Waitematā District Health Board
Best Care for Everyone

2020/21 Annual Plan

Incorporating the 2019/20-2022-23 Statement of Intent and 2020/21 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 2020/21 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

Northern Iwi-DHB Partnership Board

Gwen Tepania-Palmer

Chair

And signed on behalf of:

The Crown

Hon Andrew Little
Minister of Health

Date
18 December 2020

Hon Grant Robertson
Minister of Finance

Date
18 December 2020

Hon Andrew Little
Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

Judy McGregor
Chair
Waitemata District Health Board
Judy.mcgregor@aut.ac.nz

18 DEC 2020

Tēna koe Judy

Waitemata District Health Board 2020/21 Annual Plan

This letter is to advise you that we have approved and signed Waitemata District Health Board's (DHB's) 2020/21 Annual Plan (Plan) for one year.

We are pleased that your plan provides a strong platform to deliver on the priorities identified in the 2020/21 letter of expectation and focuses on equity, sustainability and addressing the population groups with the highest needs.

We are disappointed with your significant planned deficit position and agree to approve your DHB's Plan on the basis that it is a maximum anticipated deficit.

We ask that you provide an assurance letter to the Minister of Health confirming your focus on improving the DHB's planned financial position over the remainder of 2020/21.

We expect that the DHB will:

- provide a verbal update to the Ministry of Health on the local governance and operational arrangements in place to ensure better financial performance management including financial controls, probity, compliance, reporting and scrutiny processes at your next performance meeting

- provide a written report confirming these local assurance arrangements as part of quarter two reports due with the Ministry in January 2021.

Please ensure both your assurance letter and this approval letter are attached to any copies of your signed Plan that are made available to the public.

We expect you to work with your fellow Chairs and continue discussions about how you can share skills and expertise in order to ensure that your performance is consistent with the agreed plan.

We particularly encourage you to ensure that your senior executives maintain the tight fiscal controls and implement planned service improvements that will be necessary to sustain financial performance in the out years. Good financial performance allows us to invest more in new models of care, both in hospitals and the community, improve population prevention, and to invest in better health assets.

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The Ministry will have engaged with the DHB on the $18.8 million of sustainability funding for DHB led improvement projects, that has been made available by the Government. If your DHB has not done so already, we encourage you to accept offers from the Ministry to utilise this funding.

Please note that approval of your Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health, including changes in FTE. I expect you to continue to engage with the Ministry of Health to ensure you have a strong rationale for any adjustment to planned FTE during the year. 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 does not constitute approval of any capital business cases or requests for equity support that have not been approved through the normal process.

We are aware that an extension was provided to the requirements for finalising DHB planning documents required by the Crown Entities Act 2004 due to the impacts of COVID-19. If required, please update your published Statement of Performance expectations and Statement of Intent (if applicable) to align with your approved Plan.

Thank you for the work you and your team are doing to support equitable health outcomes for New Zealanders, during a time when our system has faced additional pressures from COVID-19.

We look forward to seeing further positive progress as you deliver your Plan.

Ngā mihi nui

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Dale Bramley
Chief Executive

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Foreword from our Chair and Chief Executive

Aotearoa New Zealand – and the health sector in particular – has faced extraordinary challenges over the past few months during the battle against COVID-19. The response of Waitematā DHB staff was nothing short of exceptional as we transformed our whole model of care over a very short period of time and prepared ourselves for worst-case scenarios.

We worked collaboratively with other DHBs in the northern region to create and maintain a state of readiness in an incredibly fast-moving and unprecedented situation. The extraordinary team spirit of our people, whether they were based on site, deployed elsewhere or asked to stay at home, contributed to an outcome far removed from what we saw overseas and we owe them all a debt of gratitude.

Now, during the recovery phase, we remain vigilant against any potential resurgence of the virus with an eye on the future and a renewed focus on ensuring our community receives timely access to the services it needs.

It is, therefore, pleasing to report that:

- post-lockdown work to build a new hospital on the North Shore Hospital campus has resumed and the new facility is scheduled to open in 2023, creating significant additional hospital capacity to meet the future health needs of our catchment and the broader region
- the building of E tū Tanekaha, a 15-bed medium security inpatient facility at our Regional Forensic Psychiatry Service (Mason Clinic), is scheduled for completion in early 2021, boosting the quality of buildings available for forensic care
- design work on the E Tū Wairua Hinengaro inpatient building at Mason Clinic starts in 2020. The facility, containing two 15-bed units, will be built on part of a newly acquired 2.8ha neighbouring block that will allow further expansion of the site to meet the future needs of our fast growing population. Construction of E Tū Wairua Hinengaro is due for completion in late 2022
- a major upgrade of the North Shore Hospital-based Central Sterile Services Department (CSSD) will help us achieve maximum efficiency while providing a safe and timely service delivery for our patients. We look forward to opening the new CSSD in 2022
- we are working closely with the Northern Iwi-DHB Partnership Board to develop a Māori health equity plan that will identify and deliver health and wellbeing priorities for iwi throughout the greater region. Our DHB continues to have one of the highest life expectancies for Māori at 82.4 years. We also saw a significant boost in the number of staff who are Māori, rising by 14% over the last two years. Chief Advisor of Tikanga, Dame Rangimarie Naida Glavish, this year celebrated her third decade of work in the health sector and continues to be a driving force in our efforts to achieve equity. We will continue to look to her for guidance during the implementation of exciting Māori pipeline projects that aim to further reduce inequity
- we are centralising our Diagnostic Breast Service in one location at North Shore Hospital, thereby improving breast cancer diagnosis and treatment times while removing barriers to care for Māori and Pacific women. The newly refurbished area is due to open in January 2021
- construction of the expanded Waitakere Hospital Special Care Baby Unit was delayed because of COVID-19 and is now due to begin in October 2020, boosting bed capacity from 12 to 18 to help meet projected regional growth by the time it opens in late 2021
- we are on track with plans to develop a $16.7 million addiction treatment centre, due to open within Auckland City Mission's HomeGround precinct in 2021.

These initiatives follow a year of significant milestones, including:

- the opening of a new high-tech CT scanner at North Shore Hospital's Radiology Department
- the completion of a ward refurbishment programme to improve patient and visitor experience at North Shore Hospital
- the opening of the new Wairua Tapu, Chapel of the Holy Spirit, catering for people of all faiths at Waitakere Hospital and funded by generous donations from our community
- the delivery of the eNotes system across both hospitals, yet another step towards a fully electronic system that puts patient safety at the very forefront of efforts to modernise our service, improve efficiency and create more time for our staff to spend on direct patient care
- the first full year of the Waitematā DHB Consumer Council, providing valuable and diverse consumer perspectives on our services and the way we communicate with patients, whānau and communities.

Childhood immunisation remains a priority and we continue to work with multiple stakeholders, including the National Child Health Information Platform (NCHIP), to do the very best that we can for our tamariki. The same applies to the

oral health care delivered by our Auckland Regional Dental Services (ARDS) and, in all respects we place a strong emphasis on early detection and intervention in our daily efforts to help people stay healthy.

We do this by making our services as accessible, user-friendly and patient-focused as possible. One example is our increased use of telehealth to improve patient experience. Video and phone consultations for non-urgent appointments were expanded and delivered across 25 services during the COVID-19 lockdowns with good effect, highlighting the many advantages that a virtual approach to healthcare delivers when face-to-face consultations are not required.

Another benefit, particularly relevant in Auckland's heavily congested traffic environment, is removing the necessity to travel. Our services delivered telehealth appointments to 15,769 outpatients over eight weeks during the pandemic response, avoiding an estimated 592,914 kilometres of commuting for outpatients and saving them an estimated $2.4 million in lost time and travel-related costs.

Our Institute for Innovation and Improvement (i3) is developing more electronic tools to help us build and enhance these telehealth options even further for our patients.

None of what we do would be possible without the hardworking and dedicated staff who frequently go to extraordinary lengths to make it all happen.

Events of the past few months have highlighted these efforts tenfold and we again take this opportunity to say a heartfelt thank you to every single staff member who works with us.

Professor Judy McGregor CNZM
Chair, Waitematā District Health Board

Dr Dale Bramley
Chief Executive, Waitematā District Health Board

Foreword from our iwi Partnership Board Chair

Kupu Whakataki

A word from the Northern Iwi-DHB Partnership Board Chair, Ms Gwen Tepania-Palmer

E nga iwi, e nga karangatanga maha, tena koutou.

E nga mate kua mene ki te po, haere, haere,haere.

Ka huri matou ki te hunga ora, tena koutou katoa

Nga mihi maha hoki ki a koutou

Tena koutou, tena koutou, tena koutou katoa.

The Northern Iwi-DHB Partnership Board is a Tiriti-based partnership between DHB Chairs and Iwi Chairs that aims to both focus attention and resources on achieving Māori health equity at all levels of the health sector, as well as to improve oversight by Māori and accountability for these activities. We are driven to achieve Māori health outcomes by empowering iwi to participate in a genuine partnership with the three northern-most DHBs.

The unjust, unfair and avoidable health inequities that Māori and other vulnerable members of our communities experience are not acceptable. This is our stance as a Partnership Board, and we are heartened to see this reflected at all levels of the organisation through the actions captured in the Annual Plan 2020/21.

This coming year will be a historic year for all of us. We will carry out the actions of this plan under the shadow of COVID-19. As a sector, as a community, and as Te Tiriti o Waitangi partners, we responded to the outbreak and will continue to work together to enhance the wellbeing of our communities and workforce. During the early months of 2020, our partnership was tested. I chaired my first partnership meeting with iwi during Alert Level 4 to support their response to the COVID-19 outbreak. As a result, I believe our partnership is stronger now.

On behalf of the Partnership Board, I look forward to seeing the actions in the Annual Plan progress over the next 12 months and beyond.

Na reira, Ka nui te Ora

Gwen Tepania-Palmer

Chair, Northern Iwi-DHB Partnership Board

Introduction

Waitematā DHB is the Government's funder and provider of health services to the estimated 629,000 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. Ten percent of Waitematā residents are Māori, 7% are Pacific, and 26% are Asian. Our Asian population is proportionally our fastest growing population and projected to increase to 30% 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 8,600 people.

In 2020/21, we have a budget of $2.03 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.

DHBs act as planners, funders and providers of health services, as well as owners of Crown assets. Health needs assessment, along with input from key stakeholders, clinical leaders, service providers and the community, establishes the important areas of focus in our district. The identified needs are balanced alongside national and regional priorities and funding constraints to plan the optimum arrangement for effective and efficient delivery of health services.

These processes inform the Northern Region Long-Term Health Plan (NRLTHP), which sets the longer-term priorities for DHBs in the Northern Region, the annual Regional Services Plan and this Annual Plan.

This Annual Plan articulates Waitematā DHB's commitment to meeting the expectations of the Minister of Health in delivering improved wellbeing and equity, and our continued commitment to our Board's promise of **best care for everyone**.

Our plan details the key activities we will provide to address the priorities identified by the Minister for 2020/21. Wellbeing and equity underpin all priority areas. We are committed to delivering equity and outcome improvements for our Māori and Pacific populations. There is a strong focus on prevention, improved and timely access, and financial sustainability. A renewed Statement of Intent (SoI) is not required for 2020/21; we made minor updates to our SoI, presented in Appendix A.

More detailed reporting, including Financial Performance and Statement of Performance Expectations for 2020/21, is contained in the appendices.

COVID-19

The COVID-19 pandemic has had an immense impact on the way we plan and deliver services. Our local and regional response work during the first COVID-19 outbreak underscored the importance of flexibility, adaptability and rapid decision making. We responded quickly and effectively, transforming our whole model of care over a very short timeframe and adapting swiftly to challenges as they arose.

During the Alert Level 4 lockdown, we moved rapidly to offer telephone and video consultations. Within 4 weeks, around 40% of specialist appointments were delivered by telehealth, increasing to 70% in 7 weeks. Waitematā DHB is now working to support increased telehealth in the longer term by developing more electronic tools to assist the delivery of virtual and paperless clinics.

The Northern Regional Health Coordination Centre demonstrates how well we can address health protection, social, welfare and cultural needs in a crisis. Both the Māori and Pacific response teams have been successful in managing COVID-19 outbreaks by working regionally, drawing in community leaders and providers, and staying firmly grounded in cultural practice.

New Zealand is now well on the path to elimination of the virus, but there is still a risk that COVID-19 will re-emerge in our communities. We have taken much learning from our response and are well-prepared for any resurgence. If a significant resurgence was to occur, it would likely have significant impact on our planned service provision, detailed in Section Two.

Our focus is now on recovery. We are working to ensure our community has equitable and timely access to the services they need. Our people are engaged in significant programmes of work to clear the backlog of activity that was deferred during lockdown and return access and participation rates to levels seen prior to COVID-19.

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. Māori in our district have better health outcomes than Māori in other DHBs. However, some of our population experience inequalities in health outcomes, and ethnicity is the strongest equity parameter. One in ten of our total population and 22% of our 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.

All DHBs have a Te Tiriti o Waitangi responsibility for Māori health improvement and a legislative responsibility to reduce health inequalities. The Ministry of Health is developing a new Māori Health Action Plan in response to the substantial challenges in achieving equitable health outcomes for Māori. The first part of Section 2 of our Annual Plan identifies our actions in furthering this work. We also focus on achieving equitable health outcomes for Pacific, Asian and other priority populations.

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

We established a Te Tiriti o 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 refreshed our current Pacific Health action plan (2016-2020) for 2020-2025 in consultation with our Pacific communities, PHOs and representatives of Pacific providers, which includes jointly identified key priority areas to improve Pacific health outcomes.

We plan to refresh our Asian, new migrant, former refugee and current asylum seeker health plan (2017-2019) for 2020-2023, based on our 2019 Health Needs Assessment, 2017 International Benchmarking of Asian Health Outcomes report and feedback from our partners and stakeholders.

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), Ola Manuia: Pacific Health and Well-being Action Plan 2020-2025, 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)
Partnership, trust and shared decision making
We will ensure Māori oversight and ownership of decision-making processes necessary to achieve Māori health equity. Active partnerships built on trust and mutual respect with iwi and Māori communities will ensure that Māori knowledge informs and drives the work that we do for Māori health gain.

Article 2 – Tino Rangatiratanga (self-determination)
Mana motuhake, Māori leadership and options
Māori leadership across the services we provide and fund is essential for a system that gives expression to tino rangatiratanga. An important component of this is supporting Māori to own and operate health services that are underpinned by their tikanga and world views, and give whānau choice to access the very best care that is aligned to their values, needs and aspirations.

Article 3 – Oritetanga (equity)
Māori health equity, justice and action
We are committed to ending unjust and unfair Māori health inequities by resourcing actions that achieve tangible health outcomes for whānau Māori. We will be bold and support Māori knowledge to inform and embed an equity-driven workforce and culture at all levels of our organisation.

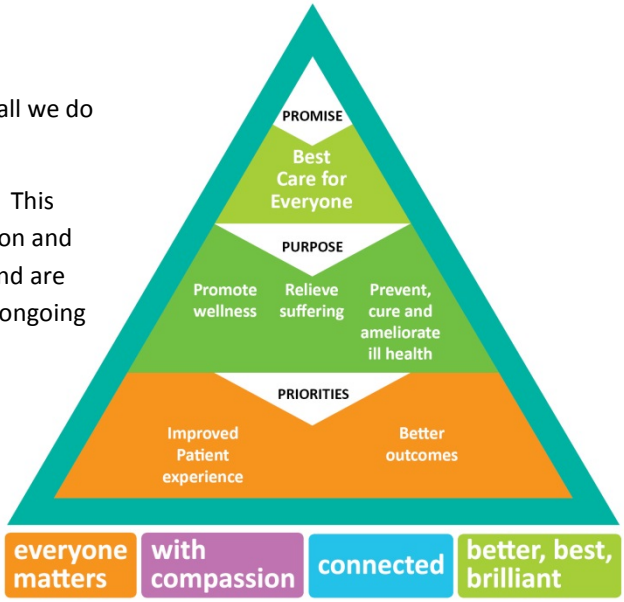
Article 4 – Te Ritenga (right to beliefs and values)
Active protection, cultural safety and value-driven
We will actively protect and honour the beliefs and values of Māori patients, staff and communities. Moving our workforce towards Māori cultural safety is one aspect of this work, while another is supporting Māori staff members, and whānau who access our services, to feel safe to express and share their culture within our organisation.

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 each 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 every day is based on our **values** of **everyone matters**; **with compassion**; **better, best, brilliant** and **connected**. Our values shape our behaviour, how we measure progress and continue to improve.

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 our 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, to plan and provide services to further Māori health gain. The establishment of the Waitematā DHB Consumer Council provides a strong voice for consumers on quality improvement and delivery of services that meet our population's needs.

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. Examples include redesigning our outpatient services to improve patient experience through e-tools and telehealth, building our e-data environment to support care redesign and developing the use of digital tools for Urogynaecology, acute medicine and district nursing.

Our values and compassion workstream focuses on appreciation, recognition and staff experience that addresses staff feedback via our Tōku Reo programme.

We also focus on learning systems and role development that create great teamwork and incorporate future technology. We aim to develop clinical leadership programmes and expand current foundation and quality care leadership offerings to partners across our district, focusing on growing emerging and established clinical and operational leaders.

We expect our population to reach nearly 720,000 by 2030; this significant growth and increased demand for clinical and community services provide both challenges and opportunities. We have several major facilities developments planned for this year and we are working 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 to deliver the best evidence-based care in a connected health system.

'Improving sustainability' in Section 2 identifies out-year planning activities that support system sustainability.

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 aligns with the health and disability system outcomes framework and the New Zealand Health Strategy.

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

The NRLTHP (previously Northern Region Long Term Investment Plan, or NRLTIP) 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. The NRLTHP, together with the Ministry of Health's priorities, continues to be the foundation that sets the long term direction of the Northern Region work plans involving all the Northern Region DHBs. The Northern Region 'whole of health system' response to COVID-19 has enabled rapid change and evolution in models of care across tier 1 and tier 2 services and has created an imperative to focus on faster, shorter, lifecycle projects and initiatives that will deliver change. During the 2020/21 year our regional plan including our response to the COVID-19 pandemic recovery, to be delivered by the Northern Regional Alliance (NRA) working with DHBs, is focused on actions to improve equity, public and population health and primary and community care. Other areas of focus include health service improvements across a range of priority areas and updated models of care, along with improved diagnostic service delivery and enhancing of health system enablers like data and digital systems, capital programmes and workforce. The annual Regional Services Plan is developed from this and reflects the Ministry's identified areas of focus as closely as possible, including actions, milestones and performance indicators for achievement in 2020/21.

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.

Strong clinical leadership is embedded at all levels of the organisation, enabling us to advocate for the health of our local population. We work with our District Alliance groups and other stakeholders to ensure a whole-of-system approach, working towards better integrated services and improved patient experience.

Regional and national networks with strong clinical leaders support work at both regional and national levels and focus DHB contribution to regional and national programmes.

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 Government's expectations.

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 two overall long-term population health outcome objectives:

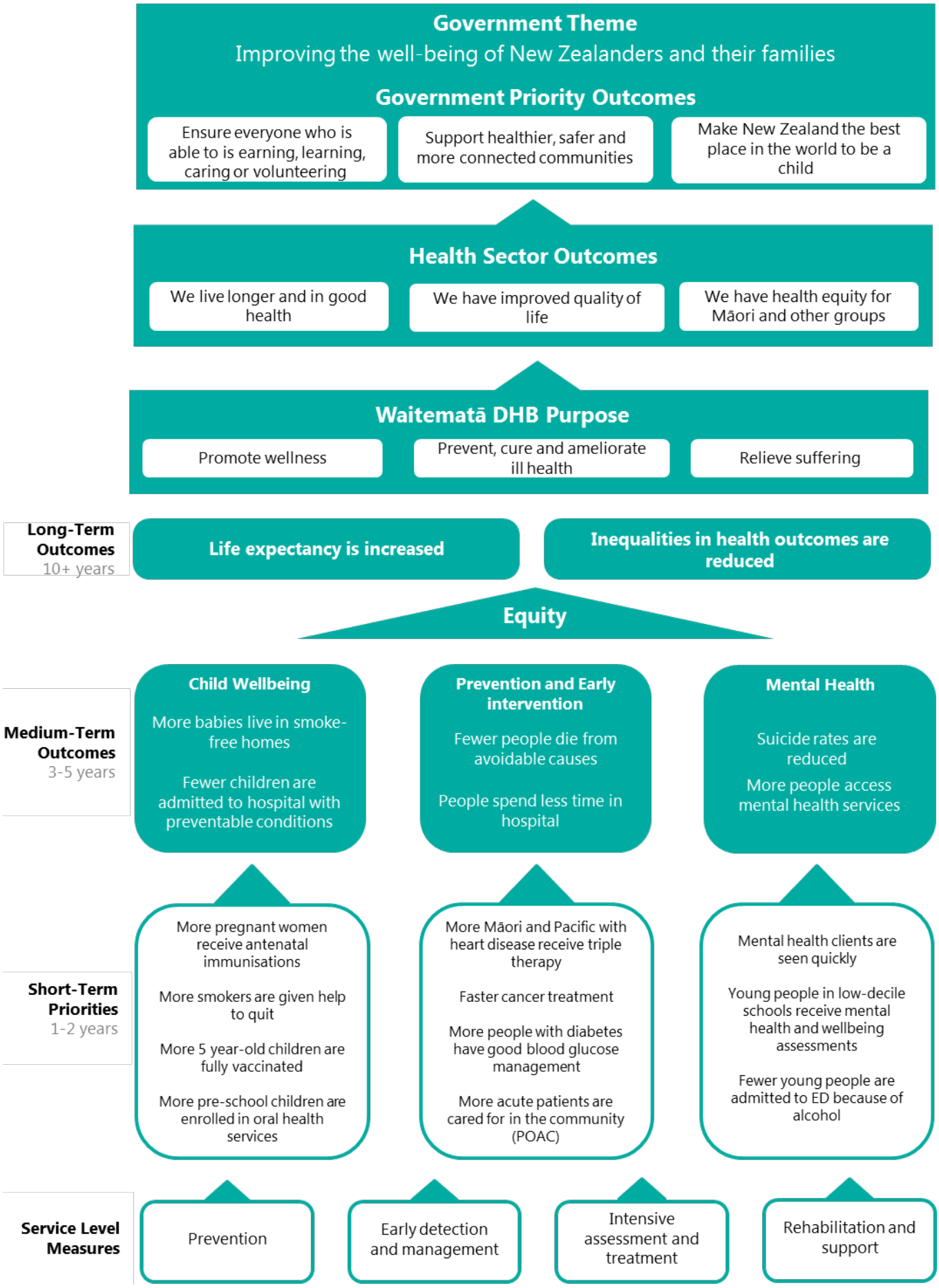
- life expectancy at birth continues to increase
- inequalities in health outcomes (measured by the ethnic gap in life expectancy) are reduced.

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

Our medium-term outcome goals and short-term priorities will support achievement of these overall objectives. Our medium-term outcomes define our priorities for the next 3 to 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. Local progress against these indicators will be tracked throughout the year.

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 and intervention framework



SECTION 2: Delivering on Priorities

Introduction

On 10 March 2020, the Minister of Health set out DHB priorities for 2020/21. 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. It is logical to progress many actions 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 longer term regional work, while the Regional Services Plan lays out the actions, milestones and performance indicators for achievement over the coming year.

This is the first year that the region's public health unit (PHU) annual plan is expected to be incorporated into the DHB Annual Plan. The Auckland Regional Public Health Service (ARPHS) is hosted by Auckland DHB, which provides these services to the three Metro Auckland DHBs, Auckland, Counties Manukau and Waitematā DHBs.

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'.

COVID-19

The COVID-19 outbreak will have ongoing impacts on our planning and service provision. We are working to reinstate services and clear the backlog, but the disruption caused by our thorough pandemic preparedness planning and the shutdown of services during lockdown will result in delays and changes to some planned activities. Any significant resurgence would also have an impact on the activities planned for 2020/21.

Government Planning Priorities

Give practical effect to He Korowai Oranga – the Māori Health Strategy

He Korowai Oranga, the Māori Health Strategy sets a vision of pae ora – healthy futures. Priorities include continuing to meet our responsibilities under Te Tiriti o Waitangi (the Treaty of Waitangi), to address and improve substantial health inequities, and to ensure all services for Māori are appropriate and safe.

