Waitematā
District Health Board

Best Care for Everyone

2018/19 Annual Plan

Incorporating the Statement of Intent and the Statement of Performance Expectations

Waitematā District Health Board

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

Mihimihi

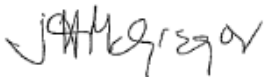
E nga mana, e nga reo, e nga karangarangatanga tangata
E mihi atu nei kia koutou
Tena koutou, tena koutou, tena koutou katoa
Ki wa tatou tini mate, kua tangihia, kua mihia kua ea
Ratou, kia ratou, haere, haere, haere
Ko tatou enei nga kanohi ora kia tatou
Ko tenei te kaupapa, 'Oranga Tika', mo te iti 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 Waitematā District Health Board Annual Plan for 2018/19 is signed for and on behalf of:

Waitematā District Health Board



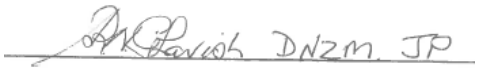
Professor Judy McGregor CNZM
Chair

Kylie Clegg
Deputy Chair

Dr Dale Bramley
Chief Executive

Our Te Tiriti o Waitangi partners

Te Runanga o Ngati Whātua



Dame Rangimarie Naida Glavish DNZM JP
Chair, Te Runanga o Ngati Whātua

John Tamihere
CEO, Te Whānau o Waipareira Trust

And signed on behalf of:

The Crown

Hon Dr David Clark
Minister of Health

Date 20/5/19

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Professor Judy McGregor CNZM
Chair
Waitemata District Health Board
Private Bag 93503
Auckland 0740
chair@waitematadhb.govt.nz

20 MAY 2019

Dear Judy

Waitemata District Health Board 2018/19 Annual Plan

This letter is to advise you I have approved and signed Waitemata District Health Board's (DHB's) 2018/19 Annual Plan for one year.

I note your DHB has planned a deficit of 7 million for 2018/19.

I have been clear that my expectation for the total DHB sector financial position was that it was an improvement on 2017/18. I am concerned that this expectation is unlikely to be met. I have previously emphasised to you that it is important DHBs are doing all they can locally to manage in a financially prudent way. Although I am approving your plan I expect that you will continue to focus on opportunities for improving financial results.

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

It is really important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders. I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2018/19 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr David Clark
Minister of Health

cc Dr Dale Bramley, Chief Executive, Waitemata District Health Board,
dale.bramley@waitematadhb.govt.nz

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SECTION 1: Overview of Strategic Priorities

Foreword from our Chair and Chief Executive

Best care for everyone

Best care for everyone is the promise we make to those living in the Waitematā district. We are committed to relieving suffering, reducing inequalities and promoting wellness, now and in the future.

Parents, families and communities expect and deserve the care and services we provide to be exemplary. We aim to live our values - that everyone matters, that we exhibit compassion, and that we strive to do better.

Our ongoing drive to be better, best and brilliant is why we have the highest life expectancy and lowest rates of cardiovascular disease and infant mortality in New Zealand.

Importantly, it is also reflected in our continual efforts to eliminate inequities wherever they exist, particularly in relation to Māori. Our efforts to date have, for example, resulted in Māori gaining over twice as many years in life expectancy compared with the non-Māori/non-Pacific population since 2008.

This is all part of our drive to deliver better health outcomes for every single person in our care.

Future focus

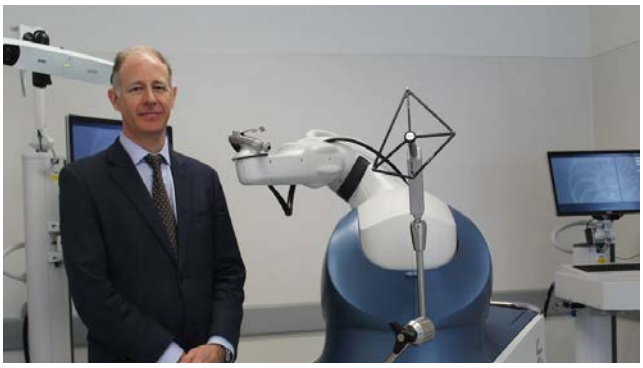
Population growth (our fast-growing population of 630,000 is expected to reach nearly 700,000 by 2025) and increased demand for clinical and community services provide both challenges and opportunities in the coming year.

The DHB will progress the following major developments over the next 12 months:

- construction of the $18.4 million, 15-bed medium secure Tanekaha Unit at Mason Clinic
- the completion and opening of a newly expanded Waitakere Hospital Radiology Department
- work with other Northern Region DHBs through a Long Term Investment Plan (LTIP) to guide medium-to long-term regional developments designed to improve health outcomes for everyone
- implement a Consumer Council to further bolster the DHB's commitment to a high quality, equitable and accessible health care service for the Waitematā community.

Each follows milestones achieved over the last year, including:

- the country's first robot-assisted partial knee replacement surgery at North Shore hospital's Elective Surgery Centre
- roll-out of initiatives, including ePrescribing, eVitals and eReferrals, revolutionising our continual efforts to put enhanced patient experience and safety first
- the implementation of TransforMED - putting the same groups of health professionals together every day on our general medicine wards to ensure better communication, teamwork and improved health outcomes for all.



Waitematā DHB Orthopaedics Clinical Director Matthew Walker carried out the country's first robot-assisted knee surgery with the Mako Unicompartmental Knee Replacement (UKR) system

Precision Driven Health (PDH), a partnership with Orion Health and the University of Auckland, delivered a Māori abdominal aortic aneurysm (AAA) screening programme (the first initiative of its kind in New Zealand), specifically designed to address the much higher rates of AAA among Māori.

Equity remains a major focus and projects are underway to eliminate existing outcome gaps within our ethnically diverse population; these include the newly launched Effective Stop Smoking Conversations with Pregnant Women Online Programme.

This training initiative is especially tailored to help health professionals initiate conversations in Māori and Pacific communities where smoking rates are disproportionately higher than the rest of the population.

This is an example of our proactive work around smoking cessation, which, along with our promotion of safer sleeping options for babies, is part of the reason for the 63% drop in Māori infant mortality across our catchment since 2001 – well ahead of the national 30% decline.

Similarly, the launch of our Awhi Tamariki health screening and prevention pilot in a number of lower decile primary schools further bolsters our commitment to put all of our children on a healthier path to a productive adulthood.

Much of this is done in partnership with primary care health providers who are equally committed to achieving better outcomes for all of our patients.

That relationship was further cemented in 2017 by the development of a Primary and Community Services Plan that significantly bolstered our support of GPs and their patients to provide more local care options and avoid unnecessary ED visits and hospitalisations.

Our partnership with primary care is also enhanced with the launch of Medinz – a new digital communications platform that we developed with Healthpoint. All three metro Auckland DHBs are now using this tool to communicate with GPs, urgent care clinics and community pharmacies right across the city – harnessing our collective strength to better meet the health needs of the people entrusted to our care.

None of this is possible, of course, without the hardworking and dedicated staff who remain our greatest asset of all.

We take this opportunity to say a heartfelt thank you.

Professor Judy McGregor CNZM
Chair, Waitematā District Health Board

Dr Dale Bramley
Chief Executive, Waitematā District Health Board

Introduction

Waitematā DHB is the Government's funder and provider of health services to the estimated 630,000 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.

This Annual Plan articulates Waitematā 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).

Our streamlined Annual Plan focuses on the key activities identified by the Minister for delivery in 2018/19. Although an updated Statement of Intent (SoI) was not requested for 2018/19, we have chosen to incorporate minor updates to align our performance framework to the 2018/19 System Level Measures Improvement Plan and reflect updated baselines. Our SoI is presented in Appendix A.

This Annual Plan is a high level document that 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 and Statement of Performance Expectations, is contained in the appendices.

Te Tiriti o Waitangi

Waitematā DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. We commit to the intent of Te Tiriti 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 high priority 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) relates to health system performance, particularly oversight and ownership of the processes necessary to reduce Māori health inequity. 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 DHB activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and thus with priorities directly linked to reducing systematic inequalities in health determinants, health outcomes and health service utilisation.

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

Waitematā DHB will participate in the development of a metro-regional Māori Health Plan, to be organised around the life-course framework incorporating regional and local activity, with the latter specific to each DHB's Plan.

While we are proud of our achievements for our Māori population, the continuation of a Māori Health Plan enables us to remain focused in the pursuit of Māori health gain as well as greater and more meaningful collaboration and sharing of intelligence across DHBs in terms of Māori health.

Population Performance

The Ministry of Health is exploring life course approaches as a way of understanding DHB population challenges.

The life-course approach aims to increase the effectiveness of interventions throughout a person's life. It focuses on a healthy start to life and targets needs at critical periods throughout a lifetime. It promotes timely investments with a high rate of return for public health and the economy by addressing the causes, not the consequences, of ill health. A life-course approach builds on the interaction of multiple promotive, protective and risk factors throughout life. [1]

The life course can be divided into five groups: pregnancy, early years and childhood, adolescence and young adulthood, adulthood, and older people. The most significant actions we expect to deliver in 2018/19 to address local population challenges for each of these groups are identified in Section 2.

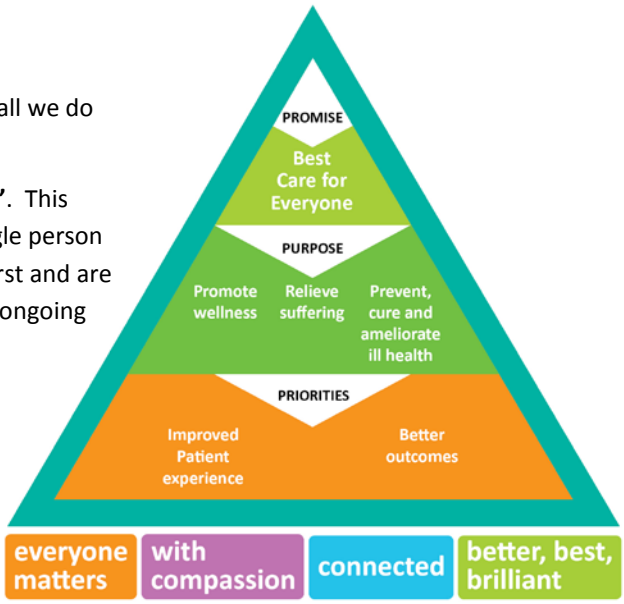
[1] World Health Organization, Europe
http://www.euro.who.int/en/health-topics/Life-stages/pages/life-course

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
  - Improved 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.

Waitematā 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

Waitematā DHB operates as part of the New Zealand health system. Our overall direction is set by the Minister's expectations and the New Zealand Health Strategy (NZHS). We are committed to delivering on the NZHS 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 NZHS themes.

The Northern Region developed its first Long-Term Investment Plan (LTIP), which sets out our region's strategic direction. It identifies the key challenges for the four Northern Region DHBs and sets some 'next steps' priorities for regional planning work, ISSP (and implementation) and capital investment. Thus, rather than supplying a Northern Regional Service Plan, the northern region DHBs will provide the LTIP to the Ministry of Health alongside implementation/action plans that:

- outline the work plans in our areas of focus
- reflect, where possible, the work in focus areas highlighted in the Ministry of Health guidelines
- include clear intervention logic, a link to national strategy and indicators to measure progress

The LTIP, and its complementary addendum, will include implementation plans on how we plan to improve the health outcomes of our population.

Waitematā and Auckland DHBs have a bilateral agreement that joins governance and some activities. Furthermore, collaboration across the three Metro Auckland DHBs allows 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 and quality improvement, while providing greater value for money. To take advantage of this opportunity and extract the full potential from our existing positive elements, we need to collectively move away from silo thinking and working towards sharing and adopting the best of each DHB, and creating the mind set, capacity and will for change.

2018/19 Strategic Intentions

At the Annual Plan workshop in July 2018, the Ministry of Health and Waitematā DHB discussed several priority areas. Strengthening collaboration across the northern region is a key enabler for DHBs to jointly plan long-term health services for the whole population, and is described by our regional LTIP, which supports the northern DHBs to work more closely together. The key work programmes for 2018/19 and beyond are summarised below.

Equity

Waitematā DHB has a strong focus on equity. In 2018/19, we plan to: 1) establish an Equity Framework to further reduce disparities in outcomes; 2) review service and health pathways to fit our Māori, Pacific and high needs groups; 3) work with iwi and our wider community to develop evidence-based practice and target priority populations, e.g. a lung cancer screening initiative in Māori; and 4) support lower paid staff and develop a living wage to improve health outcomes.

Primary and community care

Building on existing relationships with our PHOs, we plan to improve service provision to west Auckland, which has the lowest ratio of GPs to population. Strategies include working with general practices to develop their workforce and more effectively serve their communities by targeting the management of long-term conditions and developing models of care to keep people out of hospital.

Infrastructure

The Mason Clinic, which provides psychiatric forensic services to the northern region, requires significant remediation. Current demand exceeds capacity and, in 2018/19, we need to significantly expand the clinic to continue to regional service delivery.

Mental Health

In 2018/19, we plan to: 1) review services experiencing increased demand, such as health services in prisons, secondary mental health services (e.g. crisis teams) and child and adolescent mental health services; and 2) work closer with PHOs to build stronger partnerships and to develop a primary mental health model.

Hospital services

The northern region's fast growing population places increasing demand on our hospital services. The LTIP is part of the regional response to address current and future demand. Specific areas of concern include: 1) an investment strategy to address current infrastructure needs and the possible need for additional hospitals; and 2) streamline elective services across Auckland to better manage capacity and reduce patient length of stay.

Financial performance

Waitematā DHB faces significant cost pressures in 2018/19 that need to be addressed, including: 1) develop business cases for additional diagnostic radiology scanners to meet the increase in demand; 2) review capital costs for new buildings; and 3) recruit to current workforce shortages, including maternity, sonography, cardiac, anaesthetic technicians and RMOs.

Improving health outcomes for our population

Waitematā DHB's performance framework reflects the key national and local priorities that inform this 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 inequalities in health outcomes (as measured by the ethnic gap in life expectancy).

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.

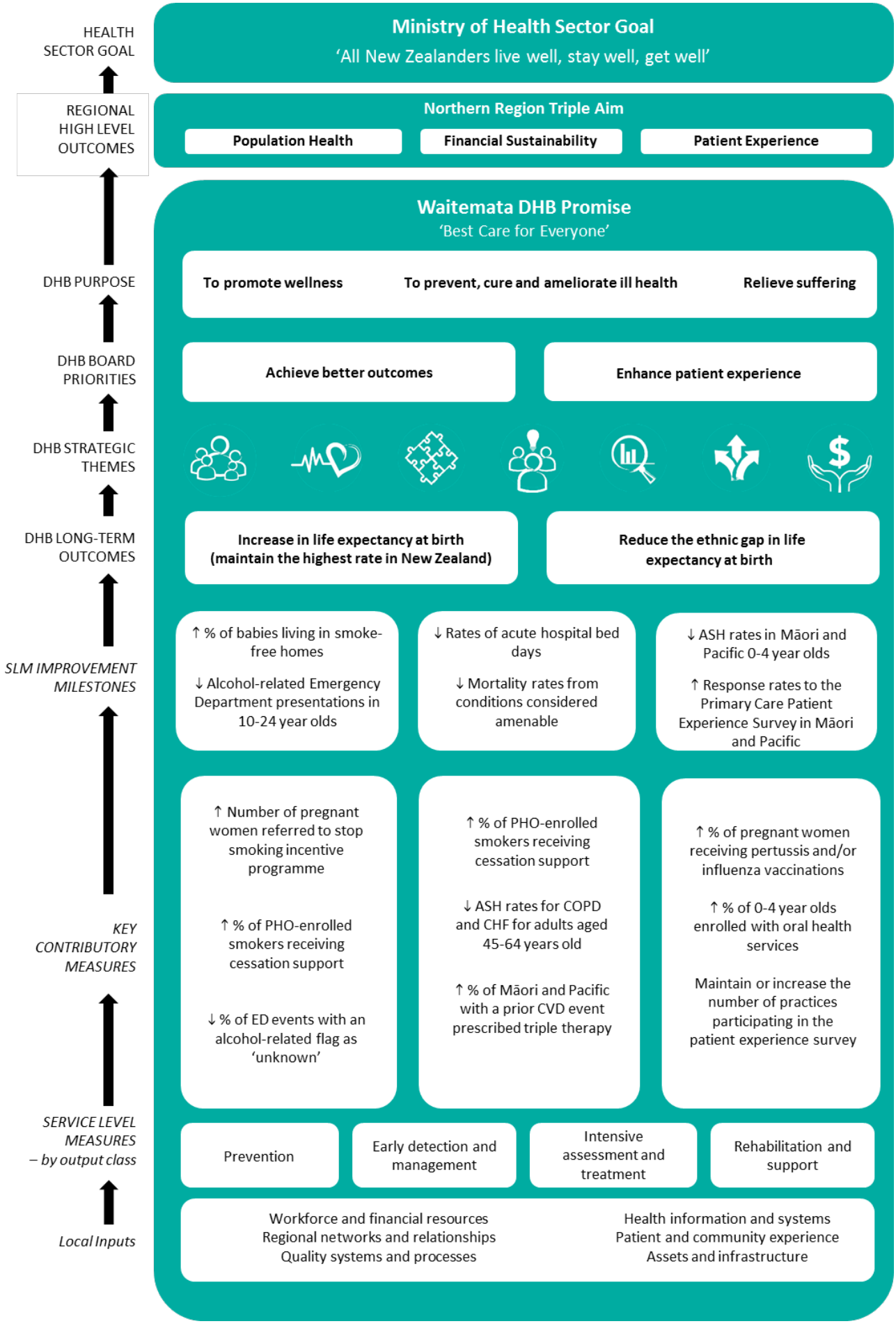
System level measures (SLMs) and contributory measures that will support achievement of these overall goals were identified. We based the SLMs in our performance framework on those set by the Ministry of Health, which align with the five strategic themes of the New Zealand Health Strategy and other national 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, and provide a system-wide view of performance. For each SLM, an annual improvement milestone has been set, and contributory measures identified to measure local progress. The key 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	**Babies living in smokefree homes**	**Ambulatory sensitive hospitalisations**	**Youth Health (Alcohol and drug related harm)✠**	**Amenable mortality**	**Acute hospital bed days**	**Patient experience**
2018/19 improvement milestone	**↑ % of babies living in smoke-free homes**	**↓ ASH rates for Māori and Pacific 0-4 year olds**	**↓ Alcohol-related Emergency Department presentations in 10-24 year olds**	**↓ Mortality rates from conditions considered amenable**	**↓ Rates of acute hospital bed days**	**↑ Response rates to Primary Care Patient Experience Survey (PES) in Māori and Pacific**
Key contributory measures	*↑ Pregnant women referred to stop smoking incentive programme* *↑ % of PHO-enrolled smokers receiving cessation support*	*↑ % pregnant women receiving pertussis and/or influenza vaccinations* *↑ % of 4 year olds enrolled with oral health services*	*↓ % of ED events with an alcohol-related flag as 'unknown'*	*↑ % of PHO-enrolled smokers receiving cesstion support* *↑ % of Māori and Pacific individuals with a prior CVD event prescribed triple therapy*	*↓ ASH rates for COPD and CHF for adults aged 45-64 years old* *↑ % of individuals with a prior CVD event prescribed triple therapy*	*Maintain or increase the number of practices participating in the patient experience survey*

✠ Note: The youth System Level Measure consists of five domains reflecting the complexity and breadth of issues impacting youth health and wellbeing. Waitematā DHB has chosen to focus on the alcohol-related harm domain, starting with improvements in the identification and coding of alcohol-related ED events. Work is ongoing to improve chlamydia testing coverage under the sexual health domain.

Performance and intervention framework



SECTION 2: Delivering on Priorities

Introduction

In May 2018, the Minister of Health wrote to DHBs to set out priorities for 2018/19. 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.

Health Equity

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

The health status of the majority of our population is very good and we are a relatively affluent population. However, some of our population does experience inequalities in health outcomes, with a large proportion living in areas of low deprivation. Ethnicity is the 'strongest' equity parameter. One in twelve (8%) of our total population, but 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.

Waitematā DHB is committed to helping all of our residents achieve equitable health outcomes. Equity has been a focus for our DHB for more than a decade. An Equity Framework for Planning and Funding was developed in 2009, alongside an Equity monitoring framework. Since that time the regional plans and local DHB Māori Health Plan, Pacific Health Action Plan and Asian Health Action Plan have been developed to indicate strategic equity direction, areas of focus, specific activities and monitoring indicators. With the Minister of Health's priority focus on equity it is timely to refresh Waitematā DHB's Equity Framework, particularly with the opportunity to align this with the Ministry of Health Achieving Equity in Health Outcomes work programme. Our CEO is the sector co-sponsor for this work programme alongside the Ministry of Health.

Section 2 identifies specific activities (identified as EOA) designed to help reduce health equity gaps for Māori and other groups, such as disabled people. We are committed to reducing the health equity gap for Māori; more specific information on targeted deliverables will be detailed in the metro-regional Māori Health Plan.

Our performance and intervention framework, detailed in our Statement of Intent in Appendix A, is focused on achieving health equity for all our population. Our overall long-term population health outcome goals are to maintain the highest life expectancy in New Zealand and reduce the difference in health outcomes between ethnic groups. We have identified System Level Measures that will support the achievement of these goals, and monitor these at ethnicity level to track the success of our actions.

Waitematā 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 most significant actions planned for 2018/19 as part of a life-course approach to address local population challenges are labelled with in the Government Planning Priorities.

