Waitematā District Health Board
Best Care for Everyone

2019/20 Annual Plan

Incorporating the 2019/20-2022-23 Statement of Intent and 2019/20 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 ngā mana, e nga reo, e nga karangarangatanga tangata
E mihi atu nei ki a koutou
Tēnā koutou, tēnā koutou, tēnā koutou katoa
Ki wā tātou tini mate, kua tangihia, kua mihia kua ea
Rātou, ki a rātou, haere, haere, haere
Ko tātou ēnei ngā kanohi ora ki a tatou
Ko tēnei te kaupapa, 'Oranga Tika', mō te iti me te rahi
Hei huarahi puta hei hāpai tahi mō tātou katoa
Hei Oranga mō te Katoa
Nō reira tēnā koutou, tēnā koutou, tēnā 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 tētahi atu ki waho
Te Tihi Oranga O Ngāti Whātua"

The Waitematā District Health Board Annual Plan for 2019/20 is signed for and on behalf of:

Waitematā District Health Board

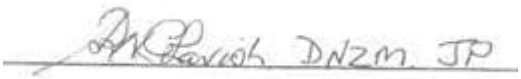
Professor Judy McGregor CNZM
Chair

Kylie Clegg
Deputy Chair

Dr Dale Bramley
Chief Executive

Our Te Tiriti o Waitangi partner

Te Runanga o Ngati Whātua



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

And signed on behalf of:

The Crown

Hon Dr David Clark
Minister of Health

Date 13/12/19

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

16 DEC 2019

FILE COPY

Ms Judy McGregor
Chair
Waitemata District Health Board
chair@waitematadhb.govt.nz

Dear Judy

Waitemata District Health Board 2019/20 Annual Plan

This letter is to advise you I have approved and signed Waitemata District Health Board's (DHB's) 2019/20 Annual Plan for one year.

I have made my expectations on improving financial performance very clear. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets. I am approving your plan with the expectation that you will continue to focus on opportunities for improving financial results for 2019/20 and into 2020/21 and beyond. The out-years have not been approved.

I am aware that you have advised the Ministry of Health (Ministry) of a break-even out-years position. However, I have asked the Ministry to request detail on the development of your savings plans for out-years as part of your 2019/20 quarter two report. I expect this report will include a granular and phased focus on cost containment, productivity and efficiency, quality, safety, and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

It is expected that as Chair, along with your Board, you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast. Should the DHB experience liquidity issues, please keep the Ministry informed of the likely timing of the need for liquidity support. Signalling the need for equity in the Annual Plan does not imply that an equity request will be approved. The available equity is limited and applications for equity support will be subject to a rigorous prioritisation and approval process.

I am aware you are planning a number of service reviews in the 2019/20 year. My approval of your Annual Plan does not constitute acceptance of proposals for service

+64 4 817 8709 Private Bag 18041 Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

changes that have not undergone review and agreement by the Ministry. 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 that will deliver on our Government's Wellbeing priorities.

I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions identified in your Annual Plan.

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 2019/20 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.

TABLE OF CONTENTS

SECTION 1: Overview of Strategic Priorities

Foreword from our Chair and Chief Executive

Waitematā DHB is committed to the relief of suffering and promotion of wellness among all who use our services, now and in the future.

Our planning and everyday delivery of healthcare is underpinned by our organisational promise to deliver the best care to everyone, by reducing health inequities and maintaining the highest life expectancy in New Zealand.

Equity achievement is at the forefront of everything we do and is a driving factor in our ongoing work with iwi to develop a high performing and efficient health system that honours the beliefs and values of our Te Tiriti o Waitangi (Treaty of Waitangi) partners.

Our catchment is home to one of the fastest growing populations in the country. More than 639,000 people live in Waitematā and that number is expected to increase to 739,000 by 2025. Our DHB values include striving to be 'better, best and brilliant', and to provide compassionate care to all who engage in our services. In 2019/20, we plan to continue the rapid expansion of our services in order to meet our population's needs, through:

- building a new $200+ million surgical hospital on the North Shore Hospital campus, creating significant additional elective capacity to meet the future health needs of our catchment and the broader region
- continuing work to build a $22 million, 15-bed, medium security unit at our Regional Forensic Psychiatry Service, known as the Mason Clinic in Pt Chevalier
- establishing a Treaty of Waitangi-based partnership board with iwi from Tāmaki and Te Tai Tokerau to lead work to improve local and regional Māori health outcomes for Northland, Waitematā and Auckland DHBs
- working with the inaugural Waitematā DHB Consumer Council to better understand the needs of our diverse population
- rebuilding the Waitakere Hospital Special Care Baby Unit, boosting bed capacity from 12 to 18 to help meet projected regional growth
- continuing to develop a $16.7 million addiction treatment centre, due to open as part of the Auckland City Mission HomeGround project in 2020.

These initiatives follow a year of significant milestones, including:

- upgraded our Radiology Departments to ensure easy access to an improved diagnostic imaging service with three new CT scanners installed across our hospitals
- completing ward refurbishment to improve patient and visitor experience at North Shore Hospital
- opening a new centre for paediatric and maternity clinics adjacent to North Shore Hospital
- partnering with Te Awanui-a-rangi to offer a diploma in Te Reo to all staff, an initiative taken up by hundreds, reflecting our desire to be more responsive to the needs of both our staff and our community
- opening of a new spiritual centre at Waitakere Hospital - Wairua Tapu, Chapel of the Holy Spirit.

Immunisation remains a priority and our DHB also places a strong emphasis on early detection and intervention in our daily efforts to help people stay healthy. An example is the Awhi Tamariki health screening and prevention programme, where public nurses screen children in low decile schools for treatable illnesses to prevent unnecessary suffering.

Our efforts are, as always, designed to improve equity of outcomes and enhance patient, family and whānau experience. We do this by making our services as accessible and user friendly as possible, by being patient focused and compassionate.

Our Institute for Innovation and Improvement (i3) continues to set the pace on this front, supporting and implementing ground-breaking and high-tech initiatives to maximise health outcomes for our people and give them the best possible experience. An example is the increased use of teleclinics by our services, which offers an alternative, where appropriate, to people who live far away or have travel difficulties. In June, Leapfrog won the Business Transformation through Digital and IT category of the 2019 NZ CIO awards. Notable Leapfrog projects include eVitals and ePrescribing.

None of what we do would be possible without our hardworking and dedicated staff, who frequently go to extraordinary lengths to make it all happen. Their phenomenal work makes a difference in the lives of thousands of people every day, and we again 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 639,000 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.

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 84.2 years (2016-18), with an increase of 3.7 years since 2001.

Waitematā DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. We employ around 8,100 people.

In 2019/20, we have a budget of $1.8 billion.

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.

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 our population's health needs 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 balanced alongside national and regional priorities. These processes inform the Northern Region Long-Term Health Plan (NRLTHP), which sets the longer-term priorities for DHBs in the northern region and this Annual Plan.

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.

It details the key activities identified by the Minister for delivery in 2019/20. There is a strong focus on improved performance and access, financial viability, health equity and service performance to meet legislative requirements. DHBs have been asked to demonstrate a renewed focus on their strategic direction; this is presented in our refreshed Statements of Intent (SoI), in Appendix A.

More detailed reporting, including Financial Performance and Statement of Performance Expectations for 2019/20, is contained in the appendices

Equity

While our population is diverse, the health status of the majority of our population is very good and we are a relatively affluent population. All DHBs have a distinct Te Tiriti o Waitangi responsibility for Māori health improvement and a legislative responsibility to reduce health inequalities. Māori in our district have better health outcomes when compared with Māori in other DHBs.

However, some of our population experience inequalities in health outcomes, and ethnicity is the strongest equity parameter. One in twelve (8%) of our total population versus 22% of Māori and Pacific live in areas ranked as highly deprived, concentrated in the Waitakere and Henderson areas. Individuals living in these areas tend to experience poorer health outcomes than those living elsewhere.

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, Pacific, Asian and other groups.

We are developing strong partnerships focused on health equity. Collaboration with our partners will allow us to offer models of care that are whānau-centric, comprehensive and holistic. As leaders in our community, it is fundamental that we understand our population, how they view health and how they want us to support them, therefore improved engagement is needed.

Equity is an over-arching priority in our performance framework, detailed in our SoI (Appendix A). We have selected a suite of high level outcome measures where equity gaps currently exist and we aim to reduce these gaps over the medium to long term.

We will establish a Treaty of Waitangi-based partnership board with iwi from Tāmaki and Te Tai Tokerau to lead work to improve local and regional Māori health outcomes for Northland, Waitematā and Auckland DHBs.

The current focus is on regional initiatives and major system change projects across the priority areas of child and youth health, mental health, and primary health care (prevention and screening).

We plan to refresh our current Pacific Health action plan (2016-2020) for 2020-2025 in consultation with our Pacific communities, PHOs and representatives of Pacific providers to jointly identify key priority areas and improve Pacific health outcomes.

The findings from the International Benchmarking of Asian Health Outcomes for Waitematā DHB will guide initiatives where there are unequal health outcomes for Asian people.

We are also committed to the principles of the United Nations' Convention on the Rights of Persons with Disabilities and are guided by 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.

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 Māori as equal partners with the Crown.

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 of Māori communities, and achieves equitable health outcomes for Māori.

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)
We will ensure Māori oversight and ownership of decision-making processes necessary to achieve Māori health equity. Active partnerships with iwi and Māori communities will ensure that Māori health equity drives, and Māori knowledge informs, the work that we do.

Article 2 – Tino Rangatiratanga (self-determination)
We will create opportunities for Māori leadership, engagement and co-design across all of our activities, especially those with the potential to impact Māori health.

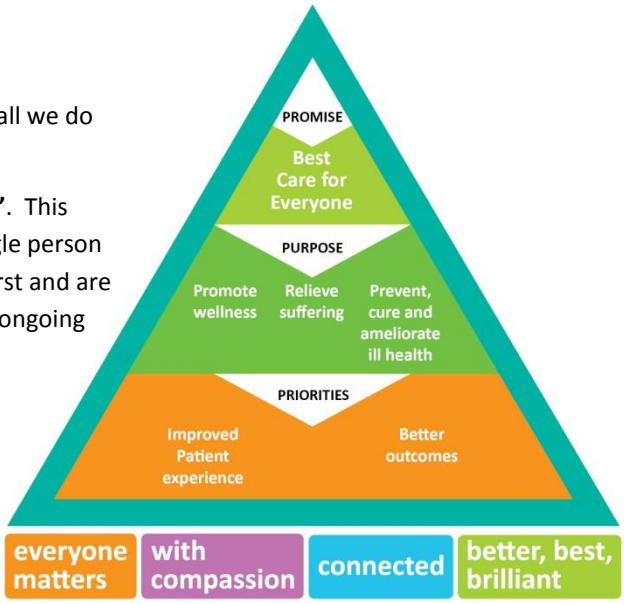
Article 3 – Oritetanga (equity)
We will demonstrate our performance in the pursuit of Māori health equity for key Māori health areas. Presenting meaningful and insightful information to Māori will support, guide and target our work to make advances in Māori health.

Article 4 – Te Ritenga (right to beliefs and values)
We will honour the beliefs and values of Māori patients, staff and communities. The services we fund and provide will honour the right of Māori to practise tikanga Māori.

Our strategic direction

Best care for everyone

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



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

The way we plan and make decisions and deliver services on a daily basis is based on our **values** of **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.

Community, family/whānau and patient centred model of care	Emphasis/investment on treatment and keeping people healthy	Service integration and/or consolidation	Intelligence and insight	Consistent evidence informed decision making practice	Outward focus and flexible service orientation	Operational and financial sustainability

Delivering on our strategic direction

Our priorities are to achieve better and more equitable health outcomes for everyone in our community and enhance patient, family and whānau experience. We will do this by working with our communities and partners to deliver high quality, effective services that are patient-focused and compassionate.

We take a population-health perspective to improve the health of the entire population and achieve healthy equity for all groups, in particular for Māori. We will work with our iwi partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, in the planning and provision of healthcare services to further Māori health gain.

We will continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services, to ensure patients receive more effective and co-ordinated care.

Our Institute for Innovation and Improvement (i3) supports the design and implementation of new models of care and best practice processes. An example is the increased use of teleclinics by our services, which offers a more accessible alternative to traditional outpatient services. Our clinical leadership programme, Transforming Care, is helping build capability for care redesign and enhanced care management.

Last year we undertook a major consultation process to inform our new organisational development plan to improve staff and patient experience. Throughout 2019/20 we will focus on compassion with organisation-wide activity around wellbeing, compassion-based leadership and education. The establishment of the Waitematā DHB Consumer Council will provide a strong voice for consumers on quality improvement and delivery of services that meet the needs of our population.

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. We have several major facilities developments planned this year and we are working together with the Northern Region DHBs on the NRLTHP to guide medium- to long-term planning decisions.

Environmental sustainability remains a priority. We have plans in place to reduce our carbon emissions and address the impact of climate change on health.

The financial challenge facing the broader health sector and Waitematā DHB is substantial. To ensure long-term sustainability we need effective governance and strong clinical leadership delivering the best evidence- based care in a connected health system.

2019/20 Strategic Intentions

At the Waitematā DHB and Ministry of Health (MoH) Strategic Conversation meeting in May 2019, several priority areas were discussed. While many of the themes are common across the country, some insights and suggestions were specific to this conversation; key themes are included below.

Equity
Significant inequalities and ill health remain, which are linked to ethnicity and deprivation, particularly for Māori and Pacific. We are working with our iwi partners to close the equity gap and improve Māori wellbeing across the region; a number of initiatives are already in place.

A workforce strategy is improving the proportion of Māori and Pacific staff employed across a number of disciplines. A shared governance group across the city oversees the implementation and monitoring of the co-developed Māori workforce development strategy. Improved recruitment of Māori and Pacific is a key focus.

Other Māori-specific projects, which are part of the Māori Health pipeline, include: abdominal aortic aneurysm (AAA) screening, self-testing of human papilloma virus (HPV) screening lung cancer screening research and community cardiac rehabilitation.

Workforce
The DHB has a number of workforce shortages, and the Northern Region Long-Term Health Plan (NRLTHP) involved analysis of issues affecting the region. MRI technologists have to undertake a post-graduate two year training programme, which is longer than elsewhere in the world. Greater influence across colleges is needed to ensure that training is appropriate and not unnecessarily long, which causes delays in growing the work force and increases costs, and to support streamlined registration.

There is a shortage of sonographers, who are often trained by the DHB and subsequently employed in the private sector. There is a potential opportunity to create a new diagnostic sonographer workforce, who are trained and accredited to undertake certain scans.

All healthcare professionals, doctors, nurses and allied health need to be working at the top of their scope. Duplication of roles needs to be avoided and a degree of flexibility needs to be achieved with colleges to allow this.

Primary care
The DHB has a good relationship with primary care and several projects are underway to ensure patients are treated in the right place. In the Emergency Department (ED), patients are triaged at the front door and, if suitable for primary care, redirected to a GP consultation paid for by the DHB. This is much more cost effective than an ED visit and focuses ED resources for more urgent cases. Currently, 400 patients per month are redirected from ED.

Additionally, a number of GP practices are funded to extend their opening hours. The DHB continues to invest in Primary Options for Acute Care (POAC), resulting in approximately 11,000 interventions per month. An on-call psychiatrist is available to GPs for support and advice.

Financial position and sustainability
The lengthy 2018/19 budget and annual planning process was discussed, having an unsigned plan for so long was not ideal. Improvement to the result was due to various wash ups, PHARMAC rebates and the sale of a property. The first draft of 2019/20 annual plan submitted a break even result, which could only be accomplished once the Crown Revenue was confirmed.

MECA increases are a pressure point and risk. The DHB was advised to assume that the funding would not be available. The Ministry acknowledged the pressures within the system, stressing that it was vital that DHBs budgeted within their allocated funding; the DHB requested guidance from the Ministry to support the decisions that will need to be made. The overall sector deficit had to be managed, and a larger deficit could potentially put capital funding at risk. This would involve careful housekeeping and some difficult decisions. Ernst and Young supported the DHB in identifying savings, but many of the projects are large and complex, involving changes to models or pathways of care and are unlikely to achieve savings within a 12-month period.

The Ministry could help with early answers to inter-district flow (IDF) pricing as we have substantial IDF out flows. The potential capital charge on the Mason Clinic land will be an issue. Revenue on electives is also a risk.

The contribution of costing and pricing work was acknowledged along with the need to strengthen this programme. The DHB made a number of suggestions on refining care pathways to reduce clinical variation. We are working with the HQSC to maintain quality and safety.

Capital

A number of capital projects were discussed that are essential for the DHB to maintain delivery of services. These include the Mason Clinic business case, infrastructure business case for remedial work at North Shore and new CSSD, and the Waitakere business case for an additional ward and ICU/HDU beds, SCBU expansion, remedial work.

The NRLTHP will help to support longer-term decisions on capacity planning and services in the region, including whether further development of the Waitakere site should occur. These were further discussed following this meeting and an approach is agreed.

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 align with the New Zealand Health Strategy and New Zealand Disability Strategy, as well as the health and disability system outcomes framework.

The actions detailed in Section 2 of this plan align to the Minister's expectations and the Government's priority outcomes.

The Northern Region Long-Term Health Plan (NRLTHP) was developed to articulate the strategic direction for the Northern Region and to identify the investments necessary to ensure the ongoing delivery of high quality healthcare. It identifies the key challenges for the four Northern Region DHBs and sets priorities for regional planning work, ISSP (and implementation) and capital investment. The regional work plan will continue to be developed around the NRLTHP, reflecting the Ministry's identified areas of focus as closely as possible, including actions, milestones and performance indicators for achievement during 2019/20.

Waitematā and Auckland DHBs have a bilateral agreement that joins governance and some activities. Furthermore, collaboration across the northern region is increasingly critical as we strive to deliver services for our whole population, invest across the health system, and increase coordination of care to improve access, equity and healthcare outcomes and reduce unnecessary duplication.

Improving health outcomes for our population

Waitematā DHB's performance framework demonstrates how the services we fund or provide contribute to the health of our population and achieve our long-term outcomes and the expectations of Government.

Our performance framework reflects the key national and local priorities that inform this Annual Plan. There is considerable alignment between our performance framework, the System Level Measures framework set by the Ministry of Health, the Minister of Health's planning priorities, and the over-arching Government priorities.

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

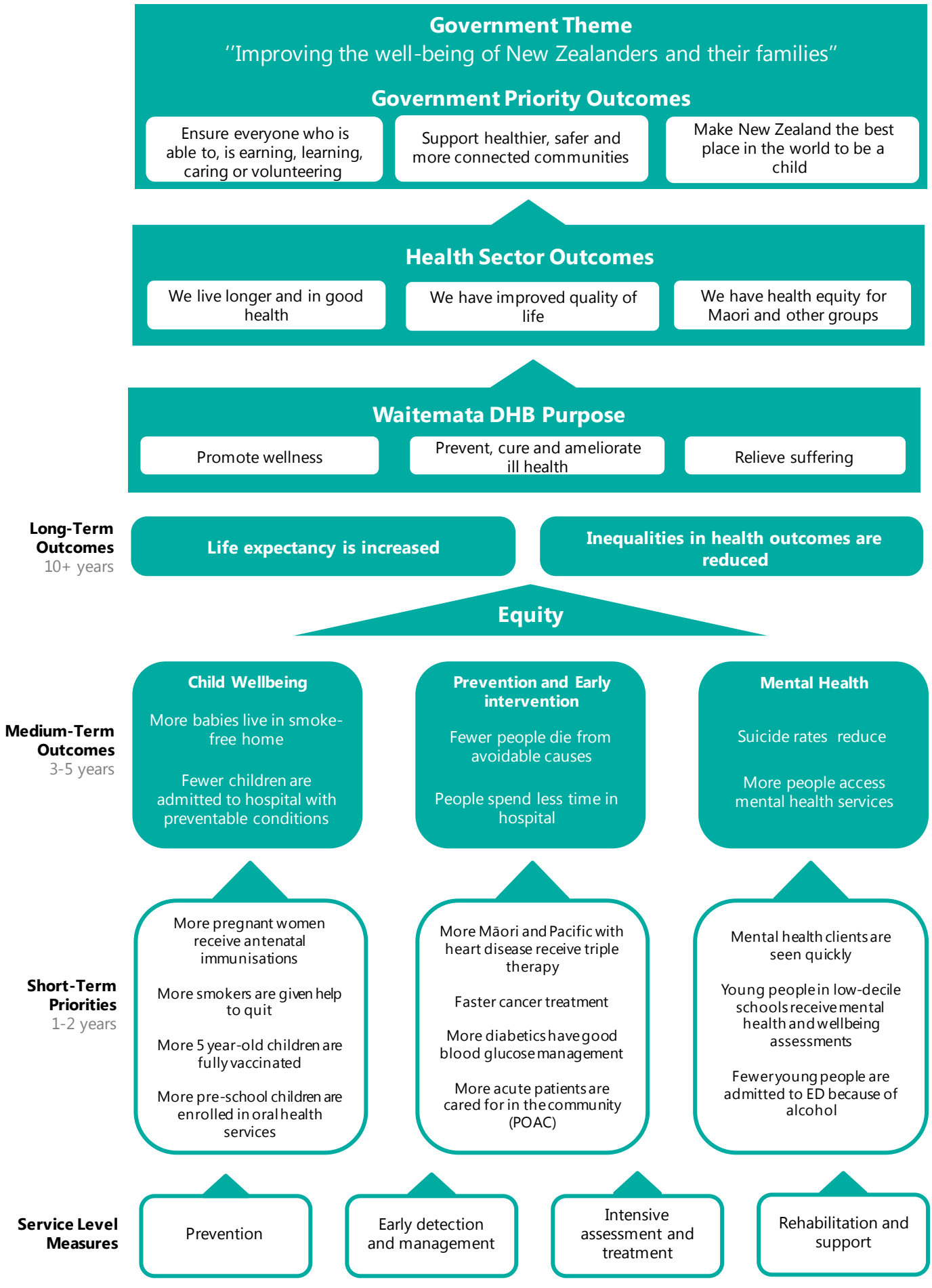
- life expectancy at birth continues to increase;
- inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced.

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.

We have identified medium-term outcome goals and short-term priorities that will support achievement of these overall objectives. For each measure, annual improvement milestones were set, and local progress will be tracked. Our medium-term outcomes define our priorities for the next 3-5 years and allow us to measure the difference we are making for our population. Our short-term priorities are essential to the achievement of our outcome goals and are front-line measurements of the success of specific health processes or activities.

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 these measures in our Annual Report.

Performance framework



SECTION 2: Delivering on Priorities

Introduction

In December 2018, the Minister of Health set out DHB priorities for 2019/20. This section details our key programmes to deliver on these priorities. 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 were 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 NRLTHP provides the detail on this regional work.

Actions to improve equity

Waitematā DHB is committed to helping all of our residents achieve equitable health outcomes. Specific activities designed to reduce health equity gaps for Māori, Pacific and other groups, such as disabled people, are identified as 'EOA'.

Government Planning Priorities

Improving child wellbeing

We are actively working to improve the health and wellbeing of infants, children, young people and their whānau, primarily through prevention and early intervention services, with a particular focus on improving equity of outcomes.