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
Northern Iwi-DHB Partnership Board • Collaborate with partner DHBs to support the operation of the Northern Iwi-DHB Partnership Board (Partnership Board) • Embed the Partnership Board in decision-making processes across the health system (Auckland, Northland and Waitematā DHBs); Partnership Board Chair to attend DHB Board meetings	Jun 2021 Jun 2021	SS12: Engagement and obligations as a Treaty partner reporting • Dec 2020 • Jun 2021 Host four Northern Iwi-DHB Partnership Board meetings
Māori-led health equity work plan Develop, in partnership with iwi, a Māori health equity work plan • Support iwi partners to identify their health and wellbeing priorities for the plan • Align the equity plan to wider national and regional health sector priorities • The Partnership Board will have oversight of the delivery of this plan as a key accountability tool for the iwi-DHB relationship • Seek endorsement for the Plan by the Partnership Board • Support and resource first-year activities from this plan in partnership with iwi where applicable	 Dec 2020 Dec 2020 Dec 2020 Dec 2020 Feb 2021	
Training for Board members Host training sessions for Waitematā and Auckland DHB Boards on: • Te Tiriti o Waitangi • racism and bias • Māori health inequities • Mātauranga Māori	Jun 2021	Monitor the number of Board members who provide evidence of Tiriti training
Support the Partnership Board and the Auckland and Waitematā DHBs' Boards and Executive teams to give effect to their Tiriti obligations	Quarterly reports to Partnership Board	One collaborative research project is operational per annum
Waitematā and Auckland DHBs will maintain their research relationships with MoU partners		

Māori Health Action Plan

Actions that demonstrate delivery of Kaupapa Māori services, improved cultural competence, reduced inequities and strengthened health care systems

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
Accelerate the spread and delivery of kaupapa Māori services		
Define and understand our Kaupapa Māori health system, services and partners • Define 'kaupapa Māori' for endorsement by the Partnership Board • Roll out this definition across Waitematā and Auckland DHBs by	Dec 2020	

Māori Health Action Plan Actions that demonstrate delivery of Kaupapa Māori services, improved cultural competence, reduced inequities and strengthened health care systems		
socialising this definition with the Boards, executive teams and the Planning, Funding and Outcomes (PFO) Department • Host a forum with kaupapa Māori health providers • Undertake a sustainability review of all current kaupapa Māori health providers across Waitematā and Auckland DHBs and report finding to the Partnership Board • Define a kaupapa Māori service delivery model within Waitematā and Auckland DHBs		
Draft the kaupapa Māori service action plan and submit to the Partnership Board	Jun 2021	
Māori health research • Tino Rangahau, the Māori Health Centre of Research Excellence, will embed kaupapa Māori research methodologies within Māori research practice requirements • Consult with iwi, Māori and MoU partners to understand their priorities that will be reflected in the DHBs' research agenda • Support Māori health researchers to undertake research into the agreed Māori/iwi health priority areas	6-monthly reports to Partnership Board	Number of attendees who respond by survey that they were satisfied with the biannual kaupapa Māori research workshops
Shifting cultural and social norms		
• Provide tikanga-based strategic leadership across Waitematā and Auckland DHBs • Tikanga Māori ethics will be at the forefront of the Māori review process across Waitematā and Auckland DHBs	Quarterly reports to Partnership Board	Number of tikanga-based training sessions scheduled annually 90% of research applications meet the minimum Māori review criteria
Establish Te Tiriti o Waitangi training as a mandatory programme, starting with executive leadership and the PFO Department	Jun 2021	
Reducing health inequities - the burden of disease for Māori		
In partnership with our Treaty partners, develop a kaupapa Māori mana tane service that aims to improve the wellbeing of Māori men	Jun 2021	
Implement the findings from the Waitematā-Auckland DHBs contract equity audit across all funder contracts and report progress to the Iwi-DHB Partnership Board	Dec 2020	
Mātauranga Māori will be a core driver of Māori research activities across Waitematā and Auckland DHBs	Quarterly reports to Partnership Board	Number of mātauranga research projects submitted for funding
Work to establish Te Kahu Aroha o Rongo as the Indigenous Addictions Centre for Waitematā and Auckland DHBs: • model of care drafted and presented to the Partnership Board • strategic business case development for an indigenous healing and addictions centre with kaupapa Māori values at the core and a multi-disciplinary model of care • funding investigation and cost benefit analysis • economic and financial case and implementation plan, to be developed for capital investment and operating activity, including management structures, processes and resource requirements	Sep 2020 Mar 2021 May 2021 Jun 2021	
Address needs identified by the Whānau House Health Needs Assessment (2016) in partnership with Te Whānau o Waipareira	Jun 2021	
Strengthening system settings		
Develop a kaupapa Māori investment framework designed in partnership with the Māori health sector • Co-design a framework for identifying gaps across the system for investment by the Partnership Board and/or DHB Boards • Use the priorities of the Partnership Board to undertake first-year system reviews	From Mar 2021	

Māori Health Action Plan Actions that demonstrate delivery of Kaupapa Māori services, improved cultural competence, reduced inequities and strengthened health care systems		
• The Waitematā and Auckland DHBs' directors/executive teams will embed tikanga imperatives within services/departments • The Waitematā and Auckland DHBs' funding processes will prioritise impact on Māori health as a funding criterion • Annual funding activity report will include an equity analysis	Regular Partnership Board reporting Jun 2021	Two tikanga audits of services per DHB will be carried out on two relevant mainstream health services
• Tino Rangahau, the Māori Health Centre of Research Excellence, will work to form international, national, and regional research enabling collaborative development of research studies that improve Māori and indigenous health	Ongoing	Monitor the number of collaborative research proposals submitted annually

Improving sustainability

As New Zealand's population has continued to grow and age, with more complex health needs, an enhanced focus on improving sustainability is required. This includes both immediate and medium term supports improvements in system sustainability including significant consideration of models of care and the scope of practice of the workforce. We need to work collectively with our sector partners to deliver the Government's priorities and outcomes for the health and disability system while managing cost growth.

Improved out year planning processes Financial and workforce actions to improve outyear planning processes		
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**
Financial		
The 2020/21 budgeted deficit of $36m is after allowing for a $15m saving initiative being achieved: • closely monitor the overall result and achievements towards the savings initiatives on a monthly basis, through the production of timely reports with commentary • review any variances in detail • put plans in place with the operating divisions to address any issues	Ongoing over 2020/21	Achieve budget
Utilise forecasting tools to help ensure financial sustainability is managed and that expenditure on focused outcomes, such as inequalities and mental health, can be measured and managed appropriately throughout the year, with a financially sustainable position being achieved by 30 Jun 2023	Ongoing over 2020/21 and out-years	
Further investment in enhancements to cash flow and balance sheet modelling tools, to be available to inform budget for 2021/22	Jun 2021	
Enhance budgeting tools to allow us to plan in detail 3 years ahead, to provide greater visibility and capability to improve long-term out-year planning and delivery of care, to inform budgets through to 2024/25	Jun 2021	
Workforce		
Establish current and out-year staff and staffing models as part of the service design and facility development programme, aligned to the Regional Services Plan • Staff modelling pilot in theatre	Mar 2021	
Introduce a desktop-based FTE and recruitment planning workflow	Mar 2021	

Savings plans – in-year gains

Actions to meet in-year savings plan objectives

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
The financial sustainability plan for 2020/21 is committed to delivering $16m in savings within the year. To achieve this, the programme is split between the Provider Arm and Corporate, with the savings apportioned based on prior year spend. This equates to a 2% and 2.5% reduction in expenses, respectively. The Provider programme will deliver $14m of savings, of which $6.8 million is already identified and currently undergoing evaluation. The programme has three clear themes, and all identified initiatives align to one of these: • removing clinical variation: 30% of total savings • removing waste within the DHB: 40% of total savings • addressing any duplication: 30% of total savings The initiatives will be closely monitored, any that are not delivering the expected savings will be closed, with new initiatives identified to address any savings gap		Positive impact vs. prior year spend, measured by comparing actual expenses with the prior year actual expenses from a comparable month
Identify and socialise initiatives • 41 Provider initiatives identified	First tranche completed Jul 2020	
Estimate and evaluate benefit • 21 initiatives have $6.8m in expected benefit • Remaining initiatives	Completed Jul 2020	
Complete planning, and load to Project Management System	Aug 2020	
Execute initiatives • Four initiatives in execution • All initiatives in execution	Jul 2020 Progressively	
Benefit realisation • One initiative realising a benefit • Remaining initiatives realising a benefit	Jul 2020 Progressively	
The Corporate programme will follow the same activity • Commence the 'identify and socialise' phase	Aug 2020	Identify initiatives that will deliver a total of $2m in savings
Additional initiatives will be added throughout the year to ensure the targeted savings total is reached	Progressively	Delivery of $16m in savings across the DHB

Savings plans – out year gains

Actions to meet out-year savings plan objectives and that support innovative models of care/workforce development

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: Ensure everyone who is able to, is earning, learning, caring or volunteering

DHB activity	Milestone	Measure
The Financial Sustainability Plan for 2021/22 and 2022/23 is planned to deliver $14m in sustainable savings in each of the out years. The programme will continue to have three clear themes, with all identified initiatives aligning to one of these: • removing clinical variation: 30% of total savings • removing waste within the DHB: 40% of total savings • addressing any duplication: 30% of total savings All initiatives will be closely monitored, any that are not delivering the expected savings will be closed, with new initiative identified to address any savings gap. Specific initiatives will need to be developed for these years and these will leverage off the learnings	From Jul 2021	Positive impact vs. prior year spend, measured by comparing actual expenses with the prior year actual expenses from a comparable month

Savings plans – out year gains Actions to meet out-year savings plan objectives and that support innovative models of care/workforce development		
developed from the delivery of the 2020/21 Financial Sustainability Plan.		
Continue to focus on enhancing operational efficiency across all areas of the organisation to manage the expected cost increases arising from demographic growth	From Jul 2021	Positive impact vs. prior year spend
Leverage off the implementation of the FPIM solution to deliver procurement savings across all categories of spend and leverage collective buying power locally, regionally and nationally	From Jul 2021	Positive impact vs. prior year spend
Consideration of innovative models of care and the scope of practice of the workforce to support system sustainability		
Joint appointment between Waitematā DHB and AUT to create a new role designed to support Māori nursing students throughout their study and clinical placements (EOA) • Joint role in place • Measures of success set	 Mar 2021 Mar 2021	
Implement a digital academy in collaboration with the University of Auckland to support ongoing development of clinically-based digital design capability • First digital fellows in place	 Dec 2020	
Commence a pilot to employ paramedics in acute care settings to enable our medical and clinical staff to work more effectively and provide our most unwell patients with the care they need sooner	Sep 2020	
Develop a simulation training strategy to deliver in situ training of clinical scenarios for individual development and group training	Jun 2021	
Develop workforce solutions that enable application of a full scope of practise for Allied Health, Scientific and Technical workforces	Ongoing	

Working with sector partners to support sustainable system improvements Actions that demonstrate collaboration with sector partners to support sustainable system improvements		
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**
Implement the actions specified under Priority Area 5 'Cross-sector action' of the Māori Health Action plan, once finalised	TBC	
Continue to develop local initiatives that bring together iwi, hapū, DHBs and other social agencies: **Noho Āhuru – Healthy homes** Work with providers to increase the number of pregnant women referred to Noho Āhura in their first trimester, and complete all interventions so that new-born babies are discharged into warm, dry healthy homes **Healthy babies healthy futures (HBHF)** Support providers to partner with eight external community organisations (including Kohanga Reo, Pacific and South Asian church groups) to deliver HBHF services (health promotion for families and pregnant women) **Healthy Auckland Together** Work with partners to implement the Healthy Active Learning initiative to encourage all schools and early learning settings (ELS) to implement healthy food and drink policies, with a focus on schools and ELS with high Māori and Pacific populations (EOA) • Complete data collection from ELS and schools through the use of the prioritisation tool to determine what schools currently have a policy in place and at what stage it is	 Mar 2021 Jun 2021 Jul 2020	Establish the baseline proportion of eligible Māori and Pacific women referred to Noho Āhura – Healthy Homes in the first trimester of pregnancy Enrol 900 people onto the TextMATCH programme by Jun 2021, with a minimum of 225 enrolments for Māori, Pacific and South Asian communities 3% reduction (from Dec 2019 baseline) in acute bed days for Māori and Pacific populations
Implement the targeted health promotion and prevention initiatives	Jun 2021	

Working with sector partners to support sustainable system improvements Actions that demonstrate collaboration with sector partners to support sustainable system improvements		
specified in the SLM Improvement Plan (once finalised) aimed to reduce acute bed days for Māori and Pacific (EOA); better integration between community, primary and secondary care will maximise the use of available health resources		

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.

Maternity and Midwifery workforce – hospital and LMC Actions to train, support, recruit and retain our maternity and midwifery workforce **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**
Work with the National Midwifery Accord (NMA) group to implement additional clinical coach roles to support the transition of undergraduate midwives to employed practice • Develop position descriptions and agree ratio of coaches to midwives with National Midwifery Leaders group and TAS • Appoint coaches in line with new graduate intake	Jul 2020 Apr 2021	Ratio of clinical coaches appointed to undergraduate midwives (target ratio to be agreed)
Work with the NMA group to implement greater wrap-around support for Māori and Pacific undergraduate students (EOA) • Agree package of support with midwifery education providers, DHB midwife leaders and MoH working group • Implement support packages	Jul 2020 Feb 2021	

Maternity and early years Actions to meet the health needs of pregnant women, babies, children and their whānau, with a focus on equity **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**
Further increase access and improve pathways to ensure more women have planned pregnancies with better access to long-acting reversible contraceptive choices	Jun 2021	Establish baseline 90% of Māori women surveyed report that their general practice helped them engage with a LMC midwife, or other appropriate maternity provider 85% of Māori and 85% of Pacific women book with an LMC in the first trimester of pregnancy 75% of Māori newborns enrolled with GP by 3 months of age 75% of Māori infants have their 6-week WCTO check on time
Develop and consult on postnatal support options for women who elect to be discharged early from maternity facilities, with a focus on culturally appropriate support for Māori and Pacific women (EOA)	Dec 2020	
Work with primary care to actively engage all pregnant women seen in primary care with a midwife	Sep 2020	
Using newly available data from NCHIP, undertake a gap analysis to review equity in the 4-6 week infant handover and engagement processes, and agree follow on actions with maternity, WCTO providers and general practice (EOA)	Sep 2020	
Scope the development of culturally appropriate 'healthy weight/healthy conversations in pregnancy' teaching package for health professionals in collaboration with maternity partners	Jun 2021	
Develop a community champions movement to support and promote SUDI prevention in Māori and Pacific whānau (EOA)	Dec 2020	
Launch safe sleep and SUDI education campaign on social media,	Dec 2020	

Maternity and early years

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

targeting Māori and Pacific whānau (EOA)		Trial four alternative safe sleep space devices
Trial alternative safe sleep space devices with Pacific women and gain feedback on acceptability (EOA) • Evaluate feedback and incorporate into safe sleep device options offered in the DHB programme to ensure a wide range of safe sleep options are available to whānau and fono	Mar 2021	
Undertake a review to better understand the access barriers to pregnancy ultrasound for hapu Māori and Pacific women (EOA)	Dec 2020	
Pregnancy and parenting education • Implement findings from review of pregnancy and parenting education (2019/20), including responding to feedback from Māori and Pacific women (EOA) • Review findings reflected in contractual arrangements for 2022	Dec 2020 Jun 2021	

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
Work with Māori partners and the National Child Health Information Platform (NCHIP) to develop an approach to monitor individual level immunisation status of quintile 5 Māori infants (EOA)	Jun 2021	95% of 8-month-old infants and children aged 2 and 5 years (including Māori) are fully immunised (CW08, CW05 measures) 50% of hapu Māori and Pacific women receive the pertussis vaccine (baseline Māori = 23%, Pacific = 24%)
Work with the Ministries of Social Development and Education to safely share contact information for quintile 5 children who are overdue immunisations and not responding to contact attempts (EOA)	Dec 2020	
Work with maternity, WCTO providers, primary care and Māori Health Gains team to implement a continuous quality improvement project to increase antenatal immunisation (EOA)	Jun 2021	
To address access issues caused by COVID-19 and with a focus on Māori and Pacific infants (EOA): • share information with PHO, WCTO and OIS providers to support catching up on all scheduled immunisations • facilitate WCTO in providing immunisation services	 Ongoing Jun 2021	

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
Implement the following quality improvement actions in line with the Youth Healthcare in Secondary Schools framework (all EOA): • introduce YouthChat as part of Year 9 HEEADSSS assessment and evaluate the effectiveness of the enhanced assessment, particularly on improving health outcomes for Māori and Pacific • establish enhanced SBHS in all decile 5 schools • ensure each ESBHS school has a healthy food and drink policy in place • scope and pilot a standardised youth appropriate education package on vaping for SBHS schools • design and implement a catch-up vaccination programme for	 Jan 2021 Jan 2021 Dec 2020 Jan 2021 Jan 2021	80% of decile 1-5 schools have a healthy food and drink policy 95% of consented Year 9 students in decile 1-5 schools are fully immunised

School-Based Health Services (SBHS) Actions to improve the health of our youth population		
students who are not fully immunised, with a particular focus on Māori and Pacific		
Use the Results-Based Accountability Framework to support quality improvements through the Youth Health Clinical Alliance	Ongoing	
Continue to provide regular reports to MoH on the: • service delivery of SBHS in decile 1-4 secondary schools, teen parent units and alternative education facilities • actions of the SLAT to improve the health of our youth	 Q2,Q4 Quarterly	
To catch up on the psychosocial/wellbeing assessments that were delayed due to COVID-19 restrictions: • support nurses with additional resources (roaming nurse and YouthChat) • prioritise HEEADSSS assessments for Māori and Pacific youth	 Jan 2021 Jan 2021	
Refer to the Healthy Food and Drink section for further activities		

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**
Introduce a standardised programme into the SBHS programme to inform young people about consent and relationship issues • Programme agreed and joint nurse and guidance counsellor training completed • Feedback from young people demonstrates improved understanding of consent	 Sep 2020 Jun 2021	
Audit family violence screening undertaken under Noho Āhuru – Healthy Housing: • establish a quality improvement plan, ensuring appropriate pathways and supports are available to victims and perpetrators (EOA) • develop and baseline a measure for routine enquiry and disclosure rates and establish a target for 2021/22	 Dec 2020 Dec 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.

Mental Health and Addiction (MHA) System Transformation

Working in collaboration with all stakeholders to transform MHA services, grounded in wellbeing and recovery and with a deliberate focus on equity of outcomes

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
Placing people at the centre of all service planning, implementation and monitoring programmes		
Continue to operate the Waitematā DHB Consumer and Family/Whānau Advisory Team, which is embedded into our service (12 FTE) (EOA)	Ongoing	
Enhance family/whānau participation in Mental Health Act reviews to reduce the number of Māori treated under compulsory treatment order in the community (EOA)	Jun 2021	MH05 measures (section 29) Mental Health Act section 7a compliance
Implement and retrieve data from a new feedback system to improve quality of services for tāngata i te whai ora and whānau across the services, including the Māori kaupapa and Pacific services. Paper and electronic surveys will be available to suit users and data will be available by service and by ethnic group so improvements can be targeted (EOA)	Dec 2020	Once implemented, collection target is 1 survey per 20 face-to-face contacts for Māori and Pacific teams
Develop a new model of care across the specialist services. Plan for improved access to cultural support (as per Code of Consumer Rights) (EOA)	Jun 2021	
Embedding a wellbeing and equity focus		
Implement an Equally Well strategy across specialist services, including: • implement the National Patient Deterioration System (NZEWS) in inpatient services	Jun 2021	NZEWS embedded in ≤50% of inpatient services
• metabolic screening and follow-up for at risk groups (including Māori and Pacific people on olanzapine and clozapine medication) (EOA)	Jun 2021	Increase metabolic screening rates for Māori and Pacific by 50% from Jan 2020 baseline (28% for Māori and 32% for Pacific)
• wrap-around medication initiation package for people starting atypical anti-psychotics, including testing of the agreed package	Jun 2021	
With Tūhono (cross-DHB and agency forum), develop a green prescription pathway for people supported by specialist and NGO services who are at high risk of co-morbidities (EOA)	Jun 2021	50 people accessing green prescription
Complete the delivery of an Individual Placement and Support (IPS) trial within Waitematā DHB secondary mental health services	Jun 2021	500 people supported by the trial over the full term
Continue with implementation of Supporting Parents, Healthy Children (COPMIA) and form a cross-sector partnership, which will enable an integrated service to children identified as vulnerable, including establishing inter-agency forum terms of reference	Dec 2020	
Engage with collaborative forums to drive transformational change in line with He Ara Oranga, including: • Tuhono (Auckland-Waitematā DHBs MHA executive leadership sector collaborative body) • the Northern Region MHA network • the Integrated Primary MHA Services governance group • the Suicide Prevention and Postvention governance Group	Jun 2021	Minimum quarterly engagement with collaborative forums noted

Mental Health and Addiction (MHA) System Transformation Working in collaboration with all stakeholders to transform MHA services, grounded in wellbeing and recovery and with a deliberate focus on equity of outcomes		
Supplement ongoing engagement with Ministry of Health and the Mental Health and Wellbeing Commission		
Develop a new model of care across the specialist services, including planning for improved engagement with Māori, Pacific, youth and rainbow communities (EOA)	Jun 2021	
Increasing access and choice of sustainable, quality, integrated services across the continuum		
Improve sustainability of ED mental health and liaison psychiatry services by implementing a one-team model	Jun 2021	
Implement brief acute assertive community interventions in three specialist mental health hubs in adult mental health	Jun 2021	
Partner with NGO and PHO services to develop a model for delivery of specialist and consult-liaison MHA interventions in primary care settings (an in-reach model) (EOA)	Mar 2021	≥20 Pacific people are referred into the Takanga a Fohe service
Strengthen and increase the focus on mental health promotion, prevention, identification and early intervention by increasing the delivery of a wider range of MHA community-based options in line with the Ministry investment in primary MHA. This includes: expansion of Health Improvement Practitioners, Health Coaches and Awhi Ora positions, in line with funding agreement to be confirmed with MoH • Contracts signed with NGO and PHO partners • Initiate procurement processes for expansion of delivery of all three models	 Sep 2020 Mar 2021	
Develop a metro-Auckland governance group to oversee the primary mental health investment from Ministry into access and choice. To include partnership with NGO, PHO, DHB, Māori, Pacific, young people and those with lived experience • Terms of reference endorsed by governance group • Develop reporting mechanisms, including setting of baseline data for primary mental health investment	 Jul 2020 Oct 2020	
Apply cost pressure funding to the price for all NGOs in the district to ensure their sustainability; develop new contracts with updated price, inclusive of cost pressure	Dec 2020	
Suicide prevention		
Work with the new national prevention and post-vention office and MoH, contribute to plans and implement programmes as required	Dec 2020	
Review the current Suicide Prevention Action Plan and develop a plan for 2020–2023, in partnership with people with Māori, people with lived experience and population groups who experience disproportionately higher rates of suicide (EOA). The actions will align with key DHB-led actions from Every Life Matters and be approved by the Suicide Prevention Office	Jul 2020	
Investigate data capture options to analyse the effectiveness of implementing the Waitematā DHB specialist mental health and regional AOD and Forensic services plan and provide data to the national suicide prevention research plan	Dec 2020	
Workforce		
Work with the DHB's Māori recruitment specialist to develop a Māori recruitment initiative (EOA)	Jun 2021	
Scope workforce expansion to carry out clinical support functions with people within specialist MHA services by developing a business case	Mar 2021	
Procure new positions to expand primary mental health models, including specific focus and reference to the value of lived experience, peers and whānau	Mar2021	

Mental Health and Addiction (MHA) System Transformation

Working in collaboration with all stakeholders to transform MHA services, grounded in wellbeing and recovery and with a deliberate focus on equity of outcomes

Forensics		
Contribute to the MoH Forensic Framework project to identify an agreed Forensic model of care, including provision of kaupapa Māori services (EOA), and implement the plan	Sep 2020	
Pending confirmation of the wellbeing budget, work with the Ministry to improve and expand the capacity of forensic responses	Jun 2021	
Work with the Ministry to agree the long-term capacity of forensic intellectual disability responses	Mar 2021	
Complete building works as required to replace deteriorating building stock at Mason Clinic, including planning and securing funding	Ongoing	
Commitment to demonstrating quality services and positive outcomes		
Improve the quality of data input for consult-liaison functions (MH01), including extension of the capability for consult-liaison reporting to addiction services	Dec 2020	
Please refer to the Cross-sectoral collaboration including Health in All Policies priority section for Consumer Council related activities		

Mental health and addictions (MHA) improvement activities

Actions to improve population MHA, 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
Continue the HQSC project to improve the quality of service transitions to primary care. This activity is supported across all services, including kaupapa Māori and Pacific MHA services and has a co-design methodology (EOA)	Jun 2021	MH02: At least 95% of clients discharged from community MH&A services have a transition (discharge) plan; baseline is 58.8% as at 31 Dec 2019 >80% of SAC1 and SAC2 adverse event investigations provide an opportunity for family/whānau involvement; baseline 17% for 12 months ending 21 Dec 2020
Participate in the HQSC project to reduce the occurrence of serious adverse events through ensuring family/whānau can be involved in the investigation and learning process in a culturally appropriate manner (using Māori, Pacific, Asian expertise) (EOA); includes a co-design methodology	Jun 2021	
Participate in the HQSC project to improve the physical health of people with MHA issues, particularly working with Māori with a high rate of co-morbidity (EOA)	Ongoing	

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
Plan an addictions consult-liaison service for our hospitals • Develop business case • Prepare for roll out	 Dec 2020 Jun 2021	>50% of referrals to CHDS have initial assessment at a regional hub 50% of AOD clinical staff are trained in a family-oriented therapeutic model
Increase access to the Community Home Detox Services CHDS by offering the service at a variety of clinics across the region	Jun 2021	
Develop capacity to implement early interventions with family/whānau of people with substance use issues	Jun 2021	
Following submission of the Northern Regional Alliance model of care AOD review, which will be cognisant of the AOD national model	Dec 2020	

Addiction Actions to support an independent and high quality of life in people with addiction issues, particularly priority groups		
of care, implement agreed recommendations with consideration of baseline funding available		
Continue to engage with the regional AOD collaborative, including DHB funder and provider attendance at the northern region collaborative quarterly meetings	Jun 2021	

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**
Continue to operate the Waitematā DHB infant mental health team (6 FTE), which accepts referrals for infant mental health and early parenting support	Ongoing	
Embed the Edinburgh Post-natal Depression Scale with service users, including Māori and Pacific women (EOA), and with HoNOS data contribute to a review of model of care	Jun 2021	Outcomes data available for 80% of discharges
Support capability development in primary care nurses/midwifery	Jun 2021	Deliver >5 professional development sessions to primary care; one module delivered to each cohort of the Primary Care Nurse Credentialing Programme
Based on research to improve equity of access for women to secondary maternal mental health services, endorse recommendations and develop an implementation plan for (EOA): • Pacific women • Asian women	 Dec 2020 Jun 2021	

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.

Environmental sustainability 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 and carbon neural New Zealand		
DHB activity	**Milestone**	**Measure**
Increase the number of initiatives that DHB staff actively engage with on emission reduction opportunities	Jun 2021	5 new emission reduction initiatives implemented
Implement Year 3 of the Staff Travel Plan	Jun 2021	500 staff participating
Reduce the tonnage of medical waste to landfill from North Shore Hospital, Elective Surgery Centre and Waitakere Hospital	Jun 2021	Reduce annual medical waste to landfill to 26 tonnes
Improve recycling infrastructure and provide ongoing education	Jun 2020	5% increase in recycling from 2018/19 baseline (32 tonnes)

Antimicrobial Resistance (AMR)

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
Aged Residential Care (ARC) Continue to use the ARC forum and cluster groups to ensure facilities are informed of front-line infection prevention and control practices and the CPE Guidelines; monitor corrective actions from ARC audits for the Infection Prevention and Control Standard	Ongoing	Three forums
Primary care • Institute a primary care clinical governance committee • Develop an education plan, endorsed by the Metropolitan Auckland Clinical Governance Forum (MACGF) and the ALT, to support improved antimicrobial prescribing, with a focus on Māori and other high need populations (EOA) • Clinical governance committee will continue to report to MACGF, who report to ALT	Dec 2020 Jun 2021 Ongoing	
Hospital • Complete a hospital-wide antimicrobial prescribing survey to assess prescribing appropriateness for all patients and analyse the results for ethnic disparity to identify gaps and target initiatives for delivery of service equity (EOA) • Establish an Adult Rheumatic Fever Service, including MDT clinics (including ID service, cardiology and district nursing/public health) to improve Māori and Pacific health outcomes (EOA) • Complete audit of compliance with Waitematā DHB MDRO Management Policy (consistent with national guidance, guidelines and relevant standards), including CPE, develop recommendations and implement actions	Sep 2020 Jun 2021 Feb 2021	Audit 100% of medical and surgical patients At least 2 MDT clinics per year

Drinking water (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs)

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
• Within the funding provided, the Auckland Regional Public Health Service (ARPHS) will work to deliver the activities contained in the Environmental and Border Health exemplar (drinking water) across the region (Auckland, Waitematā and Counties Manukau DHBs) • ARPHS reports against the performance measures contained in the Vital Few Report (drinking water) and the measures contained in the Environmental Health exemplar (drinking water)	As required	% of medium and large network water supplies compliant with the Health Act 1956 Target: 100% Baseline: 100% (2017/18[1])
ARPHS promotes compliance with the drinking water requirements of the Health Act 1956	Jun 2021	% of networked water supplies receiving at least one compliance assessment per annum with findings confirmed in writing Target: 100% Baseline: 100% (2018/19)

[1] Data source: Drinking Water Annual Survey (previous year's results). Latest baseline year available: 2017/18.

