Waitemata DHB

Annual Plan

2012
2013

INCORPORATING THE
STATEMENT OF INTENT

Waitemata
District Health Board
Te Wai Awhina

2012/13 ANNUAL PLAN

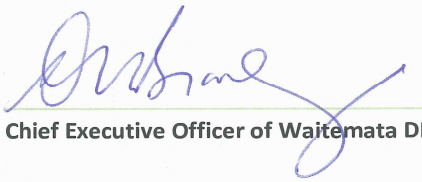
DATED THIS DAY OF 2012

Issued under section 38 of the New Zealand Public Health and Disability Act 2000 by Waitemata District Health Board

Signed by

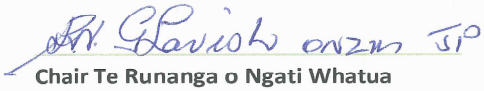
Chair of Waitemata DHB

Signed by



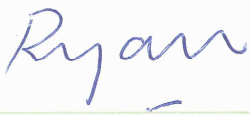
Chief Executive Officer of Waitemata DHB

Signed by



Chair Te Runanga o Ngati Whatua

CONSENT GIVEN BY



The Minister of Health
Tony Ryall

Copies of Waitemata DHB's accountability documents may be accessed on the DHB's website www.waitematadhb.govt.nz or from the Board Office, Private Bag 93-503, Takapuna, North Shore 0740, Phone: 09 442 7150.

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

Rec'd:- 5 JUL 2012

0 2 JUL 2012

Dr Lester Levy
Chair
Waitemata District Health Board
Private Bag 93 503
Takapuna
NORTH SHORE CITY 0740

Dear Dr Levy

Waitemata District Health Board 2012/13 Annual Plan

This letter is to advise you I have approved and signed Waitemata District Health Board's (DHB) 2012/13 Annual Plan for three years.

I appreciate the significant work that goes in to preparing such a thorough annual planning document and I thank you for your effort. I look forward to seeing your progress as I monitor your achievements over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In the Budget 2012, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to safeguarding and growing our public health services.

Health targets

Government Health Targets are selected to drive on-going improvements in specific priority areas in order to meet the public's growing expectations of accessing quality health care.

I appreciate your DHBs efforts to deliver on the Health Targets and your progress in achieving these. Your plan acknowledges the changes in focus with regard to the cancer, immunisation and tobacco targets and identifies actions to support their achievement. I am satisfied the activities you have identified in your Annual Plan will deliver on these new targets, while building on current achievements for emergency departments, electives as well as cardiovascular disease and diabetes.

Shorter waiting times

The Government has made commitments to New Zealanders to deliver even faster access in a number of key areas including elective surgery, diagnostic tests, chemotherapy treatment and youth drug and alcohol services. Thank you for your work to support these commitments. I look forward to seeing your planned results in these priority areas.

Integrated care

I expect all DHBs to increase their focus on service integration, particularly with respect to primary care, ensuring the scope of activity is broadened and the pace significantly stepped up. I look forward to seeing an integrated care approach driving delivery and improved performance, especially in relation to unplanned and urgent care, long term conditions and wrap around services for older people.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan and movement towards more tangible actions to show how you will achieve real progress towards providing a better range of services in the community. I expect you to be active in advancing these improvements to the way primary and community services are delivered closer to home.

The Ministry and National Health Board (NHB) will be working closely with DHBs to support the implementation of integration work programmes and I look forward to seeing progress on your work in West Auckland.

Living within our means

DHBs are required to budget and operate within allocated funding and identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery. Improvements through national, regional and sub-regional initiatives are expected to be a key focus for all DHBs.

Approval of your Annual Plan is conditional upon your Board fully supporting the investment required in Health Benefits Limited's Finance, Procurement & Supply Chain detailed business case. This is expected to follow completion of the current business case approval process with DHBs and shareholding Ministers.

I am pleased to see that your DHB is planning small surpluses which will enable some flexibility and assist with financial sustainability.

Savings from the community pharmaceutical budget

Earlier in the year, I directed DHBs to put the $30 million savings from the community pharmaceutical budget for 2012/13 towards the following initiatives:

- extending zero fees for primary care for children under six to afterhours;
- providing support for child and adolescent mental health services;
- implementing faster cancer treatment initiative;
- supporting smart investment home care for older people;
- providing an increase in aged care residential subsidy for bed day price, and for further improvements in dementia services.

I am interested to follow your progress in implementing these initiatives.

Health of older people

Our aging population poses many challenges to the health system and addressing these challenges is a government priority. DHBs are expected to develop wrap around services for older people and continue to invest in home and community support services, including post hospital discharge support to reduce acute admissions.

I am pleased to see detail in your Annual Plan on how you are planning to deliver health services for older people. I am particularly interested to follow your progress in relation to the provision of organised stroke services, services to reduce acute admissions, improvements in respite care and the development of dementia care pathways.

Regional Integration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities.

Included in these priorities are the achievements of regional workforce, IT and capital objectives that have been set, as well as your on-going support for the work of Health Benefits Limited, the National Health Committee and the Health Quality and Safety Commission. I look forward to seeing tangible benefits provided to patients as a result of these important regional initiatives being implemented.

It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan.

Whānau Ora

Whānau Ora is an inclusive interagency approach to providing health and social services in which DHBs play a key role. I expect your DHB planned actions to deliver on Whānau Ora to reflect the strategic change, confirmed support to selected Whānau Ora collectives; greater involvement of DHB leaders; and activities to improve performance and build mature providers.

Mental Health Ringfence

Updated mental health ringfence allocation is shortly to be released by the Ministry. Pending this information, I am approving your plan subject to an expectation that your DHB works closely with the Ministry of Health, to agree and ensure appropriate use of any unallocated mental health ringfence funding in 2012/13 in order to achieve improvements in mental health for your population.

Prime Ministers Youth Mental Health Project

The Prime Ministers Youth Mental Health Project cross-agency initiatives aim to prevent youth mental health problems developing and improve access to specialised treatment for those who need it. I would like to thank you for your demonstrated commitment to this government priority, including through your planned actions to build capacity and capability of specialist child and youth mental health and addition services, in order to improve service responsiveness.

Cardiac Services

The focus on improving access to cardiac surgery has resulted in very positive outcomes for patients over recent years. I am pleased to see your commitment to continuing progress in this area, through reducing waiting times and ensuring an appropriate level of access during 2012/13, not only for surgery, but across a wider suite of cardiac services.

The link between regional networks and cardiac providers is very important in this area, and I expect your local contribution to align with regional planning, and for regional collaboration to be strengthened to support delivery, waiting list management, and improved patient pathways.

Diabetes Care

This year each DHB has been asked to develop a Diabetes Care Improvement Package in consultation with primary care partners to better support prompt access to services and increasingly more effective management of people with diabetes.

These packages should enable innovation in service delivery, more focused activity to improve patient care where it is most needed and are to be built with strong evidence based best practice in mind. They should build on the good practice already provided through general practice to enhance and optimise outcomes for patients. I look forward to following the progress of these packages with your primary care partners.

Community Pharmacy Services Agreement

DHBs have undertaken to provide a well executed transition to the new Community Pharmacy Service Agreement. I know you will want to ensure your management confirms this happens locally.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the NHB. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will be contacting you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

My acceptance of your Annual Plan does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependent on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2012/13 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

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MODULE 1: Introduction

Foreword from Chair and Chief Executive

Providing the Best Care for Every One is our promise to the Waitemata community.

Our drive to achieve this promise over the last twelve months has seen the largest expansion of services in our organisation's history. We have completed a new, purpose built Emergency Department and Admission and Discharge Unit within the $45.2 million Lakeview development. We have opened a new $9.2 million renal unit on the North Shore Hospital site, bringing close-to-home care to our residents who need kidney dialysis. We have opened a new $7.3 million Lakeview Cardiology Centre including a coronary care unit, step down facility and cardiology ward, as well as commissioned two new cardiac catheter laboratories.

We now have more services than ever before, with further developments planned for 2012/13. The most significant of these will be the construction of the $39.4 million Elective Surgery Centre (ESC) on the North Shore Hospital site, due to open in July 2013. Once completed, the ESC is expected to perform around 6,000 surgeries a year, with approximately a quarter of those being additional operations. To complement new and future developments at Waitemata DHB a $24.5 million car park development has been completed with a new seven level car park building at North Shore Hospital site and additional car parking at Waitakere Hospital site.

Clinical Leadership is at the core of all we do. Clinicians are leaders at all stages of our service planning and delivery from bedside to board room, and clinical leadership will be central to ensure integration between community and hospital services to improve performance in specific priority areas including unplanned and urgent care, long term conditions and wrap-around services for older people. Clinical Leadership is also a key requirement to ensure ongoing continuous improvement in the quality outcomes for patients of the care provided.

What has been especially pleasing, in light of our significant expansion, is the sustained achievement and increase in performance across multiple indicators but in particular those areas which impact services delivered to our patients in terms of quality, access or experience. For the first time in 2011/12 we achieved the shorter stays in the Emergency Department health target, and have produced the most elective surgery procedures ever resulting in Waitemata DHB committing to delivering 25% of the additional volumes available nationally in 2012/13. We have continued to live within our means.

In order to maintain this momentum we have spent the last six months of 2011/12 focusing on those critical priorities and decisions which will impact on our ability to meet our promise in 2012/13. We have focused on our performance across the whole of the DHB. For example, we have reviewed our capacity to deliver diagnostic testing to ensure that patients are assessed promptly to enable timely treatment decisions. We have also analysed those areas where there is significant demand to identify the opportunities for improvements in how these services are delivered. This has included elective surgery where we have invested in facilities such as the Elective Surgery Centre, developed a new model of care for first specialist assessments and improved our theatre scheduling.

In terms of mental health, we are working to resolve the future of the Taharoto and Mason Clinic facilities; and capacity of the service to meet the new health targets for children and young people, where increased inter-sectoral activity is required.

We have also made decisions and established plans for the investment in information technology, on which we are heavily reliant; to ensure that continuity plans and/or back-up systems are in place. From an

infrastructure perspective we have reviewed our facilities and equipment to ensure we have adequate maintenance and replacement plans in place so that these inform our asset management plans and future capital requirements.

We have made substantial progress in our journey toward providing Best Care for Every One and the decisions and plans made this year have resulted in priorities for 2012/13 which continue our journey to reaching our full potential. Our key priorities for the 2012/13 year link directly to the Minister of Health's letter of expectations:

- *Improve population health* by:
  - Achieving the Health targets, especially waiting times
  - Improving service integration - we have continued our focus on service integration, particularly with primary care. In 2012/13 particular attention will be on developing further integrated family health services, and getting patients referred to diagnostic and clinical pathways that involve both community and hospital clinicians. Also wrap-around services for older people that support their continued safe, independent living at home. Our regional after-hours programme will be boosted to ensure there are no fees for after-hours doctors' visits for children under 6 years of age.
- *Improve patient safety and experience* – nurturing a culture of clinical excellence coupled with service to our patients. Recommendations from our review of patient experience will be implemented alongside the local patient safety and quality initiatives from the regional 'First do no harm' programme to ensure we deliver the Best Care for Every One. We will also be encouraging our senior clinicians and managers in new ways of working which create a momentum for change, and an environment where staff are responsive, transparent and innovative – with a bias for action.
- *Improved sustainability* – we will continue to achieve a break-even financial position, with a small surplus in 2012/13. This will require continued effort to improve processes, implement service improvements and reduce waste eg through new models of care, in-sourcing of services, and acceleration of our regional work with the other northern region DHBs, but particularly with Auckland DHB. The two DHBs plan to build on current collaborative activity in 2012/13 to enhance health outcomes and improve the quality of service delivery for their populations while capitalising on efficiencies through economies of scale, scope and critical mass.

The Government's key requirement of Waitemata DHB in the next financial year is to deliver better, sooner, more convenient care and to lift health outcomes for patients – within constrained funding. Whilst we all understand the international and local financial and economic environment, the good news is that the Government is continuing to increase its investment in public health, but within a tighter financial framework. We will need to be highly disciplined in order to lift our productivity to achieve this increase; we will need very strong clinical leadership. Capital expenditure will be particularly constrained for 2012/13, requiring us to carefully prioritise expenditure and to create more opportunities to fund capital from our own resources.

Alongside our local and regional commitments, Waitemata DHB will advance the work of national health sector bodies: Health Benefits Limited, Workforce NZ, and the Health Quality and Safety Commission. We can respond to these requirements. It will, however, take an intelligent, collaborative and disciplined approach to do so. Our world has changed and we need to face that reality – we cannot meet the new challenges confronting us by continuing to do things as we have in the past. It is only through innovative new models of care that we can provide the best possible access and service quality to our patients and population.

Dr Lester Levy, Chair
Waitemata District Health Board

Dr Dale Bramley, Chief Executive Officer
Waitemata District Health Board

About Waitemata DHB

Who we are

Waitemata District Health Board (DHB) has the largest population of any DHB in New Zealand with responsibility for the health and wellbeing of over 558,000 people. We provide predominantly secondary hospital and community services from North Shore Hospital, Waitakere Hospital and over 30 community sites throughout the district. We also provide child disability, forensic psychiatric services, school dental services and alcohol and drug services to the residents of the Auckland region on behalf of the other DHBs. We contract other DHBs, particularly Auckland DHB, to provide tertiary services, eg cardiac surgery, and radiation oncology services, and have contracts with approximately 900 other providers to deliver aged residential care, primary care, mental health, laboratory, pharmacy, oral health and other community services.

Our population is growing with an additional 119,000 people expected to reside in the Waitemata district in the next 15 years. This is reflected in the increase in volume of services delivered to the community particularly emergency department attendances, inpatient bed days and general practice attendances. This has required us to consider, alongside primary care and other northern region DHBs, how services are delivered to our community, including models of care and opportunities available to make services more productive and affordable.

This is an exciting period for us, though at times challenging, as we continue in our work to build our capability (in terms of new and modern facilities), continue to improve performance against the national health targets and Board priorities as well as delivering the Best Care for Every One while ensuring value for money in all that we do.

Snapshot of Waitemata DHB

- Largest and second fastest growing population of all districts – over 558,000 people, with the population expected to grow by an additional 119,000 people over the next 15 years
- We have the highest proportion of least deprived (deciles one and two) people and the second lowest proportion of highly deprived (decile 10) people of any DHB.
- People who live here have a higher life expectancy than elsewhere in the country, particularly so for Māori who have the highest life expectancy in the North Island. However, Māori and Pacific people still tend to live on average 8 years less than others. Women tend to live 4 years longer than men on average.
- Around 18% of the Waitemata population is Asian, 10% Māori and 10% Pacific
- About 21% of the population are under 15 years of age, 13% of the population are over 65 years, with around two percent over 85 years old
- Around 7,900 babies were born to Waitemata residents in 2011
- There were 108,000 public hospital discharges for Waitemata residents in 2011

Please refer to our website www.waitematadhb.govt.nz for further information on our population profile.

DHB Operating Environment – What do we do?

Waitemata DHB, established under the New Zealand Public Health and Disability Act 2000, is charged with:

- improving, promoting, and protecting the health of communities
- integrating health services, especially primary and secondary care services
- promoting effective care or support of those in need of personal health services or disability support.

Waitemata DHB is wholly owned by the Crown and is categorised as a Crown Agent under section 7 of the Crown Entities Act 2004 (CE Act 2004).

We receive funding from the Crown and are accountable to the Crown for the governance, management and administration activities relating to the allocation of these funds to providers for the provision of health services. Accountability is secured through the Crown Funding Agreement and Annual Plan approved annually by the Minister of Health, and the Statement of Intent, which is tabled in Parliament by the Minister.

The Statement of Intent forms part of this document (Modules 1, 2, 4, 5 and 7). Its component parts set out the DHB's objectives, priorities and intended achievements in 2012/13 in terms of improving the health and well being of its community. The Statement of Intent, as a public accountability document, is used at the end of the year by auditors working on behalf of the Office of the Auditor-General to compare the DHB's planned performance with the actual performance delivered which is then reported in our Annual Report. In carrying out its objectives and functions, Waitemata DHB acts in compliance with all relevant policy and legislation.

Te Tiriti o Waitangi Statement

Waitemata DHB recognises and respects the Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. It provides the framework for Māori development, health and wellbeing. The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes to enable Māori to participate in, and contribute towards, strategies to improve Māori health outcomes. References to Te Tiriti o Waitangi in this document derive from and should therefore be understood in this context.

As a Crown agent, the DHB will demonstrate how Treaty responsibilities are implemented through innovative strategies that apply the principles of Partnership, Participation and Protection. These principles are promoted by the Ministry of Health to provide direction to the health sector. Our commitment is therefore consistent with national Ministry of Health policy within *He Korowai Oranga – The Māori Health Strategy.*

Co-operative rangatiratanga and kawanatanga

The DHB has Memoranda of Understanding with Te Runanga o Ngati Whatua and Te Whanau o Waipareira that outline the principles, processes and protocols for working together at governance and operational levels. In order to achieve rapid progress towards equitable Māori health outcomes, both parties to each memorandum recognise the value of co-operative rangatiratanga and kawanatanga as the means to achieve equitable Māori health outcomes.

Whānau Ora

Waitemata DHB works in partnership with Iwi to achieve a Whānau Ora approach to regional health services and whanau empowerment.

Partnership: **Te Runanga o Ngati Whatua as Manawhenua, are partners with Auckland and Waitemata DHBs**	Memorandum of Understanding with Te Runanga o Ngati Whatua and its health arm Te Kahu Pokere. Ngati Whatua, as Manawhenua partners with the DHB at governance and operational levels. There is consultation with Iwi Māori in planning health and disability services and regarding service and other changes.
Participation: **Māori engagement in planning, development and delivery of health and disability services**	Responsible and responsive to Māori communities in our district and those who use our services. To develop and implement an innovative cross-DHB Māori health equity framework linked to co-operative rangatiratanga and kawanatanga. Active involvement of Manawhenua and Mataawaka communities at all levels. There is engagement with Māori regarding the impact service and other changes may have on Māori communities and organisations. Assistance to further develop Māori providers in our district.
Protection: **Equity of participation, access and outcomes for all Māori** **Equitable Māori health status** **Safeguard Māori cultural concepts, values and practices**	Adhere to the Waitemata DHB Tikanga Best Practice Policy to protect the rites/rights of Māori, respect the tikanga of Manawhenua and practically contribute to providing services that are responsive to Māori needs and interests. Services will meet the rights/rites, needs, interests and aspirations of Māori. This actively protects Māori interests in health planning and funding. Commitment to the Māori Health Strategy, He Korowai Oranga and other national policy. Use the national Inequalities Framework, the health inequalities impact assessment tool and the national Prioritisation Framework prioritising Whānau Ora.

Nature and scope of Waitemata DHB's Functions

Governance

We function through a governance and organisational structure based on the requirements of the New Zealand Public Health and Disability Act, 2004. Governance is provided by a Board of eleven members, seven of whom are elected, and four of whom (including the Chair) are appointed by the Minister of Health. Their role is to provide strategic oversight for the DHB, taking into account the Government's vision for the health sector and current priorities.

Three statutory advisory committees assist the Board to meet its responsibilities, the meetings of which are open to the public:

- The Community and Public Health Advisory Committee (CPHAC) – advises on the health status and needs of the population and the priorities for the use of health funding.
- The Disability Support Advisory Committee (DiSAC) – advises on disability issues and those concerning older people.
- The Hospital Advisory Committee (HAC) – advises on the operation of the hospitals (and related services) of the DHB. This committee also reviews clinical quality and risk issues.

In 2011, Waitemata DHB's Community and Public Health Advisory Committee (CPHAC) and Disability Advisory Committee moved to hold joint meetings with their equivalent advisory committees of the Auckland DHB. The Auckland and Waitemata DHBs also have a joined non-statutory Māori Health Gain Advisory Committee: Manawa Ora. These collaborations help us streamline activity across DHB boundaries.

Our Board and Committees have informed the development of this plan, setting those priorities that help us:

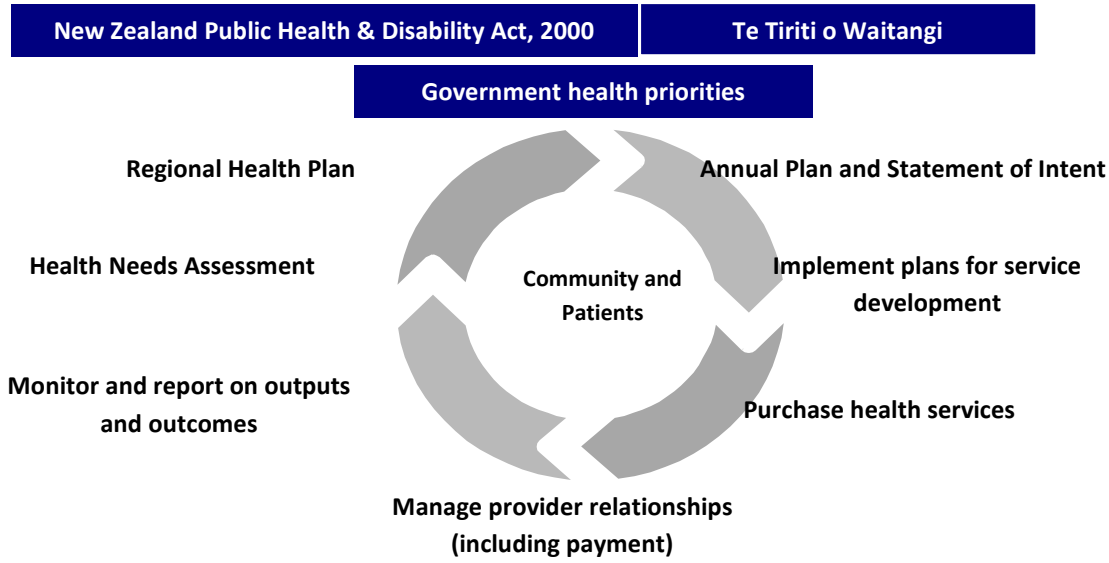
- contribute to the effective and efficient delivery of health services
- work to meet local, regional, and national health needs, and
- effectively and efficiently carry out other legislated responsibilities, including the stewardship of Crown assets.

Waitemata DHB operates a funder/provider split model, where the DHB funder has contracts (with non-DHB providers) or service level agreements (with the DHB provider arm) for the delivery of health and disability services. This model aligns to the DHB's accountability framework and provides clarity to providers, both DHB and non-DHB, regarding what they are required to deliver for what level of funding. It also supports the concept that not all services need to be provided by the DHB and that many services are better provided by non-DHB providers. This approach does not preclude collaboration between providers, or between the DHB funder and provider, as can be seen with the many examples of integration and collaboration described in this plan.

Waitemata DHB fulfils four main functions: Planner, Funder, Provider, and Owner of Crown Assets

Planner

DHB planning begins with the assessment of population health need. We balance the local needs of our patients and communities alongside national and regional health priorities.



In 2012/3 we will integrate more services across the continuum of care, especially moving service into community settings where this improves access for patients and is efficient.

Turning plans into action requires good organisational health. That means having the right workforce in place, the right information technology, and the infrastructure needed to be sustainable over the longer term. Many of these priority activities for the future are now being progressed regionally.

Funder

Our funding responsibilities cover the totality of services delivered for our population. This includes hospital based services provided at North Shore Hospital and Waitakere Hospital, and community based services (ie primary care, aged residential care, home based support services, community pharmacy services, community mental health service, and district nursing).
We also contract services from other district health boards (DHBs). These services include both hospital and community based services. Hospital services delivered out of district are mostly for specialist tertiary and/or regional services provided by Auckland DHB. For example specialist cancer treatment which is only offered at Auckland DHB for our region, and regional public health services provided by the Auckland Regional Public Health Service under a contract with the Ministry of Health.

In total the Waitemata DHB Funder is responsible for $1.3 billion in funding of which $638 million is for the provision of services by our Provider Arm and $367 million is for the provision of services through contracts with our NGOs. A further $328 million is for the funding of services by providers or contract holders not located in the Waitemata District. The remaining $9 million is to cover Governance and Funder related capability and administration.

We have alliance arrangements with Primary Care partners that span DHB boundaries. There are five Primary Health Organisations (PHOs) operating in the Auckland and Waitemata DHBs areas delivering the government's Better, Sooner, More Convenient Primary Health Care policy. These are aligned with three region-wide primary care entities/consortia which cover over 95% of the metro Auckland population.
The entities are: Alliance Health Plus (AH+); the Greater Auckland Integrated Health Network (GAIHN); and the National Hauora Coalition

- Greater Auckland Integrated Health Network (GAIHN) covers over one million enrolled people across four PHOs within the greater Auckland region
- Alliance Health+ is a coalition of the three Pacific-led PHOs in Auckland across Counties Manukau and Auckland DHBs
- National Hauora Coalition is a North Island consortium of PHOs focused on Whānau Ora.

Provider

Waitemata DHB is a major provider of health care services – providing both community-based and secondary services to close to 558,000 people.

Our DHB is one of the fastest growing because of population growth and the progressive transfer of services back to Waitemata from other DHBs.

The DHB operates North Shore Hospital and Waitakere Hospital - providing emergency, medical, surgical, maternity, community health and mental health services. We also provide a range of services for the Auckland region, including child rehabilitation and respite at Takapuna's Wilson Centre, forensic psychiatric services at the Mason Clinic in Point Chevalier, oral health services for children and young people and community alcohol and drug services. Māori and Pacific health services are also specifically provided for within the DHB and in the community.

Owner of Crown assets

As an owner of Crown assets, Waitemata DHB must operate in a fiscally responsible manner and be accountable for the assets we own and manage. We are responsible for ensuring strong governance and accountability, risk management, audit, and performance monitoring and reporting. Waitemata DHB also undertakes formal asset management planning to determine planned future asset replacement and expected financing arrangements. The plan is regularly updated. DHBs must revalue property, plant and equipment in accordance with NZ International Accounting Standard 16. Waitemata DHB's land and buildings are re-valued every three years. The last revaluation occurred in 2010 on an "Optimised Depreciated Replacement Costs" basis.

Other interests

Wilson Home Trust. Waitemata DHB is trustee for this trust, the primary functions of which are currently: provision and maintenance of building and grounds at the Wilson Home, Takapuna and funding of equipment and amenities for children with physical disabilities. Waitemata DHB leases from the Trust premises on the Wilson Home site from which the DHB provides services for children with physical disabilities.

Three Harbours Health Foundation. Waitemata DHB is the appointer of trustees to this registered charitable trust which holds donations, grants and research funds. The funds are made available for purposes consistent with the wishes of the persons or organisations that provided the funds and with the purposes of the Three Harbours Health Foundation trust deed. These purposes include: provision of comforts and amenities, provision of clinical equipment, funding of training and education, and the funding of clinical trials and research. The priorities for major fund raising for the 2012-2014 period are to strengthen research and innovation within the DHB and its contracted service delivery network. The Foundation is the umbrella trust for two further trusts, **North Shore Hospital Foundation** and **West Auckland Health Services Foundation**. These trusts have purposes identical to those of the Three Harbours Health Foundation but they assist with provision of hospital and community-based health services in their local areas.

Factors Affecting our Performance

Across the Auckland region there are similar kinds of challenges:

- Population growth and ageing
- Increasingly diverse communities, and
- Growing demand for health services (and, hence, infrastructure).

DHBs are working within a tightening fiscal environment where health spending is forecast to grow much more slowly than previously. The challenge is to continue to offer, and in some cases grow, quality health services against this economic background. We also need to consider the future make-up of the New Zealand population: there are going to be fewer people of working age; the number of people of retirement age, compared to those of working age, is going to double.

In partnership with the other northern region DHBs we have a common interest in getting best health outcomes from the available resources. We will continue to focus on:

- Changing service models and models of care (what's done where and how)
- Improving labour productivity (skill mix)
- Reprioritising towards more cost-effective treatments.

Key areas of risk and opportunity

Risks	Mitigations/ opportunities
Long-term fiscal sustainability	Clear prioritisation across all areas of the sector. Tight cost control to limit the rate of cost growth pressure, purchasing and productivity improvement to deliver services more efficiently and effectively across both community and hospital providers, and service reconfiguration to support improved national, regional and local service delivery models, including greater regional cooperation.
Diversity of need within New Zealand's population, including a rising number of older people with multiple conditions	Assist people and their families to manage their own health in their own home, supported by specialist services delivered in community settings as well as hospitals and increasing our focus on proven preventative measures and earlier intervention.
Growing demand for health services	Accelerating the pace of change, in key areas such as: • Moving intervention upstream • Meeting the diversity of needs within the population • Driving investment towards better models of care • Integrating services to better meet people's needs • Improving performance • Strengthening leadership while supporting front-line innovation • Working across government to address health and other priorities.

Module 2: Strategic Direction

Our DHB's Strategic Direction

Providing the Best Care for Every One is our promise to the Waitemata community.

Our Priorities for 2012/13

We have made great progress on our journey toward providing the Best Care for Every One. This journey continues in 2012/13 as we seek to achieve our goal of reaching our full potential. Our priorities for 2012/13 have been guided by the Minister of Health's Letter of Expectations, the Northern Region Health Plan, the needs of our community and patients and the organisation itself.

Improved population health: *adding to and increasing the productive years of Waitemata residents and reducing health inequalities*

- meet or exceed all of the national health targets
- achieve our priorities for Māori Health
- integrate primary care into a cohesive sustainable healthcare system
- integrate community and hospital services through increased community and hospital clinician involvement in our management of unplanned and urgent care, long term conditions and services for older people
- involve communities in decisions that affect them through a locality approach to health service planning
- collaborate with the northern region DHBs, with the metro-Auckland DHBs and more closely with Auckland DHB to achieve the objectives of the Northern Region Health Plan.

Improved patient safety and experience: *'first do no harm' and performance improvement*

- develop new ways of working resulting in an organisation culture which is responsive, transparent, creates a 'bias for action', is innovative and has courage
- continue to develop clinical and management leadership capacity at all levels
- practice evidence based medicine
- enhance the safety and quality of the services we deliver or fund for our community.

Improved sustainability: *the DHB's health resources are efficiently and sustainably managed to meet present and future health needs*

- provide and fund services which maximise the benefit to the community and patients within the resources available to the DHB ('allocative efficiency')
- maintain our performance focus
- develop a long term capital needs plan
- no financial deficits.

Strategic Context

National Priorities

At the highest level we are guided by the New Zealand Health and Disability strategies. These strategies are supported by national strategies such as He Korowai Oranga, Palliative Care Strategy, Cancer Control Strategy and Action Plan and the Ministry's Long Term Health Sector Plan. The annual plan also needs to support the outcomes described in the Ministry of Health's Statement of Intent (refer www.moh.govt.nz) which are in turn guided by the whole of government strategic outcomes.

DHBs along with the Ministry of Health work to achieve the overarching goal for the health sector – Better, Sooner and More Convenient health services for all New Zealanders (BSMC services). We are also committed to the National Service Improvement programmes.

The Minister of Health each year in his letter of expectations provides guidance as to the key areas of focus from a government perspective. These are summarised:

Deliver better, sooner, more convenient care

Lift health outcomes for patients within constrained funding increases

Broaden and speed up the integration of primary care with other parts of the health service to deliver:

- Integrated family health centres
- Primary care direct-referral to diagnostics
- Child and maternity services
- The Minister's health targets

Wrap-around services for older people that support their continued safe, independent living at home

Integrated care pathways designed and supported by community and hospital clinicians that better manage:

- Unplanned and urgent care
- Long-term conditions
- Zero-fees after hours GP visits for children under 6
- The Prime Minister's Youth Mental Health Project

Shorter Waiting times in a number of key areas, including:

- Surgery
- Diagnostics
- Cancer care
- Dedicated stroke units and dementia

Significant progress in implementing the Northern Region Service Plan, including the Workforce, IT and Capital objectives

Support and advance the work of Health Benefits Ltd, Health Workforce NZ and the Health Quality and Safety Commission

National Health Targets

Shorter stays in Emergency Departments	95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours
Improved access to elective surgery	Nationally, the volume of elective surgery will be increased by at least 4,000 discharges per year. Waitemata DHB will deliver 15,853 elective volumes during 2012/13 – this is an additional 1,000 of the total 4,000 national increase
Shorter waits for cancer treatment	Everyone needing radiation or chemotherapy treatment will have this within four weeks
Increased immunisation	85 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2013, 90% by July 2014 and 95% by Dec 2014
Better help for smokers to quit	90 percent of patients who smoke and are seen by a health practitioner in primary care and 95 percent in public hospitals, are offered brief advice and support to quit smoking. Within the target a specialised identified group will include: Progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer are offered advice and support to quit
More heart and diabetes checks:	90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years. DHBs are required to achieve at least 75 percent by 1 July 2013, and DHBs exceeding 75% are expected to be actively moving toward the 90% goal

We are committed to achieving and exceeding the health targets. We have made significant progress towards achieving the targets since they were introduced, but still have further improvements to make in 2012/13. The new financial year will see a focus for the areas of diabetes/CVD, cancer waiting times and immunisation especially. We see the priorities we have developed for 2012/13 working together with the focus on health targets to deliver quality health care to our community.

