by face-to-face team training (EOA)	Ongoing	PP38: Delivery of response actions agreed in annual plan (section 2)
		DHB staff training developed and delivered, e.g. providing training for Auckland Regional Dental Service on working with children with autistic spectrum disorders (EOA)	Ongoing	
		Improvements to Signage and way-finding in hospitals with more use of colour, consistent language and symbols to support easy way-finding, with a focus on people with cognitive and sensory impairments (EOA)	New external signage in place, internal signage design by Dec 2017	
Primary Care Integration	**Closer to home**	**Primary care/NGO/secondary care integration: reducing hospital demand** • After-hours new Agreement and Alliance in place involving Primary Care, St John, ACC and urgent care clinics – specific focus on quintile 5 and high needs populations (EOA) • Implement Point of Care Testing in rural general practices • POAC expansion to allow additional capacity and increased range of services • Abdominal Aortic Aneurysm (AAA) and Atrial Fibrillation screening programme specifically targeting Māori in	Oct 2017 Oct 2017 Jul 2017 Oct 2017	PP22: Delivery of actions to improve system integration including SLMs

Government planning priority	Link to NZ Health Strategy	Waitemata DHB key response actions to deliver improved performance		Measures
		Activity	Milestones	
		place (EOA) • Explore and identify options to introduce an incentive scheme aimed at increasing access to after-hours primary care service for Māori and Pacific people (EOA)	Jun 2018	
		See the Ambulatory Sensitive Hospitalisation, Cervical Screening, Breast Screening, Primary Healthcare Enrolment, and Whānau Ora sections of our 2017/18 Māori Health Plan for more information		
	Value and high performance	**System Level Measure (SLM) Improvement Plan 2017/18** The Metro Auckland region has jointly developed and agreed a 2017/18 Improvement Plan to meet jointly agreed Improvement milestones for each SLM	Deliver on actions over 2017/18	PP22: Delivery of actions to improve system integration including SLMs
		See our 2017/18 System Level Measure Improvement Plan for more information		
Pharmacy Action Plan	One team	Implement the national pharmacy contracting arrangements to support the vision of *Integrated Pharmacist Services in the Community*	Sep 2017	PP38: Delivery of response actions agreed in annual plan (section 2)
		Support local implementation of national contracting arrangements once agreed to support the vision of '*Integrated Pharmacist Services in the Community*'.	Jun 2018	
Improving Quality	Value and high performance	Work in conjunction with HQSC and Sapere Research Group by participating in an 'Always Event' pilot aimed at improving the patient experience highlighted by low scoring areas in the adult inpatient experience survey	Jul 2017	PP38: Delivery of response actions agreed in annual plan (section 2)
		Analyse results of the local Family and Friends Test (FFT) to identify areas for improvement for wards and services	Ongoing	
		Pilot FFT translated into five different languages in 2017/18 to ensure the voices of our diverse community are heard (EOA)	Dec 2017	
		Deliver Patient Experience Week activity that showcases various patient experience improvement activities occurring at service/ward level and organisation wide	Apr 2017	
		Establish a consumer council (or similar) at Waitemata DHB (EOA)	Dec 2017	
		Processes relating to the development of patient information are updated to reflect MoH's health literacy guidelines	Dec 2017	
		Pilot a new process for endorsing patient information documents that meet expected quality standards	Dec 2017	
		Embed new patient information endorsement process	Jun 2018	
		Create a benchmark measure to assess how well informed people feel after reading patient information relevant to their inpatient experience (for reporting in subsequent years)	Jun 2018	
		See the Data Quality section of our 2017/18 Māori Health Plan for more information		
Living within our Means	Value and high performance	Ongoing identification and implementation of initiatives under the Financial Sustainability Portfolio to ensure expenditure reductions in the multiyear plan are achieved, and a sustainable break-even result realised	Breakeven result	Agreed financial templates
		Enhancing the DHBs financial accountability to ensure planned financial performance is achieved through a focused "no surprises" approach	Breakeven result	
		Enhancing financial decision making and through the use of data analytics, strategic BI and driver-based forecasting to enable early identification of unfavourable and favourable scenarios	Breakeven result	

Government planning priority	Link to NZ Health Strategy	Waitemata DHB key response actions to deliver improved performance		Measures
		Activity	Milestones	
Delivery of Regional Service Plan	**NA**	**Cardiac Services – ACS** • Audit compliance with the current pathway and the Timi assessment criteria/process • Audit the appropriate referral pathway for exercise tolerance test (ETT) • Audit the rate of negative vs. positive ETTs to inform this work	Dec 2017	NA
		Cardiac Services – Heart Failure • Audit all patients with a first diagnosis of heart failure to track their readmission rates • Engage in the regional process via the regional cardiac network to agree protocols, guidance, processes and systems to ensure optimal management of patients with heart failure	Dec 2017 Jun 2018	
		Stroke • Ensure all Allied Health and Nursing staff in In-Patient Rehabilitation and Community Rehabilitation services complete a stroke competency training programme within the first year of employment • Support a range of health professionals working in stroke care to attend the Stroke Society of Australasia's annual conference in Aug 2017	Ongoing Aug 2017	
		Hepatitis C • Support the roll-out of the integrated Hepatitis C service across the region including GP practice support, raising awareness, extending services and monitoring progress	Over 2017/18	
		See the 2017/18 Northern Region Health Plan for more information		

Financial Performance Summary

Statement of Comprehensive Income	2015/16 Audited Actual $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Revenue						
MoH	1,456,260	1,506,695	1,587,555	1,619,779	1,652,009	1,684,218
IDFs & Inter DHB Provider	82,705	85,259	85,982	87,725	89,468	91,211
Other government	9,964	10,042	9,755	9,709	9,902	10,095
Other	27,090	25,010	32,579	33,234	33,889	34,543
Total revenue	**1,576,019**	**1,627,006**	**1,715,871**	**1,750,447**	**1,785,268**	**1,820,067**
Expenditure						
Personnel	582,217	604,008	637,270	650,186	663,104	676,015
Outsourced	71,768	76,281	68,254	69,635	71,016	72,397
Clinical Supplies	110,618	118,245	115,909	118,258	120,607	122,955
Infrastructure and Non-Clinical	105,222	97,954	104,657	83,088	84,759	86,426
Payments to Non-DHB Providers	704,194	727,227	789,781	829,280	845,782	862,274
Interest	10,712	6,532	0	0	0	0
Depreciation and Amortisation	27,172	28,006	29,670	30,270	30,870	31,470
Capital charge	24,501	21,560	36,924	36,924	36,924	36,924
Total Expenditure	**1,573,062**	**1,623,715**	**1,715,871**	**1,750,447**	**1,785,268**	**1,820,067**
Other comprehensive income	2,957	3,291	0	0	0	0
Revaluation of land and building	29,322	(301)	0	0	0	0
Total Comprehensive Income/(Deficit)	**32,279**	**2,990**	**0**	**0**	**0**	**0**

Four-year plan

Prospective summary of revenues and expenses by output class	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Early detection				
Total revenue	422,607	431,123	439,699	448,270
Total expenditure	422,607	431,123	439,699	448,270
Net surplus/(deficit)				
Rehabilitation and support				
Total revenue	218,820	223,229	227,670	232,108
Total expenditure	218,820	223,229	227,670	232,108
Net surplus/(deficit)				
Prevention				
Total revenue	31,159	31,787	32,419	33,051
Total expenditure	31,159	31,787	32,419	33,051
Net surplus/(deficit)				
Intensive assessment and treatment				
Total revenue	1,043,285	1,064,308	1,085,480	1,106,638
Total expenditure	1,043,285	1,064,308	1,085,480	1,106,638
Net surplus/(deficit)				
Consolidated surplus/(deficit)	**0**	**0**	**0**	**0**

Local and Regional Enablers

Local and Regional Enabler	Link to NZ Health Strategy	Waitemata DHB Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestones	
IT	Smart System	Implement the: • Regional version of eLaboratory • Single instance of Portal 8 at Counties Manukau and Waitemata DHBs with Northland migration planned • Regional version of Patient Management System (iPM) • Regional instance of Winscribe Voice To Text • Single cloud-based WorkForce Central for Waitemata and Auckland DHBs	Jul 2017 Mar 2018 Aug 2017 Nov 2017 Aug 2017	Quarterly reports from regional leads
		Refresh the regional Information Systems Strategic Plan	Sep 2017	
		Continue progress towards a paperless patient record and achieving EMRAM level 6. Includes completing closed loop medication and expanding structured templates for clinician notes	Jun 2018	
		Complete the 'closed loop' for medication safety in Pyxis and Medchart	Nov 2017	
		Develop and implement the NCHIP (National Child Health) solution	As per project plan (to be developed)	
		See the Data Quality section of our 2017/18 Māori Health Plan for more information		
Workforce	One team	Increase the size of Māori and Pacific workforces (EOA): • Set Māori and Pacific workforce growth KPIs • Begin work with metro Auckland DHBs and Auckland Council as a pledge partner in youth employment	Oct 2017 Jun 2017	NA
		Grow the capability of Māori and Pacific Workforces: • Ensure appropriate cultural and mentoring support is available to new and existing staff (EOA) • Review leadership development offerings for responsiveness to the needs of Māori and Pacific workforces (EOA)	Jun 2018 Jun 2018	PP23: Implementing the Healthy Ageing Strategy
		Focus on building workforces in Sonography, Physiotherapy, Midwifery, Palliative Care and Anaesthetic technicians: • Implement productive recruitment and retention strategies for new and experienced workforces • Prepare 2018 scholarship programme to target workforces • Collaboration with partners such as hospice to jointly govern/lead and share resources/services	Jun 2018 Dec 2017 Ongoing	
		Support the intent and undertake actions with key partners (MoH, Auckland DHB, and aged-care provider workforce) and associated Kaiawhina workforces according to the Healthy Ageing Strategy	Ongoing	
		Meet all of our training and facility accreditation requirements from regulatory bodies, including New Zealand Nursing Council, Medical Council of New Zealand, New Zealand Dental Council, Pharmacy Council and Medical Science Council	Ongoing	
		See the Workforce section of our 2017/18 Māori Health Plan for more information		

SECTION 3: 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

The Service Coverage Schedule is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability (NZPHD) Act 2000, which is subject to endorsement by the Minister of Health. The Schedule allows the Minister to explicitly agree to the level of service coverage for which the Ministry of Health and district health boards are held accountable.

Waitemata DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2017/18.

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.

Pharmacy Contracting Arrangements

During 2017/ 2018 DHBs are expected to commit to deliver on the Ministry of Health's Pharmacy Action Plan. In particular to make better use of pharmacists expertise in the safe and effectively use medicines to achieve the best health outcomes for all consumers across New Zealand, within the funding available.

DHBs are expected to participate in the implementation of the new national pharmacy contracting arrangements to enable 'Integrated Pharmacist Services in the Community' (effective 1 July 2018). The current Community Pharmacist Services Agreement will expire 30 June 2018.

The new contracting arrangements will enable District Health Boards to implement the long term Vision for 'Integrated pharmacist Services in the Community' and move from a system that funds pharmacists on transaction based medicine delivery with limited patient-centric service delivery and funding, to one that:

- is flexible enough to meet local DHB population and consumer need
- enhances the healthcare and medicines management expertise delivered by pharmacists
- supports pharmacists to work as one team with other primary care services to benefit the wider health care system and population health.

From 1 July 2018 the contracting framework will change to enable the development of patient-centric services and local DHB commissioning for integrated pharmacist services to meet population needs. The contract and funding arrangements will change to more closely mirror the PHO Services Agreement, and encourage integration across pharmacy, primary care and aged residential care.

The new contracting arrangements will provide District Health Boards flexibility to provide their local communities with equity of access to different types of pharmacist services, tailored to individual need while addressing the four target population groups (frail elderly, vulnerable children, mental health and chronic conditions).

Delivering the 'Integrated Pharmacist Services in the Community' vision will take time; and it is anticipated the vision will be delivered by 2020-2025.

During 2017/18 DHBs will develop local pharmacist services strategies which align with the Pharmacy Action Plan and the 'Integrated Pharmacist Services in the Community' vision. They will continue to develop and implement consumer focused services and better integration with wider community based interdisciplinary teams.

Service change

Type of service change	Description of service change	Benefits of Change	Change for local, regional or national reasons
Service review	**Smoking Cessation Services** Reviewing DHB funded Stop Smoking services which may impact on services in 2017/18	Align DHB services with MoH's new Stop Smoking Services and potentially address service gaps	Local (Auckland/ Waitemata DHB)
Refinement in model of service delivery and potential change of provider(s)	**Home and Community Support Services (HCSS)** Procurement for this service will commence within 2017/18	Improved delivery of services to increase responsiveness and flexibility and better respond to client needs	Local (Auckland/ Waitemata DHB)
Potential change in model of service delivery	**Community Pharmacy** DHBs will work towards different contracting arrangements for the provision of community pharmacist services by working with consumers and other stakeholders to develop local service options, once agreed, including potential options for consumer-focused pharmacist service delivery, with wider community based interdisciplinary teams	Enhanced services for consumers	Local (Auckland/ Waitemata DHB)
Potential change of provider and enhancement of services	**Active Families** RFP currently underway to select providers for each DHB to deliver pre-school Active Families (a possible new service), Active Families and Green Prescription	Improvements have been made to the Service; specification to target priority populations and enhance service delivery	Local (Auckland/ Waitemata DHB)
Level, location and configuration of services	**Maternity Services** Commissioning of an additional Waitemata DHB primary maternity facility	Improved birthing options for local population; promotion of normal delivery in the community setting	Local
Change in service configuration, location and model of care	**Transgender Services** Development of services including potential quality improvements to existing services, refinement of age of eligibility across services, new services, refinement of location of service provision	Improved access More consistent care delivery Consistent quality	Northern Region or Metro Auckland
Refinement in service design	**Rheumatic Fever** • Rapid response clinics • School based service • Other components of service	Service design informed by evaluation More targeted service delivery	Local (Auckland/ Waitemata DHB)
Response to service gaps	**Vulnerable pregnant women/infants** • Identification of service gaps • Service improvement • Refinement of additional services in place	Ensure needs of pregnant women being met in relation to depression, anxiety, housing, parenting, other social needs; improved health and wellbeing outcomes for infants	Local (Auckland/ Waitemata DHB)
Implementation of new system	**National Child Health Information Platform (NCHIP)** • Implementation of new IT system • Will result in reviews of NIR/OIS service delivery • Potential changes to B4 School Check administration	Better identification of infants at risk of poor outcomes Improved service models resulting in increased access	National
Establishment of new service	**Immunisation** Introduction of Saturday morning drop-in immunisation clinic at Waitakere Hospital/Henderson	Improved accessibility for local population Improved immunisation rates	Local
Establishment of new service	**Cardiac Lead extraction** Establish specification for service not previously provided by DHB and confirm role of Auckland DHB as supra-regional or national provider	Improved outcomes associated with high service quality Equitable access to service	Local, regional, potentially national
Implementation of an enhanced and regionally consistent model of care - stroke	**Hyperacute stroke pathway** • After hours thrombolysis to operate from Auckland DHB for local, and Auckland regional patients commencing with a first phase for Waitakere population from July 2017 progressing to include all Waitemata DHB and Counties Manukau DHB patients, with	All stroke patients receive same quality of care including equity of access. Access to 24/7 specialist stroke care Improved outcomes	Regional and local to meet national guidelines

Type of service change	Description of service change	Benefits of Change	Change for local, regional or national reasons
	telestroke service available to Northland DHB patients • Clot retrieval to operate from Auckland DHB for all northern region DHB patients and initiate planning for the Midland region population		
	Stroke care/rehabilitation • Revised model of care, agreed regionally - local stroke rehab delivery – all ages • Develop a business case for a proposed integrated Stroke Unit for NSH including impact on <65 stroke rehab (i.e. move to the stroke unit rather than Rehab Plus) • Development of a comprehensive stroke unit at ACH, integrating acute and rehabilitation services (business case pending).	Streamlined pathway Equitable access to rehabilitation services Consistent quality of care delivery	Regional Local Local
Increase in service access	**Primary Mental Health Services** Approved funding to increase volume of services, with increased Support Services (implementing Our Health in Mind Strategy 2016-2021)	Increased access to Primary MH services	Local
Increase in service access	**High and Complex Residential Services** New purpose built service - 16 bed capacity with opening due date September 2017	Increased access to appropriate treatment and rehabilitation services for people with high and complex needs; reduced demand for Acute and Hospital Inpatient Services	Local
Increase in service access Change in location Implementation of new technology	**Orthopaedic Services** • Lowering of access threshold for non-joint orthopaedic cases to increase intervention rates in line with national trends • Planning for the development of Waitemata DHB capacity to support delivery of regional service for other DHB populations • Implementation of Mako robotic surgery in ESC	Improved access for local population and regional population Improved patient outcomes	Local
Shift in service	**ORL Services** Progress regional review of ORL and Head and Neck services across Northern region with the potential to reconfigure current services provided at Waitemata DHB	Improved sustainability of local and regional services Improved patient outcomes	Regional and local
Increase in local service access	**Vascular Services** Possible local delivery of fistula and other renal related surgical services	Improved accessibility for local population	Local
Increase in local service access	**Induced sputum testing** Possible local delivery	Improved accessibility for local population Improved patient outcomes associated with decreased DNAs	Local
Potential change in model of service delivery	**Sleep Service** Progress planning towards the development of new sleep service model that makes best use of available capacity and resources including funding to increase number of patients able to be assessed and treated	Improved access Improved clinical and financial sustainability of regional model	Local and regional
Improved local services and regional consistency	**Hepatology** Progress development of new and enhanced liver services at Waitemata DHB in response to new Hep C treatment	Improved services delivered locally Increased access to liver services Improved patient outcomes	Local, regional and national
Change in service configuration and model of care	**Hospice West Auckland/Waitakere Hospital** • Appoint a joint SMO to work across both Waitakere Hospital and West Auckland Hospice	Improved integration between hospital and hospice Consistent quality of care	Local

Type of service change	Description of service change	Benefits of Change	Change for local, regional or national reasons
	to provide more seamless care • Planning in 2016/17 for implementation in 2017/18	Improved access Workforce development	
Align access to funding available through refinement in model of service delivery	**Supra Regional Eating Disorder Service (EDS)** Midland DHBs have withdrawn from all elements of Supra regional EDS services except residential service. Service has adjusted capacity accordingly however no service reduction expected for the Northern region populations	Auckland DHB service resized for Northern region population and Midland access to residential services only Potential for service capacity to become problematic should Midland seek access to other elements of the service	Supra Regional DHBs - Northern Region and Midlands DHBs
Improved patient selection process and patient pathway	**Bariatric Patient Selection Process and Patient Pathway** Waitemata DHB - establish a best practice multidisciplinary team patient selection process and optimise the preoperative patient pathway, focusing on current barriers highlighted by patient experience work Auckland DHB - Optimise the preoperative patient pathway based on patient experience work, and align the pathway with Waitemata DHB. There will be an increase in service volumes (by approximately 20 cases)	Improve equity of access for Māori and Pacific by reducing system barriers. Moving to a patient-centred preoperative pathway which will improve patient access to appropriate resources (e.g. psychology, dietitian, nursing) and improve patient understanding through provision of information resources reviewed with a health literacy lens	Local (Auckland/ Waitemata DHB)
Change in model of service delivery	**Outpatient Services** Services are expected to review traditional models of service based on face-to-face outpatient activity and develop new models that incorporate alternative methods of delivery such as Virtual, Telemedicine and Nurse-led provision	Provision of more flexible, accessible patient-centred services. Better use of new technology to deliver cost effective and efficient services	Local (Auckland/ Waitemata DHB)
Improved local access	**Local delivery Oncology services** Auckland region will progress regional planning initiated in prior years to develop a plan and business case for the local delivery of Oncology services with the timing and scope of services to be determined by the need for additional capacity in the regional service	Improved local access Additional regional service capacity developed in a planned and cost effective manner	Auckland region

SECTION 4: Stewardship

Managing our business

To manage our business effectively and deliver on the priorities described in Section 2 and our Statement of Intent, we must translate our high level strategic planning into action in an organisational sense within the DHB, with supportive infrastructure requirements in place. 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 intent to improve, promote and protect the health of our population.