Drinking water (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs) Actions to support our Public Health Unit to deliver drinking water activities		
As part of the Drinking Water Technical Advice Services, ARPHS provides: • technical and public health support to all marae-based registered networked drinking water supplies serving 25 to 5,000 people (EOA) • regular narrative reports on work with marae/papakainga	As required	

Environmental and Border Health (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs) Actions to ensure compliance with environmental and border health legislation		
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**
• Within the funding provided, the Auckland Regional Public Health Service (ARPHS) will work to deliver the activities contained in the Environmental and Border Health exemplar across the region (Auckland, Waitematā and Counties Manukau DHBs) • ARPHS reports against the performance measures contained in the Vital Few Report and the measures contained in the Environmental Health exemplar • In border health, ARPHS provides a timely response to interceptions of medical vectors, such as exotic mosquitoes of human health significance	As required	% of responses initiated within 2 hours of notification Target: 100% Baseline: 100% (2018/19)
ARPHS responds promptly to high-risk enterics due to the risk of disease spread	As required	% of high risk enteric disease cases for which the time of initial contact occurred during the same day of notification (Shigella and New Zealand acquired typhoid and paratyphoid) Target: 95% Baseline: 89% (2018/19)
When issuing permissions for the use of Vertebrate Toxic Agents (VTAs) for pest control, ARPHS ensures that consultation with Māori (iwi/hapū/whānau) has taken place and that the evidence provided by the applicant supports this consultation (EOA)	As required	% of approved applications with supporting evidence of consultation with Māori (iwi/hapū/whānau) Target: 100% Baseline: 100% (2018/19)

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:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Continue to implement the National Healthy Food and Drink Policy for staff and visitors, targeting priority groups, e.g. Māori and Pacific (EOA)	Dec 2020	Compliance with the national policy (≥55% 'green' and <45% 'amber' food options) Number of contracts with a Healthy Food and Drink Policy, and as a proportion of total contracts – report in Q2 and Q4
Ensure the pre-developed clause requiring all providers to develop a Healthy Food and Drink Policy in all locally funded contracts is being implemented by providers	Jun 2021	
In collaboration with ARPHS and the Healthy Active Learning initiative, report on the number of Early Learning Services, primary, intermediate and secondary schools that have current water and	Dec 2020	

Healthy food and drink Actions to create supportive environments for healthy eating and healthy weight		
milk only and healthy food policies		

Smokefree 2025 (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs) 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:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Fund the local stop smoking service to provide an incentive programme to support Māori and Pacific hapū wāhine and their whānau to stop smoking and encourage referrals from health professionals to this programme (EOA)	Ongoing in 2020/21	231 hapū wāhine and 75 whānau are referred to the service (measured by ethnicity: Māori, Pacific and other)
ARPHS undertakes compliance activities as per the Smoke-free Environments Act 1990 and reports against the performance measures contained in the Vital Few Report	Jun 2021	
ARPHS leads and supports collaborative actions with key stakeholders to make progress towards Smokefree 2025 and reports on outcomes	Jun 2021	
Controlled Purchase Operations (CPO) designed to monitor and enforce provisions related to the Smokefree Environments Act 2003 to focus on high deprivation areas (NZDep 7-10)	Jun 2021	% of tobacco retailers visited during CPOs in NZDep areas 7-10 Target: 70% Baseline: 77.1% (2018/19)

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**
Work with breast screening providers to develop a proposal to pilot and evaluate an incentive programme to engage low income Māori and Pacific women to attend their first breast screen (EOA)	Pilot commenced by Dec 2020	Māori coverage to increase by 2% Pacific coverage to increase by 2% (from Dec 2019 baseline)
Analyse the outcomes data from the Find 500 Māori Women campaign and review the results. Work with the project team, including the providers, to identify the limitations and strengths of the approach • Analysis complete • Recommendations shared	Dec 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**
Pilot and evaluate an incentive scheme for low income Māori and Pacific women who are not or under-screened to access a free smear, including through Family Planning, on the marae and in community settings beyond general practice (EOA)	Dec 2020	Māori coverage to increase by 2% Pacific coverage to increase by 2% (from Dec 2019 baseline)
Trial a home-delivered screening service supported by a Kaiawhina in one geographic area	Jun 2021	

Reducing alcohol related harm (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs)
Actions to support our Public Health Unit to advance activities relating to reducing alcohol related harm, undertake enforcement of the Sale and Supply of Alcohol Act 2012, and achieve equitable outcomes for Māori ,ensuring programme delivery is underpinned by the Treaty of Waitangi and its principles for Pae Ora – healthy futures for Māori

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
• ARPHS undertakes compliance activities as per the Sale and Supply of Alcohol Act 2012 and reports against the performance measures contained in the Vital Few Report • ARPHS inquiries into on-, off-, club and special licence applications in line with regulatory plan • ARPHS provides reports to the District Licensing Committee (DLC) where there are matters in opposition related to liquor licence applications	As required	Monitor the number of license applications and renewals (on, off club and special) received and processed Baseline: 2018/19: 4,153 % reports (for premises where matters in opposition were identified) provided to the licensing committee within 15 days Target 100% Baseline: 2018/19: 100%
ARPHS to re-design its processes to give greater consideration and stronger voice to Māori needs when assessing liquor licence applications and reports on outcomes (EOA)	Jun 2021	% of new bottle shop license applications consulted with Ngāti Whātua and Tainui (Te Runanga O Ngāti Whātua and Raukura Hauora O Tainui) Target 100% Baseline year: 2020/21
Following Board endorsement, ensure ongoing implementation of the DHB's Position Statement: Reducing Harms from Hazardous Alcohol Use in our communities • Work with people, whānau, families, communities, health agencies and other partners to influence the social and environmental determinants of hazardous alcohol use and improve access to healthcare services for people experiencing alcohol-related harm	Ongoing	
Refer to the 2020/21 Metro-Auckland SLM Improvement Plan – alcohol harm reduction section for further activities and measures		

Sexual health (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs)
Actions to advance sexual health services and sexual health promotion work

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
Support the completion of a Metro-Auckland communications plan alongside NGOs to maximise the impact of multiple organisations' communications, this will be co-designed with Māori and Pacific organisations (EOA)	Oct 2020	
Participate in the control of the syphilis outbreaks in Metro Auckland, through: • strengthened contract tracing • starting syphilis point-of-care (PoC) testing in outreach clinics to improve access • implementing proactive testing aimed at male sex with male, Māori and Pacific as the most at-risk groups (EOA)	Ongoing Dec 2020 Mar 2021	
Develop metrics for each service that help us understand our	Jun 2021	

Sexual health (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs) Actions to advance sexual health services and sexual health promotion work		
health outcome gaps particularly for our Māori and Pacific patients (EOA)		

Communicable diseases (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs) Actions to advance communicable diseases control work		
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**
ARPHS maintains an appropriate and efficient system for receiving, considering and responding to: • notifications of suspected and confirmed cases of communicable diseases • public health management of cases of communicable diseases and their contacts • enquiries from medical practitioners, the public and others about suspected communicable diseases of public health concern	Ongoing	Monitor the number of disease notifications received Baseline: 6,957 (2018/19)
• Conduct surveillance in which data is systematically collected, analysed, interpreted and acted upon for the purpose of preventing, identifying and responding to communicable disease issues • Provide a brief summary of surveillance activities	As required	
ARPHS receives tuberculosis (TB) disease case notifications and oversees case and contacts management in partnership with relevant clinical services	As required	% of smear positive pulmonary TB cases contacted by the Public Health Nurse within three days of clinical notification Target: 90% Baseline: 83% (2018/19)
Contact tracing protocols ensure proactive engagement with Māori and Pacific population groups – report on outcomes (EOA)	Jun 2021	

Cross-sectoral collaboration including Health in All Policies (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs) Actions to continue the integration between health and social services, with a focus on influencing healthy public policy towards achieving 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**
Consumer Council Embed Consumer Council recommendations follow-up process and reporting to ensure that the Consumer Council has visibility of the outcomes of their recommendations	Dec 2020	Report presented to every meeting (6 weekly)
Review the Consumer Council terms of reference to ensure: • specific focus on service quality improvement, particularly for vulnerable population groups (EOA), including those engaged in mental health and addictions services • the consumer voice is present in developing the DHB's cross sector work	Jun 2021	
ARPHS works in partnership with other cross-sectoral organisations across the Auckland region to support Health in All Policies to achieve equitable health outcomes (EOA). ARPHS:	Ongoing	Narrative on outcomes of collaborative work

Cross-sectoral collaboration including Health in All Policies (note Auckland DHB is the regional provider of this service for Metro Auckland DHBs) Actions to continue the integration between health and social services, with a focus on influencing healthy public policy towards achieving equity		
• leads the Healthy Auckland Together (HAT)2 coalition • leads the Auckland Intersectoral Public Health Group (AIPHG)[3] • participates in the Auckland Social Sector Leaders and the Auckland Social Sector Advisors groups (ASSLG and ASSAG, respectively)[4]	Six monthly	
ARPHS leads public health-related stakeholder engagement with Auckland Council and Council Controlled Organisations to share knowledge and expertise on public health topics and to promote Health in All policies • Analyse and disseminate public health data to support local government planning • Support Auckland local boards' health and wellbeing action plans • Support Auckland Transport planning and advocacy work	 Jun 2021 Ongoing Ongoing	Summary of pilot local board wellbeing plan development (Puketapapa)
ARPHS contributes to relevant regional and national policy development processes on wider social and economic determinants of health	As required	Monitor the number of submissions made by type

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.

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 (all are EOA)	**Milestone**	**Measure**
Māori health • Waitematā and Auckland DHBs will support the development of whānau-centred research through collaborative funding activities	Regular Partnership Board reporting	Number of collaborative research projects submitted for funding annually
Implement phase 3 of the Māori health integrated contracting project: • In partnership with kaupapa Māori providers, support the re-orientation of their services to focus on whānau-centred models of care that align to the needs of their population • Provide long-term integrated contracts for kaupapa Māori health providers	 Jun 2021 Jun 2021	
Pacific health		
Explore commissioning approaches to support the integration of services and the delivery of whānau-centred approaches to advance	Sep 2020	

[2] Stakeholders: 25 organisations representing local government, mana whenua, health agencies, NGOs, university and consumer interest groups
[3] Stakeholders: DHBs Planning and Funding representatives, Northern Regional Alliance and the Ministry of Health
[4] Forum for senior representatives of government agencies across different sectors

Delivery of Whānau Ora

Actions that demonstrate system-level changes by delivering whānau-centred approaches to Māori health and equity

and achieve Pacific health equity		

Pacific Health Action Plan

Actions that demonstrate commitment to supporting delivery of the Pacific Health Action Plan

Government theme: Improving the wellbeing of New Zealanders and their families
System outcome: We improve Pacific health outcomes
Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
We commit to support the delivery of the new Pacific health plan - Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025	Jun 2021	
We will update our Waitematā-Auckland DHBs' joint Pacific Health Action Plan to align with the key priority areas of the new Pacific health plan - Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025	Jun 2021	

Care Capacity Demand Management (CCDM)

Actions to support the implementation of CCDM for nursing and midwifery 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 FTE calculations for remaining compliant inpatient units, including midwifery	Jun 2021	
Embed the use of the CCDM Qlik Core Dataset in all Medicine and Surgery inpatient wards	Dec 2020	
Meet the H&DSS audit requirements	Dec 2020	
Prioritise recruitment of Māori and Pacific nurses and midwives when recruiting to new FTE positions (EOA)	Ongoing	

Disability Action Plan

Actions that demonstrate commitment to developing a Disability Action Plan

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
The three Metro Auckland DHBs (Waitematā, Auckland, and Counties Manukau) developed a joint Metro-Auckland New Zealand Disability Strategy Implementation Plan for 2016-2026. The Plan focuses on five outcomes of the New Zealand Disability Strategy: Health and Wellbeing, Employment, Choice and Control, Accessibility, and Attitude		
Review the Metro Auckland plan and update accordingly, with a specific focus on the needs of disabled Māori and Pacific people (EOA), as per the current plan's commitment to review the plan in 2020	Dec 2020	

Disability

Actions to improve access and health outcomes for people 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 (all are EOA)	Milestone	Measure
Provide ongoing training for front-line staff and clinicians, including advice and information on considerations needed when interacting with a person with a disability	Ongoing	Report on the number of staff who have completed the e-learning training module by Jun 2021
Review the disability alert system and make recommendations to re-design to make it easier for people to set up alerts and for healthcare staff to access and understand the alerts, and to know how to make the requested accommodations	Jun 2021	
Maintain our Accessibility Tick by completing our current Action Plan and developing a new Action Plan for 2021. This work includes a focus on accessible information and alternative formats, physical accessibility of our sites and making our recruitment process more accessible	Jun 2021	
Continue to liaise and work with ARPHS and MoH wherever practicable and appropriate to ensure that key public health information is communicated in a simple and clear fashion that makes it easily understandable for everyone • Work with ARPHS to ensure consistency across metropolitan Auckland • Align regional communications on matters of national significance (e.g. measles and coronavirus) to national messaging from MoH • Work with our Consumer Council to review the DHB's website to consider accessibility, including for people with disabilities • Where practicable, provide a platform for the publication of New Zealand Sign Language-translated key public health information provided by ARPHS and MoH for wider dissemination	 Ongoing Ongoing Dec 2020 Ongoing	Report the number of MoH/ARPHS distributed videos translated into sign language published via Facebook and other Waitematā DHB digital platforms by Q4 2020/21
Re-establish the Waitematā DHB Disability Support Advisory Committee (DiSAC) • Waitematā DiSAC Committee 2020/21 dates set • Meetings held • Seek representation from the disability community • Continue to work collaboratively with the metro-DHBs on disability issues	 Sept 2020 Quarterly Jun 2021 Ongoing	

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
The actions below support each of the five Planned Care strategic priorities. Additional actions will be developed as part of the Waitematā DHB three-year plan for Planned Care. The development and implementation of our three-year plan will involve our consumer council and other key stakeholders	Ongoing	Deliver TBC Planned Care Interventions ESPI 1 100% ESPI 2 0% ESPI 3 0% ESPI 5 0% ESPI 8 100% Coronary angiography 95% target

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

Equity. Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed		
Electives Refurbish the Diagnostic Breast Service to improve coordinated and integrated service provision in one location. This aims to improve breast cancer diagnosis and treatment times, removing barriers to care for Māori and Pacific women (EOA)	Nov 2020	Sustained achievement of FCT targets P2 <30 days (referrals to FSA) and P2 <6 weeks (referral to imaging)
Access. Balance national consistency and the local context		
Electives Implement bladder cancer testing in primary care, and where appropriate, to establish urothelial cancers, to reduce the need for secondary care assessments and referral to cystoscopy (currently all patients with macro and micro haematuria are referred for cystoscopy)	Oct 2020	Reduce the proportion of patients with haematuria referred for cystoscopy by up to 50%
Quality. Support consumers to navigate their health journeys		
Acute readmissions • Establish effective outpatient management pathways and clinics for patients with heart failure and monitor the impact of this on their readmission rate • Utilise both General Medicine and cardiology resources to support and further develop the chronic heart failure management system/clinic	Dec 2020 Jun 2021	Acute readmissions 0-28 days ≤12.4% target (Dec 2019 baseline is 12.5%)
Timeliness. Optimise sector capacity and capability		
Radiology Review production planning capability for CT and MRI, with the objective of better informing the need for internal capacity change and the need for outsourcing	Mar 2021	CT 95% target MRI 95% target
Experience. Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future		
Pharmacy Work to ensure the accurate transfer of information about medication changes on transitions of care by completing medicine reconciliation in primary care and community pharmacy settings as well as on discharge from hospital	Ongoing	Increase eMedicine Reconciliation from a baseline of 73% (CY2019) to 75% by Dec 2020 for patients discharged from acute inpatient units (excluding maternity and elective ESC)
Please refer to the Cancer priority section for additional cancer-related activities. Please refer to our service provider Auckland DHB's 2020/21 annual plan for activities related to Ophthalmology and Cardiac Surgery		

Acute demand

Actions to improve the management of acute inpatient demand 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		
Pending funding approval, develop a project to clarify ED clinician workflow and interactions with clinical systems and develop and enhance ED workflow user experience tools to better support data capture • Initiate project • Development and delivery of SNOMED • Optimisation	 Jul 2020 Dec 2020 Jun 2021	
Acute demand		
Improving patient flow for admitted patients	Ongoing	SS10: 95% of patients admitted,

Acute demand Actions to improve the management of acute inpatient demand and data in the Emergency Department		
Continue to support inpatient home-based wards in Medicine at both hospitals with a focus on further improving patient flow through daily consultant-led ward rounds, daily multidisciplinary board rounds supported by a daily review of patients with a length of stay (LOS) >7 days. Further enhance these processes by providing cultural support to facilitate discharge planning for Māori and Pacific patients (EOA)		discharged or transferred from an emergency department within 6 hours
Acute clinics		
Continue to develop same-day acute outpatient clinics in Medicine as an alternative to assessment in the Admissions and Diagnostic Unit (ADU)	Ongoing	Maintain the current number of presentations to ADU for Medicine (<1% growth rate) (baseline = 16,139 presentations in 2018/19)
Establish the baseline and for virtual clinics and develop a robust virtual clinic follow-up process in General Medicine	Dec 2020	Once baseline is established, increase the number of virtual follow-ups by 50%
Geriatric Medicine in ED and ADU Work with the Health Care of the Elderly to develop a system to ensure the early assessment and management of frail elderly patients presenting to the hospital to facilitate early discharge to community geriatric support or direct admission for rehabilitation	Dec 2020	
Acute Care of the Elderly Provide a more co-ordinated and specialised care pathway for the acute care of frail elderly (evidence suggests that this facilitates earlier discharge and shorter LOS in secondary services) • Trial concept • Implement	 Jul 2020 Jun 2021	Baseline: acute LOS for patients aged >75 years who are admitted under the ACE team Baseline: acute and rehab LOS for patients admitted under the ACE team
Improving wait times for patients requiring mental health and addiction services who present to ED		
• Implement a rapid assessment process for mental health patients to ensure timely assessment	Dec 2020	
• Review the current model of care to minimise patient waiting times; action at least one recommendation	Jun 2021	

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**
Review the Rural Alliance Work Plan Activities and determine effectiveness of access for rural Māori and Pacific (EOA)	May 2021	
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)	May 2021	
Develop a business case to increase access to imaging services (x-ray, ultrasound) for rural populations to be equitable and timely	Jun 2021	

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 and fracture prevention services • Promote, and increase enrolments in, the in-home and community strength and balance programmes • Ensure the in-home strength and balance programme is operating at capacity and agreed criteria are in place to manage any waitlist • Implement ongoing improvements in the Fracture Liaison Service (FLS) patient identification process and tracking system to ensure screening targets are being met/exceeded • Ensure patients who need bone protection treatment are routinely offered this treatment by the FLS	Jun 2021	40% of individuals screened by the FLS are either prescribed, or a letter is sent to their GP recommending, bone protection treatment
Non-acute rehabilitation pathway • Work with ACC to develop a new model of care (MOC) for non-acute rehabilitation, which spans community-based provision and minimises unnecessary inpatient stays • Include in the new MOC a proactive consideration of policy, practice and service delivery issues to maximise cultural safety and relevance for older Māori, Pacific and Asian people (EOA)	Jun 2021 Jun 2021	
Home and Community Support Services (HCSS) • Align HCSS procurement documentation (including the service specification and reporting measures) to the national framework for HCSS • Update HCSS procurement evaluation criteria to rate applicants on ability to meet Māori and Pacific needs and provide appropriate MOC (EOA) • Complete HCSS procurement	Jun 2021	
Frailty in primary care • Continue to enhance the KARE project (coordinated care, assessment, rehabilitation and education) in general practice • Develop a KARE IT tool to support practices to better manage frail older patients • Develop a dementia specific pathway with assessment, diagnosis and early support within KARE	Ongoing Jun 2021 Jun 2021	
Dementia framework Develop an improved MOC for two elements of the national framework, including identification of any new services or resources required and prioritisation of these: i) assessment, diagnosis, early intervention, and ongoing support; and ii) living well	Mar 2021	
COVID-19 response Implement actions prioritised for DHBs from the independent review of COVID-19 clusters in aged residential care	Mar 2021	

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
Improving equity - Diabetes Complete the validation phase for a co-design project, based on information in the Atlas of Variation and locally collected performance data, to transform the diabetes care system. Co-design activities will focus on engaging Māori and Pacific to improve equity (EOA) • Outcomes and learnings from the validation phase summarised and disseminated to all PHOs • Evaluate co-design programme to measure impact on outcomes • Report regularly to the Diabetes Service Level Alliance	Jun 2021 Jun 2021 Ongoing	
Improving consumer engagement • Implement actions identified in the Consumer Council annual plan • Set up a governance group and structure to guide implementation of the Consumer Engagement QSM • Upload data on to Consumer Engagement QSM dashboard and report against the framework twice yearly • Conduct gap analysis from Consumer Engagement QSM participation to identify areas of improvement	Jun 2021 Jul 2020 Dec 2020, ongoing Jun 2021	
System Level Measures *See the 2020/21 System Level Measures Improvement Plan (Appendix D)*		

New Zealand Cancer Action Plan 2019-2029

Actions that demonstrate collaboration with all stakeholders to prevent cancer and improve detection, diagnosis, treatment and care after treatment

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
Actions to maintain 31- and 62-day FCT targets (as well as other ongoing BAU actions): • Customise contact and care plans for Māori and Pacific patients on the 62- and 31-day report by our Māori and Pacific Clinical Nurse Specialists - Cancer Coordination (EOA) • Customised breach reports to each tumour stream Operations Manager and Clinical Director to identify improvement areas	Ongoing	SS11: 90% compliance for Māori and Pacific patients on the 62-day FCT pathway SS01: At least 85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat
Improve post-cancer support for Māori and Pacific women who had endometrial cancer (EOA) • Complete a co-design project to identify how to support patients to live well after cancer and address risk factors to improve their quantity and quality of life • Review findings and recommendations and plan appropriate next steps; plan implementation for one action	Sep 2020 Dec 2020	
Extend local delivery of all medical oncology care for patients diagnosed with breast cancer • Obtain local and regional approval • Implement plan to extend local delivery	Aug 2020 Nov 2020	

Bowel screening and colonoscopy wait times

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
Colonoscopy wait times		
Implement a revised scheduling process to clinically review all patients waiting >100 days and a proportion of those waiting >120 days to ensure no new patients wait >120 days, and a planned and progressive reduction of patients currently waiting >120 days	Dec 2020	No patients waiting >120 days
Review options to lower demand while continuing to maximise internal production by maintaining utilisation rates above 85% and DNA rates below 5%	Jun 2021	SS15 colonoscopy measures: Urgent diagnostic (90% within 14 days, 100% within 30 days) Non-urgent diagnostic (70% within 42 days, 100% within 90 days) Surveillance (70% within 84 days, 100% within 120 days)
Building on 2019/20 work, further develop our understanding of barriers resulting in Māori non-attendance with direct phone contact by ENCs with Māori patients on the waitlist that focus on overcoming barriers (EOA)	Jun 2021	100 Māori patients receive a documented clinical engagement conversation with an ENC
Bowel screening		
Continue with monthly data audits to ensure data accuracy and in preparation of transitioning to the new register (timing is subject to MoH confirmation and expected to be during 2020/21)	Ongoing	95% of participants of all ethnicities who returned a positive FIT have a first attempt at contact made within 15 days of their FIT result being recorded in the NBSP IT system 95% of participants of all ethnicities 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
Continue to provide existing and new nursing staff with training to maintain data accuracy, which impacts on monitoring of all activities along the screening pathway	Ongoing	
Deliver a six-week communications campaign to inform people that the bowel screening programme has re-started and that it is safe to screen, supported by ongoing health promotion and communication activities designed to restore the participation rate and equity gaps to the pre-COVID-19 levels (EOA)	Dec 2020	Overall participation rate for people aged 60-74 years for the previous 24-month period is equal to or greater than participation rate at Q2 2019/20, i.e. pre-COVID-19 participation rate of 62.2% Equity gaps for Māori and Pacific are restored to no greater than gaps at Q2 2019/20, i.e. pre-COVID-19 levels • Māori 0.4% • Pacific 15.0%

Workforce

Actions to support and improve the skills and diversity 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
DHB workforce priorities, diversity, cultural safety, leadership		
Strengthen health equity through our commitment to Te Tiriti o Waitangi (EOA) • Support employment opportunities for students in the Kia Ora Hauora programme	Ongoing	Increase Māori participation in the workforce by 5% to 7.46% (baseline 7.1% at Dec 2019)
• Re-imagine our approach to recruitment with a focus on strengthening equity and kaupapa Māori	Ongoing	
• Implement recommendations from Accelerating the Development of Māori leadership	Ongoing	
• Work with education/iwi to strengthen health equity across our workforce	Ongoing	
• Support growth in our Māori cultural competency through programmes in Te Tiriti o Waitangi, Te Reo and engaging with Māori	Ongoing	
• Focus on Ora – the wellbeing of Māori workforces	Ongoing	
Building an inclusive culture through reducing barriers in employment and appreciating difference (EOA) • Deliver disability responsiveness and confidence training	Ongoing	Report on the number of staff who have completed the e-learning training module by Jun 2021
• Re-imagine our online recruitment process; identify supportive recruitment initiatives/processes	Ongoing	
• Explore recruitment initiatives that support disability in the workplace (EOA)	Ongoing	
Develop and increase our Pacific workforces (EOA) • Expand our offerings in the Science Academies in partnership with tertiary education and NGO partners	Ongoing	Increase Pacific participation in the workforce by 5% to 6.09% (baseline 5.8% at Dec 2019)
• Offer scholarships to Pacific students in key workforces	Ongoing	
• Growing our Pacific mentoring networks	Ongoing	
• Pilot a Pacific leadership cohort through our Leading Quality Care course	Ongoing	
The DHB continues to support the development of Nurse Practitioners, ensuring their study needs are fully funded (EOA)	Ongoing	Report each year on Nurse Practitioners supported to achieve registration
Deliver Tōku Reo (my voice), our commitment to actively seek the staff voice to improve the experience at work • Staff exit survey in place • Staff feedback mechanisms rolled out	Dec 2020 Dec 2020 Jun 2021	
Planning for a cross-sector workforce approach to manage the impact on service delivery from matters such as COVID-19 To improve access to primary care for those at risk (homeless/transient/vulnerable people) and housed in managed accommodation (EOA): • work with housing and primary health care providers to provide nurse-led outreach health clinics for the at risk people during their stay in managed accommodation • support the development of capacity and capability of the primary care workforce to deliver services to people at risk • work alongside whānau ora providers and other health and social services to improve health and wellbeing of people at risk	 Sep 2020 Sep 2020 Sep 2020 Nov 2020	30% of people seen within three months