Government Planning Priorities

Government Planning Priority		Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestone	
Mental Health	Population Mental Health	One team	Assess organisational fit for implementing the Zero Suicide framework and develop work plan to implement (high prevalence of suicide in youth and Māori) (EOA) (adolescence and young adulthood life-course group)	Dec 2018	
			Review current services and create a work plan to develop the capacity and capabilities needed to implement Asian MH approaches in response to population growth (EOA)	Jun 2019	
			Evaluate prototype of Individual Placement Support programme for MHA services	Jun 2019	
			Design an action plan from the Equally Well framework with measurable outcomes using a multi-sector collaboration approach	Jun 2019	
			Support staff to submit and engage in community forums	Ongoing	
			Increase Māori and Pacific access by implementing Awhi Ora Supporting Wellbeing, a non-clinical service walking alongside people in primary care (EOA)	Sep 2018	
			Continue to implement Supporting Parents Healthy Children guidelines (phase II)	Jun 2019	
	Mental Health and Addictions Improvement Activities	One team	Participate in the HQSC project commencing Jun 2018 with the aim to improve service transitions to primary care through ensuring 95% of transition plans/discharge letters contain a follow-up plan (with a copy sent to the person concerned); this activity is supported across all services, including kaupapa Māori and Pacific mental health addiction services (EOA)	Jun 2019	PP7 measures 100% of SAC 1 and 2 recommendations are closed within 90 days
			Participate in the HQSC project commencing Mar 2019 that aims to reduce the occurrence of serious adverse events through ensuring learnings are introduced into clinical practice in a responsive manner, including Māori and Pacific representation in the adverse event investigation and recommendation process (EOA)	Jun 2019	
			Minimise restrictive care through engagement in HQSC Zero Seclusion project activities, with the aspirational goal of eliminating seclusion in inpatient units and a focus on the regional forensic services, which has a high prevalence of Māori patients (EOA)	Jun 2019	
			Implement adequate systems to identify parents across all services	Jun 2019	
	Addictions	Value and high performance	Review the addictions continuum of care to identify capacity and capability opportunities for improved access for service users	Jun 2019	PP8 measures

Government Planning Priority		Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestone	
			Develop lower threshold initiatives for community-based wellbeing support that capitalise on investments already made, such as Awhi Ora and primary mental health initiatives	Jun 2019	
Primary Health Care	Access	Closer to home	Under 14-year-olds to have free access to general practice during regular hours ≤30 minutes travel time: • implement according to the agreed PSAAP process	Dependent on PSAAP timeframe	95% of eligible children aged ≤14 years have zero fee access to general practice during regular hours ≤30 min travel time and after-hours care ≤60 min travel time
			Under 14-year-olds to have free access to after-hours care ≤60 minutes travel time: • negotiate with urgent care clinics and after hours pharmacies for implementation	Dependent on PSAAP timeframe	
			Implement the Community Service Card initiative as per national guidance	Dec 2018	
			Continue to make clinics' fees information publicly available (www.healthpoint.co.nz)	Ongoing	
	Integration	Closer to home	**Alliance** • Continue to develop the Service Level Alliances (SLAs), accountable for developing and implementing integrated service models, and associated work programmes reporting to the Alliance. SLAs in place for: o Rural o After Hours o Diabetes o Maternal and Child Services Alliance (MaCSA) o Youth	Sep 2018	Implement in 50% of general practices by Jun 2019 (prioritise practices with high numbers of Māori and Pacific) 2 FTE Health Coaches by Dec 2018
			• Develop Service Level leadership teams to ensure appropriate representation of key service providers	Sep 2018	
			• The Alliance and all Service Level Alliances will have suitable measures in place to monitor progress for Māori and Pacific populations (EOA)	Jun 2019	
			Workforce • Implement training programme to support improved general practice team skills in assessing and managing the diabetic foot and integrated service with community podiatrists	Jun 2019	Six general practices with high numbers of Māori and Pacific enrolled in the co-design work programme by Dec 2018 Minimum 12 nurses credentialed by Jun 2019
			• Diabetes co-design programme will develop general practice team competency using quality improvement methodology in supporting improved engagement with Māori, Pacific and other high need patients (EOA)	Dec 2018	
			• Run Mental Health credentialing programme for practice nurses	Jun 2019	
			• Evaluate Gerontology Training programme for general practice teams	Dec 2018	

Government Planning Priority	Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestone	
		Metro Auckland Regional Pathways will explore incorporating a reference to the prostate cancer decision support tool within the relevant pathway (see Cancer Services priority in Section 2)	Sep 2018	
		See Immunisation priority in Section 2 for activities on newborn enrolment		
System Level Measures	Value and high performance	The Metro Auckland region has jointly developed and agreed a 2018/19 Improvement Plan to meet jointly agreed Improvement milestones for each SLM	Deliver on actions over 2018/19	PP22: Delivery of actions to improve system integration including SLMs
CVD and diabetes risk assessment	One team	Implement incentive-based CVD risk management contracting to maintain CVD risk assessment rates at 90% and improve secondary CVD risk prevention	Jun 2019	60% of enrolled patients aged 25 to 74 years with known CVD are on triple therapy (aspirational target is 70% by 2022) 62% of PHO-enrolled and eligible patients with diabetes, across all ethnic groups, aged 15-74 years have good glycaemic control (HbA1c ≤64 mmol/mol) recorded in the last 15 months
		Improve foot care services received by people with diabetes living within Waitematā and Auckland DHBs by: • appointing a podiatry professional clinical leader • providing clinical oversight and support for community podiatrists • implementing quality standards • implementing a credentialing framework • implementing a continuing professional development programme	Jun 2019 Jul 2018 Jan 2019 Jun 2019 Jun 2019 Jun 2019	
		Change the diabetes care improvement funding model to support better diabetes outcomes in Māori and Pacific patients with diabetes (EOA); this model allows PHOs and general practices to identify how best to serve their Māori and Pacific patients • develop new service specifications with PHOs • agreements with PHOs in place • review and adjust funding model for 2019/20 (adulthood life-course group)	Jun 2019 Sep 2018 Dec 2018 Jun 2019	
		DHB and PHOs to work collaboratively and to share data on practice- and PHO-level performance against the five Metro-Auckland Clinical Governance Forum (MACGF) prioritised diabetes and CVD clinical indicators[2]; both the DHB and PHOs to identify strategies to support improvement against these indicators at a practice level	Ongoing with quarterly reporting	

[2] The five Metro-Auckland Clinical Governance Forum (MACGF) indicators are in various specific population groups and targets that focus on HbA1c, blood pressure, micro-albuminuria, and primary and secondary cardiovascular disease prevention.

Government Planning Priority	Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestone	
Pharmacy Action Plan	One team	To support the vision of the Integrated Community Pharmacy Services Agreement, we will: • implement the national pharmacy contract arrangements • once agreed, support local implementation of national contracting arrangements • continue to offer smoking cessation service to selected pharmacies to improve access to priority populations, including Māori, Pacific, people with mental illness, pregnant women, and smoking partners (or family living with) pregnant women (EOA)	Oct 2018 Jun 2019 Ongoing	
Support to quit smoking	One team	Contract with each PHO to provide ABC support and resources to their general practices, including training general practitioners, practice nurses and receptionists in using the ABC pathway in their practice so that it is part of business as usual	Mar 2019	90% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months
		Promote the new e-referrals process from general practice to the Stop Smoking Service, which improves the speed and ease of referrals	Mar 2019	
		Include smoking cessation as a contributory measure in the System Level Measure plan activities, including: • promote to primary care the need to refer pregnant women that smoke to stop smoking services, targeting Māori and Pacific (EOA) • employ a Midwife Smokefree Coordinator to improve the quality of ABC and smoking cessation support for pregnant women and their whānau, by engaging with midwifery staff, self-employed LMCs, antenatal services, PHOs and Primary Care practices • fund an incentive programme (up to $350 for a pregnant woman and up to $200 for a whānau member) to supplement the Ministry-funded stop smoking service; the incentive programme is being promoted to primary care • analyse and share with primary care the amount of stop smoking pharmacotherapies they prescribe to drive an increase in their use	Jun 2019	

Government Planning Priority		Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestone	
Child Health	Child Wellbeing	Value and high performance	We have several activities planned to address child wellbeing and highlight only the key ones here		≥30% of Healthy Housing referrals are for eligible pregnant women or whānau with infants (aged <1 year) 90% of Māori and Pacific pēpē receive their first core WCTO check on time 100 families complete the Triple P Healthy Lifestyles programme 80% of Māori and Pacific children receive one application of fluoride varnish by 24 months of age 60% of infants are exclusively or fully breastfed at three months (monitor by ethnicity)
			Maintain and further develop the Maternal and Child Services Alliance (MaCSA) to improve the integration and quality of care pregnant women receive	Ongoing	
			Undertake an end-to-end audit of information flow and agree a minimum standard of information and systems for sharing between midwives, general practice and WCTO during pregnancy and through early infancy	Jun 2019	
			Develop healthy weight and oral health messages and implement a communications and distribution plan	Jun 2019	
			Fully implement the fluoride varnish programme for pre-schoolers	Jun 2019	
			With Te Whānau o Waipareira, develop an approach to increase breast feeding and pilot it (EOA) (early years and childhood life-course group)	Pilot from Jan 2019	
			Develop and implement positive breast feeding messages for Asian women (EOA)	Mar 2019	
	Maternal Mental Health Services	Closer to home	Undertake a stock-take, including funding levels, of community-based maternal mental health services (antenatal and post-natal, including services provided to partners following the birth of their baby)	Dec 2018	
			Identify and report on the number of pregnant women accessing DHB-funded primary maternal mental health services	Jun 2019	
			Ensure that there are clear pathways for referral and treatment, including for women identified with perinatal depression; identify and address access barriers	Dec 2018	
			Co-design and trial the Maternal and Infant Well-being Assessment (MIWA) to support identifying psychosocial issues (e.g. perinatal depression) and increasing access to wrap-around services (e.g. primary mental health) (pregnancy life-course group)	Mar 2019	

Government Planning Priority	Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestone	
		Scope and implement a project to understand and address inequity in mothers accessing MMH services by ethnicity as compared to total births by ethnicity (EOA)	Jun 2019	
Supporting Health in Schools	Closer to home	Complete stock-take of health-funded nursing FTE going into each public primary and intermediate school	Dec 2018	50% of new entrants in decile one and two primary schools are screened for unmet health and wellbeing needs (baseline = 0)
		Ensure services are designed to prioritise increased access for Māori and Pacific children (EOA)	Ongoing	
		Waitematā DHB Child and Family Service and Starship Community to agree to and trial a shared tool to identify unmet health need in new entrants	Jun 2019	
School-Based Health Services (SBHS)	Closer to home	Complete stock-take of the nursing and oral health services provided in all public secondary schools	Dec 2018	
		Establish school-based health services in Rodney College (EOA)	From Feb 2019	
		Engage the leadership of all Waitematā DHB secondary schools regarding future school-based health services and develop an implementation plan for services in all schools to be rolled out from 2019/20, subject to additional funding from MoH	Jun 2019	
Immunisation	One team	Support IMAC and PHOs to develop and roll-out a training programme for primary care practices' non-clinical staff on their role in immunisation, including data quality and engaging with Māori women and whānau (EOA)	Dec 2018	50% of pregnant women (including Māori) receive both pertussis and influenza vaccines 95% of 8-month-old infants (including Māori) are fully immunised 95% of children aged 2 and 5 years (including Māori) are fully immunised
		Refine the hospital discharge summary process for immunisation status to be mandatory and reflect current status	Dec 2018	
		Work with PHOs and NIR to undertake systematic clean-up of practice-level data for 0-5 year olds	Mar 2019	
		Investigate cross-programme synergies and develop a model for co-ordination hub for NCHIP	Jun 2019	
		Utilise NES to improve Māori newborn enrolment with general practice (EOA)	Jun 2019	
		Test NES database access and acceptability	Sep 2018	
		Engage with PHOs and OIS services to draft standard business processes for enrolling all babies with a GP	Mar 2019	
		Plan integration of NES within NCHIP design and roll out	Jun 2019	
		See Building Capability in Section 4 for further information on NCHIP		
	Value and high performance	Complete and evaluate the catch-up MMR programme in five low-decile West Auckland high schools and students in alternative education settings, and apply learnings to improve coverage for Year 7 – 9 school students (EOA)	Sep 2018	97% of consented students are vaccinated

Government Planning Priority		Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestone	
		Value and high performance	Develop and test a smart algorithm to improve on-time immunisation for the tamariki Māori 3-month vaccination event (EOA)	Sep 2018	
			Co-design educational and promotional material to improve Māori community engagement with immunisation, including hapu wahine (EOA)	Dec 2018	
			Expand immunisation service delivery to meet Māori whānau demand for mobile clinics and/or Saturday drop-in clinics (EOA)	Jun 2019	
	Responding to childhood obesity	Value and high performance	Support Māori and Pacific health providers to establish a comprehensive Positive Parenting and Active Lifestyle Programme (PPAL) for children identified as obese via B4SC (EOA)	Sep 2018	100 families engaged with PPAL ≥80% of families engaged with PPAL are Māori or Pacific
			Use a formative evaluation approach to improve engagement of high priority Māori and Pacific families in PPAL (EOA)	Mar 2019	
			Implement an outcomes evaluation of the PPAL in partnership with Auckland University Dietetics services	Jun 2019	
System Settings	Strengthen Public Delivery of Health Services	Value and high performance	Activities that are likely to increase patient access from private to public services or the eligible cohort for public services are labelled with **§** in Section 3		
			See Building Capability in Section 4 for further information on NCHIP		
	Shorter stays in emergency departments	Value and high performance	Implement a review of all 'stranded' patients, i.e. those with a length of stay >10 days (i.e. 'stranded') in general medicine and >20 days in ATRR	Jun 2019	95% of patients admitted, discharged or transferred from an emergency department within 6 hours
			Develop and plan to improve access to acute outpatient clinics from the ADU: next day for general medicine and access to sub-specialty outpatient clinics in a timely manner for acute patients	Jun 2019	
			Ensuring diversity in our workforce to represent out patient population (EOA); please see further details in Section 4, Building Capability, Workforce	Ongoing	
	Access to Elective Services	Value and high performance	Implement patient-focused booking for scheduling first specialist assessment (FSA) appointments across all services within Elective Services	Mar 2019	22,718 elective discharges SI4 measures
			Develop processes, systems and implementation plan for scheduling follow-up appointments using the patient-focused booking process by 2019/20; implement initially within Medical Services	Jun 2019	OS3 elective length of stay Electives and

Government Planning Priority	Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestone	
		Implement perioperative nurse-led coordination and management of all procedure/theatre bookings for Elective Services, including improved coordination of patient flow with clinical guidance and oversight. This will include management of high acuity, high complexity patients, in support of better access to earlier intervention for Māori and Pacific populations (EOA)	Mar 2019	Ambulatory Initiative Elective Services Patient Flow Indicators Reduce DNA rate for FSA in Māori and Pacific by 4% (baseline = Māori 19.3%, Pacific 23.5%)
		Alignment of all Waitematā DHB services to the Elective Patient Access Policy and Guidelines to ensure our standards, key requirements and processes are adhered to for the delivery of planned care	Feb 2019	
	Value and high performance	Develop a work plan for Māori and Pacific Cancer Nurse Coordinators to further support improved cancer outcomes (EOA)	Jul 2018	90% compliance for Māori and Pacific patients on the 62-day FCT pathway
		Work with primary care to provide education and support to implement the prostate cancer decision support tool (see Integration priority in Section 2)	Ongoing	
Cancer Services		With the Northern Cancer Network (NCN), review current resourcing and provision of survivorship care	As determined by NCN	
		Further develop the local delivery of oncology plan; introduce local delivery of zoledronic acid infusions for breast cancer patients	Aug 2018	
		Evaluate the live outcome process in the melanoma MDM and plan to pilot in further MDMs	Evaluate by Aug 2018; pilot planned for Oct 2018	
	Closer to home	**Falls and fracture prevention services** Identify and address barriers to older people being referred to and using the In Home Strength and Balance Programme and the Fracture Liaison Service (FLS) (older people life-course group)	Jun 2019	In-home target = 1,170 FLS target = 1,500
		Undertake promotional activities to increases referrals, particularly from primary care	Ongoing	
Healthy Ageing		**Future Models of Care (FMC) – HCSS** Contribute to the development of the FMC framework and outcomes measures for HCSS	Jun 2019	
		Develop local model of care for HCSS; aligned with FMC framework	Oct 2018	
		HCSS procurement plan based on new model of care approved	May 2019	
		Ensure new HCSS model is accessible and appropriate for Māori and Pacific; prioritise through all components of planning and procurement (EOA)	Jun 2019	

Government Planning Priority	Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestone	
		Drivers – acute demand Coordinated Care, Assessment, Rehabilitation and education (KARE) project in general practice. Evaluation report will include any quantifiable impact on hospitalisations	Dec 2018	
		Implement changes in care processes in ED/ADU/medical wards to enable joined up care, including a geriatrician in ADU and better MDTs processes	Jun 2019	
		Respite Review Prioritise and implement actions from the respite review	Jun 2019	
Disability Support Services	**One team**	A Disability Responsiveness e-learning module is already in place; we will monitor the number of participants and assess its effectiveness by evaluating staff feedback	Ongoing	
		Regularly promote workforce training through the Learning and Development Team, staff information and team meetings to encourage staff to complete the module	Ongoing	
Improving Quality	**Value and high performance**	**Improve equity – diabetes domain** Initiate a co-design project to improve diabetes outcomes for these priority groups: people who are newly diagnosed or have poorly controlled (HbA1c >75 mmol/mol) type 2 diabetes, Māori, Pacific, Asian, and quintile 5 populations with type 2 diabetes	Jun 2019	Improve our results for the national inpatient experience survey for: • the question 'did a member of staff tell you about medication side effects to watch for when you went home' by 10% (baseline = 42% Q4 2016/17) to 46% • the communication domain (baseline = 8.2 Q4 2016/17 to 8.5)
		Other activities to improve equity in diabetes outcomes are listed in the CVD and diabetes risk assessment priority in Section 2		
		Patient experience We have several activities planned to improve patient experience, and highlight only a few here		
		With Auckland DHB, pilot a 'teach back' method with pharmacy staff to improve patient communication regarding medications	Jun 2019	
		With Auckland DHB, develop a communication with compassion programme to enhance verbal and written communication between staff and patients	Jun 2019	
Climate Change	**Value and high performance**	Further develop emissions reduction plan	Jun 2019	
		Complete second year of CEMARS certification	Jun 2019	
		Identify, investigate and pursue emissions reductions projects and activities	Report on stocktake in Dec 2018	
Waste Disposal	**Value and high performance**	**Hospitals** Deliver training in clinical areas to reduce preventable medical waste in accordance with DHB policies on waste management and disposal of pharmaceuticals	Ongoing	

Government Planning Priority	Link to New Zealand Health Strategy	DHB Key Response Actions to Deliver Improved Performance		Measures
		Activity	Milestone	
		Community pharmacy • Develop a schedule of regular waste training for staff to raise awareness on medical and pharmaceutical waste collection and disposal arrangements • Monitor community pharmaceutical waste being collected	Jun 2019 Ongoing	
		DHB • Maintain monthly waste reporting (by stream, tonnage, proportion and hospital), including communication to Senior Management • Identify and investigate waste reduction projects and activities	Ongoing Report on stocktake in Dec 2018	
Fiscal Responsibility	**Value and high performance**	Ongoing identification and implementation of savings initiatives under the Financial Sustainability Programme to ensure long-term financial and operational sustainability and ability to deliver a break even result	Performance to Budget	Financial Performance to Budget
		Enhance financial accountability and financial risk management to ensure mitigations are developed and implemented to deliver planned results	Performance to Budget	
Delivery of Regional Service Plan	**One team**	Clarify the role of our Greenlane site as one of the region's planned activity facilities as part of the regional delivery system	Mar 2019	
		Contribute to the regional work, led by the NRA, to progress a consistent approach by clarifying the model of care for: • vascular – develop a joint recruitment strategy and progress an agreed regional model of care • ophthalmology – develop a plan to share the most effective initiatives and review implications for the regional models of care from the national ophthalmology service improvement initiative • musculoskeletal – scope the plan to develop a regional pathway	Mar 2019 Jun 2019 Dec 2018	

Financial Performance Summary

Statement of Comprehensive Income	2016/17 Audited Actual $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Revenue						
MoH	1,506,695	1,595,378	1,669,254	1,702,367	1,736,275	1,770,239
IDFs & Inter DHB Provider	85,259	86,543	89,409	91,187	93,008	94,822
Other government	10,042	11,024	10,787	11,001	11,220	11,443
Other	25,117	31,752	29,522	30,607	31,183	31,767
Total revenue	**1,627,113**	**1,724,697**	**1,798,972**	**1,835,162**	**1,871,686**	**1,908,271**
Expenditure						
Personnel	604,008	641,786	660,266	671,129	677,913	691,790
Outsourced	76,281	74,166	78,056	79,044	79,734	81,389
Clinical Supplies	118,245	123,940	126,343	127,794	129,102	131,804
Infrastructure and Non-Clinical	41,856	54,541	43,222	28,310	38,341	39,195
Payments to Non-DHB Providers	727,334	778,862	829,731	861,045	878,129	894,991
Interest	6,532	0	0	0	0	0
Depreciation and Amortisation	28,006	29,508	31,407	31,493	32,120	32,755
Capital charge	21,560	36,679	36,947	36,347	36,347	36,347
Total Expenditure	**1,623,822**	**1,739,482**	**1,805,972**	**1,835,162**	**1,871,686**	**1,908,271**
Other comprehensive income	3,291	(14,785)	(7,000)	0	0	0
Revaluation of land and building	(378)	0	0	0	0	0
Total Comprehensive Income/(Deficit)	**2,913**	**(14,785)**	**(7,000)**	**0**	**0**	**0**

Four-year plan

Prospective summary of revenues and expenses by output class	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Early detection				
Total revenue	557,716	568,002	579,387	590,666
Total expenditure	558,074	566,829	575,038	586,232
Net surplus/(deficit)	**(358)**	**1,173**	**4,349**	**4,434**
Rehabilitation and support				
Total revenue	**219,115**	223,156	227,629	232,060
Total expenditure	**218,808**	222,241	225,459	229,848
Net surplus/(deficit)	**307**	**916**	**2,170**	**2,212**
Prevention				
Total revenue	**28,988**	29,523	30,115	30,701
Total expenditure	**29,149**	29,607	30,035	30,620
Net surplus/(deficit)	**(161)**	**(84)**	**79**	**81**
Intensive assessment and treatment				
Total revenue	984,923	1,003,088	1,023,193	1,043,111
Total expenditure	991,711	1,005,092	1,029,792	1,049,839
Net surplus/(deficit)	**(6,788)**	**(2,004)**	**(6,599)**	**(6,727)**
Consolidated surplus/(deficit)	**(7,000)**	**0**	**0**	**0**

The methodology used to create the above information is being reviewed during the 2018/19 financial year, in conjunction with Audit New Zealand, and external professional accounting advisors.

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.

Waitematā DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2018/19.

Activities that are likely to increase patient access from private to public services or the eligible cohort for public services are labelled with **§** in the table below; these activities support our Strengthen Public Delivery of Health Services priority in Section 2.

Ability to enter into service agreements

In accordance with section 25 of the New Zealand Public Health and Disability Act, Waitematā 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

Waitematā and Auckland DHBs will continue to engage with the agreed national process to develop and implement a new contract to deliver integrated pharmacist services in the community.

We will continue to support the vision of the Pharmacy Action Plan by working with pharmacists, consumers and the wider health sector (e.g. primary health care) to develop integrated local services that make the best use of the pharmacist workforce.