Regional Commitments

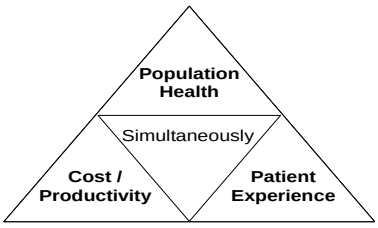
The Northern Regional Health Plan

Regional Service Plans are the medium term (5 - 10 years) accountability document for DHBs, having a strategic focus on future service configuration and models of care. By working regionally we can do more to address some of our shared challenges such as high population growth, ageing and disease trends, workforce shortages, and making health services in the region sustainable.

The Northern Region includes Auckland, Northland, Waitemata and Counties-Manukau. Collaborative activities are covered in the Northern Regional Health Plan, with DHBs assisted by the various shared service agencies: NDSA, Health Benefits Ltd and healthAlliance. In future, more work will be done across the four DHBs where this leads to greater patient care and more efficient use of resources. This is especially important in the greater Auckland (metro) area where people move across DHB boundaries and want to use health services at the time and place that suits them.

Our Mission:

*To Improve **health outcomes** and reduce disparities by delivering **better** sooner more convenient **services**. We will do this in a way that **meets** future **demand** whilst living **within our means***



First Do No Harm	Life and Years	Informed Patient
National Health Targets		
Service Changes		
Information Systems	Workforce	Facilities

The Triple Aim methodology will underpin decision making with three objectives being considered simultaneously: Population health, Service cost and productivity, Quality of patient experience.

We have made good progress in 2011/12, setting the foundations in place across the regional workstreams, such as establishing clinical networks, achieving the health targets in most districts, training staff for patient safety and quality improvements and advanced care planning, implementing the global trigger tool and launching the bowel screening pilot.

In 2012 we extended the Regional Plan to include child health, mental health and respiratory health. Real health gain depends on critical enablers such as Information Technology, workforce and capital (asset management) and these are also emphasised in the revised plan.

Waitemata DHB's activity for the 2012/13 year aligns to the Regional Plan as shown by the planning framework diagram on page 21. We are contributing to the achievement of the Northern Region Health Plan through clinical leadership of the Life and Years Diabetes and Health of Older People's campaigns, and membership of all of the workstreams, Regional Clinical Leaders' Forum, Regional Chairs / Executives Forum and the Northern Region Health Plan Steering Group. We will also contribute through the achievement of specific actions such as continuing the roll-out of the national bowel screening pilot, and establishment of a further integrated family health centre.

Three regional goals in addition to achieving national targets

First, Do No Harm This takes a primary focus on patient experience and patient safety. We also expect real benefits in terms of cost and productivity from 'getting it right first time'	First, Do No Harm
Lifting the health outcomes of the Northern Region population in terms of both 'Life and Years' A population health focus ensures we achieve longer, healthier more independent lives for the 1.6 million people living in the Northern Region. It will also reduce the gap in inequalities between Māori and non- Māori populations, and between high needs communities compared to those living with low need. Attending to prevention work delivers benefits for individual patients, reduces the cost of care, and improves productivity	Cancer Cardiovascular disease Child Health Diabetes Health of Older People Mental Health and Addiction Respiratory Disease
The Informed Patient. This is an inclusive approach which emphasises choice. We want patients to have information and support aligned to their individual context	Whanau Ora Advance care Planning

Further detail about our Region Health Plan and deliverables for the 2012-13 year is contained in this link: http://www.ndsa.co.nz

Arrangements across DHB Boundaries

Bilateral arrangements

Auckland and Waitemata DHBs have agreed a special governance and working relationship (a bi-lateral agreement). Regionalisation through collaboration is a strategic priority for both Boards who, combined, provide health services to over one million Aucklanders.

The two DHBs share a Board Chair and now have several sub-committees: Community and Public Health Advisory Committee (CPHAC), Māori Health Advisory Committee (Manawa Ora) and Disability Support Advisory Committee (DiSAC) which meet together. During 2012/13, more work areas will be joined, where we know that collaboration will improve health outcomes and improve service delivery. In some cases collaboration will also achieve better economies of scale.

A joint Collaboration Steering Group will plan and prioritise potential areas of future collaboration which may extend to the full merge of services. Any joining of activities will be managed to ensure that neither DHB is disadvantaged as a result of a change.

Current shared teams include:

Māori Health	During 2012/13, Auckland and Waitemata DHBs will do more to integrate Māori Health services. A lead GM for Māori Health, and a Chief Advisor Tikanga now sits across both DHBs, with the endorsement of Te Runanga o Ngati Whatua. A model of future operation will be developed in 2012/13, involving managers from both DHBs and our Iwi partner. Any changes proposed will be consulted on. A joint Māori health strategy will also be developed across Auckland and Waitemata DHBs. This will establish the regional strategic Māori health vision and approach for the next 3 – 5 years. The strategy will build on the first joint Māori Health Action Plan which details DHB activity in the 2012/13 financial year.
Pacific Health	Collaboration of Pacific Health services between Auckland and Waitemata DHBs will help to deliver high quality services and outcomes to our Pacific populations. We will develop new ways of working in 2012/13 that make the best use of resources across the two DHBs. The optimal arrangement will be identified after considering the strengths of our respective approaches and consultation feedback from staff, key stakeholders and other interested parties.
Primary Healthcare	Primary care planning and funding teams are now merged into one team that serves both Auckland and Waitemata districts. Specific activity to deliver better, sooner, more convenient service detailed in module 3.
Mental Health	A shared General Manager of Mental Health and Addiction services for both DHBs.

Outcomes and impacts

Our ultimate goal is to "identify the best mix of goods and services and resources to produce the greatest improvement in results"[1] for our community. To this end we monitor our performance in terms of:

- Long term outcomes
- The impact of specific DHB activities towards these outcomes
- The outputs funded and/or delivered by the DHB

Outcomes
The focus of the Statement of Intent is three years, which is aligned with the focus of the strategic goals within the Northern Region Health Plan. The three high level regional goals in the regional plan, which we have used as the basis for our own priorities for 2012/13, provide our key outcome areas for the performance framework, these are:

- Improved population health: adding to and increasing the productive life of people in the Waitemata community and reducing health inequalities
- Improved patient safety and experience: 'first do no harm' and performance improvement
- Improved sustainability: the DHB's health resources are efficiently and sustainably managed to meet present and future health needs.

These three goals, which we are also using as outcomes, align with the World Health Organisation policy guidance for health system performance measurement and improvement[2]. Three goals are defined in the World Health Organisation framework: improving health, enhancing responsiveness to the legitimate non-health expectations of the population, and assuring fairness in financial contribution. With regard to our responsiveness to our patients we are focused on whether the services provided meet their expectations regarding comfort, choice, convenience, confidentiality and cultural appropriateness, and do patients and the community have confidence in the health system, and a sense of control over their health. For the financial goal we have focused on delivering efficient health services, which is where as a DHB we have the greatest scope to ensure that our community is not required to pay excessively or unfairly for its health care. In this sense, we view high efficiency as a positive outcome in its own right because it helps to lower costs for everyone and frees up resources for other uses, be they within or outside the health sector.
For each of these three outcome areas we have identified high level measures for which progress is not generally seen within one year, but for which we expect to see an impact or improvement over 3-5 years based on the annual priorities and activities implemented. These are our main measures as defined by the Crown Entities Act.

Improved population health

One of the key DHB objectives under the New Zealand Public Health and Disability Act is to improve, promote and protect the health of the population the DHB serves. In our approach to improving population health we consider two aspects, improving the overall health gain for our community thereby improving health and reducing disability, as well as reducing inequalities.

For 2012/13 we are focusing on achieving the health targets and improving service integration as key areas which contribute to the achievement of this outcome.

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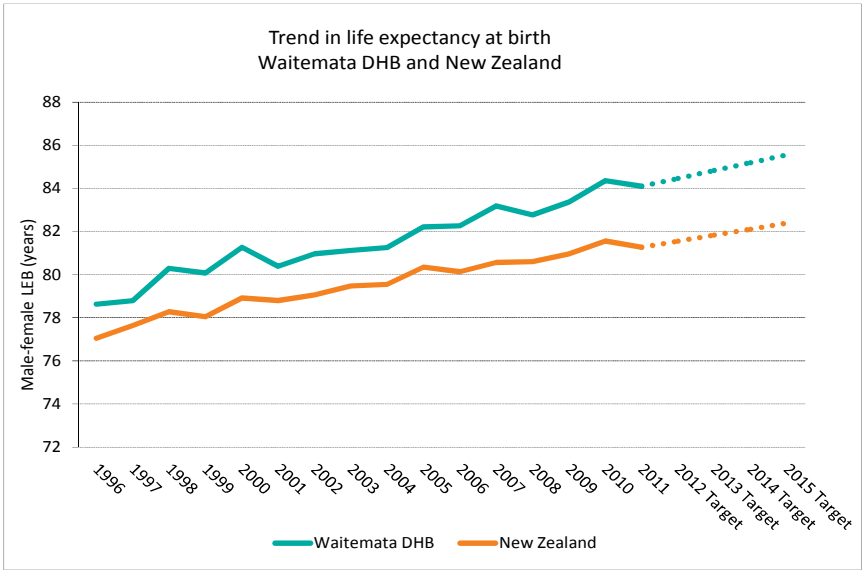
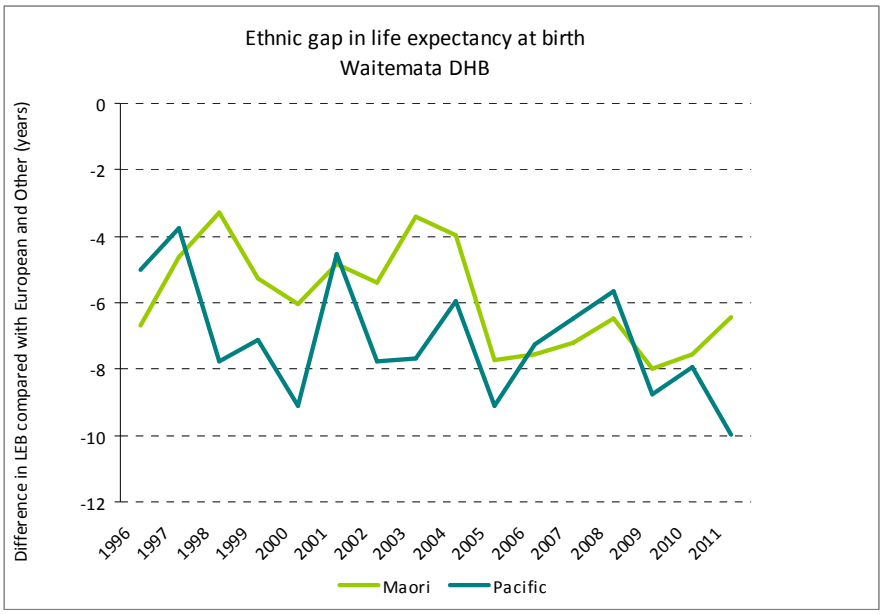
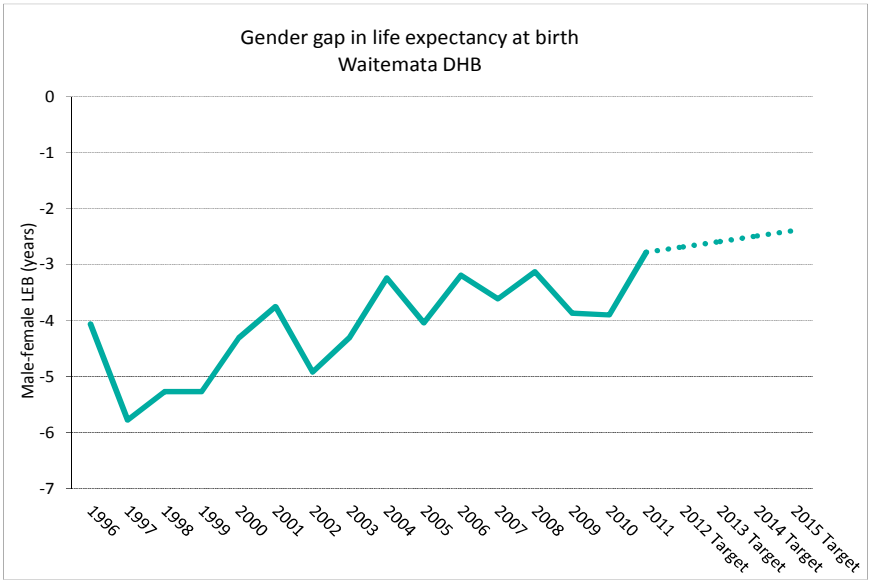
[1] State Services Commission *Planning and Managing for Results – Guidance for Crown Entities* 28 September 2005

[2] *Murray CJ, Frenk J. A framework for assessing the performance of health systems.* Bulletin of the World Health Organization*, 2000, 78(6):717-31*

Main measures	Why are these measures our focus? What's the current status?
Increased life expectancy Average annual increase in life expectancy at birth	Internationally recognised as a measure of population health status. We would expect to see the continued increase of around three years each decade. For New Zealand as a whole the trend has been 2.8 years per decade over the last 15 years, Waitemata has seen an impressive trend of 3.6 years per decade. Overall we continue to have the highest life expectancy in the country at around 84 years – almost three years higher than New Zealand as a whole. If the Waitemata district was a country we would have the highest life expectancy in the world (Japan's is 82 years).
Reduced inequalities (measured by the life expectancy gap)	While we have high life expectancy rates for Māori and non-Māori compared to other New Zealanders, there are significant differences between the ethnic groups within our community. We want to reduce this to zero in the long term. The latest life expectancy data for 2011 shows a welcome improvement in our rate for Māori, which puts their trend over the last 15 years parallel with that of Pacific. However there is still a gap of 6.4 years. Our Māori life expectancy is the fifth highest in the country (78.5 years) which is four years higher than the national level (74.8 years). Our Pacific life expectancy rate of 74.9 years is seventh equal and almost one year below the national rate of 75.7 years. The rate of life expectancy increase for Māori and Pacific peoples is almost identical at 1.9 years per decade. Our goal for the following years is to continue the improved rate for Maori and also to improve the rate for Pacific populations – gradually reducing the ethnic gap in life expectancy for our populations. Analysis undertaken last year found that coronary heart disease, lung cancer, diabetes, obesity and stroke accounted for over half the difference in life expectancy between Pacific and European ethnicities in Waitemata. These areas are reflected in our priorities for 2012/13, while recognising the requirement for a sustained, longer-term focus. The life expectancy at birth gap between males and females in the Waitemata district has shown an improving trend over the last 15 years. The gap declined from approximately 5.8 years in 1997 to less than 3 years in 2011 for our DHB population. Nationwide, there was a similar trend of improvement from 5.5 years in 1996 to 3.7 years in 2010. The improvement of the male-female gap was attributed to by all ethnic groups including Maori, Pacific and European/Other.



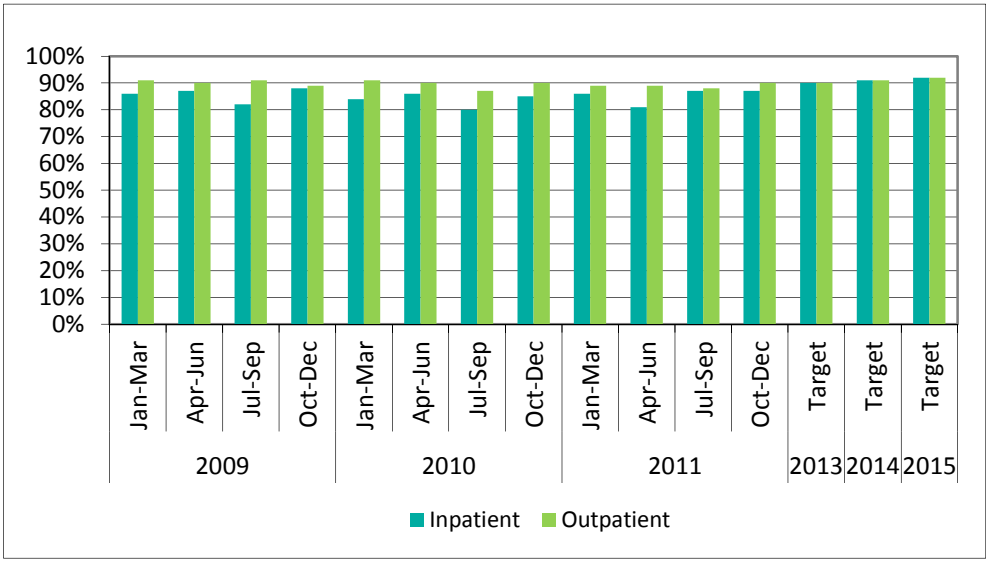
Main measures	Why are these measures our focus? What's the current status?
Ethnic gap (measured by the life expectancy gap)	
Gender gap (measured by the life expectancy gap)	

Improved patient safety and experience

We have separately focused on patient experience as an outcome area because the expectations including comfort, choice, and convenience are not considered to be merely aspects of the 'quality' of outputs, but fundamental outcomes in their own right.

We have also included patient safety in this outcome area as we see the perception of safety from the patient's perspective as part of this 'responsiveness' outcome ie impacting their confidence in the health system. Though we recognise that patient safety is also attributed to population health gain as it contributes to positive outcomes for patients extending the length and quality of their lives, we have included all elements within this outcome area.

Main measures	Why are these measures our focus? What's the current status?
Improved patient satisfaction	Understanding when we haven't provided a positive patient experience and when we have enables us to improve our systems and processes to better respond to patients and their family / whanau. Our aim is to consistently achieve over 90% for all our patients in the long term. [3]



[3] We are currently reviewing the options for measuring patient satisfaction and looking to adopt a new model during 2012/13.

Improved sustainability

DHBs are required "to ensure they seek the optimum arrangements for the most effective and efficient delivery of health services in order to meet local, regional, and national needs". We are also required to operate in a financially responsible manner and must endeavour to cover all our annual costs from our annual income.

This outcome focuses on the DHBs role in assisting to ensure that the burden of health costs does not fall unfairly. There are two roles DHBs can play to improve this outcome, the first is to ensure we do not run financial deficits. A DHB which runs budget deficits is creating a burden that future tax-payers will have to pay. The second role is through our ability to subsidise primary care and other services for vulnerable groups. The policy of free after-hours visits for children under the age of six that DHBs are expected to fund is an example of this.

Main measures	Why are these measures our focus? What's the current status?
Achieving a break-even position each year	Waitemata DHB has lived within its means for the past four years. We will continue to ensure we remain a sustainable organisation which manages its resources efficiently and achieves a $2M surplus in each of the three financial years. Thereby reducing the level of demand for additional funding by the DHB and the financial contribution by the community to the health system either directly through co-payments or indirectly through taxes.
Other measures	Average fee paid for after-hours GP visits for patients under the age of 6. We are committed to reducing the financial barriers for vulnerable groups to accessing health services. Implementing the policy of free after hours visits for children under 6 supports this goal. This is a new measure for 2012/13 with a target of zero. We are also looking at the productivity measures we monitor within the DHB and where appropriate will incorporate in the next year's Statement of Intent.

2009/10 Audited $000	2010/11 Forecast $000	2011/12 Plan $000	2012/13 Plan $000	2013/14 Plan $000	2014/15 Plan $000
$3,552	$(6,964)	$5,000	$2,000	$2,000	$2,000

Planning Framework - Our priorities, key impacts and performance measures

The following table outlines the overall planning framework adopted by both Auckland and Waitemata DHBs.

Government Policy:	**Better, sooner, more convenient health services:**	**Service Integration**	**Regional Collaboration**	**Value for Money**
Regional Vision:	**"To improve health outcomes and reduce disparities by delivering better, sooner, more convenient services. We will do this in a way that meets future demand whilst living within our means."**			
Northern Region Goals	Population Health *Adding to and increasing the productive life of people in the northern region*	Patient Experience *Aiming for zero patient harm and performance improvement*	Cost/Productivity *The region's health resources are efficiently and sustainably managed to meet present and future health needs*	
Joint ADHB & WDHB Goals	Improved population health Achieve the health targets / Improve service integration	Improve patient safety and experience	Improved financial performance and productivity	
	Priority Populations and Services			
	Child Health / Youth Health / Māori Health / Pacific Health / Mental Health / Asian and 'new New Zealander' Health / Renal and Respiratory Services			
National Priorities	Emergency Departments / Access to Elective Surgery / Cancer Services / Immunisation / Tobacco / CVD/ Diabetes / Primary Care Development & Delivery / Child & Youth Mental Health / Health of Older People / Cardiac Services / Whānau Ora / Living within our Means			
Impacts	☑ **Improve life expectancy** ☑ Fewer admissions for falls of older people ☑ Prevention of illness and fewer acute episodes ☑ Prompt recovery from acute mental illness ☑ Prompt diagnosis of acute and chronic conditions ☑ Restoration or maintenance of functional independence ☑ Good access to effective pharmaceutical treatments ☑ Effective and prompt resolution of medical and surgical emergencies and acute conditions ☑ Increased survival/reduced mortality from most common cancers ☑ Management and cure of treatable conditions ☑ Improved oral health of children and young people, with a reduction in ethnic inequalities ☑ Improved acute and chronic care of older people ☑ Maximising functional independence and quality of life of older people ☑ Reduced mortality ☑ Healthier children ☑ Improved overall oral health	☑ **Improved patient satisfaction** ☑ Satisfactory waiting times for our services ☑ Improved patient experience ☑ Pain relief and patient reassurance ☑ Prevention of mental illness relapses ☑ Fewer adverse clinical events ☑ Improved engagement of our community – including Māori, Pacific and Asian – with our health services ☑ Improved engagement of clinicians and other health professionals. ☑ Improved quality of life due to surgical intervention ☑ Improved emergency care ☑ Patients less likely to be readmitted ☑ Social integration and improved quality of life ☑ Quality of Life for those dependent on aged residential care ☑ Increased life expectancy ☑ Improved quality of life for patients with life-threatening illness (and their families)	☑ **Achieving a break-even position each year** ☑ Reduced demand on specialist outpatient appointments ☑ Minimising unnecessary use of high cost secondary care ☑ Lower per capita out of pocket and total expenditure on pharmaceuticals ☑ Prevention of illness ☑ More services delivered in primary care and community based settings ☑ Prudent financial management	
Key Impact and Output Performance Measures Note: O = output I = impact	O % of hospitalised smokers and those seen by primary care offered advice and help to quit I Smoking prevalence amongst hospitalised smokers O % of 8 month olds fully immunised O Proportion of women aged 45-69 who had a breast screen in the past 12 months, reducing inequalities O % of eligible population invited to screen for bowel cancer O Mental health services access rates O Proportion of babies fully and exclusively breastfed at 6 weeks, 3 month s and 6 months I Proportion of eligible people who have had a cardiovascular risk assessment in last 5 years, reducing inequalities for Maori I Proportion of people who have good diabetes management at their annual review (focus on Maori) I Average number of decayed, missing or filled teeth in year 8 children I Proportion of children who are caries free at 5 years O Deliver 15,853 elective surgical discharges O Elective services standardised intervention rates for our population I Total QALYs gained from the five Ministry of Health selected procedures O % of Auckland population who can access free under 6's after hours care O % reduction in aged care facility clients presenting to ED O Standardised acute admission rates from residential care	O Patients waiting longer than six months for their first specialist assessment (FSA) O Patients given a commitment to treatment but not treated within six months. I % of respondents who rate the care and treatment they receive as 'very good' or 'excellent' O % of patients admitted, discharged, or transferred from an Emergency Department (ED) within six hours. O Hospital readmission rates - focusing on Maori and Pacific O Everyone needing radiation or chemotherapy treatment will have this within four weeks O % complaints responded to within 14 days O % improvement in hand hygiene compliance I Lower the incidence of central line associated bacteraemia I % reduction in incidence of inpatient catheter associated urinary tract infections I % reduction in falls resulting in major harm	O Achieve financial break-even result O Regional achievement of national health targets O Business transformation $12M savings realized O Average fee paid for after-hours GP visits for patients under the age of 6	
Output Class	**Prevention** ❖ Health Protection ❖ Health Promotion ❖ Health Policy/Legislation Advocacy and Advice ❖ Population Based Screening	**Early Detection and Management** ❖ Community referred Testing & Diagnostics ❖ Oral Health ❖ Primary Health Care ❖ Pharmacy	**Intensive Assessment and Treatment** ❖ Acute Services ❖ Maternity ❖ Elective (Inpatient/Outpatient) ❖ Assessment, Treatment and Rehabilitation (Inpatient) ❖ Mental Health	**Rehabilitation and Support** ❖ Home Based Support ❖ Palliative Care ❖ Residential Care ❖ Mental Health

Module 3: Delivering on Priorities and Targets

Priorities and targets

Our priority actions and targets for 2012/13 are structured based on our three priority (outcome) areas for 2012/13, which are aligned with the three high level goals in the Northern Region Health Plan.

Improved population health: *adding to and increasing the productive years of Waitemata residents and reducing health inequalities*

We have aligned this section with the Minister of Health's expectations regarding health targets and service integration as follows:

Achieve the health targets*

- Emergency Departments
- Access to Elective Surgery
- Cancer Services
- Immunisation
- Tobacco
- CVD / Diabetes

Improve service integration

- Primary care development and delivery
- Mental Health including Child and Youth Mental Health*
- Health of Older People*
- Cardiac Services*
- Whānau Ora*
- Māori
- Pacific
- Asian, migrant and refugees
- Child and Women's Health*

Improved patient safety and experience: *'first do no harm' and performance improvement**

Improved sustainability: *the DHB's health resources are efficiently and sustainably managed to meet present and future health needs**

* specific priorities included in the 2012/13 Northern Region Health Plan work programme.

Emergency Department

What are we trying to do?

We want to deliver high quality emergency care to our community by exceeding the health target (95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours) and ensuring only patients who need emergency care are seen there.

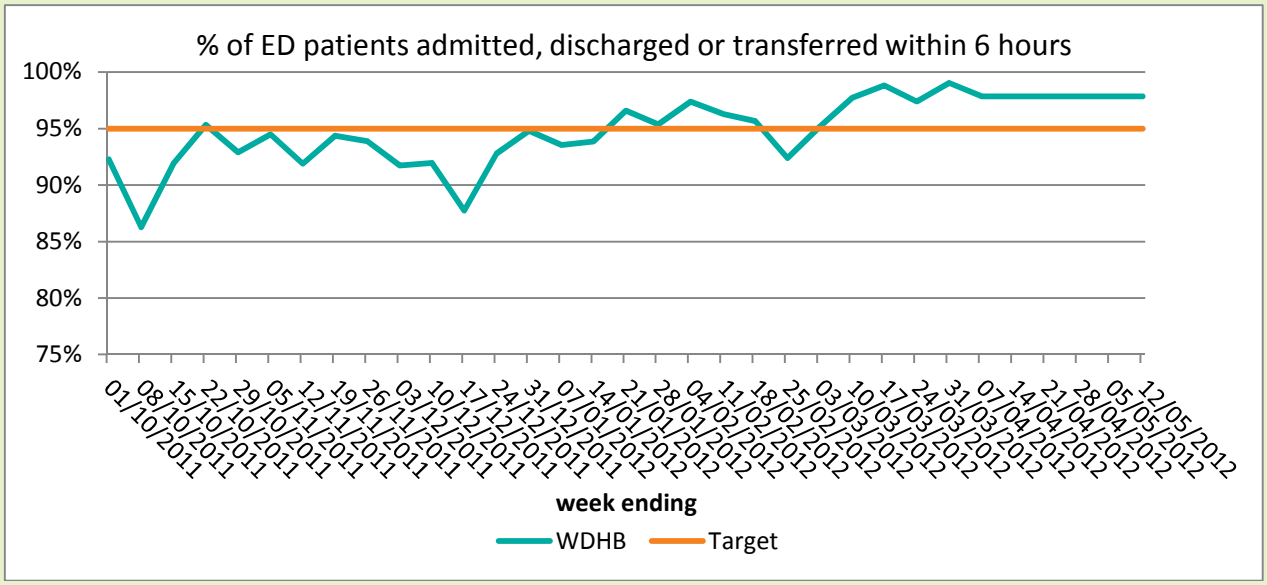
Why is this important?

Our patients expect and deserve better, sooner and more convenient health care. Less time spent waiting and receiving treatment in the Emergency Department not only gives patients a more dignified and convenient experience when they are acutely ill, but also gives rise to better outcomes and enables us to use our resources more effectively and efficiently.

This national health target is a measure of the efficiency of flow of acute patients through the hospital and into the community. It provides a whole of system's view of the organisation including primary and secondary service delivery.

Progress to date

Our performance against the target has significantly improved. In 2011 we achieved the Emergency Department waiting time health target for the first time.



We have completed our ED/Assessment and Diagnostic Unit (ADU) facilities at North Shore Hospital enabling us to move from an ED to an ED/ADU approach to service delivery, and have moved to a 24/7 service at Waitakere Hospital.

We have implemented workforce and model of care changes including the introduction of a flow coordinator, ADU physician and general surgeon, and increased the number of ED specialists.

The whole hospital has become involved in various projects to improve the patient journey. Similarly primary care has been involved through extended GP practice hours in West Auckland, rural after hours service in the west Auckland and Rodney area, primary options for acute care (POAC) and after hours nurse telephone triage service in some practices.

We have also increased our publicity on the appropriate use of ED.

How are we going to do it? (Key planning approach)

- Improve responsibility and ownership of the shorter stay in ED by all inpatient specialties
- Implement rapid rounding concept in the wards to reduce delays for those patients requiring input from various staff
- Review medical roster to reduce peaks and troughs of availability of medical staff
- Better integration of primary and secondary care to reduce acute demand
- Review the hospital-wide bed capacity
- Development and implementation of a robust capacity plan
- Better access and flow to diagnostics
- Improve partnership between primary and secondary including St John ambulance service
- Target high users of ED, Accident and Medical centres (A&Ms), GPs and St John services
- ED specialists to provide education and support to primary care providers

Specific deliverables/actions to deliver improved performance

- Consistently meet the health target for patients being admitted, discharged or transferred from the Emergency Department.
- Complete a comprehensive review and redesign of the model of care and staffing for General Medicine inpatient services (Aug 2012).
- Implement this new model in 2013
- Implement rapid rounding concept to the Hospital by December 2012
- Primary/secondary liaison role in place by December 2012
- Implement further strategies to reduce high users of ED, A & Ms, GPs and St John services by December 2012 – see Primary care development and delivery section for further information
- Implement whole of organisation patient flow project
- Implement free GP visits for the under six year olds from 1st July 2012

How will we know we've achieved it? Measured by –

For North Shore Hospital and Waitakere hospitals:

- 95% of patients will be admitted, discharged, or transferred from an ED within six hours.
- CT and MRI – 75% of accepted referrals for CT or MRI scans will receive their scan within 6 weeks (42 days)

Improve access to elective surgery

What are we trying to do?

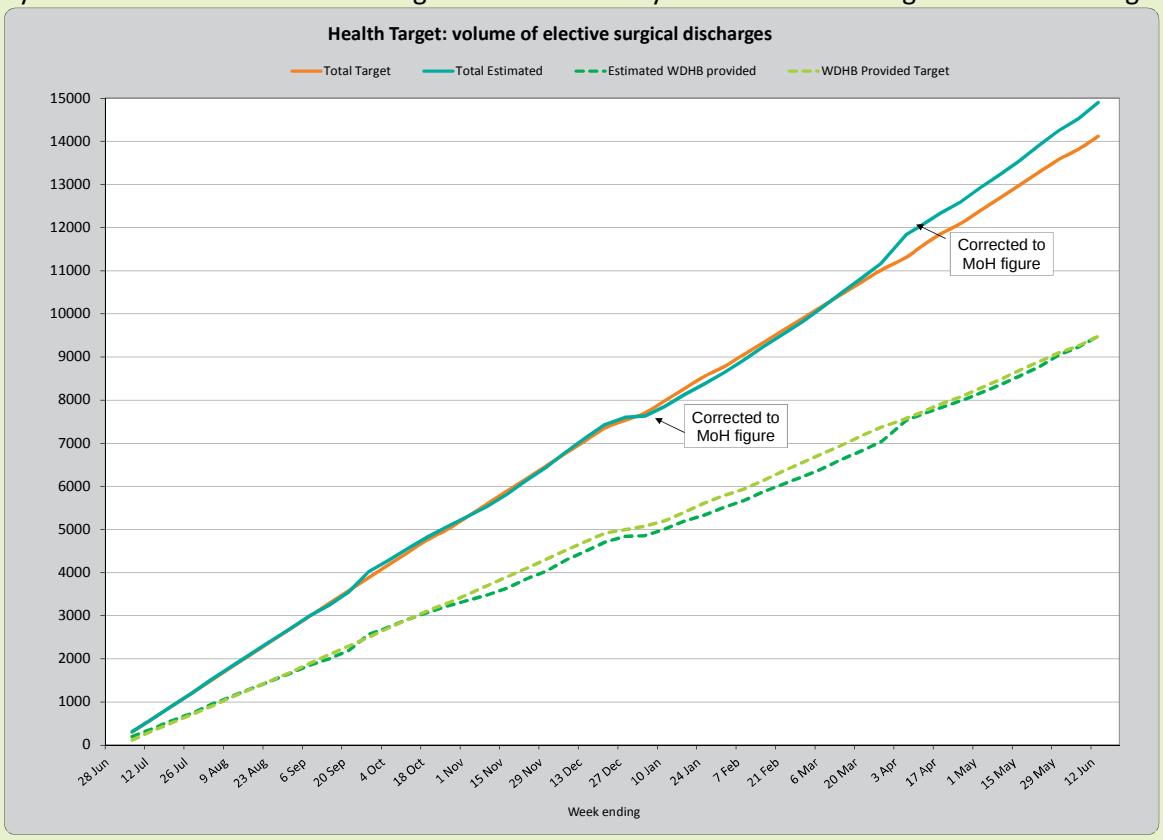
Ensure that we provide our community with timely and equitable access to elective surgery through meeting the national health target of 100% elective surgery volumes and ensuring that no one waits longer than 6 months for their first specialist appointment (FSA) and subsequent surgery (reducing to 5 months by June 2013 and 4 months by June 2014). This will also be achieved through the delivery of innovative models of care and processes which provide patients clarity and a satisfactory patient journey.