Workforce

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

• report on implementation of nurse-led Outreach Health clinics for people at risk		
Health literacy Undertake an organisation-wide health literacy assessment process to gain a baseline for health literacy performance and gap identification; develop an action plan based on identified gaps	Apr 2021	
Develop and deliver a staff communication training programme to enhance communication performance across the DHB	Dec 2020	
Develop and implement a revised outpatient letter and text message template to ensure they can be easily understood, are accessible, and support organisational equity objectives (EOA)	May 2021	
Review our digital platform via a Consumer Council-led co-design process to ensure it better meets the needs of the community	Jun 2021	
Hold a health literacy symposium as part of health literacy/patient experience month, focusing on practical health and literacy skills • Complete evaluation of symposium	Oct 2020 Nov 2020	
Further information is provided in Section 4, Building capability, Workforce		

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
Participate in national initiatives • National Health Plan • National Health Information Exchange • #FaxFree	 Ongoing Ongoing Dec 2020	
Implement the current Ministry-led delivery of the new Oracle solution (FPIM) at Waitematā DHB	Jun 2021	
Contribute to developing and implementing the Regional Information Systems Strategic Plan (ISSP) with a focus on: • telehealth. Continue to implement patient management system integration to zoom • workspace. Implement Windows 2010, Office 365 • Identity Access Management. Implement tap-on-tap-off, single sign-on for clinicians • cyber security. Continue to improve IT security maturity and strengthen disciplines associated with cyber security • Regional Collaborative Community Care (RCCC). Participate in the implementation of a new community-focused clinical care system • Infrastructure as a Service (IAAS). Initiate move of appropriate infrastructure to cloud, and develop our hybrid cloud approach	Ongoing Feb 2021 Jun 2021 Jun 2021 Jun 2021 Jun 2021 Jun 2021	
Core Clinicals. Continue to develop electronic systems to support clinical workflow	Ongoing	
Implement Smart Systems • Laboratory eOrders (bloods) • Smartpage for registrars • Outpatient online booking	 Oct 2020 Dec 2020 Mar 2021	
Use Robotics Processing Technology for automated transfer of data between systems (e.g. eReferral System to patient administration system)	Dec 2020	

Data and digital

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

Enhance existing clinical systems • eReferral optimisation. Improve communication between GPs, NGOs and hospitals • Regional Operating Model (ROM). Embed the successful regional model for continuous, incremental improvements to the clinical portal	Mar 2021 Ongoing	
Data Visualisation. Develop Qlik dashboards specific to the needs of the Māori Health Gains and Pacific teams to inform strategy and monitor progress against initiatives (EOA)	Oct 2020	
Please see Building Capability in the Stewardship section of this Annual Plan for information on embedding and extending the telehealth and other e-tool gains achieved through the COVID-19 response work		

Implementing the New Zealand Health Research Strategy

Actions that demonstrate a commitment to support the implementation of the New Zealand Health Research Strategy

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
Research and innovation strategy (RIS) • Consult with key stakeholders on the development of RIS and collate feedback • Develop an RIS that reflects the DHB's commitment to Māori and Pacific health and equity through priority areas and partnerships and supports the implementation of the New Zealand Health Research Strategy (EOA) • Seek Board endorsement for RIS • Publish RIS • Communicate RIS to staff, community, collaborators and partner organisations	Jul 2020 Sep 2020 Sep 2020 Oct 2020 From Oct 2020	Communicated to at least three collaborator/partner organisations
Research collaborations • Continue to support established research and innovation collaborations • Investigate establishing more formal high value, non-exclusive collaborative research and academic alliances/partnerships that mutually benefit cross-sectoral programmes of research and innovation; enable the sharing of resources, ideas, expertise and education; support successful seeking of funding; and increase joint appointments between alliance partners	Ongoing Dec 2020	At least one academic alliance MoU in place
Co-design • Encourage researchers to include co-design in the development of their research proposals • Update Waitematā DHB locality application from to include a question about co-design	Ongoing Dec 2020	Establish baseline: % of research proposals that are co-design
Communication Regular DHB communication of research and innovation outcomes to a range of audiences • Newsletter publication • Regular community hui/meetings • Provide progress summary update to MoH	 Ongoing Ongoing Jun 2021	At least two publication newsletters/year
Refer to the He Korowai Oranga – the Māori Health Strategy table at the beginning of Section 2 for activities related to implementation of Waitematā and Auckland DHBs' Māori Health Research Strategy		

Delivery of Regional Service Plan (RSP) priorities and relevant national service plans

Actions to support the delivery of the RSP/national service plans

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-led Planned Care recovery As part of the regional response work, support: • rapid review of selected services resulting in proposed solutions that address equity impacts related to COVID-19 (EOA) • further refinement of proposed solutions • regional agreement on solutions • implementation of solutions	 Sep 2020 Dec 2020 Dec 2020 Jun 2021	
Radiology action plan Work with the Northern Region radiology work programme to: • identify current demand and capacity • improve waiting times and optimise capacity configuration • plan for required replacement and acquisition of additional assets • develop and support a sustainable workforce, including enabling of international recruitment	 Sep 2020 Jun 2021 Jun 2021 Jun 2021	
Hepatitis C Collaborate with regional DHB partners to implement the clinical pathway and key priorities in the National Hepatitis C Action Plan (once published) by: • providing targeted testing of patients most at risk for HCV exposure through point-of-care and/or community-based laboratory services (EOA) • 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 diagnosis, treatment and ongoing management	 Dec 2020 Sep 2020	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 2021 Jun 2021	
See the Northern Regional Service Plan 2020/21 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
Auckland-Waitematā Alliance • Critical reflective review of work programme and impact on equity • Action plan to respond to recommendations addressing equity of critical reflective review • Develop an equity framework to improve responsiveness of community pharmacy services for Māori and other high needs populations (EOA)	Dec 2020 Mar 2021 Dec 2020	

Air Ambulance Centralised Tasking

Actions that demonstrate active participation in the national development of centralised tasking for aeromedical assets in New Zealand

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

DHB activity	Milestone	Measure
The DHB remains committed to the 10-year plan to achieve a high functioning and integrated National Air Ambulance service and will participate through the National Ambulance Collaborative, by supporting the: • implementation of changed governance arrangements to include DHBs to effect improved partnership with MoH and ACC in all elements of leadership of the NASO work programme • development of a robust national process to scope the requirements of a national tasking service	Jun 2021	

Pharmacy

Actions to support the optimisation of pharmacy services

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: • develop the service model for Enhanced Residential Care Pharmacy services as part of the Pharmacy Service Level Alliance (Pharmacy SLA) to achieve equitable access to the pharmacy optimisation expertise of pharmacists for people living in aged residential care facilities (EOA)	Jun 2021	

Pharmacy Actions to support the optimisation of pharmacy services		
• implement recommendations from the Schedule 1 review	Ongoing	
• provide smoking cessation service in selected local pharmacies to improve access to priority populations, e.g. Māori, Pacific, people with mental health illnesses, pregnant women and smoking partners or family living with pregnant women (EOA)	Ongoing	Report service users by ethnicity by Jun 2021
• implement key local strategies to improve access and vaccination rates to Māori, Pacific, Asian, migrant and former refugee communities (EOA)	Ongoing	Report vaccination numbers by ethnicity by Jun 2021
• commission the Safety in Practice 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 through quality improvement	Ongoing	Report number of providers who completed the programme by Jun 2021
• develop an Equity Plan for community pharmacies	Jun 2021	
We will consider the impacts of COVID-19 on the DHB and sector's capacity to undertake the activities throughout the work programme planning	Ongoing	

Long-term conditions including diabetes 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**
Microalbuminuria management Ensure the learning from high achieving practices is transferred to other practices to promote best practice and improve equity (EOA)	Dec 2020	90% of enrolled patients with diabetes (aged 15 to 74 years) who have an elevated ACR recorded on two consecutive occasions at least 90 days apart are on an ACE inhibitor or angiotensin receptor blocker 100% of PHOS report collection of participant evaluations and applications of findings for quality improvement 70% of enrolled patients (aged 25 to 74 years) with known CVD are on triple therapy (statin + BP lowering agent + antiplatelet/anticoagulant) (excluding patients with history of haemorrhagic stroke)
Diabetes Self-Management Education (DSME) Demonstrate quality improvement of DSME programmes through collection, analysis and translation of participant course evaluations	Jun 2021	
Secondary prevention of CVD Ensure the learning from high achieving practices is transferred to other practices to promote best practice and improve equity (EOA)	Jun 2021	
Annual reviews Continue reporting of Quality and Safety Performance metrics at a patient identifiable level to general practices to allow person-specific, tailored and focused annual review of patient with diabetes	Quarterly - 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	2018/19 Audited Actual $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Revenue						
MoH	1,687,495	1,789,714	1,859,661	1,970,616	2,081,628	2,192,268
IDFs & Inter DHB Provider	91,777	93,878	100,119	102,121	104,220	106,272
Other government	30,106	24,884	26,095	26,616	27,276	27,816
Other	30,125	23,346	41,885	35,560	31,090	29,876
Total revenue	**1,839,503**	**1,931,822**	**2,027,760**	**2,134,913**	**2,244,214**	**2,356,232**
Expenditure						
Personnel	801,802	789,356	782,330	801,178	814,582	831,286
Outsourced	85,348	92,460	90,862	93,055	94,637	97,566
Clinical Supplies	127,420	128,614	138,626	140,584	142,276	145,264
Infrastructure and Non-Clinical	51,105	50,819	33,730	34,083	33,701	53,500
Payments to Non-DHB Providers	831,832	880,529	961,036	1,033,461	1,102,966	1,172,564
Interest	0	0	0	0	0	0
Depreciation and Amortisation	31,870	28,927	30,999	33,252	33,252	33,252
Capital charge	36,415	29,315	26,177	24,300	22,800	22,800
Total Expenditure	**1,965,792**	**2,000,020**	**2,063,760**	**2,159,913**	**2,244,214**	**2,356,232**
Other comprehensive income	(126,289)	(68,198)	(36,000)	(25,000)	0	0
Revaluation of land and building	(1)	0	0	0	0	0
Total Comprehensive Income/(Deficit)	**(126,290)**	**(68,198)**	**(36,000)**	**(25,000)**	**0**	**0**

Note that Personnel costs in 2018/19 and 2019/20 included provisions for unpaid Holiday Pay. The Plan for 2020/21 and outer years do not include any additional Holiday Pay provisions.

Infrastructure and Non-Clinical Supplies contains $15m of savings targets for 2020/21 and each of the outer years, although savings will be achieved across other cost and revenue lines.

This budget does not include any costs for COVID-19 in 2020/21 or subsequent years.

Four-year plan

Prospective summary of revenues and expenses by output class	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Early detection				
Total revenue	449,247	478,133	506,529	535,233
Total expenditure	452,791	480,535	506,337	535,041
Net surplus/(deficit)	(3,544)	**(2,401)**	192	192
Rehabilitation and support				
Total revenue	331,972	355,289	377,874	400,574
Total expenditure	332,892	355,861	377,658	400,358
Net surplus/(deficit)	(920)	**(572)**	216	216
Prevention				
Total revenue	26,201	28,057	29,852	31,655
Total expenditure	26,261	28,093	29,834	31,637
Net surplus/(deficit)	(60)	**(36)**	18	18
Intensive assessment and treatment				
Total revenue	1,220,339	1,273,433	1,329,960	1,388,770
Total expenditure	1,251,816	1,295,424	1,330,385	1,389,196
Net surplus/(deficit)	**(31,477)**	**(21,991)**	(425)	(426)
Consolidated surplus/(deficit)	**(36,000)**	**(25,000)**	**0**	**0**

SECTION 3: Service Configuration

Service coverage exceptions and service changes are 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 2020/21.

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

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Regional sustainable services post-COVID-19	NRHCC vulnerable services identified for scoping and action plans to be completed for implementation in 2020/21: • Oral Health specialist services streamlining patient pathway, reducing wait times and review of service locations • Review of complete oral health pathway for children including Auckland Regional dental Service	Children and adolescents receive secondary level dental care in a timely manner and closer to home	Regional and local
Re-establishment of services post-COVID-19	• General Surgery not currently accepting bariatric referrals (to recommence in July) not anticipated as a long-term issue • Reconfiguration of ESC into COVID-19-ready ICU space impacted elective capacity; returning to BAU from 3 July	COVID-19 response	Local (Waitematā DHB only)
Expansion of service	Individual Placement and Support (IPS): Expand employment support service under current trial to three Waitematā DHB geographical areas. Completion of trial within all 3 co-located sites by 2021	Will extend service from 50 to 500 people, based in three key mental health hubs within Waitematā DHB	Local (Waitematā DHB only)
Re-establishment of service and change in location of services	Kaupapa Māori Forensic Step-Down Beds (regional forensic service): RFP to select a provider for replacement of 5 kaupapa Māori community residential forensic step down beds completed in 2019. Contract is under negotiation. New location will be central Auckland in the interim until a purpose built facility is sourced. Location to be agreed by Regional Forensic Service	Replace access to a kaupapa Māori forensic step-down service	Regional (delivered by Waitematā DHB)
Change in location of services	CADS regional medical detox and Regional Social Detox service to co-locate with regional social detox service at new build in central city Auckland (Mission Homeground)	Service will be delivered within a purpose-built building and located with other complementary services	Regional
Change in funding	Primary Mental Health Services: Funding of primary mental health initiatives via Ministry of Health Access and Choice will expand a range of services throughout the	Significant expansion of metro-Auckland primary mental health support options for those with mild to moderate mental health and addiction	Regional

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	Metro Auckland region. Currently pending decision of RFP outcome however clear indication of a suite of options	requirements. Will expand models including Awhi Ora, Health Improvement Practitioners and Health Coaches	
Change in location of services	High And Complex Residential Services: Due to ongoing delays with the building of a purpose-built facility, costs have escalated. The provider is exploring funding options for this. In the interim, service is still provided from the two temporary locations	Continued delivery of service while alternative is considered	Local (Waitematā DHB)
Potential change in model of service delivery	Supra Regional Eating Disorder Service (EDS): Midland DHBs originally withdrew from all elements of Supraregional EDS services except residential service and the service adjusted capacity accordingly. Midlands previously signalled an intention to withdraw from the residential service over time; engagement with them over the last 18 months confirmed we are the only provider of this service in New Zealand that can accommodate them. One of the Midland DHBs is exploring the option of delivering this service closer to home as part of their new capital build, which will likely be completed in 3-5 years. There is an ongoing need to consider a regional response to service delivery to be prepared for any potential withdrawal by Midlands DHBs in the future	Auckland DHB service resized for Northern region population for all EDSs, including residential services. Uncertainties regarding ongoing Midland population demand and potential to accommodate a residential service closer to home is expected to be clarified over time, enabling Auckland DHB to progress medium to longer term planning of residential services	Supra Regional DHBs - Northern Region and Midlands Region
Change in service provider	Bowel screening histology services LabPlus management will cease providing bowel screening histology services at the end of their current agreement with Waitematā DHB on 31 December 2020. The new provider will be the Surgical Pathology Service at Waitematā DHB	The change will allow LabPlus to create capacity to provide bowel screening histology services for the Auckland DHB bowel screening programme, which is scheduled to go live towards the end of November	Local (Waitematā DHB)
Review and change in service	Termination services: Contracting arrangements and ascertain options for new model, including possibility of local services	Services that are safe, convenient and more accessible and acceptable to women within the legislative framework Improve the sustainability of second trimester surgical abortion services to be delivered by Auckland DHB for metro Auckland and other DHBs as agreed	Metro-regional
Change in service delivery model	Maternity Services: Consult with maternity stakeholders on options to reduce the caesarean section rate at National Women's Health	Improved birthing options for local population Promotion of normal delivery in community settings	Metro-regional (delivered by Auckland DHB)
Level of service provision	Improve clarity on the range of conditions for which pre-implantation genetic diagnosis (PGD) is provided and, subject to funding approvals, remove any waiting lists for PGD	Improved access to services Improved waiting times for services	Metro-regional (delivered by Auckland DHB)
Review and change in service	Review, enhance and undertake tender for improved youth health services	Improved range and access to services	Metro-regional
Change in model of service delivery and potential change of provider(s)	Undertake a tender for improved healthy weight support services for children under 5 years of age incorporating learnings from the second PPAL review	Improved quality of services available to support healthy weight management in preschool children	Metro-regional
Change in service delivery model and potential	Home and Community Support Services (HCSS) Procurement for this service will commence	Improved delivery of services to increase responsiveness and flexibility and better respond to client needs	Local (Waitematā DHB) (aligned to national framework for HCSS)

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
change of provider(s)	within 2020/21		
Potential change in model of service delivery	Community Pharmacy: • DHBs will work towards different contracts for the provision of community pharmacist services by working with consumers and other stakeholders to develop service options, including potential options for pharmacist service delivery • DHBs will work with key stakeholders to develop the enhanced pharmacy service to achieve safe and consistent medicine 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	Enhanced services for consumers More consistent and safer service for patients	Sub-regional (Auckland and Waitematā DHBs)
Capacity increase	Development of ward 51 an adult rehabilitation and integrated stroke unit (ARISU) at Auckland City Hospital • will create approximately 41 additional adult inpatient beds, planned to open in September 2020	Improved capacity to respond to acute demand Increased rehabilitation capacity	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, which will improve patient access to appropriate resources e.g. psychology, dietitian, nursing and improve patient understanding through provision of information resources reviewed with a health literacy lens	Local (Waitematā DHB only)
Potential change in model of service delivery	VA ECMO was historically initiated by Cardiac Surgery centres when necessary; however, a national service improvement process agreed 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 referral demand. In preparation for this, we are working to implement technology to enable national cardiac surgical MDT meetings	Improved patient outcomes through delivery of care by a centre that is able to deliver the best evidence-based practise To ensure expertise is concentrated in one centre due to complexity of procedure and low volumes	National
Implementation of new service	Implementation of the procedure, left atrial appendage closure. There is new evidence to support the introduction of new technology in the management of this complex cardiac condition. This is supported by the Northern Regional Clinical Practice Committee and is currently awaiting approval from the Ministry of Health	Improved patient outcomes through provision of alternative evidence-based treatment for those patients contraindicated for oral anticoagulation and 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, which at other hospitals in the city, and how regional on-call rosters should work to better support the current surgical provision at Waitematā DHB	Improved sustainability of local and regional services Improved patient experience and outcomes	Local, regional

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
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 support current surgical provision at Waitematā DHB, including oncoplastics (breast), skin (reconstruction) and benign breast	Improved sustainability of local and regional services Improved patient experience and outcomes	Local, regional
Shift in service	Head and Neck services: A regional review of Head and Neck services across the northern region was completed and the region is working together to improve the regional oversight, coordination and management of Head and Neck services for the region's 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 new sleep service model based on ambulatory models in place already in New Zealand that makes the best use of available capacity and resources (including funding) to increase the number of patients able to be 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 (telephone and video consultations, specifically for follow-ups), community-based IV infusions and patient-generated follow-ups. This work continues to be implemented throughout Auckland and Waitematā DHBs and further changes were accelerated due to the COVID-19 response. Continuing in 2020/21	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	Redesign and integration of diabetes retinal screening services across Auckland and Waitematā DHBs The redesigned service will take screening services out into the community at a significantly expanded range of locations and make appointment booking flexible and fitted to the needs of service users	Improved screening coverage Improved equity of screening coverage Consequent reductions in the burden of diabetic retinopathy and diabetic maculopathy	Sub-regional (Auckland and Waitematā DHBs)
Change in location	Interventional Radiology Services (IRS): Progressing the implementation of an Auckland-Waitematā DHB integrated service delivery model to support sustainable provision of IRS for the Waitematā DHB 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 delivery of non-surgical cancer services locally at Waitematā and Counties Manukau DHBs, with the timing and scope of services to be determined by the need for additional regional capacity From early 2020/21, the local delivery arrangements will be extended to include all elements of non-surgical cancer treatment	Improved local access Additional regional service capacity developed in a planned and cost effective manner	Metro-regional

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
	for breast cancer, including cytotoxic chemotherapy and a five-year plan will be developed to expand local delivery to include other tumour streams		
Improved local access	National Peptide Receptor Radio-nuclide Therapy (PRRT) Service: To be developed and established by Auckland DHB through an alliance with the Auckland DHB Radiology Service, the Regional Cancer and Blood Service, the University of Auckland, and Clinical Support Services (Laboratory), following the funding decision by Pharmac. Auckland DHB Business Case for NZ National PRRT Service in development. Planned for implementation in Q4 2020/21	Improved access to New Zealand-based service for patients that meet the Pharmac funding criteria for PRRT Improved equity of access Additional regional and national service capacity developed in a planned and cost effective manner Reduction in requirement for patients to travel overseas to access this treatment at their own cost	National (based in Auckland DHB)
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 for North Shore Hospital (business case being finalised) including impact on age <65 years stroke rehabilitation (i.e. move to the stroke unit rather than Rehab Plus) • Development of an integrated stroke unit at Auckland City Hospital, business case awaiting ministerial approval due for implementation by December 2020 (timeline delayed due to COVID-19)	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): 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	Regional and national
122 additional FTEs	Implementation of Care Capacity Demand Management	Required to comply with current Nursing MECAs and safe staffing levels	National

Locally initiated reviews of Waitematā DHB's COVID-19 response

Type of Review	Brief description	Expected date of completion
IMT COVID-19 response health check	The purpose of the IMT health check is to use available tools and resources within Waitematā DHB to perform an initial review of the IMT operational and decision-making governance and record keeping. The objectives are to: 1. Review the governance and quality assurance systems and processes developed by the IMT and identify areas for improvement and/or deficit. 2. Identify opportunities to improve the DHB's overall position pre- and post-COVID-19 audits and investigations.	September 2020

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 that 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 we face, 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 by the Executive Leadership team 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 targets equity in health outcomes. To achieve our quality vision, the DHB set four aims that reflect the key elements of quality.

Safe care – no avoidable harm to patients will come 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. They will be provided with information which will enable them to make informed choices about the care they receive. 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 with providers.

We share our quality improvement activities with our community through the i3's website http://i3.Waitematādhb.govt.nz/.

Asset management

The Treasury again assigned Waitematā DHB an Investor Confidence Rating (ICR) of B in the 2019 assessment.

Waitematā DHB's asset management maturity score improved with the gap from the long-term target maturity, reducing from 14 to six points.

Waitematā DHB was identified as one of the highest maturity DHBs and our Asset Management Plan was identified as an exemplar for the sector.

Improvements identified as high priority through the ICR are outlined below.

- Further develop asset levels of service statements and related performance measures and targets
- Develop a more comprehensive rolling programme of building condition assessments based on priority and risk
- Improve the use of the BEIMS system functionality to provide greater asset management capabilities
- Consolidate all clinical equipment information into the Infor EAM system
- Improve the quality of the facility asset data in BEIMS, bringing in condition survey information, and ensuring key data for decision making is held for all building assets
- Document the asset management processes and procedures that relate to each portfolio and publish these on our intranet.

Northern Region Long-Term Health Plan (NRLTHP)

In 2018, the Northern Region Long-Term Investment Plan (NRLTIP) was published, which set out our regional strategy. It identified the three key issues the Northern Region needs to address, 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.

In 2020/21, further work will be undertaken to refine and develop our NRLTIP and progress short- to medium-term outcome quality, equity and process improvement priorities, as identified by our Regional Clinical Networks and agreed by regional executives.

This programme of regional collaborative work is delivered through regional mechanisms that function under regional oversight and governance groups.

Our local programme of regional long-term planning work is well aligned with the national guidance expectations. It also covers elements of the national priority work areas. This local long-term planning programme of work is structured around:

1. Long-Term Health Service Planning. This comprises:
   - Health planning 'design' work steams; work to clarify the desired models of care for our Region and to outline the future shape of the Northern Region health service delivery system. This is work to identify and agree:
     - The priority areas of health service delivery and models of care that need to change in our Region to ensure sustainable and equitable outcomes
     - How those services should change
   - Health planning 'implementation' work streams. This is work to progress the necessary changes relating to agreed priority areas of health service transformation; taking the prioritised and agreed new service delivery concepts and making them a reality.
2. 'Enabling' workstreams. This work relates to the strategic planning and the delivery of the 'enabling' capacity and capability to meet current and future health service delivery requirements. There are three Regional workstreams:
   - Workforce Strategy
   - Capital Investment
   - Information Systems Strategic Plan (ISSP)/implementation.

   These enabling programmes both plan and deliver the enabling workforce, capital and IS changes required to support the identified health service transformations.

A regional emphasis on equity, as well as quality and safety, is woven through all the regional plan work-streams.

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 Region 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 on 1 November 2013.

Building capability

Capital and investment development

Waitematā DHB received Ministerial approval and is progressing the delivery of several major capital programmes. These include a new Elective Capacity and Inpatient Beds facility on the North Shore ($240M), the first tranche of redeveloping the Mason Clinic ($60M), and the first tranche of critical infrastructure at North Shore Hospital ($30M). We are also progressing business cases for two additional projects, an upgraded Central Sterile Services Department (circa $12M) and a standalone ward unit to provide interim capacity prior to redeveloping Waitakere Hospital (circa $30 to 40M).

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.

Our programme of work is derived directly from the Regional Information Systems Strategic Plan (ISSP) or aligns with the ISSP in principle. All new projects are overseen by the new regional governance structure, established in 2019.

Implementation of the regional community care system (RCCC) is planned to commence in 2020/21. While Waitematā DHB plans to join in later years, our contribution to design and implementation will be crucial. This project is a major enabler of better collaboration and information exchange between community, primary and secondary care.

Our Outpatient online booking system will give patients greater control over the timing of their outpatient care. This is a small but significant step toward easier access to their health information.