Immunisation
Actions to improve and maintain high childhood immunisation rates

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Make New Zealand the best place in the world to be a child

DHB activity	Milestone	Measure
Implement the National Child Health Information Platform (NCHIP), including developing processes for identification and rapid support for under-vaccinated tamariki Māori in the first 6 months of life	Mar 2020	95% of 8-month-old infants and children aged 2 and 5 years (including Māori) are fully immunised (CW08, CW05 measures) ≥75% of eligible girls and boys born in 2006 are fully immunised for HPV (CW05 measure) 50% of hapu Māori and Pacific women receive the pertussis vaccine (baseline Māori = 23%, Pacific = 24%) Increase Māori and Pacific eligible <5 year old influenza coverage by 5% (baseline Māori = 9%, Pacific = 8%)
Minimise the impact on immunisation coverage caused by transitioning NIR administration by retaining a strong focus on existing OIS services	Jun 2020	
Develop a tracking register for the 4-year-old event	Dec 2019	
Provide coverage data to PHOs for children at additional milestone ages, including at age 4 years and 6 months	Jan 2020	
Provide lists to PHOs of children under 5 eligible for 'flu vaccination, who are also due their 4 year vaccine	Jun 2020	
Establish a Māori case review process for the 24-month, 5-year and the existing 8-month milestones, supported by NCHIP (EOA)	Jun 2020	
Re-negotiate OIS services to increase home visits for children aged 2 and 5 years, in particular Māori and Pacific (EOA)	Dec 2019	
Work with kaumatua to increase workforce diversity to better	Mar 2020	

Immunisation Actions to improve and maintain high childhood immunisation rates		
represent Māori and Pacific communities in the Waitematā School-Based Immunisation Programme (EOA)		
Undertake data match between maternity booking registration and PHO enrolment to support PHO recall for antenatal immunisation	Dec 2019	
Increase Māori- and Pacific-targeted parental awareness of influenza vaccination for eligible 0-4 year olds (EOA)	Sep 2019	
Auckland Regional Public Health Service supports DHBs to meet immunisation target rates with clinical advice to deliver on the national Immunisation Schedule and on management of cold chain failures or provider non-compliance		

School-Based Health Services (SBHS) Actions to improve the health of our youth population		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Embed enhanced SBHS in all decile 4 schools	Jun 2020	50% of Year 9 students in decile 4 schools have a HEADDSS assessment
Each SBHS has a quality improvement plan that aligns with the standard and progresses at least one improvement within: • youth appropriate AOD screening and brief advice, ensuring approaches are culturally appropriate for Māori and Pacific students (EOA) • healthy eating and activity, with a particular focus on healthy kai for Pacific students and supporting a water only policy across the school body (EOA) • sexual and reproductive health, increasing STI screening and access to long-acting reversible contraception options	Jan 2020	
The Results-Based Accountability Framework is used to support quality improvements through the YCA	Ongoing	
Primary care to nominate a youth champion in each PHO to participate in alliancing activities and be responsible for increasing enrolment and driving improvements in delivering youth-appropriate care across their network; the primary care work plan is agreed by YCA and shared with ALT	Jan 2020	
Starship Community and Waitematā DHB Child and Family Service to trial a culturally appropriate tool to identify unmet health and developmental needs in new entrants in decile 1 and 2 primary schools (EOA)	Dec 2019; trial the tool and refine for use by Jun 2020	
Continue to provide regular reports to MoH on the: • implementation of SBHS in decile one to four secondary schools, teen parent units and alternative education facilities • actions of the SLAT to improve the health of our youth	Dec 2019, Jun 2020 Quarterly	
Rheumatic fever (RhF) Work with the Auckland Regional Public Health Service to ensure all RhF cases are reviewed and managed and support awareness raising and screening programme promotion		
Improve delivery of the bicillin programme to reduce the impact of RhF, with a focus on Māori and Pacific whānau/fanau (EOA)	Ongoing	
Refer to the Healthy Food and Drink section for further activities in schools		

Midwifery workforce – hospital and LMC

Actions to train, support, recruit and retain our midwifery workforce

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Review the regional midwifery workforce plan	Jun 2020	
Support new graduates by providing dedicated clinical coach support in the first year of practice	Jun 2020	
Implement recently revised maternity model of care, including: • additional staffing • best quality learning experiences to undergraduate students • Quality Leadership Programme for all core midwives	Jun 2020	
Implement the regionally agreed Midwifery Workforce Plan, which includes: • flexible (24/7) student placements • joint appointment of clinical coaching roles to support undergraduate and newly qualified midwives (with AUT) • focus on study pathways and continue investment to support Māori and Pacific students (EOA)	Jun 2020	
Continue to ensure that all midwives operate to their competencies and to a full scope of practice (this is business as usual)	Ongoing	
Care capacity demand management (CCDM) • Establish a working group including DHB staff, MERAS and NZNO stakeholders • Implement the new version of Trendcare • Identify equitable outcomes actions in the study pathways for Māori and Pacific students and in the regional workforce plan (EOA)	Jul 2019 Jul 2019 Ongoing	
Refer to the Care Capacity Demand Management section for further CCDM activities		

First 1000 days (conception to around 2 years of age)

Actions to meet the health needs of pregnant women, babies, children and their whānau, with a focus on healthy weight

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Make New Zealand the best place in the world to be a child

DHB activity	Milestone	Measure
Continue to promote timely engagement with LMC for women in pregnancy through the ASAP campaign	Mar 2020	80% of women are registered with a LMC or community midwifery team by 12 weeks gestation Establish baseline for the proportion of Māori and Pacific first-time mothers accessing pregnancy and parenting information and education 98% of children aged 0–6 years are registered with NCHIP
Increase Māori- and Pacific-focused pregnancy and parenting options to better engage priority populations (EOA)	Mar 2020	
Pilot the standardised maternal and infant wellbeing assessment with at least one primary care practice, WCTO provider and community midwifery team; test and refine tool or pathways	Jun 2020	
Establish a Child Health Coordination Hub, underpinned by NCHIP as a population health database, to enable equitable uptake of universal child health services	Jun 2020	
Healthy weight in children Design and deliver a culturally appropriate healthy weight	Jun 2020	Provide training to 100% of WCTO provider organisations

First 1000 days (conception to around 2 years of age)

Actions to meet the health needs of pregnant women, babies, children and their whānau, with a focus on healthy weight

education programme, incorporating motivational interviewing techniques for WCTO nurses and PHNs to meet the needs of Māori and Pacific pregnant women and their whānau (EOA)		90% of health professionals who received training identify increased confidence in having conversations about healthy weight
Roll-out the oral health/healthy weight messaging guide and consumer resource	Jun 2020	

Family violence and sexual violence

Actions to reduce family violence and sexual violence in our communities

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have health equity for Māori and other groups
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Develop a scorecard for family violence screening, disclosure rates and responses provided to increase visibility of family violence as a health issue across the DHB	Mar 2020	
• Routinely report by ethnicity (Asian, Māori, Pacific) (EOA)	Jun 2020	
Work with enhanced school-based health services to develop a school-wide, standardised and evidence-informed approach to reduce sexual violence; share the consultation results on the programme concept with school principals and YSALT and members of the youth alliance	Jun 2020	

Sudden unexplained death in infancy (SUDI)

Actions to build stronger working relationships across Maternal and Child Health to address key modifiable risk factors

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Make New Zealand the best place in the world to be a child

DHB activity	Milestone	Measure
Engage Māori and Pacific community leaders in sharing SUDI prevention messages (EOA)	Dec 2019	≥4 community champions are engaged to spread SUDI prevention messages in their communities 578 SSDs, including 80 wahakura, are offered to high-risk newborns and whānau with appropriate safe sleep education 85% of DHB-employed midwives and neonatal nurses know how to access SUDI prevention and/or smoking cessation training
Increase access to safe sleep devices (SSD), including wahakura and pepi pod, to newborn infants identified as high risk for SUDI and requiring an SSD (EOA)	Jun 2020	
Increase the referral of pregnant women and whānau to smoking cessation services by ensuring LMCs have access to relevant training to support engagement	Mar 2020	

Improving mental wellbeing

Waitematā DHB will embed a focus on wellbeing and equity at all points of the system, with increased focus on mental health promotion, prevention, identification and early intervention. We will strengthen existing services to ensure that mental health services are cost effective, results focused and have regard to the service impacts on people who experience mental illness. Our range of services will be of high quality, safe, evidence based and provided in the least restrictive environment.

Inquiry into mental health and addiction Working in partnership with all stakeholders to build an integrated approach to mental health, addiction and wellbeing in response to He Ara Oranga		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Embedding a wellbeing focus Collaborate with schools to expand access to programmes led by Child Youth and Family Mental Health services on school sites, including those with high Māori and Pacific populations (EOA); expand the programme to two further schools	Jun 2020	
From the Tuhono Equally Well work stream, complete and agree a sector-wide list of minimum requirements for responding to the physical health needs of people engaged with mental health and addictions support, including a monitoring process	Jan 2020	
Please refer to the Addictions priority section below for activities to increase Pacific youth access to substance use interventions via schools (EOA) and collaborate with regional partners to develop an addictions continuum of care		
Building the continuum/increasing access and choice Develop an RFP to expand the evaluated and proven early intervention models, which supports patients with mild to moderate mental health needs within community/primary settings; includes Awhi Ora, Health Improvement Practitioners, Health Coaches and delivery of interventions by Hearts and Minds	Submit to MoH Jan 2020	
Increase access to Pacific children and youth by receiving referrals from NGOs, existing services, and Pacific parents who are clients of mental health and addictions services, consistent with the Takanga A Fohe service delivering a family-inclusive service; evaluate outcomes, including youth and family feedback	Dec 2019	
Review current primary care liaison programmes with a view to expanding effective programmes	Dec 2019	
Suicide prevention Work with the new national Prevention and Post-vention and contribute to plans and programmes as required	Ongoing	
Endorse the finalised Suicide Prevention, Post-vention Action Plan 2019-2022 with agreed strategy/model outlined for addressing high suicide rates	Sep 2019	
Crisis response Review community-based NGO crisis options, including acute alternatives	Oct 2019	90% of crisis team staff trained in UK MH Triage Scale, AOD screening, and/or brief talking therapy interventions (e.g. motivational interviewing)
Improve the consistency of crisis team responses and grow staff capability in standardised assessment tools and evidence-based brief interventions across all population groups	Jun 2020	

Inquiry into mental health and addiction Working in partnership with all stakeholders to build an integrated approach to mental health, addiction and wellbeing in response to He Ara Oranga		
NGOs In line with government investment as indicated by the Wellbeing budget, undertake projects to understand: • Alcohol and Other Drug community NGO sustainability requirements and compare with current contracts • Mental Health community NGO sustainability requirements and compare with current contracts	 Dec 2019 Dec 2019	
Workforce With workforce centres, advocate for the development of a nationally recognised peer support qualification	Jan 2020	
Develop a centralised workforce capability database to track staff training initiatives progress, including cultural competency training for working with Māori and Asian patients (EOA)	Dec 2019	
Mental Health and Wellbeing Commission Work collaboratively with any new Commission	Ongoing	
Forensics Provide a summary of existing workforce development plans or programmes within Waitematā DHB and work to expand the volume and capability of the forensic specialist staff group	Summary by Sep 2019; expansion by Dec 2019	
Confirm the establishment of any new roles allocated to Waitematā DHB during 2019/20, including risks identified, mitigated, and any impact on other essential services	Jun 2020	
Contribute as appropriate to the MoH Forensic Framework project to identify an agreed Forensic model of care, including provision of kaupapa Māori services (EOA)	Ongoing	

Population mental health Actions to improve population mental health and addiction, particularly in our priority populations		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Increase Māori and Pacific access by expanding Awhi Ora Supporting Wellbeing, a non-clinical service for people in primary care, and evaluate its efficacy to engage high needs populations	Jun 2020	40 Awhi Ora practices (currently 23) Metabolic screening and appropriate follow-up wellness interventions for 30% of Māori prescribed clozapine or olanzapine (26% baseline; Jun 2017 to May 2019) Metabolic screening and appropriate follow-up wellness interventions for 30% of Pacific prescribed clozapine or olanzapine (27% baseline; Jun 2017 to May 2019) MH05 measures At least 30% of people engage with the IPS service for 6 months Increase new enrolments for IPS support by 400 people
Please refer to the Inquiry into mental health and addiction section for suicide prevention and postvention activities		
Implement phase II of Supporting Parents Healthy Children	Dec 2019	
With Equally Well sector partners, determine and plan an appropriate response to Māori and Pacific with enduring co-morbid health issues (EOA)	Dec 2019	
Continue to reduce Māori compulsory treatment order rates (EOA)	Ongoing	
Expand Individual Placement and Support (IPS) from prototype testing to a full trial; establish North Shore and Rodney hubs	Jun 2020	
Implement the Asian Mental Health and Addiction Workstream Strategic Plan with capacity and capability development of Asian mental health service in response to the growing population	Jun 2020	

Mental health and addictions improvement activities

Actions to support an independent and high quality of life in our population

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Participate in the HQSC project to improve service transitions to primary care by ensuring transition plans/discharge letters contain a follow-up plan (with a copy to the person concerned); this activity is supported across all services, including kaupapa Māori and Pacific mental health and addiction services (EOA)	Nov 2019	MH02 measures Aspirational goal of eliminating seclusion in inpatient units
Minimise restrictive care through engagement in HQSC Zero Seclusion project activities, with a focus on the regional forensic services, which has a high prevalence of Māori patients (EOA)	Sep 2019	
Participate in the HQSC project 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)	Dec 2019	
Participate in the HQSC project to improve physical health	Jun 2020	

Addiction

Actions to support an independent and high quality of life in people with addiction issues, particularly priority groups

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
With regional partners, deliver a detox/addictions continuum of care	Jan 2020	MH03 measures Increase the number of face-to-face contacts for Māori accessing Te Ātea Marino from community probation services by 5% (baseline 403)
In collaboration with ARPHS and Metro Auckland DHBs, contribute to local responses to emerging drug threats (e.g. synthetic cannabinoids) in line with work undertaken by the National Drug Intelligence Bureau	Jun 2020	
Increase access to Māori kaupapa addiction services for Māori who are in community probation services (EOA)	Jun 2020	
Improve access for Pacific youth with substance use issues; establish a consult-liaison relationship with 5 schools across Auckland with high proportions of Pacific students (EOA)	Jun 2020	

Maternal mental health services Actions to improve equity of access and outcomes, particularly for Māori and Pacific women		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Establish a direct pathway from LMC/GP to psychological service to reduce access barriers to perinatal primary mental health	Mar 2020	At least 5% of people accessing primary mental health are pregnant or have an infant aged <1 year
Identify an appropriate outcome measure for Maternal Mental Health specialist services, ensuring cultural acceptability to Māori and Pacific (EOA)	Jun 2020	
Scope a project to evaluate equity of access for Pacific women and potentially other population groups (EOA)	Sep 2019	

Improving wellbeing through prevention

Preventing ill health and promoting wellness is vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards prevention. This preventive focus includes supporting people to live active and healthy lives, working with other agencies to address key determinants of health, and to identify and treat health concerns early in the life course and in the progress of the disease.

Cross-sectoral collaboration Actions to continue the integration between health and social services, in particular housing		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Continue to partner with MSD, HNZ and Habitat for Humanity to ensure systems and processes improve the timeliness of housing interventions for whānau referred to Kāinga Ora HHI, in particular Māori and Pacific populations (EOA)	Ongoing	Increase the proportion of Māori and Pacific eligible referrals received by Kāinga Ora HHI: • to 20% for Māori from 16% (2017/18 baseline) • to 25% for Pacific from 22% (2017/18 baseline) Increase the proportion of Kainga Ora HHI referrals for eligible pregnant women or whānau with infants aged <1 year to 37% from 34% (2017/18 baseline)
Work with maternity services to increase referrals for pregnant women/new babies to Kāinga Ora HHI	Ongoing	
Auckland Regional Public Health Service (ARPHS) cross-sectoral work on behalf of metro-Auckland DHBs: ARPHS provide policy advice and submissions on public health and social service relevant issues (e.g. the Healthy Homes Standards consultation) on behalf of metro-Auckland DHBs, working closely with DHBs to gain DHB CEOs' signoff where that is deemed particularly useful. ARPHS is also involved in the Regional Homelessness Plan led by Auckland Council		
Please see the Drinking Water priority section for activity to improve the accessibility of tap water and the Addiction priority section for activity to address emerging drug threat issues		

Climate change

Actions to positively mitigate or adapt to the effects of climate change and their impacts on health

Government themes: Improving the wellbeing of New Zealanders and their families; build a productive, sustainable and inclusive economy
System outcome: We have improved quality of life
Government priority outcome: Transition to a clean, green, carbon neutral New Zealand

DHB activity	Milestone	Measure
Hospitals and clinics • Increase the number of initiatives that DHB staff actively engage with on emission reduction opportunities • Develop sustainable building policies, and procedures - Consultation - Finalise recommendations - Commence implementation	Jun 2020 Dec 2019 Apr 2020 Jun 2020	10 initiatives
Hospitals • Implement year 2 staff travel plan at North Shore Hospital • Reduce energy/water intensity for North Shore and Waitakere Hospitals	Jun 2020 Aug 2019	400 NSH staff participating Establish 2018/19 baseline and target 1.5% reduction
Research and trial emission reduction opportunities into procurement processes	Jun 2020	

Waste disposal

Actions to support the environmental disposal of hospital and community waste products

Government themes: Improving the wellbeing of New Zealanders and their families; build a productive, sustainable and inclusive economy
System outcome: We have improved quality of life
Government priority outcome: Transition to a clean, green, carbon neutral New Zealand

DHB activity	Milestone	Measure
Hospitals and clinics • Update policies and procedures and deliver training to reduce preventable medical waste and to ensure appropriate disposal of pharmaceuticals • Research procurement alternatives for products with single use packaging • Improve recycling infrastructure and provide ongoing staff education • Maintain monthly waste reporting (by stream, tonnage, proportion and hospital), including communication to senior management	Jun 2020 Jun 2020 Jun 2020 Ongoing	100% of controlled documents updated 2% increase in recycling (compared with 16% in 2017/18) 90% of hospital departments utilise reusable or compostable dining consumables
Hospitals Complete transition to reusable and compostable dining consumables	Jun 2020	
Community pharmacy Raise awareness and actively promote the use of pharmaceutical waste collection and disposal service in community pharmacies through the annual DUMP campaign	Mar 2020	

Drinking water

Actions to support our Public Health Unit to deliver drinking water activities

Government themes: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
The Auckland Regional Public Health Service (ARPHS) leads the drinking water activities in the environmental health exemplar across the region, and Waitematā DHB: • will work closely with ARPHS where there are drinking water issues that impact on the Waitematā DHB population • inputs and reviews ARPHS Annual Operational Plan and contractual reporting	As required Annually/six monthly	% of network water supplies compliant with the Health Act 1956 (broken down by class) for metro Auckland DHBs (annual measure) 100% of medium and large suppliers are compliant
ARPHS will work with Auckland Council to improve the accessibility of drinking water availability within Auckland, with a focus on health equity and Māori and Pacific populations (EOA)	From Jul 2019	

Healthy food and drink

Actions to create supportive environments for healthy eating and healthy weight

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Ensure everyone who is able to is earning, learning, caring or volunteering

DHB activity	Milestone	Measure
Implement the National Healthy Food and Drink Policy for staff and visitors, targeting priority groups, e.g. Māori and Pacific (EOA) • Increase the number of 'green' food options • Evaluate the feasibility of moving to only water and milk as cold drink options	Dec 2019 Jun 2020	Compliance with the national policy (≥55% 'green' and <45% 'amber' food options) 80% of contracted schools have a healthy food and drink policy 100% of health provider contracts include Healthy Food and Drink Policies
Ensure the pre-developed clause requiring all providers to develop a Healthy Food and Drink Policy (that aligns with the national policy) covering all food and drinks sold on site and provided by their organisation to clients/service users/patients*, staff and visitors under their jurisdiction, is in all locally funded contracts * Excludes inpatient meal services and Meals on Wheels	Dec 2019	
Support secondary schools to adopt healthy food and drink policies and move towards selling only water and milk as cold drink options	Jun 2020	
Work with ARPHS** to evaluate the feasibility and potential method of determining how many Early Learning Settings (ELS) and schools in Waitematā DHB have a current water-only policy and/or healthy food policy consistent with the Eating and Activity Guidelines (EAG) ** ARPHS support the implementation of the strengthened nutrition and physical activity focus for ECE centres through the pre-licensing assessment process, carried out by ARPHS' Environmental Health Team	Dec 2019	
Using available data, determine the number of ELS and schools with a current water-only policy and/or healthy food policy consistent with EAG	Jun 2020	

Smokefree 2025

Actions to advance progress towards the Smokefree 2025 goal

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Ensure everyone who is able to is earning, learning, caring or volunteering

DHB activity	Milestone	Measure
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, with the aim of becoming business as usual	Jun 2020	PH04 measure in total, Māori and Pacific populations CW09 measure in total, Māori and Pacific populations
Implement an opt-off referral approach to stop smoking services for pregnant women who smoke under DHB midwifery care	Dec 2019	Once hospital targets are set, ensure that ≥50% of the total number of smokers referred to the DHB's smokefree triage service for stop smoking support are Māori or Pacific
Set hospital targets by ethnicity for the number of smokers referred to the DHB's smokefree triage service for stop smoking support (EOA)	Jun 2020	
Note: Waitematā DHB will support Auckland Regional Public Health Service in their work focused on changing social attitudes towards tobacco consumption and exposure in Tāmaki Makaurau, smokefree open areas and partnership-based compliance activity (under the Smokefree Environments Act 2003)		

Breast screening

Improve access to screening to detect cancer earlier to reduce mortality and morbidity, particularly for Māori and Pacific

Government theme: Improving the well-being of New Zealanders and their families
System outcome: We have health equity for Māori and other groups
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Lead the Northern Region data-matching project (the 500 Māori Women Campaign) of PHO enrolment data with the Breast Screen Lead Provider to identify eligible women for invitation, recall or follow-up; commence invitation, enrolment and screening of identified groups	Jan 2020	100% completion of datamatch
Alongside the regional data-match project, co-ordinate hospital data-matching to identify Māori women not enrolled in a PHO or in BSA, as agreed with the BSA provider • Complete the data-match process • BSA to begin using the provided contact information to enable invitation and recall to breast screening • Report on the proportion of data-match contacting completed to date	Jun 2020 Dec 2019 Jan 2020 Jun 2020	
• Gain in-depth understanding of the successful management approaches delivered to Counties Manukau DHB women • Apply learnings to Waitematā DHB	Dec 2019 From Mar 2020	

Cervical screening Provide equitable access to screening to reduce mortality and morbidity, particularly in Māori, Pacific and Asian women		
Government theme: Improving the well-being of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Provide localised information to and support primary care to understand and implement the change in age of entry from 20 to 25 years into the National Cervical Screening Programme from 2019	Information by Dec 2019; support is ongoing	Complete two equity-focused screen taker updates, including participant evaluation 10% reduction in the number of women who are >12 months overdue for test of cure or follow up after a high grade screening result (data drawn from the NSU-PHO data match lists) by June 2020
Review and update the how-to guide and add to Auckland Regional Health Pathways	Dec 2019	
Develop an approach under the Māori pipeline to deliver intensive support for women at increased clinical risk and overdue for treatment to access services (EOA)	Mar 2020	
Continue to work with PHOs and practices to facilitate understanding of equity of outcomes (burden of mortality and morbidity in Māori) through the provision of equity-focused screen taker updates (EOA)	Ongoing	
• Prioritise provision of screening to Māori and Pacific (EOA) via the 'free screens' contracts with PHOs (NCSP 46)	Ongoing	
• Collaborate with PHOs to provide the NSU data-match lists to practices in a format prioritised to clinical risk and ethnicity (EOA)	Ongoing	
• Begin to facilitate the use of existing tools to refer women from primary care for targeted support from support to screening providers, including linking Asian women with specific health promoters (EOA)	Jan 2020	

Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System

New Zealanders are living longer, but also spending more time in poor health. This means we can expect strong demand for health services in the community, our hospitals, and other care settings. Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development, and joined-up service planning to maximise system resources and to improve health and increase equity.

Engagement and obligations as a Treaty partner Actions to meet the Treaty of Waitangi obligations, as specified in the NZPHD Act		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome**: We have health equity for Māori and other groups **Government priority outcome**: Support healthier, safer and more connected communities		
DHB activity (all are EOA)	**Milestone**	**Measure**
Enhance our iwi relationships Establish an iwi partnership board to lead the work to improve local and regional Māori health outcomes, with representation from Tāmaki and Te Tai Tokerau	Mar 2019	SS12 measures
Complete a health needs assessment (HNA) to identify the needs and aspirations of Ngāti Whātua iwi members	Jun 2020	
With Te Whānau o Waipareira, continue to implement recommendations from the Whānau House HNA	Ongoing	

Engagement and obligations as a Treaty partner Actions to meet the Treaty of Waitangi obligations, as specified in the NZPHD Act		
Seek opportunities through the Māori Pipeline programme to pilot and research ways for Māori knowledge to inform new service developments and innovation to improve Māori health outcomes	Ongoing	
Identify and address health needs with Māori communities Pilot kohanga reo- and kura-based projects across metro Auckland to improve enrolment and uptake of health services by whānau	To commence Jul 2019	
Pilot and validate a Māori patient/whānau experience tool within selected community services and funded service providers (already underway in hospital)	Commence pilot Jul 2019	
Develop and support our Māori health community providers Establish a Māori clinical leadership forum to drive clinical excellence, safety and quality in our Māori provider network	Operational by Dec 2019	
Provide the staff of Māori health providers with free access to DHB training and support initiatives	Jul 2019	

Delivery of Whānau Ora Actions that demonstrate system-level changes by delivering whānau-centred approaches to Māori health and equity		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Māori health • Support Māori communities to identify their health priorities and aspirations, and work collaboratively to address high priority health needs to achieve Māori health outcomes (EOA) - Co-design a whānau ora solution with the partners of the Whānau House Health Needs Assessment (HNA) - Develop a whānau ora service for the South Kaipara in partnership with Ngāti Whātua	Jun 2020	
• Implement integrated contracts with Māori health providers that align their DHB contracts to our outcomes framework and supports the redevelopment of their service models to whānau ora approaches (EOA) - All Māori health providers have an integrated contract in place - All services provided by Māori health providers align to our Māori health outcomes framework	Jun 2020	
• In partnership with the Whānau Ora Commissioning Agency and other funders, evaluate local and regional whānau ora services that are making an impact in our communities and support these initiatives to grow, expand and develop (EOA) - Undertake a joint whānau ora initiative with the Whānau Ora Commissioning Agency	Jan 2020	
Pacific health • Work alongside Pacific communities and providers to refresh the Pacific Health action plan, and work collaboratively to	Jun 2020	

Delivery of Whānau Ora Actions that demonstrate system-level changes by delivering whānau-centred approaches to Māori health and equity		
address high priority health needs to achieve Pacific health outcomes (EOA)		
• Identify Pacific providers that both Waitematā DHB and Pasifika Futures fund separately in Waitematā DHB, and explore opportunities to align	Jun 2020	

Care Capacity Demand Management (CCDM) Actions to support the implementation of CCDM for nursing by June 2021		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Continue working with the key unions (NZNO, MERAS, PSA) to implement the CCDM requirements by 2021 as agreed with the Safe Staffing Healthy Workplace Unit	Ongoing	
Complete the Patient Acuity System Upgrade and support services (e.g. Mental Health, Maternity) to ensure high quality data to calculate CCDM FTE from mid-2020	Jun 2020	
Recalibrate existing Local Data Councils for Medicine, Surgery, and Child Health services, utilising CCDM Core Dataset	Dec 2019	
Complete the first cycle of FTE calculations for all Medicine and Surgery wards	Jun 2020	
Introduce improved Variance Response processes, including upgraded Variance Indicator Board and Escalation Procedures	Dec 2019	
Commence CCDM engagement with MERAS and PSA and prepare prioritised plans to implement the programme across Maternity Service and Mental Health Service	Dec 2019	
Meet the H&DSS audit requirements	Dec 2019	
Complete two new to Health Care Assistant Programmes to support recruitment; the programme focuses on attracting Māori and Pacific candidates (EOA)	Jun 2020	
Promote recruitment by: • supporting the recruitment of nursing roles identified as part of CCDM by offering additional study scholarships to Māori and Pacific students (EOA) • running open days to showcase the DHB's nursing specialities and commitment to creating a great staff and patient experience • offering courses that support the transition to acute care nursing • continuing to offer new entry to nursing programmes across tertiary, secondary and primary nursing	 Jun 2020 Ongoing Ongoing Ongoing	
Refer to the Midwifery workforce – hospital and LMC section for further CCDM activities		

Disability

Actions to improve the care of patients with a disability

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Continue to promote the Disability Responsiveness e-learning module to all staff and monitor its effectiveness by evaluating staff feedback (EOA)	Ongoing	Increase the number of staff completing the e-learning module by 20% to 129 from baseline of 108 (2017/18)
Work towards obtaining the Accessibility Tick and raising awareness of disabled people across the organisation (EOA)	Jun 2020	
Patients referred to the hospital (e.g. from GPs or other services) who have a disability are clearly identified as such. For acute or surgical patients whose first contact is with the DHB (e.g. in ED or elective surgery), any disabilities are identified on admission (e.g. through patient history, assessment, pre-operative screening). Patients are asked how they can be further supported while in our care. This information is highlighted in in their nursing care notes and in their ward, so that they receive the appropriate care. The information is also included in their discharge letter or referral to other services, as appropriate		

Planned Care

Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Ensure everyone who is able to is learning, caring or volunteering

DHB activity	Milestone	Measure
Elective Services • Implement and oversee a process of optimising booking of elective patients as identified in the elective surgery production plan to ensure delivery of 100% of the target volumes • Prioritise high risk cancer patients and clinical priority one patients (with other patients being treated in turn) for treatment within 4 months • Ensure equity of access for Māori patients by continuing interaction with Cancer Clinical Nurse Specialist Māori, Faster Cancer Tracking (EOA) • Ensure equity of access for Pacific patients by continuing patient-focused booking (PFB; EOA) - implement PFB in three additional specialty areas • Work towards enabling patients to self-book appointments online: - email validation and digital post as BAU - clinic profile review completed - vendor workshops completed • Incorporate self-referral on symptoms (SOS) process into business as usual for Orthopaedics, General Surgery and ORL and introduce to other specialities	Jun 2020 Ongoing Ongoing Ongoing Jun 2020 Dec 2019 Dec 2019 Jan 2020 From Oct 2019	Deliver 32,119 Planned Care interventions SS07 measures ESPI 1 100% ESPI 2 0% ESPI 3 0% ESPI 5 0% ESPI 8 100% Please see the Cancer Services section for measures Demonstrate equity of access for Pacific patients with 90% being seen within ESPI 2 timeframe 90% of referral and outpatient letters sent via digital post Coronary angiography 95% target CT 95% target MRI 90% target Improve the % of patients acutely readmitted post discharge (vs. baseline) • Total population (<12.8%) • 75+ year olds (<12.7%)
Coronary angiography Review the current referral and booking process to ensure capacity is maximised to achieve the 95% target	Dec 2019	