Why is this important?

Timely access to elective surgery supports our community to live longer, healthier and more independent lives. We need to meet Government and community expectations regarding the elective surgery health target discharge volumes, the outpatient and inpatient waiting list targets and the population intervention rates for hips, knees, cataracts and cardiac surgery. We need to redesign FSA processes in part by way of a one stop shop in order to streamline processes and make the patient's journey more convenient and timely.

Progress to date

Waitemata have delivered the biggest increase in elective surgical discharges of any large DHB in the country – over a thousand extra discharges. We consistently meet the health target for elective surgery.



We have also:

- increased our focus on achieving no patients waiting greater than six months by June 2012, five months by June 2013 and four months by June 2014
- increased bariatric surgery volumes, progressing work to improve access for Māori/Pacific
- added additional theatre capacity and decreased average length of stay for major joint replacements
- have commenced a one stop shop FSA process change and continued elective productivity project such as the productive operating theatre programme.

How are we going to do it? (Key planning approach)

- Redesign FSA process to "one stop shop" for the new Elective Surgery Centre for timeliness, convenience and patient focused bookings
- Continue to utilise national clinical prioritisation assessment criteria tools (CPAC) to ensure that patients are treated in accordance with their assigned priority need
- Increase theatre production by optimising the utilisation of all resourced theatre sessions
- Increase day of surgery admission rate and reduce the average length of stay
- Ensure formalised agreements are in place for private providers within the national pricing framework if required to meet volumes and waiting times
- Increase bariatric surgery capacity

Specific deliverables/actions to deliver improved performance

- 100% elective surgery discharge volumes attained each quarter
- Elective Services Patient Indicator Flow (ESPI) compliance will be maintained each month in the 2012/13 financial year through more consistent referral management, a redesign of booking and scheduling processes, outsourcing options and improved productivity.
- Elective Surgery Centre FSA project "one stop shop" to be completed by July 2013
- Continue to use the national CPAC priority scoring tool
- Formalised elective agreements will be in place with private elective providers
- Commence building of the dedicated purpose-built elective facility (Elective Surgery Centre) on the North Shore hospital campus February 2012 to be completed by 2013.
- Perform 100 Bariatric procedures in 2012/13 with a focus on Māori and Pacific people
- The "one stop shop" project will improve the quality of elective referrals from GPs

How will we know we've achieved it? Measured by –

- Increase the volume of elective surgery by delivering 15,853 elective surgical discharges in 2012/13 (25% of the entire national increase required of the country in 2012/13)
- Improve our electives services standardised intervention rates in relevant specialties
- A "one stop shop" model of FSA is developed and piloted for the Elective Surgery Centre
- Patients accepted for surgery are willing, fit and available for surgery and will have surety that they will not wait over six months for FSA or elective treatment
- Waiting times for elective surgery will be reduced to no longer than five months by June 2013 and four months by June 2014
- 100 Bariatric procedures are performed 2012/13
- Theatre capacity is consistently running at 90% with theatre utilisation meeting 85% target
- Day of Surgery Admission (DOSA) rate to meet target of 92%

Cancer Services

What are we trying to do?

Reduce the rate of disease and premature deaths caused by cancer in our community.

Why is this important?

Cancer is responsible for almost one in every three deaths of our residents and is an identified national and regional priority.

Achieving good coverage rates in screening programmes – such as breast and cervical screening – improve patient outcomes through early diagnosis. Shorter waits for consultation, diagnostic services and treatment, at every stage in the patient journey, contribute to better outcomes for patients. Better care coordination and patient navigation can contribute to this goal, especially for our more vulnerable groups.

New diagnostic and therapeutic modalities such as bowel screening and reduced intensity conditioning bone marrow transplant are creating exciting opportunities to improve cancer outcomes that we should, and will be exploring. We therefore need to be innovative in finding ways to fund, commission and deliver medical oncology and other cancer services in a more efficient manner.

Progress to date

The Auckland region has consistently achieved the four week radiotherapy target for over two years and Waitemata is current achieving 95% for the chemotherapy target. We have already commenced planning for the new 14/31/62 day waiting time indicator.

In care coordination, we are one of the few DHBs with both a Māori and Pacific navigation service in place and we have been active participants in the development of the regional model.

In 2011/12 Waitemata implemented the National Colonoscopy Prioritisation Criteria, which has enabled us to prioritise referrals.

With Bone Marrow Transplantation, a haematological clinical network was formed this year and the business case for an expanded service was approved by Auckland DHB to improve capacity.

Waitemata is making good progress in the implementation of the national Bowel Screening pilot.

How are we going to do it? (Key planning approach)

In planning and implementing improvements in cancer care Waitemata DHB works closely with the Northern Cancer Network, the Regional Oncology Operational Group and regional cancer service provider Auckland DHB, as well as our two PHOs.

Project Groups will be established to work with Regional/Ministry of Health partners to produce consistent, feasible operational definitions for the 14/31/62 day indicator. We will identify the appropriate data sources, modifying our information systems where necessary, with clinical oversight through the Waitemata Cancer Control Governance Group.

Northern region DHBs, including Waitemata are working to improve the functionality of multi-disciplinary meetings (MDM) through tumour stream work and the development of electronic MDM forms. Waitemata will introduce more accessible and expanded teleconferencing resources, determine required co-ordination, administrative and other supports for constructive MDMs.

In addition, the Northern Region has an interest in supporting 4 of the 8 tumour streams that the Ministry of Health is investing in that will yield national standards for the vast majority of cancer types. The national melanoma tumour stream will be led by Waitemata if this is agreed through the national process. We will work other Northern DHBs to establish better patient referral processes to MDM, encourage greater core

How are we going to do it? (Key planning approach) – continued

multi disciplinary participation and determine the possible need for Nurse Specialist support within tumor streams. The four tumor streams relevant to our local services will have multi disciplinary meetings. These are upper gastro intestinal, breast, bowel and melanoma.

In order to achieve the national colonoscopy waiting time target we will employ new senior medical officers to increase our capacity in gastroenterology and make more efficient use of our endoscopy infrastructure.

We will improve patient coordination, explicitly linking these services to achieving the health targets for faster cancer treatment. We will extend Māori and Pacific cancer navigation district-wide.

Our PHOs will be contracted to provide free cervical screening for Asian, Māori and Pacific women

Work to improve access to bone marrow transplantation will be conducted primarily by Auckland DHB as the regional provider of this service - we will ensure that funds are available to pay the costs of the improved service.

Specific deliverables/actions to deliver improved performance

- Work with Auckland DHB and local services to ensure the health targets for radiation and chemotherapy treatment are consistently met
- Establish baseline data for the new 'Faster Cancer Treatment (PP-17)' indicator and implement a mechanism which enables collection of the required information during quarters 1 and 2 2012/13
- New service specifications for the Whānau Ora and Pacific Navigator programmes
- Care coordination system developed in our provider arm to ensure patients receive their first appointment and cancer treatment within the specified timeframes
- New facilities for bone marrow transplant functioning at Auckland DHB by June 2013.

How will we know we've achieved it? Measured by –

- Everyone needing radiation or chemotherapy treatment will have this within four weeks (National Target)
- Baseline data for the following measures: all patients referred urgently with a high suspicion of cancer have their first specialist assessment within 14 days, and all patients with a confirmed diagnosis of cancer receive their first cancer treatment (or other management) within 31 days of decision-to-treat and all patients referred urgently with a high suspicion of cancer receive their first cancer treatment (or other management) within 62 days. [DV1]
- 50% of people accepted for urgent diagnostic colonoscopy receiving their procedure within 14 days
- 50% of people accepted for diagnostic colonoscopy receiving their procedure within 42 days
- 50% of people on surveillance or follow-up colonoscopy waiting no more than 84 days beyond the planned date
- 70% of patients with rectal and colon cancers up to and including stage 3 being discussed at Multi-disciplinary meetings (MDM)
- 60% of patients referred urgently with high suspicion of lung cancer receiving first cancer treatment within 62 days, 50% receiving first specialist assessment within 14 days, and 50% with lung cancer as confirmed diagnosis receiving first cancer treatment (or other management) within 31 days of decision to treat
- 20% increase in the number of patients receiving cancer care coordination services
- Increase in cervical screening coverage (25-69 year olds) to 75%*

* note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term

Immunisation

What are we trying to do?

Improve the health and wellbeing of children in Waitemata through achieving the national immunisation health target – children fully immunised at 8 months (85% in 2012/13, 90% in 2013/14, and 95% by 31st December 2014)

Why is this important?

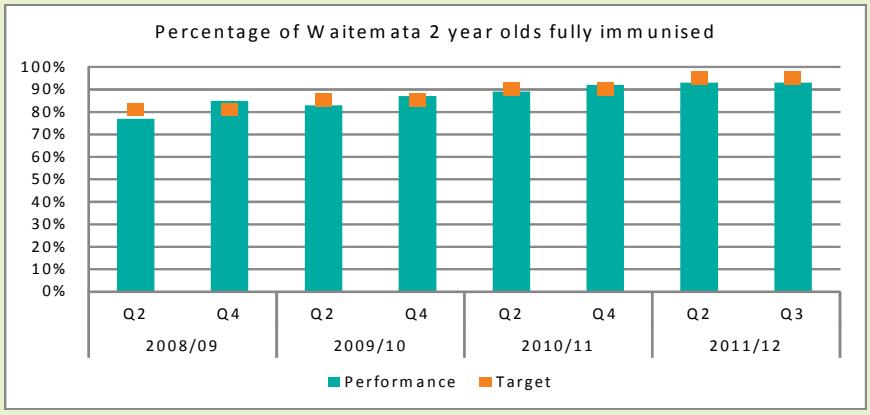
A health system that functions well for immunisation is one that:

- immunises children on time through streamlined systems for registering newborns on the National Immunisation Register (NIR) and provides accessible immunisation services that suit different population groups
- intervenes early in the life course in order to reduce unnecessary suffering, provide better long term prognosis, and better cost efficiency
- supports parents to make immunisation decisions through a well-trained, confident and trusted workforce
- ensures vertical and horizontal integration across social sector services as well as primary and community care
- has a focus on quality improvement in particular reducing unavoidable variation in service and clinical outcomes (including evaluation and monitoring)
- never misses an opportunity to immunise an infant who is overdue for an immunisation

Progress to date

This is a new national health target. With the current health target we are currently sitting at 93% of two year olds fully immunised at 24 months – the highest it has ever been for our DHB. We have achieved this result using the following strategies which will continue in 2012/13:

- Increased knowledge and awareness amongst Midwives about immunisations
- Increased number of Practice Nurses with up-to-date knowledge, and ensured General Practice are following immunisation guidelines
- Developed robust referral processes to Outreach Services
- Developed a strong and experienced steering group
- Prepared consistent data analysis to identify overdue Children in a timely manner



How are we going to do it? (Key planning approach)

- Establish ADHB/WDHB combined steering and operational groups.
- Provide training to frontline staff working with children and their families/whanau eg Plunket nurses, Whānau Ora workers, Family Start
- Review precall/recall processes eg implement 4 week precall from NIR using text reminders.
- Identify and work with practices with overdue vaccination episodes to improve timeliness.
- Undertake a parent survey on how to improve access to immunisation in the Waitemata district.
- Review and improve handover of mother and child as they move through the maternity and primary care system
- Fund Outreach Services ($450k) to improve immunisation rates

Specific deliverables/actions to deliver improved performance

- 85% of children fully immunised at 8 months by 30 June 2013
- Systematic pre-call of all children 4 weeks prior to date immunisation due by September 2012
- Practices to instigate systematic repeat recalls for all children 2 weeks overdue by September 2012
- Identify all children overdue immunisations and ensure practices have followed the recall process and referred to outreach by September 2012
- Education sessions for all Practice staff to ensure they are following new pre-call and recall process by 31 March 2013
- Children two months overdue for immunisations are referred directly to outreach by 31 March 2013
- Children with no provider at birth are referred directly to outreach to ensure early linkage with providers
- Handover between LMC and well-child providers improvements implemented by 31 March 2013
- Other processes may need to be implemented once the percentage of Waitemata children fully vaccinated at 8 months is known. This data will be provided by the Ministry in the next few months.

How will we know we've achieved it? Measured by –

- 85% children are fully immunised at 8 months (using NIR data)
- See Child and Women's health section for newborn enrolment deliverables and measures

Tobacco

What are we trying to do?

Reduce smoking prevalence and diminish the harm to our community caused by tobacco smoking.

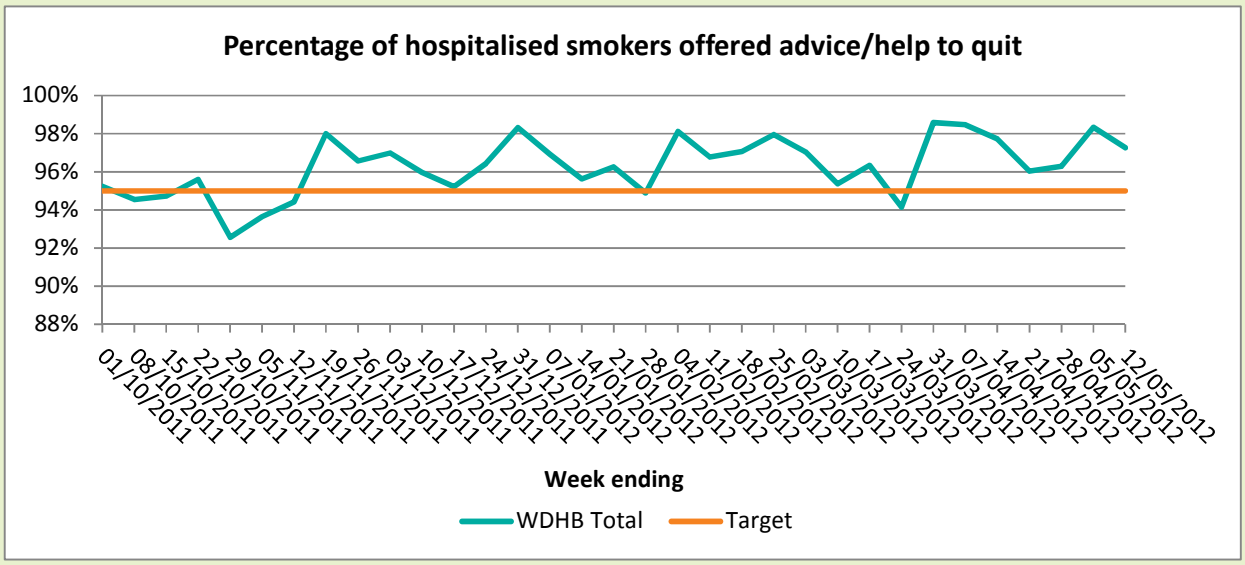
Why is this important?

Smoking is the single most modifiable risk factor causing disease and death in our community. This is particularly so for Māori and Pacific, resulting in a significant reduction of quality of life and years of life. This also results in a significant financial burden to the health system.

New Zealand also has relatively high rates of smoking in pregnancy, reducing these rates lead to better maternity and neonatal outcomes.

Progress to date

We have consistently exceeded the Health Target for hospitalised smokers.



- We have eight targeted face-to-face fully funded smoking cessation services in place
- We have supported primary care and non-government organisations (NGO)s to implement smoking cessation strategies through training over 75% of DHB and PHO clinical staff in 'Ask, Brief Advice, Cessation Support' (ABC), and providing train the trainer support.
- PHOs have the systems in place to report against PPP Smokefree Indicators
- We have an active Smokefree Advisory group
- A Community Pharmacy Smoking Cessation pilot has been successfully completed
- Joint planning and consistent smokefree approach established between ADHB and WDHB for primary care.

How are we going to do it? (Key planning approach)

Plan for consistent services and approaches for primary care across ADHB and WDHB

We will continue to implement many of the strategies in place during 2011/12 including:

- Providing timely feedback to services regarding performance against the health target
- Developing skills in ABC of all DHB and PHO clinical staff
- Funding specialist support for highly dependent/high risk smokers and face-to-face smoking cessation programmes for high priority groups
- Planning initiatives with Lead Maternity Carers (LMCs) to ensure timely advice and support to quit is provided to pregnant women who smoke
- Fund primary care and hospital services to support the provision of the above programmes to achieve the Better Help for Smokers to Quit Health Target

Specific deliverables/actions to deliver improved performance

- To further ensure that clinical staff are strongly supported in their service, 20 hospital services will have a 'STEPS' trained and supported smokefree educator within their team by July 2013.
- All parents of paediatric patients will receive advice and support to quit smoking by June 2013.
- PHOs to develop a plan by September 2012 of how they are going to raise Health Target performance, with a particular focus on high priority groups (pregnant women, Māori and Pacific).
- Work with PHOs to ensure that quitting support for smokers is included in clinical service planning
- Additional 10 NGOs will be supported to train staff in the ABC approach and develop smokefree policies
- A plan is developed by September 2012 to ensure pregnant women are provided with advice and support to quit by Lead Maternity Carers

How will we know we've achieved it? Measured by –

- Achieve the tobacco health target:
  - 90% of enrolled patients who smoke and are seen in General Practice, will be provided with advice and help to quit by July 2013
  - 95 % of hospitalised smokers will be provided with advice and help to quit by July 2013.
  - Sub-target – 90% of pregnant women who identify as smokers at the time of diagnosis of pregnancy in general practice or booking with a Lead Maternity Carer are offered advice and support to quit.
- The contracted smoking cessation services will achieve quit rates of at least 25% at 3 months and meet their target volume of clients.
- Population smoking prevalence rates decline as per 2013 census data.

Long term conditions

What are we trying to do?

Reduce the health problems and premature deaths caused by chronic disease such as cardiovascular disease and diabetes.

Why is this important?

Over 800 Waitemata residents die of ischaemic heart disease, stroke and diabetes every year. Cardiovascular disease when present with diabetes compounds the clinical risk for people and increases their likelihood of having more health problems. For this reason Waitemata, the northern region and the Ministry of Health continue to focus on this area. In 2012/13 the Ministry of Health will include 'more heart and diabetes checks' as one of the national health targets.

Progress to date

We have increased the number of heart and diabetes checks to achieve 54% coverage of the population.

We are working with the regional networks for diabetes and cardiovascular disease to improve care.

The DHB provides diabetes self-management education programme for Māori and Pacific patients with good outcomes experienced by Pacific patients.

Diabetes self-management education continues for other people with diabetes. The DHB is working with the other metro-Auckland DHBs to identify a way to provide a consistent regional overview of workforce education and service quality.

More people with diabetes are accessing podiatry for diabetic foot disease.

The DHB continues to work with the PHOs to optimise access to diabetes annual reviews and cardiovascular risk assessment.

We are working with the PHOs to align all diabetes and cardiovascular service agreements into one service.

North Shore Hospital has dedicated stroke inpatient beds, with plans for the same at Waitakere Hospital. 24/7 access to thrombolysis is also on track to be in place by July 2012. The service is subject to regular audit against international best practice standards.

How are we going to do it? (Key planning approach)

We will:

- Support the implementation of nurse led/multi-disciplinary team clinics in primary care/integrated family health centres for the five year cardiovascular risk assessment and diabetes care.
- Engage with the regional networks and business cases to ensure continuous care models developed.
- Support the northern regional diabetes network in their development of Quality Improvement Teams with an initial team funded for the West Auckland locality (which includes ADHB practices)
- Focus the diabetes improvement plan on service delivery models that reduce variance in health outcomes. Target areas: Māori/Pacific and those with high clinical needs or newly diagnosed
- Provide continuity of service for a minimum of 3 years to aid the sustainability of primary services.
- Support the development of Primary Care Networks (locality clusters) to develop as GP collaboratives to look at practice variation in diabetes care
- We will develop a new model of care for the Pain Management Service based on timely delivery of community education, integration with primary care, secondary service support and placing patient assessment and care at the centre of our service.

Specific deliverables/actions to deliver improved performance

- Five year heart and diabetes check completed by general practice/nurse led clinics for 75% of the eligible population by 30 June 2013:
  - Systematic recall of all eligible people to a nurse led clinic
  - Active recall of everyone who has not had a risk assessment in the first year of the 5 year window.
  - All people with diabetes who have a five year cardiovascular risk assessment will have their diabetes health assessment at the time of their cardiovascular risk assessment
  - Primary care/Nurse led multi-disciplinary team will provide approximately 5000 local people with diabetes/CVD care to assist with the management of their co-morbid conditions by 30 June 2013
  - Diabetes centre staff will support primary care staff to deliver nurse led clinics through shared care planning and on site sessions with practice staff through a minimum of 11 practice education and 23 practice engagement sessions by 30 June 2013.
  - Work with the Northern Region Diabetes Network to establish key functions of the Quality Performance Team and the service delivery model to improve patient care by October 2012
  - Secondary services weekly diabetes clinic at Waipareira Trust facility in west Auckland by 31 December 2012.
- See Appendix for the Diabetes Care Improvement Package plan proposal deliverables/ measures
- Speech Language Therapists are implementing a new swallow screen which will reduce the incidence of aspiration pneumonia as a complication of stroke by January 2013
- Develop and implement a training, education and resource (including a pain education and management website) programme for patients, primary care physicians and secondary services based on innovative, patient specific interventions that rely on stratifying patients to individual, group based or GP partnership models of care by 30 June 2013

How will we know we've achieved it? Measured by –

- 75% of all eligible people will have a 5 year cardiovascular risk assessment by 30 June 2013
- People known to have diabetes will receive a diabetes review at the time of their 5 year cardiovascular assessment (PHO performances data from the DHBNZ)
- 63% of the eligible population will have had their diabetes annual review by June 2013
- 72% of the eligible population will achieve good diabetes management
- Diabetes Quality Improvement Team (QIT) implemented in West Auckland (Waitakere and Whau wards) covering an enrolled population of 208,000 and 40 practices by – active by October 2012
- Development of a new model of care for diabetes in West Auckland by April 2013 to be in place through integrated family health centre developments
- Incidence of hospital acquired post stroke pneumonia rates reduced by Speech Language Therapy research (impact of the bedside cough reflex test and Fibre Optic Evaluation of Swallowing (FEES)) and revision of the swallow screening tool due January 2013.
- Progress towards 80% of patients who have had a stroke admitted to a stroke unit
- 6% of stroke patients will be thrombolysed
- An increase in the number of patients managed by the Pain Management Service, a reduction in follow up reviews, and an increase in functional improvements in our patient population.

Primary care development and delivery

What are we trying to do?

Develop a more cohesive, accessible, efficient, effective, safe, and sustainable health system for our community through increased integration of community, primary care, and secondary care health services.

Why is this important?

Integration is important for improving patient outcomes and experience. A more integrated health system will ensure that healthcare services are delivered in the right place at the right time, whether accessible and affordable first point of contact services, or intensive hospital treatments. It will also address the demands on primary and secondary care capacity, nationally, regionally and locally, caused by a growing and aging population, increasing expectations around quality of clinical outcomes and global and national economic challenges. We need to improve how clinicians work together across and within the health system, how we plan and monitor services for localities, how patients access and journey through our services, thereby creating a more efficient, effective and sustainable health system.

Progress to date

- West Auckland Health Network (consisting of primary care and DHB secondary care clinicians and community representatives) has been established with a framework of agreed principles, initial objectives and high level capacity requirements
- Quantitative local health needs assessment data compiled and presented in an interactive geographic format across all Auckland and Waitemata DHB areas
- Space has been leased and DHB services are being delivered within Whanau House in Henderson
- Space leased in the New Lynn Integrated Family Health Centre for future delivery of DHB services in 2013/14
- The Greater Auckland Integrated Health Network (GAIHN) annual plan projects are on track for 2011/12 delivery in areas such as Primary Options for Acute Care (POAC), predictive risk analysis, minor skin surgery, access to diagnostics, optimal prescribing pilot.
- 1,200 minor skin surgery procedures delivered in the community (Counties Manukau DHB: 400, Waitemata DHB: 500, Auckland DHB: 300) and 20,000 POAC referrals for 2011/12
- New clinical pathways developed for Gout, Depression, Chronic Obstructive Pulmonary Disease (COPD), Transient Ischaemic Attack (TIA), and Pneumonia
- Implementation of an agreed Auckland Regional After Hours Network

How are we going to do it? (Key planning approach)

The emphasis for 2012/13 is to:

- Create partnerships between clinicians and local communities to determine local health priorities, co-design new models of care and drive quality improvements
- Embed an inter-sectoral approach, including working with local government through elected Local Boards, to better integrate health and social services
- Develop a primary care infrastructure that encourages the integration of services both within primary care and between community and hospital based services including the development of Integrated Health Networks (IHNs) to undertake locality planning, and clinical pathway development and clusters to look at service design and provision for enrolled populations

Specific deliverables/actions to deliver improved performance

Integrated health services

- Implement overarching governance mechanism for integrated care across Auckland and Waitemata
- Up to 3 Integrated Health Networks (Auckland Central, Auckland North and Auckland West) operating across Auckland and Waitemata DHBs by June 2013
- Initial assessment of service outcome and value patients' points of view to inform locality plans completed by December 2012 – WDHB Only
- Jointly agreed locality plan for Auckland West locality submitted to the Ministry of Health by 31 December 2012
- Jointly agreed locality plans for Auckland Central and Auckland North localities submitted to the Ministry of Health by 31 March 2013
- Develop integrated models of care in the two priority areas of diabetes, and child health through clusters by June 2013
- The Integrated Health Networks (IHNs) to identify and assess opportunities where there is sufficient volume to enable integration or co-location of secondary care services with primary care
- Local implementation of the regional quality improvement plan for diabetes (via the West Auckland Health Network)
- Up to 4 Integrated Family Health Centres operational in Auckland DHB and Waitemata DHB and delivering at least 4 models of integrated care by June 2013
- Explore integrated model of care for sexual health services
- Primary / Secondary clinical liaison role in place by December 2012 – WDHB only
- A working group established to review and reshape funding models for integrated care (including nurse led clinics) by March 2013 (working group established in Q2, contracts potentially reshaped in Q3) - ADHB only

Specific services to be more accessible to our community

- Pilot integrated model of care in primary care for people with complex or lower leg wounds –WDHB only
- Deliver via the Auckland Regional After Hours Network access to free after hours care for under 6's
- Deliver regional primary options for acute care (POAC) volumes in line with regionally agreed criteria, targets and timeframes
- Provision of specialist support to aged care residences of gerontology nurse specialist, dietitian and clinical pharmacists to better support patients in the community – WDHB only
- DHB services to be delivered in Whanau House in Henderson and New Lynn IFHC determined (engagement with community, primary and secondary care in Q1, service delivery volumes and business case in Q2, Board approval in Q3)

Better management of high risk individuals

- Implement GAIHN shared care planning for high risk individuals using the GAIHN predictive risk planning tool and better response to acute events in aged residential care workstreams
- Support the GAIHN approach to management of acute events in aged residential care (both in and out of hours)
- Implementation of GAIHN's clinical pathways in Gout, deep vein thrombosis (DVT) and community acquired pneumonia (CAP) and the regional Dementia pathway – WDHB Only

How will we know we've achieved it? Measured by –

- 3 Integrated Health Networks in place (2 in WDHB, 1 in ADHB)
- 4 Integrated Family Health Centres operational across Auckland and Waitemata DHBs by June 2013
- New Lynn Integrated Family Health Centre operational and delivering new models of care in line with West Auckland's locality plan by 2013-14
- Whanau House in Henderson delivering new models of integrated care by June 2013 (engagement with surrounding practices in Q1, developing a new model of care in Q2 and implementation in Q3/4)
- Co-design process in place to explore new models of care within the development of Waiheke Integrated Family Health Centre by June 2013
- Implementation of new models of care in collaboratively agreed priority areas within Alliance Health + Integrated Family Health Centres (engagement with surrounding practices in Q1, developing a new model of care in Q2 and implementation in Q3)
- Review current integrated care models being delivered in rural settings (Rodney) by December 2012 for potential networking between Integrated Family Health Centres in 2013/14
- Supported by 4 Clusters in Waitemata DHB by June 2013 – WDHB Only
- A diabetes care pathway developed and implemented in West Auckland by December 2012 : (development in Q1 and implementation in Q2)
- 63% of the eligible population will have had their diabetes annual review by June 2013 – WDHB Only
- A child health care pathway based on the priority areas identified in the ADHB/WDHB Child Health Plan developed and implemented by June 2013 (area identified in Q1, development complete in Q3, implementation in Q4)
- Implementation of GAIHN's regional pathway for Gout by March 2013 (engagement and planning in Q2, Implementation in Q3) – WDHB Only
- Implementation of GAIHN's regional pathway for community acquired pneumonia (CAP) by March 2013 (engagement and planning in Q2, Implementation in Q3) – WDHB Only
- Implementation of GAIHN's regional clinical pathway for deep vein thrombosis (DVT) by June 2013 (engagement and planning in Q3, Implementation in Q4) – WDHB Only
- A dementia pathway, which is regionally consistent wherever possible, will be initiated by 30 June 2013
- Roll out complex or lower leg wound pilot in up to 5 practices in Waitemata by June 2013 – WDHB Only
- 95% of metro Auckland's population can access free under 6's after hours services by June 2013 (baseline in Q1 and quarterly targets set for Q2, Q3 and Q4)
- Prevent 25% of readmissions of high risk groups (Maori and Pacific patients over 55 years and all other ethnicities over 65 years) identified through WDHB's predictive risk model – WDHB only (determine baseline in Q1, 5% reduction in Q2, 15% in Q3 and 25% reduction by Q4)
- Readmission rates for 75+ population will reduce to 14.79% (current baseline: 15.63% 2011 year)
- In quarter 1 baseline and develop an avoidable admissions plan for high risk individuals identified by the GAIHN Predictive Risk Algorithm. In quarter 2 set a regional target (and specify WDHB contribution) for percentage decrease in growth of bed days and percentage reduction in inpatient admissions for identified individuals in Q2, Q3 and Q4 to be delivered by June 2013
- 2,000 bed day reduction in acute admissions from aged care sector across the northern region by June 2013

- 10% reduction in number of residents from aged care facilities presenting to Adult Emergency Department through GAIHN's project to improve primary care support within facilities by June 2013: (determine baseline in Q1 and set trajectory for Q2, Q3 and Q4)
- Support the National Hauora Coalition to reduce ASH rates for under 2 year olds by 1% from current baseline by June 2013
- Deliver in collaboration with Auckland and Counties Manukau DHBs 23,500 Primary Options Acute Care (POAC) episodes across metro-Auckland, resulting in at least 19,975 avoided attendances at hospital emergency departments by June 2013:
  - 5,700 POAC episodes of care in ADHB resulting in at least 4,845 avoided attendances at ED (up from 4,240 cases in 2011/12)
  - 6,150 POAC episodes of care in WDHB resulting in at least 5,227 avoided ED attendances (up from 2011/12 target of 5,200 cases)

Mental Health including Child and Youth Mental Health

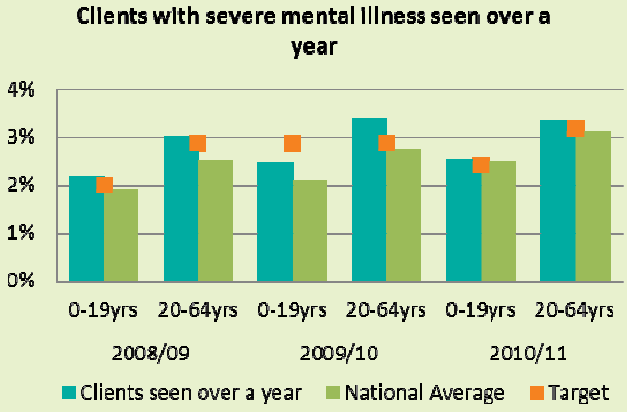
What are we trying to do?

Provide effective and accessible mental health services with our inter-sectoral partners to improve mental health outcomes with a particular focus on children and young people.

Why is this important?