Organisational performance management

We have developed an organisational performance framework that links our high-level performance 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 ISO 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's Audit and Finance Committee quarterly, providing assurance on the management of the most significant risks faced by Waitemata DHB.

Cyber-attack on critical systems leading to information being lost, corrupted or held to ransom is a significant risk for all organisations. The treatment plans implemented by the 3 Northern region DHBs are:

1. Delivery of the healthAlliance Advanced Threat Management cyber security treatment plan which includes modern anti-virus technology, firewalls, strong security protocols and penetration testing of systems
2. Training for staff to identify and avoid social engineering based attacks e.g. Phishing, Ransomware.

Quality assurance and improvement

Our Promise Statement to our community is 'Best Care for Everyone'. We aim to provide care that is safe, clinically effective, and focused on the individual needs of every patient and their whānau that enters our care. To achieve our quality vision, the DHB has set out 3 aims which reflect three key elements of quality:

Safe care – there will be no avoidable harm to patients from the healthcare they receive
Clinically effective care – the most effective treatments, support and services will be provided at the right time to those who would benefit, to achieve the best possible health outcomes
Patient and family centred care – each patient and their family will experience compassionate care, they will feel informed, supported and listened to, and they will be engaged and involved in their care.

We focus on Quality Improvement in all areas and use our quality assurance framework to identify areas requiring further work. Achieving excellent results across the Health Quality and Safety Commission (HQSC) markers is a priority.

The establishment of the Institute for Innovation and Improvement (i^3) helps to realise our Boards' priorities of improving health outcomes and patient and whānau experience. i^3 brings together experience, leadership, digital communications, and evaluation. This expertise is used to support clinical teams in the design and implementation of new models of care and best practice processes. i3 will lead the DHB's commitment to clinically-led care redesign and enhanced care management, and will build capability in the DHB to ensure that current and future health challenges can be met.

We have responsibility under the New Zealand Public Health and Disability Act (2000) to monitor the delivery and quality of contracted services. We carry out this responsibility through a number of auditing agencies, as well as through ongoing relationship management undertaken by programme managers.

Asset management

The most recent Investor Confidence Rating (ICR) assessment led by the Treasury assigned Waitemata DHB an ICR of 'B', which exceeds the 'C' rating expected of a Tranche 2 organisation. Waitemata DHB's asset management maturity was rated as middle intermediate against a long-term target of lower advanced. The

improvement plan in place will see this target being reached within two years and an advanced level of maturity achieved over the next six years.

Regional long term investment plan

The Northern Region DHBs are working together to develop a Long Term Investment Plan (LTIP). The LTIP is a high level, integrated strategic plan to guide medium to long term regional investment decisions related to Physical Infrastructure, Clinical Equipment and Information and Communication Technology (ICT). The NRLTIP work plan focuses on 'Physical Infrastructure' investment requirements facing our region. The 'Clinical Equipment' and 'ICT' portfolio investment plans will draw from relevant work currently underway in parallel investment planning work streams (e.g. the ISSP) and other completed regional investment planning work.

The plan will outline the region's strategic directions, investigate various investment scenarios and provide an approach to assess and prioritise future investments, supporting the region to deliver optimal health gain for the northern region's population within the available resources. The Plan will build on the work done by each DHB in developing their own individual LTIPs. The project is being undertaken using a three phase approach:

- Phase 1 – Preliminary Analysis – understanding the baseline and drivers for change
- Phase 2 – Understanding and agreeing counterfactuals
- Phase 3 – Agreeing and informed LTIP.

The outputs from all three phases will be reported to the Regional Governance Group. The project has completed Phase 1 in 2017.

Shared service arrangements and ownership interests

Waitemata DHB is involved in three joint venture agreements. One is a jointly controlled operation; Awhina Waitakere Health Campus. healthAlliance N.Z. Limited is a joint venture company that provides a shared services agency to the four northern DHBs (each with a 25% share) delivering information technology, procurement and financial processing support. The New Zealand Health Innovation Hub is a joint partnership between Counties Manukau, Auckland, Waitemata and Canterbury DHBs to develop and commercialise health technologies and service improvement initiatives. The Hub has been structured as a limited partnership, with the four foundation DHBs each having a 25% shareholding.

Waitemata DHB holds a 33% shareholding in Northern Regional Alliance Limited (NRA). The NRA is an associate with Auckland, Counties Manukau and Waitemata DHBs. It supports and facilitates employment and training for Resident Medical Officers across the three DHBs and to provide a shared services agency to the Northern Region DHBs in their roles as health and disability service funders.

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.

Building capability

Information communication technology

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

The direction on information management, systems and services in the Northern Region is set by the Northern Regional Information Strategy (RIS 2010–20). A refresh of this plan is being completed this year. Meanwhile, along with our regional partners we will:

- continue to strengthen our shared information service, with a focus on responsiveness and value
- continue to invest regionally in a reliable and sustainable technology infrastructure
- promote SMOMED CT as the standard system of clinical terminology for point-of-care applications and the capture of hospital information
- participate in national initiatives, e.g. the National Health Plan and National Electronic Health Record
- continue investments in electronic support of clinically-led service initiatives.

Workforce

Culture, Leadership and Development of our People

Our values underpin our people and patient focused organisational culture. Our organisational development programme 'Everyone Matters – Staff' reflects: our sense of connection with each other and our district; our compassion to ease suffering and pain; how we are better, best, brilliant in our everyday work; everyone matters in each moment.

The Health Services and Community Services Plan will guide our future workforce needs. Engagement and collaboration with our people, regional DHBs and union partners will enable us to robustly review planned changes to physical work environments, ways of working and development needs. We are committed to our equity and diversity initiatives, with intentional focus on growing our Māori and Pasific workforces, cultural competency and supporting needs of older staff and staff with disabilities. We support the workforce objectives identified in the Northern Region Health Plan 2017/18.

Key pieces of work for 2017/18 include:

1. Planning our future workforce in alignment with our Health Services Plan and Community Services Plan, including assessment of our graduate pipelines.
2. Values and behaviours – focus on team work initiatives.
3. Growing the capacity and capability of our Māori and Pasific workforces with focus on pathways into health careers, retention of current workforces and support of active mentoring and collaboration networks.
4. Leadership and Management – moving to a focus on capability and career growth and development. Ongoing development of our Fellows programme which fast tracks people into leadership roles. Supporting primary care nursing leadership development.
5. Use of technology that meets the education needs of a busy, mobile and learning oriented workforce.
6. Supporting ongoing development of professions and key skills through introducing the DHB-wide education governance.
7. Building our research capacity and capability to become a centre of research excellence.
8. Regional Workforce planning, which includes:
    - Year 2 of the Health Management Graduates programme and a middle-manager development programme
    - Support initiatives from the medical (including community placements for pre-vocational RMOs), nursing, kaiāwhina, allied health, technical and scientific workforce taskforce groups facilitated by Health Workforce New Zealand
    - Planning and use of the DHB national workforce planning intelligence tool and leadership assessment programmes.

Equal Employment Opportunities

We strive to be a good employer at all ages and stages of our employees' careers. Good employment practices 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 practice 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, bullying and harassment, health and safety, fire awareness and managing patients during a fire, moving and handling, clinical resuscitation and customer service.

Organisational Health, Safety and Wellbeing

At Waitemata DHB, 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.

Our promise is reflective of our organisational culture, where innovation, excellence and learnings mix to support our staff to achieve the best care for everyone. This year, we plan to increase our level of leadership, commitment and performance by implementing our three-year health and safety strategy, with a primary focus on staff wellbeing, workforce environment, hazard and risk management, governance and patient safety and experience. A key work programme is our Healthy Workplace Strategy, which adopts the World Health Organisation's Healthy Workplaces framework, and through 15 collaborative workstreams, supporting the evidence base that staff wellbeing influences patient wellbeing.*

Our working environment is an important component to wellbeing for patients and staff, with the DHB focussing on elements as diverse as: the values and professional behaviours that connect us and help us to work well together; safety in the community; public reception areas; hazardous substances; buildings; and the external physical environment, such as loading zones, pathways and roads.

* Boorman, 2009; Kings Fund 2012; West, 2013.

Through our Safe Way of Working policies, we aim to increase our systematic approach to health and safety monitoring of our current performance, areas of improvement and learnings from each other. Our new self audit will measure 12 elements of health, safety and wellbeing, allowing the DHB to take a whole-of-systems and a ward/unity quality improvement approach that defines, guides, measures and embeds our practises.

We are committed to working with our regional DHB partners on employee participation and training programmes, and sharing audit programmes to collectively improve our regional health and safety performance.

SECTION 5: Performance Measures

2017/18 Performance measures

The following table presents the full suite of Ministry of Health 2017/18 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		2017/18 Performance expectation/target
HS: Supporting delivery of the New Zealand Health Strategy		Quarterly highlight report against Strategy themes
PP6: Improving the health status of people with severe mental illness through improved access	**Age 0-19**	To be agreed as part of reporting for Q1 2017/18
	Age 20-64	
	Age 65+	
PP7: Improving mental health services using wellness and transition (discharge) planning	% of clients discharged will have a quality transition or wellness plan	95%
	% of audited files meet accepted good practice	95%
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm	80% of people seen within 3 weeks
		95% of people seen within 8 weeks
	Addictions (Provider Arm and NGO)	80% of people seen within 3 weeks
		95% of people seen within 8 weeks
PP10: Oral Health - Mean DMFT score at Year 8	Ratio year 1	0.68
	Ratio year 2	0.68
PP11: Children caries-free at five years of age	Ratio year 1	68%
	Ratio year 2	68%
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		
Measure 1: Number of Pre-School Children Enrolled in DHB-funded Oral Health Services	% year 1	95%
	% year 2	95%
Measure 2: Number of Enrolled Pre-School and Primary School Children Overdue for their Scheduled Examinations	% year 1	≤10%
	% year 2	≤10%
PP20: Improved management for long-term conditions (CVD, acute heart health, diabetes and stroke)		
Focus area 1: Long-term conditions	Report on activities in the Annual Plan	
Focus area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the Quality Standards for Diabetes Care	
	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% of the eligible population will have had their cardiovascular risk assessed in the last five years	90%
	Indicator 2: 90% of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the last five years	90%
Focus area 4: Acute heart service	70% of high risk patients will receive an angiogram within 3 days of admission by ethnicity	70%
	Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days	>95%
Focus area 5: Stroke Services	8% of potentially eligible stroke patients thrombolysed	8%

Performance measure		2017/18 Performance expectation/target
	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%
PP21: Immunisation coverage	% of two year olds fully immunised	95%
	% of five year olds fully immunised	95%
	% of eligible girls fully immunised - HPV vaccine	75% (2004 birth cohort)
	% of the population aged 65 years and over who are immunised against influenza annually (measured at 30 September)	75%
PP22: Improving system integration and SLMs	Report on activities in the Annual Plan	
PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan	
	% of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care of a contact assessment and completed care plan	95%
PP25: Prime Minister's youth mental health project	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS	
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below)	
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
PP26: The Mental Health and 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		
Reducing the Incidence of First Episode Rheumatic Fever	Exception reporting required if the target hospitalisation rate for acute rheumatic fever has not been reached or maintained	
PP29: Improving waiting times for diagnostic services	Coronary angiography: 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	95%
	CT and MRI – 95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days)	95% for CT scans 90% for MRI scans
	Diagnostic colonoscopy a. 90% 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	90% 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	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat	85%
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and	95%

Performance measure			2017/18 Performance expectation/target
	support to quit smoking		
PP32: Improving the accuracy of ethnicity reporting in PHO registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT)		
	% of staff trained in EDAT toolkit		>95%
PP33: Improving Māori enrolment in PHOs	% of Māori population enrolled with a PHO		90%
	Report on delivery of the actions and milestones to improve the Māori enrolment rates with PHOs		
PP34: Improving the percentage of women who are smoke free at two weeks postnatal	% of babies (up to 50 days of age) who live with a recorded household smoker		TBC
PP36: Reduce the rate of Māori on the Mental Health Act (1992): section 29 community treatment orders relative to other ethnicities	% of the Māori population under community treatment orders s29 of the Mental Health Act		↓ by 10% (Sep 2016 baseline)
	A qualitative report that identifies progress on actions to reduce Māori under compulsory treatment orders identified in the annual plan		
PP37: Improving breastfeeding rates	% of infants exclusively or fully breastfed at three months (Total and Māori)		60%
PP38: Delivery of response actions and milestones agreed in the annual plan for each Government planning priority	Section 1: Confirmation or exception report (including resolution plan) for actions and milestones supporting the health-led BPS targets • Healthy mums and babies • Keeping kids health		
	Section 2: Confirmation or exception report (including resolution plan) for any actions or milestones supporting all other priorities		
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age group 0-4 years (SLM measure)		See our 2017/18 SLM Improvement Plan
	Age group 45-64 years		4,108/100,000
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		21.0 per 10,000
	Cataract procedures		27.0 per 10,000
	Cardiac surgery		6.5 per 10,000
	Percutaneous revascularisation		12.5 per 10,000
	Coronary angiography services		34.7 per 10,000
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.		
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan		
SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan		
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan		
SI0: Improving cervical screening rates	% of women aged 25 – 69 years (by ethnicity) who have had a cervical sample taken in the last 3 years (adjusted for hysterectomy)		80% coverage for all ethnic groups and overall
SI11: Improving breast screening rates	% of women aged 50 -69 years (by ethnicity) who have had a screening mammogram in the last two years. This includes women who may have turned 70 or 71 during the monitoring period		70% coverage for all ethnic groups and overall
OS3: Inpatient Length of Stay	Elective LOS	The suggested target is 1.47 days, which represents the 75th centile of national performance	1.5 days
	Acute LOS	The suggested target is 2.3 days, which represents the 75th centile of national performance	2.5 days
OS8: Reducing Acute Readmissions to Hospital	MoH to confirm during 2017/18		MoH to confirm during 2017/18
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	New NHI registration in error (causing duplication)		

Performance measure		2017/18 Performance expectation/target
identity data	Group A >2% and ≤4% Group B >1% and ≤3% Group C >1.5% and ≤6%	Group A >2% and ≤4% Group B >1% and ≤3% Group C >1.5% and ≤6%
	Recording of non-specific ethnicity	>0.5% and ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and ≤2%
	Validated addresses unknown	>76% and ≤85%
	Invalid NHI data updates	MoH to confirm during 2017/18
Focus area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	≥97% and <99.5%
	National Collections File load Success	≥98% and <99.5%
	Assessment of data reported to NMDS	≥75%
	Timeliness of NNPAC data	≥95% and <98%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified about data quality audits.	
OP1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a. 5% variance (+/−) of planned volumes for services measured by FTE b. 5% variance (+/−) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c. actual expenditure on the delivery of programmes or places is within 5% (+/−) of the year-to-date plan	
DV4: Improving patient experience	No performance expectation/target set	
SLM DV6: youth access to and utilisation of youth appropriate health services	No performance expectation/target set	
SLM DV7: number of babies who live in a smoke-free household at six weeks post-natal	No performance expectation/target set	

DV developmental measure; ***HS*** health strategy; ***OP*** output; ***OS*** ownership; ***PP*** policy priority; ***SI*** system integration

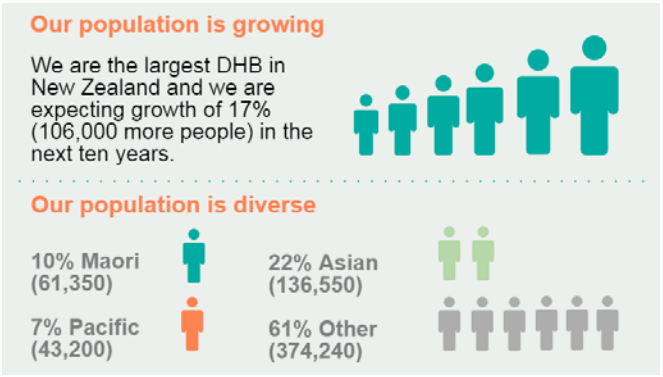
Appendices

APPENDIX A: STATEMENT OF INTENT – 2017/18 TO 2020/21

About Waitemata DHB

Who we are

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 estimated 615,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest DHB in the country, and are experiencing rapid population growth.



The age composition of Waitemata residents is similar to the national picture, with 19% aged less than 15 years, and 14% aged over 65.

Our population is diverse. 10% of Waitemata residents are Māori (61,350 people), 7% Pacific, and 22% are Asian (136,550 people). Our Asian population is proportionally our fastest growing population, and projected to increase to 27% of the total in the next ten years.

Waitemata's population is generally healthier than that of New Zealand as a whole. We have the highest life expectancy in New Zealand at 83.8 years, with an increase of 3.3 years since 2001. Our obesity rates are lower than national rates, but more than half of our adults are overweight (58%) and nearly a quarter of our adults are classified as obese (24%). 12% are current smokers.

Cancer is the most common cause of death (29%), and there are over 3,100 new cancer registrations in Waitemata every year. Cardiovascular disease (30%) and respiratory disease (10%) also account for a large proportion of deaths. Our 5-year survival rate for cancer is among the highest in New Zealand (68%) and our CVD and cancer mortality rates are also very low, a large proportion of all deaths are amenable through healthcare interventions (16% or 490 deaths in 2014).

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. The North Shore and Henderson-Massey are densely populated suburban areas, while the large rural areas to the north and west have much sparser population.

We are a relatively affluent population, with a large proportion living in areas of low deprivation. One in twelve (8%) of our total population and 22% of Māori and Pacific people live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. These individuals experience poorer health outcomes than those in more affluent areas.

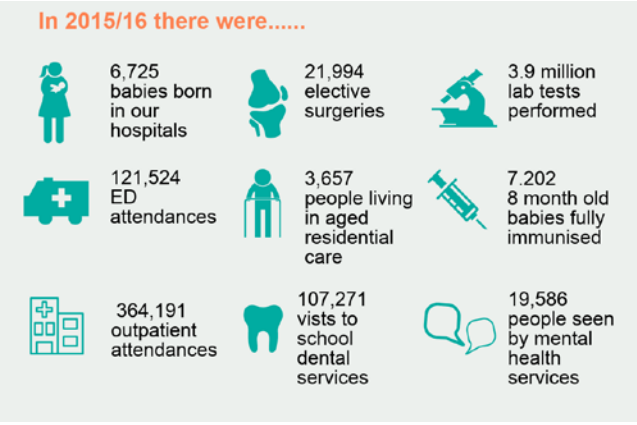
What we do

Waitemata DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. Around 7,100 people are employed by Waitemata DHB.

We have a budget of $1.588 billion in 2017/18.

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, and have contracts with approximately 600 other community providers.



We are making significant investments in state-of-the-art, modern facilities and services, with plans in place to continue developing our facilities to meet future demand.

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.

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 range of services to be purchased within the available funding 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.

Māori Health Gain

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.

Waitemata DHB will continue to develop and deliver on an annual Māori Health Plan in 2017/18. While we're proud of the achievements we've accomplished so far for our Māori population, we see the continuation of an annual Māori Health Plan as an important means of enabling us to remain focused, deliberate and intentional in the pursuit of Māori health gain. It also enables greater and more meaningful collaboration and sharing of intelligence across DHBs in terms of Māori health.

Equity

While the Waitemata population overall has the longest life expectancy in New Zealand, Māori and Pacific people have life expectancies five to six years lower than the population as a whole.
Waitemata DHB is committed to helping all our residents achieve equitable health outcomes. Section 2 of the Annual Plan identifies specific activities designed to help reduce health equity gaps for Māori and other groups.

Waitemata DHB is also committed to improving health outcomes and achieving equity for disabled people. We are guided by the Vision of the New Zealand Disability Strategy 2016-2026:

New Zealand is a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.

With the launch of the New Zealand Disability Strategy, Waitemata and Auckland DHBs have started work on developing an Implementation Plan to achieve our goal of being fully inclusive and non-disabling.

The key challenges we are facing

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

Growing and aging population – the population will increase to approximately 722,000 over the next ten years, 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 (30%) and respiratory disease (10%); a large proportion of all deaths are amenable through healthcare interventions (16% or 490 deaths in 2014).