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** A review of the DHB-funded Stop Smoking services has been completed; currently awaiting approval of the recommended changes	Align DHB services with MoH's new Stop Smoking Services and potentially address any gaps in service	Local (Waitematā and Auckland DHBs)
Review and change in service	**Consumer Council** As per our commitment in the Annual Plan, the DHB is in the process of setting up a Consumer Council, which will provide a new mechanism for consumer input into the DHB decision-making process from early 2019. This will necessitate the review of current mechanisms to manage community engagement, including review of the Healthlink contracts and functions	Ensure a structured mechanism is in place for ongoing consumer involvement in patient and whānau centred care, quality and patient safety	Local – Waitematā DHB
Change in service delivery model and potential change of provider(s)	**Home and Community Support Services (HCSS)** Procurement for this service will commence within 2018/19	Improved delivery of services to increase responsiveness and flexibility and better respond to client needs	Local (Waitematā DHB)
Cessation of service	**Day Activity Programmes** (non-dementia) The intention is to end these contracts on 31 December 2018	A review of these services found that these programmes have a weak evidence base and current contracts are historical with no clear rationale for their size or distribution, and have unclear aims. Recommendation was to disinvest funding	Local (Waitematā and Auckland DHBs)
Potential change in model of service delivery	**Community Pharmacy** DHBs will work towards different contracts for the provision of community pharmacist services by working with consumers and other stakeholders to develop service options, including potential options for pharmacist service delivery	Enhanced services for consumers	Local (Waitematā and Auckland DHBs)
	Community Pharmacy Business case in development for consideration by RFF and a proposed consultation for Q1/2 2018/19 for an enhanced pharmacy service to achieve safe and consistent medicine distribution and management for patients residing in aged-related residential care and community residential care (reducing 128 pharmacies currently providing this service to 4-10 pharmacies)	More consistent and safer service for patients	Local (Waitematā and Auckland DHBs)
Review and change in service	**Termination services** Review and change service in response to 2017 Abortion Supervisory Committee report		Metro Auckland DHBs
Level, location and configuration of services	**Maternity Services** Commissioning of an additional Waitematā DHB primary maternity facility	• Improved birthing options for local population • Promotion of normal delivery in community setting	Waitematā DHB
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

Type of service change	Description of service change	Benefits of Change	Change for local, regional or national reasons
Refinement in service design	**Rheumatic Fever** Including: • Rapid response clinics • School-based service Other components of service	• Service design informed by evaluation • More targeted service delivery	Local (Waitematā and Auckland DHBs)
Response to service gaps	**At risk 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 well-being outcomes for infants	Local (Waitematā and Auckland DHBs)
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	**Cardiac Lead extraction** Discussions regarding the establishment of a specification for service not previously provided by DHBs and to confirm role of Auckland DHB as supra-regional or national provider were initiated with the MoH and DHBs nationally during 2017/18; to progress in 2018/19	• Improved outcomes associated with high service quality • Equitable access to service	Local, regional, potentially national
	Implantable device follow-up service Auckland DHB cardiac physiology has signalled withdrawal of the implantable device follow-up service to Northland DHB. A handover process has been agreed and this will be phased from October 2018 to February 2019. It is noted that the transition of this service requires employment of an additional cardiac physiologist at Northland DHB. Auckland DHB is working closely with Northland DHB to provide training support and, post-transition, will remain in the role of complex teaching and auditing as required		Local, regional
	Regional vascular service The vascular team has begun preliminary conversations regarding a regional vascular service. These conversations have been at a clinical level at this stage, with early agreement in principle from both Counties Manukau DHB and Auckland DHB that there is merit to continuing to pursue an agreed regional MOC in the long term. Initially there will be moves to develop a weekend on-call vascular service regionally		Local, regional
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 commenced with a first phase for Waitakere population from July 2017 progressing to include all Waitematā DHB and Counties ManukauDHB patients, with telestroke service available to Northland DHB patients – in progress during 2017/18, further implementation	• 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
	in 2018/19 • Clot retrieval to operate from Auckland DHB for all northern region DHB patients and initiate planning for the Midland region population – in progress during 2017/18, further implementation in 2018/19		
	Stroke care/rehabilitation • Revised model of care, agreed regionally - local stroke rehab delivery – all ages • Proposed integrated Stroke Unit for NSH (business case being finalised) 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) – in progress during 2017/18, further implementation in 2018/19	• Streamlined pathway • Equitable access to rehabilitation services • Consistent quality of care delivery	Regional Local (Waitematā and Auckland DHBs) Local (Waitematā and Auckland DHBs)
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) with increased volumes added to current contracts with PHOs and NHO RFP process completed to allocate new Ahi Ora services to NGO providers Completed Fit for the Future Project to evaluate new services introduced with report provided to MoH by September 2018	Increased access to Primary MH services	Local (Waitematā DHB)
	High and Complex Residential Services New purpose built service with 16-bed capacity, planned opening was September 2017, but has encountered significant delays in gaining building consent with interim service provided for up to 12 patients on two separate sites	• Increased access to appropriate treatment and rehabilitation services for people with high and complex needs • Reduced demand for Acute and Hospital Inpatient Services	Local (Waitematā DHB)
Cessation of service	**Forensic Step Down (regional forensic service)** Exited NGO service provision of Forensic Step down service and intend to go to the market to identify a new regional provider for 5 beds during 2018/19 • Kaupapa Māori community residential forensic step down service • available to anyone across the Auckland region, exiting Mason Clinic.		Regional (at Waitematā DHB)
Change in funding arrangements	**Regional AOD contracts** Financial and clinical sustainability issues: • Auckland City Mission – increased funding by $250K as an interim urgent response, but another $300K is likely to be needed • Wings Trust increased funding again by $225K per annum for Regional AOD Support Services We have completed work to understand the impact of assets on contract value in Auckland and Waitematā DHB, this is reflected in the		Regional

Type of service change	Description of service change	Benefits of Change	Change for local, regional or national reasons
	urgent funding increases to keep services in place while we develop a more sustainable plan for the Boards. A concept paper was tabled with the Audit and Finance Committee in June 2018.		
Shift in service	**ORL Services** Further progress regional review of ORL and Head and Neck services across Northern region commenced in 2017/18 with the potential to reconfigure current services provided at Waitematā DHB	• Improved sustainability of local and regional services • Improved patient outcomes	Regional and 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 Waitematā DHB in response to new Hep C treatment The number of patients referred for hepatitis C was considerably less than predicted. The Pharmac funding of Pangenotypic therapy drug and not by limited to genotype should provide access to a greater number of patients	• 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 to provide more seamless care • Planning in 2017/18, for implementation in 2018/19	• Improved integration between hospital and hospice • Consistent quality of care • Improved access • Workforce development	Local
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 Suparegional EDS services except residential service. Service has adjusted capacity accordingly; however, no service reduction is expected for the Northern region populations Review of service capacity for further consideration of future service change	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** Establish the agreed single bariatric pathway across Waitematā and Auckland DHBs, including best practice multidisciplinary team patient selection, standardised assessment and support processes (with psychology input)	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 (Waitematā and Auckland DHBs)
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	Provision of more flexible, accessible patient-centred services. Better use of new technology to deliver cost effective and efficient	Local (Waitematā and Auckland DHBs)

Type of service change	Description of service change	Benefits of Change	Change for local, regional or national reasons
	delivery. Projects underway include satellite and nurse-led clinics, Telehealth, Community-based IV infusions and patient-generated follow-ups	services	
Integration of services	**Siloendoscopy** Regional discussions underway to agree provision of this service going forward to ensure appropriately funded at Counties Manukau DHB or other DoS in 2018/19	Regional service capacity developed in a planned and cost effective manner	Local (Waitematā and Auckland DHBs) Counties Manukau DHB?
Increase in service access	**Refugee Primary Care Wrap Around Service Agreement** New service component starting in 2018/19 to increase GP access for patients with refugee and asylum seeker backgrounds (one annual 90-minute consultation each), funded by reconfiguration of existing budgets	Improved access	Local (Waitematā and Auckland DHBs)
Change in location	**Interventional Radiology Services** Work with Auckland DHB to explore a more integrated service delivery model to support sustainable provision of Interventional Radiology Services for the Waitematā DHB population		Local (Waitematā DHB)

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 key Ministry of Health performance measures; monthly reporting against Annual Plan deliverables; weekly Ministry indicator 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

Waitematā DHB has a formal risk management and risk escalation framework. Our Risk Management Strategy clearly documents risk management principles and provides a framework that enables an organisation-wide consistent approach to risk management.

We continue to monitor our risk management practices to ensure we meet our obligations as a Crown Entity, including compliance with the risk standard AS/NZS ISO 31000:2009 Standard for Risk Management.

The Corporate Risk Register is the repository for the most significant risks faced by Waitematā DHB, underpinned by a structure of Division and Service risk registers. The Corporate Risk Register is reviewed by the Board's Audit and Finance Committee quarterly, providing assurance on the management of these significant risks. It is operationally managed at executive leadership level and is reviewed monthly by the Senior Management team.

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, focused on the individual needs of every patient and their whānau and that aims for equity of health outcomes. To achieve our quality vision, the DHB has set four aims that reflect key elements of quality:

Safe care – there will be no avoidable harm to patients from the care they receive, which will be provided in an appropriate, clean and safe environment at all times.

Effective care – the most appropriate treatments, support and services will be provided at the right time to those who would benefit, to achieve the best possible health outcomes and eliminate wasteful or harmful variation.

Person-centred care – each patient and their whānau will experience compassionate care, they will feel informed, supported and listened to, and they will be engaged and involved in their care. There will be mutually beneficial partnerships between patients, their whānau and those providing healthcare services.

Equity of health outcomes – there will be continuous improvement in equity of health outcomes, quality and value.

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

The Institute for Innovation and Improvement (i^3) helps us to realise our Boards' priorities of improving health outcomes and patient and whānau experience. The i^3 brings together people with a wide range of expertise and experience to support clinicians, patients and whānau lead care redesign and best practice innovation and improvement. The i^3 promotes and supports person-centred design to ensure what matters to our patients, their whānau and our community is at the heart of service design, delivery and improvement, and facilitates the rapid development, testing and implementation of ideas and innovations.

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.

We share our quality improvement activities with our community through our online Quality Accounts http://www.qualityaccounts.health.nz/ and the i3's website http://i3.Waitematādhb.govt.nz/.

Asset management

The 2016 Investor Confidence Rating (ICR) assessment led by the Treasury assigned Waitematā DHB an ICR of 'B', which exceeds the 'C' rating expected of a Tranche 2 organisation. Waitematā DHB's asset management maturity was rated as middle intermediate against a long-term target of lower advanced. The key improvement areas identified through the ICR are outlined below, including the actions that are underway to improve Waitematā DHB's asset management maturity.

- Updated Asset Management Policy, Strategy and Plan - with improved linkages to the DHB's strategic priorities and identification of asset management objectives and targets. The policy will be updated to link more closely with the new strategy and the Asset Management Plan (AMP) will provide more information and planning at a clinical division level.
- Identification of Critical Assets - assessments are underway, commencing with the identification of critical clinical equipment and building services, starting with the higher acuity clinical services.
- Asset Levels of Service and Asset Performance Measures - several new measures across the three asset portfolios (Clinical Equipment, Facilities and ICT) have been identified and will be monitored from 1 July 2018. Performance targets will be set in 2019/20.
- Asset Management System upgrades and integration- to improve understanding of asset maintenance and renewal activities and costs and to provide a single organisational view for strategic asset planning.

Regional long-term investment plan

The Northern Region has recently completed the first Northern Region Long Term Investment Plan (NRLTIP, January 2018). The plan details regionally prioritised investments over a 10 to 15 year timeframe within the context of a 25-year horizon. The NRLTIP sets the Northern Region strategic investment path, and supports the Region to deliver optimal health gain for the Northern Region's population within available resources.

The NRLTIP identifies three investment themes for the Northern Region:

- Fixing our current facilities to ensure they are fit for purpose. This includes the concepts of asset resilience, renewal and refurbishment
- Future proofing our capacity for expected demand. This recognises that there are lead times of 5 to 10 years for some asset developments and that these cannot be developed in crisis
- Accelerating model of care change programmes. This includes enhancing levels of service and transformative change.

The NRLTIP signalled an immediate requirement for a significant lift in our Region's capital expenditure; particularly to address the issues identified against the NRLTIP 'Fix' and 'Future-proof' themes. Significant and urgent investment is needed in the Northern Region to ensure population health needs are met and to ensure the sustainability of existing health services.

The plan was developed under our regional governance structure with contribution from the region's clinical networks, clinical governance groups and other region wide work groups; these workgroups included representation from across the continuum of care and from within different health care settings. The NRLTIP Programme Steering Group ensured a collaborative approach to the planning work and, in addition to regional health sector representatives, included local representation from Auckland Council as well as national representation from the Ministry of Health and Treasury.

The NRLTIP investment logic is strongly aligned with the Northern Region's strategic direction as outlined in the Northern Region Service Plan 2018/19 and in each DHBs' Annual Plans. It directly reflects the Northern Regional Intervention Logic and Regional Business Objectives to ensure that the investment plans, that shape the capital works to be progressed across our region, are based on a shared view of the priorities for our region.

Shared service arrangements and ownership interests

Waitematā DHB is involved in two 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.

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

Waitematā 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

Capital and Investment Development

Waitematā DHB is progressing planning and business case development for several major capital programmes over the next 12 to 18 months. These include a new Elective Capacity and Inpatient Beds facility on the North Shore, the first tranche of the redevelopment of the Mason Clinic campus, development of interim additional capacity at Waitakere Hospital prior to the major hospital redevelopment, replacement of critical infrastructure at both Waitakere and North Shore Hospitals, and the development of an Integrated Stroke Unit at North Shore Hospital.

Business cases requiring Crown funding and/or >$10m are subject to approval by joint Ministers.

Information communication technology

Information systems are fundamental to our ability to meet Waitematā'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.

Waitematā's IT Plan for 2018/19 leverages previous IT investments and aligns to the regional Information Systems Strategic Plan. The Plan has five core themes:

Mobility for clinicians

- Smartpage roll-out to House Officers 24/7. Implement the task management and messaging application which will replace pagers.
- MyPatientList enhancements and roll-out – a mobile application which allows clinicians to view core clinical data for current inpatients.

Core clinical systems

- eOrders for Laboratory. Extension of the clinical point-of-entry eOrders system, currently used for Radiology and Phlebotomy.
- Clinical Portal optimisation. Increase access to clinical information using a new functionality in Portal 8.
- Core Hospital Clinical systems. Scope potential solutions and propose next steps toward HER.

Point-of-care decision support

- Inpatient Snapshot enhancements and regional (CMH) roll-out – comprehensive, integrated view of clinical information for inpatients.
- Ward Whiteboard/Capacity at a Glance upgrade. Additional capability in these tools to improve patient flow, leveraging our clinical data sources.
- Identity authentication. Piloting an application (Imprivata) which makes system log-in for clinicians fast and seamless.

Data visualisation and discovery

- Embedding Qlik Sense. Future-proofing our data exploration capability.
- Predictive analytics. Developing predictive analytics capability to make best use of our clinical datasets.
- Implementation of the National Child Health Information Platform (NCHIP). Collation of child health data across the region to increase planned childhood interventions. Key NCHIP milestones include contractual baselines established by November 2018, testing to commence by March 2019, and NCHIP to go live by June 2019.

Patient engagement

- Outpatient Flow Tools. Acquisition of apps to enable patient-centred outpatient booking, new communication modes, and improved outpatient experience.
- Telehealth. Trialling a tool (Zoom) to support telehealth patient contacts and remote conferencing.
- Patient engagement system rollout – providing iPads for inpatients with access to a customised desktop.

Workforce

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. Programmes below reinforce our commitment to equity-based, good employer achievements.

Culture, Leadership and Development of our People

At our DHB, everyone matters. For our staff we commit to supporting their care of patients and their whānau through service collaboration and improvement; systems to support workload and staffing management; education and development; and wellbeing. We are seeing rapid global change in clinical, technological and social spheres and Waitematā DHB is evolving quickly with innovation, creativity and change agility. To reliably build and repeatedly enable these capabilities in our workforce, there is a strategic focus on Organisational Values, Leadership, and systems level Workforce Development.

A key achievement in becoming a values-led organisation is to define the culture through the development of a shared set of values, standards and behaviours. Co-created with patients, their whānau, and staff, our values are a reflection of what it is we want to see from each other, and a guide for how we conduct our business.

The Values Programme is an ongoing commitment to our promise of providing the 'Best Care for Everyone'. The aim of this programme is to foster a culture of compassion, connectedness and equity in order to improve health outcomes and patient experience. Programmes of work over the next 2 years focus on: culture and innovation; patient experience; high performance ways of working and health leadership.

Leadership

Our approach to leadership development is aligned to our Waitematā DHB purpose, promise and values, underpinned by the State Services Commission's Talent and Leadership Framework, and consists of three developmental stages: Aspiring Leaders, Emerging Leaders and Executive Leaders. Leading our values programme work will be a key focus for our Senior Leadership team, starting with Leadership walk rounds, staff forums and blogs. We are specifically working with our clinical teams on models of supervision and with our clinical directors on development needs for their roles.

Workforce Development

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 Youth, Māori and Pacific workforces, cultural competency and supporting the needs of older staff and staff with disabilities. The DHB has an active Healthy Workplaces Strategy which guides actions and support for our staff wellbeing. We support the workforce objectives identified in the Northern Region Health Plan and as guided by Health Workforce New Zealand.

The DHB also works in partnership with our Public Health Physicians in the Health Outcomes team and Institute for Innovation and Improvement to ensure health needs assessments and measures respond to population level health issues and outcomes.

Cooperative Developments

In addition to these key strategic initiatives, several integrated regional, national and international cooperative partnerships enable our organisational performance:

- Youth Pledge employment partnership with Auckland Council
- National collaboration on a comprehensive range of system wide improvements, encompassing capability development, technology to meet our changing educational needs, graduate pipelines and leadership development
- Growing the capacity and capability of our Māori and Pacific workforces, with focus on pathways into health careers, retention of current workforces and support of active mentoring and collaboration networks.
- Educational partnerships with New Zealand's health workforce tertiary providers, including joint venture training and research partnerships with New Zealand's cutting edge tertiary institutions.

Organisational Health, Safety and Wellbeing

At Waitematā 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 reflects 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 Organization'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 focusing on diverse elements: 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.

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 practices.

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.

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

Workforce

Healthy Ageing Workforce

Waitematā DHB has an advanced programme to identify and support the education and training of workforces that deliver care to older people. Our Residential Aged Care Integration Programme (RACIP) provides education, consultation and advice to community-based carers, Registered Nurses and Health Care Assistants in community settings across our district. A planned level of education and support is delivered by the Waitematā DHB Nursing Development Primary Health Care team. The service is also responsive to areas of special need.

Training, in the form of seminars resources and guides are developed in partnership with the whole care team, patients and whānau. Consultations, advice and assessments are provided by a team of Geriatric nurse specialists either in person or over the phone.

Health Literacy

A Health Literacy paper was endorsed by the Waitematā and Auckland DHBs' Community and Public Health Advisory Committee in 2015 to put in place a health literacy framework across both DHBs. This project has progressed through a joint steering group that focused initially on developing patient information through adopting the Rauemi Atawhai good practice guidelines.

In 2018/19, we will further embed these practice guidelines into day-to-day operations. A health literacy policy will be developed to further drive health literacy activities and guidance, including the initiation of health literacy staff training, such as the 'teach back' method.

Working with pharmacies at Waitematā and Auckland DHBs, we plan to implement the teach back method to increase staff communication with patients regarding medication side effects at hospital discharge (see Section 2). This programme will act as a prototype for other health information and communication.

Midwifery Workforce

Provision of Midwifery care and support for the growth and retention of the workforce continues to be a priority for Waitematā DHB. Locally, the DHB is focusing on implementing the recently revised maternity model of care which includes the introduction of additional staffing, providing the best quality learning experiences to undergraduate students, and running our Quality Leadership Programme for all core midwives.

A Midwifery Workforce plan was agreed across the region and includes the following actions:

- Providing flexible (24/7) student placements
- In collaboration with AUT, joint appointment of clinical coaching roles to support undergraduate and newly qualified midwives
- Focus on study pathways and continuing investment to appropriately support Māori and Pacific students.

Community-Based Attachments

Community-based attachments are an important part of the DHB's training towards our future medical workforce.

Waitematā DHB currently has five community-based attachments with a further 12 planned over the next three years. Current placements reflect a variety of experiences, including rural and urban general practice, urgent care, mental health and Māori health. Future placements would build on these including community paediatrics, public health, rehabilitation as well as additional Māori health, mental health and general practice placements.

Care Capacity Demand Management

Waitematā DHB has been a participant in the Care Capacity Demand Management (CCDM) for some years. There is a refocus in 2018 to meet the new requirements of the Safe Staffing Healthy Workplace (SSHW) Unit.

Waitematā DHB has an established governance framework through the CCDM Council and local Core Dataset groups. An annual plan was submitted to the SSHW Executive and resources were organised to deliver to the timelines and outcomes. This includes completion of the Variance Response Management (VRM) review by December 2018 and commencement of the FTE methodology review from February 2019. There was good progress to improve data accuracy using the acuity system and use of workload information daily to inform decisions about resourcing and demand matching.

There is good engagement with staff and the unions to ensure that Waitematā DHB achieves the expected CCDM outcomes. The programme is focused on the Medical, Surgical and Child Women and Family Divisions in the first instance; Mental Health and other areas will be included over time. Waitematā DHB is committed to complete CCDM implementation by June 2021.

Information Technology

The New Zealand Digital Health Strategy aims to support its vision for health technology by lifting capability in five areas: 1) accessible, trusted information, 2) access and connectivity, 3) collaboration and workflow, 4) data insights and 5) consumer experience.

The Regional ISSP strategy divides into four portfolios of work to improve our digital capability:

- Modernise and strengthen our ICT foundations
- Simplify, harmonise and rationalise our layers of applications
- Become experts at interoperability for data sharing and system connectivity
- Work effectively as a capable region.

Waitematā DHB's ICT plan for 2018/19 will lift the digital capabilities within hospitals with extension of the eOrders system for Laboratories, optimisation of Clinical Portal and piloting an identity authentication tool. Waitematā DHB continues to lead the way in developing the digital hospital, including leveraging our investment in clinical systems with the Inpatient Snapshot and MyPatientList. The discovery work in core clinical systems should assist in simplifying and rationalising our applications, and further improving clinical workflow. Waitematā DHB's IT and clinical change staff will continue to contribute to both national and regional digital work plans and advisory/working groups as required.

This ensures alignment in overall direction as well as providing input from our experience and expertise. Developing predictive analytics will contribute to the Digital Health Strategy's data insights capability. Waitematā DHB is contributing to the NCHIP implementation, which is scheduled to be completed in the 2018/19 year. Key NCHIP milestones include contractual baselines established by November 2018, testing to commence by March 2019, and NCHIP to go live by June 2019. We are supporting Auckland and Northland DHBs' plan to join the regional clinical portal platform.

Key activities for 2018/19 include:

- commence transition of the on-premise infrastructure into IaaS private cloud public cloud offerings in April 2019
- implement the New Zealand Post Statement of Accuracy standard and outsource the mailing of letters by February 2019
- implement Health Care Pathways into Clinical Portal 8, commencing in February 2019
- develop a Nursing Snapshot for desktop and mobile for trial in December 2018
- upgrade mobile application MyPatientList, including secure clinical phots in December 2019
- commence implementation of SmartPage 24/7 for House Surgeons in October 2018
- upgrade PatientTrack (eVitals) in December 2018
- evaluate the implementation of Precision Driven Health models commencing January 2019.

Our 2018/19 ICT plan supports provision of clinical services via digital technology. The telehealth trial of Zoom will enable remote patient visits, MyPatientList will allow clinicians to access their core inpatient clinical record from anywhere, VoiceToText enables clinicians to dictate patient documents from their smartphones and the regional Enterprise Mobile Management platform (Secure Hub) provides safe transfer of the information. The Leapfrog Outpatient Flow Tools project will have the patient email validation tool implemented and will have completed a procurement process by the close of 2018/19. These will contribute to all of the New Zealand Digital Health Strategy capabilities.

SECTION 5: Performance Measures

2018/19 Performance measures

The following table presents the full suite of Ministry of Health 2018/19 non-financial reporting indicators. 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 useful in monitoring progress and achievement.

Performance measure		2018/19 target
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes	
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	3.49%
	Age 20-64	3.43%
	Age 65+	2.01%
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%
	Report on activities in the Annual Plan	
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
	Report on activities in the Annual Plan	
PP10: Oral Health - Mean DMFT score at Year 8	Ratio year 1	0.61
	Ratio year 2	0.61
PP11: Children caries-free at five years of age	Ratio year 1	67%
	Ratio year 2	67%
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	Implement actions from Living Well with Diabetes	
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator)	62%
Focus area 3: Cardiovascular 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	>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 and 99% within 3 months	>95% 99% within 3 months
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF	85%

Performance measure		2018/19 target
	Composite Post-ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance, all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and those with LVEF <40% should also be on a beta-blocker (5-classes)	>85%
Focus area 5: Stroke Services	10% or more of potentially eligible stroke patients thrombolysed 24/7	10%
	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%
	60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team i.e. RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge	60%
PP21: Immunisation coverage	% of two year olds fully immunised	95%
	% of four year olds fully immunised	95%
	% of eligible girls fully immunised - HPV vaccine	75% (2005 birth cohort)
	% of the population aged 65 years and over who are immunised against influenza annually (measured at 30 Sep)	75%
	Report on activities in the Annual Plan	
PP22: Improving system integration including SLMs	Report on activities in the Annual Plan	
PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan	
	Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4–6 for assessment urgency	Establish baseline
PP25: Youth mental health initiatives	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 of: • 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 child well-being	Report on activities in the Annual Plan	
PP28: Reducing Rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever	≤0.7 per 100,000
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	95%
	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
	90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days	90% within 14 days 100% within 30 days
	70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days	70% within 42 days 100% within 90 days
	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

Performance measure		2018/19 target
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%
	Report on activities in the Annual Plan	
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 support to quit smoking	95%
PP32: Improving the quality of ethnicity data collection in PHO and NHI registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT)	
PP33: Improving Māori enrolment in PHOs	% of Māori population enrolled with a PHO	90%
PP36: Reduce the rate of Māori on the Mental Health Act: section 29 community treatment orders	% of the Māori population under community treatment orders s29 of the Mental Health Act	↓ by 10%
	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	70%
PP39: Supporting Health in Schools	Report on activities in the Annual Plan	
PP40: Responding to climate change	Report on activities in the Annual Plan	
PP41: Waste disposal	Report on activities in the Annual Plan	
PP43: Population mental health	Report on activities in the Annual Plan	
PP44: Maternal mental health	Report on activities in the Annual Plan	
PP45: Elective surgical discharges	22,718 of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	22,718 discharges
SI1: Ambulatory sensitive hospitalisations	Age group 0-4 years (SLM measure)	See our 2018/19 SLM Improvement Plan
	Age group 45-64 years (SLM contributory measure)	See our 2018/19 SLM Improvement Plan
SI2: Delivery of Regional Service Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region	
SI3: Ensuring delivery of Service Coverage	Report progress 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 procedures	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 coverage	80% coverage for all ethnic groups and overall	80% coverage for all ethnic groups and overall
SI11: Improving breast screening rates	70% coverage for all ethnic groups and overall	70% coverage for all ethnic groups and overall
SI12: SLM youth access to and utilisation of youth appropriate health services	See System Level Measure Improvement Plan	
SI13: SLM number of babies who live in a smoke-free household at six weeks post natal	See System Level Measure Improvement Plan	
SI14: Disability support services	Report on activities in the Annual Plan	
SI15: Addressing local population challenges by life course	Report on activities in the Annual Plan	
SI16: Strengthening Public Delivery of Health Services	Report on activities in the Annual Plan	
SI17: Improving quality	Report on activities in the Annual Plan	
SI18: Improving newborn enrolment in General Practice	55% of newborns enrolled in General Practice by 6 weeks of age	55%
	85% of newborns enrolled in General Practice by 3 months of age	85%

Performance measure			2018/19 target
	Report on activities in the Annual Plan		
OS3: Inpatient Length of Stay	Elective LOS	The suggested target is 1.45 days, which represents the 75th centile of national performance	1.49 days
	Acute LOS	The suggested target is 2.3 days, which represents the 75th centile of national performance	2.4 days
OS8: Reducing Acute Readmissions to Hospital			Improve from baseline (12.8%)
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections			
Focus area 1: Improving the quality of identity data within the NHI	New NHI registration in error (causing duplication)		Group A >2% and ≤4%
	Recording of non-specific ethnicity in new NHI registrations		>0.5% and ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value		>0.5% and ≤2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1		>76% and ≤85%
	Invalid NHI data updates		TBA
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		

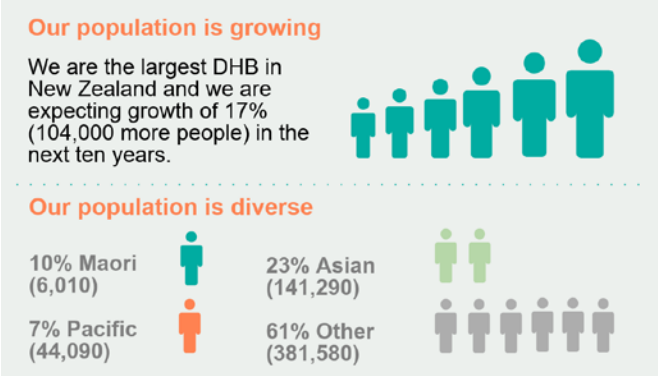
DV developmental measure; ***HS*** health strategy; ***OP*** output; ***OS*** ownership; ***PP*** policy priority; ***SI*** system integration

Appendices

About Waitematā DHB

Who we are

Waitematā DHB is one of 20 DHBs established under the Health and Disability Act (2000). Waitematā DHB is the Government's funder and provider of health services to the estimated 630,000 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 Waitematā 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 Waitematā residents are Māori, 7% Pacific, and 23% are Asian. Our Asian population is proportionally our fastest growing population, and projected to increase to 27% of the total in the next ten years.