Telehealth (telephone and video) appointments enabled us to deliver approximately 17,000 appointments over the COVID lock down period that may otherwise have been cancelled. Patient feedback has been positive and tells us we should continue to offer telehealth appointment options. Work to sustain and implement telehealth includes building patient choice into our booking processes (as outlined above), integration of the video platform with our booking system, and development of electronic tools such as patient information, patient questionnaires, eLabs, ePrescribing, eOutcome and eSurgical waitlist.

Waitematā DHB plans to take part in the HIMSS digital maturity assessment to identify gaps in our digital footprint. Our plans to implement new smart systems for eOrdering, registrar communication (smartpage) and online booking demonstrate our commitment to increasing our digital maturity.

Our Māori and Pacific Health Gain teams require intuitive data explorers to support their goal of reducing inequity of access. To this end, we plan to design specific Qlik Sense dashboards with that purpose in mind.

Our IT security matured greatly in the last two years through a significant investment in cyber-security. It is important to continually maintain and strengthen our digital security in our increasingly interconnected world. The plans for cyber security investment in 2020/21 are being finalised. Subject to funding, the aim is to build on investment to date, such as foundational security incident event management (SIEM) tools and resources, to further embed a cyber-security controls framework that complies with HISF/NZISM and Ministry of Health digital service requirements.

See further information in Section 2, Data and digital.

Workforce

Culture, leadership and development

The vision of Waitematā DHBs is to enable the conditions where it is easy to be our best in the service of others. Our people and workforce priorities encompass a dynamic landscape of people experience and culture, capability building, career development, diversity and service provision. At its heart are the Waitematā DHB values, our commitment to health equity, and our passion for innovation. 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 our staff, our values reflect 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).

Our People and Workforce priorities consist of four strategic pillars:

1. Enabled to Deliver.
Enabling our teams to deliver, support better, best, brilliant in our everyday work, and provide a safe working environment where diversity and key stakeholders are valued. We aim to be a top choice for new graduates, support and deliver career and succession aspirations and provide an inclusive workplace where health, safety and wellbeing are a priority.

2. Proud to Participate.
As defined by the Institute for Healthcare, safe, reliable care is achieved through a mix of culture, people experience and learning systems. Being proud to work at the DHB means we are valued, can make a difference and thrive at our work. The emphasis of this pillar is on our values and compassion workstream where we will focus activity on appreciation, recognition and staff experience that directly addresses staff feedback via our Tōku Reo programme. We also focus on learning systems and role development that create great teamwork and incorporate future technology.

3. Designed to Develop.
Development and leadership is the focus of this pillar. We aim to develop clinical leadership programmes and expand current foundation and quality care leadership offerings to partners across our district, focusing on growing emerging and established clinical and operational leaders.

4. Geared for Growth.
Our fourth pillar outlines several areas where informed future workforce planning will enable growth to meet additional service needs (e.g. Elective and Acute Capacity Investment) to prepare us for future workforce development, with a strong focus on strengthening health equity through the growth of Māori in line with our commitment to Te Triti O Waitangi. Good employer practices are critical 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.
We support the workforce objectives identified in the NRLTHP and as guided by the Health Workforce Directorate, Ministry of Health. We consider 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 12 nurse practitioners across 10 specialities and plan to develop future roles in mental health and Māori health.

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 and curricula, student placements, and joint education and employment ventures and research.
- 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 Planning and Health Outcomes directorate 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, and putting in place a maturity model via ISO to measure excellence in workplace health and safety.

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 us to take a whole-of-system and a ward/unit quality improvement approach that defines, guides, measures and embeds our practices.

SECTION 5: Performance Measures

2020/21 Performance measures

The following table presents the full suite of Ministry of Health 2020/21 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		65%
	Year 2		65%
CW02 Oral health: mean DMFT score at school year 8	Year 1		<0.56
	Year 2		<0.56
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	The DHB has reached the 'total population' target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the Māori population group, and (where relevant) the Pacific population group, for both targets		
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%
CW12 Youth mental health initiatives	Initiative 1: Report on implementation of school-based health services (SBHS) in decile one to four (and decile five after January 2020) 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		
Improving mental wellbeing (MH)			
MH01 Improving the health status of people with severe mental illness through improved access[5]	Age 0-19 years	Māori	≥5.25%
		Other	≥3.54%
		Total	≥3.82%
	Age 20-64 years	Māori	≥9.4%
		Other	≥3.24%
		Total	≥3.77%
	Age 65+ years	Māori	≥2.23%

[5] Mar19 – Feb20 baseline

Performance measure		Expectation
	Other	≥2.14%
	Total	≥2.14%
MH02 Improving mental health services using wellness and transition (discharge) planning	% of clients discharged will have a 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	
MH07 Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Expectation to be confirmed	
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 2020/21 SLM Improvement Plan
	Age 45-64 years (SLM contributory measure)	≤4,052/100,000
SS07 Planned Care measures		
1. Planned care interventions	Number of interventions	TBC
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 receive their scan, and the scan results are reported, within 6 weeks (42 days)	95%
	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	0%

Performance measure		Expectation
	appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service	
6. Acute readmissions (0-28 days)	The proportion of patients who were acutely re-admitted post discharge improves from base levels	12.4% (Dec 2019 baseline is 12.5%)
7. Did not attend rates (DNA) for first specialist assessment (FSA) by ethnicity	Māori Pacific Non Māori/Non Pacific	Developmental measure – no target
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	TBC
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*	
	Count of enrolled people aged 15-74 in the PHO who have completed a DAR in the previous 12 months	
	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 2nd anti-platelet agent*, and an statin (3 classes); ACEI/ARB if any of the following – LVEF, 50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes); beta-blocker if LVEF<40% (5-classes)	≥85%

Performance measure		Expectation
	* An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents	
	% 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%
	% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) 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 within 24 hours of their presentation to hospital	80%
	% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile (service provision 24/7)	12%
	% 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%
SS17 Delivery of whānau ora	Appropriate progress identified in all areas of the measure deliverable	
SS18 Financial outyear planning and savings plan	Provide reports as specified	
SS19 Workforce outyear planning	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	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period	100%
	Current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90%	>90%
PH03 Access to care (Māori PHO enrolments)	The DHB has an enrolled Māori population of 95% or above	95%
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	

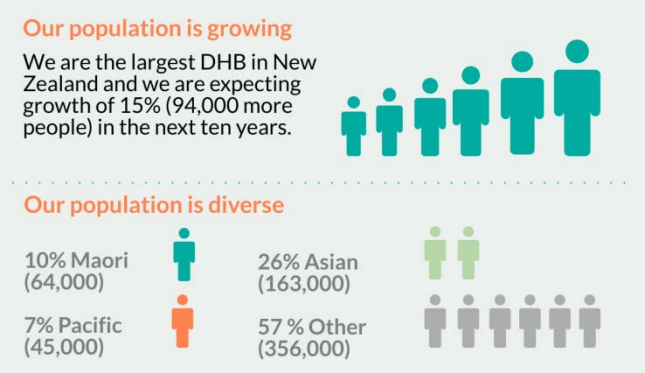
Appendices

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

About Waitematā DHB

Who we are

Waitematā DHB is the Government's funder, and provider of health services to the estimated 629,000 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 15% aged over 65.

Our population is diverse. 10% of Waitematā residents are Māori, 7% Pacific, and 26% are Asian. Our Asian population is proportionally our fastest growing population, and projected to increase to 30% 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%) (New Zealand Health Survey 2016/17). Ten percent are current smokers (2018 Census Usually Resident Population).

Cancer is the most common cause of death (33%), and there are over 2,600 new cancer registrations in Waitematā every year (excludes in-situ). Cardiovascular disease (28%) and respiratory disease (8%) 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 years are amenable through healthcare interventions (45% or 484 deaths in 2017).

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

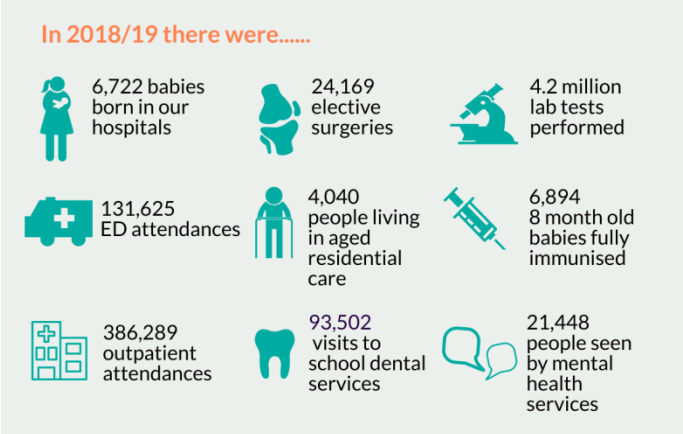
DHBs act as planners, funders and providers of health services, as well as owners of Crown assets.

Waitematā DHB provides hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 sites throughout the district. Around 8,600 people are employed by Waitematā DHB.

We have a budget of $2.03 billion in 2020/21.

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 720,000 over the next ten years, and the 65+ population will increase by more than 40% 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 (33%), cardiovascular disease (28%). A large proportion of all deaths are potentially amenable through healthcare interventions (45% or 484 deaths of those aged less than 75 in 2017).

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.

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. The establishment of the Waitematā DHB Consumer Council provides a strong voice for consumers on quality improvement and delivery of services that meet the needs of our population.

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.

We expect our population to reach more than 720,000 over ten years; 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.

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 aligns with the health and disability system outcomes framework and the New Zealand Health Strategy.

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.

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 NRLTIP 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 updated to form the Northern Region Long Term Health Plan (NRLTHP). From this the annual Regional Services Plan is developed, which reflects the Ministry's identified annual areas of focus as closely as possible, including actions, milestones and performance indicators for achievement during 2020/21.

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 around 15% since 2016, to a total of 563 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 reach more than 720,000 by 2030/31; 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 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.

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 and local progress will be tracked.

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.

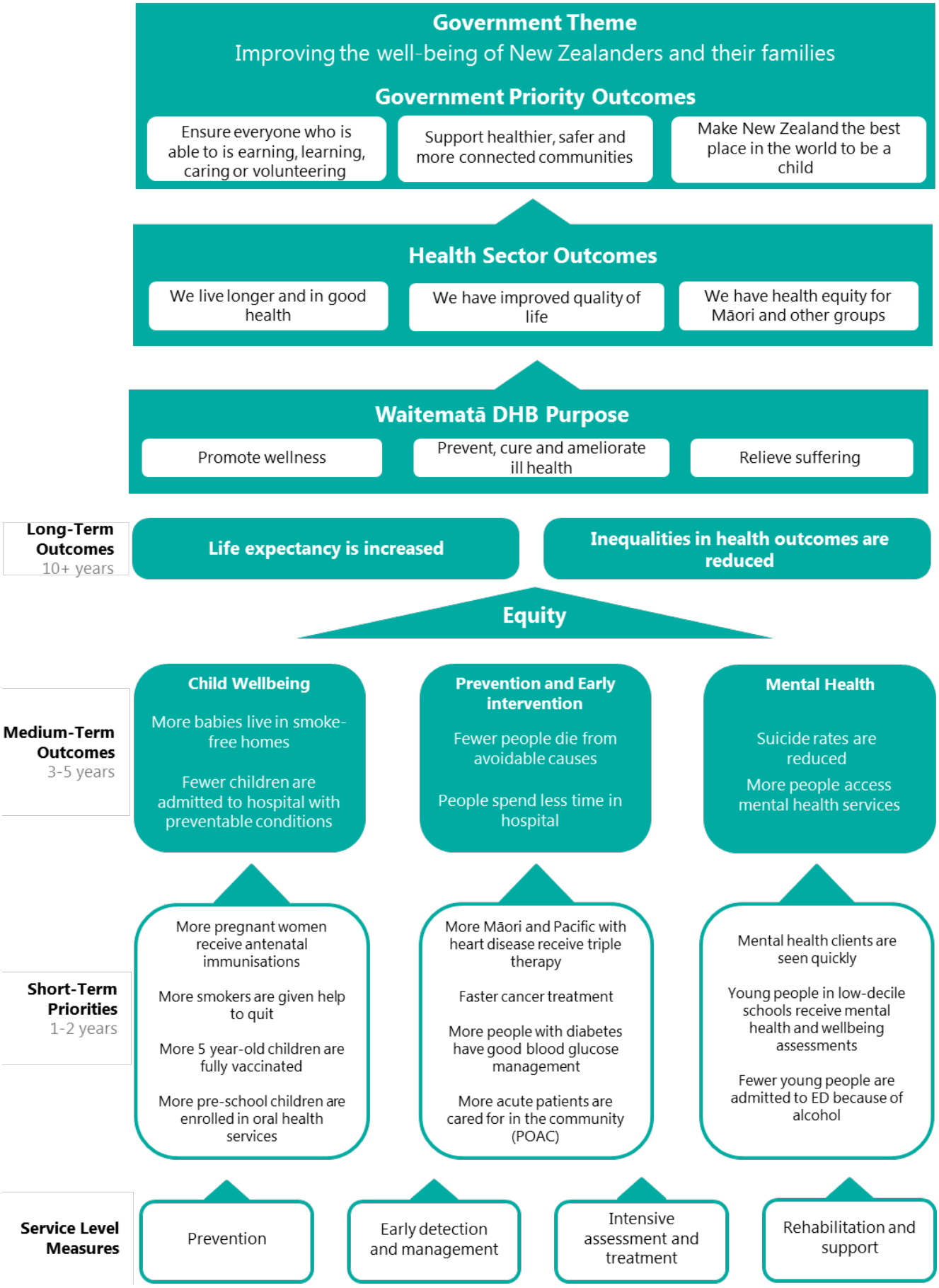
Prevention and Early Intervention

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).

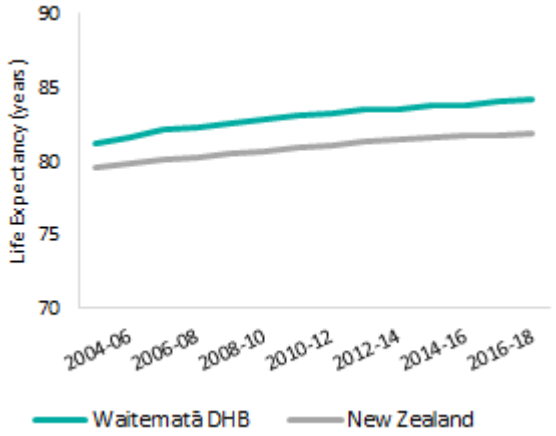
Increasing life expectancy

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

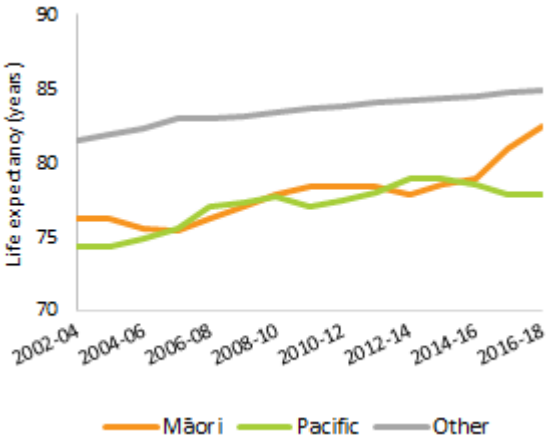
Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a lower life expectancy than other ethnicities, with a gap of 2.5 years for Māori and 7.1 years for Pacific (2016-18).

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.

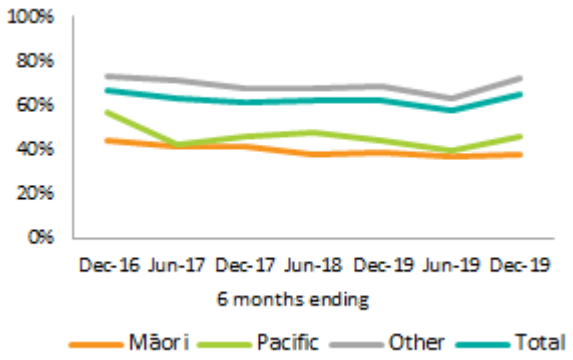
Medium-Term Outcomes

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 2019, less than half of all Māori and Pacific babies were living in a smokefree household in contrast to nearly two thirds of other ethnicities. The proportion of all babies who live in smokefree households is slowly decreasing.

Proportion of babies living in smokefree households at 6 weeks postnatal

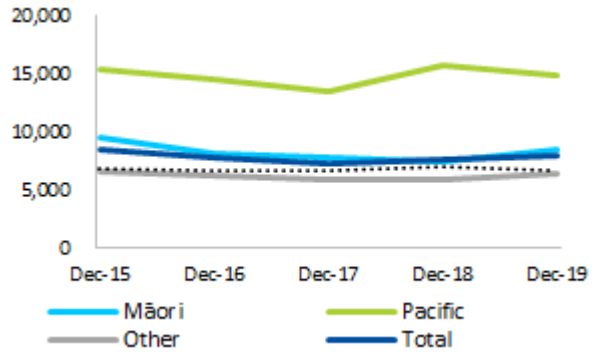


Fewer children are admitted to hospital with preventable conditions

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 December 2019, there were 2,363 admissions in 0–4 year olds that were potentially avoidable. The overall rate of admissions (5,905 per 100,000) has increased since 2015. Compared with other ethnicities, rates are higher in Māori (7,391 per 100,000) and over twice as high in the Pacific population (11,866 per 100,000).

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



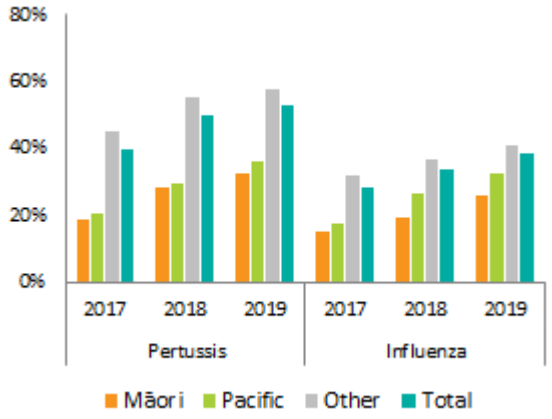
Short-Term Priorities

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 2019, around 53% and 39% of mothers received pertussis and influenza vaccinations respectively during pregnancy, with the proportion considerably lower for Māori and Pacific.

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

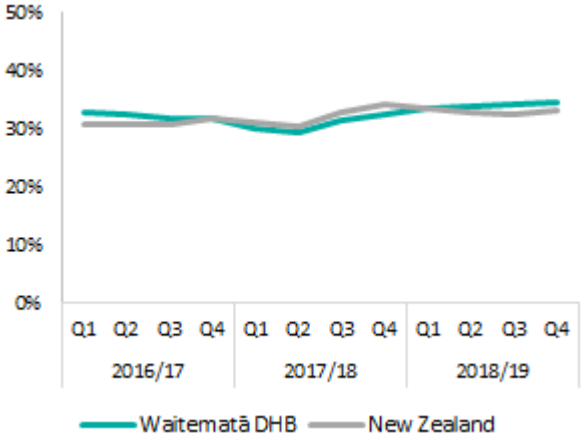


More smokers are given help to quit

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

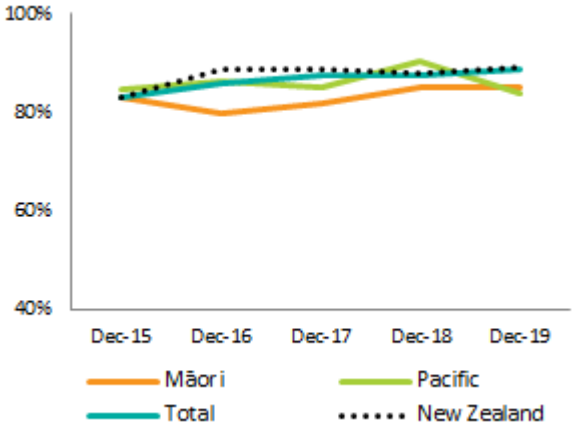


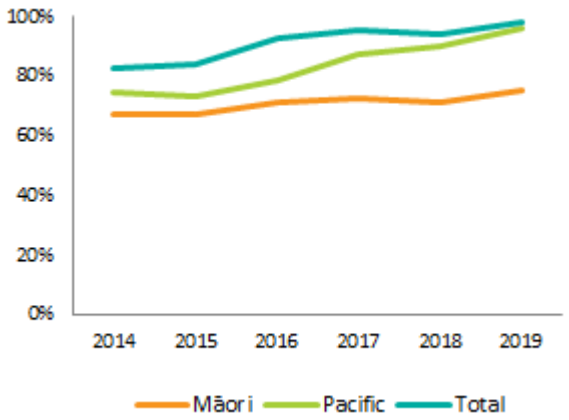
More five year-old children are fully vaccinated

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

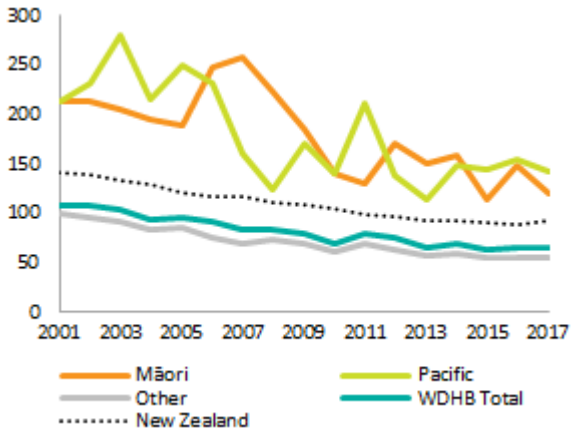


More pre-school children are enrolled in oral health services	
Dental care comprises a leading cause of preventable admission to hospital among pre-school children. The consequences of poor dental health in childhood can carry on into adulthood. Prevention and early intervention are key to reducing the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

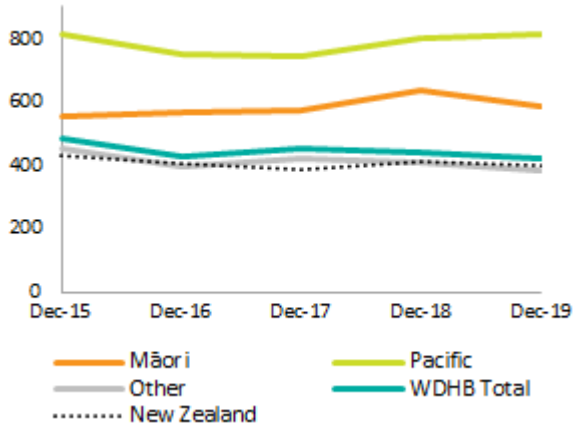
Fewer people die from avoidable causes	
Amenable mortality is defined as premature deaths (before age 75 years) from conditions that could potentially be avoided, given effective and timely care for which effective health interventions exist. In 2017, we estimate that 484 deaths (45% of all deaths in 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 65.0 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 2015, it remains higher than the national rate (424 vs. 399 per 1,000 population).

Acute hospital bed days rate per 1,000 population



Short-Term Priorities

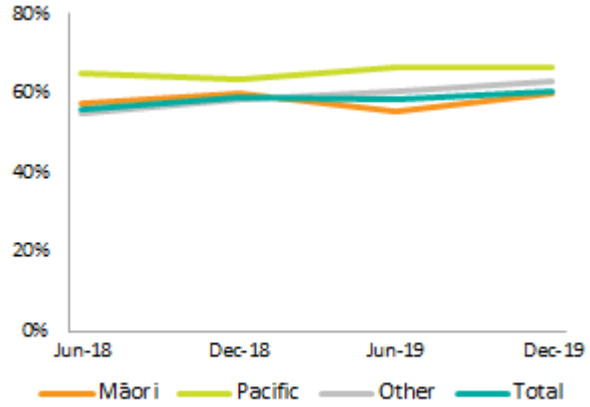
More Māori and Pacific with heart disease receive triple therapy

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, 60% of Māori and 66% Pacific who have had a CVD event are prescribed triple therapy medication.

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

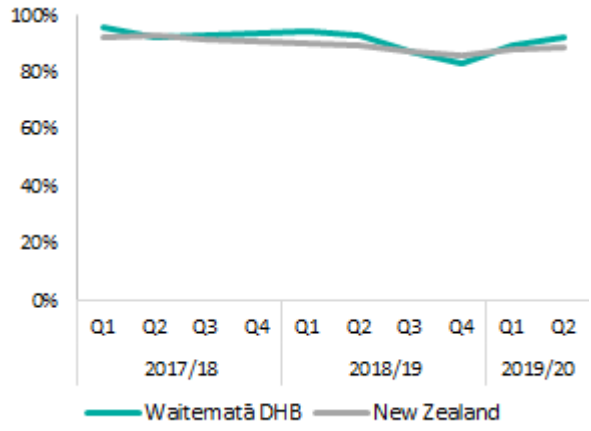


Faster cancer treatment

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.

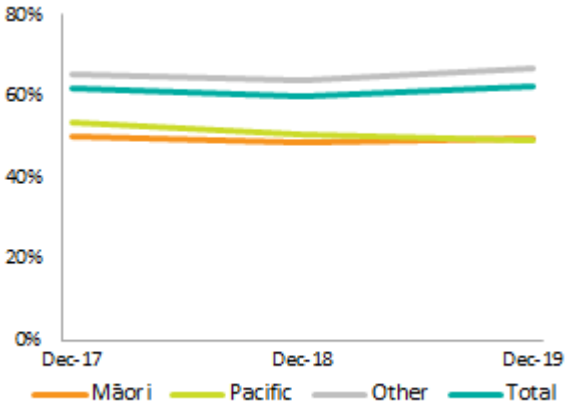
Proportion of cancer patients receiving treatment within 62 days of referral



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

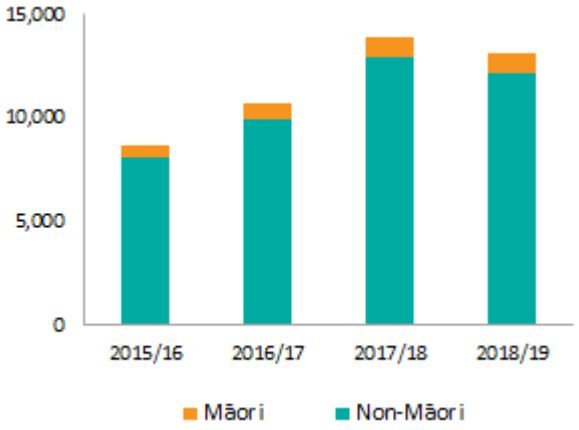


More acute patients are cared for in the community (POAC)

Primary Options for Acute Care (POAC) provides access to investigations, care or treatment for patients who can be safely managed in the community. Access to existing community infrastructure and resources is utilised to provide services that prevent acute hospital attendances or shorten hospital stays. 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.