Health inequities – particular populations in our catchment continue to experience differences in health outcomes. This is most starkly illustrated by the gap in life expectancy of 5.6 years for Māori and 6.0 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. We need to make deliberate and focused strategic investment relevant to the specific needs of our population. This may require making some hard decisions about where we commit resource including reallocation of investment into services where we know we can achieve better outcomes.

Given the challenges we are facing we have identified three key areas of risk, and the focus needed to address these.

1. **Ensuring long-term sustainability through fiscal responsibility**

   To ensure we continue to live within our means we need to focus on:

   - 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.

2. **Changing population demographics**

   To cope with our growing and ageing population, we need to:

   - Engage 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
   - Assist people and their families to better manage their own health, supported by specialist services delivered in community settings as well as in hospitals
   - Increase our focus on proven preventative measures and earlier intervention.

3. **Meeting future health needs and the growing demand for health services**

   To deliver better outcomes and experience for our growing population, we must maintain momentum in key areas:

   - 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, including working regionally and across Government and other services.
   - Quality improvement in all areas
   - Ongoing development of services, staff and infrastructure
   - Involving patients and family in their care.

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 2017/18, these were (as set by the previous Minister of Health:

- Refreshed New Zealand Health Strategy
- Living within our means
- Working across Government
- National Health Targets
- Streamlining of DHB Annual Planning.

The refreshed New Zealand Health 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'. Actions to deliver on the New Zealand Health Strategy are detailed in section 2 of this annual plan.

We will actively work with other agencies to support vulnerable families and progress outcomes for children and young people, including working with the new Ministry for Vulnerable Children, Oranga Tamariki, once established. We will continue to work with New Zealand Health Partnerships Limited to progress initiatives.

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 will be met during 2017/18 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 2017/18 NRHP is to achieve gains across the Triple Aim Framework and the themes of the New Zealand Health Strategy, in addition to a strong focus on equity.

Sub-regional

Waitemata and Auckland DHBs have a bilateral agreement that joins governance and some activities to provide mutual benefit to the planning and delivery of enhanced, sustainable health services to over one million Aucklanders. The merger of a number of teams, including planning, funding and outcomes, has increased consistency of relationships across the two DHBs. The three Metro Auckland DHBs - Auckland, Waitemata and Counties Manukau - share a Board Chair, this allow further collaboration across the three DHBs and a more integrated and aligned approach to planning and delivery of health services across Auckland.

Focus for 2017/18

Our focus is firmly on the future with our Waitemata 2025 programme. This programme encompasses all our projects designed to develop the people, services and facilities needed over the next decade to meet our anticipated growth.

We expect disciplined financial management will allow us to offer faster access to high-quality healthcare without incurring financial deficit in the coming year. This is a significant achievement given the growing demand for our services in an increasingly challenging financial landscape.

Our Patient Safety Programme continues to be a priority. We have planned a suite of projects including consistently high quality care 24/7 (safety at night; deteriorating patient), safety culture, and teamwork and safety in primary care.

Programmes to ensure that patients and whānau are at the centre of care include our existing Partners in Care programme and the development of a new patient experience feedback and reporting system.

Key programmes and initiatives in 2017/18

The Waitemata Experience programme
The Waitemata Experience is a programme of activity to co-design and deliver an excellent experience for patients, whānau and staff. The programme aligns all the patient experience work occurring in the DHB allowing improved focus and a better use of resources.

Waitemata 2025
We have a 10-year plan to redesign and improve our physical environment so it is more comfortable for patients and their whānau, and will accommodate our increasing population.

Transforming Care
Transforming Care is a clinical leadership programme designed to build capability for care redesign and enhanced care management at Waitemata DHB. The programme was developed from the work led by Professor Richard Bohmer.

The Institute of Innovation and Improvement (i3)
Our new Institute will provide expertise to support clinical teams to design and implement new models of care and best practice processes. The Institute brings together expertise in costing analysis, data analysis, digital platforms, evaluation, innovation, leadership, patient and whānau experience, population health and quality improvement.

LeapFrog programme
The Leapfrog programme is focused on accelerating the DHB's strategic innovation projects. A series of new, Phase Two, projects will lead our transformation towards an integrated digital environment. We will continue to build on our Phase One projects including completing closed loop medication safety, extending our e-ordering and ePrescribing systems, providing mobile apps to staff, and applying innovative redesign in outpatient care and our future wards and clinics. In addition, we are developing a cloud strategy, implementing kiosks in our outpatient services and telehealth for remote consultations, developing our patient engagement system in hospital and beyond, and developing faster methods for clinician and patient identification.

Underpinned by LeapFrog, Waitemata DHB is recognised as a leader in the movement toward a more mobile, electronic health record. National comparisons, using an international measure of electronic adoption in hospitals, rank Waitemata in the top three DHBs.

Health and safety

At Waitemata DHB, the health, safety and wellbeing of our people is a priority for our Board. Through our Safe Way of Working policies we, aim to increase our systematic approach to health and safety monitoring of our current performance, areas of improvement and learnings from each other.

This year we will implement our 3 year health and safety strategy with primary focus on staff wellbeing, workforce environment, hazard and risk management, governance and patient safety and experience. We are committed to working with our regional DHB partners so we can collectively improve our health and safety performance across the region.

Improving health outcomes for our population

Waitemata DHB's performance framework reflects the key national and local priorities that inform this 2017/18 Annual Plan, and demonstrate our commitment to an outcome-based approach to measuring performance.

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

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

The outcome measures are long-term indicators; therefore, the aim is for a measurable change in health status over time, rather than a fixed target.

System level measures (SLMs) and contributory measures that will support achievement of these overall goals were identified. We based the SLMs in our performance framework on those set by the Ministry of Health, which align with the five strategic themes of the New Zealand Health Strategy and other national strategic priorities.

SLMs provide an opportunity for DHBs to work with the primary, secondary and community care providers to improve health outcomes of their local populations.

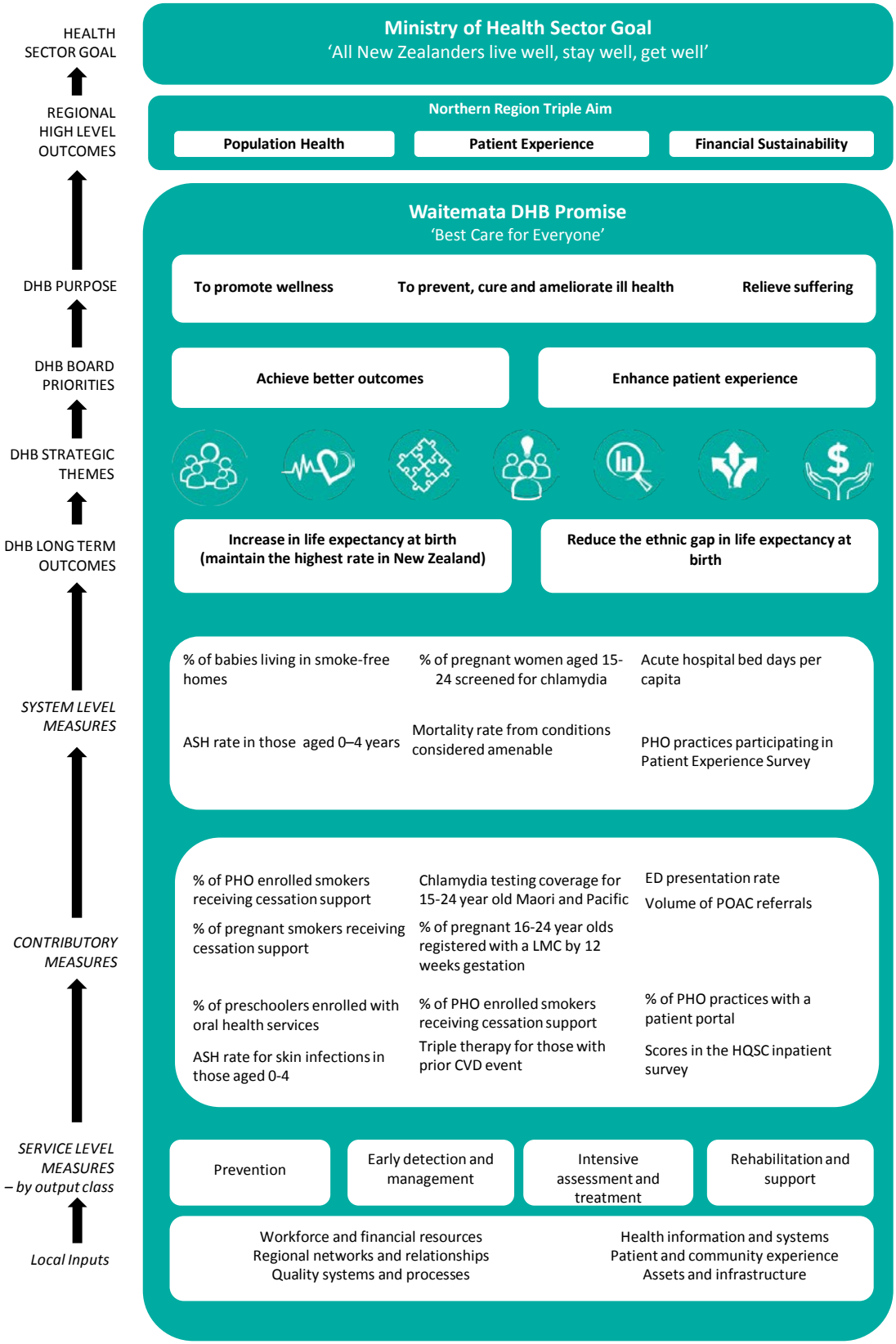
Contributory measures are essential to the achievement of SLMs and are front-line measurements of specific health processes or activities. The contributory measures included in our performance framework were selected from the set defined by our District Alliance and included in our SLM Improvement Plan.

Our SLMs and contributory measures are summarised below and presented in the intervention logic diagram on the next page. The diagram demonstrates how the services that we choose to fund or provide will contribute to the health of our population and result in the achievement of our longer-term outcomes and the expectations of Government. The Statement of Performance Expectations details a set of service-level indicators that contribute to our overall performance framework. We will report progress against all these measures in our Annual Report.

	Healthy start	Keeping children out of hospital	Youth are healthy, safe and supported	Preventing and detecting disease early	Using health resources effectively	Ensuring patient-centred care
System level measures (SLMs)	**Proportion of babies who live in a smokefree household at 6 weeks postnatal**	**Ambulatory sensitive hospitalisations 0-4 years**	**Sexual and reproductive health - chlamydia testing coverage for 15-24 year-olds, focusing on pregnant women**	**Amenable mortality**	**Acute hospital bed days**	**Patient experience of care - PHO practices participating in the PHC Patient Experience survey**
Key contributory measures	Smoking cessation: PHO-enrolled smokers receiving cessation support Pregnant smokers receiving cessation support	Children fully immunised by 8 months of age Skin infections: ambulatory senstive hospitalisations rate for skin infection 0-4 years	Chlamydia testing coverage for 15-24 year old Māori and Pacific LMC registration at 12 weeks in 16-24 year-olds	CVD management: proportion of those with a prior CVD event receiving triple therapy Smoking cessation: PHO-enrolled smokers receiving cessation support	Emergency department attendance rate Referrals to Primary Options for Acute Care	Hospital inpatient survey: aggregate score pacross all four domains Proportion of practices with patient e-portals

Note: The youth System Level Measure consists of five domains reflecting the complexity and breadth of issues impacting youth health and wellbeing. The Metro Auckland Alliances have chosen to focus on the sexual and reproductive health domain, selecting chlamydia testing as our improvement milestone.

Performance and intervention framework



Long-term outcomes

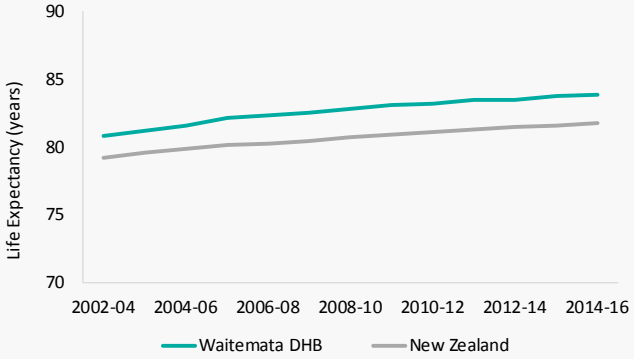
The long-term outcomes that we want to achieve are to increase life expectancy (measured by life expectancy at birth) and reduce ethnic inequalities (measured by the ethnic gap in life expectancy).

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 83.8 years (2014–16), which is 2.1 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 3.5 years since 2001, which is 0.5 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 – Life expectancy at birth



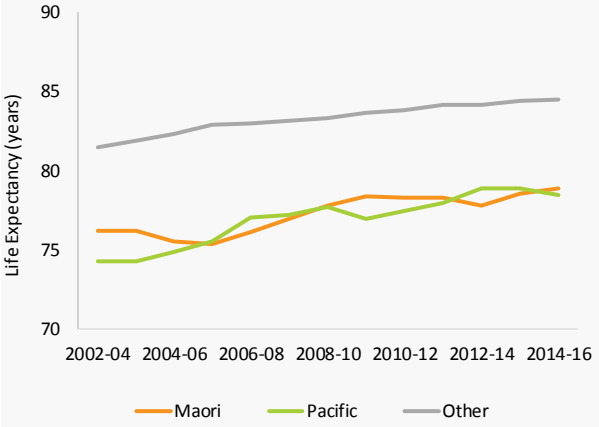
Note: Graph displays three-year rolling life expectancy calculated using Chiang II methodology. Other published estimates may differ depending on the methodology used.

Reducing 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 5.6 years for Māori and 6.0 years for Pacific (2014–16). Life expectancy has increased in our Māori (3.5 years) and Pacific (2.9 years) populations over the past decade and the gap in life expectancy continues to gradually close. Mortality at a younger age from cardiovascular disease and cancers account for over half of the life expectancy gap in Māori and Pacific.

We expect a reduction in the gap in life expectancy over the next decade, declining at least the same rate as observed in the last ten years.

Outcome measure – 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

Healthy start

Smoking during pregnancy and exposure to smoking in early childhood strongly influence pregnancy and early childhood health outcomes. The measure of the proportion of infants living in a smokefree household during the postnatal period correlates with maternal smoking in pregnancy. The rate of smoking in pregnancy, and worse pregnancy outcomes for mothers and babies, is higher among Māori and Pacific women and those living in areas of high deprivation.

Increasing the proportion of babies who live in smokefree households at 6 weeks postnatal

System level measure – Proportion of babies living in smokefree households at 6 weeks postnatal

Infants and young children are more exposed to second-hand smoke in homes than in other places. Second-hand smoke exposure has been associated with preventable and harmful effects in children, and the effects of exposure are lifelong. Exposure has been identified as a significant contributor to health inequalities in children.

Utilising a supportive approach that maximises parents' instinct to do no harm to their children may motivate cessation, thereby reduce or eliminate adult contributions to children's exposure to second-hand smoke in the home.

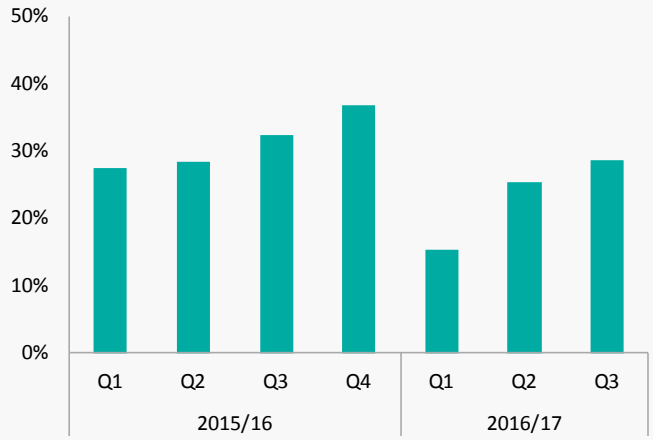
Note: baseline date currently available for this measure suggests a significant data issue. We will work to improve data quality during 2017/18 to establish a reliable baseline from which to measure improvement.

2017/18 improvement target: improve data quality to <10% missing values

Pregnancy is a time when women are likely to be highly motivated to stop smoking themselves and to encourage their whānau to stop smoking. Ensuring that pregnant women that smoke are offered cessation support and referred to cessation support are crucial steps in the pathway to them becoming smoke-free.

2017/18 improvement target: establish baseline

Contributory measure – Proportion of pregnant women smokers referred to cessation support

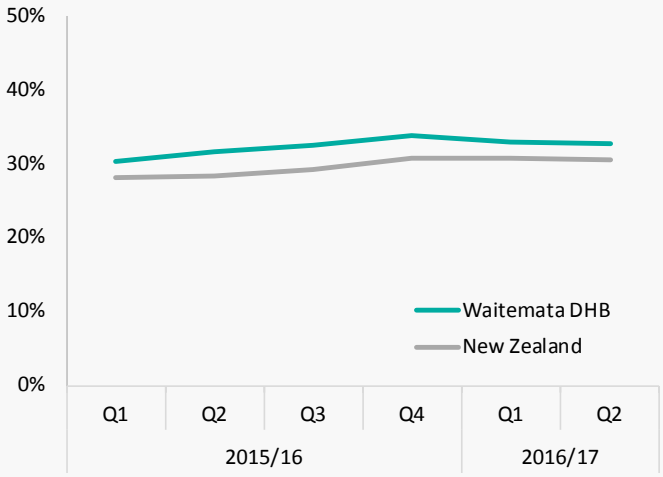


Smokers who live in the same household as babies and young children can often be reached through primary care. Offering cessation support, NRT or referral to Stop Smoking Services is important to assist whānau members to become smoke-free. The use of other settings to identify and support smokers that live with young children will also be explored. A focus on activities that will increase quit rates for Māori and Pacific is particularly important given the higher prevalence of smoking in these ethnic groups.

This contributory measure sits both under this SLM and the Amenable Mortality SLM.

2017/18 improvement target: relative 10% increase in cessation activity (baseline = 32.9%, Q1 2016/17)

Contributory measure – Proportion of PHO enrolled smokers receiving cessation support



Keeping children out of hospital

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.

We seek to reduce admission rates to hospital for a set of diseases and conditions that are potentially avoidable through prevention or management in primary care. In children, these conditions are mainly respiratory illnesses, gastroenteritis, dental conditions, and cellulitis.

ASH rates are higher for Māori and Pacific children and addressing this inequity would significantly reduce potentially avoidable hospitalisation rates.

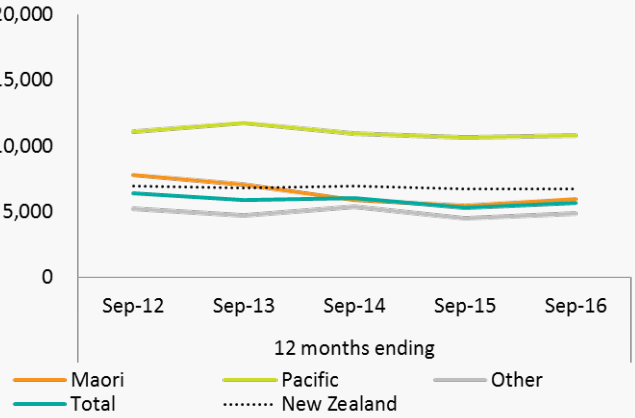
Reducing Ambulatory sensitive hospitalisation (ASH) rates for 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are admissions to hospital that are considered potentially avoidable through preventative or therapeutic interventions delivered in primary care. ASH rates for 0-4 year olds highlight the burden of disease in childhood with a strong emphasis on health equity.

In the 12 months to September 2016, there were 5,964 admissions per 100,000 in the 0–4 year old population (2,228 events) that were considered to be ambulatory sensitive. The overall rate has declined over the past five years. Rates in the Pacific population are twice as high as other ethnicities.