Mental health and addiction issues are more common than typically recognised with higher personal impact than any other disease group, and societal impacts that go beyond the individual and health sector. Earlier intervention in the life course reduces the short term effects and minimises impact in adulthood with improved health, social, cultural and social inclusion outcomes. Cohesive and/or integrated service provision is a national and regional priority. Combined with a connected multi-agency system of care the use of high risk pathways through mental health, addictions and child, youth and family services (CYFS) is minimised and is thus more cost effective.

Progress to date



Continued implementation of 5 year stakeholder plan across primary, non-government and secondary care

Maintained and continued to strengthen existing sector partnership and innovation

Continued to perform well against national health targets for Mental Health and Addiction services and sector KPI

Developed alternatives to hospital based services in partnership with stakeholders

Progressively implemented the Child and Youth workstream priorities of the agreed 5 year stakeholder plan, with a particular emphasis on Māori, Pacific and Asian populations.

How are we going to do it? (Key planning approach)

- Support and implement local, regional and sub-regional (ADHB) priorities in mental health and addictions, including clinical pathway and workforce development, joint contracting, suicide postvention planning, and youth forensic services development
- Sharing information and staff working across partner organisations – primary care, NGOs
- Continue to develop primary & multi-agency services eg Gateway, Intensive Clinical Support Service (ICSS), Child Adolescent Liaison Service (CALS), The Incredible Years/Triple P
- Support the Waitemata Stakeholder Network (WSN)
- Contribute to local, regional and national planning for perinatal and infant mental health services.
- Service development – Eating Disorders Liaison Service and Co-Existing Problems (CEP) capability
- Participation in national KPI benchmarking processes.

Specific deliverables/actions to deliver improved performance

- Agree multi-agency actions to improve early screening, detection and early interventions of mental health and addiction issues by January 2013
- Increase in Family/Whanau participation across all services /agencies and support to them (family forums) – measured through KPI reporting and participation in Family Forums by June 2013
- Identify opportunities for emerging models of integrated and/or collaborative clinical service delivery (Primary care, NGO and DHB clinical teams) Eg primary care liaison roles by June 2013
- Increase flexibility of rehabilitation services through shift to new model of contracts by end 2012/13
- Performance and productivity improvements measured through regional / national KPI benchmarking and the Te Aranga Hou (Lean Thinking) service improvement programme in provider arm, specifically – average length of stay acute inpatient, 28 day readmission rate, inpatient HONOS score; and community treatment days
- Develop a multi/interagency strategy for services for high risk children and youth, to include transition, discharge and follow up protocols by 30 June 2013
- Implement the advanced level of the Choice and Partnership Approach (CAPA)
- Child and Adolescent Mental Health Services (CAMHS) and Altered High will engage in a collaboration project to increase referrals, access rates and co-existing problems (CEP) competencies across both services
- Establish Specialist Interagency Response to Conduct Problems (SIRCP) service (Incredible Years contract) by 30 September 2012
- Enhance provision of Infant Mental Health services by developing and delivering a staff training module for infant mental health
- Develop and deliver basic Eating Disorder and Co-Existing Problems core skills training for clinical teams by 31 December 2012.
- Work with key stakeholders to perform a stocktake of self-management tools and resources and ensure access is readily available to young people and their families, by June 2013
- Meet national targets for waiting times and access rates for both CAMHS and Altered High.

How will we know we've achieved it? Measured by –

- Achievement of national access rate targets - 0-19 – 3% total, 20-64 – 3.47 % total (PP-6)
- Shorter waits for non-urgent mental health services (PP-8), 70% of people seen within 3 weeks, 90% within 8 weeks overall and for addiction services – 80% within 3 weeks, 95% within 8 weeks (0-19 years) and 80% within 3 weeks, 95% within 8 weeks (20-64 years) – provisional targets only
- Adult mental health and addiction KPIs – child and youth, adult, forensic established by December 2012
- Develop measure for recording waiting times for psychological therapies – provide quarterly report to Waitemata Stakeholder Network (WSN) by December 2012
- Development and use of WSN balanced score card to include social inclusion measures by September 2012
- Number of families supported by service from July 2012 - June 2013 and number of programmes facilitated by service up until July 2013
- Establish baseline and agree targets for rates of family and behaviour assessments performed by the service per annum by June 2013
- Number and skill mix of staff trained in Infant Mental Health module between Jan 2013-June 2013
- Number and skill mix of staff trained in Eating Disorders and Co-existing problems by December 2012

Health of Older People

What are we trying to do?

Maximise years of life and quality of life of our older people through the provision of flexible, innovative, streamlined and integrated services.

Why is this important?

Our elderly population is growing rapidly and is projected to be a significant proportion of our population (15% will be over the age of 65 years by 2021), using a substantially greater proportion of our services than other age groups. As at 2011 the >65 population in WDHB area is 66,175 (up from 47,700 in 2001 and 55,300 in 2006) which equates to increases of 16% every five years. We need to be equipped to deal quickly and efficiently with patients with complex needs to ensure they can access specialised services, particularly for stroke, dementia and delirium. Our commitment to providing high standards of quality, professionalism and humanity for our patients supports the regional goal of 'improving the quality of life for older people and their family/whanau' as well as the government's priority for health of older people.

Progress to date

The Regional Health of Older People (HOP) Clinical Network has been established and the HOP implementation plan developed. There are also cross-over objectives into the "Informed Patient" plan with regard advanced care planning; and into the "First do no Harm" plan with regard falls prevention, pressure injury prevention and medication safety for high risk patients.

Established Specialised Services for Older Adults (SSOA) Governance Group and Stakeholders' Network.

Work is well underway for the Single Point of Entry project. The other work streams are making progress. $1.2m has been set aside in capital funds to refurbish the Kingsley Mortimer Unit (Ward 12).

In 2011/12 we launched our Integrated Transition of Care (previously Readmissions) project which provides discharge support to older people who have been hospital inpatients to reduce readmissions.

InterRAI for aged residential care was started in December 2010, a four year national implementation.

InterRAI implemented into the NASC teams - 36% of staff having achieved competency in 2011.

Dementia day care services are currently being tendered with implementation from 1 July 2012.

The Home Based Support Services (HBSS) Taskforce has contained growth in expenditure to under 2%.

Residential Aged Care Integration Programme (RACIP), up and running since 2007/08, has proven to reduce admissions and improve outcomes for residential care clients

Waitemata is a late adopter of InterRAI and is still training assessors – due for completion January 2013

How are we going to do it? (Key planning approach)

Maintain SSOA Governance Group/Stakeholders' Network to oversee SSOA programme of work.

Ensure Project Work Groups have dedicated project management/ clinical engagement/leadership

Actively participate in the Regional HOP Clinical Network and the Northern Region Stroke Network Group

Continue to support the implementation of the following projects:

- The Hospital Discharge Support Service (HDSS) – part of the Integrated Transition of Care project (previously the Readmissions project)
- Review of Home based support services (HBSS)
- InterRAI (clinical assessment tool and process)
- Gerontology Nurse Specialist in Primary Care (Waitemata PHO/University of Auckland collaboration)

We will continue to advise and train health professionals in Residential Aged Care Facilities through our Residential Aged Care Integration Programme (RACIP).

Specific deliverables/actions to deliver improved performance

- We will invest our share of the $3 million in pharmaceutical budget savings in smarter services for older people, including hospital discharge and rapid response teams and our share of the $2.5 million allocated for the development of dementia pathways
- Continue the roll-out of the Integrated Transition of Care (previously Readmissions) project to identify and focus on those with the highest likelihood of hospital readmission, particularly those 65+ years.
- Support regional initiatives to improve falls and pressure area rates
- InterRAI training for NASC is completed by December 2012
- InterRAI benchmarking between DHBs on core quality measures is progressively developed nationally through 2012/13 as the volumes of clients who have had an InterRAI assessment completed increases
- Progress with the national implementation of InterRAI into aged residential care over the next four years – meet monthly with providers and utilise dedicated email service for queries
- HDSS pilot phase running from 1 April 2012 to 31 March 2013 - formative evaluation to follow
- Single Point of Entry project from pilot phase to full implementation by December 2012. This will provide an integrated access point for Older Adults and Home Health
- Re-scope delirium work as a Rigour project – subsequent improvement work complete December 2012
- Pilot(s) for regional dementia work stream to be developed and started by December 2012
- Review the memory service and work with primary care to ensure people with a diagnosis of dementia are placed on a dementia care pathway
- Implement Dementia Day Care Services starting September 2012
- Continue to work with primary care (Waitemata PHO) to develop specialist gerontology services.
- Work with GAIHN through 'Avoidable Admission/Presentations from ARRC' group to collect robust data
- Work with 'Aged Residential Care Health Utilisation' study group and with GAIHN to identify quality improvement mechanisms to reduce avoidable acute hospital admissions.
- Continue to deliver the RACIP programme which employs a team of Gerontology Nurse Specialists (GNSs) 6 in total: 3.3 FTE and two 0.5 FTE Wound Care Nurse Specialists led by the Gerontology Nurse Practitioner 0.5 FTE. (The other half of the GNS and Nurse Practitioner role is with community dwelling older adults)

  The GNSs provide outreach services to 3300 ARRC beds in 58 ARRC facilities in our district. The GNSs also provide proactive education and clinical coaching for RAC staff at individual facilities.

  Each facility (58 in total) is offered at least one formal education session lasting approximately one hour every two months: 348 sessions. Topics for 2012 are: Documentation, End of life care (including basic nursing care), Medication safety in the elderly, Diabetes, Vital Signs for Care Givers. Some facilities will request an alternative topic or an extra topic. Informal one on one sessions occur that are opportunistic e.g. when assessing a resident.

  GNSs organise quarterly education sessions for staff who work in aged residential care to which they invite guest speakers from other specialties and organisations. These sessions are targeted at perceived need across the sector. The sessions which take place off site and last 3 hours are run in Rodney District, North Shore and Waitakere: a total of 12 sessions. Topics for 2012 are: Nutrition, Hydration and Dysphagia, Person Centred Care, Prevention of Pressure Injuries and Dementia and BPSD. Attendance so far: Nutrition, Hydration: 80. Dysphagia, Person Centred Care: 72

How will we know we've achieved it? Measured by –

- The SSOA work plan is delivered on time and within budget
- At least 75% of HBSS DHB Need Assessor staff will be trained and assessing older people in the community with interRAI by 30 June 2013
- Implementation of dementia care pathway initiated by June 2013
- Complete the pilot of the Integrated Transition of Care (previously Readmissions)project
- 10% reduction in acute presentations from aged residential care, resulting in a 200 bed day reduction
- 95% of older people (new clients) receiving long-term home support will have a (InterRAI) comprehensive clinical assessment and an individual care plan from January 2013 and 20% of existing long term clients will have a (InterRAI) comprehensive clinical assessment and an individual care plan by 30 June 2013, with a goal of reaching 95% by 30 June 2015 (PP-18)
- 20% of long term residents within the facilities that have received InterRAI training will have an InterRAI clinical assessment within the year
- Readmission rates for 75+ population will reduce to 14.79%
- Access and compare readmission rates for over 65s.
- 240 conversations about advance care planning are recorded by trained level 2 practitioners across the DHB for those 65+ years
- Shorter waits for non-urgent mental health services, 65% of people seen within 3 weeks, 80% within 8 weeks and addiction services: 80% within 3 weeks, 85% within 8 weeks (65+ year age group) – provisional only.

Cardiac Services

What are we trying to do?

Improve access rates and waiting times for patients needing cardiac assessment, diagnostics or treatment, with a particular emphasis on reducing inequalities, and reducing the disease and premature death caused by cardiac disease in our community.

Why is this important?

Cardiac disease is a major cause of death, illness and disability in our population and a large component of ethnic differences in life expectancy in Waitemata. There are many effective medical and surgical treatments that can reduce the burden of disease but these depend upon good access to diagnostic services and specialist assessment as well prompt intervention where appropriate. Provision of efficient and effective cardiac services is also a regional and a national priority.

We need to reduce our waiting times for these services in order to maximise their health benefit to our population and to reduce inequalities we need to make sure that Māori and Pacific receive equal access to these services. For some services such as electrophysiology, there are significant regional disparities in access with intervention rates in Waitemata currently lower than in other parts of the country. We need to determine what level of service provision is appropriate for our population and work towards meeting this.

Progress to date

In November 2011 we significantly increased our cardiovascular service capacity with the opening of the new 25 bed Lakeview Cardiology Centre at North Shore hospital, doubling our cardiac catheterisation capacity and preparing the way for a new Implantable Cardiac Defibrillator (ICD) service

Also in 2011/12 we conducted an audit of ethnic differences in cardiac revascularisation among patients with acute ST elevation myocardial infarction in order to better understand why Māori and Pacific are less likely to receive angioplasty. This audit informs the development of our strategy to reduce inequalities in cardiac revascularisation

In 2012/13 our increased volumes of cardiac bypass surgery will build on impressive gains already made in this service provision. In 2011 the number of procedures was 20% higher than it was in 2010.

How are we going to do it? (Key planning approach)

We will commission a new ICD service at North Shore Hospital. We will employ new staff to expand diagnostic echocardiography capacity, whilst implementing referral guidelines for this service. We will purchase additional cardiovascular surgery procedures from Auckland DHB and monitor the delivery of these closely. We will make a significant contribution to the National Electrophysiology Review. We will develop a strategy that responds to the causes of ethnic inequalities in cardiac revascularisation that we identify through our audit work once this is completed.

Specific deliverables/actions to deliver improved performance

- An ICD service will have been established at North Shore Hospital by July 2012 to improve access for our population
- We will have contributed to the National Review of Electrophysiology to determine the appropriate role of cardiac electrophysiology in the diagnosis and management of arrhythmias, and commenced implementation of any mandated recommendations arising from this by December 2012
- We will have implemented a strategy to address the causes of ethnic inequalities in cardiac revascularisation for patients with acute ST elevation myocardial infarction by March 2013
- Reduce waiting times for diagnostic echocardiography by June 2013
- Increasing the numbers of patients treated with cardiac bypass surgery over 2012/13 year.

How will we know we've achieved it? Measured by –

- Cardiac bypass surgery will increase by 10% from the 285 procedures performed in 2011/12 to at least 313 procedures in 2012/13.
- No more than 5% of patients referred to and accepted/graded for a transthoracic echocardiogram will wait more than 6 months
- Standardised intervention rates for cardiac surgery will be achieved - 6.2-6.5 per 10,000 of population
- 85% of elective coronary angiograms will be performed within 90 days of booking, and no patient will wait longer than 6 months
- 70% of patients presenting with an acute coronary syndrome who are referred for an angiography receive it within 3 days of admission
- 70% of outpatients triaged to chest pain clinics to be seen within 6 weeks for cardiology assessment and stress test.

Whānau Ora

What are we trying to do?

Improve the health outcomes of Māori/whanau who reside in Auckland and Waitemata DHBs.

Why is this important?

There are large inequalities in health outcomes for the people of Waitemata and Auckland districts.

Whānau Ora is a key cross-government work programme that aims to integrate the provision of health, education and social services. It is an approach that places families at the centre of service delivery, requires the health sector to work in a more seamless way with other parts of the social sector and expects improved outcomes and results for New Zealand families.

Waitemata and Auckland DHBs contribute to the strategic change for Whānau Ora in the district and works with providers to improve service delivery and build mature providers.

Waitemata and Auckland DHBs support the Better Sooner More Convenient Health Services for New Zealanders by actively engaging with Whānau Ora provider/s operating in the district, which will lead to improved service delivery and more mature providers.

Both Auckland and Waitemata DHBs are actively involved in a number of projects to improve service integration within their own services, between services in the hospital and in the community, and within services delivered in the community.

Progress to date

Whānau Ora stock take and development of research tools (information sheet and questionnaire) were completed in December 2011, with key informant interviews taking place in January 2012

Documents will be collected for review by May 2012, with analysis of interview notes and documentation completed by June 2012.

How are we going to do it? (Key planning approach)

Whānau Ora joint DHB policy development will occur via the following process:

A specific Whānau Ora stock take and review will provide a clear conceptual basis for Auckland and Waitemata DHBs to advance Whānau Ora locally within the context of the range of current Whānau Ora policy, provision and activity.

Key informant face-to-face interviews will be carried out using a brief, structured questionnaire. Key informants will be drawn from providers in the Auckland and Waitemata districts who deliver Whānau Ora services within the implementation of Better, Sooner, More Convenient Primary Health Care, the Te Puni Kōkiri-led Whānau Ora provision and Te Ao Auahatanga Hauora. Provider interviewees will include representatives of:

- The National Hauora Coalition
- Alliance Health Plus
- Te Whānau o Waipereira Trust
- Ngāti Whātua o Orākei Health Services
- Pacific Island Safety and Prevention Project
- Te Puna Hauora
- Te Hononga o Tāmaki me Hoturoa (ADHB).

The questionnaire will be aligned directly to relevant review objectives outlined above.

Specific deliverables/actions to deliver improved performance

- Implement consistent Whānau Ora policy across both Auckland and Waitemata DHBs
- Planned establishment of 2 Whānau Ora centres and networks across both Waitemata and Auckland DHBs
- Development of Te Runanga o Ngati Whatua's Whānau Ora strategy
- Facilitate 4 Whānau Ora collective hui per year
- Attendance and representation at Tamaki Whānau Ora Leadership group hui and report back to Māori Health Gain Advisory Committee.
- Develop a plan for service integration of services to Whānau Ora Centres
- Review current contracts funded by Waitemata DHB, of Whanau Ora Collective members to identify opportunities for contract integration
- Work with collectives to develop programmes of action for Whānau Ora collectives.

How will we know we've achieved it? Measured by

- Whānau Ora stock take analysis presented to Māori Health Gain Advisory Committee by –July 2012
- Whānau Ora across both DHBs implemented by September 2012
- 4 Hui with Whānau Ora Collectives completed July 2013
- Whānau Ora service integration plan completed September 2012
- Two Whānau Ora centres delivering integrated services to their communities July 2013
- Whānau Ora collectives have Programmes of Action approved and implemented July 2013.

Māori

What are we trying to do?

Increase Māori access to quality health care, in order to improve Māori health outcomes and reduce health inequalities for Māori.

Why is this important?

The leading causes of Māori death in both Waitemata and Auckland DHBs are cardiovascular diseases, cancer, respiratory disease, and endocrine conditions including diabetes. Inequalities exist for Māori within all these disease groups. High infant and perinatal mortality rates are key areas of concern.

Across the two DHBs major causes of death vary according to age group. While motor vehicle accidents, suicide and cancer are features for younger Māori, older Māori adults (65yrs+) have higher rates of disease and die at younger ages than non-Māori from conditions such as ischemic heart disease, cancer, diabetes and COPD.

In general, Māori are more likely to die earlier than any other population groups and are more likely to have suffered from conditions that are preventable through health sector interventions, particularly at the primary care level, than other populations.

Progress to date

Good progress is being made in the following areas:

- Better help for smokers to quit with Waitemata achieving the quarter one 2011/12 target and good improvement at Auckland DHB
- Immunisation – no Māori inequalities in immunisation with 94% coverage for 2 year olds for Waitemata DHB and 93% coverage for Auckland DHB
- CVD risk assessment with both WDHB and ADHB achieving the Q4 2010/11 target and improvement at both DHBs against the higher target for the current year
- Diabetes checks were achieved for both DHBs for Q4 2010/11, however a declining performance recorded for both DHBs for Q2 2011/12
- Joint Chief Advisor Tikanga has been appointed
- District wide lactation service for Māori women has been established in Waitemata DHB
- Two Māori nurse specialists have been employed in the provider arm at Waitemata DHB
- Paediatric services have been integrated into a primary care Whānau Ora centre setting in Waitemata DHB
- Joint DHB collaboration is underway to design an optimal model for Māori health services across both DHBs.

How are we going to do it? (Key planning approach)

- Māori Health teams will work closely with primary care to ensure alignment of strategy and activity across both DHBs
- A joint Māori Health Plan will assist the process and alignment of joint activity
- Māori clinical nurse specialist positions will be increased in the provider arm of Waitemata DHB
- Develop strategy to improve access for Māori to Bariatric surgery
- Both Auckland and Waitemata DHBs will jointly continue to implement some of the strategies in place for 2011/2012, where strategies have proved successful.

How are we going to do it? (Key planning approach) – continued

- Develop closer working links with secondary care in both DHBs to understand and support the interface between primary care and secondary care, by planning and funding initiatives to support improved utilisation by Māori of secondary care services eg cardiovascular disease
- Collaborate with Auckland DHB to review current screening policy and activity for Māori women and cervical screening, breast screening
- Diabetes and cardiovascular nurse led clinics in General Practice
- Contribute to the development of joint DHB rheumatic fever project

Specific deliverables/actions to deliver improved performance

- Development of joint DHB Māori Health Plan for 2012/13
- Strategy developed to improve Māori access to Bariatric surgery (Waitemata DHB only)
- Strategy for Māori developed across Auckland and Waitemata DHBs to address Rheumatic Fever
- Establishment of Diabetes nurse led clinics in primary care to target Māori who are at risk of not accessing care, or have high clinical needs and not currently accessing CarePlus
- Diabetes self-management programmes will be offered to 85 eligible Māori patients
- All Māori people eligible for bowel screening will be invited and supported to attend screening
- We will fund through the two PHOs, to deliver 2,200 free smears for the 2012/13 financial year
- 12 antenatal breastfeeding education classes provided for Maori women in the Waitemata district
- Collaborate with northern region DHBs to develop a Māori suicide postvention plan

How will we know we've achieved it? Measured by

- Joint DHB Māori Health Plan signed off by the Māori Health Gain Advisory Committee: Q1 2012/13
- Strategy recommended to the Maori Health Gain Advisory Committee for improving Maori access and utilisation to secondary services by - Qtr 2 2012/2013
- 75% of eligible Māori women access cervical screening: Q4 2012/13 (ADHB & WDHB)*
- 70% of eligible Māori women access breastscreening: Q4 2012/13 (ADHB & WDHB)*
- Strategy developed across DHBs to address Rheumatic Fever: Q3 2012/13 (ADHB & WDHB)
- Strategy approved for Māori access to Bariatric surgery: Q1 2012/13 (WDHB)
- 63% of eligible Māori patients will access annual reviews: Q4 2012/13*
- 85% of eligible Māori will participate in the diabetes self-management programme: Q4 2012/13
- 95% of eligible Māori will be invited to participate in the bowel screening pilot during the 2 year cycle
- Māori suicide postvention plan completed: Q2 2012/13
- 75% of eligible Māori will receive a cardiovascular risk assessment: Q4 2012/13
- 85% of Māori children are immunised at 8 months: Q4 2012/13
- 12 Antenatal breast feeding education programmes delivered – Qtr 4 2012-2013

* note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term

Pacific

What are we trying to do?

Increase Pacific access to health care and quality of care received, in order to improve Pacific health outcomes and reduce health inequalities for Pacific.

Why is this important?

Pacific people currently experience poorer health outcomes overall compared to others, particularly for Pacific men. Issues can occur in regards to Pacific people accessing health services and the care received once services are accessed. These differences should be eliminated.

Our commitment to addressing the needs of priority populations including Pacific people aligns to the overall goals of the regional health plan and the national outcome: All New Zealanders living longer, healthier and more independent lives.

Progress to date

National health targets for immunisation, support to quit for hospitalised smokers and breast screening are being met or exceeded for Pacific people.

Good progress is being made to reach More Heart and Diabetes Checks target of 60% by July 2012.

Pacific specific diabetes self-management education (DSME) has been shown to be effective in reducing HbA1c for 66% of participants (blood sugar levels).

The Enua Ola programme has resulted in more participants maintaining and losing weight than participants gaining weight.

The Pacific Cancer Navigation Service is engaging patients in cancer treatment pathways and supporting families to access financial support.

How are we going to do it? (Key planning approach)

A joint Waitemata and Auckland DHB process will be undertaken and it will include:

- A review of projects that are common to both DHBs such as the Enua Ola programme and the Healthy Village Zones (HVAZ). The Enua Ola programme will be re-designed to include effective elements of HVAZ
- For health targets that have higher coverage for Auckland DHB or Waitemata DHB, the elements that contribute to this will be identified and adopted by both wherever possible.

Specific deliverables/actions to deliver improved performance

Improve good diabetes management to a target of 72%* and ensure that 75% of eligible people are engaged with the More Heart and Diabetes Checks by:

- engaging at least 120 people with the Pacific specific DSME workshops
- providing nurse lead multidisciplinary teams to engage Pacific people with diabetes especially those enrolled with non-Pacific primary care providers
- increasing the number of people actively engaged with Enua Ola and other lifestyle change support programme; and collaborate with ADHB in re-designing the programme

Increase cervical screening coverage by ensuring that eligible Pacific women access free smears.

Increase coverage of the Pacific Cancer Navigation Service by improving referral pathways with GPs and with hospitals.

Ensure that Pacific people participate in the bowel screening programme by providing awareness education and support for colonoscopy and treatment where required.

Maintain targets for immunisation, support to quit by hospitalised smokers and breast screening.

How will we know we've achieved it? Measured by –

National Health Targets achieved for Pacific People.

- 63% of Pacific people with diabetes receive annual reviews*
- 72% of Pacific people with diabetes are well managed*
- 75% of eligible Pacific people have a five year heart and diabetes check
- 216 to 270 people are referred to the Pacific Quit Smoke Service
- Increase proportion of eligible Pacific women (25-69 years) who undergo cervical screening from 60.2% to 75%*
- Implement the new format of the Enua Ola programme to include an emphasis on obesity prevention in children
- 95% of eligible Pacific people are sent an invitation to participate in the bowel screening programme in the 2 year cycle
- 85% of Pacific children are immunised at 8 months
- Maintain access to support to quit for hospitalised smokers at 95%
- Maintain breast screening coverage at 70% or more.

* note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term

Asian, Migrants and Refugees

What are we trying to do?

Increase access to health care and quality of care received, in order to improve health outcomes and reduce health inequalities for Asian, migrants and refugees

Why is this important?

Asians in Waitemata have highest life expectancy of any group. They also have lower mortality rates for many of the potentially avoidable causes.

Immunisation coverage is also high. However, there are a number of areas of concern in regard to access and utilisation of services by our growing Asian, migrant and refugee population. Language and culture forms a barrier for many people and this is reflected in low uptake rates for screening and PHO enrolment. Lack of regular physical activity and diet are significant risk factors and among the South Asian population there are high levels of heart disease, diabetes and asthma.

The Board's commitment to addressing the needs of priority populations including Asian, new migrants and refugees aligns with the overall goals of the regional health plan and the national outcome: All New Zealanders living longer, healthier and more independent lives.

Progress to date

An Asian health action plan 2010/11-2012/13 has been completed and signed off by the Board.

A working group with input from secondary and primary care, settlement support agencies, NGO providers and immigration networks to improve Asian PHO enrolment rates has been established and a media campaign is underway.

Projects promoting healthy life-styles have been implemented in Asian communities.

The number of eligible southern Asian people having a cardiovascular and diabetes risk assessment has increased.

How are we going to do it?

Continue to implement the Asian Health Action Plan (July 2010) and Auckland Regional Settlement Strategy Migrant Health Action Plan

Specific deliverables/actions to deliver improved performance

- Improve information dissemination to Asian communities and promoting PHO enrolment and prevention screening through www.yourlocaldoctor.co.nz and other Asian focused media channels
- Implement nurse/multidisciplinary primary care clinics for CVD risk and diabetes risk assessment, and care planning for people with their ethnicity recorded as Asian, particularly Indians who have a higher risk and health need
- Increase the number of free smears available to priority group women (including Asian women not screened in the last three years) to improve cervical screening
- Implement Bowel Screening Programme pilot
- Increased CALD cultural competency training uptake by primary and secondary health workforce
- Increased primary health interpreting service utilisation.

How will we know we've achieved it? Measured by –

- Improve Asian PHO enrolment rate to 80%*
- Increase good diabetes management to 72%*
- Achieving 75% of CVD risk assessment rate by June 2013
- Increase cervical screening rate to 75%*
- Achieving 700 course enrolments of CALD cultural competency training for the health and disability workforces
- Increase utilisation of primary health interpreting services by 20%.

* note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term

Child and Women's Health

Note: Other Child and Women's health information can be found in the following sections: Mental Health, Immunisation, Tobacco and Primary care development and delivery

What are we trying to do?

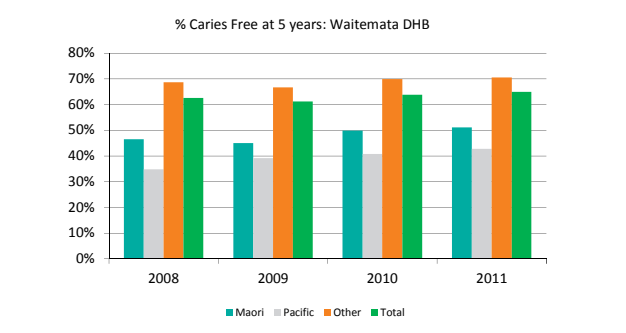
Improve the health and well-being of children and outcomes for women and infants in Waitemata through the delivery of integrated, effective, evidence-based maternity and children's services.

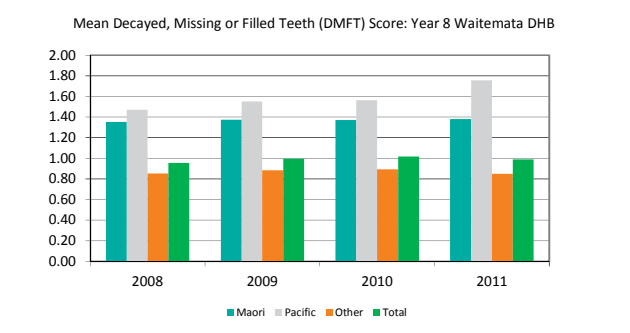
Why is this important?

The wellbeing of children is critical to the wellbeing of the population as a whole and is both a regional and a national priority. In addition, healthy children often lead to healthy adults. The health outcomes for newborns and mothers are vital to this. Achieving good rates of sustained breastfeeding is an important indicator of child health. Many admissions to hospital for children are avoidable and preventable. Waitemata children have better health status than their national counterparts. However, disparities in health status between population groups are evident, with Māori and Pacific children having poorer health status than other groups. Māori and Pacific oral health are considerably poorer than that of other ethnicities. It is important to focus on prevention to ensure positive benefits in adulthood.

Progress to date

Improvement in oral health service provision continues with the opening of seven new school dental health facilities. Four clinics remain under construction.





Preschool dental enrolment rates for children have steadily increased over time – reaching 71% in 2011. While percentage of 5 year olds caries free has improved for all ethnicities, Pacific rates of decayed, filled or missing teeth at year 8 have risen over time. Arrears rates (children who miss their annual dental review) have steadily declined over recent years, but have increased again recently with the roll-out of the school dental service reconfiguration.

In 2011 we demonstrated our commitment to family violence prevention by achieving the highest programme implementation scores of all DHBs in the Auckland University of Technology (AUT) hospital responsiveness to family violence, child and partner abuse audit.

Healthy Eating Healthy Action funding has been utilised to provide a range of programmes including lactation consultant services, ethnic specific breastfeeding classes, peer counsellor programme and breastfeeding resources.

Contracts have been signed off with Well Child Tamariki Ora service providers for additional services to vulnerable infants, new mothers and high need/high risk families/whanau.

Waitemata DHB undertook the pilot of the quality and safety standards for Maternity services during 2011 – a steering group has been established and an implementation plan will be underway by July 2012.

How are we going to do it? (Key planning approach)

- Continue the planned implementation of the oral health business case
- Improve B4 School Check rates by working with all key stakeholders to raise the profile of B4 School Checks and investigate opportunities to link with 'free after-hours care for under 6s'
- Explore opportunities to work more closely with child health and maternity community providers to provide more integrated, effective, evidence based maternity and children's services
- Support the Māori breastfeeding lactation consultant service and support Plunket (Waitemata) and the Helensville cluster to achieve Baby Friendly Community Initiative (BFCI) accreditation.
- Vulnerable children/families – implementation of the Gateway programme in Waitemata DHB
- Implement the Maternity Quality and Safety programme
- Support the initiatives in the Regional Child Health Improvement plan
- Develop review plan based on the Well Child/Tamariki Ora Quality review currently in progress
- Support general practitioners to work with lead maternity carers to encourage early registration.

Specific deliverables/actions to deliver improved performance

- Deliver the oral health business case objectives for 2012/13
- The Helensville cluster will have achieved BFCI accreditation by Q3 and Plunket by Q4
- Ongoing implementation of quality and safety standards for maternity services
- Explore service delivery channels and quality improvement with B4 School Check providers
- Support the national process for improving the numbers of newborns enrolled with primary care by ensuring mother's GP recorded on birth event booking form within WDHB facilities
- Develop a process with providers to monitor timeliness of access to referred services following Well Child/Tamariki Ora referral
- Review current DHB funded Pregnancy and Parenting education to identify strengths and weaknesses of current delivery models
- Implement systems to measure percentage of eligible women accessing pregnancy and parenting education.