Waitematā's population is generally healthier than that of New Zealand as a whole. We have the highest life expectancy in New Zealand at 84.1 years, with an increase of 3.5 years since 2001. Our obesity rates are lower than national rates, but more than half of our adults are overweight (61%) and over a quarter of our adults are classified as obese (26%). Thirteen percent are current smokers.

(New Zealand Health Survey 2016/17).

Cancer is the most common cause of death (32%), and there are over 3,500 new cancer registrations in Waitematā 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 in those aged under 75 are amenable through healthcare interventions (45% or 472 deaths in 2015).

The boundaries of Waitematā 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.

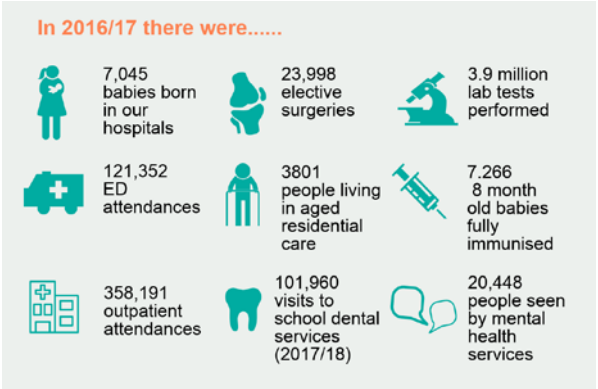
What we do

Waitematā 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 Waitematā DHB.

We have a budget of $1.799 billion in 2018/19.

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 metro-regional Māori Health Plan.

Māori Health Gain

Waitematā DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. 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 high priority members of our communities.

Waitematā DHB will continue to co-develop and deliver a metro-regional Māori Health Plan. While we are proud of our achievements for our Māori population, the continuation of a Māori Health Plan enables us to remain focused in the pursuit of Māori health gain as well as greater and more meaningful collaboration and sharing of intelligence across DHBs in terms of Māori health.

Equity

While the Waitematā population overall has the longest life expectancy in New Zealand, Māori and Pacific people have life expectancies of 3.8 and 6.8 years, respectively, lower than the population as a whole.
Waitematā 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.

Waitematā 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, Waitematā 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 ageing population – the population will increase to approximately 734,000 over the next ten years, and the 65+ population will almost 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 Waitematā 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

Waitematā 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.

The New Zealand Health Strategy provides DHBs with a clear direction and road map to deliver more integrated health services. Waitematā 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 our annual plan.

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

Regional

The Northern Region Health Plan (NRHP) was developed by the four Northern Region DHBs and primary care Alliance Partners, and provides an overall framework to meet the Government's objectives and the region's priorities each year.

The Northern Regional Alliance (NRA) oversees the NRHP. The NRA ensures 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 NRHP is to achieve gains across the Triple Aim Framework, the New Zealand Health Strategy themes, and equity.

Sub-regional

Waitematā 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. There is also further collaboration across the three Metro Auckland DHBs, which allows for a more integrated and aligned approach to health services planning and delivery across Auckland.

Focus for the year

Work is underway on visibility and alignment of the equity planning, frameworks, work programmes and integration into current activity at Waitematā DHB. Alignment with the equity focus, especially for our Māori and Pacific populations, across metro Auckland, in the Long-Term Investment Plan (LTIP) and the Ministry of Health's *Achieving Health Equity* work programme, was also undertaken. The Ministry work programme is one of several joint Ministry and sector co-leadership and governance arrangements to advance the Government's priorities: Achieving Equity, Child Wellbeing, Mental Health and Primary Health Care. Dr Dale Bramley, CEO of Waitematā DHB, is the sector co-sponsor for the Achieving Equity work programme alongside Alison Thom, Māori Leadership at the Ministry of Health.

We expect our population to reach nearly 700,000 by 2025; this significant growth in our population and increased demand for clinical and community services provide both challenges and opportunities in the coming year.

The DHB will progress the following major developments over the next 12 months:

- construction of the $18.4 million, 15-bed medium secure Tanekaha Unit at the Mason Clinic
- completion and opening of a newly expanded Waitakere Hospital Radiology Department
- work with other Northern Region DHBs through the LTIP to guide medium- to long-term regional developments designed to improve health outcomes for everyone
- implement a Consumer Council to further bolster the DHB's commitment to a high quality, equitable and accessible health care service for the Waitematā community.

Supporting and developing our staff is a key focus for our organisation. Throughout July and August 2018, over 60 teams were visited by members of the executive and senior management team. The focus of the leadership visits was to show appreciation to our teams for the work they do and to discuss how we live our value 'with compassion'.

From feedback at these discussions, we are undertaking a series of initiatives to value and support people to thrive and make a difference at work as well as remove red tape from our corporate processes. We will continue to hold more forums throughout the year, where senior leaders meet with staff teams to listen and respond to the things that matter most to our people.

Key programmes and initiatives this year

The Waitematā Experience programme

The Waitematā 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.

Waitematā 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 Waitematā 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, Waitematā 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 Waitematā in the top three DHBs.

Occupational Health and Safety

At Waitematā 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

Waitematā DHB's performance framework reflects the key national and local priorities that inform this 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.

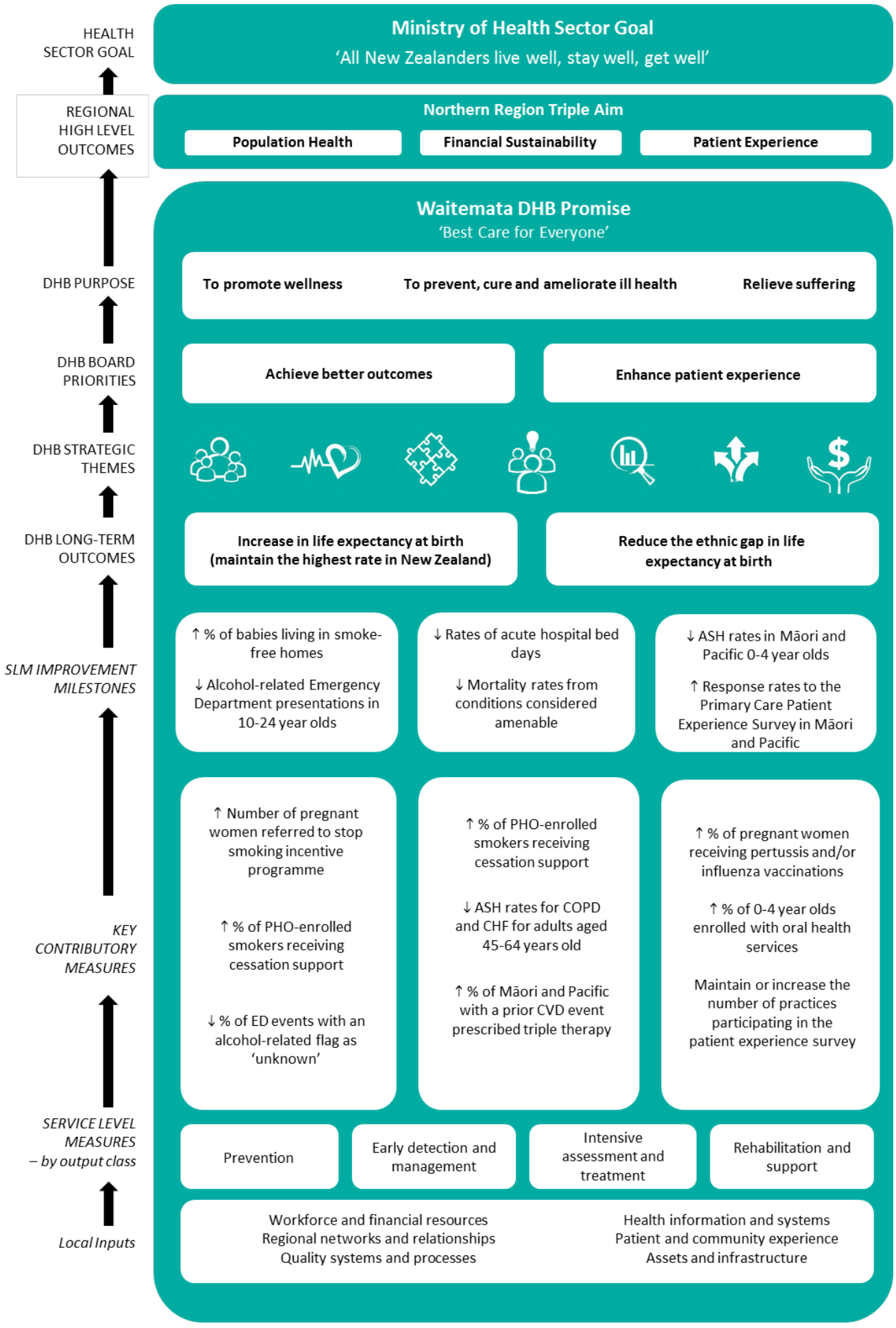
Contributory measures are essential to the achievement of SLMs and are front-line measurements of specific health processes or activities. The contributory measures included in our performance framework were selected from the set defined by our District Alliance and included in our SLM Improvement Plan.

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 (Appendix B) 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	**Babies living in smokefree homes**	**Ambulatory sensitive hospitalisations**	**Youth Health (Alcohol and other drug related harm)✠**	**Amenable mortality**	**Acute hospital bed days**	**Patient experience**
2018/19 improvement milestone	**↑ % of babies living in smoke-free homes**	**↓ ASH rates for Māori and Pacific 0-4 year olds**	**↓ Alcohol-related Emergency Department presentations in 10 to 24 year olds**	**↓ Mortality rates from conditions considered amenable**	**↓ Rates of acute hospital bed days**	**↑ Response rates to Primary Care Patient Experience Survey (PES) in Māori and Pacific**
Key contributory measures	*↑ Pregnant women referred to stop smoking incentive programme* *↑ % of PHO-enrolled smokers receiving cessation support*	*↑ % pregnant women receiving pertussis and/or influenza vaccinations* *↑ % of 4 year olds enrolled with oral health services*	*↓ % of ED events with an alcohol-related flag as 'unknown' (data quality)*	*↑ % of PHO-enrolled smokers receiving cesstion support* *↑ % of Māori and Pacific with a prior CVD event prescribed triple therapy*	*↓ ASH rates for COPD and CHF for adults aged 45-64 years old* *↑ % of individuals with a prior CVD event prescribed triple therapy*	*Maintain or increase the number of practices participating in the patient experience survey*

✠ Note: The youth System Level Measure consists of five domains reflecting the complexity and breadth of issues impacting youth health and wellbeing. Waitematā DHB has chosen to focus on the alcohol-related harm domain, starting with improvements in the identification and coding of alcohol-related ED events. Work is ongoing to improve chlamydia testing coverage under the sexual health domain.

Performance and intervention framework



Long-term outcomes

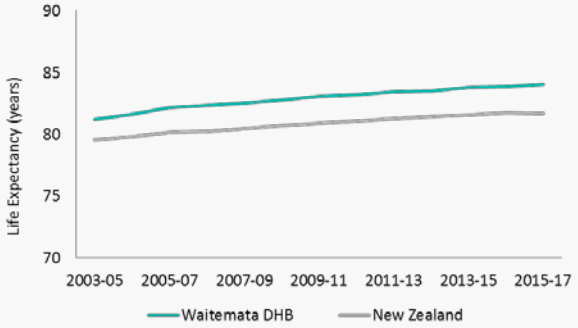
The long-term outcomes that we want to achieve are to increase life expectancy (measured by life expectancy at birth) and reduce ethnic inequalities (measured by the ethnic gap in life expectancy).

Highest life expectancy in New Zealand

Life expectancy at birth is recognised as a general measure of population health status. We have the highest life expectancy in the country at 84.1 years (2015–2017), which is 2.4 years higher than New Zealand as a whole. Half of this difference in life expectancy between New Zealand and Waitematā DHB is attributed to our lower mortality rates from cardiovascular disease and cancer. In Waitematā DHB, life expectancy has increased by 3.5 years since 2001, which is 0.8 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.

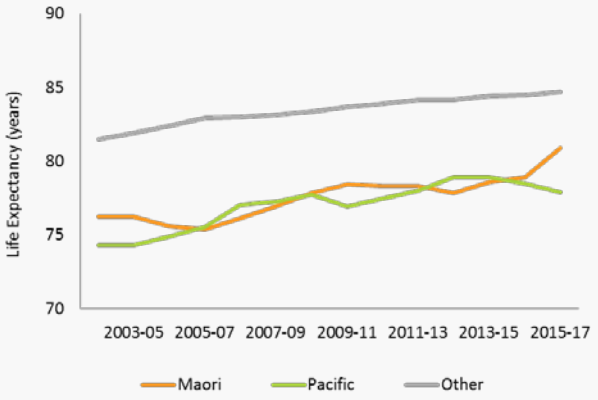
Reducing ethnic differences in health outcomes

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 3.8 years for Māori and 6.8 years for Pacific (2015–2017). Life expectancy has increased in our Māori (5.2 years) and Pacific (3.3 years) populations since 2001 and the gap in life expectancy is gradually closing.

Mortality at a younger age from cardiovascular disease and cancers account for over half of the life expectancy gap in our Māori and Pacific populations.

We expect a reduction in the gap in life expectancy over the next decade, declining at the same or greater rate than that 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.

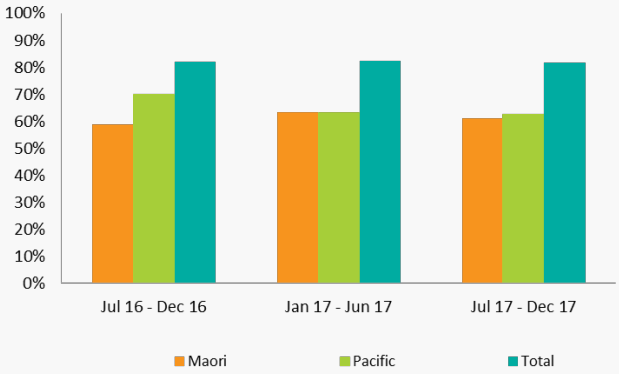
Increasing the proportion of babies who live in smokefree households at 6 weeks postnatal

Infants and young children are more exposed to second-hand smoke in homes than in other places. Second-hand smoke exposure is 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 reducing or eliminating adult contributions to children's exposure to second-hand smoke at home.

Annual improvement target: 2% increase
(baseline 82%, Jul-Dec 2017)

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



Note: processes to improve data quality relating to this measure are ongoing. A new data standard will be established by the end of the year, thus current data should be interpreted with caution

Contributory measure – Referrals to maternal incentive programme

Cigarette smoking during pregnancy is an important modifiable risk factor for poor birth outcomes, including the risk of miscarriage, premature birth and low birth weight, as well as their children's risk of asthma and sudden unexplained death in infants (SUDI).

Pregnancy is a time when women are likely to be highly motivated to stop smoking themselves and to encourage their whānau to stop smoking. Evidence suggests that incentive-based smoking cessation programmes can be successful in reducing smoking rates during pregnancy and reducing the incidence of low birth weight babies.

Annual improvement target: 83 referrals per quarter (332 referrals FY)

(baseline = 65, 2017 calendar year)

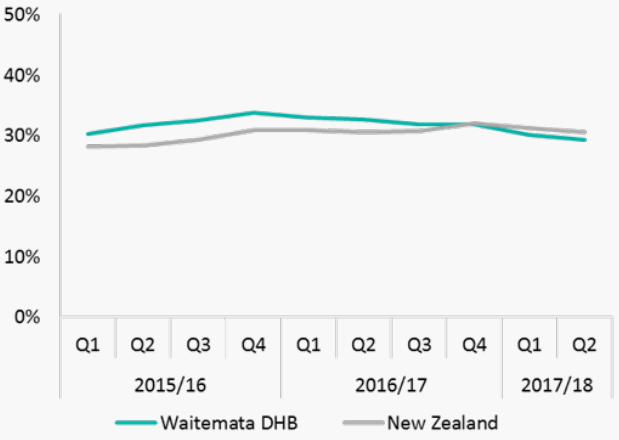
Smokers who live in the same household as babies and young children can often be reached through primary care.

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 to increase quit rates for Māori and Pacific is particularly important given the higher prevalence of smoking in these ethnic groups.

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

Annual improvement target: relative 10% increase
(baseline = 29.3%, Q2 2017/18)

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 of the total 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 conditions that are potentially avoidable through prevention or management in primary care (ambulatory sensitive hospitalisations – ASH). 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

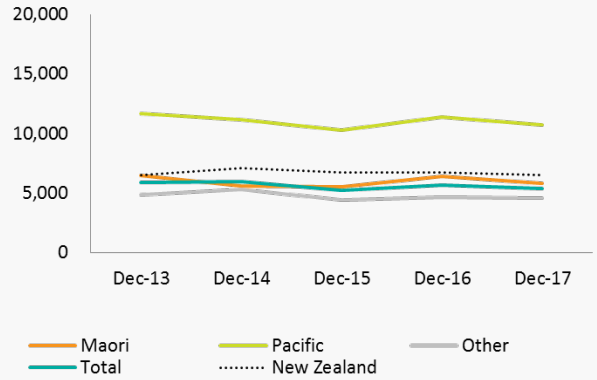
In the 12 months to December 2017, there were 2,154 admissions for 0–4 year olds that were potentially avoidable.

The overall rate of admissions (5,426 per 100,000) has declined over the past five years. Rates in the Pacific population (10,756) are twice as high as other ethnicities.

Our aim is to reduce rates by 3% and reduce the equity gap for our Māori and Pacific children.

Annual improvement target: 3% reduction (baseline = 5,426 per 100,000 population, Dec 2017)

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



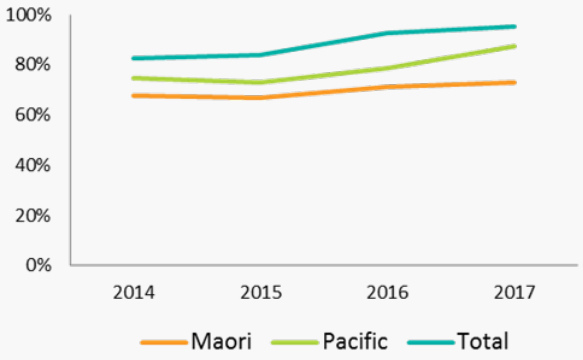
Hospitalisations due to dental conditions in the 0-4 age group make up about 10% of ASH admissions (209 events in the 12 months to Dec 2017), and are increasing.

Improving accessibility of oral health programmes will reduce the prevalence and severity of early childhood dental decay, and reduce the numbers requiring hospital admission for serious dental problems.

At the end of December 2017, 95% of all pre-schoolers were enrolled with oral health services, although this figure was much lower for Māori (73%).

Annual 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

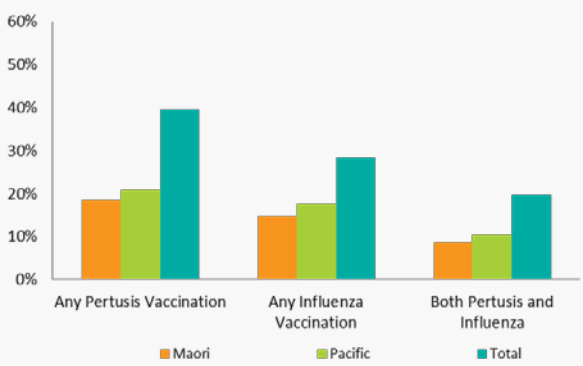


Respiratory conditions are the largest contributor to ASH rates in Auckland. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants, and can lead to further respiratory complications. Both are vaccine preventable and vaccination during pregnancy protects both mother and baby against the diseases for the first few months of life.

Pregnant women are recommended to have both vaccinations every pregnancy. For babies born in 2017, only 20% of mothers had received both vaccinations during pregnancy, with rates much lower for Māori and Pacific.

Annual improvement target: 50% coverage for influenza and pertussis vaccination in pregnancy across all ethnicities.

Contributory measure – proportion of pregnant women receiving pertussis and/or influenza vaccinations in pregnancy



Note: Graph shows vaccination coverage in the 12 months to December 2017

Youth are healthy, safe and supported

Promoting healthy behaviours during adolescence and taking steps to better protect young people from health risks are critical in preventing health problems and poor life outcomes in adulthood. Most New Zealand youth successfully transition to adulthood but some do not, mainly due to an interplay of individual, family and community circumstances, or risk factors.

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. Waitematā DHB has chosen to focus on the impact of alcohol at both an individual and health system level.

Alcohol and drugs – Alcohol-related emergency department (ED) presentations in 10 to 24 year olds

Alcohol is deemed the most commonly used recreational drug in New Zealand. Alcohol contributes to violence, self-harm, injuries and many medical conditions, and is responsible for over 1,000 deaths and 12,000 years of life lost each year in New Zealand.*

Identifying and monitoring alcohol-related ED presentations enables DHBs to better understand the contribution of excessive alcohol consumption to ED presentations for young people. It is a starting point to encourage DHBs to move toward more extensive screening, brief intervention and referrals (including to primary care and community care).

Annual improvement target: Establish Baseline

Processes are ongoing to ensure that alcohol involvement in ED presentations is captured accurately and consistently. This process will continue throughout the year.

Systems have only recently been established to enable alcohol-related ED presentations to be coded.