2017/18 improvement target: 5% reduction (baseline = 5,964 per 100,000, Sep 2016)

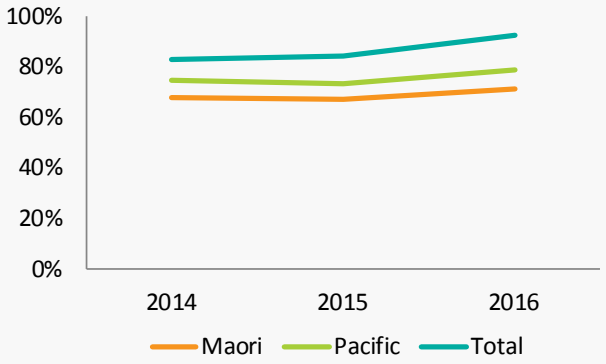
System level measure – Ambulatory sensitive hospital admissions per 100,000 in those aged 0–4 years



Poor oral health is a marker for a range of poor health outcomes in childhood and later life, and there is high variance among priority populations. Hospitalisations due to dental conditions in the 0-4 age group are significant and increasing.
By increasing the number of pre-school children who have enrolled for DHB-funded oral health services we are protecting and promoting good health and independence. Improving accessibility and availability of publicly-funded oral health programmes will reduce the prevalence and severity of early childhood caries, and reduce the numbers admitted to hospital for serious dental problems.

2017/18 improvement target: 95% of children aged 0-4 enrolled with oral health services

Contributory measure – Proportion of Preschool children (0-4 years) enrolled with oral health services

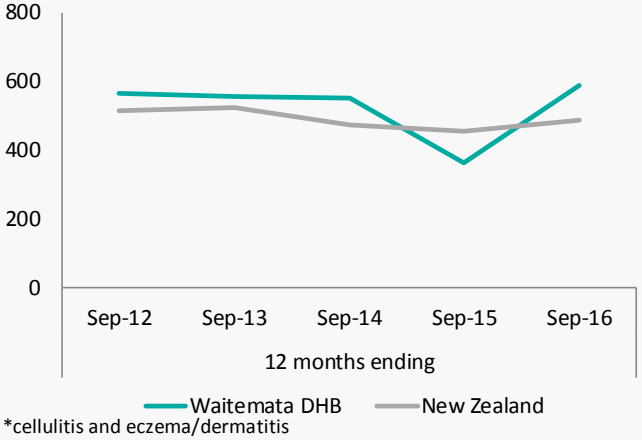


Compared to other developed countries, New Zealand has one of the highest rates of serious skin infections, particularly among children. The number of children admitted to hospital for treatment of serious skin infections is high and growing. Māori and Pacific families are most at risk, therefore targeted education, prevention and control interventions are necessary to reduce this burden of disease.

We need to improve access to early treatment of skin infections in primary care and community settings and provide consistent messaging and educational resources for families on how to manage skin infections.

2017/18 improvement target: 5% Reduction in hospitalisation rate (baseline = 800 admissions per 100,000 0-4 year olds, Sep 2016)

Contributory measure – Hospitalisations for serious skin infections* per 100,000 in those aged 0-4 years



*cellulitis and eczema/dermatitis

Youth are healthy, safe and supported

Youth have their own specific health needs as they transition from childhood to adulthood. This measure focuses on youth accessing primary and preventive health care services. Many young people are not in the habit of seeking the services or advice of a registered health practitioner when unwell. Research shows that youth whose healthcare needs are unmet can lead to poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours such as drug and alcohol abuse and criminal activities.

The youth System Level Measure consists of five domains reflecting the complexity and breadth of issues impacting youth health and wellbeing: Youth experience of health system; Sexual and reproductive health; Mental health; Alcohol and drugs; and Access to preventative services**.** The Metro Auckland Alliances have chosen to focus on the Sexual and reproductive health domain which aims to see young people manage their sexual and reproductive health safely and receive youth friendly care.

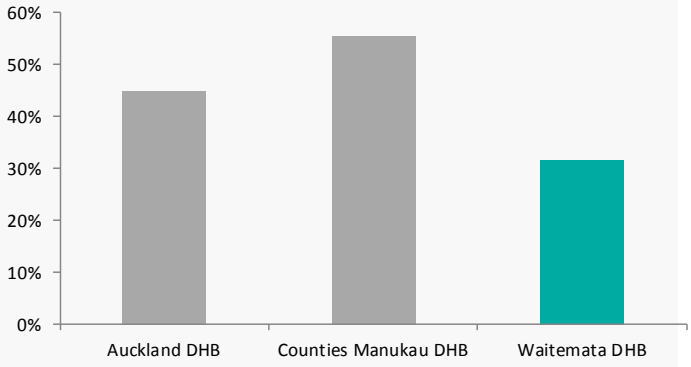
Sexual and reproductive health – chlamydia screening

Chlamydia is the most commonly diagnosed sexually transmitted infection (STI) in New Zealand, occurring most often in young people. In 2016 there were 10,484 reported cases in the metro Auckland region. The majority of chlamydia cases are asymptomatic, but infection can lead to long term health problems including pelvic inflammatory disease, infertility and ectopic pregnancy.

Maternally transferred chlamydia to newborns may cause prematurity, pneumonia and conjunctivitis. Screening during pregnancy is recommended in current national guidelines, including pre-termination of pregnancy.

2017/18 improvement target: 80% of pregnant women aged 15-24 years are screened for chlamydia

System level measure – Proportion of pregnant women aged 15-24 years screened for chlamydia



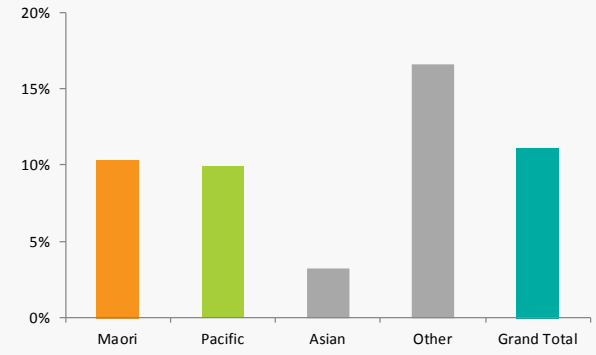
Women aged 15-24, giving birth in Q4 2016

Improving testing rates for chlamydia will lead to increased treatment rates and reduce the transmission of infection. In Q4 2016, 2.3% of the total metro Auckland population were tested for chlamydia. This is slightly higher than the national rate. However, there is significant variation in rates and testing between males and females and between Māori, Pacific and non-Māori.

Māori, and Pacific young people are under-tested in Auckland, reflecting inequities in the services and systems to meet the needs of these populations. Māori and Pacific youth are more frequently hospitalised with sexually transmitted infection complications and pregnancy-related conditions than those of other ethnicities. International modelling suggests that testing coverage needs to be 30–40% to begin to reduce infection prevalence.

2017/18 improvement target: establish baseline

Contributory measure – Chlamydia testing coverage in Māori and Pacific aged 15-24, per 100,000 population



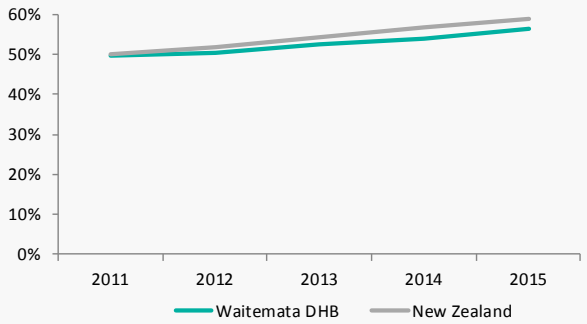
WDHB residents aged 15-24, CY 2016

Early and ongoing engagement with a Lead Maternity Carer (LMC) is associated with healthy births and better pregnancy outcomes. LMCs connect both mothers and children to other important health services, e.g. general practice, immunisation, Well Child Tamariki Ora, oral health services, and other social services that may be required.

Rates of registration with an LMC during the first trimester of pregnancy are lower for young women. In 2015, 57% of pregnant women aged 16-24 registered with an LMC in the first trimester in Waitemata DHB.

Improvement target: by 2021, 90% of pregnant women are registered with a LMC in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups

Contributory measure – LMC registration at 12 weeks: 16-24 year olds



Prevention and early detection

Amenable mortality is a measure of the effectiveness of health care based prevention programmes, early detection of illnesses, effective management of long-term conditions and equitable access to health care. It measures the number of deaths that could have been avoided through effective health interventions at an individual or population level. Amenable mortality rates are higher in Māori and Pacific people. Rates have reduced over time, but not as quickly for Pacific people as for other population groups. Sixty-six percent of amenable deaths in Waitemata DHB are due to cardiovascular diseases and cancers that are potentially amenable.

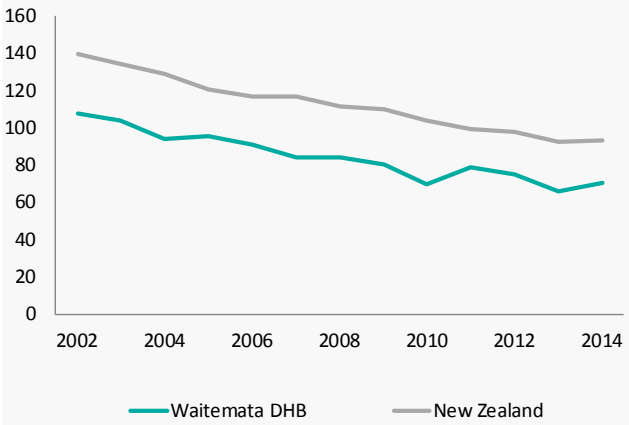
Reducing rates of amenable mortality

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 70.1 per 100,000 population. In 2014, we estimate that 490 deaths (45.8% of all deaths in those aged under 75 years) in Waitemata DHB were amenable. Despite the number and rate of amenable deaths increasing from 2013, the trend over the past decade is for the rate to be steadily declining in Waitemata. We aim to continue the reduction in amenable mortality at the same rate observed over the past decade.

2017/18 improvement target: 3% reduction
(baseline = 65.6 deaths per 100,000 population, 2013)

System level measure – Mortality from conditions considered amenable, rate per 100,000 population



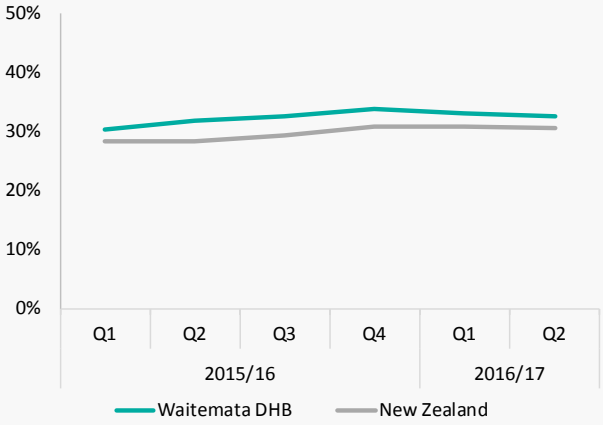
Life-long smoking is associated with a decade of life lost for an individual. Quitting smoking before the age of 40 years, and preferably much earlier, will reduce about 90% of the years of life lost from continued smoking. *

There are an estimated 57,000 smokers aged 15+ years in Waitemata DHB. By 2025 we need to reduce this to around 28,000 to reach our Smokefree 2025 target of fewer than 5% of our population smoking.

Providing smokers with brief advice to quit increases their chances of making a quit attempt. The likelihood of that quit attempt being successful is increased if behavioural support, such as a referral to 'quit smoking' services, and/or pharmacological smoking cessation aids are provided.

2017/18 improvement target: relative 10% increase
(baseline = 32.9%, Q1 2015/16)

Contributory measure – Proportion of PHO enrolled smokers receiving cessation support

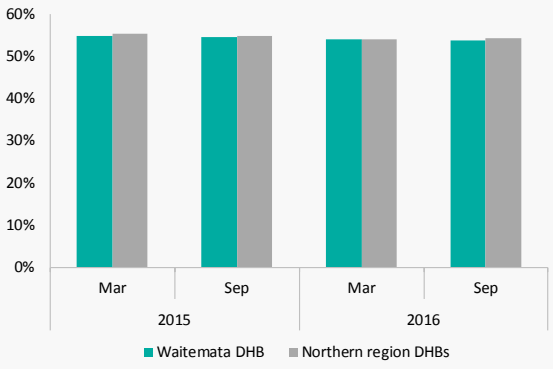


New Zealand guidelines recommend that people who experience a heart attack or stroke (where appropriate) should be treated with a combination of medication known as triple therapy (aspirin or another antiplatelet/anticoagulant agent, a beta blocker and a statin).

We intend to make sure that our patients who have had a CVD event are receiving the best possible care. Currently, 54% of our population who have had a CVD event are prescribed ongoing triple therapy medication, the same as the national rate.

2017/18 improvement target: relative 5% increase
(baseline = 53.8%, Sep 2016)

Contributory measure – Proportion of those with a prior CVD event receiving triple therapy



*Prabhat Jha, M.D et al. (2013). 21st-Century Hazards of Smoking and Benefits of Cessation in the United States. *N Engl J Med*, 368:341-350.

Using health resources effectively

Acute hospital bed days per capita is a measure of the use of acute services in secondary care. This could be improved by effective management in primary care, optimising patient flow within the hospital, discharge planning, community support services and good communication between healthcare providers. This includes access to diagnostics services. The measure will be used to manage the demand for acute inpatient services on the health system. The rate of acute bed day use is higher for Māori and Pacific people.

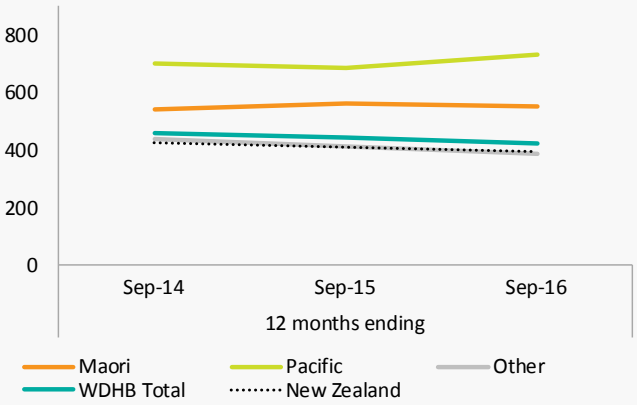
Reducing acute hospital bed days

Acute admissions account for approximately one half of all hospital admissions in New Zealand. Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressure on staff and difficulties with planning staffing levels.

Our standardised rate of acute bed days has declined slightly since 2014 (460 per 1,000 population to 422 per 1,000 population) and remains slightly higher than the national rate.

2017/18 improvement target: 2% reduction – 428.9 standardised acute bed days/1,000 population (Metro Auckland DHBs combined rate)
(baseline = 437.7 per 1,000 population, Metro Auckland DHBs, Sep 2016)

System level measure – Waitemata DHB acute hospital bed days per 1,000 population



Note: Age standardised rate

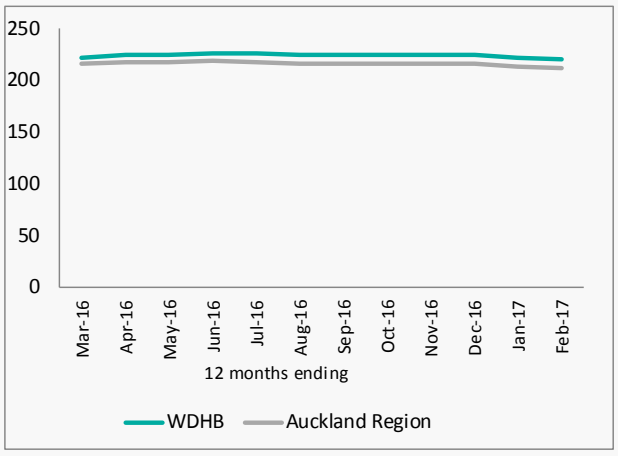
Overall reduction in Emergency Department (ED) presentation rates will result in lower admission rates and bed days.

Effective management in primary care could reduce the rate of attendances at EDs. We are focusing on the use of Primary Options for Acute Care (POAC) to help lower our ED presentation rate.

Alongside POAC, we have a number of programmes in place or under evaluation to reduce acute presentations, such as point-of-care testing in rural GPs, after-hours arrangements, and community falls prevention.

2017/18 improvement target: 2% reduction
(baseline = 222.3 per 1,000 population, Sep 2016)

Contributory measure – ED presentation rate per 1,000 population



* Age standardised rate

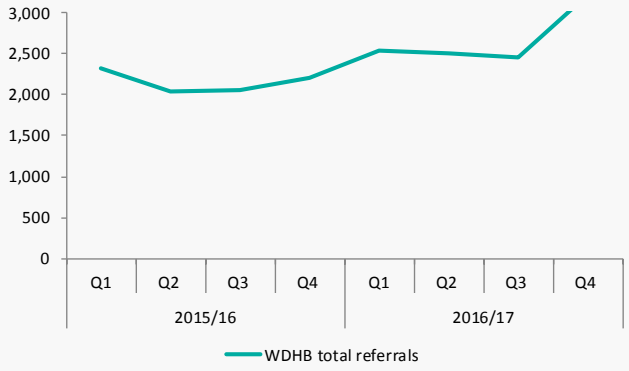
POAC is a service providing healthcare professionals access to investigations, care, or treatment for their patient, where the patient can be safely managed in the community, preventing an ED attendance/possible hospital admission.

Our focus is on maximising effective utilisation of POAC, thereby avoiding unnecessary ED attendances and hospital admissions.

There is currently a wide variation between GP practices in the use of Primary Options for Acute Care (POAC).

2017/18 improvement target: 10,811 POAC referrals
(baseline = 10,727 referrals, 2016/17)

Contributory measure – Volume of referrals to Primary Options for Acute Care (POAC)



Person-centred care

How people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Patient experience is positively associated with adherence to recommended medication and treatments, engagement in preventive care such as screening services and immunisations and ability to use the health resources available effectively, as well as overall health outcomes. This measure provides new information about how people experience health care, and how integrated their care, is and may highlight areas where a greater focus is needed.

Enhancing patient experience of care

System level measure – Proportion of PHO practices participating in the primary health care Patient Experience Survey (PHC PES)

Patient experience is an important indicator in assessing the quality of the care we provide and is strongly linked to overall health outcomes.

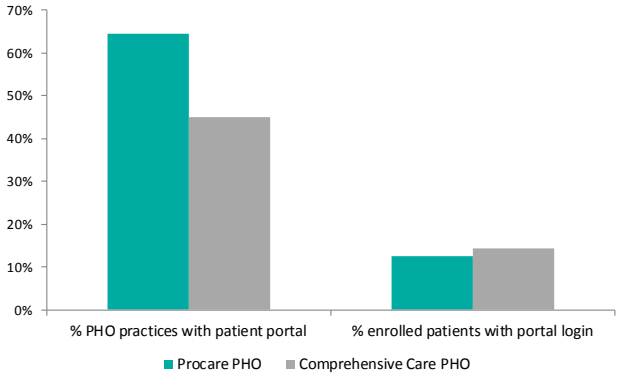
It is important that patient experience of health can be communicated to by health teams in a direct, timely and measurable manner. This information can then be used to continuously improve quality of care, service delivery and patient safety to enhance the patient experience. In 2017/18, the focus is on surveying primary care patients through the Primary Health Care Patient Experience Survey (PHC PES). Rollout of the PHC PES to all practices is dependent on establishment of the National Enrolment Service, which is expected to be complete by April 2017.

2017/18 improvement target: 50% of PHO practices (approximately 166 practices) are participating in the primary health care Patient Experience Survey (PHC PES) by June 2018

Patient e-portals are secure online sites provided by GPs where people can access their health information and interact with their general practice. Using a portal, people can better manage their own health care.

The use of patient portals is associated with improvements in patient-provider communication and an increase in patients feeling that they were able to take a more active role in medical decision making. For those with a chronic illness such as diabetes, patient portals can also provide a vehicle to receive ongoing self-management support.