Planned Care

Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes

Radiology - CT • Install new CT scanner at North Shore Hospital • Streamline acute and elective workflows across CT scanners for improved service efficiency • Recruitment and workforce development	Aug 2019 Ongoing Ongoing	
Radiology - MRI • Achieve compliance with 90% target • Continue outsourcing programme to maintain compliance	Oct 2019 Ongoing	
Acute readmissions Work with pharmacy and primary care to ensure that medicine reconciliation is conducted for 100% of patients, including those aged 75+ years	Ongoing	
Three-year plan • Outline of engagement, analysis and development activities • Consultation and analysis to understand local needs • Develop plan • Update on progress against plan	Sep 2019 Dec 2019 Mar 2020 Jun 2020	
Please refer to the Auckland DHB 2019/20 annual plan for activities related to Ophthalmology and Cardiac Surgery as Auckland DHB is the service provider for our district		

Acute demand

Actions to improve the management of patient flow and data in the Emergency Department

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Acute data capturing • Implement SNOMED coding of ED presenting complaints • Investigate and scope requirements for ED Procedures and Diagnosis codes	Jul 2019 Dec 2019	95% of patients admitted, discharged or transferred from an emergency department within 6 hours (SS10 measure)
Improving patient flow for admitted patients Improve the multidisciplinary governance model within the inpatient home-based wards, with a focus on further improving patient flow and patient whānau care standards, including for Māori and Pacific patients (EOA) • Improvements include implementing regular meetings and reviews of ward performance to improve the functionality of home-based wards	Implement model in all medical wards by Sep 2019	
Implement Home-Based Wards at Waitakere Hospital	May 2020	
Improving the management of patients in ED with long-term conditions (LTCs) Expand the role of the CNS/NP in the ED to include active management of acute exacerbations of LTCs; develop bundles of care for patients with LTCs e.g. chronic obstructive pulmonary disease (COPD)	Jan 2020	

Acute demand

Actions to improve the management of patient flow and data in the Emergency Department

Improving wait times for patients requiring mental health and addiction services who present to ED • Review the current model of care to minimise patient waiting times; action at least one recommendation • With Mental Health services, develop a model of care for patients in ED, including Mental Health representation at daily patient access meetings to review delays and daily flow and care of mental health patients • Develop a rapid assessment process for mental health patients to ensure timely assessment	Sep 2019; Jun 2020 Dec 2019 Dec 2019	
Improving the patient experience of Māori in ED • Greet all patients attending our EDs at triage in Te Reo Māori • Ensure diversity in our workforce to represent our patient population (EOA)	Nov 2019 Ongoing	
Addressing barriers to accessing primary care services With the Ministry's Kārearea Service and Te Whānau o Waipareira, develop a navigator service to support frequent users of ED services aged 0-24 years and their whānau with referrals to primary care (including holistic Māori healing), where clinically appropriate (EOA)	Implement at Waitakere Hospital from Dec 2019	

Rural health

Actions to plan and provide for the health needs of our rural population

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have health equity for Māori and other groups
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
The Auckland Waitematā Rural Alliance work plan is underpinned by the findings of the 2016 services stocktake and the priority areas agreed by the members and the general practices they represent		
Review the Rural Alliance Work Plan Activities and determine effectiveness of access for rural Māori and Pacific (EOA)	Mar 2020	
Evaluate the Rural Ferinject Pilot and use findings to support general practices to promote to rural Māori and Pacific patients to reduce the impact of iron deficiency anaemia (EOA)	Dec 2019	
Develop a business case to increase access to imaging services (x-ray, ultrasound) for rural populations to be equitable and timely	Mar 2020	

Healthy ageing

Actions to care for our older population, as identified in the Healthy Ageing Strategy 2016

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Falls prevention services Review falls prevention services and secure funding for a refined service when existing contracts end	Sep 2019	SS04 measures
Home and Community Support Services (HCSS) • Finalise a new HCSS model and service specification; confirm	Jun 2020	

Healthy ageing Actions to care for our older population, as identified in the Healthy Ageing Strategy 2016		
alignment with the national HCSS Framework • Ensure HCSS model is accessible and appropriate for Māori and Pacific; HCSS procurement evaluation criteria will rate applicants on ability to meet Māori and Pacific needs (EOA) • Complete HCSS procurement		
Addressing acute demand Develop a business case to rollout the KARE Project, which involves comprehensive geriatric assessment, care planning and proactive care for frail older people in general practice	Dec 2019	
See the Delivery of Regional Service Plan (RSP) priorities section for dementia care activities		

Improving quality Actions to improve equity in outcomes and patient experience		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Māori and other groups **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Improve equity in outcomes Complete the prototyping phase (two practices) and commence the validation phase (four practices) for a co-design project to transform the diabetes care system. Co-design activities will focus on engaging Māori and Pacific to improve equity, as articulated in the System Level Measures Improvement Plan (EOA)	Dec 2019	
Patient experience With Auckland DHB: • establish a gold standard approach to improve medication communication and patient empowerment for acute and primary care pharmacy staff and the broader multi-disciplinary team • develop a medication communication improvement plan to empower patients, including Māori and Pacific, to ask questions regarding their medications to support safety (EOA)	Mar 2020 Sep 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' from 44.8% (CY2018 baseline) to 47.0% (this is the lowest scoring question for both Waitematā and Auckland DHBs)
With our Māori and Pacific health teams (EOA), develop: • a Māori Health action plan and seek endorsement by the Māori Equity committee • Māori patient guidance (Tikanga Māori) – how to provide best care to Māori patients and whānau • evidence-based patient feedback methods for specific populations (including Māori and Pacific) to enable patients to safely comment on their experience	Sep 2019 Mar 2020 Mar 2020	
Antimicrobial resistance The DHB works closely with the Auckland Regional Public Health Service to ensure advice, information and education is disseminated about antimicrobial resistance and supports efforts to inform the public		
Complete a hospital-wide antibiotic prescribing survey using the National Antibiotic Prescribing Survey (NAPS) tool to assess prescribing appropriateness for all patients	Sep 2019	
Analyse survey results for any disparity in antibiotic prescribing	Nov 2019	

Improving quality Actions to improve equity in outcomes and patient experience		
practices between Māori vs. non-Māori (EOA)		
MACGF to review the recently released Atlas of Healthcare Variation - Community antibiotic use domain data alongside the New Zealand Antimicrobial Resistance Action Plan (MoH 2017) and identify 1-2 specific activities to focus on in 2019/20	Dec 2019	
Continue to use Aged Residential Care (ARC) forum and cluster groups to ensure facilities are informed of front-line infection prevention and control practices; monitor corrective actions from ARC audits for the Infection Prevention and Control Standard	Ongoing	

Cancer Services Actions to reduce inequalities between Māori and non-Māori patients with cancer		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Equity of access Commence a pilot programme of early contact by Māori and Pacific Cancer Nurse Specialists for all Māori and Pacific patients triaged as P1 and HSC (EOA)	Jul 2019	90% compliance for Māori and Pacific patients on the 62-day FCT pathway (SS11 measure) At least 85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat (SS01 measure)
Bowel cancer quality improvement • Review and analyse data for patients with unplanned return to surgery within 30 days • Review patient-specific data to confirm reasons why some rectal patients do not receive preoperative radiation	Sep 2019 Dec 2019	
Cancer plan development • Work with the Ministry to develop a Cancer plan • Implement and deliver local actions from the plan	Ongoing Jun 2020	

Bowel screening Actions to meet colonoscopy wait times and equitable access to bowel screening		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We live longer in good health **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Provide equitable access to diagnostic procedures for Māori and Pacific people who have a positive result by: • contacting participants with a positive result for a colonoscopy pre-assessment within 15 days (EOA) • offering an appointment for colonoscopy within 45 days (EOA)	Ongoing	95% of Māori and Pacific participants with a positive result: • are contacted for a colonoscopy pre-assessment within 15 days • receive a first offered appointment within 45 days 5% increase in Māori and Pacific participation where request for a test kit has come via primary care <5% error rate SS15 colonoscopy measures
Work with primary care to improve Māori and Pacific participation by trialling a process whereby people for whom a GP has sent a test kit request are telephoned and supported to participate (EOA)	Jun 2020	
Implement an audit process for data correctness and completeness on the Register and the endoscopy system	Jun 2020	

Bowel screening Actions to meet colonoscopy wait times and equitable access to bowel screening		
Work with our patient experience team to improve engagement with our Māori and Pacific colonoscopy patients, with the aim of reducing the ethnic gap in DNA rates between ethnicities (EOA)	Jun 2020	
Undertake a clinical audit of our colonoscopy surveillance waitlist to identify individuals or cohorts that no longer require a procedure	Dec 2019	

Workforce Actions to support and improve the skills of our staff members, and improve our organisational health literacy		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have improved quality of life **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Priorities and diversity Increase participation of Māori and Pacific workforces by: • implementing student and youth-based programmes • designing and testing a redefined recruitment process and associated tools with a focus on strengthening equity and kaupapa Māori • co-creating positive Māori health career journeys • implementing recommendations from Accelerating the Development of Māori leadership • recruitment, retention, strengthening networks and career pathway initiatives from the joint Auckland-Waitematā DHB Māori and Pacific Alliance Leadership Teams (EOA) • working with education/iwi to strengthen health equity across our workforce (EOA) • education and awareness to build Māori and Pacific cultural competency (EOA) • education and diversity education, e.g. disability awareness, e-CALD programme	Ongoing Dec 2019 Ongoing Dec 2019 Jun 2020 Ongoing Ongoing Ongoing	Increase Māori participation in the workforce by 6% to 523 (baseline 493 at Dec 2018) Increase Pacific participation in the workforce by 5% to 399 (baseline 380 at Dec 2018) 20% increase in staff completing cultural competency training to 3,167 (baseline 2,639 at Jan 2019) Increase the number of staff completing the e-learning module by 20% to 129 from baseline of 108 (2017/18)
With education institutions and primary care, grow great professionals and strengthen career pathways by contributing to curricula and supporting students with pre-registration placements and graduate transition	Jun 2020	
Specialist Mental Health and Addictions workforce • Re-design recruitment and selection process to be more culturally inclusive to build Māori cultural competence (EOA) • Co-create and implement staff wellbeing initiatives	Jun 2020	
Nursing workforce • Establish new nurse practitioner roles in Māori health and palliative care (EOA) • Provide individual annual allocations of Continuing Professional Education to nurse practitioners, which currently exceeds NZNO MECA requirements • Clarify future Nurse Practitioner roles for the next 5 years and provide support for their professional development • As with all nurses in advanced practice roles, there is	Ongoing Ongoing Ongoing	

Workforce

Actions to support and improve the skills of our staff members, and improve our organisational health literacy

expansion from traditional (e.g. books, journals) to digital resources	Ongoing	
Further information is provided in Section 4, Building capability, Workforce		
Health literacy • Launch the joint Waitematā-Auckland DHB Health Literacy Policy and e-learning module • Monitor and evaluate uptake of the e-learning module • Hold a joint DHB health literacy symposium as part of health literacy/patient experience month • Develop and deliver face-to-face training for all telephonist and patient centre staff	 Sep 2019 Ongoing Oct 2019 Dec 2019	

Data and digital

Actions to improve our information technology systems to better support healthcare delivery to our population

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Contribute to developing and implementing the Regional ISSP	Ongoing	
Core Clinicals: continue to test and develop systems to support clinical workflow (progress notes, resuscitation forms)	Aug 2019	
Implement Smart Systems • eOrders ADU • closed loop meds (ISSP) • smartpage 777 • clinical photography	 Oct 2019 Dec 2019 Mar 2020 Apr 2020	
Test and explore Robotics Processing Technology for radiology referrals	Sep 2019	
Data Visualisation – ensure equity is prioritised in presentation of clinical data e.g. ED Dashboard (EOA)	Ongoing	
Telehealth (ISSP) – continue to test and scale	Ongoing	
Implement Application Portfolio Management for prioritising upgrades, managing risk, capital planning and removing duplication	Jun 2020	
Cyber-security capability: continue to improve IT security maturity and strengthen disciplines associated with cyber security (access and authentication, authorised software and devices)	Ongoing	
Participate in national initiatives • National Health Plan • National Health Information Exchange • Complete NCHIP implementation • Maternity Clinical Information System Evaluation	 Ongoing Ongoing Sep 2019 Ongoing	
Further information is provided in Section 4, Building capability, Information technology and communications systems		

Collective improvement programme

Actions to improve collaboration between DHBs and the Government to support innovation and quality improvement

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Waitematā DHB commits to working with the Ministry of Health to develop the Collective Improvement Programme, which will: • examine key indicators of efficiency, equity and outcomes across DHBs • review and reduce unwarranted inter-DHB variations by: - supporting innovation - sharing quality improvement initiatives across DHBs • enhance collaboration between DHBs and the Government to improve outcomes efficiently	As per Ministry timelines	

Delivery of Regional Service Plan (RSP) priorities

Actions to support the delivery of the RSP

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Dementia Implement the New Zealand Framework for Dementia Care by: • contributing to a regional stocktake of dementia services and related activity, to be completed and provided to MoH • working regionally (and using the stocktake) to identify and develop an approach to progress Waitematā DHB's priority areas to implement the framework • reporting on implementation progress	Dec 2019 Jun 2020 Mar, Jun 2020	
Hepatitis C Collaborate with regional DHB partners to implement the clinical pathway by: • providing targeted testing of patients most at risk for HCV exposure (EOA) through point-of-care and/or community-based laboratory services • collaborating across primary and secondary care to support people with allied services (e.g. community alcohol and drug services, needle exchange, and other social agencies) best placed to support HCV treatment and ongoing management	Dec 2019 Sep 2019	Number of newly diagnosed HCV RNAs for the Northern Region
Collaborate with regional partners to increase access to primary care and promote primary care prescribing of the new pangenotypic hepatitis C treatments by • raising awareness and providing education on HCV, risk factors and management/treatment options to primary care teams, specifically NGOs and service providers with known at-risk patient populations • enhancing the delivery of an integrated hepatitis C service through community-based HCV testing and care	Mar 2020 Jun 2020	
See the Northern Regional Long-Term Health Plan 2019/20 for further details		

Better population health outcomes supported by primary health care

An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase use of illness-preventing behaviours and treatments, and thereby increase people's ability to participate in work and education. Primary health care is earlier, safer, cheaper, and better connected to people's daily routines. We aim to improve the primary care model to better suit people's lives and better integrate across health disciplines and facilities, thereby improving health outcomes and serving all people equitably.

Primary health care integration

Actions to strengthen our district alliances, address equity gaps and improve access to primary care services

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We live longer in good health
Government priority outcome: Ensure everyone who is able to is earning, learning, caring or volunteering

DHB activity	Milestone	Measure
Continue to develop the Service Level Alliances (SLAs), accountable for developing and implementing integrated service models, and associated work programmes reporting to the Alliance. Ensure SLAs in place for Rural, After Hours, Diabetes, Maternal and Child Services Alliance (MaCSA), Youth, and Pharmacy	Ongoing	
The Alliance and all SLAs to review and update measures to monitor progress for Māori and Pacific populations (EOA)	Mar 2020	
Implement training programme to support improved general practice team skills in assessing and managing the diabetic foot and integrated service with community podiatrists	Jun 2020	

Pharmacy

Actions to support the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA)

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
To support the Pharmacy Action Plan and the ICPSA, we will: • form a Pharmacy Service Level Alliance to produce a work programme that supports equitable health outcomes	Dec 2019	
• support the work to enable separation of dispensing into separate ICPSA schedules (medicine and supply and clinical advice)	Jun 2020	
• continue to commission smoking cessation service to selected local pharmacies to improve access to priority populations, e.g. Māori, Pacific, people with mental illness, pregnant women and smoking partners of (or family living with) pregnant women (EOA)	Ongoing	
• develop local strategies to support pharmacy and other immunisation providers to collectively improve influenza vaccination rates in Māori, Pacific and Asian people aged over 65 years and report outcomes in Q2 2020/21 (EOA)	Develop by Mar 2020; implement from Apr 2020	
• continue to commission the Safety in Practice programme to support local pharmacists working as part of an integrated system, with the key aim of working with primary care to reduce preventable patient harm and adverse drug events	Ongoing	

Pharmacy

Actions to support the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA)

through quality improvement; apply the Health Equity Assessment Tool to all clinical modules to support equitable health outcomes (EOA)		

Diabetes and other long-term conditions (LTCs)

Actions to strengthen public health promotion on preventing diabetes and other LTCs, including equitable service access

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We have improved quality of life
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
Implement a condensed Diabetes Self-Management (DSME) course in locations closer to where high risk populations live and work. Ensure courses are culturally appropriate and delivered at times/days that suit the needs of those who would benefit most from attending (EOA)	Sep 2019	SS13 measures 80% of contracts include a focus on improving equitable access to culturally appropriate DSME 100% of DSME contract holders to report on participation evaluation the DSME course
Evaluate the effectiveness of DSME through participant evaluation forms	Jun 2020	
Leverage the Diabetes Service Level Alliance leadership to attain the MACGF diabetes and CVD clinical indicator targets by ensuring that learnings from high achieving practices are transferred to other practices to promote best practice and improve equity in diabetes and CVD outcomes (EOA) • Monitor the number of practices achieving priority diabetes and CVD clinical indicator targets for Māori, Pacific, and Other populations	Ongoing	
Refer to the Healthy Food and Drink section for DHB activities focused on the prevention of diabetes and other LTCs		

Financial Performance Summary

Statement of Comprehensive Income	2017/18 Audited Actual $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue						
MoH	1,595,378	1,687,873	1,769,164	1,805,857	1,841,969	1,878,804
IDFs & Inter DHB Provider	86,543	92,087	94,267	95,478	97,387	99,333
Other government	11,077	30,106	29,602	30,193	30,795	31,410
Other	31,752	30,125	40,239	31,543	32,370	33,215
Total revenue	**1,724,750**	**1,840,191**	**1,933,272**	**1,963,071**	**2,002,521**	**2,042,762**
Expenditure						
Personnel	641,786	689,002	719,381	738,373	752,300	766,515
Outsourced	74,166	85,348	86,082	86,433	88,157	89,916
Clinical Supplies	123,940	127,420	133,550	137,631	140,379	143,183
Infrastructure and Non-Clinical	54,541	52,746	19,768	7,725	9,953	12,153
Payments to Non-DHB Providers	778,915	832,520	908,105	926,265	944,788	963,681
Interest	0	0	0	0	0	0
Depreciation and Amortisation	29,508	30,229	30,000	30,258	30,558	30,928
Capital charge	36,679	36,415	36,386	36,386	36,386	36,386
Total Expenditure	**1,739,535**	**1,853,680**	1,933,272	1,963,071	2,002,521	2,042,762
Other comprehensive income	(14,785)	(13,489)	0	0	0	0
Revaluation of land and building	15,938	0	0	0	0	0
Total Comprehensive Income/(Deficit)	**1,153**	**(13,489)**	**0**	**0**	**0**	**0**

Four-year plan

Prospective summary of revenues and expenses by output class	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Early detection				
Total revenue	197,141	201,083	205,105	209,207
Total expenditure	197,141	201,083	205,105	209,207
Net surplus/(deficit)	0	0	0	0
Rehabilitation and support				
Total revenue	74,901	76,399	77,927	79,485
Total expenditure	74,901	76,399	77,927	79,485
Net surplus/(deficit)	0	0	0	0
Prevention				
Total revenue	24,948	25,447	25,956	26,475
Total expenditure	24,948	25,447	25,956	26,475
Net surplus/(deficit)	0	0	0	0
Intensive assessment and treatment				
Total revenue	1,636,282	1,669,008	1,702,388	1,736,436
Total expenditure	1,636,282	1,669,008	1,702,388	1,736,436
Net surplus/(deficit)	0	0	0	0
Consolidated surplus/(deficit)	0	0	0	0

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 DHBs are held accountable. Waitematā DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2019/20.

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.

Service change

Service affected	Description of service change	Benefits of change	Change for local, regional or national reasons
Change in location of services	Waitematā DHB-domiciled patients with varicose veins will now be treated at Auckland DHB instead of Waitematā DHB (part of General Surgical volumes), including grading, ultrasound, FSA, procedure and FU	Centralise a relatively small service into one Auckland DHB service provider under Vascular rather than AIR at Waitematā DHB, which is currently a vulnerable service due to workforce constraints	Local (Waitematā DHB only)
Expansion of service	**Individual Placement and Support (IPS)** Expanding IPS employment support from current prototype to full trial. Transition is ongoing with current competitive process (over 2-3 years)	Will extend service from 50 to 500 people, based in three key mental health hubs	Local (Waitematā DHB only)
Re-establishment of service	**Forensic Step-Down Beds (regional forensic service)** RFP going to market to replace 5 kaupapa Māori community residential forensic step-down beds	Replace access to a kaupapa Māori forensic step-down service	Regional (delivered by Waitematā DHB)
Change in location of services	**Regional Social Detox service** Service moved to a temporary location while purpose built facility is being completed; to move to new facility in 2020	Service delivery within a purpose-built facility Co-location with complementary services	Regional
Change in location of services	**High and Complex Residential Services** Cost escalated due to ongoing delays with building the purpose-built facility. The provider is exploring funding options; service is provided from two temporary locations	Continued delivery of service while alternative is considered	Local (Waitematā DHB)
Refinement in model of service delivery	**Supra Regional Eating Disorder Service (EDS)** Midland DHBs withdrew from all elements of EDS except residential service, and signalled an intention to withdraw from the residential service over time; the EDS adjusted capacity accordingly. Discussions with Midland DHBs	Auckland DHB service resized for Northern region population and Midland access to residential services only Uncertainties regarding ongoing Midland population demand are	Supra Regional DHBs - Northern Region and Midlands DHBs

Service affected	Description of service change	Benefits of change	Change for local, regional or national reasons
	indicated a re-consideration of future arrangements for their population; discussions are expected to continue in 2019/20. Possible review of service capacity for further consideration of future service change as a result of clarifying Midland population requirements for the next five years	expected to be clarified, enabling Auckland DHB to progress medium to longer term planning of residential services	
Review and change in service	**Termination services** Review and change service in response to the 2017/18 Abortion Supervisory Committee report	Review to determine safe, legal, equitable, women-centred services provided closer to home	Metro-regional
Response to service gaps	**At risk pregnant women/infants** Identification of service gaps Service improvement Refinement of additional services in place	Meet the needs of pregnant women: depression, anxiety, housing, parenting, other social needs Improved health and well-being outcomes for infants	Sub-regional (Auckland and Waitematā DHBs)
Implementation of new system	**National Child Health Information Platform (NCHIP)** Implement new IT system and coordination hub Potential changes to B4 School Check administration and other database teams	Better identification of infants at risk of poor outcomes Improved service models resulting in increased access	National
Level, location and configuration of services	**Auckland DHB Oral Health Service** A regional review of current services, including the scope and location of services provided for the Auckland region, was completed in November 2017. Further refinements to be implemented, including CMH Otago Dental School and associated changes	Confirming role of regional provider versus other providers Confirm sustainable regional service configuration	Regional and local (Auckland DHB)
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
Cessation of service	**Day Activity Programmes (non-dementia)** A step-wise reduction in funding during 2019/20. Contracts to be terminated 1 July 2020	A review found a weak evidence base to these programmes, with historical current contracts, no clear rationale for size or distribution, and unclear aims; the recommendation is to disinvest funding	Sub-regional (Auckland and Waitematā DHBs)
Change in service delivery model and potential change of provider(s)	**Home and Community Support Services (HCSS)** Procurement for this service will commence in 2019/20	Improve delivery of services to increase responsiveness and flexibility and better respond to client needs	Local (Waitematā DHB)
Potential change in model of service delivery	**Community Pharmacy** DHBs will work towards different contracts to provide community pharmacist services by working with consumers and other stakeholders to develop service options, including potential options for pharmacist service delivery DHBs will work with key stakeholders to develop the enhanced pharmacy service to achieve safe and consistent medicine	Enhanced services for consumers More consistent and safer service for patients	Sub-regional (Auckland and Waitematā DHBs)

Service affected	Description of service change	Benefits of change	Change for local, regional or national reasons
	distribution and management for residents living in aged-related residential care (ARRC) and community residential care (CRC) facilities. This will include a review of the number of pharmacy providers required to implement the new service model		
Capacity increase	Develop an adult integrated stroke unit (ISU) and rehabilitation beds at Auckland City Hospital to create around 42 additional adult inpatient beds, planned to open in May 2020	Improved capacity to respond to acute demand	Regional/national
Capacity increase	Minor facility works to increase capacity for Critical Care services and other services (to be determined)	Improved capacity to respond to demand	Regional/national
Improved patient selection process and patient pathway	**Bariatric Patient Selection Process and Patient Pathway** Establish the agreed bariatric pathway, 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 to improve patient access to appropriate resources (e.g. psychology, dietitian, nursing) and improve patient understanding by providing information resources reviewed with a health literacy lens	Local (Waitematā DHB only)
Potential change in model of service delivery	VA ECMO was historically initiated by Cardiac Surgery centres when necessary, although national service improvement process agreed that it is more appropriate to transfer these patients to Auckland DHB preoperatively. Auckland DHB will need to assess demand and capacity implications, confirm revenue assumptions and develop a business case for investment to respond to this new demand	Improved patient outcomes through delivery of care by a centre capable of delivering the best evidence-based practise Ensure expertise is concentrated in one centre due to the complexity of procedure and low volumes	National
Implementation of new service	Implement the procedure for left atrial appendage closure. New evidence supports the introduction of new technology in managing this complex cardiac condition; the Auckland DHB Cardiology Service developed a proposal to implement this technology, which is being reviewed by the Northern region Clinical Practice Committee before funding prioritisation is considered and pending changes to the service coverage schedule and central government approval	Improved patient outcomes through provision of alternative evidence-based treatment for patients contraindicated for oral anticoagulation but who are at risk of stroke	Regional
Potential change in model of service delivery	**Vascular services** Review current model of service delivery to Waitematā DHB, including which services can be delivered on site or at other hospitals in the city, and how regional on-call rosters should work to better support current surgical provision at Waitematā DHB	Improved sustainability of local and regional services Improved patient experience and outcomes	Local, regional
Potential change in model of service delivery	**Plastic services** Review current model of service delivery to Waitematā DHB, including which elective services can be delivered on site to better	Improved sustainability of local and regional services Improved patient experience and outcomes	Local, regional

Service affected	Description of service change	Benefits of change	Change for local, regional or national reasons
	support current surgical provision at Waitematā DHB, including oncoplastics (breast), skin (reconstruction) and benign breast		
Shift in service	**Head and Neck services** A regional review across the northern region was completed and the region is working together to improve regional oversight, coordination and management of Head and Neck services for the Northern region population. There may be a change in location of some elements of service delivery arising from the regional planning process	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 a new model based on ambulatory models in place in New Zealand that makes the best use of available capacity and resources (including funding) to increase the number of patients that can assessed and treated	Improved access Improved clinical and financial sustainability of regional model	Regional and local
Change in model of service delivery	**Outpatient Services** Services are expected to review traditional models of service based on face-to-face outpatient activity and develop new models that incorporate alternative methods of delivery. Projects underway include satellite and nurse-led clinics, Telehealth, Community-based IV infusions and patient-generated follow-ups	Provision of more flexible, accessible patient-centred services Better use of new technology to deliver cost effective and efficient services	Sub-regional (Auckland and Waitematā DHBs)
Integration of services	**Community retinal screening and ophthalmology pathway** Develop model of care and pathway from community retinal screening directly to Auckland DHB's ophthalmology service	Streamlined, more efficient and cost effective patient pathway with local access at Waitakere and reduced extra clinics, which elongate the time to review/treat	Sub-regional (Auckland and Waitematā 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 our population locally	Improved sustainability Improved patient outcomes	Sub-regional (Auckland and Waitematā DHBs)
Improved local access	**Local delivery of Oncology Services** Auckland region will continue to work together to increase local delivery of non-surgical cancer services at Waitematā and Counties Manukau DHBs with the timing and scope of services to be determined by the need for additional capacity in the regional service	Improved local access Additional regional service capacity developed in a planned and cost effective manner	Metro-regional
Level, location and configuration of services	**Urology services** A regional review will establish the longer term scope and configuration of local and regional Urology services in the Metro Auckland region, including acute services to progress in 2019/20	Confirming role of regional provider versus other providers Confirm sustainable regional service configuration	Regional and local (Auckland DHB)
Improved local access	**National Peptide Receptor Radio-nuclide Therapy (PRRT) Service**	Improved access to New Zealand-based service for patients that meet	National (based in Auckland DHB)

Service affected	Description of service change	Benefits of change	Change for local, regional or national reasons
	To be developed and established with the Regional Cancer and Blood Service, the University of Auckland, and Clinical Support Services (Laboratory), following the funding decision by Pharmac	Pharmac's PRRT funding criteria Improved equity of access Additional regional and national service capacity developed in a planned and cost effective manner Reduced need for patients to travel and pay for overseas treatment	
Integration of Services	Explore potential synergies regarding greater integration of Genetic Counselling Services across the Clinical Genetics (Northern Hub) and National Familial Gastro-intestinal Cancer Services (national); possibility of developing a more integrated genetic counselling model between these services	Opportunities may exist regarding the training, recruiting and deployment of genetic counsellors between these two services	Regional National
Implementation of an enhanced and regionally consistent model of care – stroke	**Stroke care/rehabilitation** Revised model of care, agreed regionally; local stroke rehabilitation delivery all ages Proposed Integrated Stroke Unit (ISU) for NSH (business case being finalised) including impact on <65 y.o. stroke rehab (i.e. move to the stroke unit rather than Rehab Plus) Develop an ISU at ACH (implement from April 2020), business case awaiting Ministry approval	Streamlined pathway Equitable access to rehabilitation services Consistent quality of care delivery	Regional (some local delivery)
Improved local access	**Adolescent and Young Adult (AYA) acute lymphoblastic lymphoma (ALL)** Waikato DHB a wish for their AYA ALL patients to receive care at Auckland DHB to ensure access to the most up-to-date treatments through US-based COG-accredited clinical trials. This is being implemented and will result in a service change for these services between the Midland Region and Auckland DHB (small volumes) in 2019/20. The MoH National AYA Cancer Network is developing a clinical trial pathway for AYA patients nationally, which may lead to further service change in 2020/21	Additional regional and national service capacity developed in a planned and cost effective manner	Midland region and Auckland DHB DoS Regional and national

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 strategic planning into action, with supportive infrastructure in place. We must be fiscally responsible and accountable for our assets, and spend every public dollar wisely to improve, promote and protect the health of our population.