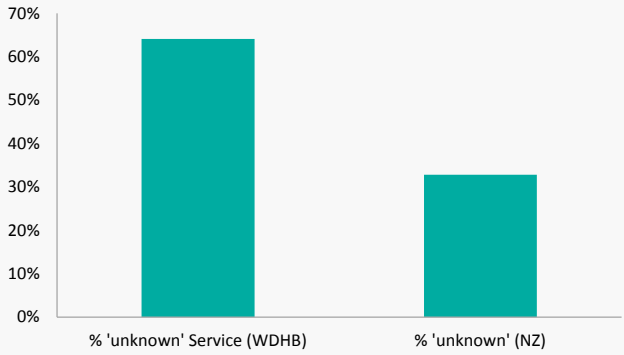
The mandatory question is: 'Is alcohol associated with this event?' Possible answers are: Yes, No, Unknown and Secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved).

In the 12 months to March 2018, more than 60% of admissions to Waitematā DHB's emergency departments had 'unknown' recorded as the answer to this question.

Significant quality improvement work has begun to ensure consistent and accurate collection of this information. This year we will continue the focus on improving the accuracy and reliability of alcohol-related data collection in our EDs.

Annual improvement target: Reduce ED events with an 'unknown' alcohol-related field to less than 10%

Contributory measure – Proportion of ED events with an alcohol-related flag as 'unknown'



* Connor J, Kydd R, Rehm J, Shield K. Alcohol-attributable burden of disease and injury in New Zealand: 2004 and 2007. Wellington: Health Promotion Agency; July 2013.

Prevention and early detection

Amenable mortality is a measure of the effectiveness of healthcare-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 be 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 less quickly for Pacific populations.

Reducing rates of amenable mortality

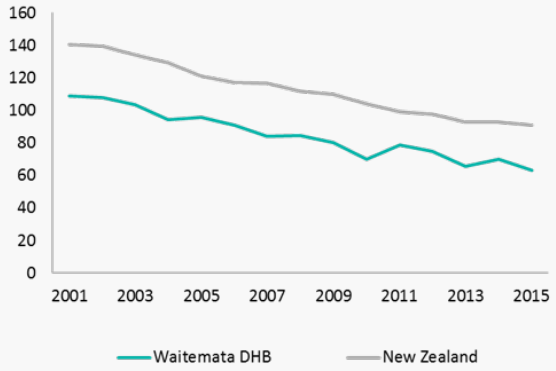
Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist.

In 2015, we estimate that 472 deaths (45% of all deaths in those aged under 75 years) in Waitematā DHB were potentially amenable. The rate of amenable mortality has steadily decreased over the past decade and is currently 63.2 per 100,000 population.

We aim to continue this rate of reduction in amenable mortality.

Improvement target: 6% reduction by 2020
(baseline = 65.6 deaths per 100,000 population, 2013)

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

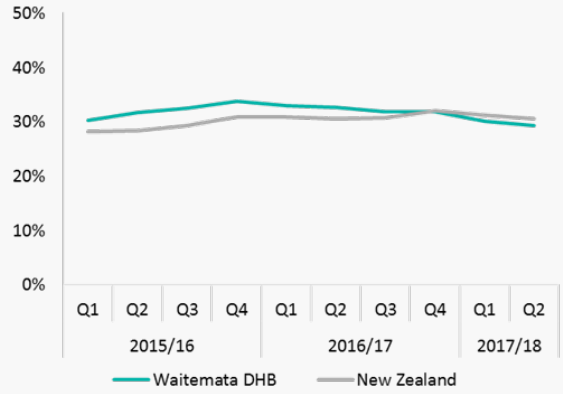


Life-long smoking is associated with a decade of life lost for an individual. Quitting smoking before the age of 40 years, and preferably much earlier, will reduce about 90% of the years of life lost from continued smoking.*

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.

Annual improvement target: relative 10% increase
(baseline = 29.3%, Q2 2017/18)

Contributory measure – Proportion of PHO enrolled smokers receiving cessation support



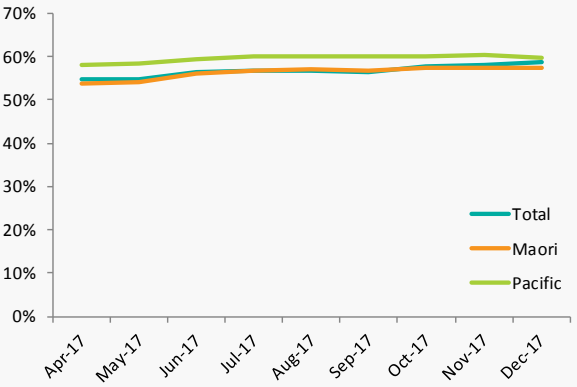
New Zealand guidelines recommend that, where appropriate, people who experience a heart attack or stroke should be treated with a combination of medications known as triple therapy (aspirin or another antiplatelet/anticoagulant agent, a beta-blocker and a statin).

We intend to make sure that our patients who have had a CVD event are receiving the best possible care.

Currently, 59% of the Metro Auckland Māori and Pacific population who have had a CVD event are prescribed triple therapy medication.

Annual improvement target: relative 5% increase
(baseline = 59%, December 2017)

Contributory measure – Proportion of Māori and Pacific with a prior CVD event prescribed triple therapy (Metro Auckland)



Note: data not currently available by DHB of domicile, to be addressed in 2018/19

*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. 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. The rate of acute bed day use is higher for Māori and Pacific people.

Reducing acute hospital bed days

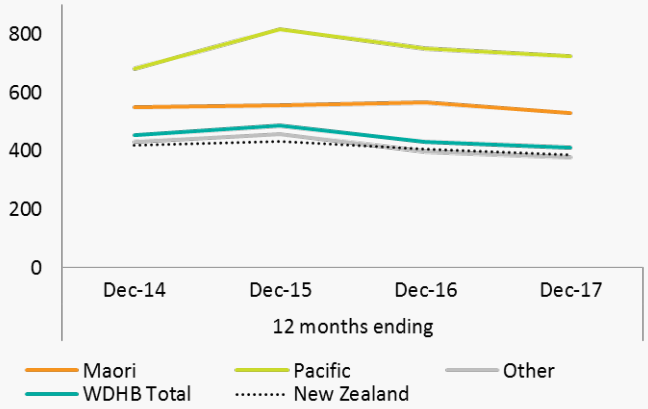
Acute admissions account for approximately one half of all hospital admissions in New Zealand. Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressure on DHB staff and facilities.

Our standardised rate of acute bed days has declined slightly since 2014 (453 per 1,000 population to 410 per 1,000 population) and remains slightly higher than the national rate.

We plan to target populations most likely to be admitted or readmitted to hospital, and focus on prevention and treatment of conditions that contribute the most to acute hospital bed days.

Annual improvement target: 3% reduction
(baseline = 409.9 per 1,000 population, Dec 2017)

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



Note: Age standardised rate

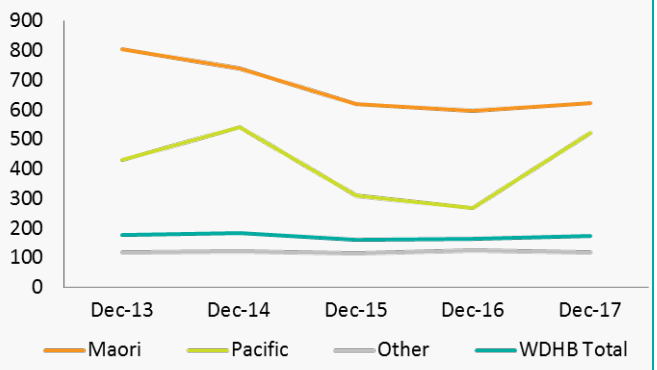
Congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) are long-term debilitating conditions that are responsible for a significant number of acute hospitalisations and overall bed days.

Both conditions can often be well managed with intensive treatment and follow-up in primary care along with patient and family education, potentially preventing the need for hospitalisation. Should hospitalisation be required, often those receiving effective management in primary care have a shorter length of stay and lower risk of readmission.

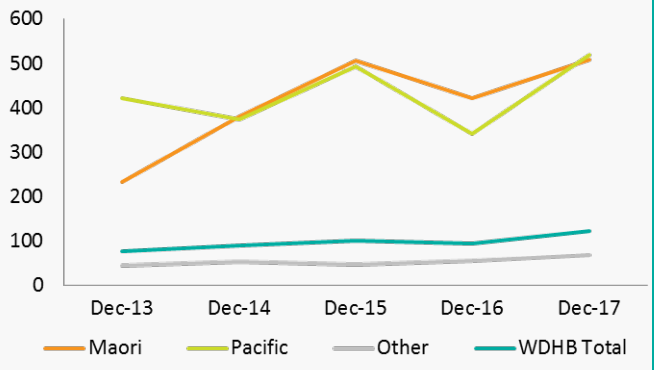
Annual improvement target: 2% reduction
(baseline COPD = 173 per 100,000 population, CHF = 123 per 100,000 population Dec 2017)

Contributory measure – ASH rates for COPD and CHF for adults aged 45-64 years old

Chronic Obstructive Pulmonary Disease



Congestive Heart Failure



Person-centred care

Patient experience is a good indicator of the quality of health services. Improved patient experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to 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

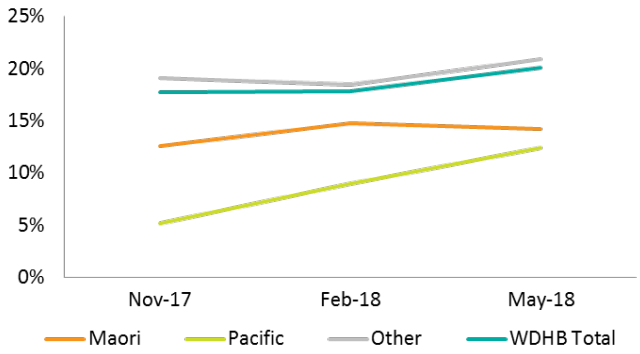
The primary care patient experience survey was developed by HQSC to find out what patients' experience in primary care is like and how their overall care is managed between their general practice, diagnostic services, specialists and/or hospital staff. The information will be used to improve the quality of service delivery and patient safety.

There is a regional focus on improving response rates to the primary care survey to ensure that the perspective of all patients can be captured and the findings from the survey can be generalised to the patient population, particularly in Māori and Pacific patients.

As at May 2018, only 12-14% of Māori and Pacific patients invited to complete surveys had participated, compared with 21% for other ethnicities.

Annual improvement target: increase response rate for completed surveys by absolute 2% for Māori and Pacific (baseline 12.6% Māori, 5.2% Pacific, November 2017)

System level measure – Response rates to the Primary Care Patient Experience Survey



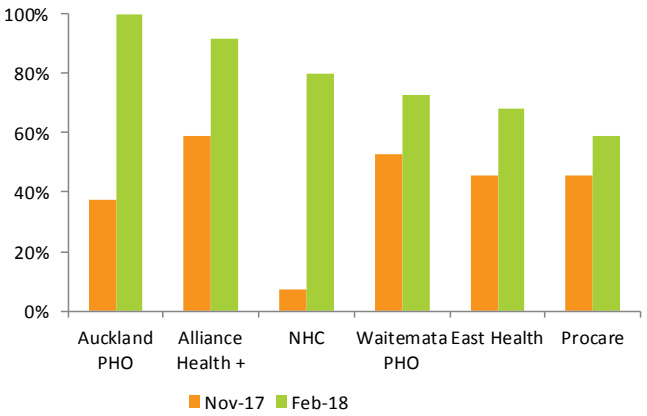
The Primary Care Patient Experience Survey (PES) was implemented in practices during 2017/18. Before reporting on patient experience scores, we want to ensure participation in the PES at a PHO and practice level.

Participation by practices in the PES requires a great deal of developmental work by PHOs including infrastructure, practice engagement, capacity building, and patient communication.

As at February 2018, 69% of all practices were participating in the survey, an increase from 43% in November 2017.

Annual improvement target: Maintain or increase participation (from June 2018 baseline)

Contributory measure – Maintain or increase the number of practices participating in the patient experience survey*



*Metro Auckland data

APPENDIX B: STATEMENT OF PERFORMANCE EXPECTATIONS – WAITEMATĀ DHB 2018/19

The Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for the 2018/19 year.

Performance measurement framework

Our focus for 2018/19 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 prevent illness and reduce unequal outcomes; 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 2016/17	Target 2018/19
Health promotion			
% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months	C	90%	90%
% of PHO-enrolled patients who smoke and received cessation support	Q	29.3%	32.2%
% of pregnant women who identify as smokers upon registration with a DHB midwife or LMC are offered brief advice and support to quit smoking	C	87%	90%
Number of pregnant women smokers referred to the stop smoking incentive programme	Q	65[1]	332
% of children identified as obese in the B4SC programme who are offered a referral to a registered health professional	Q	100%	95%
Number of clients engaged with Green Prescriptions	V	3,756[2]	5,400
Immunisation			
% of pregnant women receiving pertussis vaccination in pregnancy		40%[3]	50%
Influenza vaccination coverage for children aged 0-4 years who are hospitalised for respiratory illness - Māori - Pacific - Total		 10%[4] 7%[4] 12%[4]	15%
Increased immunisation - % 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	 92% 86%	 95%
Rate of HPV immunisation coverage (2004 birth cohort)	C	60%	75%
Population-based screening			
% of women aged 50-69 years having a breast cancer screen in the last 2 years	C	66%	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	74%	80%
% of 15-24 year olds tested for chlamydia	C	12%[4]	15%
Bowel Cancer Screening			
% of people aged 60-74 years invited to participate who returned a correctly completed kit[5] - Māori - Pacific - Other	Q	New indicators	60%
% of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 45 working days	T	97%	95%
Children			
% of 4 year olds receiving a B4 School Check	C	94%	90%
Auckland Regional Public Health Service[6]			
Number of tobacco retailer compliance checks conducted	V	321	300
Number of license applications and renewals (on, off club and special) received and are risk assessed	V	3,870	Ω
% of tuberculosis (TB) and latent TB infection cases who have started treatment and have a recorded start date for treatment	Q	96%	90%
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol	Q	New indicator	85%

[1] Data for 12 months to Dec-17
[2] Data for 2017/18
[3] CY2017 births
[4] Data as at Dec 2017
[5] Patients invited during 2018 and 2019, i.e. round 4 (this differs from previous screening rounds, which involved patients aged 50-74 years old).
[6] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.

Output class 2: Early Detection and Management

Early detection and management services are delivered by a range of health professionals in various settings, including general practice, community and Māori health services, pharmacist services and child and adolescent oral health services. 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 2016/17	Target 2018/19
Primary health care			
Rate of primary care enrolment (Māori)	C	92%	90%
Number of referrals to Primary Options for Acute Care (POAC)	V	10,727	10,811
POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions		2.4%[7]	3%
% of the eligible Māori population who have had their CVD risk assessed in the last five years	C	87%	90%
% of Māori patients with prior CVD who are prescribed triple therapy	Q	56.5%[8]	59.4%
% of Pacific patients with prior CVD who are prescribed triple therapy	Q	62.7%[8]	65.8%
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds: - Māori - Pacific - Chronic obstructive pulmonary disease (COPD) - Congestive heart failure (CHF)		 7,460 10,850 173 123	 7,311 10,633 170 121
% of PHO enrolled population who have login access to a portal	C	17%[9]	20%
% of practices participating in Primary Care Patient Experience survey		43%[10]	≥ Jun 2018 result
Primary Care Patient Experience Survey response rate - Māori - Pacific		 12.6%[11] 5.2%[11]	 14.6% 7.2%
Pharmacy			
Number of prescription items subsidised	V	7,310,184	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	37,424	Ω
Number of community laboratory tests	V	3,902,938	Ω
Oral health			
% of preschool children enrolled in DHB-funded oral health services	C	95.5%[12]	95%
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 - 2018 - 2019	Q	 0.61[12]	 0.61 0.61
% of children caries free at five years of age - 2018 - 2019	Q	 67%[12]	 67% 67%

[7] 12 months to Sep-17, assumes all POAC is ASH, excluding musculoskeletal and DVT.
[8] Jan 2018 data.
[9] 12 months to Dec-17, Metro Auckland total
[10] 12 months to Nov-17, Metro Auckland total
[11] 12 months to Nov-17, based on DHB of practice
[12] CY2017

Output class 3: Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by specialist providers in facilities that co-locate clinical expertise and specialised equipment, such as a hospital or surgery centre. These services include ambulatory, ED and inpatient services (acute and elective streams), such as 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 2016/17	Target 2018/19
Acute services			
Number of ED attendances	V	121,352	Ω
% of ED patients discharged, admitted or transferred within six hours of arrival	T	97%	95%
% of ED admissions in 10-24 year olds where alcohol-related ED presentation status is 'Unknown'	Q	New indicator	<10%
% 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	90%	90%
% of potentially eligible stroke patients thrombolysed	C	7.7%	10%
% of ACS inpatients receiving coronary angiography within 3 days	T	72%	70%
Maternity			
Number of births in Waitematā DHB hospitals	V	7,045	Ω
Elective (inpatient/outpatient)			
Number of elective surgical discharges (PP45)	V	23,998	22,073
Surgical intervention rate[13]	C		
- Major joints		28.0	21
- Cataracts		39.7	27
- Cardiac		6.1	6.5
- PCR		16.5	12.5
- Angiogram		41.7	34.7
% of people receiving urgent diagnostic colonoscopy in 14 days	T	92%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days		78%	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		98%[14]	95%
- MRI		98%	90%
Quality and patient safety			
% of opportunities for hand hygiene taken	Q	86%	80%
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.10	<0.11[15]
% of falls risk patients who received an individualised care plan	Q	96%	90%
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions	Q	0.06	<8.4[16]
% of hip and knee arthroplasties operations where antibiotic is given in one hour before incision	Q	95%	100%
% of hip and knee procedures given right antibiotic in right dose	Q	96%	95%
Surgical site infections per 100 hip and knee operations	Q	1.61	<0.93[17]
Mental Health			
% of population who access Mental Health services:	C		
- Age 0–19 years		3.7%	3.49%
- Age 20–64 years		3.6%	3.43%
- Age 65+ years		2.00%	2.01%
% of 0-19 year old clients seen within 3 weeks:	T		
- Mental Health		71%	80%
- Addictions		89%	80%
% of 0-19 year old clients seen within 8 weeks:			
- Mental Health		95%	95%
- Addictions		98%	95%

[13] Data for year ending March 2016
[14] Jun-17 result
[15] Jan12-Jun17 national median
[16] Sep14-Jun17 national median
[17] Sep15-Nov17 national median

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, home-based support, and residential care services. Rehabilitation and support services are provided by the DHB and non-DHB sector, e.g. 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.

Outputs measured by	Notes	Baseline 2016/17	Target 2018/19
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)	Q	98%	95%
Palliative care			
Proportion of hospice patient deaths that occur at home	Q	32.5%	↑
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	4.5%	5%
Residential care			
ARC bed days	V	915,023	Ω

APPENDIX C: FINANCIAL PERFORMANCE

Financial management overview

In the year to 30 June 2018, the DHB reported a deficit of $14.8m against a breakeven budget. This result reflects a breakeven operating performance, impaired by provisioning for the possible effects of the Holidays Act, and the effects on leave balances revaluation following the settlement on the NZNO wage dispute.

Within each Arm of the DHB (principally Funder and Provider), different financial results were achieved, providing a partial offset. The Provider reported a deficit against budget of $37.4m, offset by surpluses in the Funder and Governance Divisions totalling $22.6m. This situation, of deficits in Provider divisions offset by Funder surpluses, 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 2017/18 financial year, the Board made a number of significant investments, including a major organisational change management programme to improve maturity in the management of project, programmes and portfolios across the whole organisation.

Planning commenced on a number of major facility programmes to redevelop the two hospital sites and associated infrastructure. The first of these programmes is the Elective Capacity and Inpatient Beds that will see additional theatre, inpatient wards and endoscopy capacity on the North Shore Campus.

For the 2018/19 financial year, the DHB is forecasting a $7.0m deficit budget, which reflects a deficit of $21.7 in the Provider, offset by a $17.7m surplus in the Funder.

The deficit within the Provider assumes that a $13.3m savings plan will be achieved, and there is a risk to meeting this plan. The budgeted result in the Funder also contains risk with regards to IDF payments, NGO demand-driven expenditure, Pay Equity and In Between Travel.

Oversight of progress against the savings plans was strengthened by the creation of a Financial Sustainability Portfolio Governance Group (FSPGG). This group consists of three Board members (including Chair and Deputy Chair), senior financial executives, and the CFO of Auckland DHB.

The FSPGG will oversee the portfolio of Board approved savings initiatives, and report progress back to the Board.

The Board will approve any significant savings projects and plans, especially those that are high risk. The CEO and CMO have the Board's delegation to halt any project they believe might affect quality or patient outcome.

At an operational level, the savings plan is monitored by the Operational Financial Sustainability Group, chaired by the Director of Hospital Operations.

The Executive Leadership Team receives a weekly report on progress against the plan.

During the 2017/18 financial year, the DHB delivered savings of $26m, of which $8.8m were one off and will not repeat in subsequent years. The annualised value of sustainable savings achieved was approximately $19m.

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.

The financial 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 2018.

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 $86.8m above 2017/18 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 2018); 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.
- That staff cost (MECA) increases will be at 2%, with any shortfall over the settlement of the nurses' current employment negotiation funded from additional MoH revenue.
- The effects of the asset revaluation as at 30 June 2018 have not been incorporated into this plan.

Forecast Financial Statements

The Board of Waitematā 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 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 Waitematā DHB and its subsidiaries (together referred to as 'Group') and Waitematā DHB's interest in associates and jointly controlled entities.

The Waitematā DHB group consists of the parent, Waitematā District Health Board and Three Harbours Health Foundation (controlled by Waitematā 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 2016/17, year-end preliminary results for 2017/18 and plans for years 2018/19 to 2021/22. 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

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Government and Crown Agency Revenue	1,516,737	1,606,402	1,680,041	1,713,368	1,747,495	1,781,682
Patient Sourced and Other Income	24,776	31,752	29,522	30,607	31,183	31,767
IDFs and Inter DHB Provider Income	85,259	86,543	89,409	91,187	93,008	94,822
Total Funding	**1,626,772**	**1,724,697**	**1,798,972**	**1,835,162**	**1,871,686**	**1,908,271**
Personnel Costs	604,008	641,786	660,266	671,129	677,913	691,790
Outsourced Costs	76,388	74,166	78,056	79,044	79,734	81,389
Clinical Supplies Costs	118,245	123,940	126,343	127,794	129,102	131,804
Infrastructure and Non-Clinical supplies Costs	98,987	120,728	111,576	96,150	106,808	108,297
Payments to Other Providers	727,227	778,862	829,731	861,045	878,129	894,991
Total Expenditure	**1,624,855**	**1,739,482**	**1,805,972**	**1,835,162**	**1,871,686**	**1,908,271**
Net Surplus/(Deficit)	**1,917**	**(14,785)**	**(7,000)**	**0**	**0**	**0**
Other Comprehensive Income	**0**					
Gains/(Losses) on Property Revaluations	(378)	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**1,539**	**(14,785)**	**(7,000)**	**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 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 ageing of the population the DHB serves, the state of our ageing 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 the greatest they have been for several years. As a result, the DHB is now forecasting a deficit in 2018/19 and returning to breakeven in the 2019/20 financial year.