Contributory measure – Proportion of Waitemata DHB PHO practices with a patient portal and proportion of patients with login access



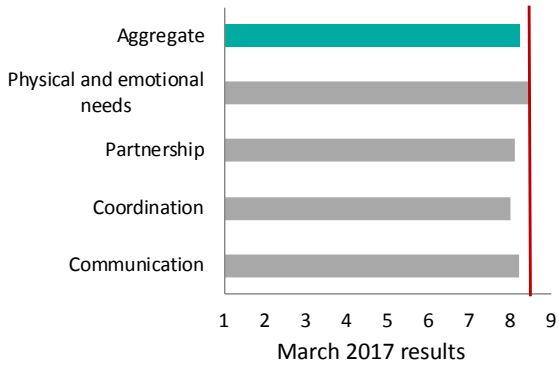
2017/18 improvement target: 50% of PHO practices are registered with a portal (and 15% of the PHO population have access to a portal)

Patient experience measures are now routinely in place for hospitals. Feedback about the care received in public hospitals is a valuable indicator of how well health services are working for patients and their families.

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.

Contributory measure – Scores across the four domains of the HQSC adult inpatient survey



2017/18 improvement target: Maintenance of an aggregated 8.5/10 score for all 4 domains

APPENDIX B: STATEMENT OF PERFORMANCE EXPECTATIONS – WAITEMATA DHB 2017/18

The Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for the 2017/18 year.

Performance measurement framework

Our focus for 2017/18 is on delivering the key targets identified in our performance framework, which will ultimately result in better health for our population, measured by our two long term outcomes:

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

Measures within this SPE represent the outputs/activities we deliver to meet our goals and objectives in Section 2 and our Statement of Intent, and also provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of key indicators. The national System Level Measures are not included in our SPE as these are high level population health goals and not necessarily appropriate as direct measures of annual service performance. We are reporting the SLM contributory measures in our SPE as these measures contribute to the achievement of the SLMs and are measurements of specific health processes or activity.

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.

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 protect and promote health in the whole population or identifiable sub-populations by targeting changes to physical and social environments that engage and support individuals to make healthier choices. Prevention services 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. By supporting people to make healthy choices and maintain good health, effective prevention services can have a significant impact on health outcomes.

Outputs measured by	Notes	Baseline 2015/16	Target 2017/18
Health promotion			
HT: % of PHO-enrolled patients who smoke have been offered help to quit in the last 15 months	C	89%	90%
HT: % of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and help to quit smoking	C	91%	90%
% of PHO-enrolled patients who smoke who received cessation support	Q	32.9%[1]	36.2%
Raising Healthy Kids HT: % of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Q	41%[2]	95%
Number of clients engaged with Green Prescriptions	V	New indicator	4,920
Increased Immunisation HT: - % of eight months olds will have their primary course of immunisation on time (total population) - % of eight months olds will have their primary course of immunisation on time (Māori)	C	 93% 90%	95%
Rate of HPV immunisation coverage (2004 birth cohort)	C	60%[3]	75%
Population-based screening			
% of women aged 50-69 years having a breast cancer screen in the last 2 years	C	67%	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	76%	80%
Bowel Cancer Screening			
% of people invited to participate who returned a correctly completed kit	Q	53.4%[4]	60%
Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 45 working days	T	96%[5]	95%
Children			
HEEADSS assessment coverage in DHB funded school health services	C	88%[6]	95%
% of 4 year olds receiving a B4 School Check	C	93%	90%
Auckland Regional Public Health Service[7]			
Number of tobacco retailer compliance checks conducted	V	342	300
Number of license applications and renewals (on, off club and special) received and are risk assessed	V	4,208	Ω
% of tuberculosis (TB) and latent TB infection cases who have started treatment and have a recorded start date for treatment	Q	98%	95%
Number of assessments related to requirements of the Drinking-Water Standards	V	45	57

[1] Results Q1 2015/16
[2] Results for the 6 months ending March 2016 (new health target)
[3] CY 2015
[4] Round 3 participation (January-March 2016)
[5] CY2016 result
[6] 2016 academic year
[7] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all 3 DHBs.

Output class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals including general practice, community and Māori health services, pharmacist services and child and adolescent oral health services. Good access to these services ensures that those at risk, or with disease onset, are recognised early and their condition is appropriately managed. Early detection and management services also enable patients to maintain their functional independence with less invasive intervention.

Outputs measured by	Notes	Baseline 2015/16	Target 2017/18
Primary health care			
Rate of primary care enrolment (Māori)	C	82%	90%
Number of referrals to Primary Options for Acute Care (POAC)	V	8,642	10,811
% of people with diabetes aged 15-74 years enrolled with Waitemata DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol	Q	New indicator	75%[8]
% of the eligible population who have had their CVD risk assessed in the last five years (Māori)	C	72%	90%
% of patients with CVD risk >20% on dual therapy (dispensed)	Q	41.4%[9]	43.5%
% of patients with prior CVD who are prescribed triple therapy (dispensed)	Q	53.8%[9]	56.5%
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 0-4 year olds - skin infections subset	Q	800[9]	760
Pharmacy			
Number of prescription items subsidised	V	7,067,601	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	31,486	Ω
Number of community laboratory tests	V	3,931,334	Ω
Oral health			
% of preschool children enrolled in DHB-funded oral health services	C	84%[10]	95%
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 - 2017 - 2018	Q	0.67[10]	 0.68 0.68
% of children caries free at five years of age - 2017 - 2018	Q	66%[10]	 68% 68%
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years	C	73%[10]	85%

[8] Interim target; regional aspirational target is 80% by 2020
[9] 12 months to September 2016
[10] CY2016 result

Output class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by specialist providers in facilities that enable co-location of clinical expertise and specialised equipment, such as a hospital or surgery centre. These services include ambulatory services, ED services and 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 2015/16	Target 2017/18
Acute services			
ED presentation rate per 1,000 population	V	222.3[11]	217.9
Shorter Stays in Emergency Departments HT: % of ED patients discharged, admitted or transferred within six hours of arrival	T	95%	95%
Faster Cancer Treatment HT: % 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	71.5%	90%
% of potentially eligible stroke patients thrombolysed	C	5.5%	8.0%
% of ACS inpatients receiving coronary angiography within 3 days	T	81%	70%
Maternity			
Number of births in Waitemata DHB hospitals	V	6,725	Ω
Proportion of women registering with LMCs ≤12 weeks	T	72%[12]	80%
Elective (inpatient/outpatient)			
Improved Access to Elective Surgery HT: number of elective surgical discharges	V	21,994	22,073
Surgical intervention rate[13]	C		
- Joints		21.4	21
- Cataracts		33.17	27
- Cardiac		6.83	6.5
- PCR		14.63	12.5
- Angiogram		40.83	34.7
% of people receiving urgent diagnostic colonoscopy in 14 days	T	90%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days		54%	70%
% of patients waiting longer than 4 months for their first specialist assessment	T	0%	0%
% of accepted community referrals receiving their scan within 6 weeks	T		
- CT		96%	95%
- MRI		88%	90%
Quality and patient safety			
Aggregated score for the four domains of the HQSC inpatient survey	Q	8.5[14]	8.5
% of opportunities for hand hygiene taken	Q	83%[15]	80%
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.05	<0.12[16]
% of falls risk patients who received an individualised care plan	Q	98%[15]	90%
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions	Q	10.15	<8[17]
% of hip and knee arthroplasties operations where antibiotic is given in one hour before incision	Q	92%[15]	100%
% of hip and knee procedures given right antibiotic in right dose	Q	94%[15]	95%
Surgical site infections per 100 hip and knee operations	Q	0.59	<0.8[18]

[11] Data for year ending September 2016
[12] MAT data CY2015, independent midwives only
[13] Data for year ending March 2016
[14] Data from Q2 CY2016
[15] April-June 2016
[16] Jan12-Jun16 national median
[17] Nov14-Jun16 national median
[18] Aug15-Apr16 national median

Outputs measured by	Notes	Baseline 2015/16	Target 2017/18
Mental Health			
% of population who access Mental Health services: - Age 0–19 years - Age 20–64 years - Age 65+ years	C	 3.44% 3.55% 2.05%	 3.10% 3.40% 2.10%
% of 0-19 year old clients seen within 3 weeks: - Mental Health - Addictions % of 0-19 year old clients seen within 8 weeks: - Mental Health - Addictions	T	 61% 85% 91% 99%	 80% 80% 95% 95%

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 2015/16	Target 2017/18
Home-based support			
Proportion of people aged 65+ years receiving long-term home and community support who have had a comprehensive clinical assessment and a completed care plan (interRAI) in the last 24 months	Q	89%	85%
Palliative care			
Proportion of hospice patient deaths that occur at home	Q	35%	↑
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	7.4%	5%
Number of Palliative Pathway Activations (PPAs)	V	New indicator	250[19]
Number of Hospice Proactive Advisory conversations between the Hospice Service, Primary Care and ARRC health professionals	V	New indicator	250[19]
Residential care			
ARC bed days	V	905,263	Ω
% of people in aged residential care (ARC) who have a subsequent interRAI long-term care facility (LTCF) assessment completed within 230 days of the previous assessment	Q	63%	80%

[19] This is a Metro Auckland regional indicator, with a combined target of 650 for Auckland, Counties Manukau and Waitemata DHBs

APPENDIX C: FINANCIAL PERFORMANCE

Financial management overview

Financial sustainability is critical to our ability to deliver on our organisational promise and purpose.

In the year to 30 June 2017, the DHB reported a surplus of $3.3m against a budgeted surplus of $4.5m. Although still in surplus, the small shortfall against budget reflected continuing cost pressure on the DHB.

Within each Arm of the DHB (principally Funder and Provider), offsetting financial results were achieved. The Provider reported a deficit against budget of $18.8m, offset by corresponding surpluses in the Funder and Governance Divisions. This situation is not uncommon in the DHB sector.

The Board recognises that these offsetting results are unacceptable and are not sustainable. Continued adverse variances in the Provider Arm of the DHB necessarily limit the options available to the Board to invest in new services and initiatives, both in the Hospital sector and in Primary Care.

During the 2016/17 financial year, the Board made a number of significant investments in new facilities, including an expanded Emergency Department at Waitakere Hospital, a refurbished facility providing outpatient services at North Shore Hospital, a new clinical skills centre at North Shore Hospital, a new 15-bed inpatient facility at the Mason Clinic, and additional beds at Waitakere Hospital. The Board also invested in strategic Information Systems to improve patient safety and clinical care. Accordingly, the additional operating costs that these investments incur are required to be accommodated in the additional revenue we received from the Ministry of Health for the 2017/18 financial year.

A financial recovery plan has been presented to the Board, and progress is reported to the Board via the Audit and Finance Committee. Improving the financial performance of the Provider Arm is being delivered via a series of strategic initiatives as well as opportunistic short-term strategies. The strategic initiatives are developed with senior management and clinicians, with a high degree of focus on improving patient care as well as improving financial performance. The Board will not compromise patient care and safety in its endeavours to improve financial performance.

For the 2017/18 financial year, the DHB is forecasting a breakeven budget, which reflects a deficit of $7m in the Provider, offset by a similar surplus in the Funder.

Although budgeting a breakeven position for 2017/18, the challenges facing the DHB are considerable, and as noted above, the current performance of the Provider Arm is not sustainable.

The challenges we face include:

- Continuing clinical wage settlement and contractual increases well above funding levels
- Reliance in the past of one-off windfalls or non-repeatable benefits, and surpluses generated within the Funder
- High population growth driving service demand with a lagging funding stream
- Critical restraint in regional IT infrastructure
- 'Hump funding' to transition/transform the organisation
- Investment in facilities to replace those not fit for purpose, and to accommodate growth.

Key assumptions for financial projections

Revenue Growth

Revenue has been based on the Ministry of Health advice received in June 2017.

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

Expenditure Growth

Expenditure growth of $92.2m above 2016/17 actual expenditure 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 including increases in the NGO sector for pay equity; 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 2016) 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, estimated 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.

Forecast Financial Statements

The Board of Waitemata DHB is 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 for issue on 20 November 2017.

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 financial statements for the audited result for 2015/16, year-end forecast for 2016/17 and plans for years 2017/18 to 2020/21. The financial statements have been prepared on the basis of the *Key Assumptions for Financial Forecasts* and the significant accounting policies summarised in the *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

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Government and Crown Agency Revenue	1,467,084	1,516,737	1,597,310	1,629,488	1,661,911	1,694,313
Patient Sourced and Other Income	26,742	25,010	32,579	33,234	33,889	34,543
IDFs and Inter DHB Provider Income	82,705	85,259	85,982	87,725	89,468	91,211
Total Funding	**1,576,531**	**1,627,006**	**1,715,871**	**1,750,447**	**1,785,268**	**1,820,067**
Personnel Costs	582,217	604,008	637,270	650,186	663,104	676,015
Outsourced Costs	71,768	76,281	68,254	69,635	71,016	72,397
Clinical Supplies Costs	110,618	118,245	115,909	118,258	120,607	122,955
Infrastructure and Non-Clinical supplies Costs	105,222	97,954	104,657	99,413	101,409	103,401
Payments to Other Providers	704,857	727,227	789,781	812,955	829,132	845,299
Total Expenditure	**1,574,682**	**1,623,715**	**1,715,871**	**1,750,447**	**1,785,268**	**1,820,067**
Net Surplus/(Deficit)	**1,849**	**3,291**	**0**	**0**	**0**	**0**
Other Comprehensive Income	**0**					
Gains/(Losses) on Property Revaluations	29,322	(301)	0	0	0	0
TOTAL COMPREHENSIVE INCOME	31,171	2,990	0	0	0	0

Historically, we have performed well financially, with surpluses generated in the past five years. The business transformation programme implemented in 2010/11 and continued in subsequent years has contributed significantly to the achievement of surpluses in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures.

However, the rate of recent population growth, the aging of the population the DHB serves, the state of our aging infrastructure and facilities, and requirements for the development of services, facilities and Information Systems to provide high quality, safe and effective care has increased the financial pressures on the DHB, and the financial challenges are at the greatest they have been for several years.

Forecast Statement of comprehensive income – group

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Government and Crown Agency Revenue	1,466,224	1,516,737	1,597,310	1,629,488	1,661,911	1,694,313
Patient Sourced and Other Income	27,090	25,010	32,579	33,234	33,889	34,543
IDFs and Inter DHB Provider Income	82,705	85,259	85,982	87,725	89,468	91,211
Total Funding	**1,576,019**	**1,627,006**	**1,715,871**	**1,750,447**	**1,785,268**	**1,820,067**
Personnel Costs	582,217	604,008	637,270	650,186	663,104	676,015
Outsourced Costs	71,571	76,281	68,254	69,635	71,016	72,397
Clinical Supplies Costs	110,618	118,245	115,909	118,258	120,607	122,955
Infrastructure and Non-Clinical supplies Costs	104,462	97,954	104,657	99,413	101,409	103,401
Payments to Other Providers	704,194	727,227	789,781	812,955	829,132	845,299
Total Expenditure	**1,573,062**	**1,623,715**	**1,715,871**	**1,750,447**	**1,785,268**	**1,820,067**
Net Surplus/(Deficit)	**2,957**	**3,291**	**0**	**0**	**0**	**0**
Other Comprehensive Income	**0**					
Gains/(Losses) on Property Revaluations	29,322	(301)	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**32,279**	**2,990**	**0**	**0**	**0**	**0**

Forecast Statement of comprehensive income – governance & funding administration

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Revenue	12,512	12,878	14,209	14,496	14,783	15,070
Expenditure						
Personnel	9,553	10,166	12,591	12,840	13,089	13,338
Outsourced services	7,624	7,387	8,664	8,838	9,012	9,186
Clinical supplies	0	0	1	1	1	1
Infrastructure & non clinical supplies	(5,350)	(5,707)	(7,047)	(7,183)	(7,319)	(7,455)
Total Expenditure	**11,827**	**11,846**	**14,209**	**14,496**	**14,783**	**15,070**
Surplus/(Deficit)	**685**	**1,032**	**0**	**0**	**0**	**0**

Forecast Statement of comprehensive income – provider

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Income						
MoH via Funder	761,951	786,617	834,402	851,340	868,281	885,212
MoH Direct	38,458	38,569	22,443	22,896	23,349	23,801
Other	42,497	40,679	48,036	48,760	49,723	50,685
Total Income	**842,906**	**865,865**	**904,881**	**922,996**	**941,353**	**959,698**
Expenditure						
Personnel	572,664	593,842	624,679	637,346	650,015	662,677
Outsourced services	63,947	68,894	59,590	60,797	62,004	63,211
Clinical supplies	110,618	118,245	115,908	118,257	120,606	122,954
Infrastructure & non clinical supplies	109,812	103,661	111,704	106,596	108,728	110,856
Total expenditure	**857,041**	**884,642**	**911,881**	**922,996**	**941,353**	**959,698**
Surplus / (Deficit)	**(14,135)**	**(18,777)**	**(7,000)**	**0**	**0**	**0**

Forecast Statement of comprehensive income – funder

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Income						
Revenue	1,494,803	1,547,612	1,645,170	1,678,565	1,711,966	1,745,347
Expenditure						
Personal Health	1,089,750	1,123,580	1,179,872	1,210,988	1,235,106	1,259,211
Mental Health	200,911	208,297	221,863	226,355	230,849	235,339
DSS	161,770	167,762	209,914	214,166	218,419	222,671
Public Health	10,667	11,124	9,371	9,558	9,745	9,932
Māori Health	3,047	3,081	3,163	3,228	3,294	3,358
Governance	12,251	12,732	13,987	14,270	14,553	14,836
Total Expenditure	**1,478,396**	**1,526,576**	**1,638,170**	**1,678,565**	**1,711,966**	**1,745,347**
Surplus/(Deficit)	**16,407**	**21,036**	**7,000**	**0**	**0**	**0**

Forecast capital costs

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Depreciation	**27,172**	28,006	29,670	30,270	30,870	31,470
Interest Costs	**10,712**	6,532	0	0	0	0
Capital Charge	**24,501**	21,560	36,924	36,924	36,924	36,924
Capital Costs	**62,385**	**56,098**	**66,594**	**67,194**	**67,794**	**68,394**

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 New Zealand 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 last prepared on 30 June 2015. A full revaluation on land and buildings was carried out for the financial year ending 30 June 2015 and has resulted in increases in Capital Charge.

Capital Charge has increased following the conversion of Crown Debt to Crown Equity in February 2017, with a corresponding decrease in interest expenditure, and increase in revenue to ensure this charge is cost neutral to the DHB.

Forecast statement of cashflows – parent

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,522,006	1,592,375	1,685,799	1,719,426	1,753,699	1,787,951
Other Income	46,527	28,326	27,262	27,810	28,358	28,905
Interest received	5,082	4,166	2,810	3,211	3,211	3,211
Payments for Personnel	(575,928)	(608,107)	(637,270)	(650,186)	(663,104)	(676,015)
Payments for Supplies	(944,826)	(984,173)	(1,012,007)	(1,033,067)	(1,054,370)	(1,075,658)
Capital Charge Paid	(24,299)	(21,762)	(36,924)	(36,924)	(36,924)	(36,924)
GST Input Tax	(71)	749	0	0	0	0
Interest payments	(10,630)	(8,349)	0	0	0	0
Net cashflow from operating activities	**17,861**	**3,225**	**29,670**	**30,270**	**30,870**	**31,470**
Cashflow from investing activities						
Sale of Fixed Assets	0	0	0	0	0	0
Capital Expenditure (-ve)	(72,208)	(63,717)	(30,901)	(31,413)	(27,542)	(22,524)
Acquisition of investments	(35,415)	24,440	0	0	0	0
Net cashflow from investing activities	**(107,623)**	**(39,277)**	**(34,501)**	**(31,413)**	**(27,542)**	**(22,524)**
Cashflow from financing activities						
Capital contributions from the Crown	0	0	0	0	0	0
Proceeds from borrowings	0	0	0	0	0	0
Repayment of borrowings	0	0	0	0	0	0
Net cashflow from financing activities	**0**	**0**	**0**	**0**	**0**	**0**
Net cash movements	**(89,762)**	**(36,052)**	**(1,231)**	**(1,143)**	**3,328**	**8,946**
Cash and cash equivalents at the start of the year	143,393	53,631	17,579	16,348	15,205	18,533
Cash and cash equivalents at the end of the year	**53,631**	**17,579**	**16,348**	**15,205**	**18,533**	**27,479**

On 15 February 2017, all of the DHB's Crown debt, $276.7M, was converted to Crown equity.