Organisational performance management

We developed an organisational performance framework that links our high-level performance framework with daily 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, ongoing analysis of inter-district flow performance, and monitoring of responsibility centre performance and services analysis. Performance monitoring is built into our human resource processes; all staff have key performance indicators linked to organisational performance and these are reviewed 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 management guidelines ISO 31000:2018 and SA/SNZ HB 436:2013.

The Corporate Risk Register is the repository for the most significant risks faced by Waitematā DHB, underpinned by a structure of Committee, 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 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 targeting equity in health outcomes. To achieve our quality vision, the DHB has set four aims that reflect key elements of quality.

Safe care – 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 – 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 in the Health Quality and Safety Commission (HQSC) markers is a priority.

The Institute for Innovation and Improvement (i3) helps us to realise our Board's priorities of improving health outcomes and patient and whānau experience. I3 brings together people with a range of expertise and experience to support clinicians, patients and whānau to lead care redesign and best practice innovation and improvement. I3 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 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 Asset Management Strategy has been completed and the policy is being updated to link more closely with it. The Asset Management Plan (AMP) is underway and will provide more information and planning at a clinical division level.
- Identification of Critical Assets is now complete for clinical equipment and has supported the development of a 10-year clinical equipment replacement programme. Building criticality is being developed as part of the development of the National Asset Management Plan led by the Ministry of Health.
- Asset Levels of Service and Asset Performance Measures - several new measures across the three asset portfolios (Clinical Equipment, Facilities and ICT) were identified and monitored from 1 July 2018. Performance targets for new measures will be set in 2019/20.

Northern Region Long-Term Health Plan (NRLTHP)

In 2018, the Northern Region Long-Term Investment Plan (NRLTIP) was published. The NRLTIP set out our regional strategy. It identified the three key issues the northern region needs to address, along with some 'next step' priorities for regional work. These next steps defined three programme streams:

- Northern Region Health Planning;
- ISSP (and implementation); and
- Capital Investment.

The 2019/20 year is focused on further development of the three programme streams set out above. We will place a strong emphasis on health planning for our region and to signal this, we will be developing our plan as the Northern Region Long-Term Health Plan (NRLTHP) in 2019/20. This work area will expand the first NRLTIP strategic aims and will reflect regional health service directions for primary and community services as well as population health services. The Long Term Health Planning programme will be structured around:

1. Health planning 'design' work steams – to clarify the desired models of care for our region and outline the future shape of the northern region health service delivery system. This work will identify and agree:
   - Which priority areas of health service delivery need to change in our region
   - How those services should change in our region.
2. Health planning 'implementation' work streams – this work will progress the necessary changes relating to agreed priority areas of health service transformation.

The Capital Investment and ISSP work will continue to focus on delivery of the 'enabling' capacity and capability to meet the health service delivery requirements. These programmes of work will plan and deliver the enabling capital and IS changes required to support the identified health service transformations.

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 in the next 12 to 18 months. These include a new Elective Capacity and Inpatient Beds facility on the North Shore ($220M), the first tranche of redeveloping the Mason Clinic ($170M), and replacement of critical infrastructure at both Waitakere and North Shore Hospitals ($60M). Other major programmes and capital investment will be required over the next 10 years with planned investment of more than $2 billion in the NRLTHP.

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

Information technology and communications systems

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

Together with our regional partners, we will:

- continue to strengthen our shared information service, with a focus on responsiveness and value
- continue to improve access to our health data through Qlik Sense data visualisations
- participate in the Regional ISSP governance forums
- continue to contribute to development and implementation of the Regional ISSP
- continue to invest regionally in a reliable and sustainable technology infrastructure
- participate in national initiatives, e.g. the National Health Plan and National Health Information Exchange
- continue to improve the maturity of our regional cyber-security capability
- continue investments in electronic support of clinically-led service initiatives.

Further information is provided in Section 2, Data and digital.

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

Waitematā DHB is committed to fostering a positive culture and living our values every day. 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 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 to improve health outcomes and patient experience (Boorman, 2009; Kings Fund 2012; West, 2013). Within the Values Programme is our two-year organisational development plan that has two streams of work: our response to our staff, and our response to patients and the community. The activities in the plan respond directly to staff and patient feedback, and focus on: the introduction of Tōku Reo (my voice), our voice of employee programme, which includes supportive ways for staff to speak up for behaviours we love to see, ways for staff to give regular feedback and a simple way to raise concerns; use of innovative technologies for patient and staff experience and wellbeing; high performance ways of working and health leadership.

Workforce development

Alongside the DHB's organisational development plan, we are focusing on strengthening workforce equity, capability and development. The key focus areas are as follows:

- Strengthening health equity and competency. We aim to increase participation of Māori and Pacific workforces in our DHB (see Section 2, Workforce for further information).
- Supporting professional pathways. We aim to grow great professionals and achieve this in partnership with education institutions and primary care (see Section 2, Workforce for further information). We implemented a new graduate transition support programme for Allied Health, Scientific and Technical Professions and pre-vocational medical trainees (PGY1 and PGY2), and support the growth of our community-based placements (CBAs).
- A great place to work. We aim to provide an environment where everyone can thrive. We continue to undertake activities that support our values, staff recognition and organisation development programme (e.g. create safe and flexible rostering, promote easy-to-use corporate processes, focus on compassionate teamwork and appreciation). We collaborate with Careerforce on flexible work relevant modules for our support workforces. We support continuing professional development, clinically-based education, study days

and research, and our self-funded Professional Education Fund for professions without existing education funding. We are committed to completing key milestones for Care Capacity and Demand Management.

- Wellbeing. We aim to support healthy teamwork, positive mental health, timely debrief and supervision. We support continuation of current wellbeing initiatives underpinned by the World Health Organization's Healthy Workplaces framework and Te Whare Tapa Whā, such as our two fitness hubs, focus on wairua, mindfulness and healthy workplace education sessions, and SMO wellbeing programme.

We support the workforce objectives identified in the NRLTHP and as guided by the Health Workforce Directorate, Ministry of Health.

Waitematā DHB considers the development of senior clinical practitioners to be an important way to support advanced practice. We will continue to fund Nurse Practitioners and other advanced practice roles across secondary, community and primary care. We have 10 Nurse Practitioners across 8 specialities and plan to develop future roles in palliative care, long-term conditions and Māori Health over the next two years.

Cooperative developments

Integrated regional, national and international cooperative partnerships enable our organisational performance:

- We collaborate with our educational partners on NZQA support and profession-based workforce planning, curricula; student placements; joint education and employment ventures and research
- We are active members of the Youth Pledge employment partnership with Auckland Council
- We collaborate nationally and regionally on a comprehensive range of system wide improvements, encompassing capability development, technology to meet our changing educational needs, graduate pipelines and leadership development
- Our residential aged care integration programme (RACIP) provides education, consultation and advice to community aged carers, Registered Nurses and Health Care Assistants in community settings.

We work with our public health physicians in the Health Outcomes team and the Institute for Innovation and Improvement to ensure health needs assessments and measures respond to population-level health issues and outcomes.

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, visitors and 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, our strategic focus includes implementing risk management that is purposeful in decreasing likelihood of poor consequences of health, safety and wellbeing outcomes; reviewing security and safety practises; and ensuring governance processes are best in class.

Through our Safe Way of Working policies, we have a systematic approach to monitoring our health and safety performance. Our annual self-audit measures 12 elements of health, safety and wellbeing, allowing the DHB to take a whole-of-systems and a ward/unit quality improvement approach that defines, guides, measures and embeds our practices.

SECTION 5: Performance Measures

2019/20 Performance measures

The following table presents the full suite of Ministry of Health 2019/20 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		Expectation
Improving child wellbeing (CW)		
CW01 Children caries free at 5 years of age	Year 1	67%
	Year 2	67%
CW02 Oral health: mean DMFT score at school year 8	Year 1	<0.59
	Year 2	<0.59
CW03 Improving the number of children enrolled and accessing the Community Oral Health Service		
Children (0-4) enrolled	Year 1	≥95%
	Year 2	≥95%
Children (0-12) not examined according to planned recall	Year 1	≤10%
	Year 2	≤10%
CW04 Utilisation of DHB-funded dental services by adolescents (school Year 9 up to and including age 17 years)	Year 1	≥85%
	Year 2	≥85%
CW05 Immunisation coverage	% of eight-month-olds fully immunised	95%
	% of five-year-olds fully immunised	95%
	% of girls and boys fully immunised – human papilloma virus (HPV) vaccine	75%
	% of 65+ years olds immunised - influenza vaccine	75%
CW06 Child health (breastfeeding)	% of infants exclusively or fully breastfed at three months	70%
CW07 Newborn enrolment with General Practice	Newborns enrolled with general practice by age 6 weeks	55%
	Newborns enrolled with general practice by age 3 months	85%
CW08 Increased immunisation at two years	% of two-year-olds fully immunised	95%
CW09 Better help for smokers to quit (maternity)	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer are offered brief advice and support to quit smoking	90%
CW10 Raising healthy kids	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions	95%
CW11 Supporting child wellbeing	Provide report as per measure definition	
CW12 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	
	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	
CW13 Reducing rheumatic fever	Reducing the incidence of first episode rheumatic fever	≤0.7 per 100,000
Improving mental wellbeing (MH)		
MH01 Improving the health status of people with severe mental illness through improved access	Age 0-19 years Māori Other Total	 4.70% 3.50% 3.49%

Performance measure		Expectation
	Age 20-64 years Māori Other Total	 7.80% 3.00% 3.43%
	Age 65+ years Māori Other Total	 2.00% 2.13% 2.13%
MH02 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%
MH03 Shorter waits for non-urgent mental health and addiction services (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
MH04 The Mental Health and Addiction Service Development Plan	Provide reports as specified	
MH05 Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by the end of the reporting year (baseline is Q3 2018/19)	↓ by 10%
MH06 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 c. actual expenditure on the delivery of programmes or places is within 5% (+/−) of the year-to-date plan	
Improving wellbeing through prevention (PV)		
PV01 Improving breast screening coverage and rescreening	% coverage for all ethnic groups and overall	70%
PV02 Improving cervical screening coverage	% coverage for all ethnic groups and overall	80%
Better population health outcomes supported by strong and equitable health and disability system (SS)		
SS01 Faster cancer treatment (31-day indicator)	% of patients receive their first cancer treatment (or other management) within 31 days from date of decision to treat	85%
SS02 Ensuring delivery of Regional Service Plans	Provide reports as specified	
SS03 Ensuring delivery of service coverage	Provide reports as specified	
SS04 Delivery of actions to improve Wrap Around Services for older people	Provide reports as specified	
SS05 Ambulatory sensitive hospitalisations	Age 0-4 years (SLM measure)	See our 2019/20 SLM Improvement Plan
	Age 45-64 years (SLM contributory measure)	<4,150/100,000
SS07 Planned Care measures		
1. Planned care interventions	Number of interventions	32,119
2. Elective service patient flow indicators	ESPI 1 (>90% of referrals within each service are processed in ≤15 calendar days)	100%
	ESPI 2 (patients waiting over four months for FSA)	0%
	ESPI 3 (patients in active review with a priority score above the actual treatment threshold)	0%
	ESPI 5 (patients waiting over 120 days for treatment)	0%
	ESPI 8 (patients prioritised using an approved national or nationally recognised prioritisation tool)	100%
3. Diagnostic waiting times	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	95%
	95 % of patients with accepted referrals for CT scans will	95%

Performance measure		Expectation
	receive their scan, and the scan results are reported, within 6 weeks (42 days)	
	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days)	90%
4. Ophthalmology follow-up waiting times	No patient will wait ≥50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service	0%
6. Acute readmissions	Total population	<12.7%
SS08 Planned Care three-year plan	Provide reports as specified	
SS09 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% to ≤4%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% to ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% to ≤2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% to ≤85%
	Invalid NHI data updates	No MoH target
Focus area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures	≥90% to <95%
	National Collections completeness	≥94.5% to <97.5%
	Assessment of data reported to NMDS	≥75%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified	
SS10 Shorter stays in emergency departments (EDs)	% of patients will be admitted, discharged or transferred from an ED within six hours	95%
SS11 Faster cancer treatment (62-day indicator)	% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	90%
SS12 Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified	
SS13 Improved management for long-term conditions (CVD, acute heart health, diabetes and stroke)		
Focus area 1: Long-term conditions (LTCs)	Report on actions to support people with LTC to self-manage and build health literacy	
Focus area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care*	
	Ascertainment	95-105% and no inequity
	HbA1c <64 mmol/mol	60% and no inequity
	No HbA1c result	7-8% and no inequity
Focus area 3: Cardiovascular health	Provide reports as specified	
Focus area 4: Acute heart service	Door to cath within 3 days for >70% of acute coronary syndrome (ACS) patients undergoing coronary angiogram	>70%
	% 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 3 months of discharge	>95% within 30 days ≥99% within 3 months
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF	≥85%
	In the absence of a documented contraindication/ intolerance, >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge: aspirin, a	>85%

Performance measure		Expectation
	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)	
	% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of the procedure	≥99%
Focus area 5: Stroke Services	% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	80%
	% or more of potentially eligible stroke patients thrombolysed 24/7	10%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	80%
	% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge	60%
SS15 Improving waiting times for colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure within 14 calendar days, 100% within 30 days	90% within 14 days 100% within 30 days
	70% of people accepted for a non-urgent diagnostic colonoscopy receive (or are waiting for) their procedure within 42 calendar days, 100% within 90 days	70% within 42 days 100% within 90 days
	70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure within 84 calendar days of the planned date, 100% within 120 days	70% within 84 days 100% within 120 days
	95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system	95%
SS16 Delivery of collective improvement plan	Currently on hold	
SS17 Delivery of whānau ora	Provide reports as specified	
Better population health outcomes supported by primary care and prevention (PH)		
PH01 Delivery of actions to improve system integration and SLMs	Provide reports as specified	
PH02 Improving the quality of ethnicity data collection in PHO and NHI registers	Provide reports as specified	
PH03 Access to care (PHO enrolments)	Meet and/or maintain the national average enrolment rate	90%
PH04 Better help for smokers to quit (primary care)	% of PHO-enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	90%
Annual plan actions		
Annual plan actions – status update reports	Provide reports as specified	

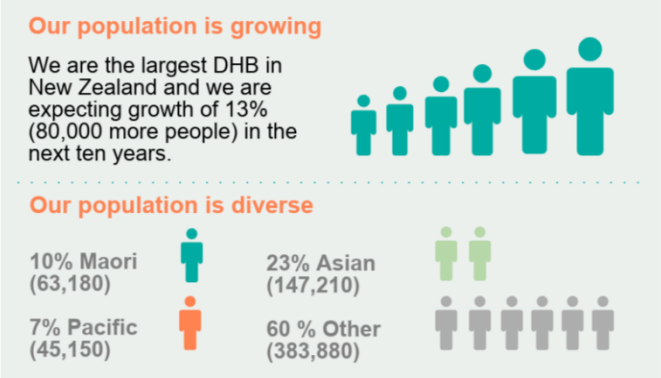
Appendices

APPENDIX A: STATEMENT OF INTENT – 2019/20 TO 2022/23

About Waitematā DHB

Who we are

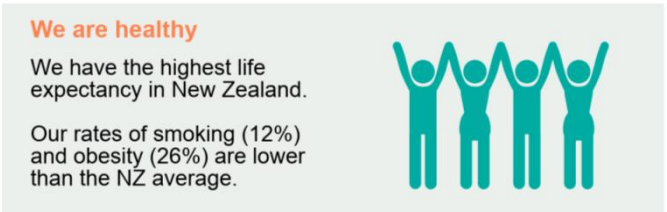
Waitematā DHB is one of 20 DHBs established under the Health and Disability Act (2000). Waitematā DHB is the Government's funder, and provider of health services to the estimated 639,000 residents living in the areas of North Shore, Waitakere and Rodney. We are the largest DHB in the country, and are 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 84.2 years (2016-18), with an increase of 3.7 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. There is room for improvement however, as a significant 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 a 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

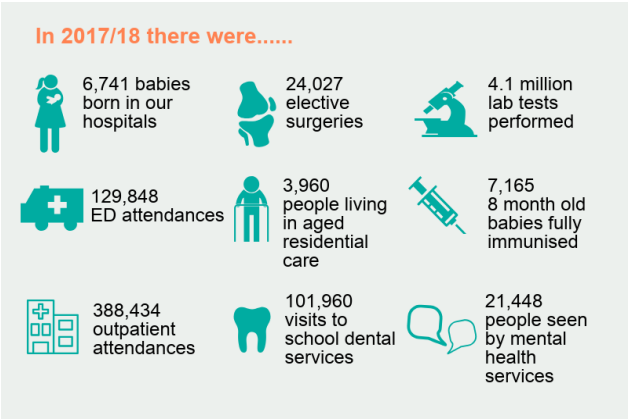
DHBs act as planners, funders and providers of health services, as well as owners of Crown assets.

Waitematā DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. Around 8,136 people are employed by Waitematā DHB.

We have a budget of $1.8 billion in 2019/20.

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.



The key challenges we are facing

Although the majority of our population enjoy very good health, a number of challenges exist as a provider and funder of health services.

Growing and ageing population – the population will increase to approximately 739,000 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 half 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 2.5 years for Māori and 7.1 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
   - tight cost control to limit 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 and 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, by:
   - focusing 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 regionally and across Government and other services
   - addressing quality improvement in all areas
   - ongoing development of services, staff and infrastructure
   - involving patients and families in their care.

Our strategic direction

Best care for everyone

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

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

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

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

Community, family/whānau and patient centred model of care	Emphasis/investment on treatment and keeping people healthy	Service integration and/or consolidation	Intelligence and insight	Consistent evidence informed decision making practice	Outward focus and flexible service orientation	Operational and financial sustainability

Delivering on our strategic direction

Our strategic objectives are to achieve better and more equitable health outcomes for everyone in our community and enhance patient, family and whānau experience. We will do this by working with our communities and partners to deliver high quality, effective services that are patient focused and compassionate.

We are taking a population health perspective to improve the health of the entire population and achieve health equity for all groups, in particular for Māori. We will work with our iwi partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, in the planning and provision of healthcare services to further Māori health gain.

We will continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services, to ensure patients receive more effective and co-ordinated care.

Our Institute for Innovation and Improvement (i3) supports the design and implementation of new models of care and best practice processes. An example is the increased use of teleclinics by our services, which offers a more accessible alternative to traditional outpatient services. Our clinical leadership programme, Transforming Care, is helping build capability for care redesign and enhanced care management.

Last year we undertook a major consultation process to inform our new organisational development plan to improve staff and patient experience. Throughout 2019/20 we will focus on compassion with organisation-wide activity around wellbeing, compassion-based leadership and education. The establishment of the Waitematā DHB Consumer Council will provide a strong voice for consumers on quality improvement and delivery of services that meet the needs of our population.

We expect our population to reach more than 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. We have several major facilities developments planned this year and we are working together with the Northern Region DHBs on the NRLTHP to guide medium- to long-term planning decisions.

Environmental sustainability continues to be a priority. We have plans in place to reduce our carbon emissions and address the impact of climate change on health.

The financial challenge facing the broader health sector and Waitematā DHB is substantial. To ensure long-term sustainability we need effective governance and strong clinical leadership delivering the best evidence- based care in a connected health system.

2019/20 Strategic Intentions

At the Waitematā DHB and Ministry of Health (MoH) Strategic Conversation meeting in May 2019, several priority areas were discussed. While many of the themes are common across the country, some insights and suggestions were specific to this conversation; key themes are included below.

Equity
Significant inequalities and ill health remain, which are linked to ethnicity and deprivation, particularly for Māori and Pacific. We are working with our iwi partners to close the equity gap and improve Māori wellbeing across the region; a number of initiatives are already in place.

A workforce strategy is improving the proportion of Māori and Pacific staff employed across a number of disciplines. A shared governance group across the city oversees the implementation and monitoring of the co-developed Māori workforce development strategy. Improved recruitment of Māori and Pacific is a key focus.

Other Māori-specific projects, which are part of the Māori Health pipeline, include: abdominal aortic aneurysm (AAA) screening, self-testing of human papilloma virus (HPV) screening lung cancer screening research and community cardiac rehabilitation.

Workforce
The DHB has a number of workforce shortages, and the Northern Region Long-Term Health Plan (NRLTHP) involved analysis of issues affecting the region. MRI technologists have to undertake a post-graduate two year training programme, which is longer than elsewhere in the world. Greater influence across colleges is needed to ensure that training is appropriate and not unnecessarily long, which causes delays in growing the work force and increases costs, and to support streamlined registration.

There is a shortage of sonographers, who are often trained by the DHB and subsequently employed in the private sector. There is a potential opportunity to create a new diagnostic sonographer workforce, who are trained and accredited to undertake certain scans.

All healthcare professionals, doctors, nurses and allied health need to be working at the top of their scope. Duplication of roles needs to be avoided and a degree of flexibility needs to be achieved with colleges to allow this.

Primary care
The DHB has a good relationship with primary care and several projects are underway to ensure patients are treated in the right place. In the Emergency Department (ED), patients are triaged at the front door and, if suitable for primary care, redirected to a GP consultation paid for by the DHB. This is much more cost effective than an ED visit and focuses ED resources for more urgent cases. Currently, 400 patients per month are redirected from ED.

Additionally, a number of GP practices are funded to extend their opening hours. The DHB continues to invest in Primary Options for Acute Care (POAC), resulting in approximately 11,000 interventions per month. An on-call psychiatrist is available to GPs for support and advice.

Financial position and sustainability
The lengthy 2018/19 budget and annual planning process was discussed, having an unsigned plan for so long was not ideal. Improvement to the result was due to various wash ups, PHARMAC rebates and the sale of a property. The first draft of 2019/20 annual plan submitted a break even result, which could only be accomplished once the Crown Revenue was confirmed.

MECA increases are a pressure point and risk. The DHB was advised to assume that the funding would not be available. The Ministry acknowledged the pressures within the system, stressing that it was vital that DHBs budgeted within their allocated funding; the DHB requested guidance from the Ministry to support the decisions that will need to be made. The overall sector deficit had to be managed, and a larger deficit could potentially put capital funding at risk. This would involve careful housekeeping and some difficult decisions. Ernst and Young supported the DHB in identifying savings, but many of the projects are large and complex, involving changes to models or pathways of care and are unlikely to achieve savings within a 12-month period.

The Ministry could help with early answers to inter-district flow (IDF) pricing as we have substantial IDF out flows. The potential capital charge on the Mason Clinic land will be an issue. Revenue on electives is also a risk.

The contribution of costing and pricing work was acknowledged along with the need to strengthen this programme. The DHB made a number of suggestions on refining care pathways to reduce clinical variation. We are working with the HQSC to maintain quality and safety.

Capital

A number of capital projects were discussed that are essential for the DHB to maintain delivery of services. These include the Mason Clinic business case, infrastructure business case for remedial work at North Shore and new CSSD, and the Waitakere business case for additional ward and ICU/HDU beds, SCBU expansion, remedial work.

The NRLTHP will help to support longer-term decision on capacity planning and services in the region, including whether further development of the Waitakere site should occur. These were further discussed following this meeting and an approach is agreed.