How will we know we've achieved it? Measured by –

- Exclusive breastfeeding rates: 67% at 6 weeks, 54% at 3 months, 23% at 6 months (SI-7)
- 80% of 4 year olds will receive a B4 School check
- Quality and safety standards for maternity services – monitoring against plan and contract
- 28,882 under 5s are enrolled in primary care by June 2013 (PP-13a)
- 65% of adolescents are utilising oral health care services by June 2013 (PP-12)
- Oral health arrears rates are reduced to 10% by June 2013 (PP-13b)
- The average number of permanent teeth of children in school Year 8 (12/13-year olds) that are decayed, filled or missing (due to caries) of those examined in the year (PP-10)
- The proportion of 5 year olds caries free of those examined in the year (PP-11)
- 90% of newborns enrolled in a PHO by 2 weeks of age
- Meet ASH targets for 0-4 year olds: maintain rates below the national rate

Improving patient safety and experience: *aiming for first do no harm and performance improvement*

What are we trying to do?

Deliver the Best Care for Every One by creating a health system which is highly responsive to our patients and the community, and which delivers high quality health care.

Why is this important?

Evidence demonstrates that health systems are safer, quality outcomes improve, costs decrease and satisfaction increases when patients, their families / whanau and communities are involved in their design and delivery.

By putting the patients and community we serve at the centre of all that we do we can deliver the Best Care for Every One. We need to continuously earn the trust placed in us by our community by insisting on quality and striving to get the basics right first time, every time.

Designing patient centred systems and processes that are capable of improving patient flow, outcomes and experience, and clinically led continuous quality improvement, will drive patient centred improvement in care and will enable patients, employees and the community to receive the type of health service they need.

Our commitment to building a culture of patient responsiveness supports the regional health plan's focus on quality and safety, the objectives of the Health Quality and Safety Commission, and the national outcomes including: ensuring people receive better health and disability services; a trusted system and services that can be used with confidence and a more unified and improved health and disability system.

Progress to date

- A strategic framework for improving patient experience and patient engagement is on track to be completed by September 2012
- Part 1 of a comprehensive community engagement strategy has been developed and a review of community engagement models is on track to be completed by June 2012
- A community engagement intranet site has been established to support staff undertaking consumer and community engagement within their services
- Projects are in place to implement the Health Quality and Safety Commission's national projects to improve medication safety, infection prevention and control and consumer engagement
- Projects are in place to implement the region's 'First Do No Harm' patient safety interventions to reduce harm from falls, pressure injuries, central line-associated bacteraemia (CLAB), and improve medication management and advance care planning
- Projects are in place to implement Waitemata DHB quality initiatives around medication safety (including implementation of the national medication chart), health care associated infections, improving care processes, reducing readmissions and use of the Global Trigger Tool
- Twenty staff have completed the Advanced Care Planning programme and more staff are being selected for training later in the year
- A quality improvement and assurance scorecard has been implemented to track progress against the national, regional and local quality and safety initiatives and for reporting to DHB staff, the Clinical Governance Group and the Hospital Advisory Committee
- A second cohort of staff has completed our in-house leadership programme, Leadership at the Point of Care, and further cohorts are being selected for training.

How are we going to do it? (Key planning approach)

- Implement the recommendations of the patient experience review
- Implement the consumer engagement strategy
- Continue to implement the Health Quality and Safety Commission and the regional 'First Do No Harm' initiatives
- Continue to implement quality improvement initiatives through our Patient Smart programme
- Implement the workforce strategy
- Continue to develop education, research and innovation through Awhina, including the development of an open-source network to foster and share innovation and research
- Investigate opportunities for training and up-skilling consumers through collaboration with Healthlinks North and Waitakere and Awhina
- Support staff to incorporate patient and community engagement in service design and development reflective of the 'Partners in Care' framework
- Continue to implement Part 1 of the Consumer/community engagement plan, and develop Part 2 which incorporates locality planning.

Specific deliverables/actions to deliver improved performance

- Implementation of the Health Quality and Safety Commission regional plan and DHB medication safety initiatives including:
  - Pilot and roll out of electronic medicine reconciliation (eMR) to acute medical services
  - Pilot electronic prescribing in two inpatient older adult wards
  - Improve the utilisation of Guardrail infusion safety software
  - Reduce medication errors by reducing the Pyxis override rate in inpatient wards
  - Use the Global Trigger Tool to inform further cycles of quality improvement
- Implementation of the Health Quality and Safety Commission's and the region's 'First Do No Harm' initiatives including:
  - Hand Hygiene New Zealand (HHNZ),CLAB, and surgical site infection surveillance (SSI) programmes
  - Reducing harm from falls and pressure injuries
- Complete implementation of the DHB's quality initiatives including: reducing catheter associated urinary tract infections (CAUTI); reducing the rate of surgical site infections (SSIs); improving venous thrombo-embolus (VTE) prophylaxis; reducing specimen errors; improving delirium prevention and management; improving the transition of care; and continued use of the Global Trigger Tool, by June 2013
- Patient information continued to be reviewed by Healthlinks
- Healthlink sourced consumer involvement in DHB activities
- Implement the culture and change leadership element of the Workforce Strategy by 30 June 2013.

How will we know we've achieved it? Measured by –

- 95% of complaints investigated and responded to within 14 days
- 100% RMOs complete eLearning medication safety modules
- Reduce the Pyxis override rate in inpatient wards to <15%
- >95% of infusions run using the Guardrails pump safety software
- 20% improvement in hand hygiene compliance in selected wards
- <1 CLAB per 1000 line days
- 50% reduction in incidence of inpatient CAUTI in selected wards
- 20% reduction in falls resulting in major harm (SAC 1 and SAC 2 incidents)
- 10% reduction in incidence of inpatient pressure injuries
- 70% reduction in specimen collection and processing errors
- 90% adult inpatients have VTE risk assessment completed and documented and 75% pharmacological prophylaxis charted at the appropriate dose
- Increase in staff retention due to work place/job satisfaction (no more than 8% of staff leave within first 6 months).

Achieving sustainability: *the DHB's health resources are efficiently and sustainably managed to meet present and future health needs*

What are we trying to do?

Be a sustainable and productive organisation while improving the health outcomes and reducing inequalities for our community.

Why is this important?

Like all other DHBs, we are operating in a financially constrained environment, where health expenditure is growing at a faster rate than health funding and where demand for health services is insatiable and growing. Health service demand growth is particularly an issue for our DHB being the largest DHB in New Zealand (12% of national population), the second fastest growing of all DHBs and having the fastest aging population in the country.

During the last few years, we have managed our budgets prudently in order to continue delivering services to our population and improving health outcomes within the funding available. This required providing services in a more efficient and effective way and this has been achieved through our business transformation programme. The gains made during the past two years have reduced duplication and introduced new ways of delivering services for the same value. We have improved our processes, increased productivity, optimised utilisation of our staff, reviewed our contracted services, reduced utilisation of consumables and increased transparency in the prioritisation of resources to the frontline.

DHBs have a role to ensure that the burden of health costs is spread fairly across generations and this can be achieved through sustainable financial and operational performance and ensuring capital investments required to sustain services are undertaken timely and in an affordable manner.

Progress to date

We have lived within our means for the past four years, achieving year-end financial results better than approved plans and more recently, generating surpluses that have been reinvested into health services to meet the needs of our growing population.

The DHB is forecasting a surplus of $5M for the 2011/12 year. This has been achieved by a significant business transformation programme which commenced in 2010/11 and realised $45M savings in that initial year. For 2011/12, Business Transformation savings of $23M were planned and are expected to be achieved.

Strategies that have contributed to our savings programme include:

- Implementing savings through Health Benefits Limited
- Implementing nurse model of care
- Streamlining inventory management system
- Implementing electronic timesheet system
- Procurement savings
- In-source cleaning services.

How are we going to do it? (Key planning approach)

- The Business Transformation will continue through to 2012/13 and beyond.
- Continue the principles of transformation that will maximise the benefit to the community and patients through more efficient and effective use of resources
- Introduce new innovations through models of care and skill-mix reviews to improve service efficiencies and increase productivity
- Work with shared services healthAlliance and Health Benefits Limited to improve inventory control and purchasing of equipment, clinical and non-clinical supplies
- Maintain our performance focus
- Work collaboratively with primary care and NGO sector to improve patient transfer of care between primary and secondary services.
- Work collaboratively on regional activities that will deliver tangible benefits for the DHB
- Develop a long term capital needs plan
- Work more closely with Auckland DHB to improve quality of health outcomes and improve efficiencies for both DHB populations for Auckland region
- Continue to contain growth of management/administration FTE to ensure resources are focused on frontline staff.

Specific deliverables/actions to deliver improved performance

- Inventory management for clinical and non-clinical supplies
- Introduction of new nurse model of care in theatres
- Implement Fleet Management policy for fleet vehicles
- Implement new Outpatient Service model (staffing, booking & scheduling)
- Development of the Allied Health Strategy
- Development of business cases for in-sourcing services (eg orderlies)
- Development of joint workstreams where applicable with Auckland DHB (eg Māori health, Child hospital services, health service planning, Pacific Health, Planning & Funding, Employee relations, Telephonists/call centre, Central sterile supplies department, Human resources.

How will we know we've achieved it? Measured by

- $2M surplus achieved for each of the three financial years
- Business Transformation savings of $12M realised
- New models of care and skill mix reviews will be developed and implemented in 2012/13
- Collaboration with Primary and NGO sector will be scoped and workstreams developed for implementation in 2012/13 and beyond
- Regional health plan workstreams fully implemented
- Improved efficiencies with Auckland DHB identified and implemented
- Capped FTE count maintained per budget levels.

Module 4: Stewardship

Managing our business

In order to manage our business effectively and efficiently to deliver on the priorities described in modules 2, 3 and 5, we must translate our high level strategic planning into action in an organisational sense within the DHB and have in place supportive infrastructure requirements to achieve this. We must operate in a fiscally responsible manner and be accountable for the assets we own and manage. We must also ensure that every public dollar spent is spent wisely with the overall intention of improving, promoting and protecting the health of our population.

Strengthening our Workforce

Organisational health

"Best Care for Every One" is the primary purpose of this DHB. We are committed to building a performance and patient focused culture. This culture change is our top priority and specific work is happening to establish the values that support the purpose statement and can be articulated, behaviours established which model the values and are embedded in our organisational culture.

Clinical leadership is at the core of all we do. Processes are in place to ensure clinicians are leaders at all stages of service planning and delivery from bedside to board room. Clinical leadership will be central to work undertaken to ensure integration between community and hospital services to improve performance in specific priority areas including unplanned and urgent care, long term conditions and wrap around services for older people. Clinical leadership is a key requirement to ensure ongoing continuous improvement in the quality outcomes for patients of the care provided.

The establishment of Awhina, Waitemata Health Campus is a crucial enabler to support Best Care For Every One in an environment where lifelong professional education and learning is supported across the entire DHB including primary care and community care partners. Awhina provides a new platform to assist in the development of excellent and productive relationships with tertiary education providers to ensure a fit –for – purpose health care workforce. Awhina will help Waitemata achieve excellence in organisational development, learning and development, education, training and innovation. Awhina will also promote and support an increase in research collaborations between tertiary institutions, government and crown entities and private research and health related companies. This research and development will be predominantly applied research that offers the opportunity for clinical improvements and better health outcomes for Waitemata's communities. An overarching aim of Awhina is to ensure that education, research and service delivery is informed and changed for the better by innovation.

We seek to be a good employer. The DHB is aware of its legal and ethical obligations in this regard. The DHB is also aware that good employment practices are a critical aid in the building of a reputation which attracts and retains top health professionals who choose to work for our DHB as they align with the patient centred culture we endorse.

Waitemata DHB's Good Employer policy makes clear that the DHB will provide:

- Good and safe working conditions
- An equal employment opportunities programme
- Recognition of the employment requirements of women
- Recognition of the employment requirements of men
- Recognition of the employment requirements of people with disabilities

- The impartial selection of suitably qualified persons for employment
- Recognition of the aims, aspirations and employment requirements of Māori people
- Recognition of the aims, aspirations, cultural differences and employment requirements of Pacific Island people and people from other ethnic or minority groups
- Opportunities for the enhancement of the abilities of individual employees.

Our Workforce Development Strategy

This year we have developed a standalone DHB Workforce Strategy 2012-2016 plan. This is a requirement of Health Workforce New Zealand using the State Services Commission framework.

In conjunction with our regional partners, Auckland, Counties Manukau and Northland DHBs the Workforce Section of the Northern Region Health Plan 2012/13 has been developed. The Health Workforce New Zealand (HWNZ) and the Northern Regional Training Hub (NoRTH) priorities are included in the regional plan.

The work-streams associated with each of the four workforce strategy elements are detailed in the DHB Workforce Strategy document (refer www.waitematadhb.govt.nz) in line with regional priorities established to support the achievement of the Regional Health Plan objectives as well as local priorities and requirements.

Regional Information Systems

Information systems are fundamental to the Northern Region's ability to deliver on the whole of system approach to health service delivery that is embedded throughout the Northern Region Health Plan. A key clinical driver in the Plan is to improve the continuity of care for patients in our region across primary, secondary and tertiary care. This will require consistent and reliable access to core clinical information by all clinicians involved in a patient's care.

Over time the Northern Region's shared services support agency, healthAlliance NZ Ltd, will work with the region's four DHBs to continue to progress the five priority areas identified in the 2011/12 plan as well as three new areas of focus for 2012/13 to align with national priorities:

- Single patient administration system
- Single clinical workstation
- Regional clinical data repository
- Population health data repository
- Information systems infrastructure resilience
- Electronic solutions to support safe medication management
- Shared care plan
- Patient portals.

Additional investment will also be possible and required in other regional projects, such as:

- Shared financial management systems
- Content Management
- eReferrals phase 2
- eDischarges (implemented to national standards)
- eRostering
- Regional electronic laboratory orders

- Continuation of regional network integration, single sign-on and single service desk as part of the shared service programme of work
- Information Systems support for the Better Sooner More Convenient business case workstream
- Maternity shared care and DHB systems.

Specific activities in 2012/13 that will support delivery of the Northern Region Health Plan include:

- Implementation of 'Acute Predict' for consistent cardiovascular disease and diabetes risk assessment
- Information systems support for Clinical Pathways, 'Access to Diagnostics' and After-Hours model of care programmes
- Implementation of systems to support Advance Care Planning.

The region is committed to improving effectiveness and efficiency through shared services. Following the initial creation and integration of the shared service in 2011/12, the focus in 2012/13 will be to further standardise and optimise processes.

The region will gradually move to a more strategic approach to regional capital investment planning for information services. healthAlliance is committed to working closely with Health Benefits Limited and the National Health Information Technology Board to ensure that regional capital investment plans are aligned with national priorities and programmes of work.

The Northern Region Information Systems Implementation plan provides a multi-year view of the Information Systems programme of work that supports the National Health IT Plan. This programme is updated quarterly in line with decisions that are made as part of annual regional health planning and DHB capital planning and project management processes. Further detail is available in the Northern Regional Information Strategy 2010 to 2020.

Quality Assurance and Improvement

Waitemata DHB is committed to delivering a patient centred, clinically driven high quality health care approach that has the patient, their family / whanau and the community as the primary focus and that facilitates all health care teams in providing services that are safe, effective, timely and appropriate.

The plan for 2012/13 focuses on improving the patient experience, enhancing patient safety and increasing organisational capability regarding quality assurance and improvement; it is built on a foundation of clinical governance and is consistent with the recommended priorities from the New Zealand Ministry of Health, the Health Safety and Quality Commission and the Northern Region Health Services Plan. Specific actions are included in Module 3 'Improve patient safety and experience'.

We also have responsibility under the New Zealand Public Health and Disability Act to monitor the delivery and quality of contracted services. Waitemata DHB carries out this responsibility through a number of auditing agencies, as well as through ongoing relationship management undertaken by programme managers. The contracts manager coordinates the audits and receives and reviews the audit reports before passing them on to the relevant programme manager for review and follow up. If any critical issues are reported, the contracts manager informs the planning and funding finance manager of these and they are escalated if necessary.

Asset Management

We are currently in the process of updating the 2009 Waitemata DHB Asset Management Plan (AMP), aiming for completion by 30 June 2012. The AMP outlines Waitemata DHB's current physical asset base used in delivering health services, the condition of the assets, refurbishment, upgrades and replacement

requirements over the long term. The AMP therefore supports investment decision by providing asset replacement profiles which facilitate management and ongoing maintenance of the current asset base. Work is underway to confirm the key strategic capital projects and timing of these in the medium to long term, including the financing options. The DHB will also commence the second iteration of the Clinical Services Plan and the Site Master Plan in order to inform the long term asset requirements. Key local AMP improvement projects and regional considerations will be discussed in detail in the updated AMP. In the meantime, the DHB continues to provide asset management data to the National Health Board and input into regional asset management development.

Facilities Modernisation

We aim to modernise outdated and inadequate facilities in line with the strategic objective of providing high quality and productive health services.

Projects delivered in 2011/12	Project planned for 2012/13

• Lakeview Extension
• Lakeview Cardiology Centre
• Car Parks at North Shore and Waitakere Hospitals
• Waitakere Hospital Surgical Expansion
• North Shore Renal office suite and dialysis unit
• Bowel Screening Pilot
• Oral Health
  o 5 Children's Community Dental Clinics (CCDCs) at Henderson, Glenfield, Edmonton, Belmont and Northcross
  o 3 Transportable Dental Units (TDUs) and 17 concrete Pads (which the TDUs sit on)
• Health Campus Stage 1 North Shore and Waitakere Hospitals
• North Shore Hospital Theatres Refurbishment
	• North Shore Hospital Ablution Block upgrade
	• North Shore Hospital Ward 5 refurbishment
	• North Shore Hospital ESC Infrastructure
	• North Shore Hospital external and internal painting
	• Oral Health - a further 6 Community Dental Clinics, 42 Pads and 12 Transportable Dental Units
	• North Shore Hospital Car Park variation works
	• North Shore Hospital Podium roof repair
	• North Shore Hospital Marae
	• North Shore Hospital Kingsley Mortimer Unit Ward 12 upgrade
	• Waitakere Hospital Rangatira Ward Expansion
	• North Shore Hospital Lift refurbishment
	• North Shore Hospital Elective Surgical Centre

We are also actively pursuing the following projects as we move towards 2013/14:

- North Shore Hospital Taharoto Adult Mental Health Unit redevelopment
- Mason Clinic remedial works due to water tightness issues
- Waitemata DHB Renal Phase II
- North Shore Hospital MRI Phase II
- Strategic stage business case for a new 'mini-tower' at North Shore Hospital.

Sustainability

Waitemata DHB is leading the way across District Health Boards in New Zealand in addressing the issue of sustainability with the appointment of a sustainability officer and has gained a Bronze Level Enviro-Mark Award. The purpose of the sustainability officer role is to improve the sustainability of the DHB and reduce our carbon footprint whilst having the benefit of saving costs, as well as ensuring we contribute to being responsible corporate citizens. Hospitals as they run today are energy and resource hungry, therefore, it makes good business sense to attempt to reduce these costs and at the same time reduce our impact upon the environment.

The development of a sustainability statement and policy has been a crucial first step to the implementation of an Environmental Management System (EMS) in the WDHB's journey towards becoming a more environmentally friendly and sustainable organisation.

Organisational performance management

We have developed an organisational performance framework which links our high-level outcomes framework with day to day activity. The organisational performance monitoring processes in place include:

- Those processes developed in response to legislative requirements, eg Statement of Service Performance within the Annual Report and Health Target reporting
- In response to the Board requirements, eg organisational performance scorecard, provider divisional scorecards, Hospital Advisory Committee Provider Performance Report and quarterly reporting against the deliverables set out in the Annual Plan
- In response to general business requirements, eg analysis of inter-district flow performance, monitoring of responsibility centre performance, services analysis.

We also have performance monitoring built into our human resource processes, where all staff are expected to have key performance indicators which are linked to overall organisational performance; these are reviewed at least annually.

Risk management

During 2011/12 we reviewed our approach to risk management to ensure we were meeting our obligations as a Crown Entity, including compliance with the risk standard AS/NZS 31000: 2009 Standard for Risk Management. This included establishing a risk management framework as a means of improving the quality of services across the organisation and minimising risks in the delivery of those services. The risk management framework consists of a risk management policy and procedures and a committee of senior DHB clinical and management staff to provide oversight, monitor and review risks in accordance with the policy framework and to report high risks to senior management and Board on a monthly basis. We also provide risk management training for senior staff within the DHB to encourage consistent practice in risk management strategies.

The DHB is working with Auckland DHB in having a joint risk management framework to be consistent in the approach to manage/control risks particularly if some risks are similar and also in consideration of risks that may arise from the current collaboration work underway with children's hospital services, Planning and Funding, Human Resources, Pacific Health and Māori Health.

Emergency planning

Waitemata DHB, together with the other Northern region DHBs, plans to undertake a number of activities to support regional emergency planning and management in 2012/13

The emergency planning and management requirements of the Operating Policy Framework will be met. This includes completion of all regional work plans, in particular the update of the regional Health Emergency Plan, and testing DHB and regional Health Emergency Management function and capability. This will ensure the readiness of DHBs to co-ordinate a sustainable response if an emergency arises.

The DHBs will work collaboratively with emergency services in each district and the region to ensure timely notification, and accurate communication and liaison in the event of an emergency.

Strengthening research and innovation and prioritising fund-raising

The Three Harbours Health Foundation (also refer Module 1 Other interests) administers research, trials and special innovation funding for Waitemata DHB. The priorities for major fund raising for the 2012-2014 period are to strengthen research and innovation within the DHB and its contracted service delivery network.

Specific priorities are:

- A flagship Awhina Health Campus building and activities on the North Shore site by Lake Pupuke
- A national quality and safety centre of excellence/innovation research and development for healthy aging and long- term health conditions
- Enhanced Waitakere Awhina Health Campus facilities and activity in collaboration with Unitec and other partners
- Innovation at local and national levels including facilitating the participation of Waitemata DHB and district clinicians, technicians, managers in opportunities created locally and through the new NZ Health Innovation Hub
- Enhancing innovation through publications and promotion and through collaborating with health and education organisations, relevant government agencies, local and international firms and institutions
- A centre of excellence/innovation research and development for child, family and Whānau Ora in Waitakere/West Auckland/Rural Rodney. This encompasses specific enhancements to Rangitira Ward and its parent support activities.

Health Benefits Limited

Health Benefits Limited is a crown-owned company, established in 2010 to help the health sector save money by reducing administrative, support and procurement costs for DHBs. Using a commercial model, Health Benefits Limited works for all DHBs, to reduce the cost of shared services, as well as leading initiatives that make savings. Savings are reinvested in clinical areas.
Waitemata DHB supports and understands that national work may result in changes to our local processes, systems, functions and ultimately positions.

Several work streams are underway. These build sustainable national health services by:

- Reducing costs
- Achieving operational efficiencies in administration, procurement and support services
- Sharing good practice in administration, procurement and support services.

The workstreams underway are outlined in the following table.

Collective procurement	Clinical Advisory Groups are assembled around identified projects. A number of projects will go to market in 2012/13 as Requests for Proposals. These include: Pulse Oximetry, Exam Gloves, Diathermy Consumables and Hospital Beds. Data collection has commenced for Sutures, Skin Staplers and Skin Adhesives, and Urinary Catheters & Bags (hospital). Audiology aids and Sterilising consumables have both been investigated and will not proceed as national projects.
Finance	A Case for Change has been released with work underway to confirm the high level processes required within a national system. The first draft of individual DHB business cases is expected by the start of the 2012/13 year.
Supply chain	Supplier site visits have been undertaken with design workshops underway. Health Benefits Limited is analysing the information provided by DHBs and will work with DHBs to produce detailed current state information.
Facilities management and support services	Health Benefits Limited and DHBs will work to align work to those areas where DHBs need to address concerns or find efficiencies. Priorities are food, laundry and facilities with a focus on how these areas work, what issues exist and where opportunities exist. Other opportunities include waste removal and reviewing fleet and parking arrangements. Health Benefits Limited may use an Expression of Interest process to find the options available and suitable for DHBs across these areas. All work in this area, including procurement processes or investing in significant assets – within the scope of this programme, will be carried out in collaboration with Health Benefits Limited and will not preclude national design options. DHB experts will be involved in feasibility studies to develop options for delivering services. The Indicative Case for Change will be released in the first half of 2012.
Information Services	Information Services (IS) has agreed the approach to a national infrastructure programme for DHBs. Health Benefits Limited is establishing the information systems programme advisory groups to ensure Health Benefits Limited receives the right input and guidance, both for technical and commercial considerations. A coordinated approach to short and longer term national infrastructure will result in significant collaborative, financial and operational benefits for `back office' information technology. A Request for Information has been issued, followed by an evaluation of service delivery options to determine the shape of national infrastructure. 2012/13 activities involve: • Completing an evaluation of the options available for national infrastructure service delivery • Identifying the right model for national infrastructure for the health sector • Planning the technology and commercial roadmap that will define the transition from today to that model. Information Systems Procurement – Vendor Consolidation: Health Benefits Limited is working with DHBs on consolidation opportunities – ensuring cross-DHB or national licenses meet the needs of the sector. National contracts for video conferencing will be released to the sector by the start of the 2012/13 year. Website www.itcontracts.health.nz is active, providing MSA standard document templates online for download and use.
Human resources **workforce management**	The Human Resource/Workforce Programme of work will commence and work with the DHBs to identify an HR information system that can be rolled out nationally. The first stage of the project is to agree the business requirements, functional requirements and high-level processes that DHBs would expect to be supported by the system. Health Benefits Limited and DHBs will identify best practice and a national standard in these areas. This will support the system(s) being rolled out in a consistent manner and allow training, process documentation and best practice to be shared across DHBs. Auckland DHB staff will be involved in workshops to agree requirements and design processes.

Reporting and consultation

We will provide the Ministry of Health with information that enables monitoring of performance against any agreement between the parties, and providing advice to the Minister in respect to this. This includes routine monitoring against the funding, DHB service delivery, and DHB ownership performance objectives.

We will provide the Minister and the Director-General of Health with the following reports during the year:

- Annual reports and audited financial statements
- Quarterly reports
- Monthly reports
- Any ad hoc information that the Minister or Ministry requires.

Ability to enter into Service Agreements

In accordance with section 25 of the New Zealand Public Health and Disability Act, Waitemata DHB is permitted by this annual plan to:

a) Negotiate and enter into service agreements containing any terms and conditions that may be agreed; and

b) Negotiate and enter into agreements to amend service agreements.

Memoranda of Understanding

We hold a number of Memoranda of Understanding (MoUs) with other groups and agencies which outline the principles, processes and protocols for working together at governance and operational levels to deliver better health care outcomes to the people of the district. These include the MoUs currently held with Manawhenua, and with Te Whanau o Waipareira.

Through the Awhina health campus we have or expect to create MoUs with a number of partners, focusing on creating umbrella Board level agreements centred on goals and opportunities that are of mutual interest. These include:

- The University of Auckland
- AUT University (update of existing MoU in progress)
- Unitec Institute of Technology (building on existing MoU)
- Massey University
- Otago Polytechnic
- Te Whare Wananga o Awanuiarangi
- The University of Otago
- The New Zealand Health Innovation Hub (shareholding of new entity being set up with Auckland, Counties Manukau and Canterbury DHBs)
- Coast to Coast Hauora Trust
- Waitemata PHO
- ProCare PHO.

These MoU will enable us to streamline and further develop opportunities for education and workforce development (for the existing and future workforce). For example a regional allied health clinical school, cohorts of students and post-graduate trainees will be able to come to the district's provider network for a continuous year, and participate in relevant research and innovation as well as training.

Module 5: Statement of forecast service performance

Statement of forecast service performance

The statement of forecast service performance is very valuable for us as a way of 'telling our performance story' and of structuring our thinking about what we are producing and why we are producing it. The statement of forecast service performance is a requirement of the Crown Entities Act, and requires the DHB to provide measures and forecast standards of output delivery performance against which the entity's actual delivery of classes of outputs will be reported and audited in the statement of service performance at the end of the financial year. Actual performance against these measures will be reported in the DHB's Annual Report, and audited at year end by the DHB's auditors, AuditNZ. This intervention logic approach is summarised below from the guidance 'Planning and Managing for Results'. In preparing this statement of forecast service performance we have sought advice from AuditNZ and worked with the other northern region DHBs, particularly Auckland DHB, to ensure we provide improved service performance information in our Statement of Intent compared with prior years.

Summary of definitions from Planning and Managing for Results

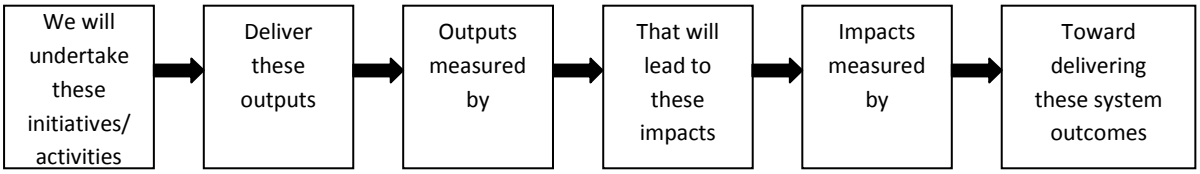
Planning and Managing for Results – Treasury and State Services Commission

"The ultimate goal is to identify the best mix of goods and services and resources to produce the greatest improvement in results."

Outcome	A state or condition of society, the economy or the environment and includes a change in that state or condition. It normally describes a state or condition that is influenced by many different factors which may operate independently and where attributing change to the activities of one agency (DHB) is very difficult. *Example: Improve the health status of the Waitemata DHB community* *Health status is influenced by education, socio-economic status, housing and other determinants as well as by health services provided.*
Impact	The contribution made to an outcome by a specified set of good and services (outputs), or actions, or both. It normally describes results that are directly attributable to the activity of an agency (DHB) *Example: Reduce the morbidity and mortality for patients with diabetes* *Providing specific review, management and specialist services to people with diabetes, the expected impact is an improvement in life expectancy, a reduction in complications and delayed onset of the other conditions, eg eye disease, associated with diabetes*
Output	Final goods and services – supplied to someone outside the entity (DHB) *Example: Number of Diabetes Get Checked reviews provided annually*

Throughout the statement of forecast service performance this intervention logic model has been used to describe the relationships between resources, activities, results (inputs, actions planned, outputs, expected impacts and link to outcomes). It provides a common approach for integrating the planning, implementation, evaluation and reporting that occurs for this DHB.

This logic framework has been used to help articulate how the work that is being carried out in the DHB impacts on our performance in meeting the Government's priorities and specific health targets. It is also used to explain how the DHB's planned activities will impact upon the health of our population under each output class. The intervention logic model used in the tables throughout the statement of forecast service performance is shown below.



The approach we have taken to develop the statement of forecast service performance is to consider the full breadth of activities funded and provided by the DHB, in addition to the specific priority activities that provide the focus for the annual plan. The output areas and measures have been selected to illustrate a good overall indication of our performance, and cover most but not all of the activities and outputs that the DHB produces.

Within the output classes we have focused on three high level outcomes which encompass all levels of priorities, these are:

- Improved population health: *adding to and increasing the productive years of Waitemata residents and reducing health inequalities*
- Improved patient safety and experience: *aiming for 'first do no harm' and performance improvement*
- Achieving sustainability: *the DHB's health resources are efficiently and sustainably managed to meet present and future health needs.*

Many of the impact measures are relatively new, and are still being developed, so that in some cases the impacts may not be seen for many years. Therefore not all impact measures lend themselves to annual targets or even annual analysis. Some need to be viewed on a longer time frame, as part of our health needs analyses.

Outcomes measurement framework

Our focus for 2012/13 is ensuring we have a positive impact on our community in terms of health outcomes, their experience of the health services provided to them and our efficient use of resources. However, it is important that the actions we take during 2012/13 link to the expected outcomes sought in the future. The output classes, summarised below, are described more fully later in the section. Please refer to the planning framework in Module 2 which links the outcomes and impacts with the national, regional and local strategic direction.

Key to the output classes for 2012/13

- Prevention services
- Early detection and management
- Intensive assessment and treatment
- Rehabilitation and support.

Within each output class section, a series of relevant time trend graphs are included. It is intended that these give a broad overview of relevant outputs, where time trend information is relevant and useful.

Cost of Outputs

Old Output Class Name	Hospital	Support	Primary	Public	Total
New Output Class Name	Intensive Assessment & Treatment	Rehabilitation and Support	Early Detection & Management	Prevention Services	Total
	Plan	Plan	Plan	Plan	Plan
Total Revenue	**816,561,695**	**198,019,423**	**369,369,674**	**32,891,209**	**1,416,842,000**
Expenditure					-
Personnel	400,394,124	28,876,237	54,767,066	9,104,877	**493,142,304**
Outsourced Services	32,937,034	4,141,717	4,494,972	747,277	**42,321,000**
Clinical Supplies	68,486,676	5,667,847	9,640,731	1,602,745	**85,398,000**
Infrastructure & Non-Clinical Supplies	84,984,936	4,885,783	11,431,779	1,900,502	**103,203,000**
Payments to Providers	227,758,925	154,447,838	289,035,126	19,535,807	**690,777,696**
Total Expenditure	**814,561,695**	**198,019,423**	**369,369,674**	**32,891,209**	**1,414,842,000**
Net Surplus / (Deficit)	**2,000,000**	-	-	-	**2,000,000**

Targets and Achievement

The rationale and targets for each of the output measures included in the following sections is included in Module 8 Appendices. It is important to note, that while there are disparities in health service access and health outcome between ethnic groups, the health sector does not have differential targets for different ethnic groups compared to Others. We have an expectation that all New Zealanders should receive the same level of care and service regardless of ethnicity and we should all enjoy the same health outcomes.