Forecast statement of cashflows – group

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,522,006	1,592,375	1,685,799	1,719,426	1,753,699	1,787,951
Other Income	47,035	28,326	27,262	27,810	28,358	28,905
Interest received	5,118	4,166	2,810	3,211	3,211	3,211
Payments for Personnel	(575,928)	(608,107)	(637,270)	(650,186)	(663,104)	(676,015)
Payments for Supplies	(944,826)	(984,173)	(1,012,007)	(1,033,067)	(1,054,370)	(1,075,658)
Capital Charge Paid	(24,299)	(21,762)	(36,924)	(36,924)	(36,924)	(36,924)
GST Input Tax	(71)	749	0	0	0	0
Interest payments	(10,630)	(8,349)	0	0	0	0
Net cashflow from operating activities	**18,405**	**3,225**	**29,670**	**30,270**	**30,870**	**31,470**
Cashflow from investing activities						
Sale of Fixed Assets	0	0	0	0	0	0
Capital Expenditure (-ve)	(72,208)	(63,717)	(30,901)	(31,413)	(27,542)	(22,524)
Acquisition of investments	(35,415)	24,440	0	0	0	0
Net cashflow from investing activities	**(107,623)**	**(39,277)**	**(30,901)**	**(31,413)**	**(27,542)**	**(22,524)**
Cashflow from financing activities						
Capital contributions from the Crown	0	0	0	0	0	0
Proceeds from borrowings	0	0	0	0	0	0
Repayment of borrowings	0	0	0	0	0	0
Net cashflow from financing activities	**0**	**0**	**0**	**0**	**0**	**0**
Net cash movements	**(89,218)**	**(36,052)**	**(1,231)**	**(1,143)**	**3,328**	**8,946**
Cash and cash equivalents at the start of the year	144,900	55,682	19,630	18,399	17,256	20,584
Cash and cash equivalents at the end of the year	**55,682**	**19,630**	**18,399**	**17,256**	**20,584**	**29,530**

Forecast statement of financial position – parent

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Current Assets	137,311	89,547	90,853	90,710	95,038	104,984
Non-current assets	748,470	792,314	796,912	804,439	814,011	817,997
Total assets	**885,781**	**881,861**	**887,765**	**895,149**	**909,049**	**922,981**
Current Liabilities	255,699	216,765	221,674	224,986	236,394	248,004
Non-current liabilities	294,112	49,508	50,503	54,575	57,067	59,389
Total liabilities	**549,811**	**266,273**	**272,177**	**279,561**	**293,461**	**307,393**
Net assets	**335,970**	**615,588**	**615,588**	**615,588**	**615,588**	**615,588**
Total equity	**335,970**	**615,588**	**615,588**	**615,588**	**615,588**	**615,588**

Loan portfolio

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Term Loans - Crown (current portion)	(25,710)	0	0	0	0	0
Term Loans – Crown (non-current portion)	(250,996)	0	0	0	0	0
Total Loans	**(276,706)**	**0**	**0**	**0**	**0**	**0**

The Crown current and non-current loans were converted to Crown Equity on 15 February 2017.

Forecast statement of financial position – group

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Current Assets	140,192	89,547	125,853	125,710	130,038	139,984
Non-current assets	755,726	792,314	761,912	769,439	779,011	782,997
Total assets	**895,918**	**881,861**	**887,765**	**895,149**	**909,049**	**922,981**
Current Liabilities	255,729	216,765	221,674	224,986	236,394	248,004
Non-current liabilities	294,112	49,508	50,503	54,575	57,067	59,389
Total liabilities	**549,841**	**266,273**	**272,177**	**279,561**	**293,461**	**307,393**
Net assets	**346,077**	**615,588**	**615,588**	**615,588**	**615,588**	**615,588**
Total equity	**346,077**	**615,588**	**615,588**	**615,588**	**615,588**	**615,588**

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

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Balance at 1 July	**304,723**	**335,970**	**615,965**	**615,965**	**615,965**	**615,965**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	1,849	3,291	0	0	0	0
Other Comprehensive income	29,398	(2)	0	0	0	0
Total Comprehensive Income	**31,247**	**3,289**	**0**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown *	0	276,706	0	0	0	0
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	**335,970**	**615,965**	**615,965**	**615,965**	**615,965**	**615,965**

*Conversion of Crown loans to equity on 15 February 2017.

Statement of movement in equity – group

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Balance at 1 July	**313,720**	**346,077**	**625,773**	**625,773**	**625,773**	**625,773**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	2,957	3,291	0	0	0	0
Other Comprehensive income	29,400	(301)	0	0	0	0
Total Comprehensive Income	**32,357**	**2,990**	**0**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown	0	276,706	0	0	0	0
Repayments of capital to the Crown	(0)	(0)	0	(0)	(0)	(0)
Balance at 30 June	**346,077**	**625,773**	**625,773**	**625,773**	**625,773**	**625,773**

Additional information

Capital expenditure

	2015/16 Audited $000	2016/17 Forecast $000	2017/18 Plan $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000
Funding Sources:						
Free cashflow from depreciation	27,172	28,006	29,670	30,270	30,870	31,470
External Funding	0	0	0	0	0	0
Inflow from sale of fixed asset	0	0	0	0	0	0
Cash reserves	58,639	17,177	(15,330)	(13,660)	(14,803)	(11,475)
Total Funding	85,811	45,183	14,340	16,610	16,067	19,995
Baseline Capital Expenditure						
Land	(8,850)	0	0	0	0	0
Buildings and Plant	(36,446)	(19,442)	(3,284)	(10,479)	(11,194)	(9,933)
Clinical Equipment	(6,390)	(8,880)	(2,201)	(7,906)	(8,039)	(7,864)
Other Equipment	(1,719)	(427)	(656)	(1,563)	(1,689)	(1,649)
Information Technology	(4,050)	(5,499)	(2,004)	(1,779)	(1,870)	(1,828)
Intangible Assets (Software)	(863)	0	0	(750)	(750)	0
Motor Vehicles	0	(1,622)	(120)	0	0	(750)
Total Baseline Capital Expenditure	**(58,318)**	**(35,870)**	**(8,265)**	**(22,477)**	**(23,542)**	**(22,024)**
Strategic Investments						
Land	0	0	0	0	0	0
Buildings and Plant	(13,306)	(24,643)	(8,679)	(7,728)	(3,320)	(400)
Clinical Equipment	0	0	(1,668)	(573)	(400)	(65)
Other Equipment	0	0	(1,176)	(420)	(200)	(25)
Information Technology	0	0	(4,404)	(215)	(80)	(10)
Intangible Assets (Software)	0	0	(3,768)	0	0	0
Motor Vehicles	0	0	(40)	0	0	0
Total Strategic Capital Expenditure	**(13,306)**	**(24,643)**	**(19,735)**	**(8,936)**	**(4,000)**	**(500)**
Total Capital Payments	**(71,624)**	**(60,513)**	**(28,000)**	**(31,413)**	**(27,542)**	**(22,524)**

Banking facilities and covenants

Term debt facilities

All Crown loans were converted to Crown Equity in February 2017. Accordingly, the DHB now has no such holdings.

Shared commercial banking services

Waitemata DHB is in the shared commercial banking arrangements with various other DHBs, the Bank of New Zealand ('BNZ') and New Zealand Health Partnerships Limited. BNZ has been selected to provide banking services to the sector, following a procurement process run by New Zealand Health Partnerships Limited. DHBs are no longer required to maintain separate standby facilities for working capital.

Banking covenants

Since the conversion of Crown Loans to Crown Equity in February 2017, there are now no financial covenants for the DHB to comply with.

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 2016/17 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%.

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. In the financial year ended 30 June 2017, Milford Secure Properties Limited was deregistered. In the prior year, the DHB did not consolidate its controlled entity Milford Secure Properties as it was dormant and was not material.

Joint ventures

A joint venture is a binding arrangement whereby two or more parties committed to undertake an economic activity that is subject to joint control. Joint control is the agreed sharing of control over an activity. Where the joint venture's results are material, the DHB includes the interest in the joint venture in the consolidated financial statements, using the equity method, from the date that joint control commences until the date that joint control ceases. The investments in joint ventures are accounted for in the parent entity financial statements at cost.

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 revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks. Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year 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 New Zealand dollar (NZD, 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.

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.

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) 2–80 years (1.25–50%)
- 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 but are reviewed annually for impairment.

National Oracle Solution

The National Oracle System Project ('NOS') (previously part of the Finance Procurement Supply Chain programme) is a national initiative, funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector-wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Waitemata DHB holds an asset at cost of capital invested by the DHB in NOS. This investment represents the right to access the NOS assets and is considered to have an indefinite life. 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 and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets' standard of performance or service potential indefinitely. As the 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.

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.

APPENDIX D: 2017/18 SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

System Level Measures Improvement Plan

Auckland, Waitemata & Counties
Manukau Health Alliances

2017
2018
FINANCIAL YEAR

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

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

– Sir James Henare

Photo Credit (cover): John Hettig Westone Productions

CONTENTS

Version	Date	Updates
Final Draft with MOH revisions	20 October 2017	Endorsed by ALTs, Submitted to Ministry of Health. Updated Milestone for proportion of babies who live in a smoke-free household at six weeks postnatal. Refinement of three contributory measures to two and reorganisation of actions under contributory measures for the above SLM. Update of Executive Summary Table as a result of changes.
Final Draft	30 June 2017	Endorsed by ALTs, Submitted to Ministry of Health

1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitemata Alliance Leadership Teams (the Alliances) have jointly developed a 2017-18 System Level Measures Improvement Plan.

Continuing with the *one team* theme in the New Zealand Health Strategy, the joint approach to development of the single improvement plan will ensure streamlined activity and reporting, and best use of resources within the health system. Building on the work outlined in the 2016-17 System Level Measures Improvement Plan, in 2017-18, improvement milestones and contributory measures for each of the system level measures (SLMs) have been prioritised, in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Alliances are firmly committed to including more contributory measures over the medium to longer term, once the structures, systems and relationships to support improvement activities are more firmly embedded. This plan reflects a strong commitment to the acceleration of Māori health gain and the elimination of inequity for Māori.

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

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

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

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

The diagram below shows an overview of the measures chosen for this improvement plan.

AMBULATORY SENSITIVE HOSPITALISATIONS 0-4 YEARS

Improvement Milestone

5% reduction in rate by June 2018

- Māori children fully immunised by 8 Months of Age
- Skin Infections
- Oral Health
- Respiratory Conditions Potentially Prevented by Special Immunisations

Keeping children out of hospital

ACUTE HOSPITAL BED DAYS

Improvement Milestone

2% reduction – 438.7 standardised acute bed days/1000 by June 2018

3% reduction for Māori populations – 604.6 standardised acute bed days/1000 by June 2018

3% reduction for Pacific populations – 729.6 standardised acute bed days/1000 by June 2018

- Emergency Department Attendance Rate
- Acute Readmission Rates in 28 Days

Using health resources effectively

PATIENT EXPERIENCE OF CARE

Improvement Milestones

PHC Patient Experience Survey: 50% of each PHO practices participating in the Primary care survey by June 2018

Hospital inpatient survey: Aggregate score of 8.5 across all four domains measured

- District Health Board Inpatient Survey
- E-portals
- Participation in PHC Patient Experience Survey

Ensuring patient-centred care

AMENABLE MORTALITY

Improvement Milestone

6% reduction for each DHB (on 2013 baseline) by June 2020

- Cardiovascular Disease Risk Assessment (CVD RA) for Māori
- Cardiovascular Disease Management
- Smoking Cessation

Preventing and detecting disease early

YOUTH ACCESS TO AND UTILISATION OF YOUTH-APPROPRIATE HEALTH SERVICES

Improvement Milestones

Sexual and reproductive health: 80% of pregnant women 15-24 years are screened for chlamydia during pregnancy

Other domains: Establish baselines

- Development of Future Sexual and Reproductive Health Contributory Measures
- All Pregnant Women are Screened for Chlamydia
- Chlamydia Burden of Disease
- Health Care Utilisation by 15–24 year olds
- Participation in Child and Adolescent Mental Health Services Mārama Real-Time Survey
- Development of Baseline Data for Youth Domains

Youth are healthy, safe and supported

PROPORTION OF BABIES WHO LIVE IN A SMOKE-FREE HOUSEHOLD AT SIX WEEKS POST-NATAL

Improvement Milestone

Reduce missing smokefree household data to <10% by June 2018

- Better help for smokers to quit – pregnancy health target
- Maternal Smokefree Services
- Household Smoking Cessation
- Maternal Smoking Prevalence Data

Healthy start

2. PURPOSE

This document outlines how the 2017-18 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the high-level activities that will be fundamental to this improvement. Please note that, as further discussed in section 3.2, implementation planning will be developed to sit under this document to provide a higher level of detail.

3. BACKGROUND

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

a) Four SLMs, which were implemented from 1 July 2016:
   - ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds;
   - acute hospital bed days per capita;
   - patient experience of care, and
   - amenable mortality rates.
b) Two developmental SLMs, to be implemented from 1 July 2017:
   - youth access to and utilisation of youth-appropriate health services, and
   - proportion of babies who live in a smoke-free household at six weeks post-natal.
c) For each SLM, an improvement milestone to be achieved in 2017-18. The milestone must be a number that either improves performance from the baseline or reduces variation to achieve equity.
d) For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally.

3.1 Process

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

Working groups are responsible for drafting contributory measures and identifying the related interventions to be included in the implementation planning. Each working group is chaired by a PHO lead. Working group membership consists of senior primary care and DHB clinicians, personnel and portfolio managers. Groups have public health physician support. This year, there has been further work to involve other areas of the sector in the working groups including pharmacy and maternity.

The steering group and working groups will continue to meet in 2017-18, in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs.

In 2016, working groups completed in-depth analytics to inform development of the improvement plan. This was built upon again in the development of the 2017-18 plan. The selection of contributory measures and

activities was guided by the impact that measures could have on each SLM, current activity or models of care in an area, and amenability of a contributory measure to change. The process also included a review of national and regional data, analysed by DHB, facility, ethnicity, deprivation and condition. The groups considered both an overarching approach and a condition-specific approach for each SLM. Among the factors considered were the number of hospitalisation events (as well as rates), readmission rates, bed days, general practitioner (GP) visits, DHB inpatient experience survey rates, condition specific amenable mortality rate recent trends, and evidence to support improvement activities and the ability to address equity gaps.

Working groups have engaged with key stakeholders in the process of drafting and selecting contributory measures. In 2017, this included engaging more broadly than primary and secondary care; in particular, the babies in smoke-free households SLM working group included pharmacy and maternity stakeholders. Stakeholder engagement included a sector-wide socialisation workshop, cultural consultation workshops, and a presentation of draft measures, milestones and interventions to the Alliances. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

This plan reflects a strong commitment to the acceleration of Māori health gain and the elimination of inequity for Māori. Each working group has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those most disadvantaged.

The 2017-18 Improvement Plan has been shared with the Māori, Pacific and Asian health teams at Auckland, Counties Manukau and Waitemata DHBs and their feedback has been incorporated. The Māori health gain teams across the region were invited to workshop the final draft of the plan and provided valuable input. The 2017-18 SLM Improvement Plan has been designed to align with the Auckland and Waitemata DHBs Māori Health Plan and the Counties Manukau DHB Maaori Health Plan. Consultation with the relevant cultural groups and equity partners has been an essential part of this process.

Reporting processes, both at a local and regional level, are in development. The data to inform this reporting will comply with the Metro Auckland Data Sharing Framework, agreed by the Alliances in 2015.

3.2 Regional Working

As in 2016-17, a single improvement plan has been developed in 2017-18 for the Alliances and three Metro Auckland DHBs. The rationale for this is that a number of PHOs cross the Metro Auckland DHB boundaries and are members of both Alliances. It was not considered to be practicable or achievable, given limited resources, to have two improvement plans with different contributory measures. Improvement milestones and contributory measures have been carefully selected to take into account the context, population and current performance of each DHB in the wider Auckland region. One regional plan also promotes closer regional collaboration between stakeholders, and ensures that patient outcomes are promoted in a consistent way.

4. SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

The following section outlines the specific improvement plan for each of the six SLMs for 2017-18. For each, a system level milestone is set. Under these milestones, contributory measures provide the structure which direct and measure improvement activity. This ensures activities support the improvement of the system as a whole, and the milestone in particular

4.1 Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds

<table>
<tr><td>System level outcome</td><td colspan="4">Keeping children out of hospital</td></tr>
<tr><td>Improvement milestone</td><td colspan="4">5% reduction in total rate by 30 June 2018</td></tr>
<tr><td>Baseline</td><td colspan="4">Ambulatory sensitive hospitalisation rates for 0-4 year olds, by DHB and ethnicity (per 100,000 population) 12 months to September 2016:

<table>
<tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>6,071</td><td>8,025</td><td>14,379</td><td>7,661</td></tr>
<tr><td>Waitemata</td><td>4,879</td><td>5,940</td><td>10,825</td><td>5,694</td></tr>
<tr><td>Counties Manukau</td><td>4,789</td><td>6,264</td><td>11,977</td><td>7,109</td></tr>
<tr><td>Metro Auckland</td><td>5,213</td><td>6,494</td><td>12,305</td><td>6,758</td></tr>
</table></td></tr>
<tr><td>Rationale and context</td><td colspan="4">Ambulatory sensitive hospitalisations are admissions considered potentially preventable through prophylactic or therapeutic interventions in primary care. The admissions included are made up of a specified set of discharge codes considered to be ambulatory sensitive, and are assigned based on the primary diagnosis assigned. This is a challenging indicator as social determinants of health are a significant contributor. The amount realistically amenable to timely access to quality primary care has not been quantified and there is little evidence about what works outside of immunisation for vaccine preventable diseases. Despite these challenges there are many promising approaches that could be taken.

Exposure to smoking and quality of housing has an impact on this measure; the intention is to recognise the linkages to existing smoke-free activity in the amenable mortality SLM and with the babies in smoke-free households SLM.

Overarching activities
Connect this work with the Better Public Services target Keeping Kids Healthy: ‘By 2021, a 25% reduction in the rate of hospitalisations for avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019’. The avoidable hospitalisations include dental conditions, respiratory conditions (such as bronchiolitis, pneumonia, asthma and wheeze), skin conditions (such as skin infections, dermatitis and eczema), and head injuries.</td></tr>
<tr><td>Linkages</td><td colspan="4">Ambulatory sensitive hospitalisation rates: See the Access to Care section of the Auckland DHB and Waitemata DHB Māori Health Plan and the Hospitalisations section of the Counties Manukau DHB Maaori Heath Plan for more information.
Immunisation: See the Immunisation sections of the Auckland DHB and Waitemata DHB Māori Health Plan, Counties Manukau DHB Maaori Heath Plan and the Increased Immunisation Better Public Service and Health Target in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.
Oral health: See the Oral Health sections of the Auckland DHB and Waitemata DHB Māori Health Plan and Counties Manukau DHB Maaori Health Plan and the Child Health section of the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.</td></tr>
<tr><td colspan="5">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
</table>

<table>
<tr>
<td>Māori Children Fully Immunised by 8 Months of Age</td>
<td>Immunisations are required to prevent serious communicable childhood illnesses, which can lead to hospitalisations. Despite great progress there is still an equity gap for Māori babies.

This target may support maintenance or lowering of vaccine preventable disease rates and related hospitalisations, including for rotavirus/gastrointestinal and pneumococcal pneumonia.