National, regional and sub-regional strategic direction

National

Waitematā DHB operates as part of the New Zealand health system. Our overall direction is set by the Minister's expectations and align with the New Zealand Health Strategy and New Zealand Disability Strategy, as well as the health and disability system outcomes framework.

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.

Waitematā DHB is committed to working in partnership with the Auckland Regional Public Health Service in their work on health promotion/improvement services, delivering services that enhance the effectiveness of prevention activities in other parts of the health system, and in undertaking regulatory functions.

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'.

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 Long-Term Health Plan (NRLTHP) was developed to articulate the strategic direction for the Northern Region and to identify the investments necessary to ensure the ongoing delivery of high quality healthcare. It identifies the key challenges for the four Northern Region DHBs and sets priorities for regional planning work, ISSP (and implementation) and capital investment. The regional work plan will continue to be developed around the NRLTHP, reflecting the Ministry's identified areas of focus as closely as possible, including actions, milestones and performance indicators for achievement during 2019/20.

Sub-regional

Waitematā and Auckland DHBs have a bilateral agreement that joins governance and some activities. Furthermore, collaboration across the northern region is increasingly critical as we strive to deliver services for our whole population, invest across the health system, and increase coordination of care to improve access, equity and healthcare outcomes and reduce unnecessary duplication.

Focus for the year

Waitematā DHB is committed to achieving healthy equity for everyone in our community, in particular for Māori. We will work with our iwi partners, Te Rūnanga o Ngāti Whātua and Te Whānau o Waipareira Trust, to plan and provide healthcare services to further Māori health gain.

We want a culturally aware workforce that reflects our communities to care for our patients. The Māori Advisory Leadership Team (MALT) oversees the implementation of the joint Waitematā and Auckland DHBs' Māori Health Workforce Development Strategy. This helped our total Māori workforce increase by more than 75% since 2015, to a total of 493 current Māori employees. By 2025, we aim to reach parity with the proportion of Māori and Pacific people in our working age population.

We expect our population to exceed 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:

- Design and begin construction of a new $220 million, four-storey surgical hospital at the North Shore Hospital campus.

- Complete and open the $22.46 million, 15-bed medium secure Tanekaha Unit at the Mason Clinic.
- Engage with the other northern region DHBs in the 2019/20 planning process. The regional work plan will continue to be developed around the NRLTHP.
- Establish the new Consumer Council to provide a strong voice for consumers on quality improvement and delivery of services.

Last year our senior management teams visited teams throughout the DHB and heard from around 1,500 staff. This staff and patient feedback has been used to create our new organisational development plan to improve staff and patient experience.

Throughout 2019/20 we will focus on compassion with organisation-wide activity such as: wellbeing initiatives; compassion based leadership and education programmes; collecting and sharing stories of compassion; and trialling compassion grand rounds.

Key programmes and initiatives this year

Māori Health Partnerships

We plan to establish a new Māori health committee representing Northland, Waitematā and Auckland DHBs in partnership with our iwi partners, with the intention of working together to achieve Māori health equity. A similar committee is to be formed between Counties Manukau and Waikato DHBs and their iwi partners. The two Māori governance groups will regularly meet to share regional opportunities to advance Māori health gain.

Māori pipeline projects

A Māori Health Pipeline of projects has been established which focuses on identified areas to accelerate Māori health gain and reduce the life expectancy gap. The pipeline provides an opportunity to develop a more streamlined process for proposals, project implementation and robust evaluation. The pipeline work programme includes: Lung cancer screening; alternative community cardiac and pulmonary rehabilitation prototypes; breast screening data match '500 Māori women campaign'; Māori provider and PHO data match; and targeted cervical cancer projects.

The Waitematā Experience programme

This programme encompasses all activity that seeks, collects and analyses patient and whānau feedback to inform quality improvement activity. Co-design methodology is used to redesign services and to ensure we deliver an excellent experience for patients, whānau and staff. The programme aligns all the patient experience work occurring in the DHB with the staff values programme to ensure the patient's voice is heard and patient/whānau centred care practices are embedded throughout the organisation. Key priorities for 2019/20 include programmes that focus on listening and working with our patients, whānau and staff, communicating effectively and consistently and ensuring we have a welcoming and friendly environment.

Waitematā DHB Consumer Council

The establishment of the Waitematā DHB Consumer Council will provide a strong voice for consumers on quality improvement and delivery of services that meet the needs of our population. Aligning strategically with DHB priorities, the Consumer Council will enhance consumer engagement and patient experience across all services. The Consumer Council will further focus our organisation to become more patient- and whānau-centred, and transform our culture to one where working in partnership with our community is business as usual.

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 i3 Institute provides 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. The programme advances the support of patient care through electronic systems, the use of data and improved workflows. A series of new Phase Three projects will lead our transformation to an integrated digital environment. Underpinned by the LeapFrog programme, Waitematā DHB is recognised as a leader in the movement toward a more mobile, electronic health record.

Managing Our Business

Section 4 of our Annual Plan details how Waitematā DHB will manage our functions and operations in order to deliver on our strategic intentions, and maintain our organisational health and capability.

Improving health outcomes for our population

Waitematā DHB's performance framework demonstrates how the services that we choose to fund or provide contribute to the health of our population and result in the achievement of our longer-term outcomes and the expectations of Government.

Our performance framework reflects the key national and local priorities that inform this Annual Plan. There is considerable alignment between our performance framework, the System Level Measures framework set by the Ministry of Health, the Minister of Health's planning priorities, and the over-arching Government Priorities.

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

- Life expectancy at birth continues to increase
- Inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced

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.

We have identified medium-term outcome goals and short-term priorities that will support achievement of these overall objectives. Equity underpins our performance framework and our goals are focused on three key areas: Child Wellbeing, Prevention and Early Intervention and Mental Health.

For each measure, annual improvement milestones have been set, and local progress will be tracked. Our medium-term outcomes define our priorities for the next 3-5 years and allow us to measure the difference we are making for our population. Our short-term priorities are essential to the achievement of our outcome goals and are front-line measurements of the success of specific health processes or activities. To help identify equity gaps and measure progress, we will monitor all our medium term outcomes by ethnicity.

Child Wellbeing

We want to ensure that all children in our district have the best start to life. Pregnancy and early childhood are the most effective times to intervene to reduce inequalities and improve long term health and wellbeing. Smoking is a leading risk factor for many diseases, and exposure to smoke during pregnancy and early childhood strongly influences health outcomes. Smoking rates among Māori and Pacific are double that of other ethnicities and less than half of all Māori and Pacific babies currently live in smokefree households. By supporting whānau to quit, we aim to increase the number of babies living in smokefree homes. Pacific children in particular have very high rates of admission to hospital for conditions that can be potentially prevented or managed by primary and community care. We will improve immunisation rates and access to oral health services to help keep these children out of hospital.

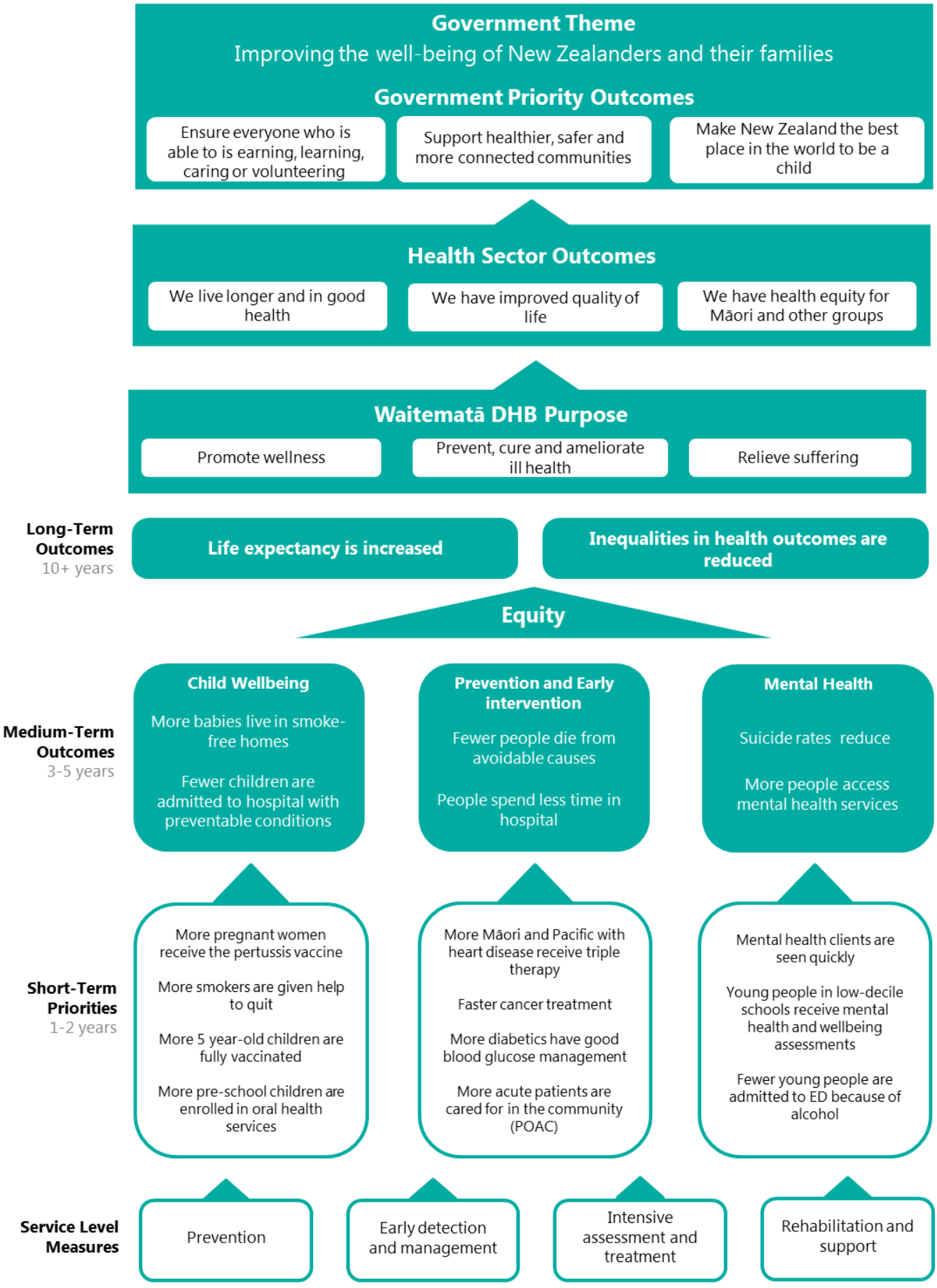
Prevention and Early Intervention

Preventative care is centred around individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Māori and Pacific have a higher incidence of chronic conditions and experience poorer outcomes and we want to address this inequity. Our aim is for fewer people to die from potentially avoidable conditions. We also want to make sure that where possible, treatment and management happens in community settings and for people to spend less time in hospital when they are acutely unwell. The rates of cardiovascular disease and diabetes are higher for our Māori and Pacific populations. We need to focus on good management of these conditions through support and education and prescribing of appropriate medications, to improve the health outcomes of those most affected. Likewise, we need to continue to ensure that our cancer pathways remain timely and that there are no barriers to accessing cancer treatment.

Mental Health

Mental health and addiction problems affect the lives of many people in our district, with around 20% experiencing mental illness or distress. New Zealand has high suicide rates, with rates for Māori twice that of other ethnicities. We will ensure that practical help and support is available in the community to all people who need it, but also that there is good access to acute mental health support when required. Young people in lower decile schools will be supported to receive help for mental health, alcohol and drug, sexual health, social and physical health issues.

Performance and intervention framework



Long-term outcomes

The long-term outcomes that we aim 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).

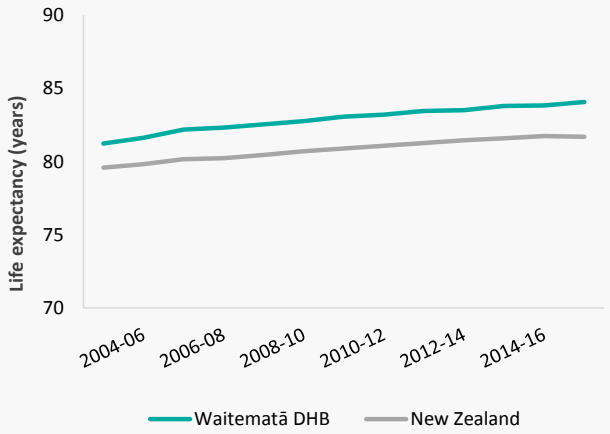
Increasing life expectancy

Life expectancy at birth is recognised as a general measure of population health status.

We have the highest life expectancy in the country at 84.2 years (2016-18), 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. Our life expectancy has increased by 3.7 years since 2001, which is 0.8 years more than New Zealand.

Over the longer term, we aim to maintain the highest life expectancy in the country and a 1.7 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.

Reduce inequalities for all populations

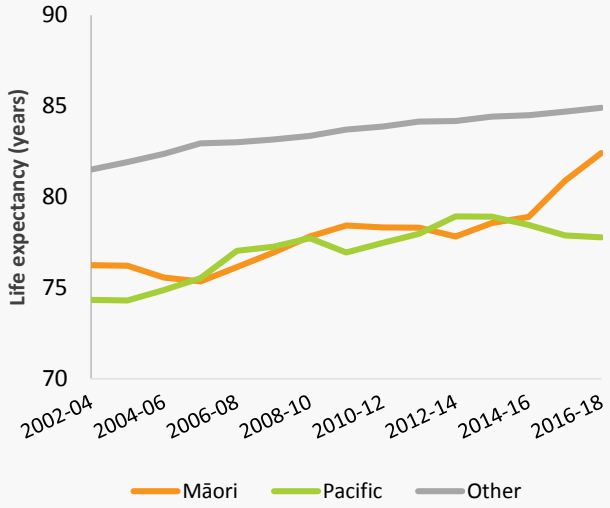
Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 2.5 years for Māori and 7.1 years for Pacific (2016-18).

Life expectancy has increased in our Māori (6.7 years) and Pacific (3.2 years) populations since 2001. While the gap in life expectancy is closing for Māori, it appears to be growing for Pacific.

Mortality at a younger age from cardiovascular disease and cancers accounts 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.

Child Wellbeing

The foundations of a healthy adult life are laid in early childhood. Promoting healthy behaviours and environments, along with ensuring access to well integrated primary and community services can prevent health problems and improve health outcomes. We aim to increase the proportion of babies living in smoke-free homes and reduce the number of children admitted to hospital with preventable health conditions.

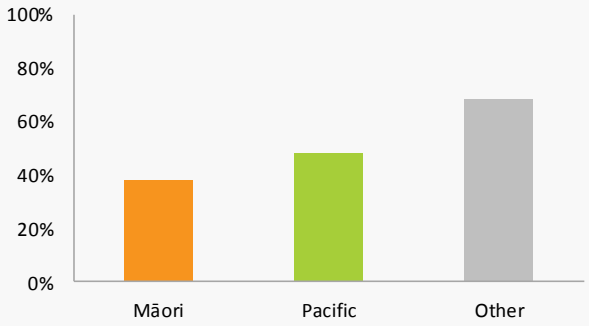
Medium-Term Outcomes

More babies live in smoke-free homes

Infants and young children are exposed to second-hand smoke more often 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 is a significant contributor to health inequalities in children.

As at June 2018, less than half of all Māori and Pacific babies were living in a smokefree household in contrast to nearly three quarters of other ethnicities.

Proportion of babies living in smokefree households at 6 weeks postnatal

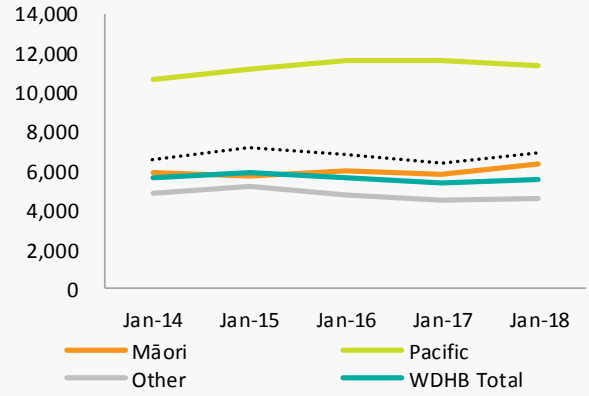


Fewer children are admitted to hospital with preventable conditions

We seek to reduce admission rates to hospital for a set of conditions that are potentially avoidable through prevention or management in primary care, known as ambulatory sensitive hospitalisations (ASH). In children, these conditions are mainly respiratory illnesses, gastroenteritis, dental conditions, and cellulitis.

In the 12 months to June 2018, there were 2,214 admissions in 0–4 year olds that were potentially avoidable. The overall rate of admissions (5,577 per 100,000) has declined slightly since 2014. Compared with other ethnicities, rates are higher in Māori (6,323 per 100,000) and over twice as high in the Pacific population (11,323 per 100,000).

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



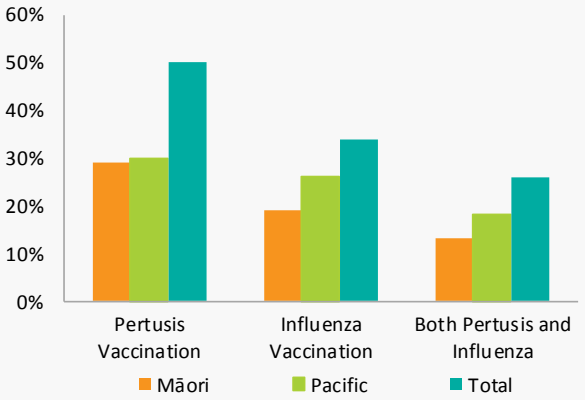
Short-Term Priorities

More pregnant women receive antenatal immunisations

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

Pregnant women are recommended to have both vaccinations every pregnancy. For babies born in 2018, only 26% of mothers received both vaccinations during pregnancy, with the proportion much lower for Māori and Pacific.

Proportion of pregnant women receiving pertussis and/or influenza vaccinations in pregnancy

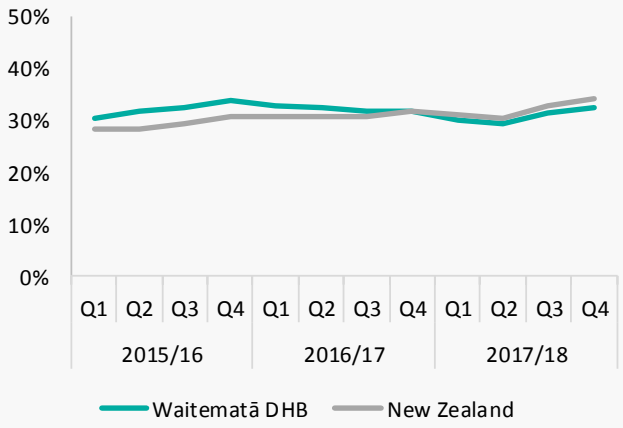


More smokers are given help to quit

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 increases if behavioural support, such as a referral to quit smoking services, and/or pharmacological smoking cessation aids are provided.

Proportion of smokers receiving cessation support in primary care

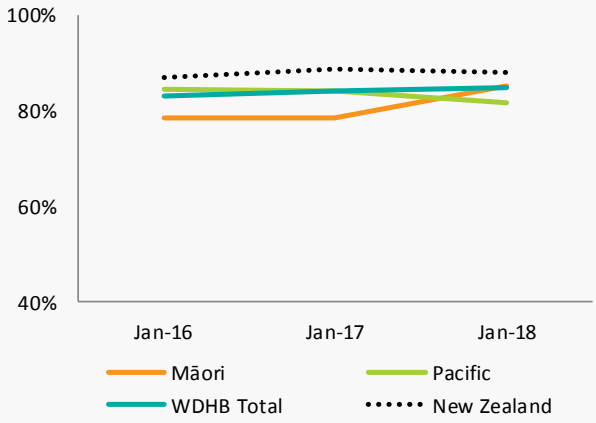


More five year-old children are fully vaccinated

Immunisation is one of the most effective and cost-effective medical interventions to prevent disease. Vaccine-preventable diseases (such as measles, mumps, and rubella) can cause serious health problems, disabilities, and even death. Immunisation not only protects the child, but others that are unable to be vaccinated, via herd immunity.

Receiving scheduled vaccinations on time provides a good opportunity for children and families to engage with health services on a relatively regular basis.

Proportion of children fully vaccinated by five years of age

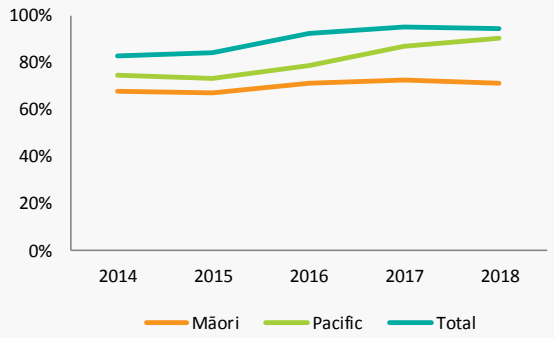


More pre-school children are enrolled in oral health services

Dental care comprises a leading cause of preventable admission to hospital among pre-school children. The consequences of poor dental health in childhood can carry on into adulthood. Prevention and early intervention are key to reducing the number of children hospitalised for dental conditions.

Dental care for preschool children is free; however, a large number of children are not enrolled in oral health services. We aim to ensure that all children are enrolled in oral health services and receiving dental care.

Proportion of pre-school children enrolled in oral health services



Prevention and Early Intervention

Chronic diseases are the leading cause of death and disability, with increasing prevalence linked to increasing health costs. Preventative care is centred around individuals, keeping people healthy, treating problems quickly, and empowering people to manage their own health. Identifying and preventing potential problems downstream, such as addressing the socio-economic determinants of health, is one strategy to improve health outcomes. When people do become unwell, prompt diagnosis and early intervention in the initial stages can have significant impact on the outcome. Our aim is for fewer people to die from potentially avoidable conditions and for people to spend less time in hospital when they are acutely unwell.

Medium-Term Outcomes

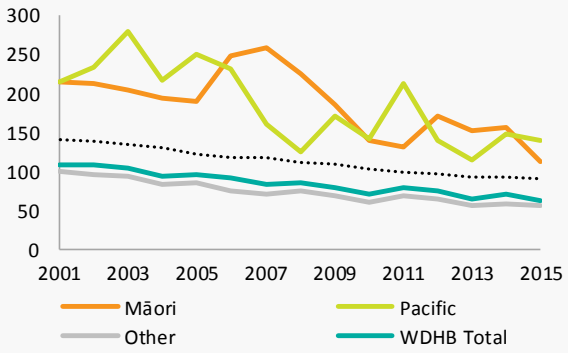
Fewer people die from avoidable causes

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.

Mortality rate from conditions considered amenable, per 100,000 population

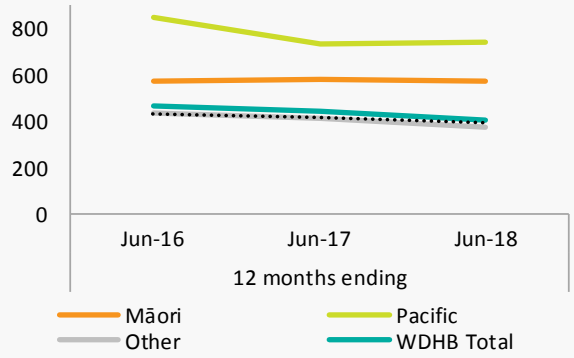


People spend less time in hospital

Acute admissions account for approximately half of all hospital admissions in New Zealand. Reducing the demand for acute care maximises the availability of resources for planned care, and reduces pressures on DHB staff and facilities. Reductions may result from effective management in primary care, optimising hospital patient flow, discharge planning, community support services and good communication between healthcare providers.

Although our standardised rate of acute bed days has slowly declined since 2016, it remains higher than the national rate (406.8 vs. 391.7 per 1,000 population).

Acute hospital bed days rate per 1,000 population



Short-Term Priorities

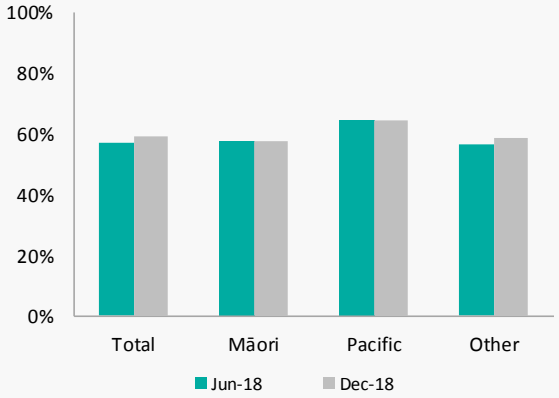
More Māori and Pacific with heart disease receive triple therapy

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

We aim to ensure that all of 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.

Proportion of Māori and Pacific with a prior CVD event prescribed triple therapy

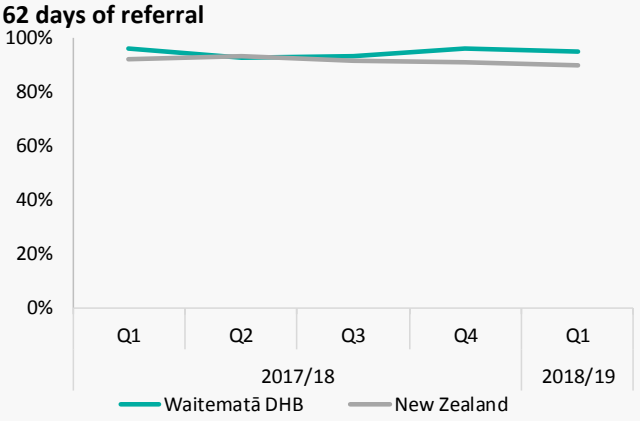


Faster cancer treatment

Cancer is a leading cause of morbidity and mortality in Waitematā DHB, accounting for over one quarter of all deaths. Prompt investigation, diagnosis and treatment increases the likelihood of better outcomes for cancer patients, and assurance regarding waiting time can reduce the stress on patients and families at a difficult time.

We aim to ensure that patients diagnosed with cancer receive their first treatment or other management within 62 days.