Forecast Statement of comprehensive income – group

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Government and Crown Agency Revenue	1,516,737	1,606,402	1,680,041	1,713,368	1,747,495	1,781,682
Patient Sourced and Other Income	25,117	31,752	29,522	30,607	31,183	31,767
IDFs and Inter DHB Provider Income	85,259	86,543	89,409	91,187	93,008	94,822
Total Funding	**1,627,113**	**1,724,697**	**1,798,972**	**1,835,162**	**1,871,686**	**1,908,271**
Personnel Costs	604,008	641,786	660,266	671,129	677,913	691,790
Outsourced Costs	76,281	74,166	78,056	79,044	79,734	81,389
Clinical Supplies Costs	118,245	123,940	126,343	127,794	129,102	131,804
Infrastructure and Non-Clinical supplies Costs	97,954	120,728	111,576	96,150	106,808	108,297
Payments to Other Providers	727,334	778,862	829,731	861,045	878,129	894,991
Total Expenditure	**1,623,822**	**1,739,482**	**1,805,972**	**1,835,162**	**1,871,686**	**1,908,271**
Net Surplus/(Deficit)	**3,291**	**(14,785)**	**(7,000)**	**0**	**0**	**0**
Other Comprehensive Income	**0**					
Gains/(Losses) on Property Revaluations	(378)	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**2,913**	**(14,785)**	**(7,000)**	**0**	**0**	**0**

Forecast Statement of comprehensive income – governance & funding administration

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Revenue	12,878	14,040	15,431	15,737	16,051	16,363
Expenditure						
Personnel	10,166	10,609	13,511	13,773	14,039	14,307
Outsourced services	7,387	6,742	8,545	8,714	8,886	9,058
Clinical supplies	0	0	1	1	1	1
Infrastructure & non clinical supplies	(5,707)	(5,452)	(6,626)	(6,751)	(6,875)	(7,003)
Total Expenditure	**11,846**	**11,899**	**15,431**	**15,737**	**16,051**	**16,363**
Surplus/(Deficit)	**1,032**	**2,141**	**0**	**0**	**0**	**0**

Forecast Statement of comprehensive income – provider

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Income						
MoH via Funder	786,617	840,616	869,244	886,628	904,360	922,356
MoH Direct	38,569	22,106	23,688	24,158	24,638	25,125
Other	40,679	48,563	46,178	47,594	48,508	49,436
Total Income	**865,865**	**911,285**	**939,110**	**958,380**	**977,506**	**996,917**
Expenditure						
Personnel	593,842	631,177	646,755	657,356	663,874	677,483
Outsourced services	68,894	67,424	69,511	70,330	70,848	72,331
Clinical supplies	118,245	123,940	126,342	127,793	129,101	131,803
Infrastructure & non clinical supplies	103,661	126,180	118,202	102,901	113,683	115,300
Total expenditure	**884,642**	**948,721**	**960,810**	**958,380**	**977,506**	**996,917**
Surplus/(Deficit)	**(18,777)**	**(37,436)**	**(21,700)**	**0**	**0**	**0**

Forecast Statement of comprehensive income – funder

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Income						
Revenue	1,547,612	1,653,963	1,729,046	1,763,349	1,798,478	1,833,647
Expenditure						
Personal Health	1,123,687	1,175,884	1,229,465	1,268,846	1,294,118	1,319,477
Mental Health	208,297	219,302	230,495	235,071	239,757	244,421
DSS	167,762	211,183	226,042	230,530	235,128	239,704
Public Health	11,124	9,998	9,681	9,869	10,063	10,256
Māori Health	3,081	3,111	3,292	3,357	3,423	3,489
Governance	12,625	13,975	15,371	15,676	15,989	16,300
Total Expenditure	**1,526,576**	**1,633,453**	**1,714,346**	**1,763,349**	**1,798,478**	**1,833,647**
Surplus/(Deficit)	**21,036**	**20,510**	**14,700**	**0**	**0**	**0**

Forecast capital costs

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Depreciation	28,006	29,508	31,407	32,032	32,669	33,315
Interest Costs	6,532	0	0	0	0	0
Capital Charge	21,560	36,679	36,947	36,347	36,347	36,347
Capital Costs	**56,098**	**66,187**	**68,354**	**68,379**	**69,016**	**69,662**

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 funded by specific new revenue from the Ministry of Health.

Waitematā 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 Waitematā DHB was last prepared on 30 June 2015. A full revaluation on land and buildings has been carried out for the financial year ending 30 June 2018 but the effect of this revaluation has not yet been included in these financial plans. However, revaluations will increase Capital Charge.

Forecast statement of cashflows – parent

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Cashflow from operating activities						
MoH and other Government/Crown	1,592,374	1,686,859	1,761,753	1,804,555	1,840,503	1,876,504
Other Income	28,560	28,477	33,940	30,607	31,183	31,767
Interest received	4,166	2,076	1,803	1,583	1,583	1,583
Payments for Personnel	(608,107)	(624,385)	(658,527)	(668,629)	(677,913)	(691,790)
Payments for Supplies	(984,172)	(1,017,136)	(1,088,701)	(1,098,693)	(1,125,306)	(1,147,379)
Capital Charge Paid	(21,762)	(36,679)	(36,948)	(36,347)	(36,347)	(36,347)
GST Input Tax	749	1,523	(639)	0	0	0
Interest payments	(8,349)	0	0	0	0	0
Net cashflow from operating activities	**3,459**	**40,735**	**12,681**	**33,076**	**33,703**	**34,338**
Cashflow from investing activities						
Sale of Fixed Assets	0	0	0	0	0	0
Capital Expenditure (-ve)	(63,717)	(24,878)	(34,533)	(25,119)	(34,422)	(35,455)
Acquisition of investments	24,440	(2,952)	0	0	0	0
Net cashflow from investing activities	**(39,277)**	**(27,830)**	**(34,533)**	**(25,119)**	**(34,422)**	**(35,455)**
Net cash movements	**(35,818)**	**12,905**	**(21,852)**	**7,957**	**(719)**	**(1,117)**
Cash and cash equivalents at the start of the year	53,631	17,813	30,718	8,866	16,823	16,104
Cash and cash equivalents at the end of the year	**17,813**	**30,718**	**8,866**	**16,823**	**16,104**	**14,987**

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

Forecast statement of cashflows – group

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Cashflow from operating activities						
MoH and other Government/Crown	1,592,375	1,686,859	1,761,753	1,804,555	1,840,503	1,876,504
Other Income	28,326	28,477	33,940	30,607	31,183	31,767
Interest received	4,166	2,076	1,803	1,583	1,583	1,583
Payments for Personnel	(608,107)	(624,385)	(658,527)	(668,129)	(677,913)	(691,790)
Payments for Supplies	(984,173)	(1,017,136)	(1,088,701)	(1,098,193)	(1,125,306)	(1,147,379)
Capital Charge Paid	(21,762)	(36,679)	(36,948)	(36,347)	(36,347)	(36,347)
GST Input Tax	749	1,523	(639)	0	0	0
Interest payments	(8,349)	0	0	0	0	0
Net cashflow from operating activities	**3,225**	**40,735**	**12,681**	**33,076**	**33,703**	**34,338**
Cashflow from investing activities						
Sale of Fixed Assets	**0**	0	0	0	0	0
Capital Expenditure (-ve)	(63,717)	(24,878)	(34,533)	(25,119)	(34,422)	(35,455)
Acquisition of investments	24,440	(2,952)	0	0	0	0
Net cashflow from investing activities	**(39,277)**	**(27,830)**	**(34,533)**	**(25,119)**	**(34,422)**	**(35,455)**
Net cash movements	**(36,052)**	**12,905**	**(21,852)**	**7,957**	**(719)**	**(1,117)**
Cash and cash equivalents at the start of the year	55,682	19,630	32,535	10,683	18,640	17,921
Cash and cash equivalents at the end of the year	**19,630**	**32,535**	**10,683**	**18,640**	**17,921**	**16,804**

Forecast statement of financial position – parent

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Current Assets	85,856	97,914	79,519	91,276	93,807	95,890
Non-current assets	784,389	787,647	789,155	784,023	786,612	789,199
Total assets	**870,245**	**885,561**	**868,674**	**875,299**	**880,419**	**885,089**
Current Liabilities	218,353	241,205	231,288	237,213	241,633	245,553
Non-current liabilities	37,677	33,446	33,476	34,176	34,876	35,626
Total liabilities	**256,030**	**274,651**	**264,764**	**271,389**	**276,509**	**281,179**
Net assets	**614,215**	**610,910**	**603,910**	**603,910**	**603,910**	**603,910**
Total equity	**614,215**	**610,910**	**603,910**	**603,910**	**603,910**	**603,910**

Forecast statement of financial position – group

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Current Assets	89,484	97,914	79,519	91,276	93,807	95,890
Non-current assets	792,313	787,647	789,155	784,023	786,612	789,199
Total assets	**881,797**	**885,561**	**868,674**	**875,299**	**880,419**	**885,089**
Current Liabilities	218,424	241,205	231,288	237,213	241,633	245,553
Non-current liabilities	37,677	33,446	33,476	34,176	34,876	35,626
Total liabilities	**256,101**	**274,651**	**264,674**	**271,389**	**276,509**	**281,179**
Net assets	**625,696**	**610,910**	**603,910**	**603,910**	**603,910**	**603,910**
Total equity	**625,696**	**610,910**	**603,910**	**603,910**	**603,910**	**603,910**

Disposal of land

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

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Balance at 1 July	**612,676**	**614,215**	**599,428**	**592,428**	**592,428**	**592,428**
Comprehensive Income/(Expense)						
Surplus/(deficit) for the year	1,917	(14,785)	(7,000)	0	0	0
Other Comprehensive income	(378)	(2)	0	0	0	0
Total Comprehensive Income	**1,539**	(14,787)	**(7,000)**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown *	0	0	0	0	0	0
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	**614,215**	**599,428**	**592,428**	**592,428**	**592,428**	**592,428**

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

Statement of movement in equity – group

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Balance at 1 July	**622,783**	**625,696**	**610,911**	**603,911**	**603,911**	**603,911**
Comprehensive Income/(Expense)						
Surplus/(deficit) for the year	3,291	(14,785)	(7,000)	0	0	0
Other Comprehensive income	(378)	0	0	0	0	0
Total Comprehensive Income	**2,913**	**(14,785)**	**(7,000)**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown	0	0	0	0	0	0
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	**625,696**	**610,911**	**603,911**	**603,911**	**603,911**	**603,911**

Additional information

Capital expenditure

	2016/17 Audited $000	2017/18 Forecast $000	2018/19 Plan $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000
Funding Sources:						
Free cashflow from depreciation	28,006	29,508	31,407	32,032	32,669	33,315
External Funding	0	0	0	0	0	0
Inflow from sale of fixed asset	0	0	0	0	0	0
Cash reserves	58,973	310	(15,060)	(28,186)	(31,898)	(34,288)
Total Funding	86,979	29,818	16,347	3,846	771	(973)
Baseline Capital Expenditure						
Land	0	0	0	0	0	0
Buildings and Plant	(22,646)	(9,841)	(11,533)	(1,165)	(11,500)	(11,845)
Clinical Equipment	(8,880)	(7,592)	(13,227)	(13,624)	(14,033)	(14,454)
Other Equipment	(427)	(458)	(4,105)	(4,228)	(4,355)	(4,485)
Information Technology	(5,499)	(2,758)	(400)	(412)	(424)	(437)
Intangible Assets (Software)	(1,622)	(122)	(2,844)	(2,929)	(3,017)	(3,108)
Motor Vehicles	0	0	0	0	0	0
Total Baseline Capital Expenditure	**(39,074)**	**(20,771)**	**(32,109)**	**(22,358)**	**(33,329)**	**(34,329)**
Strategic Investments						
Land	0	0	0	0	0	0
Buildings and Plant	(24,643)	(4,107)	(2,424)	(2,761)	(1,093)	(1,126)
Clinical Equipment	0	0	0	0	0	0
Other Equipment	0	0	0	0	0	0
Information Technology	0	0	0	0	0	0
Intangible Assets (Software)	0	0	0	0	0	0
Motor Vehicles	0	0	0	0	0	0
Total Strategic Capital Expenditure	**(24,643)**	**(4,107)**	**(2,424)**	**(2,761)**	**(1,093)**	**(1,126)**
Total Capital Payments	**(63,717)**	**(24,878)**	**(34,533)**	**(25,119)**	**(34,422)**	**(35,455)**

Banking facilities

Shared commercial banking services

Waitematā DHB is in the shared commercial banking arrangements with various other DHBs, the Bank of New Zealand ('BNZ') and New Zealand Health Partnerships Limited. The BNZ provide banking services to the sector, managed by New Zealand Health Partnerships Limited. DHBs are no longer required to maintain separate standby facilities for working capital.

APPENDIX D: 2018/19 SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

System Level Measures Improvement Plan

Auckland, Waitemata &
Counties Manukau Health Alliances

2018
2019
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

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1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (the Alliances) have jointly developed a 2018/19 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 previous System Level Measures Improvement Plans, in 2018/19, improvement milestones and interrelated contributory measures for each of the system level measures (SLMs) have been prioritised and focused, in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Alliances are firmly committed to including additional well-aligned contributory measures over the medium to longer term, as the structures, systems and relationships to support improvement activities are further embedded. This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples.

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

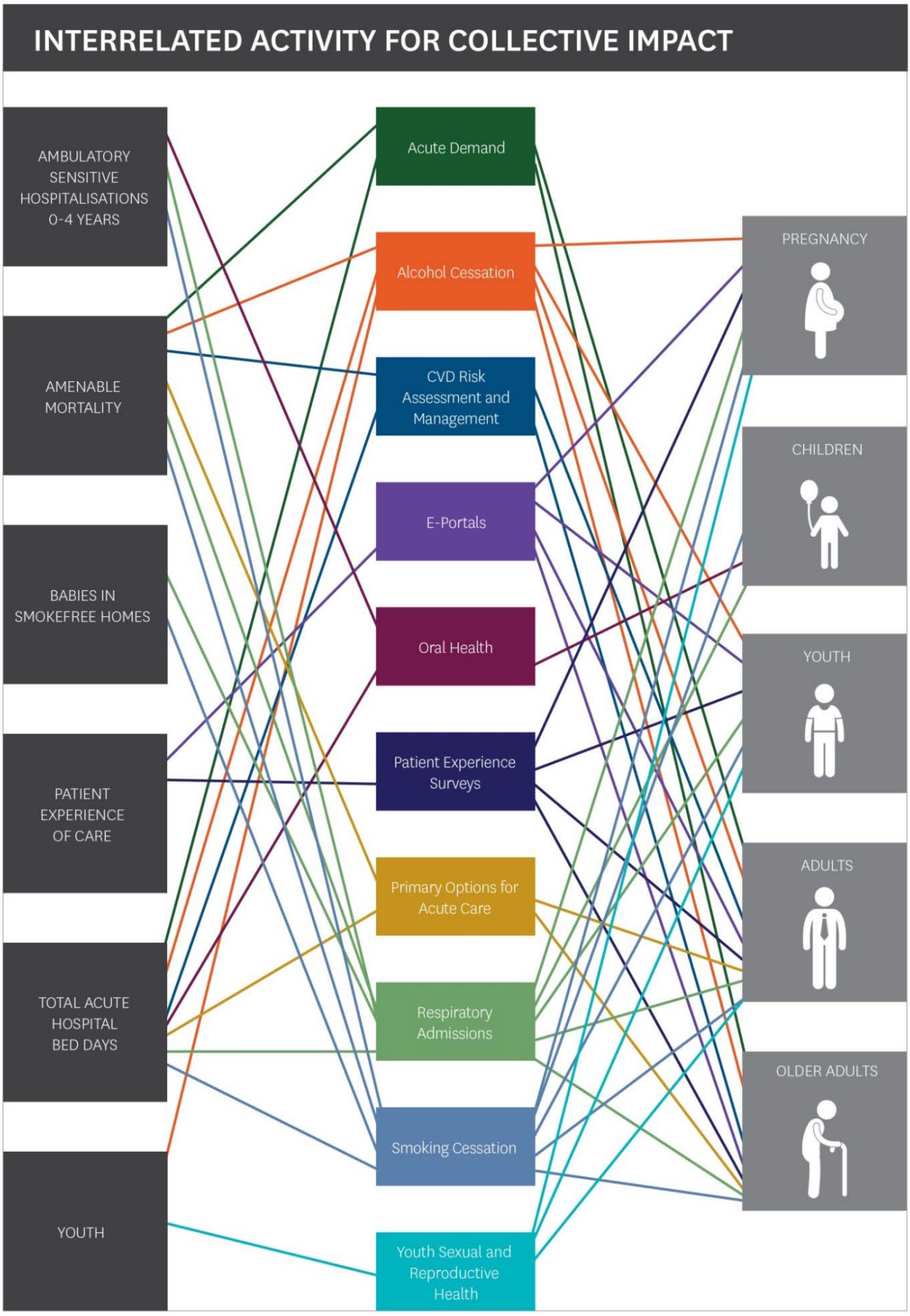
- Auckland DHB;
- Waitematā DHB, and
- Counties Manukau DHB.

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 relationship between milestones and key activity areas chosen for this improvement plan, and the stage of life they represent. In 2018/19 improvement activities and contributory measures were chosen for their application to multiple milestones where possible. Overarching priorities for 2018/19 are a prevention approach, improvements in equity of outcome or access, activities which support intervention in high risk populations, and collective impact. Population focus has been developed to include consultation with patients, family and whānau, and community in our planning and activities.

2. INTERRELATED ACTIVITY FOR COLLECTIVE IMPACT



3. PURPOSE

This document outlines how the 2018/19 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 4.1, implementation planning is developed annually to sit under this document to provide a higher level of detail.

4. BACKGROUND

The New Zealand Health Strategy outlines a high-level direction for New Zealand's health system over 10 years to 2026, 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 worked 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;
   - total acute hospital bed days per capita;
   - patient experience of care, and
   - amenable mortality rates.

b) Two further SLMs, which were implemented from 1 July 2017:
   - youth access to and utilisation of youth-appropriate health services, and
   - babies living in smokefree homes.

c) For each SLM, an improvement milestone to be achieved in 2018/19. The milestone must be a number that shows improvement (either for Māori, total population, or a specifically identified population to address equity gaps) for each of the six SLMs.

d) A brief description of activities to be undertaken by all alliancing partners (primary, secondary and community) to achieve the SLM milestones.

e) Contributory measures for each of the six SLMs that is chosen by the district alliance based on local needs, demographics and service configurations that enables the alliance to measure local progress against the SLM activities.

f) Signatures of all district alliance partners to demonstrate an integrated and partnership approach to the development and implementation of the improvement plan.

4.1 Process

In 2016, the Counties Manukau Health and Auckland Waitematā Alliances agreed to a joint approach to the development of the SLM 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.

In 2018/19, SLMs will transition to a business-as-usual state. The governance structure of Alliance Leadership and Steering Group continue to guide improvement processes. The responsibilities of the working groups will transition, with primary responsibility for implementation resting with the newly established PHO Implementation Group. This group has primary care representation and flexible subject matter expertise dependant on topic and requirements. The PHO Implementation Group will meet to further develop key actions (particularly at a local level) and inform implementations planning, monitor data, facilitate systems partnerships, and will collaboratively guide the ongoing development of the SLMs with the Steering Group and Alliance Leadership Teams. This group contributes to regional and organisational implementation plans, which sit under the Improvement Plan.

We continue to benefit from PHO leadership. The role of PHO lead has been retained from the original working group structure, and leads now have responsibility for diffused matrix management of SLM planning and implementation in their key activity areas. They continue to engage with other systems partners, broadening from pharmacy and maternity to a raft of flexible working alliances with various partners named in the 'enablers to capacity and capability' diagram in Section 5.

Reporting processes, both at a local and regional level have been embedded over the 2017/18 year. DHBs and PHOs have access to both static and dynamic reporting in order to monitor progress and identify opportunities for improvement and individual performance is routinely discussed supportively in the PHO Implementation Group.

4.2 Equity Approach, Consultation and Partnership

This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples. In planning, each contributor has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those with the poorest health outcomes.

Consultation prior to and during planning for 2018/19 was more extensive than previous years. This process was extended to better address the expectations of mana whenua, and to discuss decision-making proactively. In addition, the Māori health gain teams across the region were invited to workshop the concepts and various drafts of the plan and provided valuable input. Feedback received from the engagement sessions with stakeholders was incorporated into development of the improvement plan. This included a sector-wide pre-planning workshop, cultural consultation workshops, consumer meetings, and a presentation of draft measures, milestones and interventions to stakeholders, the Steering Group and Alliances. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

The 2018/19 Improvement Plan has been shared with the Māori, Pacific and Asian health teams at Auckland, Counties Manukau and Waitematā DHBs and their feedback has been incorporated. Consultation with the relevant cultural groups and equity partners has been an essential part of this process. The 2018/19 SLM Improvement Plan has been designed to align with DHB Māori Health Plan(s). There is ongoing engagement and dialog with Māori and Pacific providers with a view to improving service integration.

4.3 Regional Working

As in previous years, a single improvement plan has been developed in 2018/19 for the Alliances and three Metro Auckland DHBs. As a number of PHOs cross the Metro Auckland DHB boundaries and are members of both Alliances this is considered the most practical and achievable approach given limited resources. 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.

4.4 2018/19 Priorities for System Level Measures

In 2018/19, the Auckland Metro Region has focused on cross–system activities which have application to multiple milestones. Activities with a prevention focus may show collective impact across the life course over time. It seems pragmatic for each milestone to benefit equally from activities which add value in multiple areas. This is demonstrated in the 'interrelated activity for collective impact' diagram in Section 2. This year we also recognise those activities which enable achievement of the SLM activities and milestones. This essential work is the foundation for quality improvement activities, and illustrates enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

Overarching priorities for 2018/19 are a prevention approach, improvements in equity of outcome or access, activities which support intervention in high risk populations, and collective impact. We have developed our population focus to include specific consultation with patients, family and whānau, and community in our planning and activities.

5. ENABLERS TO CAPACITY AND CAPABILITY

ENABLERS TO CAPACITY AND CAPABILITY

TRAINING AND EDUCATION	▪ SLM related Continuing Medical Education/ Continuing Nursing Education is filmed and shared regionally ▪ Health literacy improvement ▪ Auckland Regional HealthPathways ▪ Resources and key messages on various SLM work streams ▪ Planned communications of key messages at regular intervals.
DATA AND INFORMATION MANAGEMENT	▪ SLM data definitions, sourcing, analysis and reporting ▪ Ongoing use of the Metro Auckland Data Sharing Framework ▪ Increased use of data to inform implementation and improvement activities ▪ National Child Health Information Platform being rolled out in A/WDHB and Northland. Offers similar functionality to Kidzlink in CMH ▪ Advanced forms for improved data collection ▪ Commitment to equity view in data analysis and reporting, identifying areas for Māori and Pacific health gain.
SYSTEMS PARTNERSHIP	▪ Lead Maternity Carer (LMC) ▪ Well Child Tamariki Ora (WCTO) ▪ Auckland Regional Dental Services (ARDS) ▪ Immunisation Advisory Center (IMAC) ▪ Association with Auckland Regional Public Health Service (ARPHS) ▪ Pharmacy support ▪ Community laboratories ▪ Primary Care teams ▪ Secondary Care services ▪ Māori and Pacific providers ▪ Health navigators and health coaches ▪ School based health services.
QI SUPPORT	▪ Use of improvement methodologies underlying improvement activities ▪ Supported integration of cross-sectorial improvement activities.
CLINICAL LEADERSHIP	▪ Liaison with Metro Auckland Clinical Governance Forum ▪ Population health clinical leadership in planning and implementation.
CULTURAL LEADERSHIP	▪ Stepwise consultation and feedback huis with Māori and Pacific providers ▪ Support from Mana Whenua.

6. SYSTEM LEVEL MEASURES 2018/19 MILESTONES

Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2019.** **3% reduction for Māori populations by 30 June 2019.** **3% reduction for Pacific populations by 30 June 2019.**

Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori populations by 30 June 2019.** **3% reduction for Pacific populations by 30 June 2019.**

Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: Baseline response rate by ethnicity by 30 June 2019.** **Primary care survey: Increase response rate for completed surveys by 2% from baseline for Māori and Pacific by 30 June 2019.**

Amenable Mortality	
System level outcome	Preventing and detecting disease early
Improvement milestone	**6% reduction for each DHB (on 2013 baseline) by 30 June 2021.** **2% reduction for Māori and Pacific by 30 June 2019.**

Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care Young people experience less alcohol and drug related harm and receive appropriate support
Improvement milestone	**Increase coverage of chlamydia testing to 15% by 30 June 2019.** **Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2019.**

Babies in Smokefree Homes	
System level outcome	Healthy start
Improvement milestone	**Increase the proportion of babies living in a smokefree homes by 2% by 30 June 2019.**

7. IMPROVEMENT ACTIVITIES AND CONTRIBUTORY MEASURES

The following section outlines the specific improvement activity plan for the six SLMs for 2018/19. Improvement activities create change and work towards improved outcomes in the various SLM milestones. These activities are measured locally by contributory measures which support a continued focus in each area. Activities support the improvement of the system as a whole. For 2018/19, Auckland Metro region are focused on choosing activities which relate to multiple milestones where possible for best collective impact.