This is a National Health Target.</td>
<td>Immunisation rate for babies 8 months of age, Q1 2016/2017, by PHO (enrolled patients):

<table>
<tr><th>PHO</th><th>Total</th><th>Māori</th></tr>
<tr><td>Alliance Health Plus</td><td>93%</td><td>89%</td></tr>
<tr><td>Auckland PHO</td><td>92%</td><td>88%</td></tr>
<tr><td>East Health Trust</td><td>96%</td><td>96%</td></tr>
<tr><td>National Hauora Coalition</td><td>95%</td><td>92%</td></tr>
<tr><td>ProCare Networks</td><td>93%</td><td>88%</td></tr>
<tr><td>Total Healthcare Charitable Trust</td><td>94%</td><td>86%</td></tr>
<tr><td>Comprehensive Care</td><td>93%</td><td>91%</td></tr>
</table>
</td>
<td>95% of Māori babies fully immunised by 8 months of age.</td>
<td>

Current immunisation programme (primary care coordinators, general practice systems, outreach immunisation service, Māori and Pacific providers, secondary care).
Continue to develop specific activity to improve Māori coverage (including ways to improve timeliness of immunisation), with leadership from Māori health gain teams and Māori leaders within primary care.
Develop links between immunisation outreach services and Māori Tamariki Ora providers to improve immunisation coverage for their enrolled children.
Investigate the possibility of Well Child Tamariki Ora nurses providing immunisation.
Utilise Whānau Ora services for immunisation of hard to reach children.
Promote immunisation in antenatal classes.
Investigate whether significant numbers of Māori babies are not engaged with general practice, with a view to include improvement activities to connect Māori whānau into the current newborn enrolment work.

</td>
</tr>
<tr>
<td>Skin Infections</td>
<td>There are high and growing rates of serious skin infections in Metro Auckland, particularly for Māori and Pacific and those living in areas of high deprivation. Skin infections have not received sufficient attention in primary care and community settings.

The proportion of ASH admissions due to skin infections is higher (nearly double at 14%) in Metro Auckland than elsewhere in New Zealand.

Although resources are available, there is not consistent access to or use of resources across the system. In addition there is a lack of consistent messaging and interventions. There is potential to</td>
<td>Skin infection subset of ambulatory sensitive hospitalisation data (per 100,000 population), 12 months to September 2016*:

<table>
<tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>371</td><td>1,432</td><td>2,323</td><td>812</td></tr>
<tr><td>Counties Manukau</td><td>334</td><td>1,288</td><td>2,195</td><td>1,073</td></tr>
<tr><td>Waitemata</td><td>467</td><td>1,248</td><td>2,306</td><td>800</td></tr>
<tr><td>Metro Auckland</td><td>399</td><td>1,303</td><td>2,226</td><td>907</td></tr>
</table>
*Cellulitis and dermatitis/eczema dataset via Ministry of Health SI1 Quarterly data
</td>
<td>Reduction in hospitalisation rate by 5% by 30 June 2018 (compared to baseline).</td>
<td>These activities build on those already developed by the skin infection working group of the regional Child Health Network.

Delivery of an educational package for skin infections to primary care, urgent care, Well Child Tamariki Ora services, and early childhood education centres. Use forums such as the Pacific Community Child Health Network (managed by TAHA, the Well Pacific Mother and Infant Service) to reach community groups.
Use DHB nurse educators and other health promotion resources in a coordinated way, so that health promotion messages reach early childhood education centres and other organisations that connect with families of young children. Currently Counties Manukau DHB and Auckland DHB have nurse educators; Waitemata DHB does not.
Link in to early childhood education centre health promotion activities delivered Auckland Regional Public Health Service.

</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td>improve opportunities for prevention, early detection and treatment in primary care..

The Northern Regional Child Health Skin Infection Project has undertaken significant developmental work in this area. The resources and enablers could be more systematically applied and delivered in primary and community settings.</td>
<td></td>
<td></td>
<td>• Consider further development of primary care skin clinics.
• Consider new approaches for providing access to care, e.g. community outreach, pharmacies, parish nurses.
• Consider the opportunities for community pharmacy to provide more education on the best use of topical and oral products.
• Consider targeted outcomes for Pacific and Māori children.</td>
</tr>
<tr>
<td>Oral Health</td>
<td>Poor oral health is a significant and increasing health issue for Pacific (Tongan in particular) and Māori children.

Poor oral health outcomes lead to dental decay, extractions and general anaesthetics. Dental decay is linked to range of other health conditions.

There are opportunities in primary care to provide health promotion messages and address barriers to care for Pacific children, and link with messaging in the child healthy weight space.

Although enrolment is not an ideal measure, further measures will be developed over the coming year.</td>
<td>Percentage of pre-school children enrolled in DHB-funded oral health services, 2016 calendar year:

<table>
<tr><th>DHB</th><th>Other</th><th>Māori</th><th>Pacific</th><th>Total</th></tr>
<tr><td>Auckland</td><td>86.6%</td><td>64.8%</td><td>84.4%</td><td>83.3%</td></tr>
<tr><td>Counties Manukau</td><td>90.0%</td><td>73.2%</td><td>85.9%</td><td>84.7%</td></tr>
<tr><td>Waitemata</td><td>100%</td><td>71.9%</td><td>80.3%</td><td>93.0%</td></tr>
<tr><td>Metro Auckland</td><td>93.7%</td><td>71.2%</td><td>84.4%</td><td>87.3%</td></tr>
</table>
</td>
<td>95% enrolment with oral health services amongst preschool children.</td>
<td>From the Draft 2017 Pre-school Oral Health Strategy:
• Oral health promotion at national, community and individual level. Focus on Pacific churches and parenting groups.
• Messaging to align with Raising Healthy Kids National Health Target.
• Increase awareness of free dental services.
• Upskill primary care, Well Child Tamariki Ora and secondary care providers in lift-the-lip assessments, knowledge of dental services and referral processes.
• Engage with the newborn enrolment project, which is: implementing systems to refer newborns for enrolment with the National Immunisation Register, general practice, oral health providers, Well Child Tamariki Ora providers and newborn hearing screening services.
• Increased number of extended hours and Saturday dental clinics in appropriate locations.
• Consider a targeted intervention for Pacific and Māori children to address inequity.</td>
</tr>
<tr>
<td>Respiratory Conditions Potentially Preventable by Special Immunisations</td>
<td>This measure provides an opportunity to have a more coordinated and focused approach to doing special immunisations for children, thereby reducing hospitalisations for relevant respiratory illness and preventing readmissions.</td>
<td>Baseline setting year.</td>
<td>Increase flu vaccination coverage by (absolute) 10% for children aged 0-4 who are hospitalised for respiratory illness.</td>
<td>• Develop the current activity to identify and vaccinate all children aged 0–5 who qualify for the free influenza vaccine.
• Build on current activity to support both influenza and pertussis vaccine offer to all pregnant women, e.g. vaccinator at antenatal clinics, promotion campaigns, lead maternity carers education opportunities.
• Undertake activities in primary and secondary</td>
</tr>
</table>

	Vaccination of pregnant women is a Ministry of Health priority, especially for pertussis for newborns who are too young to be vaccinated. Current uptake is low (around 20%) and many women are unaware.		Establish baseline data to measure pertussis and flu vaccines coverage rates for pregnant women.	care: • Secondary care o Develop a documented, consistent system for providing lists of hospitalised children to PHOs and monitoring through the Influenza season (when the vaccine is available); o Make it mandatory to fill in the sections on discharge letters on eligibility for special immunisations, and o Promote vaccinations to patients and their families and proactively refer patients back to GPs for vaccinations. • Primary care o Immunisation coordinators in PHOs provide education to general practice staff on special immunisations while visiting practices, and o The Immunisation Advisory Centre will provide education and support to general practice, to improve understanding of who is eligible for special immunisations and to enhance processes for identification and recall, through continuing medical and nursing education sessions. • Develop systems for measuring the impact of these activities, e.g. on readmissions for respiratory illness. • Consider the feasibility of offering Influenza vaccination to all children aged 0-4 years. • Pregnancy related immunisations: develop data definitions and agreed consistent process steps and monitoring points.

4.2 Acute Hospital Bed Days per Capita

System level outcome	Using health resources effectively
Improvement milestone	2% reduction for total population – 428.9 standardised acute bed days/1000 by June 2018 3% reduction for Māori populations – 604.6 standardised acute bed days/1000 by June 2018 3% reduction for Pacific populations – 729.6 standardised acute bed days/1000 by June 2018
Baseline	Acute hospital bed days per capita, (age standardised) year to September 2016, by ethnicity:

DHB	Other	Māori	Pacific	Total
Auckland	375.7	595.8	851.1	433.6
Counties Manukau	370.2	690.8	710.1	460.1
Waitemata	390.3	554.8	730.6	422.3
Metro Auckland	380.4	623.3	752.2	437.7

Rationale and context	Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers. The intent of the measure is to reflect integration between community, primary and secondary care, and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. We will achieve a greater reduction in bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific milestones for these populations are higher due to the inequity when compared to the total population. We plan to target populations most likely to be admitted or readmitted to hospital, and focus on conditions that contribute most to acute hospital bed days. Conditions identified as highest priority are Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and the frail elderly. Risk stratification to identify patients at highest risk of readmission will be undertaken by Counties Manukau Health stakeholders and explored by those in Auckland and Waitemata DHBs.
Linkages	Emergency department attendance rate: *See the Shorter Stays in Emergency Departments Health Target and the Primary Care Integration section in the Auckland DHB and Waitemata DHB annual plans for more information.* Acute hospital readmission: *See the Primary Care Integration section in the Counties Manukau DHB Annual Plan for more information.*

Contributory measures

	Rationale	Current state	Target future state	Improvement activities
Emergency Department (ED) Attendance Rate	Overall reduction in ED presentations will result in fewer admissions and lower bed day use. Improving the appropriate use of Primary Options in Acute Care (POAC) should reduce ED attendance. Currently there is wide variation in POAC use at a practice level.	ED attendance per 1000 population by ethnicity (standardised), 12 months to 30 September 2016:	Reduce the ED attendance rate by 2% by June 2018 by promoting and supporting more effective use of POAC.	Primary Options in Acute Care (POAC) activities: • Determine baseline utilisation of POAC across the region, including an ethnicity-level and a practice-level analysis. • Identify gaps and areas for potential improvement. • Convene expert group to determine and agree consistent interventions. • Monitor POAC utilisation, intervention rate and impact. • Develop and implement an education programme to promote appropriate use of

DHB	Other	Asian	Māori	Pacific	Total
Auckland	196.9	170.1	260.0	351.1	206.0
Counties Manukau	187.0	135.9	283.3	337.6	215.4
Waitemata	224.1	150.6	275.3	382.9	222.3
Metro Auckland	206.1	150.2	274.0	349.3	214.3

				POAC. • Explore current barriers to general practices using POAC. • Develop practice-level reports showing POAC usage relative to peers. Pilot new and innovative ways to encourage patients to use primary care services appropriately, e.g. social media campaigns, vouchers for after-hours care.
Acute Readmission Rates in 28 Days	Current clinical processes associated with discharge planning focus on quality of care in hospitals. The risk of readmission is partly determined by this care, but the literature also suggests that factors such as presence of a social network after discharge and the patient's capacity for managing their own care also influence the likelihood of being readmitted. The focus is on understanding the discharge planning processes that are currently undertaken in hospitals and augmenting them with interventions that support effective transitions of care. The proposed intervention involves identifying patients discharged from hospital who have a relatively high risk of readmission and developing a care plan with them to prevent avoidable admissions in the future. While it is expected that it will reduce the rate of readmissions, it will also provide the necessary infrastructure for risk stratification and care planning.	Methodology for this rate currently in progress and data will be supplied once confirmed.	Target TBC, considering an equity reduction target once data is available.	• Determine baseline readmission rates by ethnicity, by PHO and across the region. • Explore the potential of risk stratification to identify patients at highest risk of readmission. • Review discharge planning processes across the hospital systems. • At the point of discharge and in primary care, target patients discharged with CHF, COPD and the frail elderly. • Encourage active follow up of patients discharged from hospital with a relatively high risk of readmission, in particular for those with CHF, COPD and the frail and elderly • Ensure that patients discharged from hospital with a relatively high risk of readmission have a patient centred care plan and, ensure Advance Care Plans (ACP) are in place, with a focus on initiating the ACP in primary care settings.

4.3 Patient Experience of Care

<table>
<tr><td>System level outcome</td><td colspan="4">Ensuring patient-centred care</td></tr>
<tr><td>Improvement milestones</td><td colspan="4">• Hospital inpatient survey: aggregate score of 8.5 across all four domains measured.
• Primary care survey: 50% of each PHO's practices (approximately 166 practices) are participating in the Primary Health Care Patient Experience Survey (PHC PES) by June 2018.</td></tr>
<tr><td>Improvement outcome</td><td colspan="4">Improved clinical outcomes for patients in primary and secondary care, through improved patient safety and experience of care</td></tr>
<tr><td>Context and rationale</td><td colspan="4">Patient experience is a good indicator of the quality of health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes. The Health Quality and Safety Commission (HQSC) patient experience survey (PES) scores domains covering key aspects of a patient's experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs.
Hospital Inpatient PES: This has been in place since 2014. A stretch milestone has been selected to improve on gains made in the 2016-17 year.
Primary Health Care PES: The PHC PES was developed more recently and has not yet been implemented widely, in part due to the slower than expected roll out of the National Enrolment Service. Before reporting on PES scores, the focus must be on ensuring participation in the PES at a PHO and practice level. This is the focus for the 2017-18 year. A milestone of 50% participation has been selected as achievable based on the PHC PES pilot evaluation and the experience of the two Auckland PHOs (ProCare and National Hauora Coalition) that participated in the PHC PES pilot. Practice participation in the PHC PES will require a great deal of developmental work by PHOs (for example, infrastructure, practice engagement, capacity building, and patient communication).</td></tr>
<tr><td>Linkages</td><td colspan="4">DHB inpatient survey: See the Improving Quality section in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.</td></tr>
<tr><td colspan="5">Contributory measures</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities (equity and communication lens)</td></tr>
<tr><td>DHB Inpatient Survey Communication Score</td><td>Communication is an essential component of patient experience of care and as such is one of the four domains that make up the PEC score.

Our focus across the three DHBs will be on communications and equity aspects in recognition of the fact the survey cannot adequately address all domains in a concentrated or focussed way. These will mirror activities already recognised as part of the district annual plans and will include aspects such as the discharge planning programme, Friends and Family Test, patient experience week improvement activities, and engagement with consumer literacy groups.</td><td>DHB Inpatient Survey Results for Q1 2016-17 by domain:

<table><tr><th>Domain</th><th>Auckland</th><th>Counties Manukau</th><th>Waitemata</th></tr><tr><td>Communication</td><td>8.7</td><td>8.7</td><td>8.2</td></tr><tr><td>Partnership</td><td>8.6</td><td>8.5</td><td>8.2</td></tr><tr><td>Coordination</td><td>8.6</td><td>8.9</td><td>8.5</td></tr><tr><td>Physical and emotional needs</td><td>8.5</td><td>8.7</td><td>8.7</td></tr><tr><td>Aggregate across domains</td><td>8.6</td><td>8.7</td><td>8.4</td></tr></table></td><td>Aggregate 8.5/10 for four domains.</td><td>• Individual DHB focus areas via annual planning will be worked on at a local level. For 2017-18 there will be a particular focus on enhancing connections through improved communication and addressing equity gaps, via specific programmes and initiatives, which will be locally delivered.
• A regional DHB group for patient experience of care meets monthly via teleconference and quarterly face-to-face. The SLM Improvement Plan will become core business for this group.
• Develop long-term strategies in response to specific equity challenges (Pacific and Māori specialist team engagement), and broaden communication and conversations for patients to improve their experience and journey of care.
• Share individual DHB learning and harness opportunities to replicate successes across Metro Auckland.</td></tr>
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<tr>
<td>E-portals</td>
<td>E-portals can enhance patient experience by giving patients more control over ordering prescriptions, booking appointments and viewing lab results. Research shows that the use of patient portals is associated with higher patient retention rates, lower appointment no-shows, improved communication, increased trust and confidence in their healthcare providers and an increase in patients feeling that they are able to take a more active role in their health care and decision-making. This measure is linked to the Youth SLM and the potential to positively affect the youth experience of healthcare via a mode of engagement that is relevant, safe and supported.</td>
<td>E-portal implementation by PHO, February 2017 data:
<table>
<tr><th>PHO</th><th>Percentage of practices registered with a portal</th><th>Percentage of enrolled patients (18+) with login access to a portal</th></tr>
<tr><td>Auckland</td><td>40%</td><td>10%</td></tr>
<tr><td>Alliance Health Plus</td><td>66%</td><td>5%</td></tr>
<tr><td>Waitemata</td><td>42%</td><td>12%</td></tr>
<tr><td>East Health</td><td>27%</td><td>24%</td></tr>
<tr><td>ProCare</td><td>64%</td><td>15%</td></tr>
<tr><td>Total Healthcare</td><td>100%</td><td>5%</td></tr>
<tr><td>National Hauora Coalition</td><td>0%</td><td>0%</td></tr>
<tr><td>Metro Auckland</td><td>52%</td><td>13%</td></tr>
</table>
Note: later data sets will not restrict data to 18+ enrolled.</td>
<td>Increase to 55% of each PHO's practices registered with a portal.

Increase to 15% of each PHO's enrolled population who have login access to a portal.</td>
<td>• E-portal ambassadors and provider options will continue to be socialised amongst clinicians and consumers via PHOs and practices.
• PHO teams will provide support to practices to implement e-Portal enrolment systems.
• Portal options are explored by practices and adopted in a staged approach relative to level of clinician confidence and consumer request. These will include:
o access to clinical data – diagnoses, notes, allergies, immunisations, lab results;
o access to communications – messaging to doctor or nurse, repeat prescription, requesting appointments, self-scheduling;
o access to education – condition specific information, websites with merit, self-management activities, and
o PHOs will access resource materials and actively use these to support e-Portal implementation in practices and e-Portal uptake by patients.</td>
</tr>
<tr>
<td>Practice Participation in the PHC PES</td>
<td>Patient experience is a good indicator of the quality of primary health services. The PES is the mechanism by which this can be measured and improved. Further activity and input into its ongoing evaluation and modification through the Ministry of Health and the HQSC is expected in order for it to more ably serve the needs of our diverse Metro Auckland population, particularly for service users with English as a second language.</td>
<td>Two Auckland PHOs participated in the PHC PES pilot (ProCare and the National Hauora Coalition). All of the National Hauora Coalition's (12) and 25% of ProCare's practices (53) participated.</td>
<td>50% of each PHO's practices participate in the PHC PES</td>
<td>• Ensure socialisation of resources and support for practice-related activities, such as, PHOs follow HQSC/Ministry of Health 'Getting Started' resource pack and advice.
• PHOs advise Cemplicity of PHO name and contact for survey, and IT key contact to enable log on via email address.
• Practices are supplied with and follow getting started guide and resources.
• Practices provide PHO with details to appear on survey invitation email, text message and online survey.
• Marketing of the survey week (one week every quarter), process and survey intent across practices is enabled.
• Practices check email addresses of all patients 15 years and over and save preferences.
• Follow up by PHO and practices to view real-time patient experiences and appropriately respond to request for contact or any indicated follow up required.
• Once survey is closed, practices and PHOs will review the final results of the survey.</td>
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</table>

4.4 Amenable Mortality Rates

System level outcome	Preventing and detecting disease early
Improvement milestone	**6% reduction for each DHB (on 2013 baseline) by June 2020**
Baseline	Amenable mortality rate per 100,000 population (age standardised), 0–74 year olds, using New Zealand estimated resident population as at June 30:

DHB	2013	2009–2013
Auckland	72.9	87.5
Counties Manukau	104.4	113.0
Waitemata	65.6	74.6
Metro Auckland	80.2	89.4

Context and Rationale

There were four contributory measures for the Amenable Mortality SLM for 2016-17: cardiovascular disease risk assessment (CVD RA) and management; smoking cessation; hepatitis C (identification and support to treatment); and breast screening (data matching to improve Māori coverage). Of these, only the first two contributory measures will be retained for the 2017-18 Improvement Plan. The reasons for discontinuing hepatitis C and breast screening are:

- Insufficient capacity for primary care to deliver against a large number of indicators;
- Hepatitis C is currently already in the Northern Regional Alliance workplan, and
- Breast screen data matching is still pending Ministry of Health progress against resolving confidentiality and privacy issues.

Therefore the decision was made to continue with the two contributory measures that have the greatest evidence-based impact on amenable mortality – cardiovascular disease (CVD) management and smoking cessation.