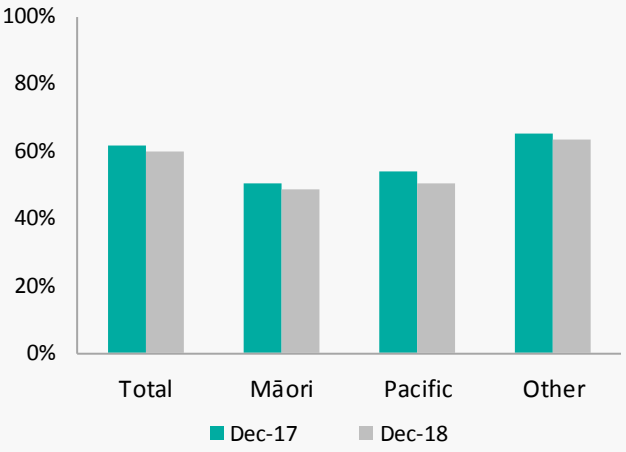
Proportion of cancer patients receiving treatment within 62 days of referral

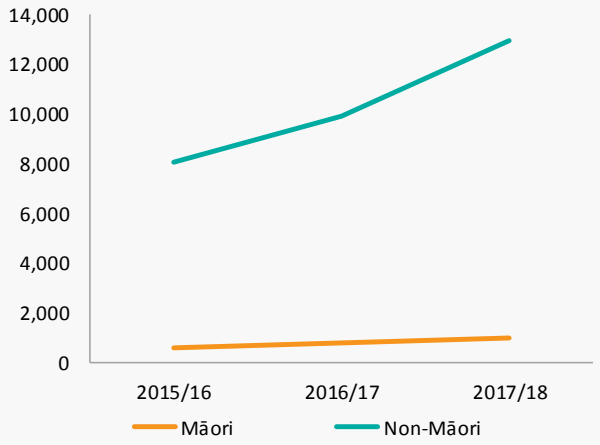


More people with diabetes have good blood glucose management

The management of type 2 diabetes is multi-faceted. Following diagnosis, patients require education to self-manage their condition and make lifestyle changes. HbA1c is a measure of an average blood glucose (average blood sugar) level over the past few months and can be used as an indicator of a patient's diabetes control. Well managed diabetes decreases the onset and progression of microvascular complications such as retinopathy, nephropathy and neuropathy.

Proportion of people with diabetes with good blood glucose management

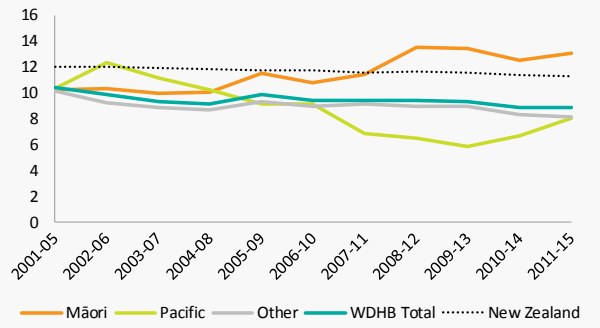
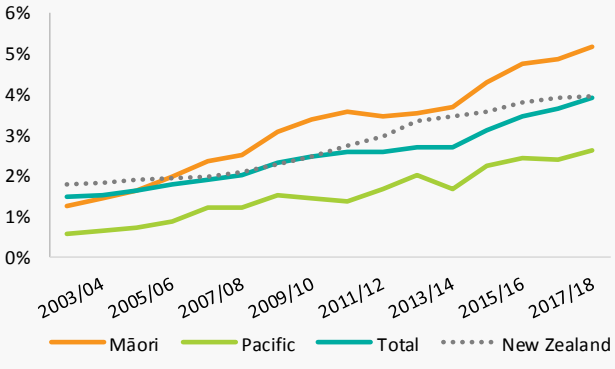


More acute patients are cared for in the community (POAC)	
Primary Options for Acute Care (POAC) provides healthcare professionals with access to investigations, care or treatment for their patient, when the patient can be safely managed in the community. Access to existing community infrastructure and resources is utilised to provide services that prevent an acute hospital attendance or shortens hospital stay for patients who do attend or are admitted. The aim of POAC is to deliver timely, flexible and coordinated care, meeting the healthcare needs of individual patients in a community setting. We aim to have more individuals being treated (where appropriate) through the POAC pathway, thus preventing unnecessary and costly acute hospital admission.	**Number of POAC referrals** 

Mental Health

Mental health and addiction problems affect the lives of many people in our district. Each year, around one in five of our population experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. In addition, New Zealand has persistently high suicide rates. The responsibility for improving mental health outcomes for our population does not lie solely with the health system; there are clear links between poverty and poor mental health. We aim to ensure that practical help and support is available in the community to people who need it; our people need safe and affordable houses, good education, jobs and income for mental wellbeing.

Medium-Term Outcomes

Suicide rates reduce	
Suicide is a serious health and social issue. Suicide rates reflect the mental health and social wellbeing of the population. Suicide prevention initiatives aim to promote protective factors, reduce risk factors for suicide and improve the services available for people in distress. Although our suicide rates are lower than the national rate, it is unacceptably high, and we aim for zero suicide. Reducing suicide rates requires a whole-of-government approach to supporting wellbeing and addressing multiple social determinants.	**Rate of suicide per 100,000 population** 
More people access mental health services	
Each year, around one in five individuals experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. While not all individuals with mental health and addiction challenges need or will seek to access a specific service intervention, over time, more people should be able to access support. Given the current prevalence, the expected access rates should be higher than the current 3%.	**Access rates to mental health services** 

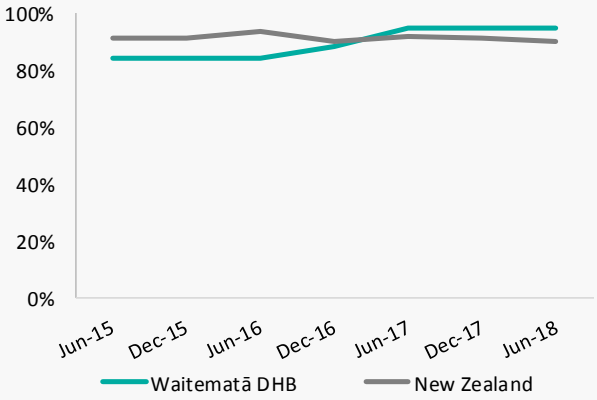
Short-Term Priorities

Mental health clients are seen quickly

Individuals experiencing mental distress or with mental health needs do not always require a referral or access to specialist mental health services. However, where a need does arise and people reach a point of crisis, it is critical to intervene quickly with a variety of well-supported and culturally safe treatment options, which may include a referral to specialist mental health services.

We aim to ensure that when individuals are referred to specialist mental health services, they are seen quickly.

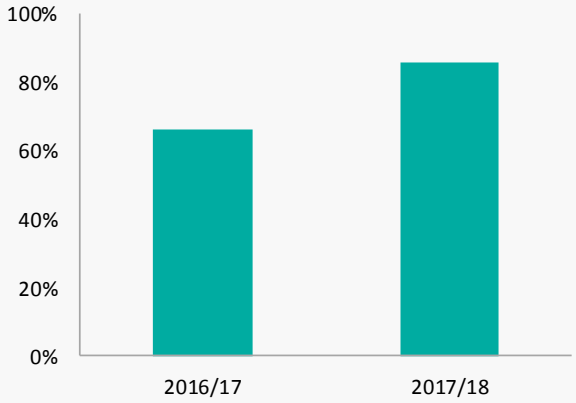
Proportion of non-urgent referrals to mental health services that are seen within three weeks



Young people in low-decile schools receive mental health and wellbeing assessments

Adolescence is a challenging time when many emotional and physical changes take place. Most adolescents make it through their teenage years and enter adulthood without major trauma. However, for some teenagers this may be a very dangerous time of experimentation. HEEADSSS is a validated assessment tool that is commonly used to help assess youth wellbeing through a series of questions relating to home life, education/employment, eating, activities, drugs, sexuality, suicide/depressions and safety. The tool is administered to year 9 students in a number of schools and provides a mechanism for health professionals to evaluate young people's developmental stage, risk taking behaviour, risk and protective factors for them and the environment around them.

HEEADSSS assessment coverage

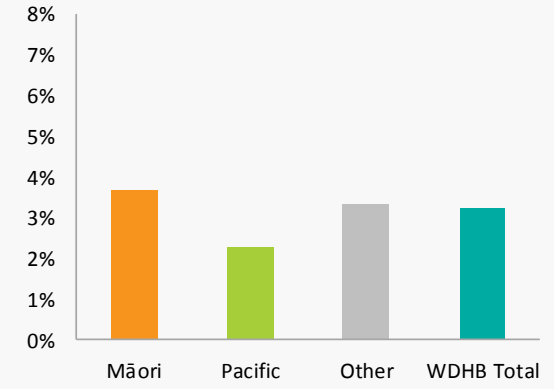


Fewer young people are admitted to ED because of alcohol

Alcohol is deemed to be 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).

Proportion of youth Emergency Department presentations which are alcohol-related (12 months to Dec-18)



* 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.

APPENDIX B: STATEMENT OF PERFORMANCE EXPECTATIONS – WAITEMATĀ DHB 2019/20

The Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for the 2019/20 year. The Crown Entities Act 2004 requires the DHB's Statement of Performance Expectations (SPE) to include forecast financial statements for the financial year, prepared in accordance with generally accepted accounting practice. The DHB's forecast financial statements for the year ended 30 June 2020 are included in Appendix C and the Financial Performance Summary table is included in Section 2 of this Annual Plan document. Both these form part of the DHB's SPE for the 2019/20 financial year.

Performance measurement framework

Our focus for 2019/20 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.

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 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, e.g. immunisation and screening services. By supporting people to make healthy choices and maintain good health, effective prevention can significantly improve health outcomes. The DHB works with the Auckland Regional Public Health Service to promote and protect wellness and prevent disease.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Health promotion			
% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months	C	89%	90%
% 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	90%	90%
Number of pregnant women smokers referred to the stop smoking incentive programme	Q	157[1]	231
% 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	4,171[2]	4,861
% of clients engaged with Green Prescriptions	C		
- *Māori*		*14*[2]	*13%*
- *Pacific*		*16*[2]	*12%*
- *South Asian*		*7*[2]	*9%*
Immunisation			
% of pregnant women receiving pertussis vaccination in pregnancy	C	50%[2]	50% (or maintain if >50%)
- *Māori*		*29%*[2]	
- *Pacific*		*30%*[2]	
- *Asian*		*60%*[2]	
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness	C	15%[2]	15%
- *Māori*		*9%*[2]	
- *Pacific*		*8%*[2]	
% of eight months olds will have their primary course of immunisation on time	C	92%	95%
- *Māori*		*86%*	
- *Pacific*		*93%*	
% of five year olds will have their primary course of immunisation on time	C	85%	95%
- *Māori*		*81%*	
- *Pacific*		*83%*	
- *Asian*		*91%*	
Rate of HPV immunisation coverage	C	60%	75%
Population-based screening			
% of women aged 50-69 years having a breast cancer screen in the last 2 years	C	65%	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	71%	80%
HEEADSSS assessment coverage in DHB funded school health services	C	88%	95%
% of 4 year olds receiving a B4 School Check	C	90%	90%
Bowel Cancer Screening			
% of people aged 60-74 years invited to participate who returned a correctly completed kit[3]	Q	63%	60%
- *Māori*		*60%*	
- *Pacific*		*46%*	
- *Asian*		*55%*	

[1] Q4 2017/18 to Q3 2018/19 data.

[2] CY2018 data. Differs from the result published in the 2017/18 Annual Report, which is for the 2017/18 financial year (3,756).

[3] Patients invited during 2018 and 2019, i.e. round 4 (this differs from previous screening rounds, which involved patients aged 50-74 years old).

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
- *Asian*		*55%*	
- *Other*		*66%*	
% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system	T	93%	95%
Auckland Regional Public Health Service[4]			
Number of tobacco retailer compliance checks conducted	V	372	300
Number of alcohol licence applications and renewals (on, off club and special) that were inquired into	V	2,112	Ω
% of smear-positive pulmonary tuberculosis cases contacted by the Public Health Nurse within 3 days of clinical notification	Q	New indicator	98%
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol	Q	New indicator	95%
% of compliance assessments conducted of large and medium networked drinking water supplies	Q	100%	100%

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 2017/18	Target 2019/20
Primary health care			
Rate of primary care enrolment in Māori	C	83%	90%
Number of referrals to Primary Options for Acute Care (POAC)	V	13,944	10,811
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices who does not have an HbA1c recorded in the last 15 months	C	13%	<12.0%
- *Māori*		*16%*	
- *Pacific*		*13%*	
% of people with diabetes aged 15-74 years and enrolled with Waitematā DHB practices whose latest HbA1c in the last 15 months was ≤64 mmol/mol	Q	63%	65%
- *Māori*		*49%*	
- *Pacific*		*53%*	
% of Māori patients with prior CVD who are prescribed triple therapy	Q	59%[5]	62%
% of Pacific patients with prior CVD who are prescribed triple therapy	Q	64%[5]	66%
Ambulatory sensitive hospitalisation (ASH) rate per 100,000 for 45-64 year olds	Q	4,235[5]	4,150
- *Māori*		*7,952*[5]	9,257
- *Pacific*		*11,748*[5]	9,146
Average response score to the primary care survey question 'in the last 12 months, when you ring to make an appointment how quickly do you usually get to see your current GP?'	T	5.4[5]	6.0
Pharmacy			
Number of prescription items subsidised	V	7,401,580[6]	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	38,842	Ω
Number of community laboratory tests	V	4,082,639	Ω

[4] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.
[5] CY2018 data.
[6] Full year result; differs from the result published in the 2017/18 Annual Report, which is for Q1-3.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Oral health[7]			
% of preschool children enrolled in DHB-funded oral health services	C	96%	95%
- *Māori*		*73%*	
- *Pacific*		*87%*	
- *Asian*		*90%*	
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8	Q	0.61	<0.59
- *Māori*		*0.76*	
- *Pacific*		*0.89*	
- *Asian*		*0.65*	
% of children caries free at five years of age	Q	67%	67%
- *Māori*		*55%*	
- *Pacific*		*48%*	
- *Asian*		*58%*	
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years	C	68%	85%

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 2017/18	Target 2019/20
Acute services			
Number of ED attendances	V	129,848	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	65%[8]	<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	94%	90%
% of potentially eligible stroke patients thrombolysed	C	10%	10%
% of ACS inpatients receiving coronary angiography within 3 days	T	72%	70%
Maternity			
Number of births in Waitematā DHB hospitals	V	6,741	Ω
% of babies exclusively breastfed on discharge	Q	78.6%	75%
Elective (inpatient/outpatient)			
Number of planned care interventions	V	New indicator	22,682
% of people receiving urgent diagnostic colonoscopy in 14 days	T	97%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days	T	71%	70%
% of patients waiting longer than 4 months for their first specialist assessment	T	0%	0%
% of accepted referrals receiving their CT scan within 6 weeks	T	83%	95%
% of accepted referrals receiving their MRI scan within 6 weeks	T	78%	90%

[7] All oral health measures have CY2017 data as baseline.

[8] CY2018 data.

Outputs measured by	Notes	Baseline 2017/18	Target 2019/20
Quality and patient safety			
% of opportunities for hand hygiene taken	Q	88%[9]	80%
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.06[10]	<0.11[11]
% of older patients assessed for the risk of falling	Q	97%	90%
% of falls risk patients who received an individualised care plan	Q	97%	90%
Rate of in-hospital falls resulting in fractured neck of femur per 100,000 admissions	Q	12.6[12]	<8.4[13]
% of hip and knee arthroplasties operations where antibiotic is given in one hour before incision	Q	96%[14]	100%
% of hip and knee procedures given right antibiotic in right dose	Q	97%	95%
Surgical site infections per 100 hip and knee operations	Q	0.63	<0.93[15]
% occasions insertion bundle used in ICU	Q	99%	90%
% occasions maintenance bundle used in ICU	Q	94%	90%
% of 'yes, completely' responses to the national inpatient survey question 'did a member of staff tell you about medication side effects to watch for when you went home'	Q	45%	47%
% of patients audited for pressure injury risk who received a score	Q	86%	90%
% of patients with the correct pressure injury care plan implemented	Q	78%	90%
Mental Health			
% of population who access Mental Health services	C		
- Age 0–19 years		3.91%	3.49%
- *Māori*		*5.13%*	*4.70%*
- Age 20–64 years		3.57%	3.43%
- *Māori*		*8.60%*	*7.80%*
- Age 65+ years		2.07%	2.01%
- *Māori*		*2.24%*	*2.13%*
% of 0-19 year old clients seen within 3 weeks	T		
- Mental Health		77%	80%
- Addictions		91%	80%
% of 0-19 year old clients seen within 8 weeks			
- Mental Health		95%	95%
- Addictions		99%	95%

[9] Full year result; differs from the result published in the 2017/18 Annual Report, which is for Q1-3 (89%).
[10] This result was updated by HQSC from that published in the 2017/18 Annual Report (0.07).
[11] Jan 2012 to Jun 2017 national median.
[12] This result was updated by HQSC from that published in the 2017/18 Annual Report (9.71).
[13] Sep 2014 to Jun 2017 national median.
[14] Full year result; differs from the result published in the 2017/18 Annual Report, which is for Q1-3 (97%).
[15] Sep 2015 to Nov 2017 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 2017/18	Target 2019/20
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			
Hospice			
Total number of contacts in the community	V	21,827	Ω
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	16%	<5%
Hospital			
Total number of referrals	V	New indicator	Ω
Average time to first contact with referrer	T	New indicator	≤6 h
Average time from referral to first face-to-face patient assessment	T	New indicator	≤24 h
Residential care			
ARC bed days	V	966,718	Ω

APPENDIX C: FINANCIAL PERFORMANCE

In the 2018/19 financial year, Waitematā DHB's operating result, before Ministry of Health informed late adjustments, was $160k favourable to plan. In the year to 30 June 2019, the DHB reported a draft result with a deficit of $13.489m against the $7.00m deficit budget approved by the Minister of Health on 20 May 2019. This result reflects Ministry of Health late advised, one-off authorised adjustments for holiday pay $1.5m, FPIM Impairment $1.624m and IDF wash-ups, which deteriorated what would otherwise have been an operating performance favourable to budget. The Annual Report for the year ended 30 June 2019 reports the DHB's performance against the deficit budget of $14.7m in the Statement of Performance Expectations adopted by the Board in October 2018. It is a requirement of the Crown Entities Act that DHBs report their financial performance in their Annual Report against their Board's adopted budget as set out in the Statement of Performance Expectations, rather than the final Ministerial approved budget. The Annual Report for the year ended 30 June 2019 is due for finalisation in October 2019, and there may be further impacts on the result for that year and the balance sheet at 30 June 2019 due to costs associated with Holiday Pay Act.

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 $44.9m, offset by surpluses in the Funder and Governance Divisions totalling $36.0m. 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.

Planning is progressing 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 2019/20 financial year, the DHB is forecasting a breakeven budget, which reflects a breakeven in both the Provider and in the Funder.

The breakeven within the Provider assumes that a $30.5m 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 an independent review of the Financial Sustainability Portfolio in May 2019. This review found the DHBs financial performance compares well and a number of further strategic opportunities are available to build on the successes of clinical transformation work undertaken to date.

The Board approves 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 Financial Sustainability Governance Group, chaired by the CFO and Head of Corporate Services.

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

During the 2018/19 financial year, the DHB forecasted to deliver savings of $10m, of which some were one off and will not repeat in subsequent years.

Improving the financial performance of the Provider Arm is being delivered via a series of tactical, operational and strategic initiatives. 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 May 2019.

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 $79.6m above 2018/19 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 and inflationary pressure on clinical and non-clinical supplies and service contracts. Key expenditure assumptions include the below.

- 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 aligned with planned settlements of current employment negotiations.
- The effects of the asset revaluation as at 30 June 2018 have 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 2017/18, year-end planned results for 2018/19 and plans for years 2019/20 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

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Government and Crown Agency Revenue	1,606,402	1,717,979	1,796,766	1,836,050	1,872,764	1,910,214
Patient Sourced and Other Income	29,510	30,125	40,239	31,543	32,370	33,215
IDFs and Inter DHB Provider Income	86,543	92,087	94,267	95,478	97,387	99,333
Total Funding	**1,722,455**	**1,840,191**	**1,933,272**	**1,963,071**	**2,002,521**	**2,042,762**
Personnel Costs	641,786	689,002	719,381	738,373	752,300	766,515
Outsourced Costs	74,113	85,348	86,082	86,433	88,157	89,916
Clinical Supplies Costs	123,940	127,420	133,550	137,631	140,379	143,183
Infrastructure and Non-Clinical supplies Costs	120,728	119,390	86,154	74,369	76,897	79,467
Payments to Other Providers	778,915	832,520	908,105	926,265	944,788	963,681
Total Expenditure	**1,739,482**	**1,853,680**	**1,933,272**	**1,963,071**	**2,002,521**	**2,042,762**
Net Surplus/(Deficit)	**(17,027)**	**(13,489)**	**0**	**0**	**0**	**0**
Other Comprehensive Income	**0**	**0**	**0**	**0**	**0**	**0**
Gains/(Losses) on Property Revaluations	15,939	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**(1,088)**	**(13,489)**	**0**	**0**	**0**	**0**

Historically, we have performed well financially, with surpluses generated in the past five of six 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. However, the DHB is forecasting a breakeven in 2019/20.

Forecast Statement of comprehensive income – group

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Government and Crown Agency Revenue	1,606,455	1,717,979	1,798,766	1,836,050	1,872,764	1,910,214
Patient Sourced and Other Income	31,752	30,125	40,239	31,543	32,370	33,215
IDFs and Inter DHB Provider Income	86,543	92,087	94,267	95,478	97,387	99,333
Total Funding	**1,724,750**	**1,840,191**	**1,933,272**	**1,963,071**	**2,002,521**	**2,042,762**
Personnel Costs	641,786	689,002	719,381	738,373	752,300	766,515
Outsourced Costs	74,166	85,348	86,082	86,433	88,157	89,916
Clinical Supplies Costs	123,940	127,420	133,550	137,631	140,379	143,183
Infrastructure and Non-Clinical supplies Costs	120,728	119,390	86,154	74,369	76,897	79,467
Payments to Other Providers	778,915	832,520	908,105	926,265	944,788	963,681
Total Expenditure	**1,739,535**	**1,853,680**	**1,933,272**	**1,963,071**	**2,002,521**	**2,042,762**
Net Surplus/(Deficit)	**(14,785)**	**(13,489)**	**0**	**0**	**0**	**0**
Other Comprehensive Income	**0**	**0**	**0**	**0**	**0**	**0**
Gains/(Losses) on Property Revaluations	15,939	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**1,154**	**(13,489)**	**0**	**0**	**0**	**0**

Forecast Statement of comprehensive income – governance & funding administration

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Revenue	14,040	15,816	16,133	16,455	16,783	17,118
Expenditure						
Personnel	10,609	10,822	14,462	14,746	15,034	15,326
Outsourced services	6,742	7,949	8,965	9,144	9,326	9,511
Clinical supplies	0	0	3	3	3	3
Infrastructure & non clinical supplies	(5,452)	(5,396)	(7,297)	(7,438)	(7,580)	(7,722)
Total Expenditure	**11,899**	**13,375**	**16,133**	**16,455**	**16,783**	**17,118**
Surplus/(Deficit)	**2,141**	**2,441**	**0**	**0**	**0**	**0**

Forecast Statement of comprehensive income – provider

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Income						
MoH via Funder	840,616	881,467	911,159	929,382	947,969	966,928
MoH Direct	22,106	25,177	39,403	41,502	42,329	43,173
Other	48,563	49,182	58,472	49,467	50,652	51,862
Total Income	**911,285**	**955,826**	**1,009,034**	**1,020,351**	**1,040,950**	**1,061,963**
Expenditure						
Personnel	631,177	678,180	704,919	723,627	737,266	751,189
Outsourced services	67,424	77,399	77,117	77,289	78,831	80,405
Clinical supplies	123,940	127,420	133,547	137,628	140,376	143,180
Infrastructure & non clinical supplies	126,180	124,786	93,451	81,807	84,477	87,189
Total expenditure	**948,721**	**1,007,785**	**1,009,034**	**1,020,351**	**1,040,950**	**1,061,963**
Surplus / (Deficit)	**(37,436)**	**(51,959)**	**0**	**0**	**0**	**0**

Forecast Statement of comprehensive income – funder

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Income						
Revenue	1,653,963	1,765,515	1,835,367	1,872,072	1,909,510	1,947,697
Expenditure						
Personal Health	1,175,937	1,249,580	1,333,324	1,360,012	1,387,233	1,414,995
Mental Health	219,302	232,310	247,852	252,797	257,841	262,989
DSS	211,183	220,604	227,173	231,710	236,337	241,056
Public Health	9,998	8,190	7,280	7,421	7,566	7,715
Māori Health	3,111	3,303	3,635	3,707	3,780	3,854
Governance	13,922	15,499	16,103	16,425	16,753	17,088
Total Expenditure	**1,633,453**	**1,729,486**	**1,835,367**	**1,872,072**	**1,909,510**	**1,947,697**
Surplus/(Deficit)	**20,510**	**36,029**	**0**	**0**	**0**	**0**

Forecast capital costs

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Depreciation	29,508	30,229	30,000	30,258	30,558	30,928
Interest Costs	0	0	0	0	0	0
Capital Charge	36,679	36,415	36,386	36,386	36,386	36,386
Capital Costs	**66,187**	**66,644**	**66,386**	**66,644**	**66,944**	**67,314**

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.

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 2018.