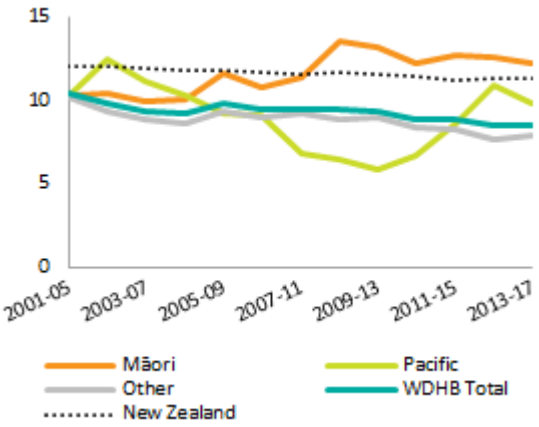
Medium-Term Outcomes

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, there is a clear equity issue and a concerning trend, particularly among our Pacific population. Our long term aim is for zero suicides. Reducing suicide rates requires a whole-of-government approach to supporting wellbeing and addressing multiple social determinants.

Rate of suicide per 100,000 population

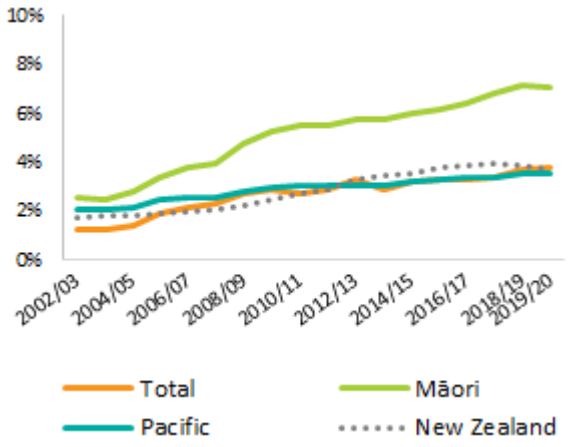


More people access mental health services

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 3.6%.

Note: the data in this graph has not yet been updated to reflect the 2019 population projections

Proportion of population accessing mental health services – all ages



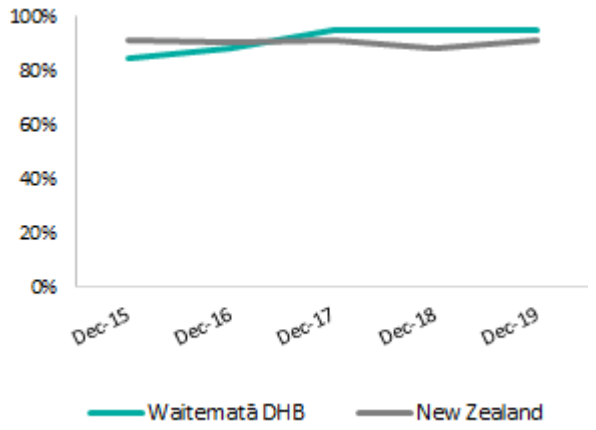
Short-Term Priorities

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.

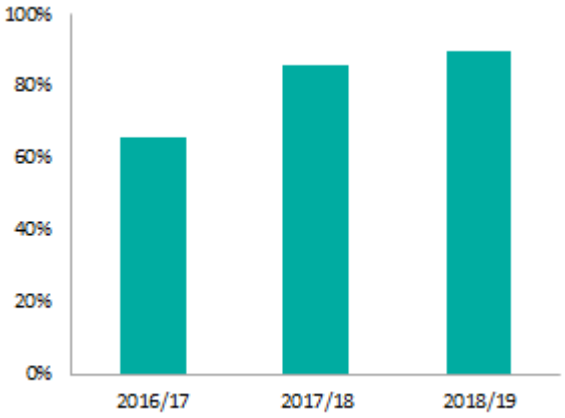
Proportion of non-urgent referrals to mental health services that are seen within eight weeks



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



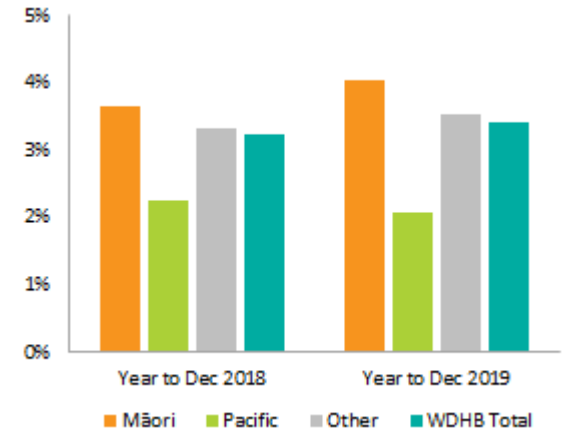
Fewer young people are admitted to ED because of alcohol

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).

* 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.

Proportion of youth Emergency Department presentations which are alcohol-related (12 months to Dec-19)



APPENDIX B: STATEMENT OF PERFORMANCE EXPECTATIONS – WAITEMATĀ DHB 2020/21

The Statement of Performance Expectations (SPE) is a requirement of the Crown Entities Act (2004) and identifies outputs, measures and performance targets for 2020/21. Recent actual performance is used as the baseline. The Crown Entities Act 2004 requires the SPE to include forecast financial statements for the financial year, prepared in accordance with generally accepted accounting practice. Our forecast financial statements for the year ended 30 June 2021 (Appendix C) and the Financial Performance Summary table (Section 2) form part of our 2020/21 SPE.

Measures in our SPE represent the outputs/activities we deliver to meet our goals and objectives in Section 2 and our Statement of Intent (Appendix A), and provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of key indicators.

Stats New Zealand and the Ministry of Health recently released updated population estimates and projections using new methodology (and there are likely to be further updates to these figures). This had a significant impact on the population figures for Waitematā DHB, with substantially fewer people living within the DHB boundaries according to these new figures compared with previous estimates and projections. This will in turn have a substantial impact on performance against those measures that use DHB population as denominator. Going forward, there may be marked changes in both current results and trend information.

Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures will be reported in our Annual Report and audited at year end by our auditors, AuditNZ.

Performance measurement framework

Our focus for 2020/21 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.

Please note that some population-based measures have been removed this year due to population estimate and projection changes noted above. Baseline results have not been included for other population-based measures as these will change once the new population data is released (expected in September 2020, which is after the publication of this document).

Targets and achievements

Targets and comparative baseline data for each of the output measures are included in the following sections. We use a grading system to rate performance against each measure. This helps to identify measures where performance was very close to target versus those where under-performance was more significant. The criteria to allocate 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 no progress made	

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

Key to output tables

Symbol	Definition	Symbol	Definition
Ω	Measure is demand driven – not appropriate to set target	V	Measure of volume
↓	A decreased number indicates improved performance	T	Measure of timeliness
↑	An increased number indicates improved performance	C	Measure of coverage
↔	Maintain current performance	Q	Measure of quality

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 2018/19	Target 2020/21
Health promotion			
% of PHO-enrolled patients who smoke have been offered brief advice to stop smoking in the last 15 months	C	88%	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	91%[6]	90%
Number of pregnant women smokers referred to the stop smoking incentive programme	Q	168	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	5,340	4,861
% of clients engaged with Green Prescriptions - *Māori* - *Pacific* - *South Asian*	C	 *16.2%* *18.6%* *7.5%*	 *13%* *12%* *9%*
Immunisation			
% of pregnant women receiving pertussis vaccination in pregnancy - *Māori* - *Pacific* - *Asian*	C	52%	50% (or maintain if >50%)
Influenza vaccination coverage in children aged 0-4 years and hospitalised for respiratory illness - *Māori* - *Pacific*	C	12% *8%* *11%*	30%
% of eight months olds will have their primary course of immunisation on time - *Māori* - *Pacific*	C	92% *86%* *96%*	95%
% of five year olds will have their primary course of immunisation on time - *Māori* - *Pacific* - *Asian*	C	87% *84%* *85%* *92%*	95%
Rate of HPV immunisation coverage	C	56%	75%
Population-based screening			
% of women aged 50-69 years having a breast cancer screen in the last 2 years	C	[7]	70%
% of women aged 25-69 years having a cervical cancer screen in the last 3 years	C	[7]	80%
HEEADSSS assessment coverage in DHB funded school health services	C	90%[8]	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[9] - *Māori* - *Pacific* - *Asian* - *Other*	Q	[7]	60%

[6] The Ministry states that this measure is still under development and reported results cover only a proportion of pregnant women who identify as smokers.
[7] Baseline not included as will be recalculated once updated population estimates are available
[8] 2019 academic year
[9] CY2018

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
% 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	97%	95%
Auckland Regional Public Health Service[10]			
Number of tobacco retailer compliance checks conducted	V	432	300
Number of alcohol licence applications and renewals (on, off club and special) that were inquired into	V	3,010	Ω
% of smear-positive pulmonary tuberculosis cases contacted by the Public Health Nurse within 3 days of clinical notification	Q	83%	90%
% of high risk enteric disease cases for which the time of initial contact occurred as per protocol	Q	89%	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 2018/19	Target 2020/21
Primary health care			
Rate of primary care enrolment in Māori	C	[7]	90%
Number of referrals to Primary Options for Acute Care (POAC)	V	13,173	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 - *Māori* - *Pacific*	C	15.0%[11] 24.0%[11] 15.5%[11]	<12.0%
% 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 - *Māori* - *Pacific*	Q	59%[11] 45%[11] 48%[11]	65%
% of Māori patients with prior CVD who are prescribed triple therapy	Q	55%[11]	70%
Pharmacy			
Number of prescription items subsidised	V	7,639,059	Ω
Community-referred testing and diagnostics			
Number of radiological procedures referred by GPs to hospital	V	39,398	Ω
Number of community laboratory tests	V	4,250,213	Ω
Oral health[12]			
% of preschool children enrolled in DHB-funded oral health services - *Māori* - *Pacific* - *Asian*	C	[7]	95%
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8 - *Māori* - *Pacific* - *Asian*	Q	0.61 *0.85* *0.79* *0.63*	<0.56

[10] Services delivered by Auckland Regional Public Health Service (ARPHS) on behalf of the three Metro Auckland DHBs. Results are for all three DHBs.
[11] As at Q4 2018/19
[12] All oral health measures normally use calendar years as baseline.

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
% of children caries free at five years of age - *Māori* - *Pacific* - *Asian*	Q	58% *49%* *38%* *47%*	65%
Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years	C	[7]	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 2018/19	Target 2020/21
Acute services			
Number of ED attendances	V	131,625	Ω
% of ED patients discharged, admitted or transferred within six hours of arrival	T	94%	95%
Rate of alcohol-related ED admissions for 15-24 year olds	Q	New measure	n/a[13]
% 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	88%	90%
% of potentially eligible stroke patients thrombolysed	C	8%	12%
% of ACS inpatients receiving coronary angiography within 3 days	T	71%	70%
Maternity			
Number of births in Waitematā DHB hospitals	V	6,722	Ω
% of babies exclusively breastfed on discharge	Q	77.5%	>75%
Elective (inpatient/outpatient)			
% of people receiving urgent diagnostic colonoscopy in 14 days	T	98%	90%
% of people receiving non-urgent diagnostic colonoscopy in 42 days	T	53%	70%
% of patients waiting longer than 4 months for their first specialist assessment	T	4.5%	0%
% of accepted referrals receiving their CT scan within 6 weeks	T	70%	95%
% of accepted referrals receiving their MRI scan within 6 weeks	T	76%	90%
Quality and patient safety			
% of opportunities for hand hygiene taken	Q	89%	80%
Rate of healthcare-associated Staphylococcus bacteraemia per 1,000 inpatient bed days	Q	0.05[14]	<0.13[15]
% 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	12.5	<9.7[16]
% of hip and knee arthroplasties operations where antibiotic is given in one hour before incision	Q	97%	100%
% of hip and knee procedures given right antibiotic in right dose	Q	98%	95%

[13] Will require 2020/21 baseline data before establishing target
[14] 11 months to May-19
[15] National median May-17 to Dec-19
[16] National median Sep-14 to Dec-19

Outputs measured by	Notes	Baseline 2018/19	Target 2020/21
Quality and patient safety			
Surgical site infections per 100 hip and knee operations	Q	0.46	<0.97[17]
Friends and Family Test Net Promoter Score[18]	Q	74[19]	>65
Mental Health			
% of population who access Mental Health services[20]	C	[7]	
- Age 0–19 years			≥3.82%
- *Māori*			*≥5.25%*
- Age 20–64 years			≥3.77%
- *Māori*			*≥9.40%*
- Age 65+ years			≥2.14%
- *Māori*			*≥2.23%*
% of 0-19 year old clients seen within 3 weeks	T		
- Mental Health		70%	80%
- Addictions		93%	80%
% of 0-19 year old clients seen within 8 weeks			
- Mental Health		93%	95%
- Addictions		99%	95%

Output class 4: Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination provided by the Needs Assessment and Service Coordination (NASC) Service for a range of services, including palliative care, 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 2018/19	Target 2020/21
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%[21]	95%
Palliative care			
Hospice			
Total number of contacts in the community	V	21,010	Ω
Proportion of patients acutely referred who waited >48 hours for a hospice bed	T	21%	<5%
Hospital			
Total number of referrals	V	1,158	Ω
Average time to first contact with referrer	T	4.4	≤6 h
Average time from referral to first face-to-face patient assessment	T	8.55	≤24 h
Residential care			
ARC bed days	V	974,841	Ω

[17] Sep 2015 to Sep-19 national median.
[18] The proportion of responses that are promoters and the proportion that are detractors are calculated and the proportion of detractors is then subtracted from the proportion of promoters to provide an overall 'net promoter' score. Those that say they are 'extremely likely' are counted as promoters. 'Likely' is neutral, 'neither unlikely nor likely', 'unlikely' and 'extremely unlikely' are all counted as detractors
[19] Q4 2018/19
[20] Target set using latest data available (March 2019 – February 2020 activity, 2018 population projections) , but note this will be subject to change once new population projection information is released
[21] Q4 2018/19

APPENDIX C: FINANCIAL PERFORMANCE

In the 2019/20 financial year, Waitematā DHB's operating result, before one-off adjustments for Holiday Pay and COVID-19 impacts is forecast to be breakeven.

This operating result is however impacted by COVID-19 in the final quarter estimated to be $14.6m at 30 June 2020, as well as the delayed sale of assets of $10.1m deferred until 2020/21 and further provisions required in relation to the Holidays Act; this being $23m for the 2019/20 year and a further $18.8m in relation to a prior year; total $68.2m deficit.

Within each arm of the DHB (principally Funder and Provider), different financial results are expected to be achieved, providing a partial offset. The Provider is forecasting a deficit against budget of $89.9m, offset by surpluses in the Funder and Governance Divisions totalling $21.7m. 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 but this is expected to realign with the recent announcement of an uplift in the national price model allocated to outputs. 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 Bed Facility that will see additional theatre, inpatient wards and endoscopy capacity on the North Shore Campus.

For the 2020/21 financial year, the DHB is forecasting a $36m deficit in the Provider and breakeven in the Funder.

For 2020/21 there has been no provision for Holiday Pay or additional COVID-19 costs.

The Provider result assumes that a $16m savings plan will be achieved. The budgeted result in the Funder also contains risk with regards to IDF payments, NGO demand-driven expenditure, Pay Equity and In Between Travel.

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, which is chaired by the Director of Hospital Services. The Executive Leadership Team receives a regular report on progress against the plan.

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:

- A reduction in Waitematā DHB's estimated population has led to a reduction in the share of population based funding received, which in turn has led to a reduction in the anticipated revenue growth for 2020/21. Therefore, despite the Vote Health uplift being significantly greater for the sector, Waitematā DHB received the same dollar uplift in 2020/21 as it did for 2019/20.
- Increased personnel costs for Care Capacity Demand Management (CCDM)
- Continuing clinical wage settlement and contractual increases
- Reliance in the past on one-off windfalls or non-repeatable benefits, and surpluses generated within the Funder
- High population growth, particularly in the 65+ age group, is 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
- Increases in National Price from the NCCP review increased IDF net outflows by $24m in the 2020/21 financial year and is anticipated to repeat in 2021/22.

Key assumptions for financial projections

Revenue Growth

Revenue has been based on the Ministry of Health advice received in May 2020.

For the out-years, we have assumed that the national funding uplift for Vote Health will remain at $990m each year and Waitematā DHB will receive its PBFF share of this uplift. Other revenue is based on contractual arrangements in place and reasonable and risk assessed estimates for other income.

Expenditure Growth

Expenditure growth of $63.7m above 2019/20 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 also include the below.

- The impact of Care Capacity Demand Management (CCDM) has added 122 FTEs in 2020/21 (pro-rated as a phased uplift is planned)
- 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 were incorporated into the plan in 2019/20.
- There has been no provision in 2020/21 or outer years for Holidays Act or additional COVID-19 costs.

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.

These forecasts do not include any further provisions for uplifting Holiday Pay because of uncertainty regarding value. An estimate of the unbudgeted cost is $24m per annum.

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 healthSource 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. Waitematā DHB's interest in South Kaipara Medical Centre Limited is in the process of being sold.

The tables below provide a summary of the financial statements for the audited result for 2018/19, year-end forecast for 2019/20, planned results for 2020/21 and out years 2021/22 to 2023/24. 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	1,717,601	1,814,598	1,885,756	1,997,232	2,108,904	2,220,084
Patient Sourced and Other Income	28,679	23,346	41,885	35,560	31,090	29,876
IDFs and Inter DHB Provider Income	91,777	93,878	100,119	102,121	104,220	106,272
Total Funding	**1,838,057**	**1,931,822**	**2,027,760**	**2,134,913**	**2,244,214**	**2,356,232**
Personnel Costs	801,802	789,356	782,330	801,178	814,582	831,286
Outsourced Costs	86,208	92,460	90,862	93,055	94,637	97,566
Clinical Supplies Costs	127,420	128,614	138,626	140,584	142,276	145,264
Infrastructure and Non-Clinical supplies Costs	119,390	109,061	90,906	91,635	89,753	109,552
Payments to Other Providers	831,832	880,529	961,036	1,033,461	1,102,966	1,172,564
Total Expenditure	**1,966,652**	**2,000,020**	**2,063,760**	**2,159,913**	**2,244,214**	**2,356,232**
Net Surplus/(Deficit)	**(128,595)**	**(68,198)**	**(36,000)**	**(25,000)**	**0**	**0**
Other Comprehensive Income	0					
Gains/(Losses) on Property Revaluations	0	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**(128,595)**	**(68,198)**	**(36,000)**	**(25,000)**	**0**	**0**

Historically, we have performed well financially, with surpluses generated in the past five of seven years. Continued focus on financial sustainability contributes 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. Remediation of the Holiday Pay situation will potentially increase the DHB's operating costs by $24m per annum, excluding any other similar increase incurred by our NGO providers.

Forecast Statement of comprehensive income – group

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Government and Crown Agency Revenue	1,717,601	1,814,598	1,885,756	1,997,232	2,108,904	2,220,084
Patient Sourced and Other Income	30,125	23,346	41,885	35,560	31,090	29,876
IDFs and Inter DHB Provider Income	91,777	93,878	100,119	102,121	104,220	106,272
Total Funding	**1,839,503**	**1,931,822**	**2,027,760**	**2,134,913**	**2,244,214**	**2,356,232**
Personnel Costs	801,802	789,356	782,330	801,178	814,582	831,286
Outsourced Costs	85,348	92,460	90,862	93,055	94,637	97,566
Clinical Supplies Costs	127,420	128,614	138,626	140,584	142,276	145,264
Infrastructure and Non-Clinical supplies Costs	119,390	109,061	90,906	91,635	89,753	109,552
Payments to Other Providers	831,832	880,529	961,036	1,033,461	1,102,966	1,172,564
Total Expenditure	**1,965,792**	**2,000,020**	**2,063,760**	**2,159,913**	**2,244,214**	**2,356,232**
Net Surplus/(Deficit)	**(126,289)**	**(68,198)**	**(36,000)**	**(25,000)**	**0**	**0**
Other Comprehensive Income	0					
Gains/(Losses) on Property Revaluations	0	0	0	0	0	0
TOTAL COMPREHENSIVE INCOME	**(126,289)**	**(68,198)**	**(36,000)**	**(25,000)**	**0**	**0**

Forecast Statement of comprehensive income – governance & funding administration

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Revenue	15,816	16,561	16,862	17,198	17,534	17,882
Expenditure						
Personnel	10,822	12,226	14,746	14,986	15,238	15,490
Outsourced services	7,949	8,178	9,125	9,293	9,461	9,640
Clinical supplies	0	7	4	4	4	4
Infrastructure & non clinical supplies	(5,396)	(6,237)	(7,813)	(7,885)	(7,957)	(8,041)
Total Expenditure	**13,375**	**14,174**	**16,062**	**16,398**	**16,746**	**17,093**
Surplus/(Deficit)	**2,441**	**2,387**	**800**	**800**	**788**	**789**

Forecast Statement of comprehensive income – provider

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Income						
MoH via Funder	881,467	930,030	943,975	982,980	1,024,980	1,066,980
MoH Direct	25,177	42,766	43,149	44,436	45,768	46,632
Other	49,182	42,656	62,738	56,836	52,966	52,172
Total Income	**955,826**	**1,015,452**	**1,049,862**	**1,084,252**	**1,123,714**	**1,165,784**
Expenditure						
Personnel	790,980	777,130	766,989	786,192	799,344	815,796
Outsourced services	77,399	84,282	81,313	83,760	85,176	87,924
Clinical supplies	127,420	128,607	139,064	140,580	142,272	145,260
Infrastructure & non clinical supplies	124,786	115,298	99,296	99,520	97,710	117,593
Total expenditure	**1,120,585**	**1,105,317**	**1,086,662**	**1,110,052**	**1,124,502**	**1,166,573**
Surplus / (Deficit)	**(164,759)**	**(89,865)**	**(36,800)**	**(25,800)**	**(788)**	**(789)**

Forecast Statement of comprehensive income – funder

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Income						
Revenue	1,763,967	1,846,061	1,921,813	2,033,581	2,145,420	2,257,368
Expenditure						
Personal Health	1,248,423	1,315,705	1,384,533	1,466,925	1,547,984	1,629,860
Mental Health	232,310	241,848	261,227	272,868	284,976	296,916
DSS	221,073	226,069	248,317	265,214	283,070	300,434
Public Health	8,190	23,301	7,196	7,524	7,836	8,124
Māori Health	3,303	3,636	3,738	3,912	4,080	4,212
Governance	14,639	16,222	16,802	17,138	17,474	17,822
Total Expenditure	**1,727,938**	**1,826,781**	**1,921,813**	**2,033,581**	**2,145,420**	**2,257,368**
Surplus/(Deficit)	**36,029**	**19,280**	**0**	**0**	**0**	**0**

Forecast capital costs

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Depreciation	31,870	28,927	30,999	30,996	30,996	30,996
Capital Charge	36,415	29,315	26,177	24,012	21,984	21,984
Capital Costs	**68,285**	**58,242**	**57,176**	**55,008**	**52,980**	**52,980**

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

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,803,450	1,912,292	1,985,875	2,099,353	2,213,124	2,326,356
Other Income	30,854	17,275	25,262	34,924	30,430	29,876
Interest received	2,267	1,596	623	636	660	0
Payments for Personnel	(677,605)	(722,580)	(782,330)	(801,178)	(814,582)	(831,286)
Payments for Supplies	(1,088,103)	(1,136,724)	(1,224,254)	(1,301,183)	(1,373,580)	(1,468,894)
Capital Charge Paid	(36,415)	(28,834)	(26,177)	(24,017)	(21,982)	(21,982)
GST Input Tax	(159)	417	0	0	0	0
Net cashflow from operating activities	**34,289**	**43,442**	**(21,001)**	**8,535**	**34,070**	**34,070**
Cashflow from investing activities						
Sale of Fixed Assets	0	0	38,729	0	0	0
Capital Expenditure (-ve)	(28,069)	(46,837)	(114,861)	(158,522)	(143,122)	(73,600)
Acquisition of investments	(813)	(7,144)	0	0	0	0
Net cashflow from investing activities	**(28,882)**	**(53,981)**	**(76,132)**	**(158,522)**	**(143,122)**	**(73,600)**
Cashflow from financing activities						
Capital contributions from the Crown	2,200	26,050	56,563	123,643	113,123	41,103
Net cashflow from financing activities	**2,200**	**26,050**	**56,563**	**123,643**	**113,123**	**41,103**
Net cash movements	**7,607**	**15,511**	**(40,570)**	**(26,344)**	**4,071**	**1,573**
Cash and cash equivalents at the start of the year	29,078	36,685	52,196	11,626	(14,718)	(10,647)
Cash and cash equivalents at the end of the year	**36,685**	**52,196**	**11,626**	**(14,718)**	**(10,647)**	**(9,074)**

Forecast statement of cashflows – group

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Cashflow from operating activities						
MoH and other Government / Crown	1,802,760	1,912,292	1,985,875	2,099,353	2,213,124	2,326,356
Other Income	31,765	17,275	25,262	34,924	30,430	29,876
Interest received	2,267	1,596	623	636	660	0
Payments for Personnel	(677,605)	(722,580)	(782,330)	(801,178)	(814,582)	(831,286)
Payments for Supplies	(1,086,940)	(1,136,724)	(1,224,254)	(1,301,183)	(1,373,580)	(1,468,894)
Capital Charge Paid	(36,415)	(28,834)	(26,177)	(24,017)	(21,982)	(21,982)
GST Input Tax	(159)	417	0	0	0	0
Net cashflow from operating activities	**35,673**	**43,442**	**(21,001)**	**8,535**	**34,070**	**34,070**
Cashflow from investing activities						
Sale of Fixed Assets	**0**	0	38,729	0	0	0
Capital Expenditure (-ve)	**(28,069)**	(46,837)	(114,861)	(158,522)	(143,122)	(73,600)
Acquisition of investments	(1,286)	(7,144)	0	0	0	0
Net cashflow from investing activities	**(29,355)**	**(53,981)**	**(76,132)**	**(158,522)**	**(143,122)**	**(73,600)**
Cashflow from financing activities						
Capital contributions from the Crown	**2,200**	26,050	56,563	123,643	113,123	41,103
Net cashflow from financing activities	**2,200**	**26,050**	**56,563**	**123,643**	**113,123**	**41,103**
Net cash movements	**8,518**	**15,511**	**(40,570)**	**(26,344)**	**4,071**	**1,573**
Cash and cash equivalents at the start of the year	32,535	41,053	56,564	15,994	(10,350)	(6,279)
Cash and cash equivalents at the end of the year	**41,053**	**56,564**	**15,994**	**(10,350)**	**(6,279)**	**(4,706)**