When assessing achievement against each measure we use a grading system to rate performance. This helps to identify those measures where performance was very close to target versus those where under-performance was more significant. The criteria used to allocate these grades are as follows:

Criteria	Rating
> 20% away from target	Not Achieved
9-20% away from target	Partly Achieved
0.01-9% away from target	Substantially Achieved
On target or better	Achieved

Output Class Prevention Services

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.

Prevention and health promotion services are delivered by many organisations across the Waitemata region, including;

- Screening services such as BreastScreen Aotearoa (BSA)
- Directly by the DHB, for example through the community services arms of Child, Women and Family Services
- Public health services are largely delivered by the Auckland Regional Public Health Service (ARPHS). ARPHS is managed by Auckland DHB and provides regional public health services to the DHBs of the greater Auckland region. These services include health protection (environmental health, communicable disease control, and emergency planning and response), health promotion (healthy housing, alcohol & tobacco and nutrition & physical activity) and population screening (breast, bowel, cervical, preschool and newborn)
- A significant portion of the work of Primary Care is preventive in nature. Preventive outputs and Activities provided by General Practice teams (including cervical screening and immunisation) are covered under Primary Care in the Early Detection and Assessment Output class.

Contribution to Outcomes

Our population's health is improved through the delivery of **prevention services** as they reduce the amount and size of disease outbreaks and reduce the harm from environmental hazards and at an individual patient level increase the survival and reduce the morbidity from breast and bowel cancer.

These services also contribute to reducing health inequalities as the poor and most vulnerable in society are generally those most at risk from communicable disease outbreaks and environmental hazards, and they also stand the most to gain from a regulatory environment that protects population health.

From a financial sustainability or efficiency perspective a quick and effective response to outbreaks, environmental hazards and other emergencies also reduces downstream expenditure on the consequences of uncontrolled health threats. Other public health services, such as health promotion and healthy public policy, also help to reduce downstream demands on DHBs for personal health services though influencing medium and long - term health outcomes.

Output: Health Protection

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Communicable disease surveillance and control activities	Investigation and control measures	***Quantity*** Number of outbreaks investigated Number of contacts traced in relation to CDC cases ***Quality*** Communicable disease protocols up-to-date Communicable disease protocols adhered to	Population health protected by reducing secondary cases	Number of outbreaks investigated

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Output: Health Protection (continued…)

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Environmental control activities including: air quality; border health protection; burial and cremation; contaminated land; water quality; hazardous substances; radiation; sewage; waste management; resource management.	Surveillance, investigation and control of hazards	***Quantity*** Number of investigations in relation to built environments. ***Quality*** Proportion of Hazardous Substances and New Organisms (HSNO) events responded to appropriately ***Timeliness*** Proportion of public health risk management plan (PHRMPs) reports submitted to the water supplier within 20 working days	Reduction in adverse effects of environmental hazards	Number of environmental hazards detected.

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Output: Health Protection (continued…)

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Emergency planning and response	Emergency plans Emergency responses	***Quantity*** Number of emergency response exercises participated in Number of emergencies responded to ***Quality*** Emergency Plan up-to-date ***Timeliness*** Proportion of reports submitted to the Ministry of Health within 24 hours of occurrence of a public health event at the border.	Rapid and effective emergency responses	Evaluation reports and inquiries into emergency responses to show adherence to best practice.

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Output: Health Promotion

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Monitoring compliance with smoke free and alcohol sales legislation	Monitoring and enforcement of liquor and tobacco premises	***Quantity*** Number of liquor license applications processed by ARPHS and all problematic premises that receive a compliance check ***Quality*** Alcohol compliance protocols are adhered to when site visits are carried out ***Timeliness*** Liquor licensing applications processed within 15 days Tobacco complaints responded to within 5 days	Reduced sales of cigarettes and alcohol to youth and minors, safer drinking environments and smokefree environments	Proportion of controlled purchase operations in which alcohol or tobacco product sales are sold to minors.

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Output: Health Policy / Legislation Advocacy and Advice

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Analysis and comment on health policy proposals and draft legislation with implications for public health	Submissions on health policies, regulations and legislation.	***Quantity*** Numbers of submissions made. ***Quality*** Submissions policy adhered to ***Timeliness*** Submission documents submitted by deadline	A national policy, regulatory and legislative framework favouring improved and more equitable health.	Changes in draft legislation / regulation / policy made in response to submissions

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Output: Population Based Screening

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Population breast screening of women aged 45-69 years	Eligible women screened for breast cancer	***Quantity*** Screening coverage rates among eligible groups ***Quality*** Breastscreening - Proportion of women screened who report that their privacy was respected ***Timeliness*** Proportion of women screened who receive their results within 10 working days	Increased survival / reduced mortality from breast cancer.	Imputed years of life gained among Waitemata domiciled women through breast screening
Pilot a population based bowel screening programme ❖	Eligible men and women screened for bowel cancer	***Quantity*** Proportion of eligible population sent an invitation letter each two year screening cycle ***Quality*** Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure/any other investigations. ***Timeliness*** Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 50 working days	Increased survival / reduced mortality from bowel cancer.	Imputed QALYs gained through bowel screening of Waitemata residents.

NB. Outputs and Activities provided by General Practice Teams (including cervical screening and immunisation) are covered under Primary Care in the Early Detection and Assessment Output class. A significant portion of the work of Primary Care is preventive in nature.

❖ Note: the Bowel Screening Policy and Operating Procedures, Service Delivery Model and associated Quality Standards for the delivery of the screening services are interim documents. These documents will be modified to reflect the outcomes from evaluations and reviews of the services throughout the four-year term of the pilot. Waitemata DHB will work with the Ministry to agree changes which may impact on these interim reporting measures

Output Class Early Detection and Management

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. These include general practice, community and Māori health services, pharmacist services, community pharmaceuticals (the Schedule) and child and adolescent oral health and dental services. These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB. On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals.

Waitemata DHB works with the district's Primary Health Organisations (PHOs), their general practitioners and other community based providers, including community pharmacists and child and adolescent dental services, to deliver a range of services to our population.

Contribution to Outcomes

Ensuring good access to **early detection and management services** for all population groups, including prompt diagnosis of acute and chronic conditions, management and cure of treatable conditions, and giving consideration to health disparities in the prioritisation of service mix helps to reduce those disparities and improve population health. Early detection and management services also enable patient's to maintain their functional independence and prevent relapse of illness.

Our patients' experience is improved through timely access to services, reassurance in the case of negative results and prompt management of complaints and incidents. Ensuring services undertake clinical audit also provides patients and their family / whanau confidence in the quality of the health system.

Effective early detection and management of patients reduces demand on more costly secondary and tertiary care services and can lower per capita out of pocket and total expenditure on pharmaceuticals.

Output: Community Referred Testing & Diagnostics

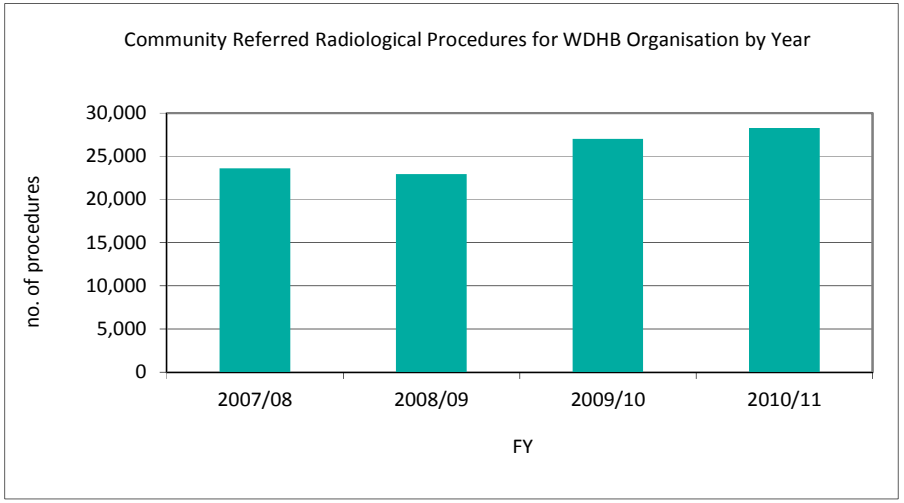
We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Purchase and monitor community referred testing and diagnostic services including: • laboratory tests • radiological services for cardiology, neurology, audiology, endocrinology, respiratory, orthopaedics • pacemaker physiology tests • ante-natal screening.	Community referred laboratory tests and other diagnostics services.	***Quantity*** Number community laboratory tests by provider. Number radiological procedures referred by GPs to hospital. ***Quality*** Complaints as percentage of total no. of laboratory tests ◈ ***Timeliness*** Average waiting time in minutes for a sample of patients attending Waitemata DHB collection centres between 7am and 11am (peak collection time) 75% of accepted community referrals for MRI or CT scans receive their scan within 6 weeks (42 days) by July 2013 ❖	Prompt diagnosis of acute and chronic conditions. Patient reassurance in the case of negative results. Reduced demand on specialist outpatient appointments	The percentage of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing absolute CVD risk in the last five years. Proportion of patients attending First Specialist Appointments for back pain who have already had MRI imaging. *WDHB Only*

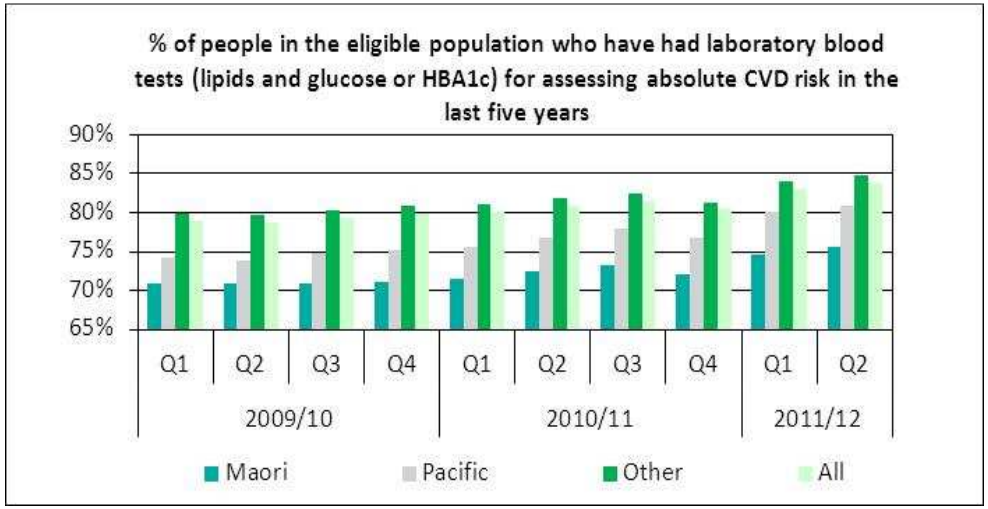
◈ Note the data to support this measure is for all three metro Auckland DHBs

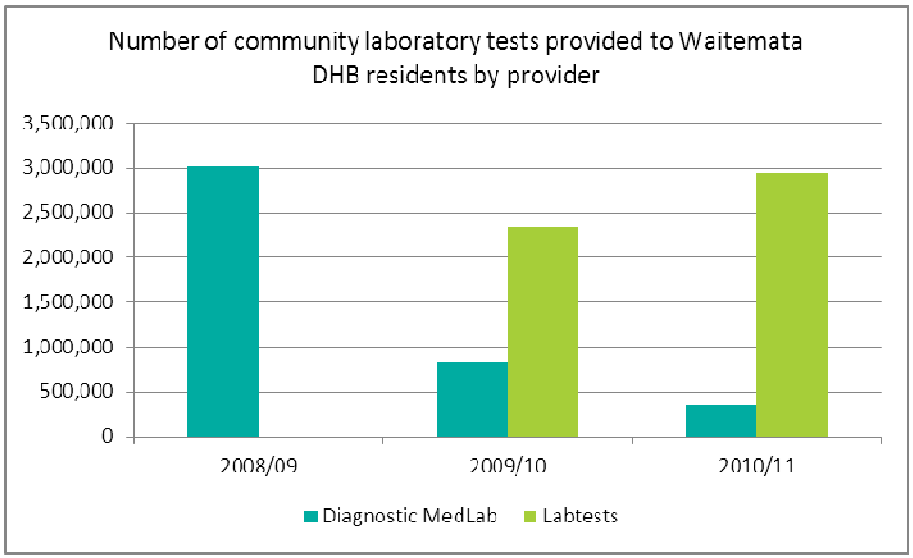
❖ Note: waiting time targets apply to all MRI/CT scans, however for the purposes of this table, only the community referred tests/scans are referred to here.

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Trend graphs for key measures for community referred testing & diagnostics





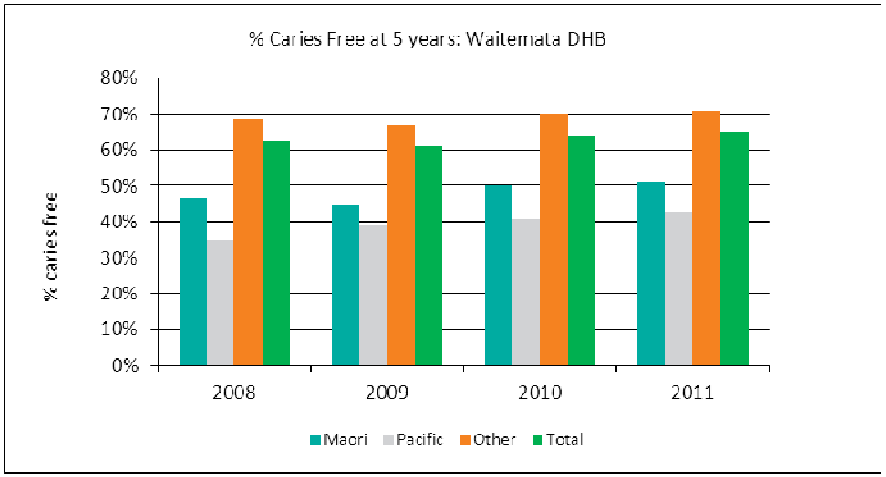


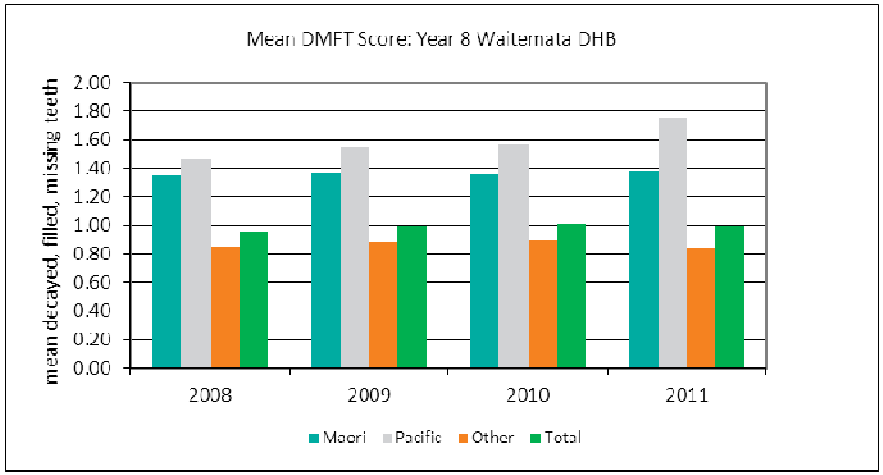
Output: Oral Health

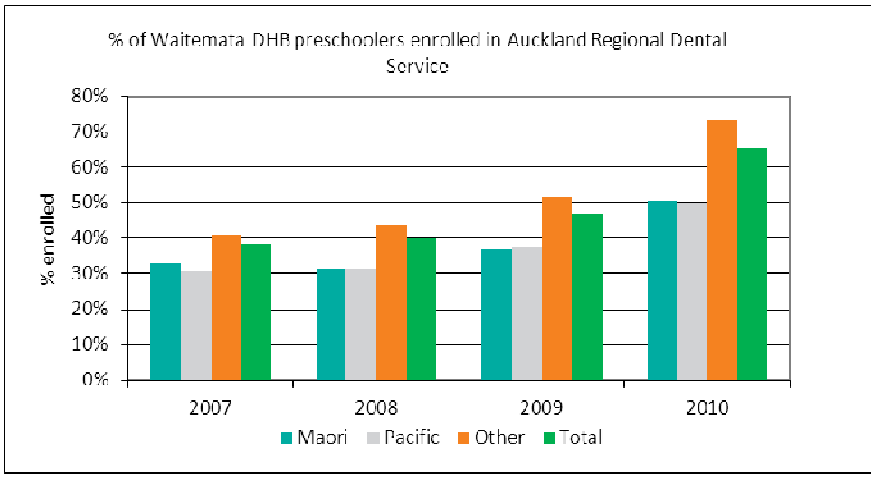
We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Fund and/or provide a range of services for the metro Auckland region that promote, improve, maintain and restore good oral health including: Health promotion activities targeting children and adolescents living in disadvantaged areas. Particularly Māori and Pacific Oral health examination and oral health education provided to preschool children & their parents Oral health examination and education provided to school age children and adolescents. Oral health examination and pain relief provided to low income adults with oral health problems	Oral Health education Oral examinations and treatment among preschool children, school children, and adolescents.	**Quantity** Enrolment rates in children under five by ethnicity: - Māori - Pacific - Other - Total population Utilisation rates for adolescents Number of visits of preschool, and school children to oral health services (including adolescents) **Quality** Number of complaints in the financial year **Timeliness** Arrears rates by ethncity: - Māori - Pacific - Other - Total population	Caries among children and adolescents is prevented, detected early and treated before major damage to teeth occurs. Improvement of overall oral health with the reduction of inequalities among different ethnic groups	Percentage of children caries free and average Decayed , Missing and Filled Teeth (DMFT) of year 8 children by ethnic group Percentage of children caries free and average decayed , missing and filled teeth of 5-year-old children by ethnic group

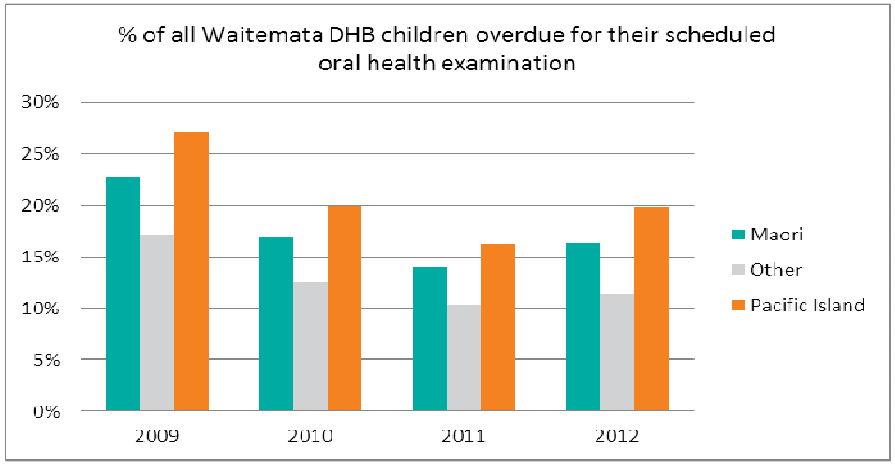
The rationale and targets for each of the output measures is included in Module 8 Appendices.

Trend graphs for key measures for oral health







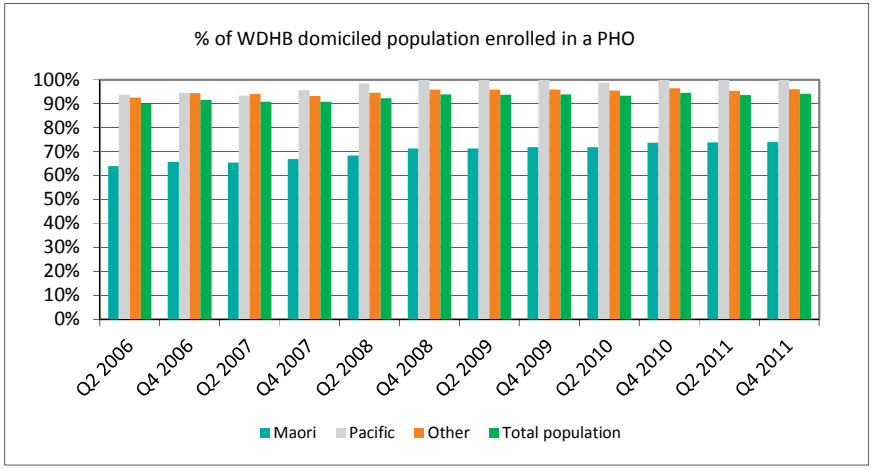


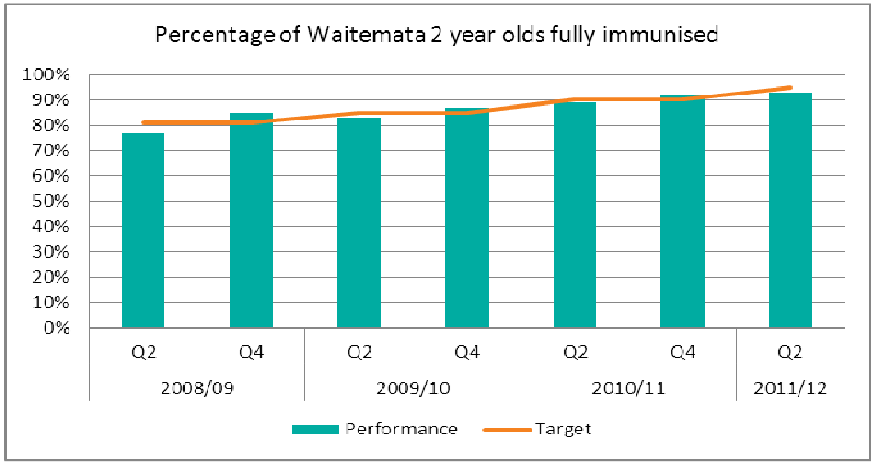
Output: Primary Health Care

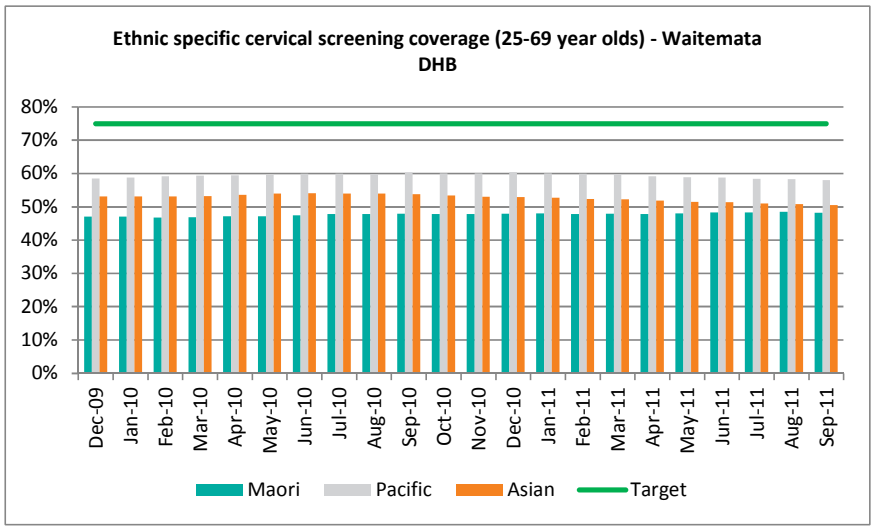
We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Subsidise the provision of primary care services provided by GP teams, including certain specific health programmes e.g. CVD Risk assessment and management, immunisation and before schools checks Subsidise the provision of primary care services provided by Primary Health Organisations including diabetes coordination and services to improve access for high risk groups Subsidise Region-wide work to improve the performance of primary care through the GAIHN. Contract cancer care coordination (navigation) services for Māori and Pacific populations	Enrolment in PHO affiliated general practice teams. Primary care nurse and doctor consultations, diagnosis and treatment for acute and long term conditions as well as social support and advice to families, in enrolled populations. Preventive health care including immunisation, before schools checks, and advice and help to quit smoking. Referral to secondary care services when appropriate. [Community referred diagnostic and pharmaceutical outputs included in a separate output subclass]	**Quantity** Primary care enrolment rates Immunisation health target achievement - 85% of eight month olds fully immunised by July 2013 Cervical screening coverage Percentage of B4 School Checks completed **Quality** Proportion of practices with cornerstone accreditation Proportion of patients who smoke and are seen by a health practitioner in primary care that are offered brief advice and support to quit smoking Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years **Timeliness** GMS claims from after-hours providers per 10,000 of population	Management and cure of treatable conditions. Prevention of illness. Maintenance of functional independence. Pain relief and reassurance. Minimising unnecessary use of high cost secondary care (“gate-keeping”)	Standardised acute discharge rate and case-weights – trend and benchmarked against other DHBs

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Trend graphs for key measures for primary health care







Output: Pharmacy

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Subsidise the community based provision of prescribed pharmaceuticals.	Community dispensing of pharmaceutical products subsidised in accordance with Pharmac stipulations.	**Quantity** Total value of subsidy provided. Number of prescription items subsidised. Number of Medicine Use Reviews conducted by community pharmacy *WDHB Only* **Quality** Proportion of prescriptions with a valid NHI number. **Timeliness** The proportion of the population living within 30 minutes of an extended-hours pharmacy (ie any pharmacy open at 8pm on a Sunday)	Good access to effective pharmaceutical treatments. Lower per capita out of pocket and total expenditure on pharmaceuticals	Proportion of hypertensive patients (identified from hospital discharge records) who receive anti-hypertensive medication within six months of last discharge.

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Output Class Intensive Assessment and Treatment

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment such as a 'hospital' or surgery centre. These services are generally complex and provided by health care professionals that work closely together. They include:

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

On a continuum of care these services are at the complex end of treatment services and focused on individuals.

Waitemata DHB provides a broad range of secondary services that align with this output class that are provided by our North Shore and Waitakere hospitals and the Mason Clinic forensic psychiatric facility. These include maternity services, surgical services (including orthopaedics, general surgery and gynaecology), medical services (including general medicine, gastroenterology, cardiology and respiratory medicine), emergency department, mental health, older adult services (assessment, treatment and rehabilitation), paediatric medicine and others.

The DHB provides mental health and addiction services, including forensic services and alcohol, drug and other addiction treatment to the other DHBs in the northern region.

Waitemata DHB funds Auckland DHB to provide a number of tertiary services for its population that align with this output class. These services include neurology, cardiac surgery, radiotherapy and quaternary paediatric services.

Contribution to Outcomes

Effective and prompt resolution of medical and surgical emergencies and acute conditions reduces mortality, restores functional independence in the case of elective surgery and improves the health-related quality of life in older adults, thereby improving population health.

Ensuring good access to **intensive assessment and treatment** for all population groups, and giving consideration to health disparities in the prioritisation of service mix helps to reduce those disparities.

The overall patient experience, both as an outpatient and as an inpatient, is improved with prompt service delivery, caring and courteous staff and comfortable, easily accessed facilities catering for all patients' needs.

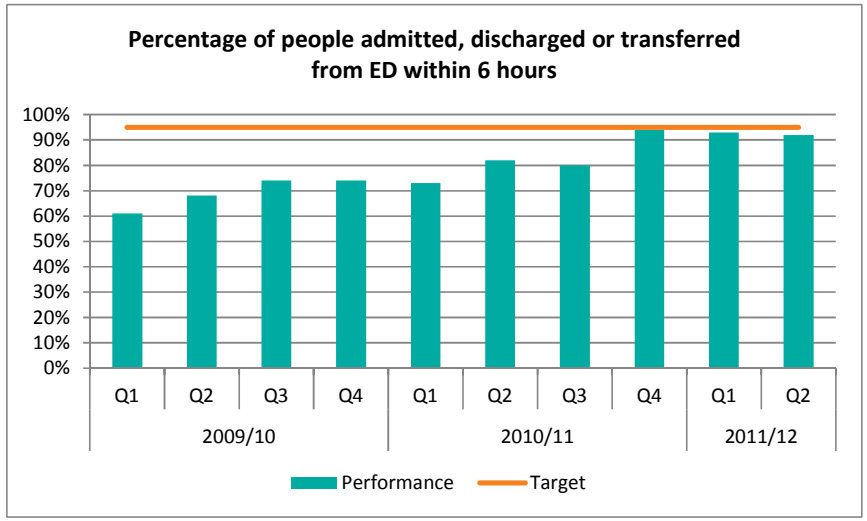
Efficient elective and acute service delivery and careful prioritisation of **intensive assessment and treatment** services maximise the cost-effectiveness of these services provided to our community.

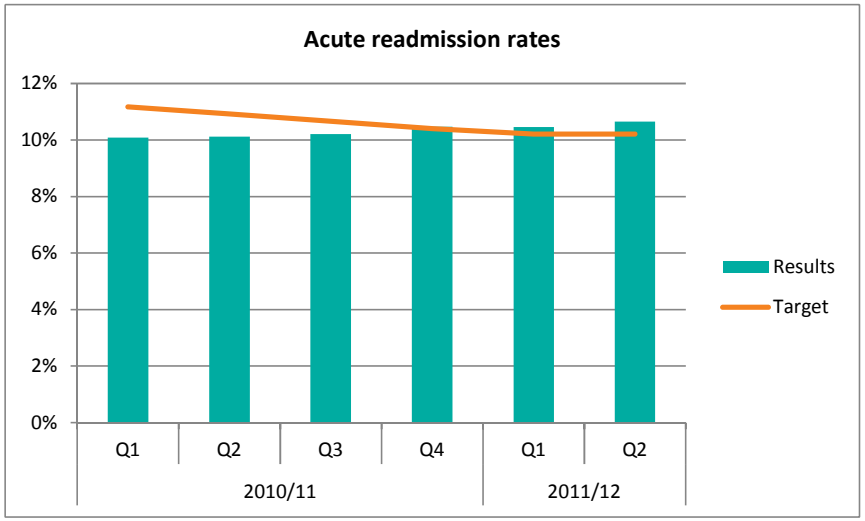
Output: Acute Services

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Provide an emergency and acute care service with the following characteristics: • Timely access to all service components (including diagnostics) and appropriate timely discharge • Capacity to meet needs • Right treatment in the right place • Timely patient transfer to appropriate services from Emergency Department • Good access to support services in the community or primary care level to support patient recovery.	Acute inpatient services Emergency department services	**Quantity** Number of ED attendances. Acute WIES total (Provider). **Quality** Readmission rates. **Timeliness** Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival. Compliance with national health target of 100% of patients needing radiation or chemotherapy treatment will have this within four weeks	Effective and prompt resolution of medical and surgical emergencies and acute conditions. Reduced mortality. Improved patient experience of our services Improved engagement of clinicians and other health professionals Patients less likely to be readmitted	Age standardised 30 day survival from acute transmural myocardial infarction.

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Trend graphs for key measures for acute services





Output: Maternity

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Provide readily accessible maternity, obstetric and neonatal care services.	Non-specialist antenatal consultations. Obstetric antenatal consultations. Postnatal inpatient and outpatient care. Labour and birth services. Specialist neo-natal inpatient and outpatient care. Amniocentesis	**Quantity** Number of births. Number of first obstetric consultations. Number of subsequent obstetric consults. **Quality** Proportion of all births delivered by caesarean section Established breastfeeding at discharge excluding NICU admissions. Third/fourth degree tears for all primiparous vaginal births **Timeliness** Percentage of term elective caesarean performed at ≥ 39 weeks	Safer childbirth. Healthier children.	APGAR score ≤ 6 at 5 mins for live term infants Blood loss ≥ 1500 ml during first 24 hours following a vaginal birth Blood loss ≥ 1500mls during first 24 hours following caesarean birth

The rationale and targets for each of the output measures is included in Module 8 Appendices.