7.1 Respiratory Admissions in 0-4 year olds

Activities	Contributory Measure
• Increase uptake of children's influenza vaccination to prevent respiratory admissions by: o Reporting newly eligible children to primary care at the beginning of influenza season. o Following up reporting of vaccination uptake provided throughout the season. o Prioritised vaccination of eligible Māori and Pacific children. o Exploring other options for delivering influenza vaccination in the community.	Increase influenza vaccination coverage for children aged 0-4 years old, who are hospitalised for respiratory illness to at least 15% (absolute) by ethnicity. Increase influenza and pertussis vaccine coverage rates for pregnant women to 50% by ethnic group.
• Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness leading to hospital admission by: o Increasing the use of pregnancy registers in primary care. o Identifying pregnant women through booking and set immunisation recalls in primary care. o Opportunistic immunisation at antenatal clinics. o Promotion of pregnancy immunisation especially to Māori and Pacific women, through the use of vouchers, in primary care, pharmacy, LMC, and in other pregnancy service providers.	Increase referrals to maternal incentives smoking cessation programmes, for pregnant women referred each quarter, to at least 46 for ADHB and 83 for WDHB, and 180 for CMH.
• Support a decrease in respiratory admissions with social determinants by: o Supporting the development and implementation of e-referrals from primary care to healthy housing programmes. o Increasing healthy housing referrals during pregnancy for low income Māori and Pacific women. o Supporting mothers and whānau of babies to live in smokefree homes by increased referrals from LMCs, primary care, healthy housing programmes, pharmacies and other referrers, to pregnancy smokefree services. o Referral of pregnant women who smoke for support to stop smoking when they visit General Practice to confirm their pregnancy.	
• Improve the quality of data collected on post-natal smoking, as an indicator of smoking in pregnancy, by: o Active support for Well Child Tamariki Ora providers to improve the quality of smoking status data, through feedback, education and reporting.	
• Support population groups who have inequitable child health outcomes by: o Identifying Māori children (and their parents and whānau) who are not enrolled in primary care and supporting enrolment with their choice of primary care provider. o Supporting a regional Pacific Providers forum to support equitable outcomes for Pacific children by improving communication and linkages. o Promotion of enrolment with WCTO providers opportunistically in primary care, particularly for Māori and Pacific children.	

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.2 Oral Health

Activities	Contributory Measure
• Primary care will share information and work collaboratively with systems partners to promote improved patient outcomes by: o Matching data from primary care to identify children enrolled, who are not enrolled in the Auckland Regional Dental Service (ARDS). o Providing data to ARDS on children identified as not enrolled in their service, for contact, and enrolment in pre-school oral health services. o Supporting the Preschool Oral Health Strategy by ongoing work with ARDS to promote and implement their lift the lip training in primary care practices. • Facilitation of ARDS lift the lip programme for Māori and Pacific Well Child Tamariki Ora providers.	95% enrolment in DHB funded oral health services for 0-4 year olds.

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.3 Youth Sexual and Reproductive Health

Activities	Contributory Measure
• Improve chlamydia testing in young people 15-24 years old in particular, and in sexual and reproductive health of youth in general by: o Increased sexual health screening for young people in a variety of youth appropriate settings. o Increased engagement of young males in a variety of youth appropriate settings. o Reporting the rate of chlamydia testing coverage across all youth health specific services, with a view to those with outstanding performance championing best practice in youth healthcare, and services with low testing coverage rates increasing their testing rates. o Implementing chlamydia prevalence reporting to relevant stakeholders, with an expectation that this prevalence will increase as testing improves. • Youth utilisation of and access to sexual health services is increased by: o Development of clear and consistent regional criteria for flexible funding pool (FFP) or SIA funded youth sexual health visits for under 22 years of age. o Continuing to work towards consistent regional criteria for free-to-youth sexual health consultations in primary care.	Increase coverage of chlamydia testing to 15% (reported by gender and ethnicity) for 15-24 year olds.

Milestones: The Youth milestone will be improved by these activities.

7.4 Alcohol Harm Reduction

Activities	Contributory Measures
• Improve data collection and reporting on alcohol harm reduction interventions through the following activities: o Development and agreement of a data standard for primary care that defines: alcohol ABC indicators, data to be collected, and standard terms and codes for data recording and extract. o Establishment of an alcohol ABC baseline in primary care for reporting indicators. o Quality improvement activities focused on data collection for alcohol-related ED presentations, including youth. • Take an integrated approach to alcohol harm reduction by working with other systems partners: o Work with ambulance services and urgent/after-hours services to explore the availability of alcohol-related data and feasibility of adopting/developing alcohol ABC data standard and reporting. o Work with student and other youth health services to explore the availability of alcohol-related data and feasibility of adopting/developing alcohol ABC data standard and reporting.	Baseline measurement of delivery of alcohol ABC in general practice. Establish a baseline for alcohol-related ED presentations. Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2019.

Milestones: The Amenable Mortality, Total Acute Hospital Bed Days and Youth milestones will be improved by these activities.

7.5 Smoking Cessation for Māori and Pacific

Activities	Contributory Measure
• Patient outcomes related to harm from smoking will be improved by: o Continuing to focus on brief advice in primary care. o An increase in referrals to cessation support. o Support for the delivery of medication therapy in primary care. • The importance of smoking cessation as an intervention will be promoted by: o Continued working with cessation providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services. o Further development of smoking indicators from PMS data to inform primary care interventions. o Development of a communication plan with regular updates to primary care and other referrers (i.e. LMCs, WCTO) to increase engagement in smoking cessation.	An increase in cessation support received by enrolled patients who are current smokers by 10%. Metro Auckland smoking indicators (in development). Establish a baseline with a view to an increase in the proportion of smokers who receive medicines to support their cessation.

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.6 Cardiovascular Disease (CVD) Risk Assessment and Management

Activities	Contributory Measure
• Primary care and systems partners work together to support equitable CVD RA for Māori by: o Provision of prioritised lists of eligible patients for risk assessment to practices, with Māori and Pacific first. o Referral of highest risk Māori to culturally appropriate providers for self-management and wellness support. • Identification of and support to enrol Māori patients who are seen by Māori providers and are not enrolled in primary care. • In the absence of a tool to fully implement the National Consensus Statement for Assessment and Management of CVD in Primary Care, a staged process will be designed to facilitate uptake and use of the tool when it becomes available. • Continued reporting of the indicator 'prescribed dual therapy for those with CVD RA greater than 20%', with a view to emphasis of the importance of this intervention, throughout change created by the implementation of the National Consensus Statement for Assessment and Management of CVD in Primary Care. • Where the equity gap for Māori and Pacific has closed, PHOs are to identify other populations with unequitable access and facilitate interventions for those groups. • Reporting and improvement of clinical management through prescribing is facilitated through: o Continued development of NHI level reporting in secondary prevention. o Comparing dispensing data to prescribing data and identifying any opportunities for improvements. • Improved outcomes for patients with a high risk of CVD event are sought by: o Patients who have previously had a CVD event and who are eligible receive the funded influenza vaccination. o Interventions to improve uptake of triple therapy for Māori and Pacific people. o Development and implementation of processes for identification of patients with serious mental illness (SMI) in primary care to support an annual CVD risk management review. • Opportunities to improve data collection and quality are advanced through: o Development and baselines for a set of quality indicators to support the implementation of CVD consensus statement (with a focus on coding specified conditions e.g. IHD, AF, CKD, diabetes, SMI). o Development of an indicator and establishment of baselines for influenza vaccination coverage in patients with a prior CVD event under 75 years of age. o Extension of the current CVD data extract to include a domicile field for DHB level reporting.	90% CVD RA for Māori.5% increase (relative) in prescribed triple therapy for those Māori and Pacific with a prior CVD event. Develop an indicator and establish baseline for influenza vaccination coverage for patients with a prior CVD event under 75 years of age.

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.7 Complex Conditions

Activities	Contributory Measures
• Chronic obstructive pulmonary disorder (COPD) and coronary heart failure (CHF) patients are supported to best access appropriate health services through: o Refinement of the end to end patient journey for CHF and COPD. o Improvements in coding in primary care for specified long term and complex conditions (e.g. COPD and CHF). o Quality improvement activities which support transfer of care o Testing of appropriate primary care based bundles of care for COPD and CHF patients. • Māori and Pacific patients with ASH conditions (e.g. CHF, CVD, COPD, AF/Stroke and Cellulitis) receive appropriate clinical support: o Māori and Pacific patients aged 45-64 with ASH conditions who are eligible receive the funded influenza vaccination. o Māori and Pacific patients who present in primary care with ASH conditions, or comorbidities which contribute to ASH conditions, are referred to appropriate self-management or wellness support services. o Primary care collaborates with Māori providers to identify the Māori primary care population with long term conditions with a view to additional support. • Patients who have SMI have their general health and wellness reviewed annually.	2% reduction in ASH rates for COPD and CHF for adults aged 45-64 years old. 2% reduction in the overall ASH rate for both Māori and Pacific adults aged 45-64 years old.

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.8 Primary Options for Acute Care (POAC)

Activities	Contributory Measure
• PHOs will work together with the POAC team to support practices to utilise POAC for high needs populations, particularly Māori and Pacific people aged 45-64 by: o Increasing utilisation of POAC for high needs populations, particularly Māori and Pacific people aged 45-64, through promotion by PHOs. o Increasing utilisation of POAC for ASH conditions, particularly, CHF, COPD and cellulitis. o Linking with ambulance services to increase POAC utilisation where patients are able to be best managed in the community, if transport or social requirements are met. o Investigation of options for supportive, early discharge from hospital, such as usage of POAC, interim care, or early discharge services managed by primary, community or secondary care providers.	Increased POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions to 3 per 100 for each PHO.

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.9 E-portals

Activities	Contributory Measure
• Increase practices offering prescription orders, lab results and/or consultation notes, initially by increased visibility of practices providing this service, through e-portals, followed by investigation of benefits and promotion of value to early adopters. • Continued support for patient enrolment (logon) to e-portals by practices. • PHO actively support practices to improve in patient uptake (logon) by distribution of resources and information.	Baseline and increase in practices offering prescriptions, laboratory results, and view of consultation notes. Increase to 20% of each PHO's enrolled population with login access to a portal.

Milestones: The Patient Experience of Care milestone will be improved by these activities.

7.10 Patient Experience Surveys in Primary and Secondary Care

Activities	Contributory Measure
• Primary care will improve patient experience by: o Implementing a programme of responsive improvement activity following survey results, including: ▪ Practices supported to participate in 'You said, we did' (PES to PDSA) PHC PES feedback quality improvement initiative, quarterly. o Work with the HQSC to improve the PHC PES to better engage Māori, Pacific and Asian respondents, including implementation of new culturally specific resources supplied by the HQSC. o Improved recording of cell phone numbers and email addresses in practice management systems, to enable sending of PHC PES invitations. o Secondary care will improve patient experience by: o Ongoing work in DHB settings focusing on culturally appropriate, patient-centered communication. o Sharing learnings with primary care through established networks and forums. o Improve visibility of reporting of Māori and Pacific response rates, with a view to encouraging awareness. o Activity to support community pharmacy teach-back method to improve patient medicines knowledge. • Primary and secondary care will work together to explore the underlying data for Māori and Pacific patients enrolled in primary care to identify barriers to participations in the PHC PES.	50% of each PHOs practices participating in PHC PES to PDSA 'You said, we did' quality improvement initiative at least once in the financial year. Increase response rate for completed surveys by 2% for Māori and Pacific from baseline by 30 June 2019. Maintain or increase practice participation in the PHC PES as at end June 2018. Baseline response rate by ethnicity in the secondary care in-patient survey.

Milestones: The Patient Experience of Care milestone will be improved by these activities.

8. SYSTEM LEVEL MEASURE MILESTONES IN DETAIL

8.1 Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2019.**
	3% reduction for Māori populations by 30 June 2019.
	3% reduction for Pacific populations by 30 June 2019.

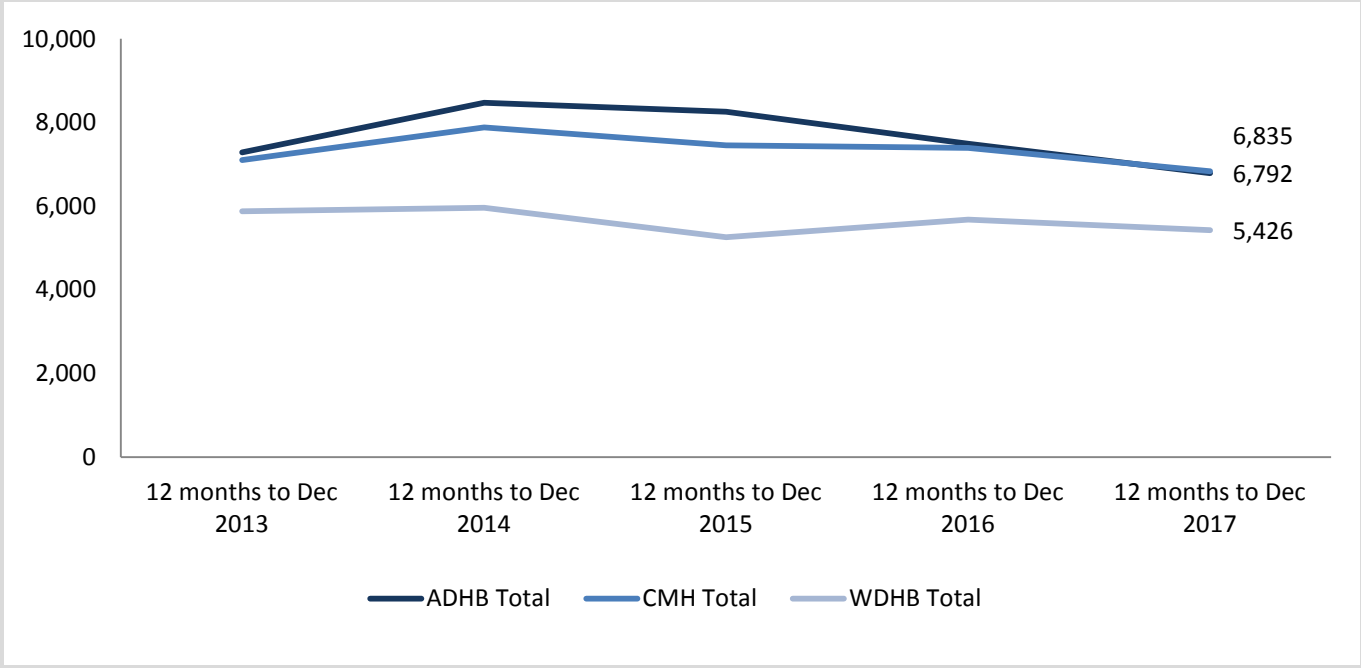
Ambulatory sensitive hospitalisations are admissions considered potentially preventable through pre-emptive or therapeutic interventions in primary care. The admissions included are made up of a specified set of discharge codes considered to be ambulatory sensitive, and are assigned based on the primary diagnosis. 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.

In addition to immunisation, smoking cessation and improving the housing environment are important for improving this milestone; this year we have chosen to focus on these aspects of the Child and Adolescent Asthma Guidelines, fitting with a broader focus on respiratory admissions, which is the largest contributor to Ambulatory Sensitive Hospitalisations in 0-4 across the three DHBs. In addition we are working to improve enrolment in the dental service.

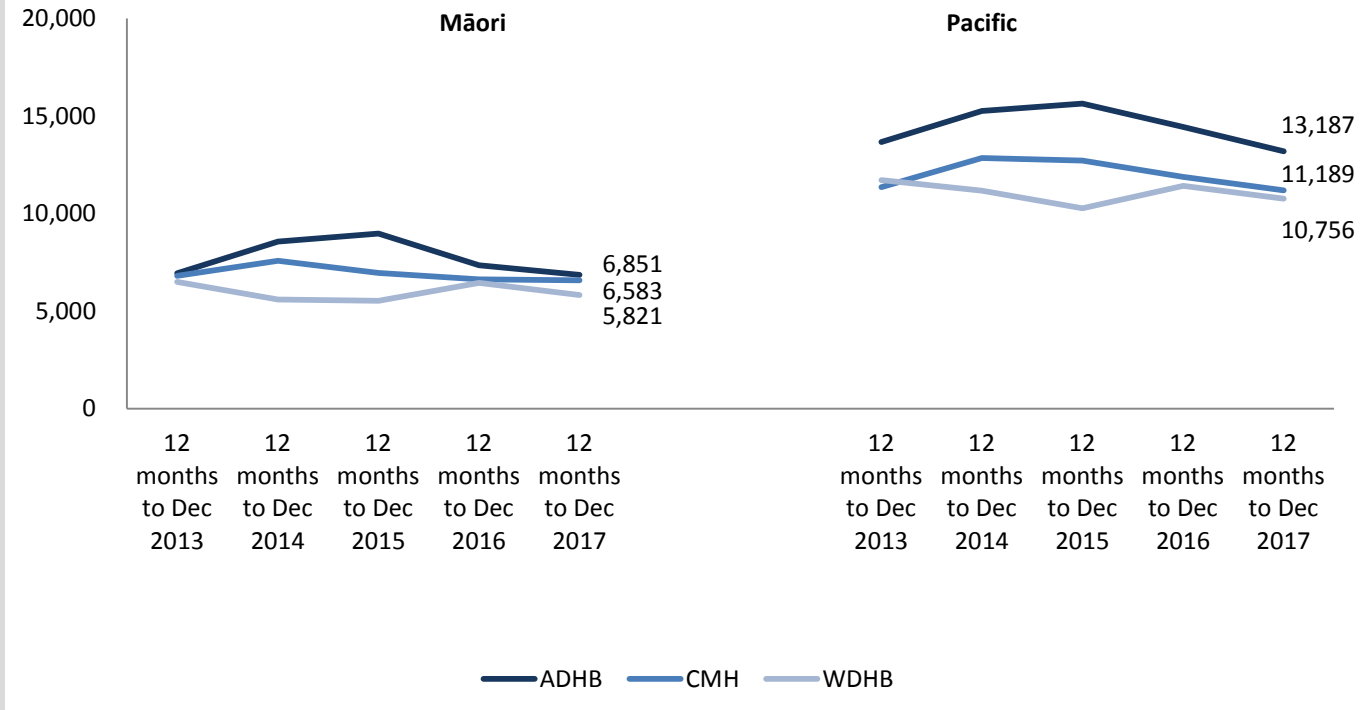
We plan to connect this work with the increased immunisation for eight-month olds indicator which will support improved outcomes.

This year we aim to maintain our improvement in total rate and focus on an equity related improvement for Māori and Pacific rates.

Rate per 100,000 of Ambulatory Sensitive Hospitalisations (ASH) in children aged 0-4 years.



Rate per 100,000 of Ambulatory Sensitive Hospitalisations (ASH) in children aged 0-4 years for Māori and Pacific.

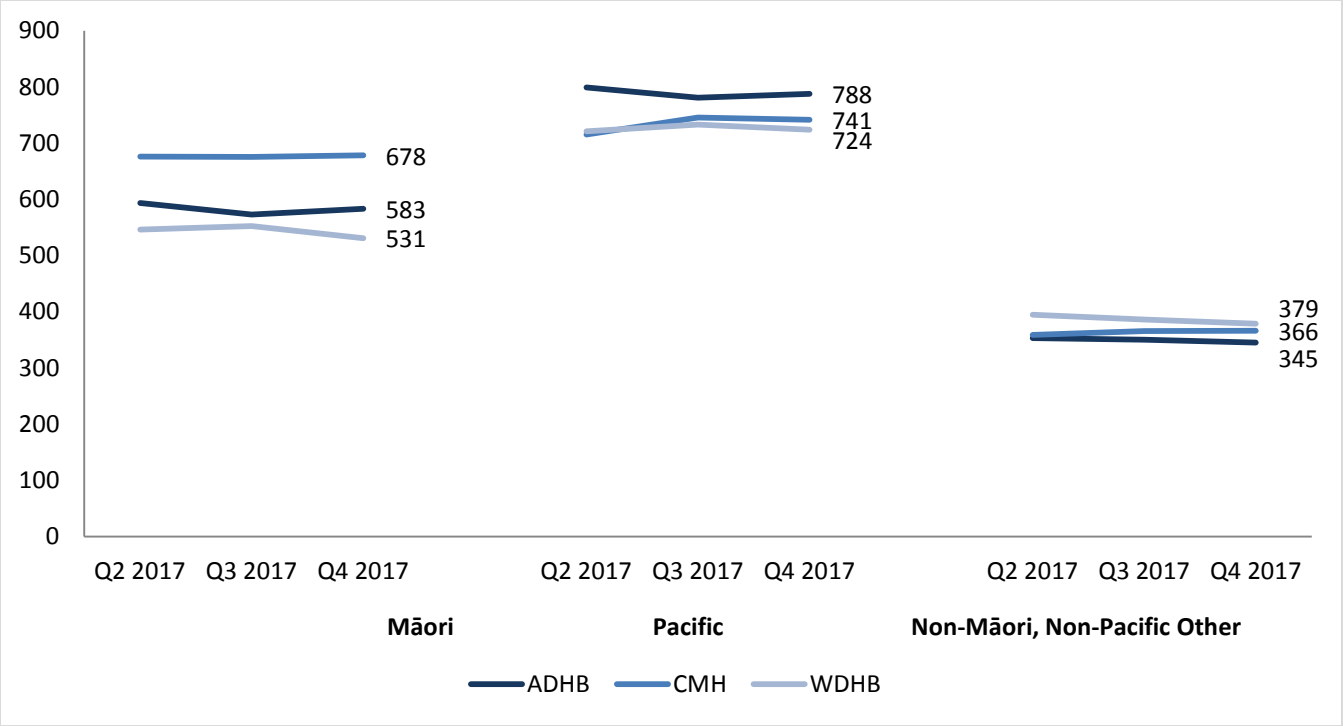


8.2 Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori population by 30 June 2019.**
	3% reduction for Pacific population by 30 June 2019.

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between community and hospital settings, optimal discharge planning, development of 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 acute bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific targets 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 prevention and treatment of conditions that contribute the most to acute hospital bed days. Conditions identified as highest priority include congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and cellulitis. Total acute hospital bed days for 2017/18 for Māori and Pacific identify marked inequities when compared to non-Māori, non-Pacific rates, so we will also focus on patients from this population in addition to the prioritised conditions.

Acute hospital bed days rate per 1,000. Calendar quarter, rolling 12 months by ethnicity



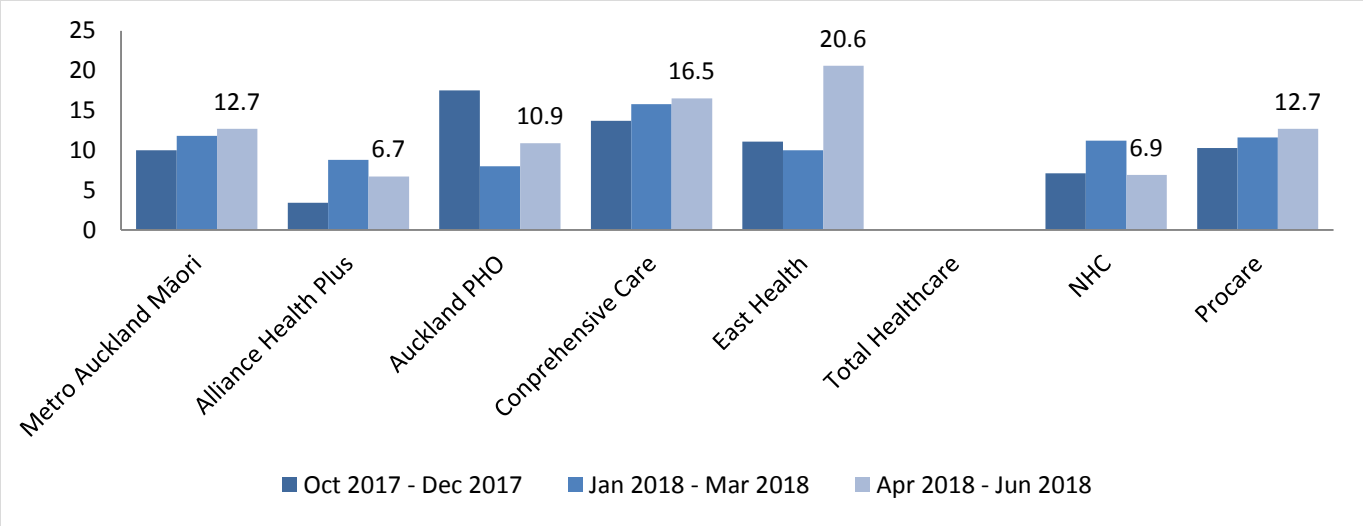
8.3 Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: Baseline response rate by ethnicity by 30 June 2019.** **Primary care survey: Increase response rate for completed surveys by 2% from baseline for Māori and Pacific by 30 June 2019.**

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) domains cover key aspects of a patient's experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs.