Forecast statement of financial position – parent

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Current Assets	123,157	139,036	75,231	50,262	56,031	59,331
Non-current assets	769,120	797,244	880,539	1,009,225	1,121,499	1,164,362
Total assets	**892,277**	**936,280**	**955,770**	**1,059,487**	**1,177,530**	**1,223,693**
Current Liabilities	364,743	447,947	444,049	447,558	451,078	454,538
Non-current liabilities	41,266	45,210	48,035	49,600	51,000	52,600
Total liabilities	**406,009**	**493,157**	**492,084**	**497,158**	**502,078**	**507,138**
Net assets	**486,268**	**443,123**	**463,686**	**562,329**	**675,452**	**716,555**
Total equity	**486,268**	**443,123**	**463,686**	**562,329**	**675,452**	**716,555**

Forecast statement of financial position – group

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Current Assets	128,946	146,939	83,134	58,165	63,934	67,234
Non-current assets	779,834	808,267	891,562	1,020,248	1,132,522	1,175,385
Total assets	**908,780**	**955,206**	**974,696**	**1,078,413**	**1,196,456**	**1,242,619**
Current Liabilities	365,217	449,847	445,949	449,458	452,978	456,438
Non-current liabilities	41,266	45,210	48,035	49,600	51,000	52,600
Total liabilities	**406,483**	**495,057**	**493,984**	**499,058**	**503,978**	**509,038**
Net assets	**502,297**	**460,149**	**480,712**	**579,355**	**692,478**	**733,581**
Total equity	**502,297**	**460,149**	**480,712**	**579,355**	**692,478**	**733,581**

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

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Balance at 1 July	**613,126**	**486,268**	**444,120**	**464,683**	**563,326**	**676,449**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	(128,595)	(68,198)	(36,000)	(25,000)	0	0
Other Comprehensive income	(463)	0	0	0	0	0
Total Comprehensive Income	**(129,058)**	(68,198)	**(36,000)**	**(25,000)**	**0**	**0**
Owner transactions						
Capital contributions from the Crown	2,200	26,050	56,563	123,643	113,123	41,103
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	**486,268**	**444,120**	**464,683**	**563,326**	**676,449**	**717,552**

Statement of movement in equity – group

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Balance at 1 July	**626,849**	**502,297**	**460,149**	**480,712**	**579,355**	**692,478**
Comprehensive Income/(Expense)						
Surplus / (deficit) for the year	(126,289)	(68,198)	(36,000)	(25,000)	0	0
Other Comprehensive income	(463)	0	0	0	0	0
Total Comprehensive Income	**(126,752)**	**(68,198)**	**(36,000)**	(25,000)	**0**	**0**
Owner transactions						
Capital contributions from the Crown	2,200	26,050	56,563	123,643	113,123	41,103
Repayments of capital to the Crown	0	0	0	0	0	0
Balance at 30 June	**502,297**	**460,149**	**480,712**	**579,355**	**692,478**	**733,581**

Additional information

Capital expenditure

	2018/19 Audited $000	2019/20 Forecast $000	2020/21 Plan $000	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000
Funding Sources						
Free cashflow from depreciation	31,870	28,927	30,999	30,996	30,996	30,996
External Funding	2,200	26,050	56,563	123,643	113,123	41,103
Inflow from sale of fixed asset	0	0	22,729	0	0	0
Cash reserves	34,289	43,442	(5,001)	(2,948)	30,998	30,998
Total Funding	**68,359**	**98,419**	**105,290**	**151,691**	**175,117**	**103,097**
Baseline Capital Expenditure						
Land	0	0	0	0	0	0
Buildings and Plant	(14,815)	(14,987)	(16,025)	(16,025)	(16,025)	(16,025)
Clinical Equipment	(5,306)	(6,561)	(5,735)	(5,735)	(5,735)	(5,735)
Other Equipment	(2,360)	(1,181)	(2,555)	(2,555)	(2,555)	(2,555)
Information Technology	(3,800)	5,627	(4,115)	(4,115)	(4,115)	(4,115)
Intangible Assets (Software)	0	0	0	0	0	0
Motor Vehicles	(1,449)	(923)	(1,570)	(1,570)	(1,570)	(1,570)
Total Baseline Capital Expenditure	**(27,730)**	**(18,025)**	**(30,000)**	**(30,000)**	**(30,000)**	**(30,000)**
Strategic Investments						
Land	0	(16,373)	0	0	0	0
Buildings and Plant	(339)	(12,439)	(84,861)	(128,522)	(113,122)	(43,600)
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	**(339)**	**(28,812)**	**(84,861)**	**(128,522)**	**(113,122)**	**(43,600)**
Total Capital Payments	**(28,069)**	**(46,837)**	**(114,861)**	**(158,522)**	**(143,122)**	**(73,600)**

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 2020

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 2020 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 arrangements are incorporated and domiciled in New Zealand. The DHB has reported in note 30 on the patient trust monies which it administers. The financial statements for the DHB and the Group are for the year ended 30 June 2020, and were approved for issue by the Board on 31 October 2020.

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 were 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 9IPSAS 34 Separate Financial Statements, PBE IPSAS 35 Consolidated Financial Statements, PBE IPSAS 36 Investments in Associates and Joint Ventures, PBE IPSAS 37 Joint Arrangements, PBE IPSAS 38 Disclosure of Interests in Other Entities and PBE IPSAS 39 Employee Benefits for the first time. The nature and effect of the changes as a result of adoption of the new accounting standards are described below. Aside from the standards applied above, the Group has not early adopted any standards, interpretations or amendments that have been issued but are not yet effective.

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. The DHB and Group have not applied these standards retrospectively.

The main changes under PBE IPSAS 34-38 that are relevant to the DHB and Group are:

(a) Control: The new standards introduce an amended definition of control including extensive guidance on this definition.

(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.

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

The effects of the implementation of PBE IPSAS 34-38 are as follows:

(a) Control: The DHB has assessed the new definition of control and adoption of new standards did not result in the consolidation of additional entities.

(b) Joint arrangements: The DHB has reassessed existing Joint arrangements and decided to classify an arrangement with Awhina Waitakere Health Campus as Joint Operations. Joint operators recognise their assets, liabilities, revenue and expenses in relation to their interest in the joint operation. Refer to Note 12 for further details.

(c) Additional disclosures for the Group and DHB regarding controlled on interests in other entities, associates and are summarised as:

- Significant judgements, assumptions and the methodology used to determine that the reporting entity has control of another entity, that the reporting entity has joint control of an arrangement. Waitematā DHB is not early adopting these standards or significant influence over another entity; and the type of joint arrangement;
- Additional financial information for joint ventures;
- The nature and extent of significant restrictions on its ability to access or use assets, and settle liabilities.

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 main changes under PBE IPSAS 39 that are relevant to the DHB and Group are:

- The new standard removes the option to defer the recognition of certain actuarial gains and losses arising from defined benefit plans (the 'corridor approach');
- It eliminates some of the presentation options for actuarial gains and losses arising from defined benefit plans;
- It 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 effects of the implementation of PBE IPSAS 39 are as follows: The DHB's current treatment of 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 under PBE IPSAS 39. Refer to Note 1 Statement of Accounting Policies Superannuation Schemes.

Standards issued and not yet effective, and not early adopted

Amendment to PBE IPSAS 2 Statement of Cash Flows

An amendment to PBE IPSAS 2 Statement of Cash Flows requires entities to provide disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities, including both changes arising from cash flows and non-cash changes. This amendment is effective for annual periods beginning on or after 1 January 2021, with early application permitted. Waitematā DHB does not intend to early adopt the amendment.

PBE FRS 48 Service Performance Reporting

PBE FRS 48 replaces the service performance reporting requirements of PBE IPSAS 1 and is effective for reporting periods beginning on or after 1 January 2021. Waitematā DHB has not yet determined how application of PBE FRS 48 will affect its statement of performance.

PBE IPSAS 41 Financial Instruments

The XRB issued PBE IPSAS 41 Financial Instruments in March 2019. This standard supersedes PBE IFRS 9 Financial Instruments, which was issued as an interim standard. It is effective for reporting periods beginning on or after 1 January 2022. Although Waitematā DHB has not assessed the effect of the new standard, it does not expect any significant changes as the requirements are similar to PBE IFRS 9.

Subsidiaries

Subsidiaries are entities controlled by Waitematā DHB that are exposed, or have rights to variable benefits from its involvement with the other entity and has the ability to affect the nature or amount of those benefits through its power over the other entitiy. 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 arrangements

Investments in joint arrangements are classified as either joint ventures or joint operations. The classification depends on the contractual rights and obligations of each investor.

Joint Venture

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint control is the agreed sharing of control of an arrangement by way of a binding arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control. 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.

Joint Operation

A joint operation is a joint arrangement whereby the parties that have joint control of the arrangement recognise their direct right to the assets, liabilities, revenues and expenses of joint operations and their share of any jointly held or incurred assets, liabilities, revenues and expenses. These have been incorporated in the financial statements under the appropriate headings.

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 arrangement. The investment in an associate is recognised at cost of the investment plus the DHB's share of the change in the net assets of associates on an equity accounted basis, from the date that the power to exert significant influence commences until the date that the power to exert significant influence ceases. When The DHB's share of losses exceeds its interest in an associate, The DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that The DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

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 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 were 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 transaction outcome can be estimated reliably. Revenue from these services is recognised in proportion to the completion stage 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.

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.

Financial Instruments – Initial recognition and subsequent measurement

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Financial Assets

Initial recognition

Financial assets are classified, at initial recognition, as 'measured at amortised cost', 'fair value through other comprehensive revenue and expense' and 'fair value through surplus or deficit'. See discussion below for determination of classification. A financial asset is initially measured at its fair value plus, in the case of a financial asset not at fair value through surplus or deficit, transaction costs that are directly attributable to the acquisition or issue of the financial asset or financial liability.

Subsequent measurement

Financial assets at amortised cost

This category is the most relevant to the DHB and Group. The classification of financial assets at amortised cost at initial recognition depends on the financial asset's contractual cash flow characteristics and the business model for managing them. In order for a financial asset to be classified and measured at amortised cost, it needs to give rise to cash flows that are 'solely payments of principal and interest' on the principal amount outstanding (SPPI). This assessment is referred to as the SPPI test and is performed at an instrument level. The business model for managing financial assets refers to how it manages its financial assets in order to generate cash flows. The business model determines whether cash flows will result from collecting contractual cash flows, selling the financial assets, or both.

Financial assets at amortised cost are subsequently measured using the effective interest rate (EIR) method and are subject to impairment. Gains and losses are recognised in surplus or deficit when the asset is derecognised, modified or impaired. The DHB and Group measure the following financial assets at amortised cost, Cash and cash equivalents, Short Term Deposits, Trade and Other Receivables, Prepayments and Trusts and Special Purpose Funds not recognised at a market value. 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 3 months or less.

Financial assets at fair value through surplus or deficit

Financial assets at fair value through surplus or deficit include financial assets held for trading, financial assets designated upon initial recognition at fair value through surplus or deficit, or financial assets mandatorily required to be measured at fair value. Financial assets are classified as held for trading if they are acquired for the purpose of selling or repurchasing in the near term. Financial assets with cash flows that are not solely payments of principal and interest are classified and measured at fair value through surplus or deficit, irrespective of the business model. Notwithstanding the criteria for debt instruments to be classified at amortised cost or at fair value through other comprehensive revenue and expense, as described above, debt instruments may be designated at fair value through surplus or deficit on initial recognition if doing so eliminates, or significantly reduces, an accounting mismatch.

Financial assets at fair value through surplus or deficit are carried in the statement of financial position at fair value with net changes in fair value recognised in the statement of surplus or deficit. The DHB and Group has the following financial assets classified at fair value though surplus or deficit, Investments in associates and portfolio investments.

Financial assets at fair value through other comprehensive revenue and expense

Financial assets at fair value through other comprehensive revenue and expenses comprise of those equity instruments that the DHB and Group has elected to classify as fair value through other comprehensive income on initial recognition when they meet the definition of equity instruments. Gains and losses on these financial assets are never recycled to surplus or deficit. Dividends are recognised in surplus or deficit when the right to receive payment has been established. The Group does not hold any financial assets classified at fair value through other comprehensive revenue and expense.

Derecognition

A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is primarily derecognised (i.e., removed from the Group's consolidated statement of financial position) when the rights to receive cash flows from the asset have expired.

Impairment of financial assets

The DHB recognises an allowance for expected credit losses (ECLs) for all debt instruments not held at fair value through surplus or deficit. ECLs are based on the difference between the contractual cash flows due in accordance with the contract and all the cash flows that the DHB and Group expects to receive, discounted at an approximation of the original effective interest rate. ECLs are recognised in two stages. For credit exposures for which there has not been a significant increase in credit risk since initial recognition, ECLs are provided for credit losses that result from default events that are possible within the next 12-months (a 12-month ECL). For those credit exposures for which there has

been a significant increase in credit risk since initial recognition, a loss allowance is required for credit losses expected over the remaining life of the exposure, irrespective of the timing of the default (a lifetime ECL).

For trade and other receivables, the DHB and Group applies a simplified approach in calculating ECLs. Therefore, credit risk is not tracked, but instead the DHB and Group recognises a loss allowance based on lifetime ECLs at each reporting date. The DHB and Group has established a provision matrix that is based on its historical credit loss experience, adjusted for forward-looking factors specific to the debtors and the economic environment. The DHB and Group considers a financial asset in default when contractual payments are 90 days past due. However, in certain cases, the DHB and Group may also consider a financial asset to be in default when internal or external information indicates that the DHB and Group is unlikely to receive the outstanding contractual amounts in full before taking into account any credit enhancements held. A financial asset is written off when there is no reasonable expectation of recovering the contractual cash flows.

Financial liabilities at amortised cost

Initial recognition and measurement

Financial liabilities are classified, at initial recognition, as financial liabilities at fair value through surplus or deficit, or at amortised costs, as appropriate. All financial liabilities are recognised initially at fair value and, in the case financial liabilities at amortised cost, net of directly attributable transaction costs. The DHB's and Group's financial liabilities include trade creditors and other payables, borrowings including an overdraft facility which are classified at amortised cost. The DHB has not classified any financial liabilities as financial liabilities through surplus or deficit. 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.

Subsequent measurement

The measurement of financial liabilities depends on their classification, as described below. This is the category most relevant to the DHB. After initial recognition, financial liabilities at amortised cost are subsequently measured at amortised cost using the effective interest rate (EIR) method. Gains and losses are recognised in surplus or deficit when the liabilities are derecognised as well as through the EIR amortisation process. Amortised cost is calculated by taking into account any discount or premium on acquisition and fees or costs that are an integral part of the EIR. The EIR amortisation is included as finance costs in the statement of surplus or deficit. Short-term payables are recorded at their face value due to the short-term nature of them they are not discounted. A financial liability is derecognised when the obligation under the liability is discharged or cancelled or expires.

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:

- 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:

- 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.

Finance, Procurement and Information Management System (formerly National Oracle Solution)

The Finance, Procurement and Information Management System (FPIM), (previously part of the National Oracle Solution 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 FPIM. This investment represents the right to access the FPIM 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.

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
- the likelihood that staff will reach the point of entitlement and contractual entitlement information; and
- the present value of the estimated future cash flows.

Presentation of employee entitlements

Sick Leave, continuing medical education, 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.

Make Good Lease Provision

A make good lease provision is made where operating leases contain clauses which specify that the Group should incur periodic charges for maintenance, make good dilapidations or other damage occurring during the rental period or requires the Group to return the asset to the configuration that existed at inception of the lease. The provision reflects the estimate of only the conditions as at the reporting date. The outflow of the provision would be expected at cessation of each lease. Assumptions were made around the term of the period of the lease based on the contractual term and expectations around exercising rights of renewal, which is subject to uncertainty. Further assumptions are made around the expected cost of meeting these lease obligations and estimating the present value of the provision, which also come with inherent uncertainty.

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 future cash flows.

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
- trust funds.

Contributions from/(repayment to) the Crown

The DHB Crown approved projects funding.

Property Revaluation reserve

The revaluation reserve movement relates to the independent valuation of land and buildings carried out by Telfer Young (Auckland) Ltd.

Trust /special funds

Trust/special funds are funds donated or bequeathed for a specific purpose. The use of these assets must comply with the specific terms of the sources from which the funds were derived. The revenue and expenditure in respect of these funds is included in the surplus or deficit. An amount equal to the expenditure is transferred from the Trust fund component of equity to retained earnings. An amount equal to the revenue is transferred from retained earnings to trust funds. All trust funds are held in bank accounts that are separate from the DHB's normal banking facilities. Refer to Note 29 for details.

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 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 (SPE) as approved by the Board at the beginning of the financial year to ensure we report against original approved budget. The budget figures were prepared in accordance with NZ GAAP, using accounting policies consistent with those adopted by the Board in preparing these financial statements. The format of the budget is different to that shown in the Financial Statements. The amounts that are disclosed are the same, however what has been presented has been reformatted to the purpose of 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 were 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 13 provides information on 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 13.

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

Holiday Pay Provision

Refer to Note 17 for details on the exposure in relation to the estimates and uncertainties surrounding holiday provisions.

Provision for expected credit losses

The Group uses a provision matrix to calculate ECLs for trade and other receivables and contract assets. The provision rates are based on days past due. The ECL calculation is initially based on the Group's historical observed default rates. The Group will adjust the historical credit loss experience with forward-looking information. For instance, if forecast economic conditions are expected to deteriorate over the next year, the historical default rates are adjusted. At every reporting date, the historical observed default rates are updated and changes in the forward-looking estimates are analysed. The assessment of the correlation between historical observed default rates, forecast economic conditions and ECLs is a significant estimate. The amount of ECLs is sensitive to changes in circumstances and of forecast economic conditions. The Group's historical credit loss experience and forecast of economic conditions may also not be representative of customer's actual default in the future. The information about the ECLs on the Group's trade receivables and contract assets is disclosed in Note 8.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Leases classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB. Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised. The DHB has exercised its judgement on the appropriate classification of leases, and has determined a number of lease arrangements are finance leases.

Agency relationship

Determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sales of goods or the rendering of services. The judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.

The DHB entered into a contract for services with providers for laboratory services. Services are provided across several DHB districts. The contracting DHB makes payment to the provider on behalf of all the DHBs receiving the services, and the recipient DHB will then reimburse the contracting DHB for the cost of the services provided in its district. There is a Memorandum of Understanding that sets out the relationships and obligations between each of the DHBs. Based on the nature of the relationship between the contracting DHB and the recipient DHBs, the contracting DHB has assumed it has acted as agent on behalf of the recipient DHBs. Therefore, the payments and receipts in relation to the other DHBs are not recognised in the contracting DHB's financial statements.

APPENDIX D: 2020/21 SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

System Level Measures Improvement Plan

Auckland, Waitemata &
Counties Manukau Health Alliances

2020
2021

FINANCIAL YEAR

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

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

– Sir James Henare

Photo Credit (cover): John Hettig Westone Productions

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EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (the Alliances) have jointly developed a 2020/21 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 further consolidation of the 2018/19 plan. The COVID-19 pandemic has had a significant impact on the delivery of the SLM programme. Primary care capacity to engage with a broad plan has been reduced. The 2020/21 plan has been through a prioritisation process to focus on post-pandemic priorities. Some activities have been removed from the current plan and will be reintroduced in subsequent plans.

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. Activities have been included where they can be expected to contribute to milestone measures over a three year time frame. 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 a three year timeframe, 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.

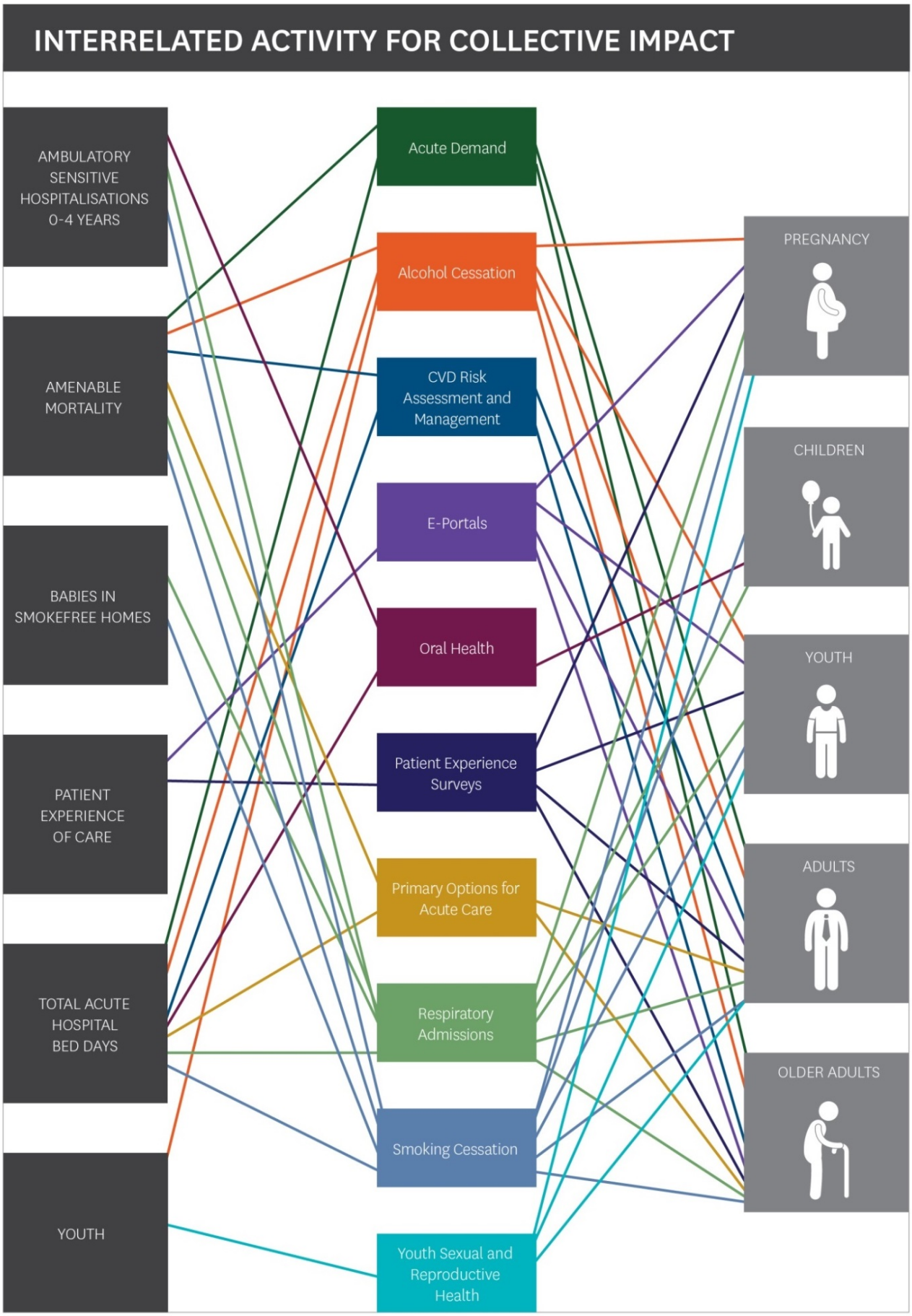
The primary health organisations (PHOs) included in this improvement plan are:

- Alliance Health Plus Trust;
- Auckland PHO;
- East Health Trust;
- National Hauora Coalition;
- ProCare Health (PHO) Limited;
- 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.

INTERRELATED ACTIVITY FOR COLLECTIVE IMPACT



PURPOSE

This document outlines how the 2020/21 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.

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 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.

Each SLM has an improvement milestone to be achieved in 2020/21. 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. A brief description of activities to be undertaken by all alliancing partners (primary, secondary and community) to achieve the SLM milestones. 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. 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 2020/21, SLMs continue to be business-as-usual. There is a focus on risk factors for respiratory infections including smoking, vaccination for influenza and pertussis. There is also priority given to effective use of Primary options for Acute Care (POAC) to prevent unnecessary use of hospitals and greater use of primary care patient portals to improve efficiency of contactless primary care where appropriate. 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 Groups stopped meeting during the pandemic but will again meet regularly during 2020/21 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.

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 was 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 2020/21 plan is a consolidation of the 2018/19 plan and therefore continues with a strong focus on equity.

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.

2020/21 Priorities for System Level Measures

The 2020/21 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. The COVID-19 pandemic put the health system, particularly primary care, under pressure. This year's plan was influenced by this event and has a focus on preventing respiratory illness by concentrating on smoking cessation and vaccination for respiratory conditions, and referral to healthy housing. Other priorities include effective use of POAC and greater use of patient portals to improve efficiency of delivery of care. Management of cardiovascular risk factors for both primary and secondary prevention is also a priority.

The plan was developed using a medium term approach. It includes immediate activity that will contribute to goals to be achieved within 3 years. This year, we continue to support the essential work that is the foundation for quality improvement activities, including enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes. Overarching priorities for 2020/21 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 population,s 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.

ENABLERS TO CAPACITY AND CAPABILITY

SYSTEM LEVEL MEASURES 2020/21 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 2021. 3% reduction for Māori populations by 30 June 2021. 3% reduction for Pacific populations by 30 June 2021.
Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	3% reduction for Māori populations by 30 June 2021. 3% reduction for Pacific populations by 30 June 2021.
Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	Hospital inpatient survey: 5% relative improvement on Inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with in a way you could understand?' by 30 June 2021. Primary care survey: 5% relative improvement on PES question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?' by 30 June 2021.
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 2021. * Five year target set in 2016 to be achieved by 30 June 2021
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
Improvement milestone	Increase coverage of chlamydia testing for males to 6% by 30 June 2021.
Babies in Smokefree Homes	
System level outcome	Healthy start
Improvement milestone	2% relative increase in the proportion of babies living in smoke free homes by 30 June 2021.

IMPROVEMENT ACTIVITIES AND CONTRIBUTORY MEASURES

The following section outlines the specific improvement activity plan and contributory measures for the six SLMs for 2020/21. Improvement activities create change, improvement in contributory measures and contribute to improved outcomes in the various SLM milestones. For 2020/21, Auckland Metro region are focused on choosing activities which relate to multiple milestones where possible for best collective impact.