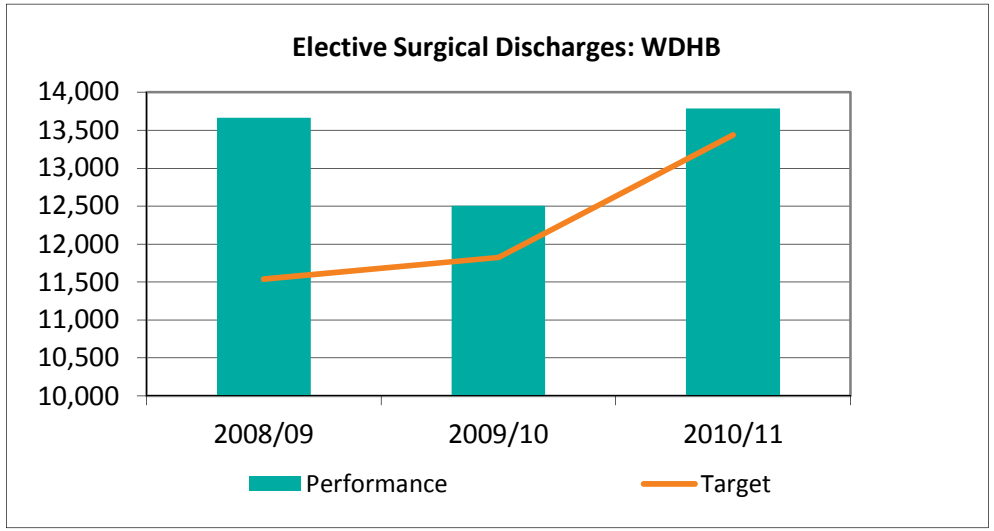
Output: Elective (Inpatient/Outpatient)

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Provide and purchase elective inpatient and outpatient services.	Elective inpatient services. Elective outpatient services.	**Quantity** Delivery of health target for elective surgical discharges (Health target) Surgical intervention rate. Number of first specialist assessment (FSA) outpatient consultations **Quality** Surgical infection rates **Timeliness** Patients waiting longer than six months for their first specialist assessment (FSA) Patients given a commitment to treatment but not treated within six months	Restoration of functional independence. Increased life expectancy. Improved surgical infection rates Improved waiting times for our services Fewer adverse clinical events Patients less likely to be readmitted	Total QALYs[4] gained from the five Ministry of Health selected procedures calculated as the number of procedures multiplied by QALYs per procedure as follows: Hip replacement (primary) = 0.85 Hip replacement (revision) = 0.15 Knee replacement (primary) = 0.8 Cataract = 1.1 CABG = 1.3 PCI = 1.64

The rationale and targets for each of the output measures is included in Module 8 Appendices.

[4] QALY – Quality Adjusted Life Year. QALY gains are discounted by 3% per annum. Specific values cited here for each procedure are based on review of the international literature.

Trend graph for key measure for elective services



Output: Assessment Treatment and Rehabilitation (Inpatient)

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Provide an inpatient specialist geriatric evaluation, management and rehabilitation service for older adults	Sub-acute inpatient care of older adults.	**Quantity** AT&R bed days No. of AT&R inpatient events **Quality** Average no. of falls per 1,000 occupied bed days **Timeliness** Proportion waiting 4 days or less from waitlist date to admission to AT&R service.	Maximising functional independence and health-related quality of life in older adults	The proportion of patients with an improvement in function between AT&R admission and within 3 days of discharge as measured by the: • FIM (functional independence measure). *WDHB Only* • Barthel index *ADHB Only*

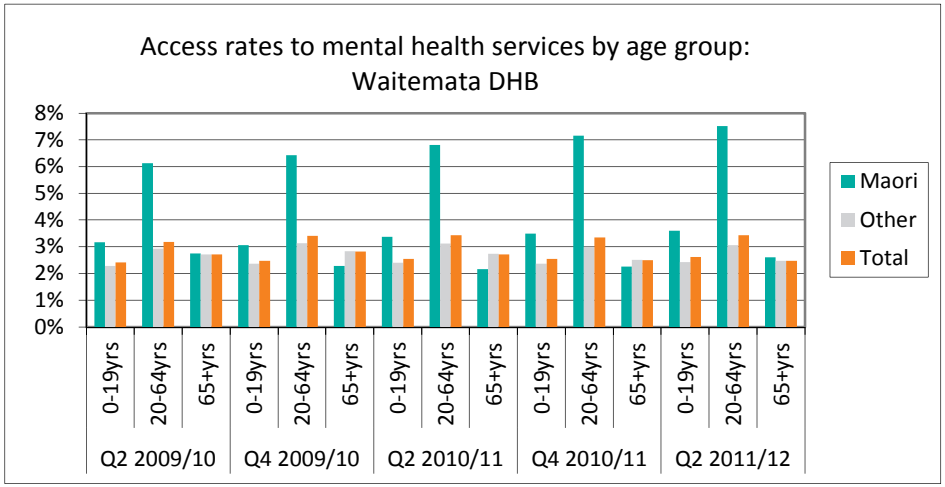
The rationale and targets for each of the output measures is included in Module 8 Appendices.

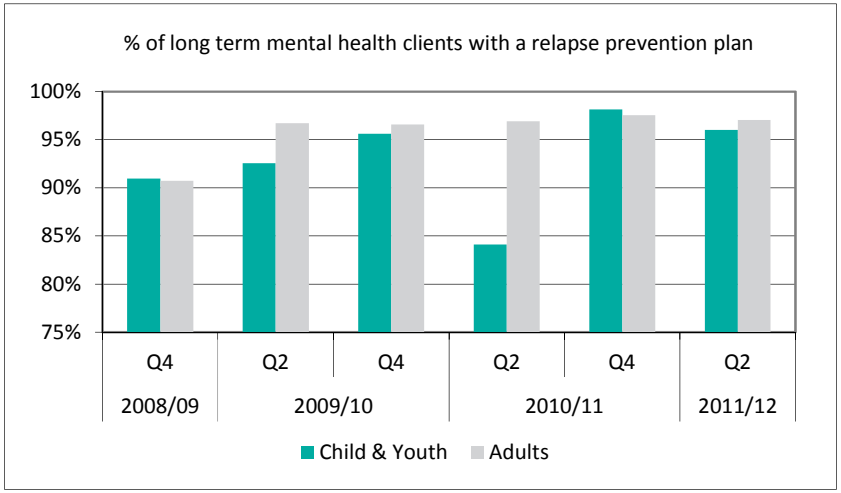
Output: Mental Health

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Provide and/or contract mental health inpatient, outpatient, community, residential, rehabilitation, support and liaison services	A matrix of comprehensive and/or specialist inpatient, residential or community based Mental Health & Addiction services covering Child, Adolescent & Youth; Adult; and Older Adult Age bands. The matrix of services comprise - Acute & Intensive services - Community based clinical treatment & therapy services - Services to promote resilience, recovery and connectedness.	**Quantity** Access Rates for total and specific population groups (defined as the proportion of the population utilising Mental Health and Addiction services in the last year). The population groups for which this indicator is measured are: • Total / child & youth / adult / older adult population (all ethnicities) • Māori (total / adult / child & youth / older adult) **Quality** Proportion of long term clients with Relapse Prevention Plan (RPP) [target of 95%] in the above population groups **Timeliness** Shorter waits for non-urgent mental health and addiction services (Policy Priorities 8)	Prompt recovery from acute mental illness. Prevention of mental illness relapses. Social integration and improved quality of life.	

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Trend graphs for key measures for mental health





Output Class Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by NASC Services for a range of services including palliative care services, home-based support services and residential care services. On a continuum of care these services provide support for individuals.

Waitemata DHB's aim is to have a fully inclusive community, where people are supported to live with independence and can participate in their communities. To achieve this aim, following their needs being assessed, support services are delivered to people with long-term disabilities; people with mental health problems and people who have age-related disabilities. These services encompass home-based support services; residential care support services; day services and palliative care services.

Rehabilitation and support services are provided by the DHB and non-DHB sector, for example residential care providers, hospice and community groups.

Contribution to Outcomes

By helping to restore function and independent living the main contribution of **rehabilitation and support services** to health is in improving health-related quality of life. There is some evidence that this may also improve length of life.

Ensuring that rehabilitation and support services are targeted to those most in need helps to reduce health inequalities.

In addition to its contribution to health related quality of life, high quality and timely rehabilitation and support services provide patients with a positive experience and a sense of confidence and trust in the health system.

Effective support services make a major contribution to enabling people to live at home for longer, thereby not only improving their well-being but also reducing the burden of institutional care costs to the health system.

Output: Home Based Support

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Assess and plan the needs of older people for Home Based Support Fund home based support services delivered in accordance with assessed needs.	Home based support assessments Home based support care.	**Quantity** Average number of hours per month of home based support services for: • Personal care • Household management *WDHB Only* Total number of InterRAI assessments per month *ADHB only* **Quality** The proportion of people aged 65 and older receiving long-term home-support services who have had a comprehensive clinical assessment and a completed care plan (PP-18) **Timeliness*:*** Percentage of NASC clients assessed within 6 weeks	Older people with complex needs remain living in their home for longer Better health and fewer accidents (eg falls) among people over 65 years. Improved happiness and quality of life for older adults.	Proportion of NASC referrals assessed to have high or very high needs who reside in their own home.

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Output: Palliative Care

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Contract or provide high quality generalist and specialist palliative care services	Hospice provided palliative care. Specialist community palliative care services. Home based palliative care services.	**Quantity** Number of contacts *WDHB Only* Total number of completed episodes of care (death or discharge) *ADHB Only* **Quality** Proportion of cancer patients admitted to hospice who are Māori, Pacific or Asian versus proportion of cancer deaths who are Māori, Pacific or Asian (historical baseline) **Timeliness** Proportion of patients acutely referred who had to wait >48 hours for a hospice bed	Improved quality of life for patients with life-threatening illness (and for their families/whanau)	Proportion of hospice patient deaths occurring in hospitals versus at home.

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Output: Residential Care

We will undertake these activities	And deliver these outputs	Outputs measured by	That will lead to these impacts	Impacts measured by
Ensure access to subsidised beds is based on assessed need. Ensure sufficient contracted beds are available to people assessed as requiring long term residential care.	Residential care bed days.	**Quantity:** Total number of subsidised aged residential care bed days. **Quality:** Proportion of long term residents residing within facilities that have received InterRAI training who have had an InterRAI clinical assessment within the year. **Timeliness:** Percentage of NASC clients assessed within 6 weeks	Safe care with good management of long term conditions and maximised quality of life for those no longer able to live independently in their own home.	Standardised acute admission rates from residential care.

The rationale and targets for each of the output measures is included in Module 8 Appendices.

Module 6: Service Configuration

Service coverage and service change

Service coverage

Service coverage is the mechanism by which the Crown articulates the national minimum quality, range and levels of access to services that are expected to be provided from public health and disability funding. These expectations are set out in the service coverage schedule (SCS) which, together with the operating policy framework, forms part of the funding agreement accountabilities of DHBs.

We will continue to strive to meet service coverage requirements and have not at this stage identified any new exceptions or gaps that have not previously been reported to and/or discussed with the Ministry of Health.

Service change

The Minister of Health agreed a new process to manage "significant" service change from 2011. The overarching consideration (including what constitutes "significant") is alignment to or departure from current service levels and the National Service Framework.

The DHB will follow the service change protocols in the Operational Policy Framework (OPF) and notify the National Health Board of any service changes that may arise from any service reviews planned for the coming year.

Funder

We conduct service reviews and evaluations as part of our quality and audit framework and as part of ensuring we are maximising the health gain we can achieve from the available resources and ensure our financial sustainability (refer Module 3). Processes undertaken are consistent with Treasury Guidelines and the requirements of the operational policy framework.

The following proposed service changes were advised to the Ministry of Health in February 2012:

- Investigations underway for possible integration or merger of services between Waitemata DHB and Auckland DHB.
- National initiative to improve community pharmacist services. National commitment to review pharmacist services as part of current national agreement.
- Reconfiguration of pharmacy services to Age Related Residential Care (ARRC) facilities.
- Reconfiguration of youth health services based on the outcome 2011/12 of the service review.
- Reconfiguration of treatment of biological infertility services based on the outcome 2011/12 of the service review.
- Reconfiguration of Home Based Support Services for high and very high need patients.
- Development of local interventional radiology service to support secondary specialist services being provided already locally at Waitemata.
- Development of local Implantable Controllable Devices service which will enable a full range of interventional cardiology services to be provided locally from Waitemata facilities as a result of the transfer of this service from ADHB.
- Phase 2 Renal Service development.

The following areas have been identified for review in 2011/12 and the outcome of these reviews may result in some service reconfiguration in 2013:

- Sexual health
- Ophthalmology
- Plastics.

Service Reviews for 2012/13 include respiratory, particularly sleep services, configuration of secondary and primary maternity services, NIR and immunisation outreach services, palliative care and B4School Checks.

Service issues

There are a number of national activities underway, particularly through DHB Shared Services (DHBSS), which are likely to require consultation eg any proposed substantive changes to the community pharmacy services and agreement.

Module 7: Financial Performance

Financial management overview

Our financial goal is to remain a sustainable and productive organisation while improving the health outcomes for our community. The uncertainty in the current economic environment, combined with significant cost pressures faced by the public health sector requires a deliberate strategy to maintain our financial sustainability. We will manage cost growth and achieve our financial goal through:

- A culture of financial accountability and discipline underpinned by a Business Transformation programme that seeks to continuously identify and implement savings initiatives
- Careful planning and implementation of affordable capital developments that enable us to continue meeting the health service delivery requirements for our population
- Implementing smarter ways of delivering quality health services more efficiently, more cost effectively and reducing any waste. We will do this in partnership with our Auckland DHB colleagues, also regionally through mechanisms such as healthAlliance and nationally through participation in processes such as national contract reviews.

Based on year to date financial performance and expectations for the rest of the 2011/12 financial year, and informed by robust organisational and financial analysis:

- We are forecasting a surplus of $5M for the 2011/12 year, against a planned breakeven result. This positive result reflects containment of cost growth, aided by continued success and progress on the Business Transformation Initiative implemented during the 2010/11 financial year, with $45M savings achieved, enabling the DHB to realise a surplus of $3.552M for that year. For 2011/12, Business Transformation savings of $23M were planned and we expect to achieve the full savings target, including unplanned savings that offset those no longer achievable.
- Potential risk to this forecast result includes the impact of the final Inter District Flow wash-ups (either positive or negative) and a severe early winter season, if this occurs in the last two months of this financial year. We will proactively manage any identified risks in order to meet the forecast financial result.
- We are planning a surplus of $2M in each of the three planning years. Waitemata will continue to drive cost reductions where feasible in order to generate surpluses. The planned surpluses are expected to fund capital projects for the DHB. Generating more cash for application to capital projects is now considered imperative given the limited capital envelope for the DHB sector (and indeed for most government sectors). This will be required, given the need for extensive investment in facilities and infrastructure in order to meet the long term growth in demand for health services driven by the DHB's population demographics.

Key Assumptions for Financial Projections

Revenue Growth

Growth in Population Based Funding Formula (PBFF) revenue for 2012/13 is based on the National Health Board funding envelope advice, with an increase of $42.654M or 3.64 per cent over the 2011/12 funding envelope. This is comprised of a 1.49 per cent ($17.453M) increase to fund cost pressures and 2.15 per cent ($25.201M) for demographic growth.

For the out-years, we have assumed that the funding increase will be of the same nominal value as that signalled for 2012/13 by the National Health Board. Other revenue is based on contractual arrangements in place and reasonable estimates for other income.

Expenditure Growth

Expenditure growth of $52.218M above the 2011/12 forecast level is planned and this is driven by demographic growth pressure on services provided by the DHB, demographic growth impact on demand driven third party contracts, clinical staff volume and cost growth to meet service growth requirements, costs for settled employment contracts (including automatic step increases), cost of capital for facility developments and inflationary pressure on supplies and services. Key expenditure assumptions include:

- Impact on Personnel Costs of all settled employment agreements, automatic step increases and new FTEs, risk provisions for expired employment contracts and of employment agreements expiring during the planning period.
- Clinical supplies cost growth is based on the actual known inflation factor in contracts, estimation of price change impacts on supplies and adjustments for known specific information within services. Costs also reflect the impact of growth in services provided by the DHB.
- The DHB reduced the management and administration cap as required by 3% (30.27 FTEs) from 1009 FTEs to 978.73 FTEs. This reduction has been achieved despite significant growth in services from service transfers and demographic growth for the DHB (of at least two percent per year) which have required administrative support.

Apart from cost pressures from employment contract settlements and inflationary factors on consumables and infrastructure costs, the other key driver for expenditure growth for Waitemata DHB is demographic growth and the fast ageing population. Based on the 2006 Census, Waitemata DHB has the second fastest growing population in New Zealand. This rate of growth is not expected to change for the three years of this plan. Every five years our population grows by over 50,000 people and the population is aging faster than the national average. Growth in the over 65 population group is the second highest in the country and in the over 85 year olds it is the fourth highest.

The Business Transformation initiative first implemented in 2010/11 is a key tool being used by the DHB to manage cost pressures by identifying savings to ensure the DHB lives within its means. For 2012/13, savings of $12M are planned. The Business Transformation programme is described in Module 3 of the Annual Plan.

Forecast Financial Statements

The tables below provide a summary of the consolidated financial statements for the audited result for 2010/11, year-end forecasts for 2011/12 and plans for 2012/13 to 2014/15.

Statement of Comprehensive Income

	2010/11 Audited $000	2011/12 Forecast $000	2012/13 Plan $000	2013/14 Plan $000	2014/15 Plan $000
Government and Crown Agency Revenue	1,218,388	1,264,641	1,318,299	1,362,714	1,407,057
Patient Sourced and Other Income	22,643	25,149	22,571	23,344	24,050
IDFs & Inter DHB Provider Income	79,121	77,834	75,972	78,532	81,090
Total Funding	**1,320,152**	**1,367,624**	**1,416,842**	**1,464,590**	**1,512,197**
Personnel Costs	447,633	468,185	493,142	510,433	526,994
Outsourced Costs	42,708	43,668	42,321	43,809	45,239
Clinical Supplies Costs	77,387	84,172	85,398	88,390	91,261
Infrastructure & Non-Clinical supplies Costs	100,460	97,936	103,203	106,831	110,316
Payments to Other Providers	648,412	668,663	690,778	713,127	736,387
Total Expenditure	**1,316,600**	**1,362,624**	**1,414,842**	**1,462,590**	**1,510,197**
Net Surplus / (Deficit)	**3,552**	**5,000**	**2,000**	**2,000**	**2,000**
Other Comprehensive Income					
Gains/(Losses) on Property Revaluations	(10,516)	0	0	0	0
TOTAL COMPREHENSIVE INCOME	(6,964)	5,000	2,000	2,000	2,000

Strong financial performance continues to be demonstrated with achievement of a breakeven plan being a key principle for both financial budgeting and financial performance.

The forecast surplus for 2011/12 and planned surpluses for 2012/13 through to 2014/15 demonstrate the DHB's ability to contain costs in a challenging environment with high demographic growth, high impact of the ageing population and continuing operational and capital cost pressures. Revenue continues to grow at a slower rate and the ability to achieve financial breakeven is becoming more and more dependent on the success of savings initiatives undertaken. The need to continue to increase elective volumes in line with the rest of New Zealand means that productivity improvements, process improvements, efficiencies and savings need to continue to be progressed by the DHB.

Statement of Cashflows

	2010/11 Audited $000	2011/12 Forecast $000	2012/13 Plan $000	2013/14 Plan $000	2014/15 Plan $000
Cashflow from operating activities					
MoH and other Government / Crown	1,393,868	1,342,475	1,394,271	1,441,246	1,488,147
Other Income	30,720	22,250	19,961	21,140	21,775
Interest received	4,905	2,899	2,610	2,204	2,275
Payments for Personnel	(437,478)	(468,185)	(493,142)	(510,433)	(526,994)
Payments for Supplies	(911,968)	(845,155)	(867,970)	(896,547)	(925,790)
Capital Charge Paid	(12,130)	(13,623)	(14,082)	(14,575)	(15,048)
GST Input Tax	(6,127)	(4,000)	(3,996)	(4,000)	(4,000)
Interest payments	(10,083)	(11,148)	(13,748)	(14,229)	(14,690)
Net cashflow from operating activities	**51,759**	**25,513**	**23,904**	**24,806**	**25,675**
Cashflow from investing activities					
Capital Expenditure (-ve)	(60,764)	(62,610)	(64,792)	(26,670)	(26,770)
Net cashflow from investing activities	**(60,764)**	**(62,610)**	**(64,792)**	**(26,670)**	**(26,770)**
Cashflow from financing activities					
Capital contributions from the Crown	5,621	5,081	0	0	0
Proceeds from borrowings	22,000	33,000	38,472	0	0
Repayment of borrowings	0	0	0	0	0
Net cashflow from financing activities	**27,621**	**38,081**	**38,472**	**0**	**0**
Net cash movements	**18,616**	**984**	**(2,416)**	**(1,864)**	**(1,095)**
Cash and cash equivalents at the start of the year	33,900	52,516	53,500	51,084	49,220
Cash and cash equivalents at the end of the year	**52,516**	**53,500**	**51,084**	**49,220**	**48,125**

Cashflow forecasts reflect the impact of capital projects approved by the Minister of Health (such as the Lakeview Extension, Car Park, Oral Health Project and the Elective Surgery Centre) and other capital projects approved by the Waitemata DHB Board. The deterioration in closing cash forecast for 2012/13 is due to significant cash contributions by the DHB towards these capital projects, with the DHB meeting 41% of the $131M funding required for capital expenditure for the 2011/12 and 2012/13 years from internally generated cash. Equity injections reflect Crown funding for the Oral Health project.

Waitemata DHB currently has borrowing facilities with the Crown Health Financing Agency (CHFA) of $262.820M, of which $218.796M is drawn. The undrawn facilities relate to balances on the Lakeview Extension, Car Park and Elective Surgery Centre loan facilities.

Statement of Financial Position

	2010/11 Audited $000	2011/12 Forecast $000	2012/13 Plan $000	2013/14 Plan $000	2014/15 Plan $000
Current Assets	93,901	90,500	93,084	86,220	85,125
Non-current assets	438,864	471,049	521,170	532,912	539,785
Total assets	**532,765**	**561,549**	**614,254**	**619,132**	**624,910**
Current Liabilities	200,544	217,108	228,275	229,737	232,087
Non-current liabilities	172,528	174,667	214,205	215,621	217,049
Total liabilities	**373,072**	**391,775**	**442,480**	**445,358**	**449,136**
Net assets	**159,693**	**169,774**	**171,774**	**173,774**	**175,774**
Total equity	**159,693**	**169,774**	**171,774**	**173,774**	**175,774**

The financial projections show a strong financial position, despite a reduction in the value of buildings of $10.516M from asset revaluations as at 30 June 2011.

Disposal of Land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, Waitemata DHB will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. Waitemata DHB will comply with the relevant protection mechanism that addresses the Crown's obligations under the Treaty of Waitangi and any processes related to the Crown's good governance obligations in relation to Māori sites of significance.

Statement of Movement in Equity

	2010/11 Audited $000	2011/12 Forecast $000	2012/13 Plan $000	2013/14 Plan $000	2014/15 Plan $000
Balance at 1 July	**161,036**	**159,693**	**169,774**	**171,774**	**173,774**
Comprehensive Income/(Expense)					
Surplus / (deficit) for the year	3,552	5,000	2,000	2,000	2,000
Other Comprehensive income	(10,516)	0	0	0	0
Total Comprehensive Income	**(6,964)**	**5,000**	**2,000**	**2,000**	**2,000**
Owner transactions					
Capital contributions from the Crown	5,621	5,081	0	0	0
Repayments of capital to the Crown	0	0	0	0	0
Balance at 30 June	**159,693**	**169,774**	**171,774**	**173,774**	**175,774**

Asset revaluations as at 30 June 2011 resulted in a $10.516M reduction in building values, which reduced the equity closing position in 2010/11. Equity injections for the Oral Health project and a surplus forecast for the 2011/12 financial year improve the equity position.

Additional Information

Financial performance for each of the DHB arms is summarised in the tables below:

Provider Arm Financial Performance

	2010/11 Audited $000	2011/12 Forecast $000	2012/13 Plan $000	2013/14 Plan $000	2014/15 Plan $000
Income					
MoH via Funder	593,746	597,585	641,397	663,897	685,486
MoH Direct	33,089	50,784	39,678	41,067	42,399
Other	33,509	36,009	34,751	35,950	37,065
Total Income	**660,344**	**684,378**	**715,826**	**740,914**	**764,950**
Expenditure					
Personnel	441,640	462,886	487,672	504,778	521,154
Outsourced services	40,276	40,474	40,101	41,515	42,871
Clinical supplies	77,387	84,172	85,398	88,390	91,261
Infrastructure & non clinical supplies	98,198	96,082	101,655	105,231	108,664
Total expenditure	**657,501**	**683,614**	**714,826**	**739,914**	**763,950**
Surplus / (Deficit)	**2,843**	**764**	**1,000**	**1,000**	**1,000**

A surplus of $2.843M was realised in 2010/11, a remarkable result given the Provider arm is emerging from an era of deficits which were mainly driven by cost growth greater than revenue growth. The Provider is also planning surpluses of $1M in each of the planning years.

The DHB's Production Plan provided as part of this planning package summarises the service volumes planned to be delivered by the Provider in 2012/13.

Governance and Funding Administration Arm Financial Performance

	2010/11 Audited $000	2011/12 Forecast $000	2012/13 Plan $000	2013/14 Plan $000	2014/15 Plan $000
Revenue	11,141	10,947	9,238	9,549	9,860
Expenditure	10,711	10,347	9,238	9,549	9,860
Surplus/(Deficit)	430	600	0	0	0

The Governance and Funding Administration arm continues to perform within the funding allocated, with a surplus achieved in 2010/11 and also expected for 2011/12, and breakeven planned throughout the

planning period. The forecast surplus for 2011/12 includes efficiency savings that are currently being achieved, additional to those budgeted. Similar savings are included in the 2012/13 plan, resulting in reduced revenue and expenditure. The reduced revenue and expenditure in the 2012/13 plan also results from funded project establishment costs not continuing into 2012/13.

Funding Arm Financial Performance

	2010/11 Audited $000	2011/12 Forecast $000	2012/13 Plan $000	2013/14 Plan $000	2014/15 Plan $000
Revenue	1,253,303	1,280,783	1,342,177	1,387,329	1,432,481
Expenditure					
Personal Health	898,295	927,930	971,434	1,004,150	1,036,866
Mental Health	207,670	197,212	199,124	205,825	212,524
DSS	131,655	135,402	150,355	155,409	160,465
Public Health	2,540	3,872	4,427	4,575	4,723
Maori Health	1,974	1,832	6,835	7,065	7,295
Governance	10,890	10,899	9,002	9,305	9,608
Total Expenditure	1,253,024	1,277,147	1,341,177	1,386,329	1,431,481
Surplus/(Deficit)	279	3,636	1,000	1,000	1,000

The Funder generated a small surplus in 2010/11, forecasts a $3.6M surplus for 2011/12 being achieved across Funder Inter District Flow Services as well as across Funder Third Party Provider Services (Non Government Organisations). This surplus represents a favourable position additional to the budgeted savings initiatives required of the Funder for 2011/12. For the planning period, the funder is planning surpluses of $1M in each of the planning years.

Capital Expenditure

	2010/11 Audited $000	2011/12 Forecast $000	2012/13 Plan $000	2013/14 Plan $000	2014/15 Plan $000
Funding Sources:					
Free cashflow from depreciation	23,953	24,513	25,906	26,812	27,681
External Funding	27,537	38,081	38,472	0	0
Cash reserves	9,274	16	414	(142)	(911)
Total Funding	60,764	62,610	64,792	26,670	26,770
Baseline Capital Expenditure					
Land	0	0	0	0	0
Buildings & Plant	15,040	13,519	10,404	10,000	10,000
Clinical Equipment	4,493	5,306	5,724	9,500	9,000
Other Equipment	314	490	516	520	520
Information Technology	3,396	2,658	4,320	3,500	3,500
Intangible Assets (Software)	1,030	1,400	3,000	2,500	3,000
Motor Vehicles	0	0	1,000	650	750
Total Baseline Capital Expenditure	24,273	23,373	24,964	26,670	26,770
Strategic Investments					
Land	0	0	0	0	0
Buildings & Plant	36,491	39,237	39,828	0	0
Clinical Equipment	0	0	0	0	0
Other Equipment	0	0	0	0	0
Information Technology	0	0	0	0	0
Intangible Assets (Software)	0	0	0	0	0
Total Strategic Capital Expenditure	36,491	39,237	39,828	0	0
Total Capital Payments	60,764	62,610	64,792	26,670	26,770

The major capital development included in the strategic capital expenditure is the Elective Surgery Centre, approved by the Minister of Health in August 2012 with a total capital cost of $39.4M (being funded by Crown debt of $36.9M and DHB cash of $2.5M). This is planned to be completed by 1 July 2013.

We are currently developing business cases for National Capital Investment Committee consideration for the Taharoto Mental Health Unit (capital cost estimated at $25M, planned to be funded by DHB cash contribution combined with existing undrawn Crown debt facilities ($10M) and the balance to be funded by new Crown debt) and for the Mason Clinic (capital cost under $10M, to be fully funded by DHB cash).

Banking Facilities and Covenants

Term Debt Facilities

Waitemata DHB has term debt facilities of $262.82M with the Crown Health Financing Agency, of which $218.796M is currently drawn and $44.02M is undrawn.

Working Capital Facilities

Waitemata DHB has a total working capital facility of $40M with private sector banks as follows:

- A Cash Advance Facility of $39M with ANZ bank which has not been drawn since it was established; and
- An overdraft facility of $1M with Westpac bank. Westpac also provides transactional banking services for the DHB.

New Shared Commercial Banking Services Proposal

Health Benefits Limited undertook a project on behalf of all DHBs to identify a preferred commercial banking services provider for the DHB sector. Westpac was the preferred supplier of banking services from the RFP process. All DHBs have been offered the option to accept Westpac as the banking services provider for the sector and Waitemata DHB Board accepted this offer. Once this arrangement is in place, the DHBs will no longer be required to maintain separate stand-by facilities for working capital. Waitemata expects to be in the new arrangement prior to the end of 2011/12. The new arrangements are expected to generate savings of over $4M for the sector.

The working capital facilities will be cancelled from 1 July 2012 as they will no longer be required under the shared commercial banking arrangements.

Banking Covenants

Standard financial covenants are in place for all our three banking relationships and are all being met, although CHFA covenants are currently waived.

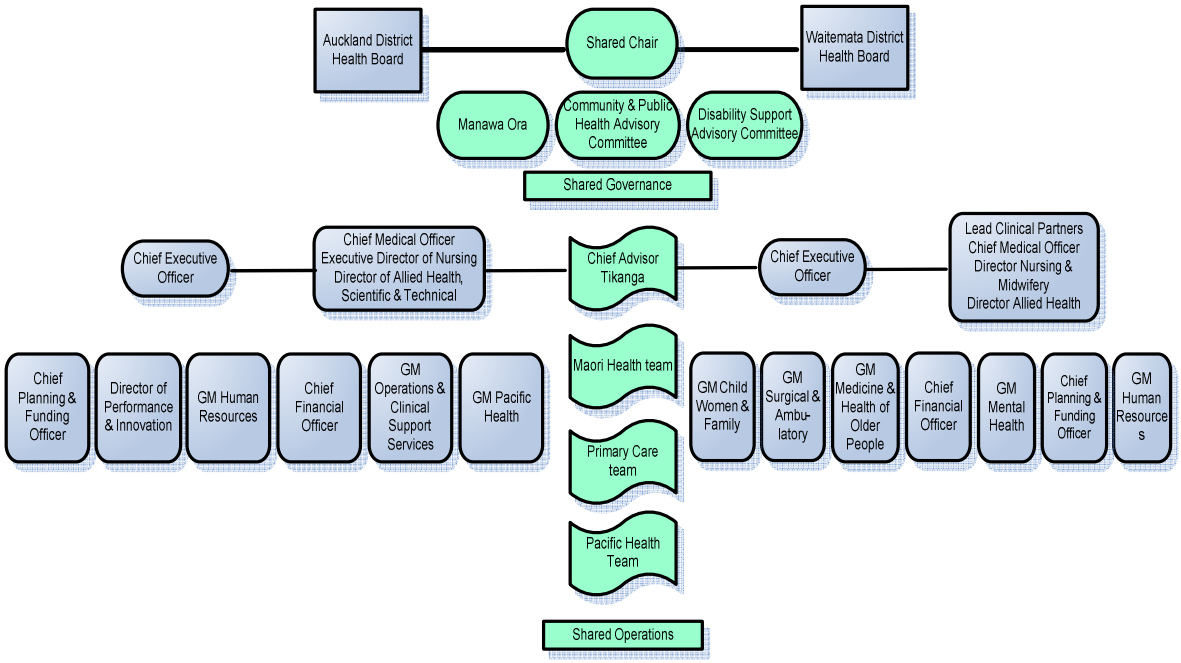
Module 8: Appendices

Structure of our Organisation

Governance for Waitemata 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. These people provide strategic oversight for the DHB, taking into account the Government's vision for the health sector and its current priorities.

Board Members	Dr Lester Levy, Chair	(appointed)
	Professor Max Abbott, Deputy Chair	(elected)
	Warren Flaunty	(elected)
	Gwen Tepania-Palmer	(appointed)
	Pat Booth	(elected)
	Wendy Lai	(appointed)
	Sandra Coney	(elected)
	Rob Cooper	(appointed)
	James Le Fevre	(elected)
	Christine Rankin	(elected)
	Allison Roe	(elected)

We are increasingly aligning activity with Auckland DHB. The following diagram shows Waitemata and Auckland DHBs' organisational structures, including where the DHBs share governance and operational arrangements.