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

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

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

For the first financial year we plan to achieve 2% reduction for each DHB (on single year baseline) by June 2018.

Linkages

See the Long Term Conditions and the Ambulatory Sensitive Hospitalisation 45-65 years of age sections of the Auckland DHB and Waitemata DHB Māori Health Plan, the Cardiovascular Disease section of the Counties Manukau DHB Maaori Health Plan and the Living Well with Diabetes and Better Help for Smokers to Quit Health Target section of the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.

Contributory measures

	Rationale	Current state	Target future state	Improvement activities
Cardiovascular Disease Risk Assessment (CVD RA) for Māori	CVD RA for Māori is lower than the 90% national	CVD RA eligible patients who received a CVD RA, Quarter 1 2016-17:	90% CVD RA for Māori.	• Follow up phone calls (evenings) for practice generated CVD RA recall letters

	target. Successful implementation of dual therapy replies on identification of people with CVD RA ≥20%.			to Māori. • Pilot of phlebotomy services in the practices or point-of-care testing when Māori males visit opportunistically.
Cardiovascular Disease (CVD) Management	Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Increasing dual or triple therapy for those with a CVD RA ≥20% or a prior CVD event should lead to morbidity and mortality gains.	1. Cardiovascular disease management contributory measures (Percentage of enrolled patients with a CVD risk assessment score ≥20% dispensed dual therapy pharmaceuticals, and 2. Percentage of enrolled patients with a prior CVD event dispensed triple therapy pharmaceuticals.	5% increase (relative) in dual therapy for those with CVD RA greater than 20%. 5% increase (relative) in triple therapy for those with a prior CVD event.	• Identification of patients at a NHI level who have had a CVD event and are not dispensed triple therapy. Feedback and comparison of these results to GPs via PHOs. • Total population and specific interventions for Māori, Pacific and Asian peoples to improve uptake and adherence to dual and triple therapy. • Post-event medication counselling and other rehabilitation services in hospital. • Ongoing medication counselling by community pharmacists. • Consider an activity focussed on ensuring access to prescription subsidy cards and reducing prescription co-payments. • Establish a single process to report CVD indicators from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.

DHB	Other	Māori	Pacific	Total
Auckland DHB	92.7%	88.7%	91.5%	92.2%
Counties Manukau DHB	93.1%	88.6%	91.4%	92.0%
Waitemata DHB	91.7%	86.7%	90.2%	91.1%
Metro Auckland	92.4%	88.1%	91.3%	91.8%

Percentage of enrolled patients who are on dual or triple therapy (dispensing records), by ethnicity, 12 months ended 30 September 2016:

Ethnicity	% CVD RA ≥20% on dual therapy			
	Auckland	Counties Manukau	Waitemata	Metro Auckland
Māori	37.8%	48.3%	43.3%	45.1%
Pacific	54.2%	49.2%	50.0%	50.5%
Asian	45.7%	43.4%	38.2%	42.2%
Indian	44.4%	51.3%	45.7%	48.1%
Other	36.4%	44.2%	39.4%	40.2%
Total	41.6%	49.1%	41.4%	44.4%

Ethnicity	% CVD on triple therapy			
	Auckland	Counties Manukau	Waitemata	Metro Auckland
Māori	51.9%	55.1%	55.0%	54.4%
Pacific	57.4%	61.7%	60.5%	60.4%
Asian	46.9%	50.5%	46.0%	47.5%
Indian	61.7%	69.1%	65.6%	65.7%
Other	51.3%	56.5%	53.2%	53.7%
Total	52.7%	58.1%	53.8%	55.0%

Smoking Cessation	This contributory measure sits both under this SLM and the Babies in Smoke-free Households SLM.	Better Help for Smokers to Quit (Primary Care) 2016/2017 Indicator 4: Cessation support received by enrolled patients, Q1 2016/2017:	An increase in cessation support by 10% (desegregated by	• Analyse reasons for historical low referrals to smoking cessation providers. • Improve referral pathways to smoking cessation providers.

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<td></td>
<td>Smokers lose at least one decade of life expectancy compared with those who have never smoked. Cessation before the age of 40 years reduces the risk of death associated with continued smoking by about 90%.

Aim: an increase in smokers who successfully quit, and a reduction in smoking prevalence.

This supports the Better Help for Smokers to Quit National Health Target.</td>
<td>
<table>
<tr><th>DHB</th><th>Cessation support rate</th></tr>
<tr><td>Auckland</td><td>24.7%</td></tr>
<tr><td>Counties Manukau</td><td>24.4%</td></tr>
<tr><td>Waitemata</td><td>32.9%</td></tr>
<tr><td>Metro Auckland</td><td>27.0%</td></tr>
</table>
</td>
<td>ethnicity).</td>
<td>

Improve feedback to referrers from smoking cessation providers.
Access aggregated data for Auckland population.
Establish a single process to report smoking from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.
Benchmark ‘access to smoking cessation‘ READ codes across PHOs: i.e. the number of patients with codes 1, 2 and 3:

ZPSC10 – referral to smoking cessation support;
ZPSC20 – prescribed smoking cessation medication, and
ZPSC30 provided smoking cessation behavioural support.

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4.5 Youth Access to and Utilisation of Youth-appropriate Health Services

System level outcome	**Youth are healthy, safe and supported**			
Domains	**Youth access to and utilisation of youth-appropriate health services as measured via:** • **Youth experience of the health system: Child and Adolescent Mental Health Services Mārama Real-Time Survey results for 10–24 year olds;** • **Sexual and reproductive health: chlamydia testing coverage for 15–24 year olds – percentage of age group tested in one year;** • **Mental health and wellbeing: intentional self-harm hospitalisations (including short-stay hospital admissions through ED) for 10–24 year olds;** • **Alcohol and other drugs: alcohol-related ED presentations for 10–24 year olds, and** • **Access to preventive services: utilisation of DHB-funded dental services by adolescents from school Year 9 up to and including 17 years of age.**			
Improvement milestone	**Sexual and reproductive health: 80% of pregnant women aged 15–24 years are screened for chlamydia during pregnancy**			
Context and rationale	Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet can lead to increased risk for poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours, in terms of drug and alcohol abuse and criminal activities. **Youth experience of the health system:** Evidence shows that young people who do not have positive interactions with health care services and providers do not return, which can lead to increased risk for poor health as adults. Research suggests that lapses in healthcare can lead to overall poor life outcomes. **Chlamydia testing coverage:** Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most commonly diagnosed in females aged 15-19 years and in males aged 20–24 years. There is significant variation in rates and testing between males and females and between Māori, Pacific and non-Māori. Males, Māori, and Pacific young people are under-tested in Auckland laboratory data, reflecting inequities in the services and systems to meet the needs of these populations. Māori and Pacific youth are more frequently hospitalised with sexually transmitted infection complications and pregnancy-related conditions than young people of other ethnicities. International modeling suggests that testing coverage needs to be between 30–40% to begin to reduce prevalence of infection. In the UK, data from the youth screening programme shows that more than 50% of 16–24 years olds with chlamydia have no or non-specific symptoms. **Intentional self-harm:** Intentional self-harm is a mal-adaptive coping mechanism indicating young people who are in distress and coping with that distress in an unhealthy way. It is often associated with low mood, depression, anxiety, wider family or peer group issues and events, stress, bullying, bereavement, relationship issues, trauma, intense or difficult feelings, or being in a group that self-harms. **Alcohol-related ED presentations:** Identifying and monitoring alcohol-related ED presentations enables better understanding of the contribution of excessive alcohol consumption to health outcomes in young people and supports appropriate public health responses. **Utilisation of DHB-funded dental services by adolescents:** There is strong evidence that dental care is associated with improved oral health outcomes. This measure is a marker of inequalities in utilisation and youth engagement into health services by deprivation and ethnicity.			
Linkages	*See the Youth Mental Health section of the Auckland DHB and Waitemata DHB Māori Health Plan, Mental Health (Youth) section of the Counties Manukau DHB Maaori Health Plan and the Prime Minister's Youth Mental Health Project in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans, and the Mental Health section of the Counties Manukau DHB Annual Plan for more information.*			
Contributory measures – Sexual and Reproductive Health				
	Rationale	**Current state**	**Target future state**	**Improvement activities**
Development of Future Sexual and Reproductive Health Contributory Measures	Baseline data is required for planning, identifying appropriate contributory measures and	To be determined.	Establish baseline.	• Analysis of SLM data by age, ethnicity, and PHO. • Identify gaps and potential areas for

<table>
<tr><td></td><td>developing improvement activities.</td><td></td><td></td><td>improvement.
• Review the literature to identify options for improving access to chlamydia testing for Māori and Pacific youth including school-based services, pharmacy, community laboratories, primary care, outpatients, justice systems, and other opportunistic settings.</td></tr>
<tr><td>All Pregnant Women are Screened for Chlamydia</td><td>Screening during pregnancy is recommended in current national guidelines including pre-termination of pregnancy. A 2015 publication of implementation of this guideline for pregnant women could be strengthened, expanding screening to male partners.</td><td>To be determined.

Screening in pregnancy, Middlemore and Auckland Hospitals:<table><tr><th>Hospital</th><th colspan="3">% screened</th></tr><tr><th></th><th><19 yrs</th><th>19-23 yrs</th><th><25 yrs</th></tr><tr><td>Middlemore*</td><td>74%</td><td>65%</td><td></td></tr><tr><td>Auckland**</td><td></td><td></td><td>68%</td></tr></table>*2011 **2013</td><td>80% of pregnant women aged 15–24 years are screened for chlamydia.</td><td>• Workforce development activities for lead maternity carers.
• Data analysis looking for missed opportunities, e.g. primary care visits during pregnancy.
• Data analysis looking for the potential to report back screening rates to lead maternity carers.</td></tr>
<tr><td>Chlamydia Burden of Disease</td><td>The purpose of increasing chlamydia screening is to reduce the disease burden. It is important to monitor this to assess the impact of screening activities on health outcomes.</td><td>To be determined.</td><td>Baseline.</td><td>• Establish regular reporting of chlamydia prevalence by age, ethnicity and locality.</td></tr>
<tr><td colspan="5">Contributory measures – Other Domains</td></tr>
<tr><td></td><td>Rationale</td><td>Current state</td><td>Target future state</td><td>Improvement activities</td></tr>
<tr><td>Health Care Utilisation by 15–24 year olds</td><td>Understanding where and how frequently youth access health care services across the system will support planning for improving access.</td><td>To be determined.</td><td>Analysis completed.</td><td>• Explore the availability of data across services potentially accessed by youth and the feasibility of data linkage to explore systems-wide youth health service utilisation and identify gaps.
• Baseline primary health care enrolment and utilisation.</td></tr>
<tr><td>Participation in Child and Adolescent Mental Health Services Miramar Real-Time Survey</td><td>Baseline data is required for planning, identifying appropriate contributory measures, and developing improvement activities.</td><td>To be determined.</td><td>Establish baseline.</td><td>• Analysis of SLM data.
• Engage with Miramar, the regional child and adolescent Mental Health Service group, and service providers to identify gaps and potential areas for improvement.</td></tr>
<tr><td>Development of Baseline Data for Youth Domains:
alcohol and other drugs,
access to preventative services,
mental health and wellbeing</td><td>Baseline data is required for planning, identifying appropriate contributory measures and developing improvement activities.</td><td>To be determined.</td><td>Establish baseline.</td><td>• Analysis of SLM data by age, ethnicity, and PHO.
• Identify gaps and potential area for improvement.</td></tr>
</table>

4.6 Proportion of Babies Who Live in a Smoke-free Household at Six Weeks Post-natal

System level outcome	Healthy start
Improvement milestone	**Reduce missing smokefree household data to <10% by June 2018**
Context and rationale	The definition of a smoke-free household is one where no person ordinarily resident in the home is a current smoker. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whanau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasizes the need to focus on the collective environment that an infant will be exposed to – from pregnancy, to birth, to the home environment within which they will initially be raised. Of note, smoking during pregnancy and exposure to tobacco smoke in infancy is highest for Māori and Pacific. Baseline data from Well Child Tamariki Ora providers suggests that 98% of babies lived in a smokefree household at 6 weeks post-partum during Q1-2 of 2016/17. Given current smoking prevalence, this is unlikely to be accurate. In addition, nearly 1 in 5 babies in Metro Auckland did not have smokefree household data recorded WCTO activities in the 17/18 plan focus on improving data quality. As data quality improves, the proportion of babies living in smokefree households is likely to decline initially. Therefore, measuring the impact of activities on the SLM will be challenging in the short term. **Proportion of Babies in SmokeFree homes at 6 weeks post-partum, July-Dec 2016**

DHB	Māori	Pacific	Asian	Other	Total
Auckland	96.1%	96.8%	99.6%	99.4%	98.8
Counties Manukau	96.4%	97.9%	99.5%	99.1%	98.5
Waitemata	96.2%	99.5%	99.0%	98.4%	98.3
Metro Auckland	96.3%	98.0%	99.3%	98.9%	98.5

Proportion of babies for whom there is no information about their smokefree home status at 6 weeks post-partum, July-Dec 2016

DHB	% missing
Auckland DHB	14.8%
Counties Manukau	25.6%
Waitemata DHB	16.3%
Metro Auckland	19.5%

Note: Includes babies for whom the response was missing, unknown, or was not asked.

Linkages	*See the Tobacco section of the Auckland DHB and Waitemata DHB Māori Health Plan and the Death in Infants, the Babies Exposed to Smoking section of the Counties Manukau DHB Maaori Health Plan, and the Better Help for Smokers to Quit Health Target in the Auckland DHB, Counties Manukau DHB and Waitemata DHB annual plans for more information.*

Contributory measures

	Rationale	Current state	Target future state	Improvement activities
Maternal Smoke-free Services Pregnant smokers referred to cessation support by lead maternity carers. Referrals of pregnant smokers to stop smoking services (SSS).	Ensuring that pregnant women who smoke are offered referral to cessation support is a crucial step in the pathway to them becoming smoke-free. This measure has two components. One looks at the proportion of pregnant smokers referred to cessation support using data collected from DHB employed midwives and from lead maternity carers using the Midwifery and Maternity Providers programme. As this dataset does not currently give a complete	Due to the number of referral services and inconsistent systems for recording referrals sent and referrals received, accurate data is not available. Available data is of poor quality but suggests that referral rates are low.	Baseline data.	• Improve regional data collection so that timely maternal smoking prevalence data is available, brief advice and quit support can be monitored, and referral to SSS for women who are pregnant and are current smokers can be monitored. • Analyse reasons for historical low referrals to smoking cessation providers, particularly for Māori women. • Promote regional pathway for first trimester visit (includes smoking cessation referral) with a focus on Māori women.

	picture of the number of pregnant smokers offered intervention, it is supplemented by the second component, the number of referrals received by SSS.			• Facilitate early enrolment of pregnant women with lead maternity carers. • Provide lead maternity carers and GP training on smoking cessation. • Provide feedback to lead maternity carers on their referral rates. • Provide pregnancy SSS incentives programme. • Arrange for SSS providers to attend pregnancy and parenting classes in the community (particularly those for Māori and Pacific). • Explore innovative ways of engaging pregnant smokers to quit, with a focus on Māori women, e.g. through use of a Sudden Unexpected Death in Infancy App.
Household Smoking Cessation	**Whānau:** Smokers who live in the same household as babies and young children may be reached through community, primary care and secondary care. Offering cessation support, stop smoking therapy or referral to SSS is important to assist whānau members to become smoke-free. The use of other settings to identify and support smokers that live with young children will also be explored. A focus on activities that will increase quit rates for Māori and Pacific is particularly important given the higher prevalence of smoking in these ethnic groups. **Other:** This contributory measure sits both under this SLM and the Amenable Mortality SLM. A total population approach undertaken in the amenable mortality SLM will support an overall increase in quit rates.	Whānau smoking cessation support information is not yet available. As per data supplied in amenable mortality SLM.	Obtain robust, timely data. Scoping complete data for smoking exposure and prevalence through Well Child Tamariki Ora, and scope data collection in DHBs. Scope providing whānau smoking cessation through maternity services and Well Child Tamariki Ora for 2018-19 plan.	• WCTO Data Quality Improvement: Review and align data collection processes for SLM measure across WCTO providers and provide SOPs for data collectors. • Provide WCTO providers feedback on missing smokefree data rates. • Scope processes to identify household members of pregnant women and newborns who are current smokers, including data collection processes. • Explore opportunities to offer smoking cessation support to whānau of newborn inpatients and outpatients, and paediatric ED attendances. • Explore additional ways of offering smoking cessation support to whānau of young children, e.g. pharmacy initiatives, Well Child providers. • Support the work undertaken in the Amenable Mortality SLM.

5. GLOSSARY

CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular disease
CVD RA	Cardiovascular disease risk assessment
DHB	District health board
ED	Emergency department
GP	General practitioner
HQSC	Health Quality and Safety Commission
NHI	National Health Index
PES	Patient experience survey
PHC PES	Primary health care patient experience survey
PHO	Primary health organisation
POAC	Primary Options in Acute Care
SLM	System level measures
SSS	Stop smoking services

APPENDIX E: 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, Chairman	(appointed)
	Kylie Clegg, Deputy Chairman	(appointed)
	Professor Max Abbott	(elected)
	Brian Neeson	(elected)
	Sandra Coney	(elected)
	Warren Flaunty	(elected)
	James Le Fevre	(elected)
	Morris Pita	(appointed)
	Edward Benson-Cooper	(elected)
	Allison Roe	(elected)
	Dr Matire Harwood	(appointed)

Senior Leadership Team for Waitemata DHB	Dr Dale Bramley	Chief Executive
	Robert Paine	Chief Financial Officer
	Dr Debbie Holdsworth	Director – Funding
	Dr Karen Bartholomew	Acting 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, Scientific and Technical Professions
	Dr Jonathon Christiansen	Head of Division (HOD) Medicine and Health of Older People
	Michael Rodgers	HOD Surgical and Ambulatory Services
	Dr Meia Schmidt-Uili	HOD (Acting) Child, Women and Family Services
	Pam Lightbrown	HOD Mental Health Services
	Gillian Cossey	GM Surgical and Ambulatory Services
	Debbie Eastwood	GM Medicine and Health of Older People
	Stephanie Doe	GM Child, Women and Family Services
	Helen Wood	Acting GM Mental Health Services
	Fiona McCarthy	GM Human Resources
	Naida Glavish	Chief Advisor Tikanga (Waitemata, Auckland DHBs)

APPENDIX F: GLOSSARY

ACC	Accident Compensation Commission
AOD	Alcohol and Other Drugs
ARDS	Auckland Regional Dental Service
ASH	Ambulatory sensitive hospitalisation
B4SC	Before School Checks
CADS	Community Alcohol, Drug and Addictions Service
CAMHS	Child, Adolescent Mental Health Service
CT	Computerised tomography
CVD	Cardiovascular disease
DNA	Did not attend
ECE	Early childhood education
ED	Emergency Department
EOA	Equitable outcomes action
FTE	Full time equivalent
GP	General Practitioner
HQSC	Health Quality and Safety Commission
Inequality	Differences in health status or in the distribution of health determinants between different population groups (WHO definition)
Inequity	Avoidable inequalities in health between groups of people, whether the groups are defined socially, economically, demographically or geographically (WHO definition)
Iwi	Tribe
Kaiāwhina	Support person
Kaupapa	Agenda
Kōhanga Reo	Māori language nest
LMC	Lead Maternity Carer
LOS	Length of stay
Mana whenua	People who have authority over the land
MDM	Multidisciplinary meeting
MH	Mental health
Mihimihi	Acknowledgement
MoH	Ministry of Health
MOU	Memorandum of Understanding
MRI	Magnetic resonance imaging
NGO	Non-governmental organisation
NRA	Northern Region Alliance (North and Northern Region DHB support Agency)
ORL	Otorhinolaryngology (ear, nose, and throat)
PHO	Primary Healthcare Organisation
POAC	Primary Options Acute Care
Q1, Q2, Q3, Q4	Quarters 1–4, i.e. by 30 September, 31 December, 31 March or 30 June
QALY	Quality-adjusted life year
RFP	Request for proposal
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 Ora	Families supported to achieve their maximum health and wellbeing
YTD	Year to date