Ambulatory Sensitive Admissions in 0-4 year olds	
Activities	**Contributory Measures**
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 children. Target 30%. Influenza vaccination rates for eligible Pacific children. Target 30%.
Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness leading to hospital admission by: • Develop a process to include primary care consultation in the data set to better understand where missed opportunities exist. • Implementing the Best Start Pregnancy Tool so it can function as a pregnancy register in primary care. • Set primary care recalls for pregnant women to ensure they have developed a relationship with a midwife. • Improve the flow of health information by increasing usage of the Best Start Pregnancy tool by midwives. • Develop a process for making pertussis vaccination more readily available in primary care.	Influenza vaccine coverage rates for pregnant Māori. Target 50%. Influenza vaccine coverage rates for pregnant Pacific. Target 50%. Pertussis vaccine coverage rates for pregnant Māori. Target 50%. Pertussis vaccine coverage rates for pregnant Pacific. Target 50%.
Support a decrease in respiratory admissions with social determinants by: • Develop a baseline measurement of referrals to healthy housing with the aim of increasing referrals rates from primary care. • Prompt e-referral to Healthy Housing using Best Start Pregnancy, with a focus on pregnant low income Māori and Pacific women. • Increase referral of pregnant women who smoke for support to stop smoking when they visit general practice to confirm their pregnancy.	Percentage of practices that have Best Start Pregnancy tool installed. Target 30%. Referrals to maternal incentives smoking cessation programmes, for pregnant women. Target each quarter: 27 for ADHB; 58 for WDHB, and 180 for CMH.
Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.	

Youth Sexual and Reproductive Health

Activities	Contributory Measures
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 to encourage participation in the RNZCGP MOPS Youth Service audit. • Increased sexual health screening and funded sexual health consults for enrolled young people 15-24 years old (including screening for pregnant woman). • Develop a process to include primary care consultation in the data set to better understand where missed opportunities exist.	Percentage of practices with at least one GP who has completed an RNZCGP approved youth audit. Target 50%

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

Alcohol Harm Reduction

Activities	Contributory Measures
Improve data collection and reporting on alcohol harm reduction interventions in Counties Manukau Health through: • Establishment of an alcohol ABC baseline in primary care for reporting indicators. • Provide general practices with localised resources, training and effective tools to support the systematic and equitable delivery of alcohol ABC to their enrolled population. • Improve data collection capability to multiple practice management systems.	Percentage of the enrolled population aged 15 years and over with alcohol status documented. Target 55%.

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

Smoking Cessation for Māori and Pacific

Activities	Contributory Measures
Patient outcomes related to harm from smoking will be improved by: • Regularly reporting rates of referrals received by cessation support providers and rates of cessation medication therapy prescribed in primary care. • Audit a selection of practices to ensure referral data is accurate • Develop a surveillance report to monitor smoking prevalence by ethnicity and age. • Develop a report to monitor cessation rates by practice. • Query build lists of pregnant women coded as smoking to update smoking brief advice and direct them into cessation support programmes. • Assuring those who have been prescribed cessation medications are followed up by the local smokefree team for support with medication adherence & quitting. • Identify role of RN in Quit Smoking and upskill by completing a fast-track version of the National Training Standards Programme for smoking cessation. Ensure at least one person is trained per practice.	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.

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. Practices will set recalls and screen patients.	CVDRA rates for Māori. Target 90%.
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. • Implement a regionally agreed process to identify at practice level, high risk patients who are not taking recommended medications and record where medications are not tolerated or patients have declined treatment.	Percentage of Māori with a previous CVD event who are prescribed triple therapy. Target 70%. Percentage of Māori with a CVD risk over 20% who are prescribed dual therapy. Target 60%.
Reporting and improvement of clinical management through prescribing is facilitated through: • Comparing dispensing data to prescribing data and identifying any opportunities for improvements. • Specific actions will be developed after the analysis is complete.	
Opportunities to improve data collection and quality are advanced through: • Continue with a pilot focused on coding specified conditions (e.g. IHD, AF, CKD, diabetes). The results, expected in the next six months will inform further activities.	

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

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.	
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.	
Increase referral of patients at high risk of falls to an appropriate Strength and Balance Falls Prevention Programme by: • PHOs to promote the uptake of falls prevention screening templates in all primary care patient management systems. • Development of an updated Goodfellow Unit falls prevention webinar. • DHBs to support contracted programme providers to engage directly at a general practice level to increase the profile of the falls prevention programme, prioritising practices with a high proportion of older people in their enrolled population.	Percentage of patients aged 75 years and over (65 years for Māori and Pacific) who have been screened for falls risk. Target 50%.

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

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. • Focusing on increasing utilisation of POAC for ASH conditions, particularly, CHF, COPD and cellulitis. • Develop regular reports for PHOs on POAC usage	POAC initiation rate in primary care. Target 3 per 100 for each PHO. Report by ethnicity

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

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.	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.

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 focused 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. • Develop processes for collection and monitoring of email addresses for Māori and Pacific patients.	Percentage of Māori and Pacific patients eligible for the primary care patient experience survey who have valid email addresses. Target 40%.
Secondary care will improve patient experience by: • Focusing on the medication safety question in the National Inpatient Survey with a multidisciplinary approach. • Create training package in conjunction with a Health Psychologist for all hospital pharmacists and student pharmacists with links to patient experience, multidisciplinary team relationships, framing and communication approaches. • Development of Health Navigator resources and online resources. • Development of an acute pain management discharge checklist. • Testing of electronic solutions via Medchart to prompt patient conversations. • Co-design of patient experience initiatives with a focus on Māori and Pacific people (CMDHB). • 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.	ADHB/WDHB Percentage of hospital pharmacists will have completed the medication safety training package. Target 50%

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

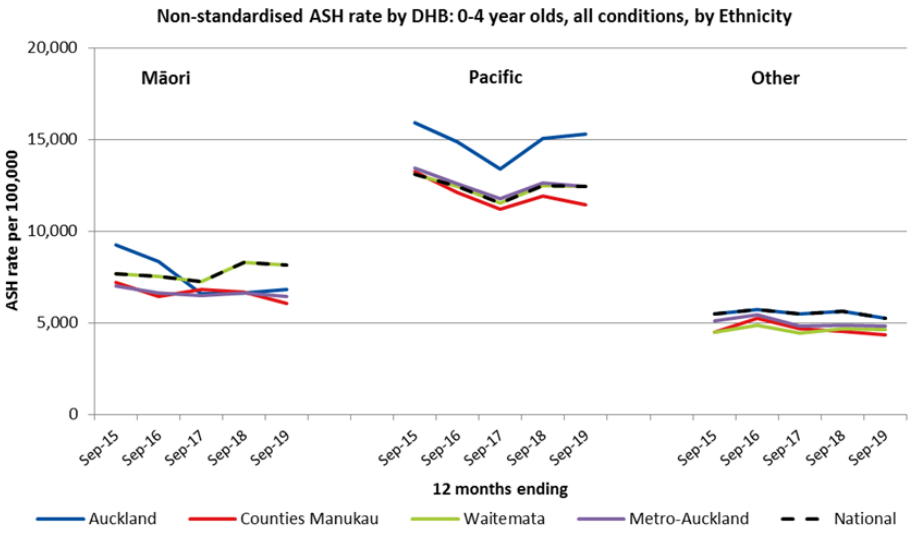
SYSTEM LEVEL MEASURE MILESTONES IN DETAIL

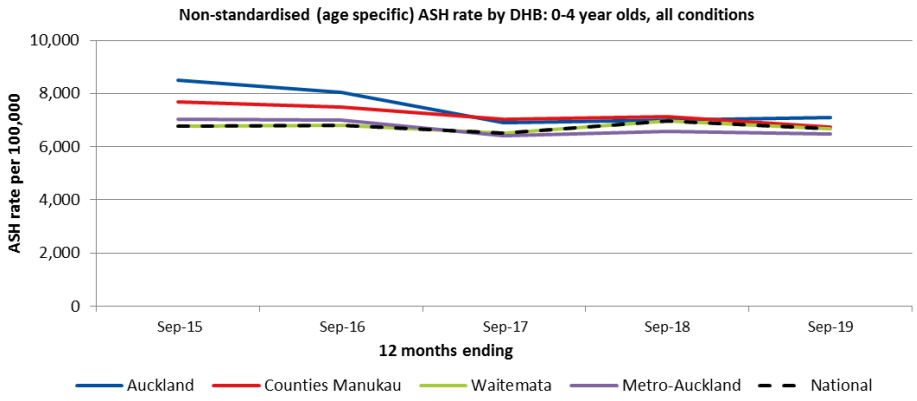
Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	3% reduction for total population by 30 June 2021.
	3% reduction for Māori populations by 30 June 2021.
	3% reduction for Pacific populations by 30 June 2021.

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.





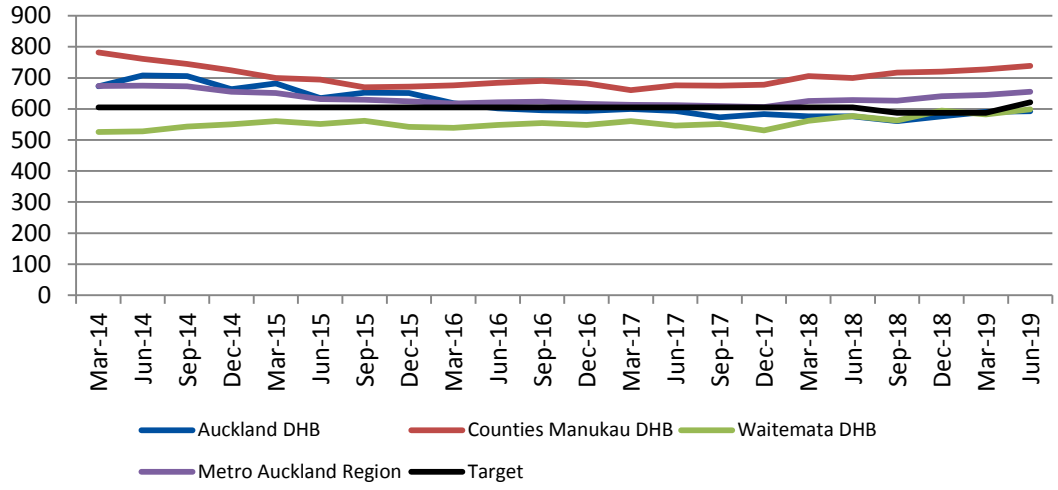
This year we aim to continue our focus on equity with an improvement for Māori and Pacific rates.

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.

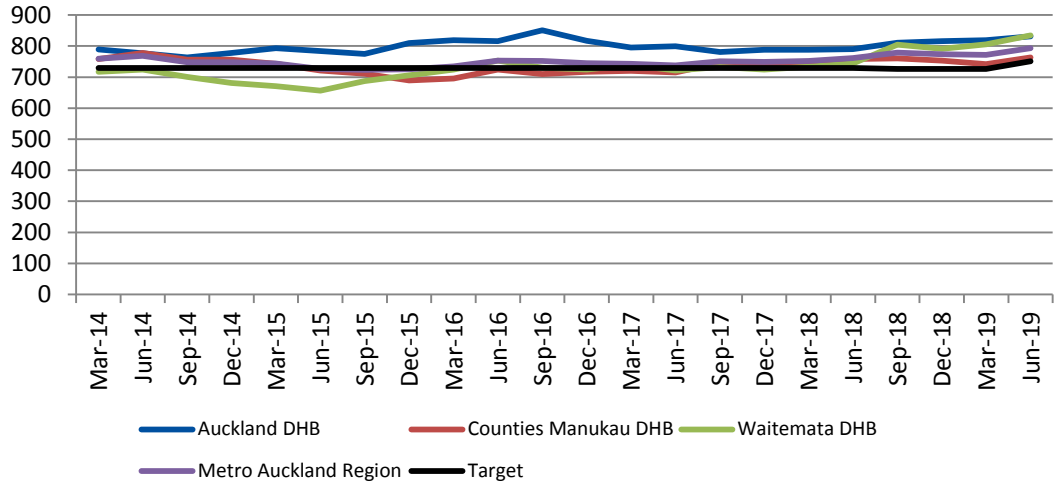
Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between community and hospital settings, optimal discharge planning, development of community 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 2019/20 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.

Standardised Acute Bed Days per 1,000 Maori Population: 12 months ending



Standardised Acute Bed Days per 1,000 Pacific Population: 12 months ending



Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	Hospital inpatient survey: 5% relative improvement on Inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with in a way you could understand?' by 30 June 2021. Primary care survey: 5% relative improvement on PES question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?' by 30 June 2021.

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 2020/21 plan continues to look at performance of individual questions rather than response rates to the survey.

The patient experience surveys have been significantly disrupted during 2019/20 with:

A refresh of the survey precluding direct comparison of questions between the old and new surveys

A change in provider contributing to a pause in delivery of the survey and discontinuous data flow

The COVID-19 crisis which further contributed to pausing the survey and also resulted in a significant changes in the way patients accessed primary care

Hospital Inpatient PES: The medication side effect question has been modified for the recent inpatient survey. At the time of submission of this plan data was not available for the modified question. It is highly likely that the communication of medication information will continue to be an area for improvement for the total population and also for Māori.

The milestone for 2020/21 will continue to focus on the knowledge patients have about possible medication side effects when they are discharged from hospital. This will be achieved by education of multidisciplinary teams focusing on patient empowerment, health literacy, and equity. A baseline will be established and improved upon when the first survey is conducted using the new survey.

Primary Health Care PES: The PHC PES is also well established in primary care. In keeping with the aim of reducing inequality the question about individual or cultural needs was chosen. This question has been introduced in the new survey and again a baseline will be established with the first round of the survey. Patient feedback and PDSA improvement cycles will lead to changes in practices that are important to patients and will promote cultural awareness.

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.

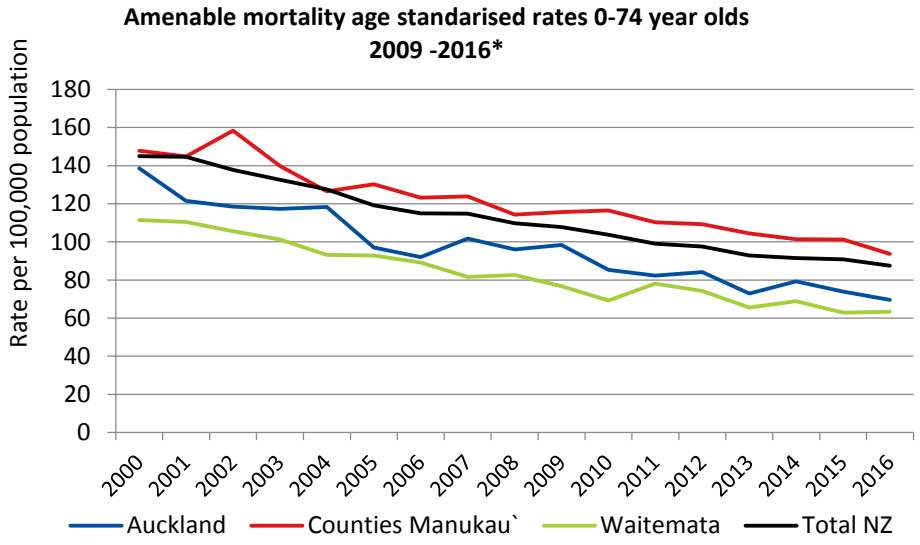
CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed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

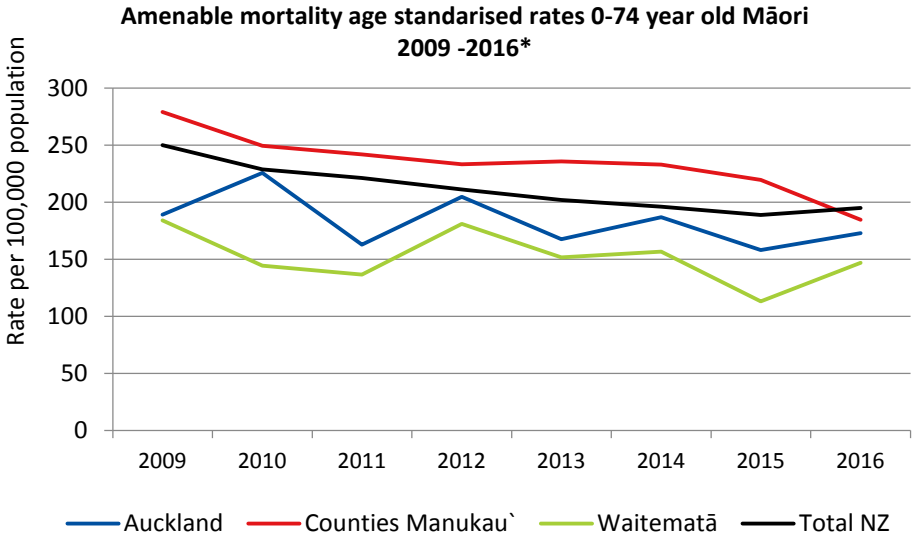
In 2020/21 we aim to build on the work done in implementation of the new Consensus Statement for Assessment and Management of CVD. With the risk assessment algorithms available to primary care there will be a stronger emphasis on risk assessment for Māori and primary prevention for those at greatest risk. We continue to focus on secondary prevention for this population.

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.

Through the use of data sharing we can focus on referrals to smoking cessation services by practitioners in different parts of the health system.

The 2020/21 plan will build on the successful implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption.




Amenable mortality age standarised rates 0-74 year old Māori
2009 -2016*
Rate per 100,000 population
300
250
200
150
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50
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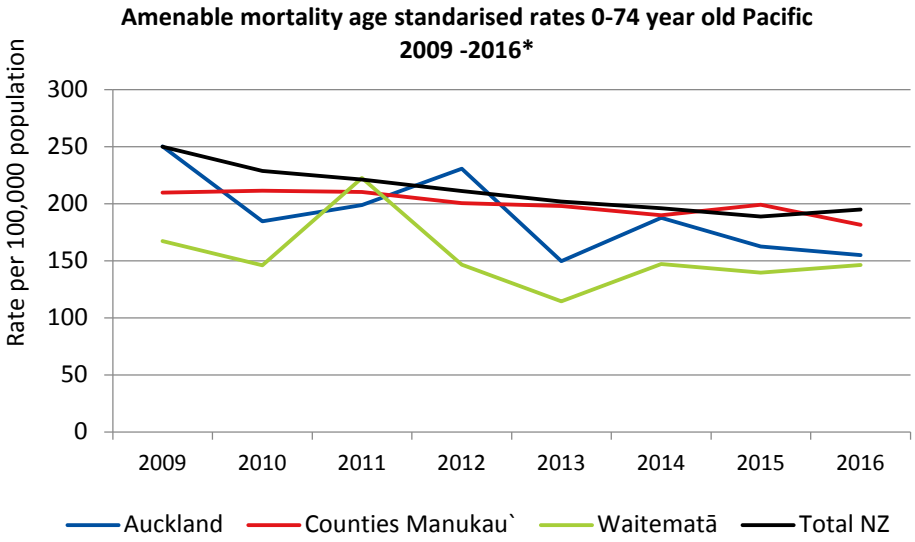
2009
2010
2011
2012
2013
2014
2015
2016
Auckland
Counties Manukau`
Waitematā
Total NZ

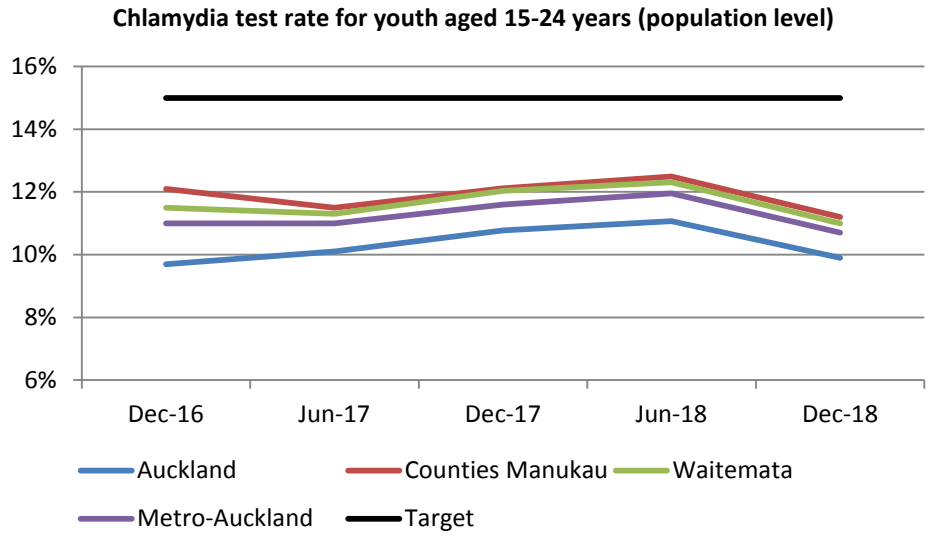

Amenable mortality age standarised rates 0-74 year old Pacific
2009 -2016*
Rate per 100,000 population
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
2016
Auckland
Counties Manukau`
Waitematā
Total NZ

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
Improvement milestone	Increase coverage of chlamydia testing for males to 6% by 30 June 2021.

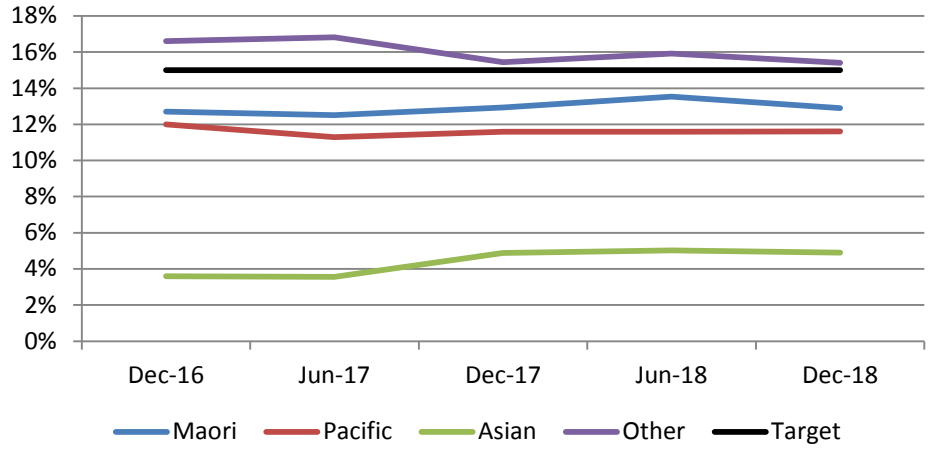
Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows 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. While we aim to increase screening rates for all youth there is a focus on improving rates for males.



Chlamydia test rate for youth aged 15-24 years by ethnicity (population level) - metro-Auckland DHBs

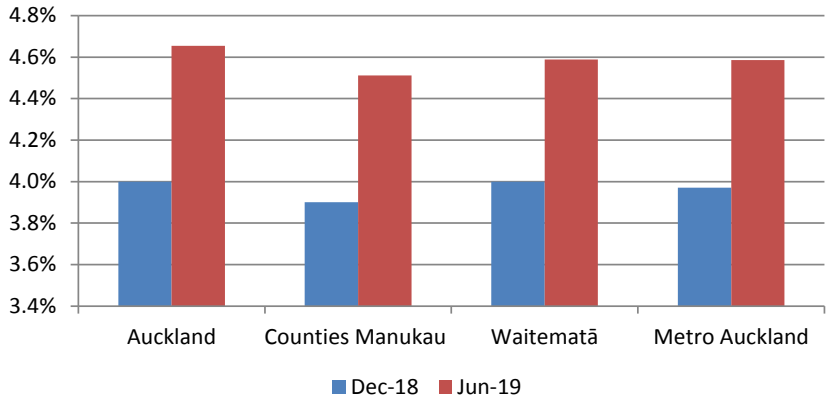


Chlamydia testing coverage in 15-24 year old males

Results for the 6 month period to June 2019: males only.

DHB	Ethnicity	No of people having chlamydia tests	Population	Chlamydia test rate (%)
Auckland	Māori	184	4,230	4.3
	Pacific	244	5,480	4.5
	Asian	256	16,480	1.6
	Other	1,344	17,380	7.7
Counties Manukau	Māori	454	8,700	5.2
	Pacific	553	11,500	4.8
	Asian	261	9,880	2.6
	Other	663	12,720	5.2
Waitematā	Māori	263	6,110	4.3
	Pacific	190	4,170	4.6
	Asian	161	9,270	1.7
	Other	1,387	24,060	5.8
Metro-Auckland	Māori	901	19,040	4.7
	Pacific	987	21,150	4.7
	Asian	678	35,630	1.9
	Other	3,394	54,160	6.3

Chlamydia test rate for males in the 6 months to Dec 18 and Jun 19 by DHB



Babies in Smokefree Homes

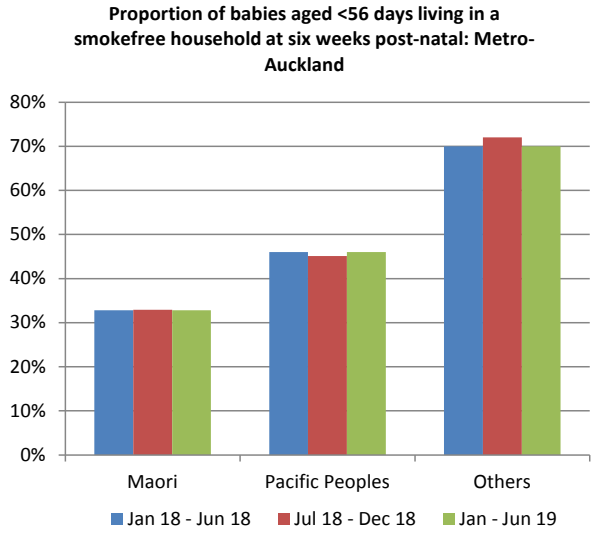
System level outcome	Healthy start
Improvement milestone	Increase the proportion of babies living in smokefree homes by 2%

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.

Babies living in smokefree homes at 6 weeks postnatal

Reporting period		DHB of domicile		
	Metro-Auckland	Auckland	Counties Manukau	Waitematā
Jan 18 - Jun 18	59.5%	66.8%	52.8%	61.9%
Jul 18 – Dec 18	60.9%	68.3%	54.7%	62.2%
Jan 19 - Jun 19	54.6%	66.2%	44.7%	57.5%
2019/20 Targets	**60.7%**	**68.2%**	**53.9%**	**63.2%**

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.



Fewer Māori babies live in smokefree homes. Rates for Pacific are also lower than other ethnicities. This correlates with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations.

Our work will be supported by earlier identification of smoking in pregnancy and referral to services for pregnant women and their whānau.

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 and 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)
	Vacancy	(elected)
	Chris Carter	(elected)
	Sandra Coney	(elected)
	Warren Flaunty	(elected)
	John Bottomley	(elected)
	Renata Watene	(appointed)
	Edward Benson-Cooper	(elected)
	Allison Roe	(elected)
	Vacancy	(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
	Mark Shepherd	Director Provider Healthcare 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
	Karen Hellesoe	GM Surgical and Ambulatory Services (Acting)
	Dr Meia Schmidt-Uili	HOD Child, Women and Family Services
	Stephanie Doe	GM Child, Women and Family Services
	Dr Murray Patton	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 Andrew Old	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
	Vacancy	GM Pacific Health (Waitematā, Auckland DHBs)
	Vacancy	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