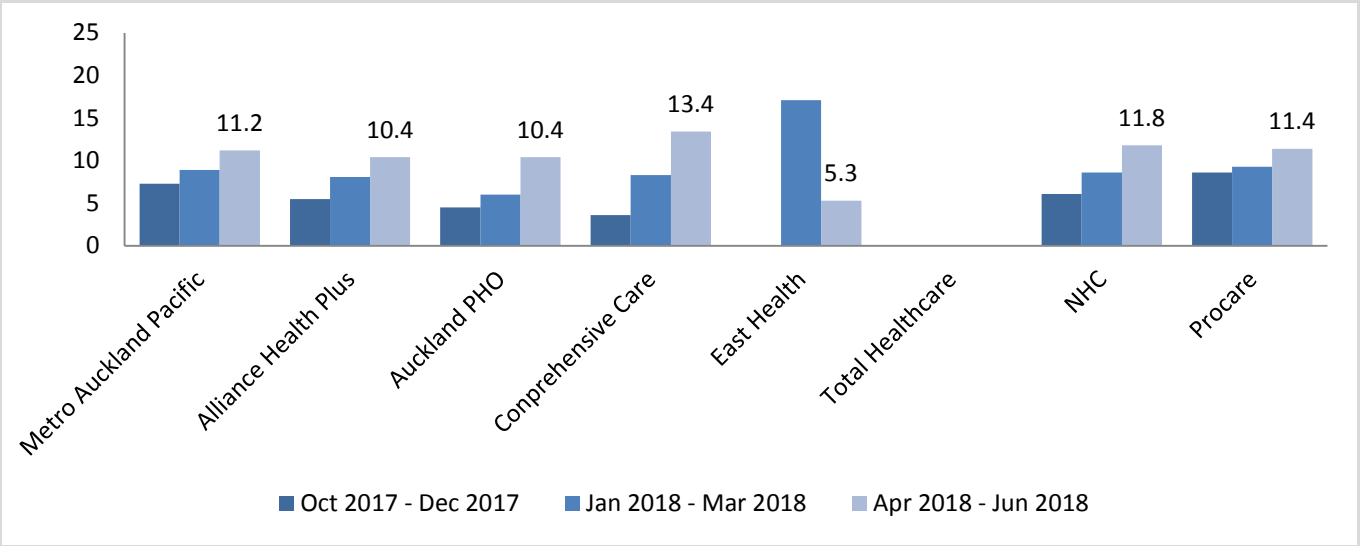
Hospital Inpatient PES: This has been in place since 2014. The milestone for 2018/19 has been selected to begin work on an increase in responses from Māori and Pacific patients. Ethnicity data is available at a local level but will require some work to collate before a baseline is available. This will be supported by continued work on improved communication in hospital, with a stronger focus on culturally appropriate communication and health literacy.

Primary Health Care PES: The PHC PES was developed more recently and has been implemented in practices over the 2017/18 year. Completed surveys for Māori and Pacific invitees are lower than for European. As such, the focus this year is on increasing the response rate for Māori and Pacific invitees, to work towards equitable response rates. This will be supported by work towards utilization of the PHC PES data by practices, for PDSA improvement cycles.

PHC PES response rate for Māori invitees



PHC PES response rate for Pacific invitees



8.4 Amenable Mortality	
System level outcome	Preventing and detecting disease early
Improvement milestone	**6% reduction for each DHB (on 2013 baseline) by 30 June 2020.** **2% reduction for Māori and Pacific by 30 June 2019.**

Two contributory measures have been consistent in amenable mortality improvement planning to date, those that have the greatest evidence-based impact – cardiovascular disease (CVD) management and smoking cessation. In 2018/19 we aim to build on the work already underway in this area and embed the new Consensus Statement for Assessment and Management of CVD. We plan to achieve a 2% reduction in our milestone for each DHB to contribute to our 2021 target. We note we have transitioned to regionally agreed Metro Auckland Clinical Governance indicators in the CVD contributory measure this year.

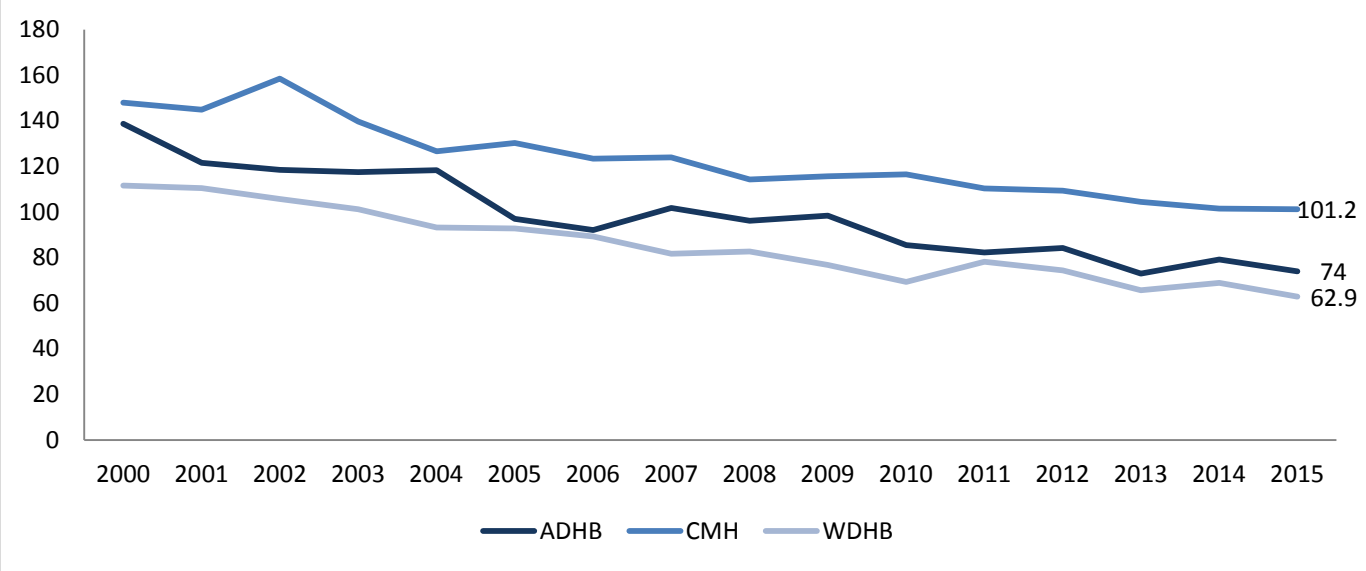
CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed 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.

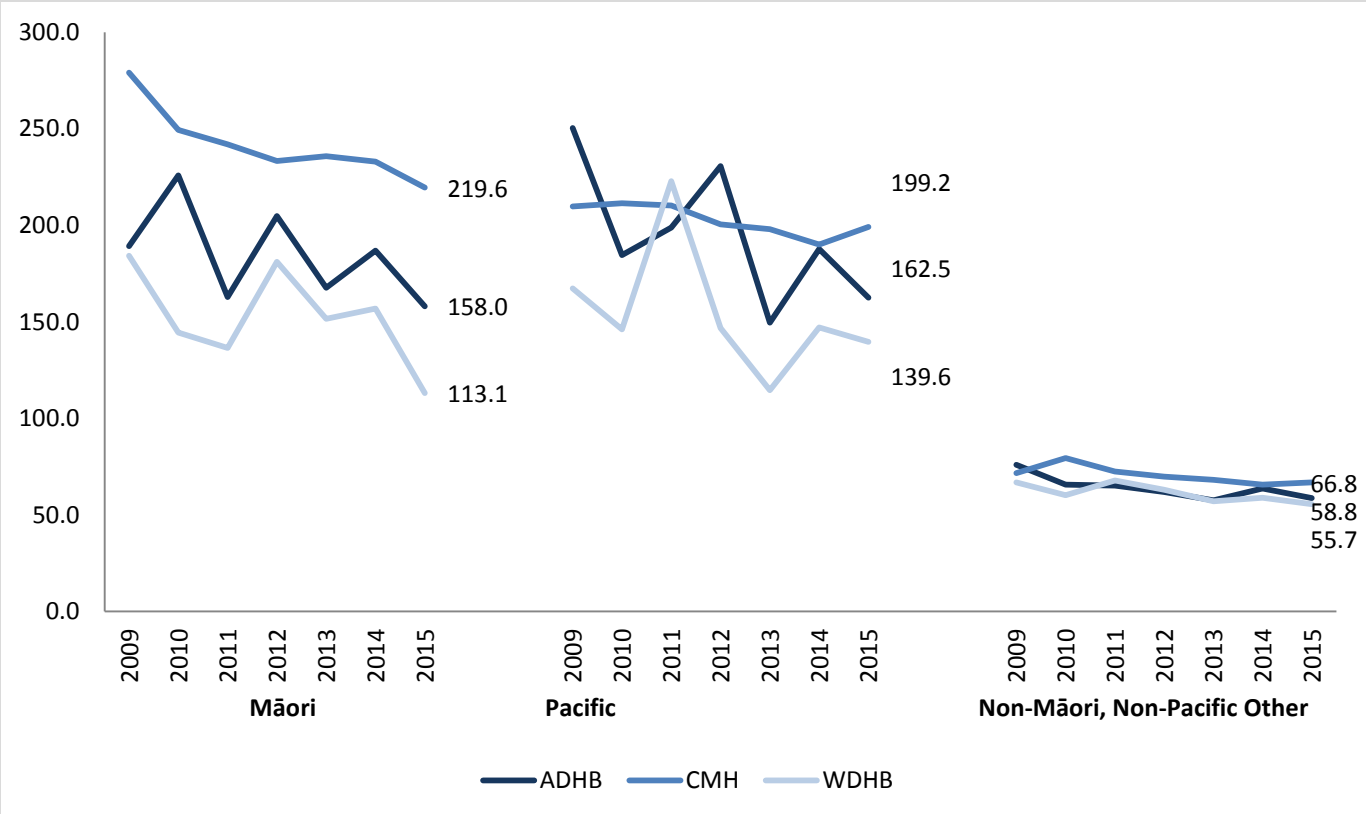
Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and 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.

We plan to connect this work with the Better Help for Smokers to Quit indicator which will support improved outcomes.

Amenable mortality rates per 100,000. Rates are age standardised to WHO world standard population.



Amenable mortality rates per 100,000 by ethnicity. Rates are age standardised to WHO world standard population.



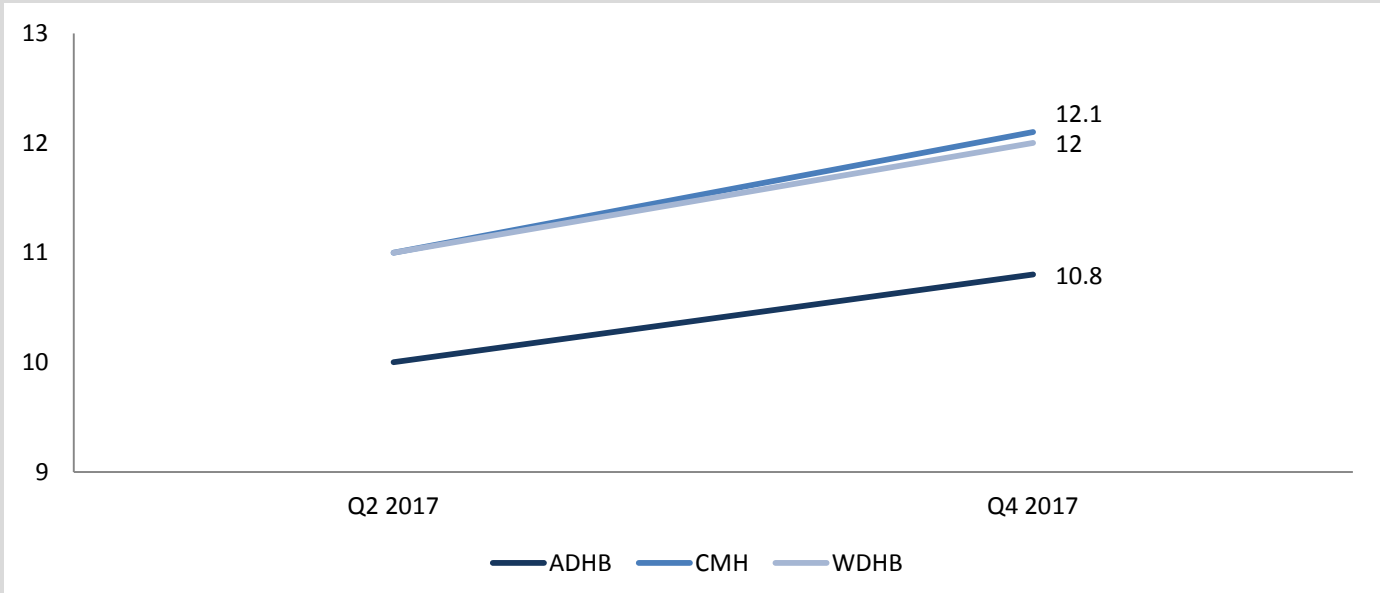
8.5 Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care Young people experience less alcohol and drug related harm and receive appropriate support
Improvement milestone	**Increase coverage of chlamydia testing rate to 15% by 30 June 2019.** **Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2019.**

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 may progress to adults with an increased risk for poor health and overall poor life outcomes through disengagement and isolation from society and riskier behaviours, in terms of drug and alcohol abuse and criminal activities.

Chlamydia testing coverage: This is an indicator of young people's access to confidential youth appropriate comprehensive healthcare. For those young people 15 years and older who have been, or are sexually active, access to chlamydia testing is an indicator of access to condoms, contraceptives, and to a discussion with a clinician about consent, sexuality and other harm minimisation. For some young people this may mean addressing their safety, unmet mental health needs, or alcohol and drug problem.

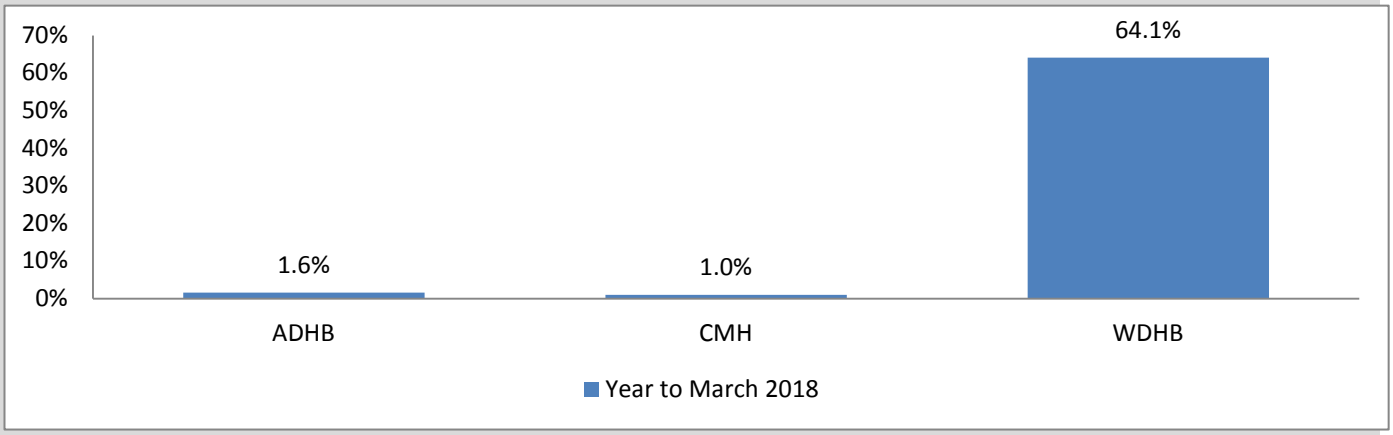
Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most often diagnosed in females aged 15-19 years and in males aged 20–24 years. Māori and Pacific young people have substantially higher rates of chlamydia than non Māori non Pacific youth. In addition, when tested, males are more likely to test positive, although this may be because they are only presenting when they have symptoms. 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. For testing coverage to be effective in reducing the prevalence of chlamydia it needs to target those who have the highest risk of infection, namely males, and Māori and Pacific youth of either gender.

Sexual and Reproductive Health - Chlamydia test rate of youth aged 15-24 years



Alcohol-related ED presentations: Identifying and monitoring alcohol-related ED presentations will enable better understanding of alcohol harm, populations and communities most affected. From July 2017, a mandatory data item was added to the National Non-admitted Patient Collection. In some DHBs, full implementation and reporting to the Ministry is not complete or is more recent than 1 July 2017. The mandatory question is "Is alcohol associated with this event?" Possible answers are: yes, no, unknown and secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved). It should be noted that the response recorded may be a subjective assessment by healthcare staff and not confirmed by alcohol testing. Data quality is still poor, with significant missing data in some areas, therefore the 2018/19 plan will focus on quality improvement for alcohol data collection across primary care, youth services, and emergency departments.

Alcohol-related ED presentations – Percentage of total ED attendances with 'unknown' alcohol relationship status

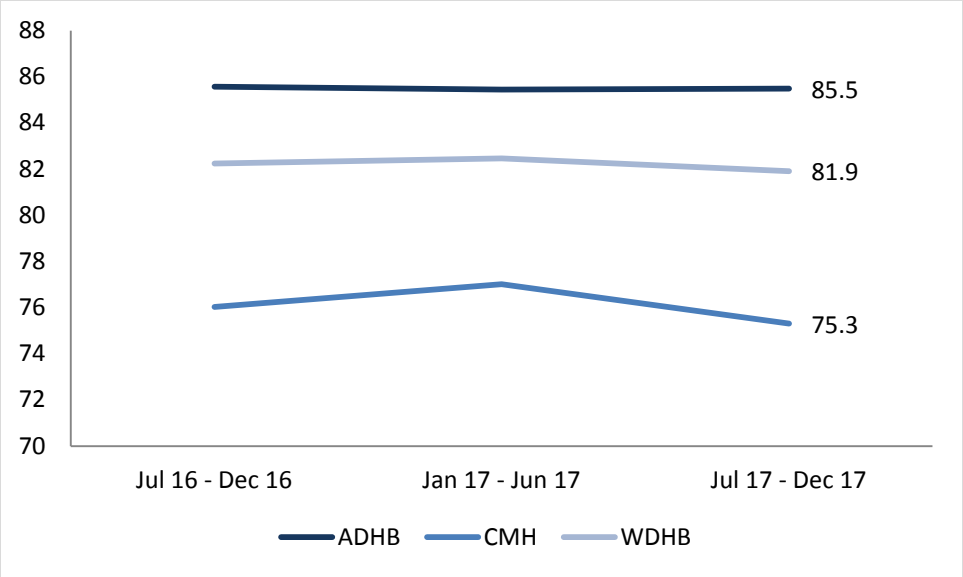


8.6 **Babies in Smokefree Homes**	
System level outcome	Healthy start
Improvement milestone	**Increase the proportion of babies living in smokefree homes by 2%**

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/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises 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.

Data from Well Child Tamariki Ora providers now suggests that around 75-85% of babies live in a smokefree household at 6 weeks post-partum. Data reported for the 2017/18 plan indicated that data quality was an issue, and an improvement programme was put in place at a national level throughout 2017/18. Data supplied in June 2018 was of sufficient quality to move from a measure of data quality to a quality improvement focus. There is still some work to be done, as data does not reflect live births. This may be improved by an increase in the proportion of births enrolled with WCTO providers. This work should support both smoking intervention in pregnancy and the post-natal period, and continued quality data collection in the Well Child Tamariki Ora space.

Proportion of Babies Living in a Smokefree Homes at 6 weeks post natal



9. GLOSSARY

ABC	Assessment, Brief Advice, and Cessation Support
ADHB	Auckland District Health Board
AF	Atrial Fibrillation
ARDS	Auckland Regional Dental Service
ARPHS	Auckland Regional Public Health Service
ASH	Ambulatory Sensitive Hospitalisations
A/WDHB	Auckland/Waitematā District Health Boards
CHF	Coronary Heart Failure
CKD	Chronic Kidney Disease
CME/CNE	Continuing Medical Education/Continuing Nursing Education
CMH	Counties Manukau Health (referring to Counties Manukau District Health Board)
COPD	Chronic Obstructive Pulmonary Disorder
CVD	Cardiovascular Disease
CVD RA	Cardiovascular Disease Risk Assessment
DHB	District Health Board
ED	Emergency Department
GP	General Practice/General Practitioner
HQSC	Health Quality Safety Commission
IHD	Ischaemic Heart Disease
IMAC	Immunisation Advisory Center
LMC	Lead Maternity Carer
MACGF	Metro Auckland Clinical Governance Forum
MADSF	Metro Auckland Data Sharing Framework
PDSA	Plan, Do, Study, Act
PES	Patient Experience Survey
PHC PES	Primary Healthcare Patient Experience Survey
PHO	Primary Healthcare Organisation
PMS	Practice Management Systems
POAC	Primary Options for Acute Care
SLM	System Level Measure
SMI	Serious Mental Illness (refers to schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder as per the National Consensus Statement for Risk Assessment and Management of CVD in Primary Care)
STI	Sexually Transmitted Infection
UK	United Kingdom
WDHB	Waitematā District Health Board
WCTO	Well Child Tamariki Ora

APPENDIX E: DHB BOARD AND MANAGEMENT

Governance for our DHB is provided by a Board 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	Professor Judy McGregor, Chair	(appointed)
	Kylie Clegg, Deputy Chair	(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 Waitematā DHB	Dr Dale Bramley	Chief Executive
	Robert Paine	Chief Financial Officer
	Dr Debbie Holdsworth	Director of Funding (Waitematā, Auckland DHBs)
	Dr Karen Bartholomew	Acting Director of Health Outcomes (Waitematā, Auckland DHBs)
	Dr Andrew Brant	Chief Medical Officer
	Dr Jocelyn Peach	Director of Nursing and Midwifery, Emergency Systems Planner
	Lucy Adams	Associate Director of Nursing
	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) Medical, Associate Chief Medical Officer
	Dr Michael Rogers	Chief of Surgery, Director of Elective Surgery Centre
	Debbie Eastwood	GM Surgical and Ambulatory Services
	Dr Meia Schmidt-Uili	HOD Child, Women and Family Services
	Stephanie Doe	GM Child, Women and Family Services
	Susanna Galea	Clinical Director of Specialist Mental Health and Addiction Services
	Pam Lightbown	GM Specialist Mental Health and Addiction Services
	Fiona McCarthy	Director of Human Resources
	Dame Rangimarie Naida Glavish	Chief Advisor Tikanga (Waitematā, Auckland DHBs)
	Dr Penny Andrew	Director of the Institute for Innovation and Improvement
	Dr Sheryl Jury	Clinical Director of Health Gain
	Dr Gerard de Jong	HOD Acute and Emergency Medicine
	Alex Boersma	GM Acute and Emergency Medicine
	Dr John Scott	HOD Specialty Medicine and Health of Older People
	Brian Millen	GM Specialty Medicine and Health of Older People
	Nigel Ellis	GM Facilities and Development
	Bruce Levi	GM Pacific Health (Waitematā, Auckland DHBs)
	Riki Nia Nia	GM Māori Health (Waitematā, Auckland DHBs)
	David Price	Director of Patient Experience
	Matthew Rogers	Director of Communications

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