Forecast statement of cashflows – parent

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,686,859	1,803,450	1,892,951	1,928,166	1,966,721	2,006,049
Other Income	26,837	31,765	29,774	38,785	39,555	40,342
Interest received	2,076	2,267	2,149	2,858	2,915	2,973
Payments for Personnel	(624,385)	(677,605)	(716,642)	(737,663)	(751,584)	(765,793)
Payments for Supplies	(1,017,136)	(1,088,103)	(1,158,363)	(1,165,502)	(1,190,663)	(1,216,257)
Capital Charge Paid	(36,679)	(36,415)	(36,386)	(36,386)	(36,386)	(36,386)
GST Input Tax	1,523	(159)	(2,043)	0	0	0
Interest payments	0	0	0	0	0	0
Net cashflow from operating activities	**39,095**	**35,200**	**11,440**	**30,258**	**30,558**	**30,928**
Cashflow from investing activities						
Sale of Fixed Assets	0	0	31,250	0	0	0
Capital Expenditure (-ve)	(24,878)	(28,069)	(81,444)	(71,214)	(139,067)	(81,470)
Acquisition of investments	(2,952)	(813)	0	0	0	0
Net cashflow from investing activities	**(27,830)**	**(28,882)**	**(50,194)**	**(71,214)**	**(139,067)**	**(81,470)**
Cashflow from financing activities						
Capital contributions from the Crown	0	2,200	32,580	40,947	108,509	50,542
Proceeds from borrowings	0	0	0	0	0	0
Repayment of borrowings	0	0	0	0	0	0
Net cashflow from financing activities	**0**	**2,200**	32,580	**40,947**	**108,509**	**50,542**
Net cash movements	**11,265**	**8,518**	**(6,174)**	**(9)**	**0**	**0**
Cash and cash equivalents at the start of the year	17,813	29,078	37,596	31,422	31,413	31,413
Cash and cash equivalents at the end of the year	**29,078**	**37,596**	**31,422**	**31,413**	**31,413**	**31,413**

Forecast statement of cashflows – group

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,686,859	1,803,450	1,892,951	1,928,166	1,966,721	2,006,049
Other Income	28,477	31,765	29,774	38,785	39,555	40,342
Interest received	2,076	2,267	2,149	2,858	2,915	2,973
Payments for Personnel	(624,385)	(677,605)	(716,642)	(737,663)	(751,584)	(765,793)
Payments for Supplies	(1,017,136)	(1,088,103)	(1,158,363)	(1,165,502)	(1,190,663)	(1,216,257)
Capital Charge Paid	(36,679)	(36,415)	(36,386)	(36,386)	(36,386)	(36,386)
GST Input Tax	1,523	(159)	(2,043)	0	0	0
Interest payments	0	0	0	0	0	0
Net cashflow from operating activities	**40,735**	**35,200**	**11,440**	**30,258**	**30,558**	**30,928**
Cashflow from investing activities						
Sale of Fixed Assets	**0**	0	31,250	0	0	0
Capital Expenditure (-ve)	**(24,878)**	(28,069)	(81,444)	(71,214)	(139,067)	(81,470)
Acquisition of investments	(2,952)	(813)	0	0	0	0
Net cashflow from investing activities	**(27,830)**	**(28,882)**	**(50,194)**	**(71,214)**	**(139,067)**	**(81,470)**
Cashflow from financing activities						
Capital contributions from the Crown	**0**	2,200	32,580	40,947	108,509	50,542
Proceeds from borrowings	**0**	0	0	0	0	0
Repayment of borrowings	**0**	0	0	0	0	0
Net cashflow from financing activities	**0**	**2,200**	**32,580**	**40,947**	**108,509**	**50,542**
Net cash movements	**12,905**	**8,518**	**(6,174)**	**(9)**	**0**	**0**
Cash and cash equivalents at the start of the year	19,630	32,535	41,053	34,879	34,870	34,870
Cash and cash equivalents at the end of the year	**32,535**	**41,053**	**34,879**	**34,870**	**34,870**	**34,870**

Forecast statement of financial position – parent

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Current Assets	92,948	128,952	101,315	105,901	107,851	109,751
Non-current assets	794,662	779,834	833,960	872,812	985,461	1,039,593
Total assets	**887,610**	**908,786**	**935,275**	**978,713**	**1,093,312**	**1,149,344**
Current Liabilities	241,299	252,248	245,710	246,888	251,478	255,468
Non-current liabilities	33,185	41,440	41,887	43,200	44,700	46,200
Total liabilities	**274,484**	**293,688**	**287,597**	**290,088**	**296,178**	**301,668**
Net assets	**613,126**	**615,098**	**647,678**	**688,625**	**797,134**	**847,676**
Total equity	**626,849**	**615,098**	**647,678**	**688,625**	**797,134**	**847,676**

Forecast statement of financial position – group

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Current Assets	97,914	128,952	101,315	105,901	107,851	109,751
Non-current assets	803,586	779,834	833,960	872,812	985,461	1,039,593
Total assets	**901,500**	**908,786**	**935,275**	**978,713**	**1,093,312**	**1,149,344**
Current Liabilities	241,205	252,248	245,710	246,888	251,478	255,468
Non-current liabilities	33,446	41,440	41,887	43,200	44,700	46,200
Total liabilities	**274,651**	**293,688**	**287,597**	**290,088**	**296,178**	**301,668**
Net assets	**626,849**	**615,098**	**647,678**	**688,625**	**797,134**	**847,676**
Total equity	**626,849**	**615,098**	**647,678**	**688,625**	**797,134**	**847,676**

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

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Balance at 1 July	**614,215**	**613,126**	**601,837**	**634,417**	**675,364**	**783,873**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	(17,027)	(13,489)	0	0	0	0
Other Comprehensive income	15,938	0	0	0	0	0
Total Comprehensive Income	**(1,089)**	**(13,489)**	**0**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown	0	2,200	32,580	40,947	108,509	50,542
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	**613,126**	**601,837**	**634,417**	**675,364**	**783,873**	**834,415**

Statement of movement in equity – group

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Balance at 1 July	**625,695**	**626,849**	**615,560**	**648,140**	**689,087**	**797,596**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	(14,785)	(13,489)	0	0	0	0
Other Comprehensive income	15,939	0	0	0	0	0
Total Comprehensive Income	**1,154**	**(13,489)**	**0**	**0**	**0**	**0**
Owner transactions						
Capital contributions from the Crown	0	2,200	32,580	40,947	108,509	50,542
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	**626,849**	**615,560**	**648,140**	**689,087**	**797,596**	**848,138**

Additional information

Capital expenditure

	2017/18 Audited $000	2018/19 Forecast $000	2019/20 Plan $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000
Funding Sources						
Free cashflow from depreciation	29,508	30,229	30,000	30,258	30,558	30,928
External Funding	0	2,200	32,580	40,947	108,509	50,542
Inflow from sale of fixed asset	0	0	31,250	0	0	0
Cash reserves	39,095	35,200	11,440	30,258	30,558	30,928
Total Funding	**68,603**	**67,629**	**105,270**	**101,463**	**169,625**	**112,398**
Baseline Capital Expenditure						
Land	0	0	0	0	0	0
Buildings and Plant	(9,841)	(14,815)	(8,336)	(7,800)	(7,800)	(7,800)
Clinical Equipment	(7,592)	(5,306)	(14,488)	(15,600)	(15,600)	(15,600)
Other Equipment	(458)	(2,360)	(283)	(177)	(177)	(177)
Information Technology	(2,758)	(3,800)	(2,048)	(2,080)	(2,080)	(2,080)
Intangible Assets (Software)	(122)	0	0	0	0	0
Motor Vehicles	0	(1,449)	(292)	(343)	(343)	(343)
Total Baseline Capital Expenditure	**(20,771)**	**(27,730)**	**(25,447)**	**(26,000)**	**(26,000)**	**(26,000)**
Strategic Investments						
Land	0	0	(17,000)	0	0	0
Buildings and Plant	(4,107)	(339)	(38,997)	(45,214)	(113,067)	(55,470)
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	**(4,107)**	**(339)**	**(55,997)**	**(45,214)**	**(113,067)**	**(55,470)**
Total Capital Payments	**(24,878)**	**(28,069)**	**(81,444)**	**(71,214)**	**(139,067)**	**(81,470)**

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.

Statement of accounting policies

Statement of accounting policies for the year ended 30 June 2019

Reporting entity

The Waitematā District Health Board (the DHB) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing the DHB's operations is the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. The DHB's ultimate controlling entity is the New Zealand Crown.

The consolidated financial statements of Waitematā DHB for the year ended 30 June 2018 comprise Waitematā DHB and its subsidiaries (together referred to as the "Group"). The Group consists of the controlling entity, Waitematā District Health Board and Three Harbours Health Foundation.

The Waitematā District Health Board's primary objective is to deliver health, disability, and mental health services to the community within its district. The group does not operate to make a financial return. Accordingly, the DHB and Group are public benefit entities (PBE) for financial reporting purposes.

The DHB's subsidiary, associates and joint ventures are incorporated and domiciled in New Zealand. The DHB has reported in note 29 on the patient trust monies which it administers. The financial statements for the DHB and the Group are for the year ended 30 June 2019, and were approved for issue by the Board on 31 October 2019.

Basis of preparation

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

Statement of compliance

The financial statements of the DHB and Group have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). These financial statements of the DHB and Group comply with PBE Standards.

Measurement base

The financial statements have been prepared on a historical cost basis, except for items identified below which have been measured at fair value.

Presentation currency and rounding

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

Changes in accounting policies and disclosures – New and amended standards and interpretations

The Group applied PBE IFRS 9 for the first time. The nature and effect of the changes as a result of adoption of this new accounting standard are described below. Several other amendments and interpretations apply for the first time in 2018, but do not have an impact on the consolidated financial statements of the Group. The Group has not early adopted any standards, interpretations or amendments that have been issued but are not yet effective.

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. When applied, this standard supersedes parts of PBE IPSAS 29 Financial Instruments: Recognition and Measurement. Compared with PBE IPSAS 29, PBE IFRS 9 introduces a number of changes to the recognition and measurement of financial instruments. The DHB and Group has applied PBE IFRS 9 retrospectively.

PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. However, all entities who report their financial statements (actuals and forecasts) in accordance with Crown accounting policies are required to adopt the new accounting standard PBE IFRS 9 at the same time as the for-profit sector, for annual periods beginning on or after 1 January 2018.

The main changes under PBE IFRS 9 that are relevant to The DHB and Group are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost
- A new impairment model for financial assets based on expected credit losses.

The effects of the implementation of PBE IFRS 9 are as follows.

- The classification of Financial Assets has been revised and there have been no classification changes due to the adoption of IFRS 9.
- The expected credit loss model has been applied as outlined by the standard. This has impacted the valuation of both the current year and prior year receivables balances through the provision for impairment. In the 2017/18 Financial Statements the provision for impairment was $2,273,000. The application of PBE IFRS 9 has changed the assumptions around valuation of this provision and the provision for the 2017/18 year has been reassessed to be $2,736,000. This increase in cost of $463,000 has been recognised directly in equity as a prior period adjustment. The valuation of the 2018/2019 provision for impairment is $3,239,000 when applying the same methodology as prescribed by PBE IFRS 9.

Standards issued and not yet effective, and not early adopted

PBE IPSAS 34 *Separate Financial Statements*; PBE IPSAS 35 *Consolidated Financial Statements*; PBE IPSAS 36 *Investments in Associates and Joint Ventures*; PBE IPSAS 37 *Joint Arrangements* and PBE IPSAS 38 *Disclosure of Interests in Other Entities.*

The NZASB issued these standards to incorporate the equivalent standards issued by the IPSASB into PBE Standards. These standards replace PBE IPSAS 6, PBE IPSAS 7 and PBE IPSAS 8 and are effective for annual periods beginning on or after 1 January 2019. Early

application of these standards is permitted, as long as all the standards are applied at the same time. The key changes introduced by the new standards that are expected to impact the DHB and Group are as follows.

(a) Control: The new standards introduce an amended definition of control including extensive guidance on this definition. The DHB does not expect the new standards to result in the consolidation of additional entities. These requirements do not apply to the DHB, as neither the DHB nor any of its controlled entities meet the definition of an investment entity.

(b) Joint arrangements: PBE IPSAS 37 Introduces a new classification of joint arrangements, sets out the accounting requirements for each type of arrangement (joint operations and joint ventures), and removes the option of using the proportionate consolidation method. The DHB will not reclassify any joint arrangements under the new standards, and will continue to account for this interest using the equity method in the consolidated financial statements of the Group and at cost in the DHB's separate financial statements.

(c) Disclosures on interests in other entities: The standards disclosure of information about their interests in other entities, including some additional disclosures that are not currently required under PBE IPSAS 6, 7 and 8.

This will result in additional disclosures for the Group and DHB regarding controlled entities, associates and joint arrangement. Waitematā DHB is not early adopting these standards.

PBE IPSAS 39 Employee Benefits

PBE IPSAS 39 replaces the current standard on employee benefits, PBE IPSAS 25 Employee Benefits. PBE IPSAS 39 is based on IPSAS 39, which was issued by the IPSASB to update its standards for the amendments to IAS 19 by the IASB during the 2011-2015 period.

The new standard could impact the DHB and Group in relation to the classification of employee benefits as either short-term or other long-term employee benefits. The standard is effective for annual periods beginning on or after 1 January 2019. In general, entities must apply PBE IPSAS 39 retrospectively.

The new standard also changes the accounting for defined benefit plans as follows:

- Removes the option to defer the recognition of certain actuarial gains and losses arising from defined benefit plans (the "corridor approach");
- Eliminates some of the presentation options for actuarial gains and losses arising from defined benefit plans;
- Introduces the net interest approach, which is to be used when determining the defined benefit cost for defined benefit plans; and
- Structures the disclosures for defined benefit plans according to explicit disclosure objectives for defined benefit plans.

The new standard will have the following impact on the DHB's financial statements. The DHB's current treatment if defined benefit plans is to treat them as defined contribution schemes. This is due to insufficient information being available to use defined benefit accounting as outlined in the Superannuation schemes accounting policy. The DHB's treatment of the defined benefit plans would remain the same when adopting PBE IPSAS 39.

Subsidiaries

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

Joint ventures

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

Associates

An associate is an entity over which the DHB has significant influence and that is neither a controlled entity nor an interest in a joint venture. The investment in an associate is recognised at cost. The DHB's interest in Northern Regional Alliance Limited (formerly Northern DHB Support Agency Ltd) is not accounted for in the DHB financial statements as it is not material to the group. The DHB is party to a Limited Partnership agreement, with 20% share of initial capital contributed to the South Kaipara Medical Centre Limited Partnership established on 1 November 2013.

Revenue

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

Revenue from exchange transactions

MoH population-based revenue

The DHB receives annual funding from the Ministry of Health (MoH), which is based on population levels within the Waitematā DHB region. MoH population-based revenue for the financial year is recognised based on the funding entitlement for that year.

MoH contract revenue

The revenue recognition approach for MoH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as the DHB provides the services. For example, where funding varies based on the quantity of services delivered, such as number of screening tests or heart checks. Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the

funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

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

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

Interest revenue
Interest revenue is recognised using the effective interest method.

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

Provision of services
Services provided to third parties on commercial terms are exchange transactions. When the outcome of the transactions can be estimated reliably. Revenue from these services is recognised in proportion to the stage of completion in the Statement of Comprehensive Revenue and Expense.

Non exchange transactions

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

Donations and bequests
Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/(deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

Expenses

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

Borrowing costs
Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases
Finance leases
A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases where the DHB is the lessee are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no reasonable certainty as to whether the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

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

Cash and cash equivalents
Cash and cash equivalents includes cash on hand, deposits held at call with banks and with NZ Health Partnerships Limited, other short-term highly liquid investments with original maturities of three months or less.

Receivables
Short term receivables are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that the DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Investments

Bank term deposits

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

Inventories

Inventories held for distribution at no charge or for a nominal charge or consumption in the provision of services to be rendered at no charge or for a nominal charge are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Inventories held for use in the provision of goods and services on a commercial basis are valued at the lower of costs (using the FIFO method) and net realisable value. The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in surplus or deficit in the period of the write-down.

Property, plant, and equipment

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

- Land
- Buildings (including fit outs and underground infrastructure)
- Clinical Equipment
- IT Equipment
- Other Equipment and Motor Vehicles.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every three years. The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value at the reporting date. If there is evidence supporting a material difference, then the off-cycle asset classes will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost less impairment, and is not depreciated. In most instances, an item of property, plant, and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction it is recognised at fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant and equipment have been estimated as follows:

- Buildings (including components) 2 to 80 years (1.25%-50%)
- Clinical equipment 3 to 20 years (5%-33%)
- Other equipment and motor vehicles 3 to 15 years (6.67%-33%)
- IT Equipment 5 to 15 years (6.67%-20%).

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter. The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end. Work in progress is recognised at cost, less impairment, and is not amortised.

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs

include the software development employee costs and an appropriate portion of relevant overheads. Staff training costs are recognised as an expense when incurred. Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit. The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

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

Indefinite life intangible assets are not amortised but are reviewed annually for impairment.

National Oracle Solution

The National Oracle System Project ('NOS') (previously part of the Finance Procurement Supply Chain programme), is a national initiative, funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. Waitematā DHB holds an asset at cost of capital invested by the DHB in NOS. This investment represents the right to access the NOS assets and is considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets' standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

Impairment of property, plant, and equipment and intangible assets

The DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information. If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

Payables

Short-term payables are recorded at their face value due to the short-term nature of them they are not discounted.

Borrowings

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method. Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

Employee entitlements

Short-term employee entitlements

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

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

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

Long-term entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on the:

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

Presentation of employee entitlements

Sick Leave, continuing medical education, annual leave and vested long service and, sabbatical leave, are classified as a current liability. Non-vested long service leave, sabbatical leave, retirement gratuities, sick leave and continuing medical education expected to be settled

within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

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

Defined benefit schemes

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

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

If the other participating employers ceased to participate in the Scheme, the employer could be responsible for any deficit of the Scheme. Similarly, if a number of employers cease to have employees participating in the Scheme, the DHB could be responsible for an increased share of the deficit.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

ACC Accredited Employers Programme

The DHB belongs to the ACC Accredited Employers Programme (the Full Self Cover Plan) whereby the DHB accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, the DHB is liable for all its claims costs for a period of two years after the end of the cover period in which injury occurred. At the end of the two-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for on-going claims passes to ACC.

The liability for the ACC Accredited Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Equity

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

- crown equity;
- accumulated surplus/(deficit);
- property revaluation reserves; and
- trust funds.

Property Revaluation reserve

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

Trust funds

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

Goods and services tax

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

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

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

Commitments and contingencies are disclosed exclusive of GST.

Income tax

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

Budget figures

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

Cost allocation

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

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner, with a specific output.

Direct costs are charged directly to outputs. Indirect costs are charged to outputs based on cost drivers and related activity/usage information. Depreciation is charged on the basis of asset utilisation. Personnel costs are charged on the basis of actual time incurred. Property and other premises costs, such as maintenance, are charged on the basis of floor area occupied for the production of each output. Other indirect costs are assigned to outputs based on the proportion of direct staff costs for each output.

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

Critical accounting estimates and assumptions

In preparing these financial statements, the DHB has made estimates and assumptions concerning the future.

These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Land and building revaluations

Note 12 provides information about the estimates and assumptions applied in the measurement of revalued land, buildings, underground infrastructure and fixed dental clinics and pads. The significant assumptions applied in determining the fair value and buildings are disclosed in note 12.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires a number of factors to be considered such as the physical condition of the asset, expected period of use of the asset by the DHB, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit and the carrying amount of the asset in the statement of financial position. The DHB minimises the risk of this estimation uncertainty by:

- physical inspection of assets;
- asset replacement programmes;
- review of second-hand market prices for similar assets; and
- analysis of prior asset sales.

The DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Retirement and long service leave

Note 16 provides an analysis of the exposure in relation to estimates and uncertainties surrounding retirement and long service leave liabilities.

APPENDIX D: 2019/20 SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

System Level Measures Improvement Plan

Auckland, Waitemata &
Counties Manukau Health Alliances

2019
2020
FINANCIAL YEAR

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

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

– Sir James Henare

Photo Credit (cover): John Hettig Westone Productions

CONTENTS

1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (the Alliances) have jointly developed a 2019/20 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.

Extensive consultation was carried out across the sector in the development of the 2018/19 System Level Measures Improvement Plan. This year's plan is a consolidation of the 2018/19 plan. Some activities have been removed as they have been successfully achieved. Some have been found to be impractical or not easily measurable. These too have been removed. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement. New contributory measures have been added where data collection processes have been developed in response to identified clinical priorities. Examples of this include alcohol harm reduction and smoking cessation rates. An extensive stocktake of activity against the 2018/19 plan, across primary and secondary care allowed stakeholders to contribute to the prioritisation of activities in the current plan.

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.

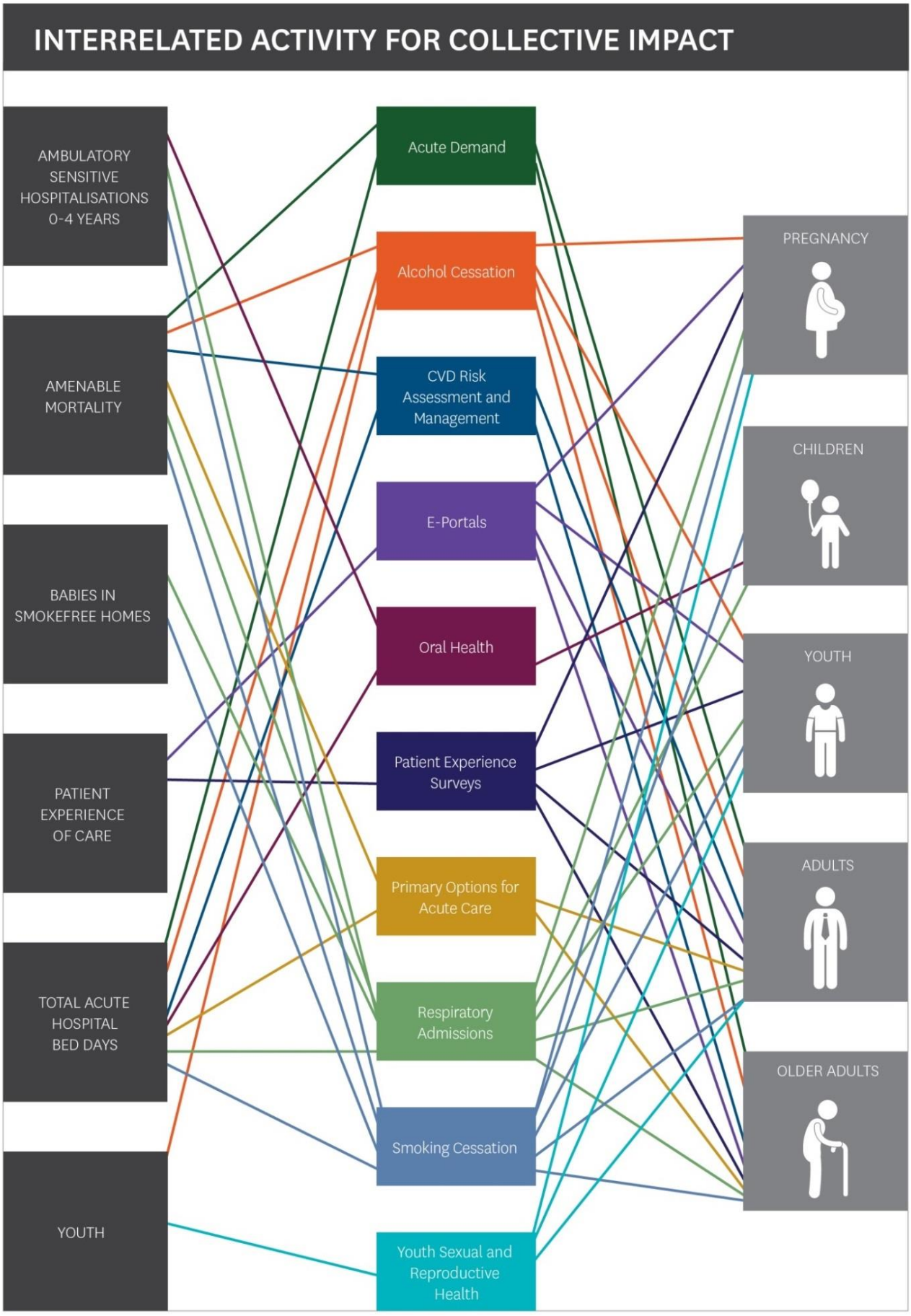
The primary health organisations (PHOs) included in this improvement plan are:

- 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 activities chosen for the Metro Auckland System Level Measures, and the stage of life they represent. The current plan will maintain this approach of supporting activities and contributory measures that will have impact on multiple milestones.

The plan continues to promote a prevention approach and a strong focus on improving equity of outcome for Māori and other populations with high health need across the greater Auckland region.

2. INTERRELATED ACTIVITY FOR COLLECTIVE IMPACT



3. PURPOSE

This document outlines how the 2019/20 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the activities that will be fundamental to this improvement. Please note that, as further discussed in section 4, 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) Six SLMs:
   - ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds
   - total acute hospital bed days per capita
   - patient experience of care
   - amenable mortality rates
   - youth access to and utilisation of youth-appropriate health services, and
   - babies living in smokefree homes.

b) For each SLM, an improvement milestone to be achieved in 2019/20. 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.

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

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

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

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 2019/20, SLMs continue to be business-as-usual. The governance structure of Alliance Leadership and Steering Group continue to guide improvement processes. The responsibility for implementation sits primarily with the Implementation Group. This group has primary care representation and flexible subject matter expertise dependant on topic and requirements. The Implementation Group meet regularly to further develop key actions (particularly at a local level) and inform implementation planning, monitor data, facilitate systems partnerships, and collaboratively guide the ongoing development of the SLMs with the Steering Group and Alliance Leadership Teams.

The work of the Implementation Group is guided by an Implementation Plan which sits under this plan and contains considerably more detail on activities and timeframes, and how a quality improvement approach will be taken for each area. The distinction between this high level plan and an implementation plan is necessary in a relatively complex environment of seven PHOs spanning three DHBs.

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.

Data sharing between primary and secondary care is developing under the Metro Auckland Data Sharing Framework. This allows data matching with primary care and non-primary care data sources, more consistent reporting, establishment of baseline performance across DHBs and PHOs and drives quality improvement facilitated by the Implementation Group.

Reporting processes, both at a local and regional level have been embedded and 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 Implementation Group.

4.1 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 was shared with the DHB Māori, Pacific and Asian health gain teams and their feedback was incorporated. Consultation with other relevant cultural groups and equity partners has been an essential part of this process. The 2018/19 SLM Improvement Plan was designed to align with DHB Māori Health Plans.

The 2019/20 plan is a consolidation of the 2018/19 plan and therefore continues with a strong focus on equity. There is ongoing engagement and dialog with Māori and Pacific providers with a view to improving service integration.

4.2 Regional Working

As in previous years, a single improvement plan has been developed in 2019/20 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.

4.3 2019/20 Priorities for System Level Measures

The 2019/20 plan continues to focus on cross–system activities which have application to multiple milestones as demonstrated in the 'interrelated activity for collective impact' diagram in Section 2. An extensive stocktake was conducted with both primary and secondary care stakeholders to establish the uptake of the SLM activities, identify barriers and focus on the areas for prioritisation for the 2019/20 plan. The results of the stocktake were discussed with the Implementation Group and clinical leaders before being considered by the Steering Group. The aim was to consolidate the plan.

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 2019/20 continue to adopt a prevention approach, and focus on improvements in equity of outcome or access. These activities support intervention in high risk populations, and collective impact. They were developed and planned with a population focus that included specific consultation with patients, family and whānau, and community. Some contributory measures aim for improvement in specific populations such as Māori and Pacific, particularly where significant inequity exists. It is expected that activity to improve these measures will also improve results for the total population as the processes are universal with a focus on high risk groups.

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 2019/20 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 2020.** **3% reduction for Māori populations by 30 June 2020.** **3% reduction for Pacific populations by 30 June 2020.**

Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori populations by 30 June 2020.** **3% reduction for Pacific populations by 30 June 2020.**

Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 5% improvement on Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' by 30 June 2020.** **Primary care survey: 10% relative improvement on PES question: 'When you ring to make an appointment how quickly do you usually get to see your current GP?' by 30 June 2020.**

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 2020.**

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 for males to 6% by 30 June 2020.** **Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2020.**

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 2020.**

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 Ambulatory Sensitive Admissions in 0-4 year olds

Activities	Contributory Measure
Increase uptake of children's influenza vaccination to prevent respiratory admissions by: • Improving vaccination rates in primary care of children aged 0-4 years with previous respiratory admissions through the provision of data, practice-level improvement activities, and following up reporting of vaccination uptake provided throughout the season. • Prioritised vaccination of eligible Māori and Pacific children.	Influenza vaccination rates for eligible Māori and Pacific children. Target 15%.
Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness leading to hospital admission by: • Implementing the Early Pregnancy Assessment Tool (EPAT) so it can function as a pregnancy register in primary care. • Identifying pregnant women through booking and set immunisation recalls in primary care. • Opportunistic immunisation at antenatal clinics. • 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.	Influenza and pertussis vaccine coverage rates for pregnant Māori and Pacific. Target 50%.
Support a decrease in respiratory admissions with social determinants by: • Increasing e-referrals rates from primary care to healthy housing programmes by identifying practices with low referral rates and prompting referral using EPAT, with a focus on pregnant low income Māori and Pacific women. • 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. • Increase referral of pregnant women who smoke for support to stop smoking when they visit general practice to confirm their pregnancy.	Baseline measurement of referrals to Healthy Housing/AWHI. Referrals to maternal incentives smoking cessation programmes, for pregnant women. Target each quarter: 27 for ADHB; 58 for WDHB, and 180 for CMH.
Improve the quality of data collected on post-natal smoking, as an indicator of smoking in pregnancy, by supporting 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: • Implementing the National Child Health Information Platform (NCHIP) for ADHB and WDHB to align with Kids Link in CMH. • 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 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: • Increasing engagement with young people by working with general practices and other youth healthcare providers to improve the youth friendliness of settings and enrolment rates. • Increasing sexual health screening by improving access to screening	Rate of chlamydia testing (reported by gender and ethnicity) for 15-24 year olds. Target 6% for males.

7.2 Youth Sexual and Reproductive Health

(including opportunistic) and screening for pregnant women.
- 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.
- Implementing chlamydia prevalence reporting to relevant stakeholders, with an expectation that this prevalence will increase as testing improves.

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

7.3 Alcohol Harm Reduction

Activities	Contributory Measures
Improve data collection and reporting on alcohol harm reduction interventions through: • Establishment of an alcohol ABC baseline in primary care for reporting indicators. • Quality improvement activities focused on implementing Alcohol ABC in practice. 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: • 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. • 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.	Percentage of the enrolled population aged over 14 years with alcohol status documented. Target 40%. Establish a baseline for alcohol-related ED presentations. Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2020.

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

7.4 Smoking Cessation for Māori and Pacific

Activities	Contributory Measure
Patient outcomes related to harm from smoking will be improved by: • Regularly reporting rates of referrals to cessation support and rates of medication therapy in primary care. • Use of a surveillance report to monitor smoking prevalence by ethnicity and age. The importance of smoking cessation as an intervention will be promoted by: • Continued working with cessation providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services. • Further development of smoking indicators for quality, to inform primary care approaches and interventions from PMS. • Development of a communication plan with regular updates to primary care and other referrers (i.e. LMCs, WCTO) to increase engagement in smoking cessation. Data quality will be improved by continued development of the Metro Auckland smoking indicators.	Rate of referral to smoking cessation providers by PHO. Target 6%. Rate of prescribing of smoking cessation medications by PHO. Target 12%.

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.

7.5 Cardiovascular Disease (CVD) Risk Assessment and Management

Activities	Contributory Measure
Primary care and systems partners work together to support equitable CVD Risk Assessment (RA) for Māori by: • Provision of prioritised lists of eligible patients for risk assessment to practices, with Māori and Pacific first. • 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. Implement a process to ensure all PHOs will have the ability to calculate and update CVD risk consistent with the National Consensus Statement for Assessment and Management of CVD in Primary Care. 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: • Continued development of NHI level reporting in secondary prevention. • Comparing dispensing data to prescribing data and identifying any opportunities for improvements.	CVDRA rates for Māori. Target 90%. Percentage of Māori with a previous CVD event who are prescribed triple therapy. Target 70%.
Improved outcomes for patients with a high risk of CVD event are sought by: • Patients who have previously had a CVD event and who are eligible receive the funded influenza vaccination. Monitored by DHB and ethnicity. Coverage will be monitored for the 65 – 74 year age group • Interventions to improve uptake of triple therapy for Māori and Pacific people. Opportunities to improve data collection and quality are advanced through: • 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). ***Note:** We anticipate a disruption in the data for primary prevention with the implementation of the new CVD Consensus Statement therefore this has been removed as a contributory measure for this year, although monitoring will continue.	Influenza vaccination rate for patients with a prior CVD event under 65 years of age. Target 35%.

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

7.6 Complex Conditions and Frail Elderly

Activities	Contributory Measures
Māori and Pacific patients with ASH conditions (e.g. CHF, CVD, COPD, AF/Stroke and Cellulitis) receive appropriate clinical support: • Māori and Pacific patients aged 45-64 with ASH conditions who are eligible receive the funded influenza vaccination. • 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. Improve coding in primary care for specified long term and complex conditions (e.g. COPD and CHF) by matching ICD10 codes from secondary care with PHO registers and developing a process to supplement coding as clinically appropriate. Primary care collaborates with Māori providers to identify the Māori primary care population with long term conditions with a view to additional support. Increase referral of patients at high risk of falls to an appropriate Strength and Balance Falls Prevention Programme.	ASH rate for both Māori and Pacific adults aged 45-64 years old. Target 2% reduction. Baseline influenza vaccine coverage for patients with an eligible ASH condition and establish an improvement target. Rates of referrals of eligible older people to appropriate Strength and Balance Falls Prevention Programmes.

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

7.7 Primary Options for Acute Care (POAC)

Activities	Contributory Measure
Primary and secondary care will work together with the POAC team to increase utilisation of POAC for high needs populations, particularly Māori and Pacific people aged 45-64 by: • Promotion of POAC and referral pathways within general practice. • Focussing on increasing utilisation of POAC for ASH conditions, particularly, CHF, COPD and cellulitis. • 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. • 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.	POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions. Target 3 per 100 for each PHO.

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

7.8 E-portals

Activities	Contributory Measure
Continued support for patient enrolment (logon) to e-portals by practices (given that unique email addresses are a critical dependency) by carrying out the following activities: • Receptionist training and socialisation. • Linking with practice accreditation processes. • Ensuring information and resources are available to practice teams. • Greater visibility on 'How to' log on is promoted in practices.	Percentage of each PHO's enrolled population with login access to a portal. Target 30%.

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

7.9 Patient Experience Surveys in Primary and Secondary Care Activities	Contributory Measure
Primary care will improve patient experience by: • Working with early adopter practices to champion engagement. • Prioritising feedback from Māori and Pacific patients. • Participating in CQI activity via 'PES to PDSA' or 'You said – We did activity/Kōrero mai'. • Developing a PDSA activity focussed on Māori and Pacific. • PHO to practice support continues in monitoring and managing reports post survey week. • Practices utilise feedback from patients and whānau when making changes in the practice.	Practice participation rate in the PHC PES as at end June 2019. Target: maintain or increase current rates. Percentage of valid email addresses in the PMS for patients invited to participate in the PES.
Secondary care will improve patient experience by: • Focusing on the medication safety question in the National Inpatient Survey with a multidisciplinary approach. • Focussing on culturally appropriate patient centred information • Co-design of patient experience initiatives with a focus on Māori and Pacific people (CMDHB) • Develop an integrated approach to feedback so patient stories can be heard outside of traditional survey collection mechanisms (ADHB and WDHB). • Develop a Māori Patient Experience plan endorsed by Māori Health Equity Committee (WDHB) • Convene Consumer Council to advise on DHB priorities, strategy, health literacy and patient experience (WDHB) • Sharing learnings with primary care through established networks and forums. • Improving visibility of reporting of Māori and Pacific response rates, with a view to encouraging awareness via activities as noted above. 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.	Average score in Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' Target 5% improvement.
Milestones: The Patient Experience of Care milestone will be improved by these activities.	

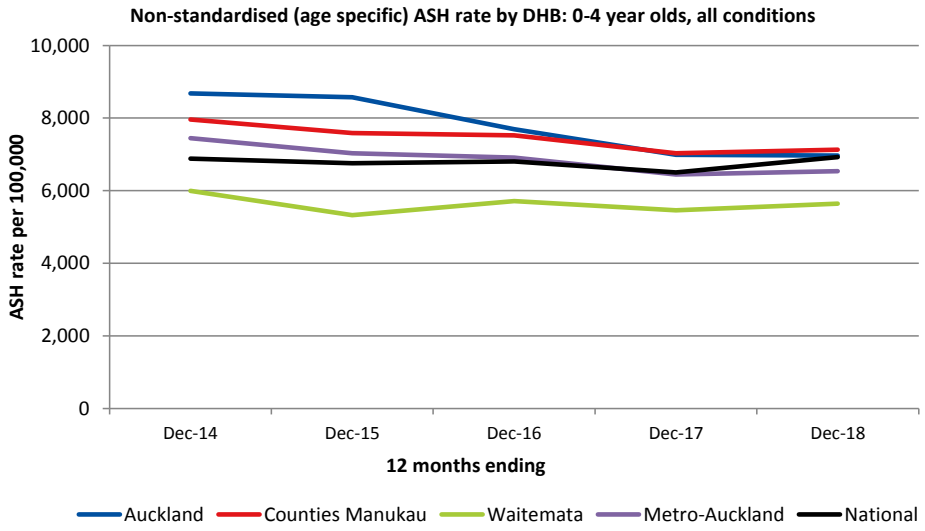
8. SYSTEM LEVEL MEASURE MILESTONES IN DETAIL

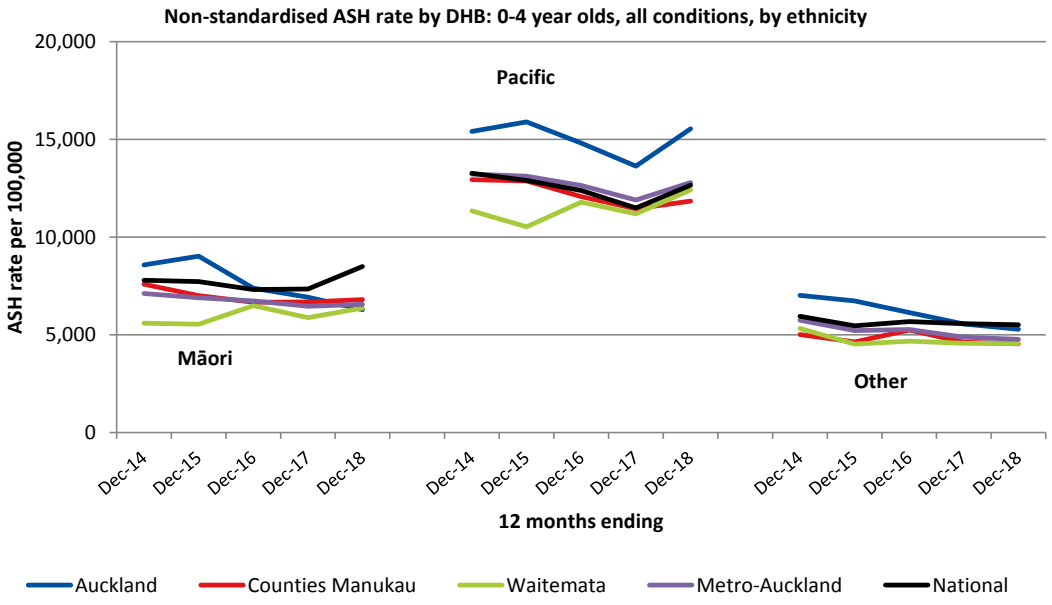
8.1 Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2020** **3% reduction for Māori populations by 30 June 2020** **3% reduction for Pacific populations by 30 June 2020**

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 paediatric and maternal 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.

We plan to build on improvements in immunisation rates and spread the methodology to other high risk cohorts which will improve outcomes in acute hospital bed days. This year we aim to continue our focus on equity with an improvement for Māori and Pacific rates.

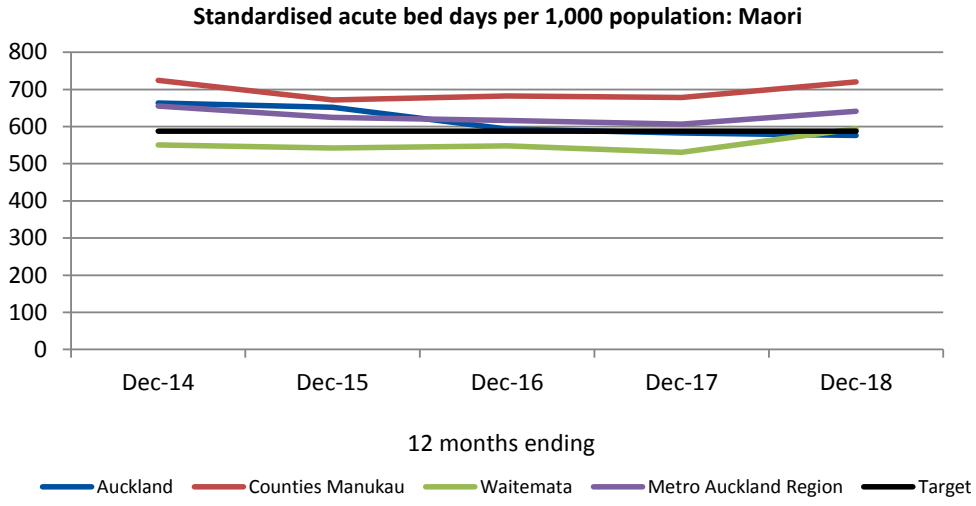


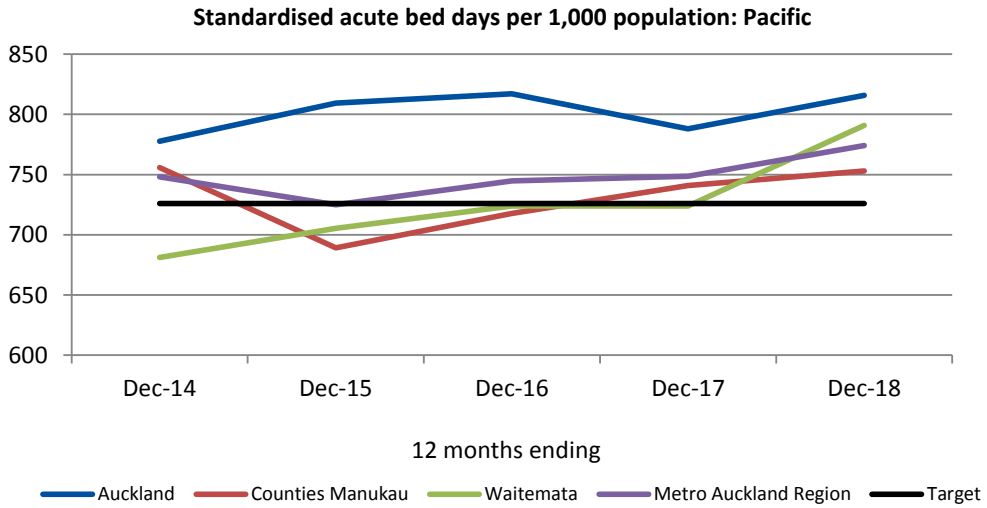


8.2 Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori population by 30 June 2020** **3% reduction for Pacific population by 30 June 2020**

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. Priority areas include alcohol harm reduction, CVD management, influenza vaccination for high risk groups and effective use of POAC. Conditions identified as highest priority include congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Coding for these conditions in primary care will be improved so effective interventions can be targeted. Total acute hospital bed days for 2018/19 for Māori and Pacific identify marked inequities when compared to non-Māori, non-Pacific rates, so we will continue to focus on patients from this population in addition to the prioritised conditions.





8.3 Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 5% improvement on Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' by 30 June 2020** **Primary care survey: 10% improvement on PES question: 'When you ring to make an appointment how quickly do you usually get to see your current GP?' by 30 June 2020**

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.

The 2019/20 plan reflects a shift from response rates to improvement in low scoring survey questions.

Hospital Inpatient PES: This has been in place since 2014. The milestone for 2019/20 focuses on the knowledge patients have about possible medication side effects when they are discharged from hospital. This will be achieved by multidisciplinary teams focusing on patient empowerment, health literacy, equity, and community awareness. This will be supported by continued work on culturally appropriate communication and health literacy.

Primary Health Care PES: The PHC PES was developed more recently and has continued to be implemented in practices over the 2018/19 year. The focus this year is to increase engagement of patients with the survey and strengthening a culture of quality improvement. This use of patient feedback and PDSA improvement cycles will lead to changes in practices that are important to patients.

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 2021** **2% reduction for Māori and Pacific by 30 June 2020**

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 2019/20 we aim to build on the work already by continuing to prepare for 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.

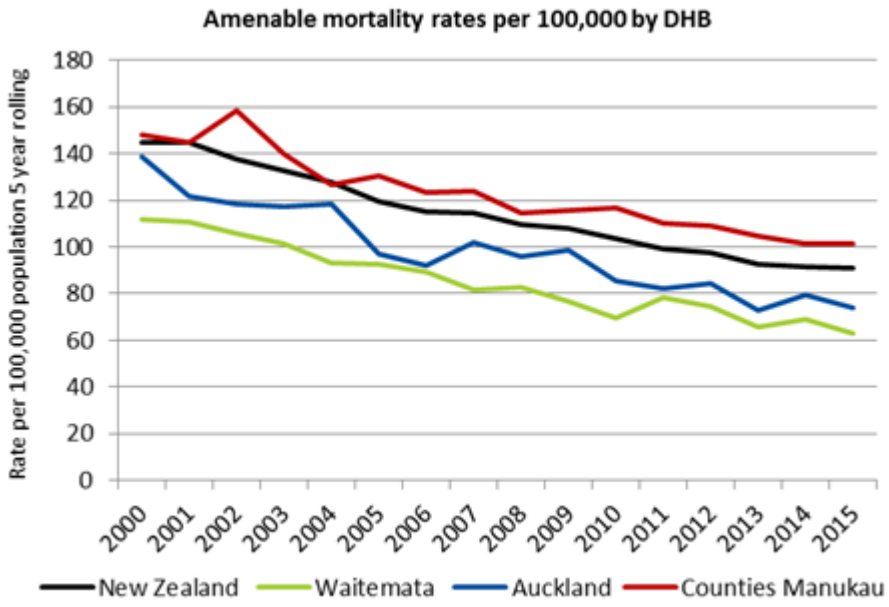
CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed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

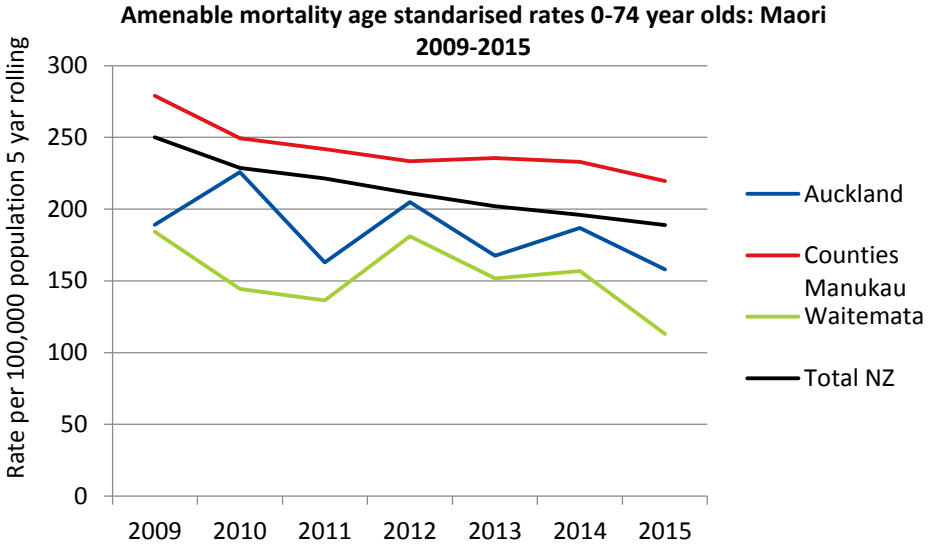
The burden of CVD falls disproportionately on Māori and Pacific populations, and there are well-documented inequities in CVD mortality, case fatality and incidence. Reducing these inequities is a high priority and can be achieved through increased use of evidence-based medical management of high-risk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

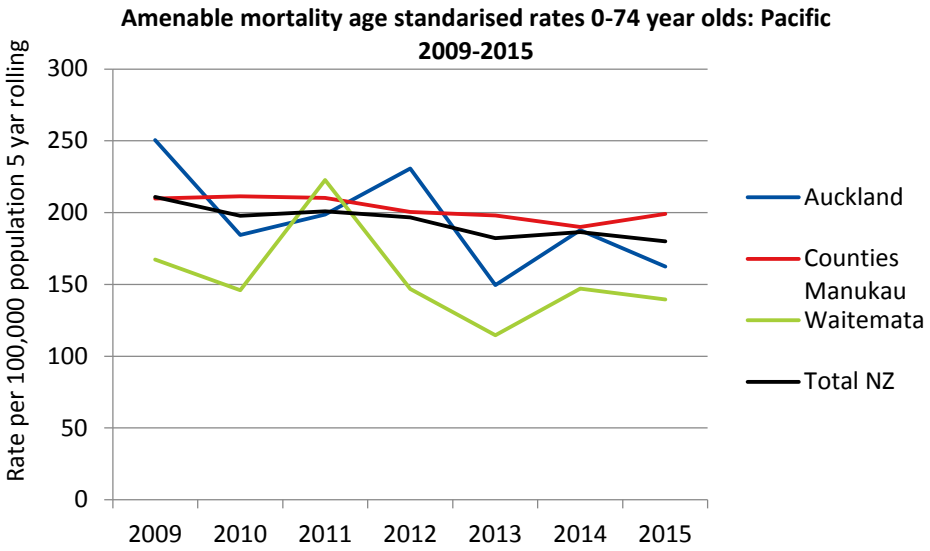
Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and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

The 2019/20 plan will also focus on implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption.


Amenable mortality rates per 100,000 by DHB
Rate per 100,000 population 5 year rolling
180
160
140
120
100
80
60
40
20
0
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
New Zealand
Waitemata
Auckland
Counties Manukau


Amenable mortality age standarised rates 0-74 year olds: Maori
2009-2015
Rate per 100,000 population 5 yar rolling
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
Auckland
Counties Manukau
Waitemata
Total NZ

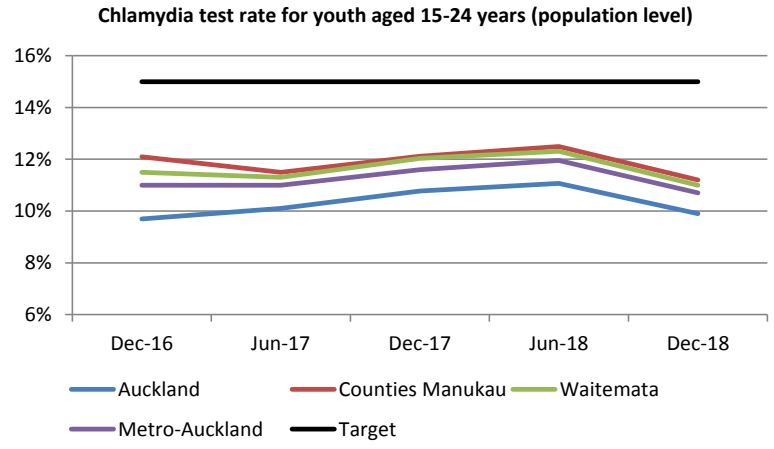

Amenable mortality age standarised rates 0-74 year olds: Pacific
2009-2015
Rate per 100,000 population 5 yar rolling
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
Auckland
Counties Manukau
Waitemata
Total NZ

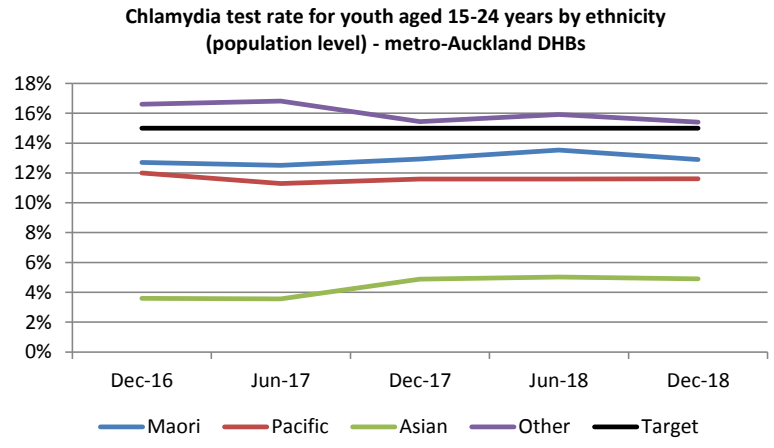
8.5 Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care Young people experience less alcohol and drug related harm and receive appropriate support
Improvement milestone	**Increase coverage of chlamydia testing for males to 6% by 30 June 2020.** **Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2020**

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 behaviors, 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.

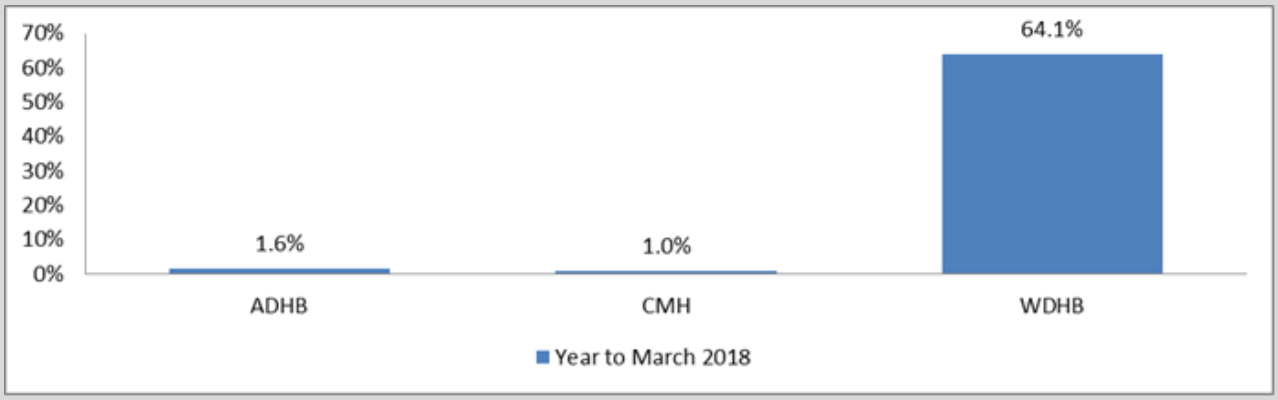
Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most often diagnosed in females aged 15-19 years and in males aged 20–24 years. Māori and Pacific young people have substantially higher rates of chlamydia than non-Māori non Pacific youth. In addition, when tested, 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.





Alcohol-related ED presentations: Identifying and monitoring alcohol-related ED presentations will enable better understanding of alcohol harm and which populations and communities are 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. 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 2019/20 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.

The definition of this indicator has recently changed so we only have one data point and cannot compare with older data.

Babies living in smokefree homes at 6 weeks postnatal

Reporting period	DHB of Domicile			
	New Zealand	Auckland	Counties Manukau	Waitematā
Jan 18 - Jun 18	53.8%	66.8%	52.8%	61.9%

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.

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 Centre
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	Director of Health Outcomes (Waitematā, Auckland DHBs)
	Dr Jonathan Christiansen	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