Senior Leadership Team for Waitemata DHB	Dr Dale Bramley	Chief Executive
	Dr Debbie Holdsworth	Chief Planning & Funding Officer
	Dr Andrew Brant	Chief Medical Officer
	Dr Jocelyn Peach	Director of Nursing & Midwifery
	Phil Barnes	Director Allied Health
	Rosalie Percival	Chief Financial Officer
	Cath Cronin	GM Surgical & Ambulatory Services
	Peng Voon	GM Medicine & Health of Older People
	Linda Harun	GM Child, Women and Family Services
	Helen Wood	GM Mental Health Services
	Sam Bartrum	GM Human Resources

Diabetes Care Improvement Package Proposal - Waitemata District Health Board

1. Introduction

1.1. Waitemata District Health Board (DHB) will be implementing a Diabetes Care Improvement Package from 1 July 2012 to replace the current Diabetes Free Annual Review Programme. This change in service has been mandated by the Ministry of Health.

1.2. Waitemata DHB will invest $800,000 of funding into this service. Waitemata DHB has used the guidance provided by the Ministry of Health to develop this plan. We have also conducted a workshop that included the Local Diabetes Team (Diabetes Clinical Advisory Group) and service providers to identify the key services this funding should target.

1.3. The final proposal for the Diabetes Care Improvement Package has been developed using local and regional resources to identify the target population and the outcomes we will measure.

2. Focus Area

2.1. The Ministry of Health estimated diabetes prevalence in Waitemata DHB at 18,625 for 2011/12. The DHB estimates 12,884 people will have a free diabetes annual review in 2011-12. 8,859 have had a check in the reporting period from 1 July 2011 to 31 March 2012.

2.2. In the 2010-11 year 11,628 received a free diabetes annual review. 8,476 of these people had good diabetes management, HbA1c ≤ 8% (≤ 64mmol/mol). The table below provides ethnicity data on the number of people who had their annual review in 2011-12.

	# Type 1 Diabetes	# Type 2 Diabetes	Other Diabetes	Total Diabetes
Māori	33	883	45	961
Pacific	27	1212	39	1278
Other	592	8600	297	9389
TOTALS	652	10695	381	11628

2.3. In addition to the people who have a free diabetes annual review an undisclosed number of people are reported by general practice to receive standard diabetes care.

2.4. In considering the options for the Diabetes Care Improvement Package Waitemata DHB undertook a range of activities with key stakeholders. This included discussion with the secondary care Diabetes Centre and a workshop with key stakeholders including the Diabetes Clinical Advisory Group. This work resulted in the recommendations for the services to be provided from 1 July 2012. These include:

- 2.4.1. Nurse led/Multidisciplinary primary care clinics that allowed for the continuation of existing clinics and the development of new clinics
- 2.4.2. Continued discussion and collaboration with regional network and primary care business cases
- 2.4.3. Target services to Māori and Pacific people and people with high clinical need or who have a new diagnosis of diabetes
- 2.4.4. Ensuring that service are accessible and used by Māori and Pacific people
- 2.4.5. Quality processes to increase service consistence across the primary care setting
- 2.4.6. Sustainability of the service model to allow for continuity of care and confidence that care will continue to be available.

3. Justification

3.1. Waitemata DHB normally reports the number of people with good diabetes management against the number of people who have had their annual review, as per the Free Diabetes Annual Review Programme reporting programme. When we look at the number people with good management against our estimated diabetes population (2010-11 activity) only 45% of people were reported as having good management. The good management coverage rates for the estimated diabetic population are noted in the next table.

	Diabetes population 2010-11	Number of people with good management 2010-11	Percent with good management
Māori	1483	601	40.5%
Pacific	2108	697	33%
Other	15169	7884	51.9%
TOTALS	18760	8476	45%

3.2. The percent of Māori and Pacific people with good management is significantly lower than that of the other group.

3.3. The poor coverage rates and the high burden of disease in this group of people have led the stakeholders and Planning and Funding team to focus the Diabetes Care Improvement Package services on this group.

3.4. The benefit of optimising medical treatment for people known to have poor diabetes control has led to the inclusion of other people with sustained elevated HbA1c as the other group of people this funding will support.

3.5. Waitemata DHB also recognises the importance of regular health services for people with Diabetes. The Planning and Funding team have made it a requirement that all people will continue to have diabetes reviews and this data will be provided to the DHB to assist us to monitor the health of all our enrolled diabetic population.

4. Outputs/ deliverables to be achieved

4.1. Waitemata DHB will continue to collect information from our PHOs on people receiving diabetes services as contracted under the Long Term Conditions Service Schedule. A service component of this Schedule is the Diabetes Improvement Package. The PHOs will be reporting on:

	Measure (KPI s) *	2012-13	2013/14	2014/15
1	Practices to have a practice audit tool that will provide the practice with the mechanism to monitor the care of their diabetic population	95%	100%	100%
2	Number of people with diabetes known to the PHO (enrolled population) update quarterly			
3	Percent of people with diabetes having a diabetes review	63%	65%	67%
4	% of these patients with an HbA1c of ≤ 64mmol/mol	72%	75%%	75%

4.2. Waitemata DHB will be able to provide quarterly reports for the following Key Performance Indicators:

	Number of clinic visits provided				
	1	2	3	4 or more	Total
Māori					
Pacific					
Asian					
NZ European					
Other					
Not Stated					
TOTALS					

Measure (KPI s) *	Quarter One	Quarter Two	Quarter Three	Quarter Four
Number of people with diabetes known to the PHO (enrolled population)				
Total number of eligible people attending a practice clinic				
Number of people who have an annual review				

4.3. The Regional Diabetes Network is developing a range of management indicators. Waitemata DHB will work with this group and with the agreement of our PHOs will introduce the management indicators when they have been finalised and there is confirmation from the PHO that they can collect the data for 95% of their enrolled diabetic population. The next table includes the current indicators:

	Measure (KPI s) *	**2012-13**	**2013/14**	**2014/15**
7	% of patients with diabetes receiving a statin	Establish baseline	% increase	% increase
8	% of Patients with HbA1c of ≥ 64mmol/mol with microalbuminuria recorded	Establish baseline	% increase	% increase
9	% of Patients with microalbuminuria or overt nephropathy receiving an ACEI or ARB	Establish baseline	% increase	80%
10	% of patients with a blood pressure ≤ 130/80mm Hg	Establish baseline	% increase	% increase
11	% of patients who have had a annual CVD risk assessment	Establish baseline	% increase	% increase
12	Number of patients who have had a 2 year retinal screening assessment	Establish baseline	% increase	% increase

4.4. The collection of data for the best clinical outcome measures will be reliant on the active use of patient management systems and practice audit tools. In 2012-13 there may be a small number of practices that need to install and move to active use of these tools for the management for their diabetic patients.

4.5. The PHOs will be responsible for the collection of data from the practices and providing this to the DHB and DHB Shared Services for the PHO performance programme. Without the full participation of the section accurate data will not be available.
4.6. The retinal screening outcomes will be reliant on services provided outside of the Diabetes Care Improvement Package. This will be reliant on data provided by the retinal screening services contracted by Waitemata DHB.

5. How are these outcomes to be achieved

5.1. Waitemata will contract with the PHOs to provide the Diabetes Care Improvement Package. This service will sit within the PHOs Long Term Conditions Service Schedule to increase the cohesion of care for people with co-morbidities and diabetes associated clinical conditions. The Diabetes Care Improvement Package has a specified set of service components and is identified within the service schedule as the Diabetes Improvement package.
5.2. The service funding through the primary care diabetes service will include one of three levels of care according to the patients' needs:
- 5.2.1. **Routine clinical care** as funded by capitation payments and patient user charge – for patients at lowest risk of poor outcomes
- 5.2.2. **Diabetes Improvement Service** with funded care for those patients at moderate risk of poor outcomes or who are at risk of not accessing care
- 5.2.3. **Care Plus** funded care for patients with the greatest risk of poor outcomes and co-morbidities
  - 5.2.4.1. Part of the **routine clinical care** will require all people with diabetes to continue to receive a yearly diabetes review, data collection and reporting as part of best practice care for patients with diabetes. This includes all people with type one and two diabetes. The PHOs will be required to ensure that they meet the Annual Plan targets for this service delivery in the 2012/13 year:
    - 63% of the eligible population will have had their diabetes annual review
    - 72% of the eligible population, including 64% of Māori and 57% of Pacific people will achieve good diabetes management
- 5.2.4. **Diabetes Improvement Service.** This service component replaces the Free Diabetes Annual Review programme. However, whilst the Free Diabetes Annual Review was for all patients with diabetes the Diabetes Improvement Service is targeted at people at risk of poor outcomes. This will include practice clinics for people with Diabetes. The practice clinics for people with diabetes will be available to people diagnosed with diabetes who:
  - 5.2.5.1. Are Māori or Pacific and who are at risk of not accessing normal general practice services for care of their diabetes, or
  - 5.2.5.2. Have high clinical needs i.e:
    - 5.2.5.2.1. Newly diagnosed
    - 5.2.5.2.2. Have poor glycaemic control (HbA1c ≥ 64 mmol/mol) and need to commence insulin
    - 5.2.5.2.3. Have poor glycaemic control (HbA1c ≥ 64 mmol/mol) on normal care
    - 5.2.5.2.4. Have other high clinical needs such as risk of macrovascular or microvascular complications
  - 5.2.5.3. And are not funded under CarePlus.
- 5.2.5. The practice clinics will be designed to improve patient health outcomes and self-management strategies.

5.2.6. The clinics will include:
- 5.2.7.1. The development and ongoing maintenance of a disease register and proactive recalls of clinic patients
- 5.2.7.2. The practices will work with the Regional Diabetes Network or PHO Quality Improvement Teams (QITs) to develop quality improvement cycles that demonstrate increase access for people with poor diabetes control and increased adherence to best practice guidelines for care
- 5.2.7.3. The use of a practice audit system (such as Dr Info and Healthstat) to demonstrate feedback processes to improve care
- 5.2.7.4. The use of electronic decision support tools for diabetes management
- 5.2.7.5. Nurse consultations and care planning for continued care
- 5.2.7.6. Consultation by other members of the multidisciplinary team employed by the practice or PHO to provide care for their patients
- 5.2.7.7. Referral to other diabetes services for the prevention of secondary complications eg eye disease, foot disease etc. eligible for services and they are not provided within the practice. Eg Retinal Screening, Podiatry.

5.2.7. The clinics will deliver:
- 5.2.8.1. Core information and education to people who have been recently diagnosed with diabetes
- 5.2.8.2. Optimisation of medication and clinical care for people requiring this level of care
- 5.2.8.3. Close monitoring and care planning for people with long standing elevated HbA1c and diabetes complication including renal, vascular and neurological.

5.2.8. **Care Plus care**- it is expected that the patients with diabetes with the highest clinical needs will be funded via the Care Plus programme and will meet the standards of care laid down by that programme.

5.3. In addition to the Diabetes Care Improvement Package Waitemata DHB invests in a range of other services that provide care for diabetes services these include:
- 5.3.1. Cardiovascular and diabetes five year risk assessments
- 5.3.2. Community retinal screening for diabetes
- 5.3.3. Community podiatry for people with moderate foot disease
- 5.3.4. Diabetes coordination and quality improvement work
- 5.3.5. Diabetes self management education
- 5.3.6. Care Plus
- 5.3.7. Pacific diabetes nurse
- 5.3.8. Māori disease state management nurses.

5.4. Services in sections 5.3.1 to 5.3.5 are included in the PHOs Long Term Condition Service Schedule. The overall DHB investment in this group of services is noted in section 8 of this appendix.

5.5. Waitemata DHB also invests in outpatient services run by the secondary service team. This will include the provision of clinics in Henderson to compliment the service currently provided to Pacific patient seen at West Fono. The secondary service clinical nurse specialist will continue to work with practices with high needs patients to improve care. Their contribution to primary care education through the Long Term Conditions education programme and CME/CNE sessions is invaluable to the development of workforce skills.

6. Reporting

6.1. The reporting for this service will be provided by the PHOs. This will be sent to two sources as variation of their activity:
- 6.1.1. Diabetes review data will be collected by DHBNZ PHO Performance Programme for diabetes detection and diabetes follow-up after detection. This information will also be

made available to the DHB for review by the Planning and Funding Programme Manager and Diabetes Clinical Advisory Group, (LDT equivalent).

6.1.2. Other indicators will be reported to Sector Services and the DHB as part of the PHOs Performance Monitoring Returns. This information will also be made available to the DHB for review by the Planning and Funding Programme Manager and Diabetes Clinical Advisory Group, (LDT equivalent).

6.2. The PHOs will be required to maintain an electronic system for the collection and validations from service delivery. The service schedule will be audited on a three year cycle. Waitemata DHB can also undertake an issues based audit in the event this is required to verify activity.

7. Governance

7.1. Waitemata DHB has a Diabetes Clinical Advisory Group as its equivalent of the Local Diabetes Team (LDT). This group includes a wide range of providers and consumer representatives who meet at least six times a year to discuss diabetes services and provide advice to the DHB. This group also provides content for the Local Diabetes Team annual report and sign off on this before it is sent to the Ministry of Health. In view of the development of the Regional Diabetes Network the DHB will continue to have a Diabetes Clinical Advisory Group that provides local advice and works in tandem with the regional network to meet both the Regional Health Plan and DHB Annual Plan requirements. As the Regional Diabetes Network matures this may result in the DHB modifying the function of the Diabetes Clinical Advisory Group into one that provides governance to diabetes services. This will be confirmed once Waitemata and Auckland DHB confirm their Planning and Funding structure in the new financial year.

7.2. The Diabetes Clinical Advisory Group includes two consumer representatives, one for the north and west areas of the district. Additional consumer representation is used if the group is involved in a specific piece of work like the 2010 collaborative process where patient from practices were involved in all aspects of the collaborative.

8. Funding allocation

8.1. Waitemata DHB is investing $800,000 per annum in the Diabetes Care Improvement Package.

8.2. Waitemata DHB investment in the primary care and community based diabetes services noted in section 5.3.1 to 5.3.5 is included in the following table.

8.3. Waitemata DHB also invests $211,419 in Comprehensive Diabetes Nursing Services for Pacific people and Disease State Management Nursing for Māori people. The Disease State Management Nursing Service includes care associated with asthma, heart and other significant long term conditions alongside diabetes care.

PU Description	PU Definition	Total annual budget (Excl GST)
Diabetes education and management	Self-management education courses	$206,700
Cardiac education and management	more heart and diabetes checks and risk management	$1,195,000
Diabetes_ Fundus screening	Photo screening and grading	$417,085
Targeted Activity-community podiatry services	community podiatry	$411,835
Diabetes coordination services	Diabetes coordination services	$148,815
Training and workforce development	Long term condition workforce training	$178,508
Total		$2,557,943.40

8.4. Other PHO funding sources for the care of people with diabetes come from Care Plus, Services to Assist Access to care and Primary Options for Acute Care. Waitemata DHB has not added the value of these services as the PHO manages this funding on behalf of their population, a portion of which would go to the care of people with diabetes.

9. Risks

9.1. Waitemata DHB is committed to the improvement of diabetes care for our population. In changing the primary service in general practice from the Free Diabetes Annual Review programme to the Diabetes Care Improvement Package we have identified some risks that we will need to manage. The risk and mitigating actions are noted in the table below:

Risk	Implications	Actions to mitigate risks
Low diabetes review rates through lack of data from general practice	Waitemata DHB does not meet the District Annual Plan Targets	Inclusion of diabetes reviews in the service components of the PHO agreement. Quarterly monitoring of the PHO results. Requirement for action plan by PHO to increase coverage if people quarter targets. Funding recovery if PHO does not meet service obligations.
Incomplete data due to low number of practices with practice audit tools	Inability to complete service reports for Ministry of Health	In first quarter of the year identify the number of practice mot using an audit tool. Identify size of population covered in this group. Seek confirmation from the PHOs of the timeline to have 95% of practices online for data. PHO Plan for 100% coverage by end of 2013-14
Variance of clinical management indicators by the Regional Diabetes Network	Waitemata DHB will need to adjust clinical indicators to reflect regional service developments	Remain informed of the Regional Networks development of the clinical management indicators. Inform the Ministry of Health of any changes in these in a timely manner. Provide the Ministry of Health with update of measures as they become available.
Failure of the PHOs to achieve the outcomes for the Diabetes Care Improvement Plan	No improvement in care for people with diabetes	Monitor service delivery. Assess implementation phases to ensure services continue Assess service to determine if the planned care is meeting patient need. Monitor for care improvements.

Monitoring framework performance measures

Dimensions of DHB Performance Measures (Non financial)

Policy Priorities Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
PP1 Clinical leadership self assessment The DHB provides a qualitative report identifying progress achieved in fostering clinical leadership and the DHB engagement with it across their region. This will include a summary of the following – how the DHB is: • Contributing to regional clinical leadership through networks • Investing in the development of clinical leaders • Involving the wider health sector (Including primary and community care) in clinical inputs • Demonstrating clinical influence in service planning • Investing in professional development • Influencing clinical input at board level and all levels throughout the DHB – including across disciplines. What are the mechanisms for providing input?	No quantitative target qualitative deliverable required.	NA	Annual
PP2 Implementation of Better, Sooner, More Convenient primary health care The DHB provides a qualitative report as follows: 1. Those DHBs with BSMC Alliance are required to submit jointly agreed • Year Two Implementation Plans by 31 December 2011 or earlier. • Quarterly reports outlining progress against the key deliverables in the jointly agreed Year Two Implementation Plans including resolution plans for any areas of slippage against deliverables • Quarterly reports on the operation and expenditure of the Flexible Funding Pool, including how pool funding has been jointly prioritised to deliver services. 2. All DHBs are required to report progress against the deliverables in their jointly agreed approach to meeting the following expected measures: • Description of how all necessary clinicians and managers (primary/community and secondary) will be involved ongoing in the process of development, delivery and review • Activities to integrate community pharmacy • Activities to expand and integrate nursing services • Evidence of health needs analysis of population by localities	No quantitative target qualitative deliverable required.	NA	Quarterly

Policy Priorities Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
PP2 Implementation of Better, Sooner, More Convenient primary health care (continued…) 2. All DHBs are required to report progress against the deliverables in their jointly agreed approach to meeting the following expected measures: • Identification of targeted areas/patient groups for improved outcomes as a result of enhanced primary and community service delivery (with a focus on managing long term conditions i.e. CVD/Diabetes) including: o Identification of and achievement against targets for the number of people that are expected to be appropriately managed in a primary/community setting instead of secondary care o Identification of and achievement against targets for growth reduction in ED attendance, acute inpatient admissions and bed days o Identification of and achievement against a target for the prevention of readmissions for the 75+ population (and any other target populations) o Identification of, and achievement against new service activity in quantified patient terms • Identification of and activities (with timeline) to ensure infrastructure and revenue streams appropriate to support the identified change in activities and service delivery model • Progress against the above infrastructure and revenue stream milestones • Identification of and progress against the activities to ensure free after-hours services to children under six years of age. ***Additional reporting deliverable required for Quarter 4:*** Each DHB must provide a report with the following information: • each PHO's working capital requirements • each PHO's total cash balance and total income in advance at the end of the financial year • the PHOs that the DHB has required to provide forecast expenditure plans for both cash balances and income in advance, including quarterly targets for reductions in cash balances to the agreed level, and • a copy of the relevant PHO's forecast expenditure plans.	Baseline Q1 Baseline Q1 14.79% (standardised) Baseline Q1 Qualitative deliverable required	NA	Quarterly

Policy Priorities Dimension

Performance Measure and description			2012/13 Target	National Target	Frequency
PP6 Improving the health status of people with severe mental illness The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for: • child and youth aged 0-19, specified for each of the three categories Māori, Other, and in total • adults aged 20-64, specified for each of the three categories Māori, Other, and in total • older people aged 65+, in total.	**Age 0-19**	Māori	3.6%	NA	Six-Monthly
		Total	3.0%		
	Age 20-64	Māori	7.5%		
		Total	3.5%		
	Age 65+	Total	2.36%		
PP7 Improving mental health services using relapse prevention planning 1. The number of adults and older people (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (* in treatment = at least one provider arm contact every three months for two years or more.) The subset of alcohol and other drug only clients will be reported for the 20 years plus. 2. The number of Child and Youth who have been in secondary care treatment* for one or more years (* in treatment = at least one provider arm contact every three months for one year or more) who have a treatment plan. 3. The number and percentage of long-term clients with up to date relapse prevention/treatment plans (NMHSS criteria 16.4 or HDSS [2008]1.3.5.4 and 1.3.5.1 [in the case of Child and Youth]). 4. Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided. DHBs that have fully implemented KPP across their long-term adult population should state KPP as the methodology.	**Adult (20+)**	Total	95%	**95%**	Six-Monthly
		Maori	95%	**95%**	
	Child & Youth	Total	95%	**95%**	
		Maori	95%	**95%**	

* note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term

Policy Priorities Dimension

<table>
<tr><th colspan="3" rowspan="2">Performance Measure and description</th><th colspan="2">2012/13 Target</th><th>National Target</th><th>Frequency</th></tr>
<tr><th>MH</th><th>Addict</th><th></th><th></th></tr>
<tr><td rowspan="6">PP8 Shorter waits for non-urgent mental health and addiction services

80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks. DHBs will be required to meet this target within three years. DHBs will need to set and agree with the Ministry individualised targets (based on data provided by the Ministry) stepped over the three years to ensure the target is met.

Rolling annual waiting time data will be provided by the Ministry sourced from PRIMHD

A narrative is required to:
1. identify what processes have been put in place to reduce waiting times
2. explain variances of more than 10% waiting times target

Note: The Midland region DHBs will include, as requested, their Child and Youth NGO Mental Health services as part of this performance measure.

NOTE: these are provisional targets only and will be reviewed once accurate baseline data is available</td><td>0-19 years</td><td>3 weeks</td><td>70%</td><td>80%</td><td rowspan="6">Within 3 years

80% of people referred for non-urgent mental health or addiction services are seen within three weeks

and 95% of people are seen within 8 weeks.</td><td rowspan="6">Six-Monthly</td></tr>
<tr><td></td><td>8 weeks</td><td>90%</td><td>95%</td></tr>
<tr><td>20-64 years</td><td>3 weeks</td><td>80%</td><td>80%</td></tr>
<tr><td></td><td>8 weeks</td><td>95%</td><td>95%</td></tr>
<tr><td>65+ years</td><td>3 weeks</td><td>65%</td><td>80%</td></tr>
<tr><td></td><td>8 weeks</td><td>80%</td><td>85%</td></tr>
</table>

Policy Priorities Dimension

Performance Measure and description		2012/13 Target	National Target	Frequency
PP10 Oral Health DMFT Score at year 8 * Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the total number of permanent teeth of children in school Year 8 (12/13-year olds) that are – • Decayed (D), • Missing (due to caries, M), and • Filled (F); and	Total population	year 1: 0.95 year 2: 0.90	NA	Annual
	Māori	year 1: 0.95 year 2: 0.90		
	Pacific	year 1: 0.95 year 2: 0.90		
PP11 Children caries free at 5 years of age * At the first examination after the child has turned five years, but before their sixth birthday, the total number of children who are caries-free (decay-free)	Total population	year 1: 68% year 2: 71%	NA	Annual
	Māori	year 1: 68% year 2: 71%		
	Pacific	year 1: 68% year 2: 71%		
PP12 Utilisation of DHB funded dental services by adolescents In the year to which the reporting relates, the total number of adolescents accessing DHB-funded adolescent oral health services, defined as: i. the unique count of adolescent patients' completions and non-completions under the Combined Dental Agreement; and ii. the unique count of additional adolescent examinations with other DHB-funded dental services (e.g. DHB Community Oral Health Services, Māori Oral Health providers and other contracted oral health providers). To reduce duplication of effort, at the end of each quarter in the year to which the reporting relates, the Ministry will organise a data extract from Sector Services for all DHBs for claims made by dentists contracted under the Combined Dental Agreement, and provide this data for DHBs' use in determining part (i) of the Numerator.	Total	Year 1: 65% Year 2: 85%	**85%**	Annual

* note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term

Policy Priorities Dimension

Performance Measure and description		2012/13 Target	National Target	Frequency
PP13 Improving the number of children enrolled in DHB funded dental services				
Measure 1 - In the year to which the reporting relates, the total number of children under five years of age, i.e. aged 0 to 4 years of age inclusive, who are enrolled with DHB-funded oral health services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers).	Children Enrolled **0-4 years**	Year 1: 75% Year 2: 76%		
Measure 2 - In the year to which the reporting relates: i. the total number of pre-school children and primary school children in total and for each school decile who have not been examined according to their planned recall period in DHB-funded dental services (DHB's Community Oral Health Service and other DHB-contracted oral health providers such as Māori oral health providers); and ii. the greatest length of time children has been waiting for their scheduled examination, and the number of children that have been waiting for that period.	Children not examined **0-12 years**	Year 1: 10% Year 2: 7%	NA	Annual
PP16 Workforce - Career Planning The DHB provides quantitative data to demonstrate progress achieved for career planning in their staff. For each of the following categories of staff a measure will be given for Numbers receiving HWNZ funding/ number with career plan for required categories: • Medical staff • Nursing • Allied technical • Maori Health • Pacific • Pharmacy • Clinical rehabilitation • Other		No quantitative target. Supply of quantitative data required.	NA	Annual
PP18 Improving community support to maintain the independence of older people Numerator: The number of people aged 65 and older who have received long-term home-support services in the last three months who have had a Comprehensive Clinical Assessment and a completed care plan. Denominator: The number of people aged 65 and older who have received long-term home-support services in the last three months.		20%❖	95%+	Quarterly

❖Note: progress towards the 95% will need to be staged as Waitemata DHB was a late adopter of the InterRAI tool and training in its use will not be completed until January 2013.

Policy Priorities Dimension

Performance Measure and description		2012/13 Target	National Target	Frequency
PP 20 improved management for long term conditions (CVD, diabetes and Stroke)				
Part 1, Focus area 1: Cardiovascular disease DHBs supply a quarterly narrative report that comments on data supplied by the Ministry, and DHB performance in relation to the number of people diagnosed with ischemic heart disease and on lipid lowering medications, with a view to establishing a formal performance baseline for application in 2013/14.		No quantitative target Progress to be demonstrated via qualitative deliverable	N/A	Quarterly
Part 1, Focus area 2: Stroke services DHBs are to provide a quarterly narrative report on stroke services delivered including plans and actions to improve services.				
Part 1, Focus area 3: Maintain or Improve access to Diabetes Annual Reviews Numerator - Count of enrolled people in the PHO with a record of a Diabetes Annual Review during the reporting period Denominator - The number of enrolled people in the PHO who would be expected to have diagnosed diabetes, using the Diabetes Prevalence Estimate Data Source: PHO Performance Programme Indicators Definitions 1 July 2011 version5.3 Sept11		63%		
Part 2, Focus area 1. Progress in delivery of Diabetes care improvements Provide a quarterly progress report on delivery of actions and volumes agreed for each Improvement area identified in the Annual Plan.		Qualitative		Annual
Part 2, Focus area 2 Local Diabetes Team Service (or an equivalent service) Provide the annual report from the local diabetes team to the Ministry as outlined in the Service Specification for Specialist Medical and Surgical Services – Diabetes Service – Local Diabetes Team Service (or an equivalent service).				
Part 2, Focus area 3. Diabetes Management * Numerator: (Data source: DHB to provide). The number of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 64mmol/mol at their free annual check during the reporting period. Denominator: (Data source: DHB to provide. Note that this is the numerator from the Diabetes Free Annual Check indicator). The number of unique individuals with type I or type II diabetes on a diabetes register whose date of their free annual check is during the reporting period.	Total	72%		Quarterly
	Maori	72%		
	Pacific	72%		

* note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term

Policy Priorities Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
PP 21 Ensure immunisation coverage for 2 years Each quarter, DHBs are expected to provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan. The Ministry will provide summary data for the quarter on the nationwide service framework library web site NSFL homepage: http://www.nsfl.health.govt.nz/	95%	95%	Quarterly

System Integration Dimension

Performance Measure and description			2012/13 Target	National Target	Frequency
SI1 Ambulatory sensitive (avoidable) hospital admissions * Each DHB is expected to provide a commentary on their latest 12 month ASH data that's available via the nationwide service library. This commentary may include additional district level data that's not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions. Each DHB should also provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds.	**Age 0-74**	Total	98	NA	Six-Monthly
		Māori	98		
		Pacific	98		
	Age 0-4	Total	<95		
		Māori	<95		
		Pacific	<95		
	Age 45-64	Total	105		
		Māori	105		
		Pacific	105		
SI2 Regional service planning A single progress report on behalf of the region agreed by all DHBs within that region. The report should focus on the actions agreed by each region as detailed in its regional implementation plan. For each action the progress report will identify: • the nominated lead DHB/person/position responsible for ensuring the action is delivered • whether actions and milestones are on track to be met or have been met • performance against agreed performance measures and targets • financial performance against budget associated with the action. If actions/milestones/performance measures/financial performance are not tracking to plan, a resolution plan must be provided. The resolution plan should comment on the actions and regional decision-making processes being undertaken to agree to the resolution plan.			No quantitative target. Progress to be demonstrated via qualitative deliverable.	NA	Quarterly

* note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term

System Integration Dimension

Performance Measure and description		2012/13 Target	National Target	Frequency
SI3 Ensuring delivery of Service coverage Exception report - Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: • analysis of explanatory indicators • media reporting • risk reporting • formal audit outcomes • complaints mechanisms • sector intelligence.		No quantitative target exception based qualitative deliverable required.	NA	Six-Monthly
SI4 Elective services standardised intervention rates				
Data sourced from National Minimum Dataset. Exception report - For any procedure where the standardised intervention rate in the 2011/12 financial year is significantly below the target level a report demonstrating: 1. what analysis the DHB has done to review the appropriateness of its rate AND 2. whether the DHB considers the rate to be appropriate for its population OR 3. a description of the reasons for its relative under-delivery of that procedure; and 4. the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved	**Major joint replacement procedures**	21 per 10,000	21.0 per 10,000	Annual quarter1
	Cataract Procedures	27 per 10,000	27.0 per 10,000	
Cardiac Procedures Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter is significantly below the target level a report demonstrating: 1. what analysis the DHB has done to review the appropriateness of its rate AND 2. whether the DHB considers the rate to be appropriate for its population OR 3. a description of the reasons for its relative under-delivery of that procedure; and 4. the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved	**Cardiac Surgery**	6.2-6.5 per 10,000	For cardiac surgery a target intervention rate of between 6.2 and 6.5 per 10,000	Quarterly
	Percutaneous Revascularisation	11.9 per 10,000	For percutaneous revascularisation a target rate of at least 11.9 per 10,000	
	Coronary Angiography	32.3 per 10,000	For coronary angiography services a target rate of at least 32.3 per 10,000	

System Integration Dimension

Performance Measure and description			2012/13 Target	National Target	Frequency
SI5 Delivery of Whānau Ora The DHB provides a qualitative report identifying progress within the year that shows the DHB's active engagement with existing and emerging Whānau Ora Provider Collectives that steps towards improving service delivery within these providers, and supports the building of mature providers. This will include a summary of the following – how the DHB is: • Contributing to the strategic change for Whānau Ora in the district • Contributing information about Whānau Ora within the district at appropriate forums, including nationally. • Investing in Whānau Ora Provider Collectives through deliberate activities • Involving the DHB's governors and management in the Whānau Ora activity in the district Demonstrating meaningful activity moving towards improved service delivery and building mature providers.			No quantitative target qualitative deliverable required.	NA	Annual
SI7 Improving breast-feeding rates * DHBs are expected to set DHB-specific breastfeeding targets with a focus on Māori, Pacific and the total population respectively (see Reducing Inequalities below) to incrementally improve district breastfeeding rates to meet or exceed the National Indicator. DHBs will be expected to maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeted Māori and Pacific communities. The Ministry will provide breastfeeding data sourced from Plunket, and DHBs must provide data from non-Plunket Well Child providers. DHBs are to report providing the local data from non-Plunket Well Child providers.	**6 weeks**	Total	67%	**74%**	Annual
		Māori	67%		
		Pacific	67%		
	3 Months	Total	54%	**57%**	
		Māori	54%		
		Pacific	54%		
	6 Months	Total	23%	**27%**	
		Māori	23%		
		Pacific	23%		

* note: we are working towards the achievement of these targets, aiming towards equivalent health outcomes in the medium term

Ownership Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
OS3 inpatient length of stay Data sourced from National Minimum Dataset. Exception report - For any procedure / service where the standardised intervention rate in the quarter is significantly below the target level a report demonstrating: 1. what analysis the DHB has done to review the appropriateness of its rate AND 2. whether the DHB considers the rate to be appropriate for its population OR 3. a description of the reasons for its relative under-delivery of that procedure; and 4. the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved.	3.88 Days	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	Quarterly
OS5 Theatre Utilisation Each quarter, the DHB is required to submit the following data elements, represented as a total of all theatres in each Provider Arm facility. • Actual theatre utilisation, • resourced theatre minutes, • actual minutes used as a percentage of resourced utilisation The expectation is that DHBs will supply information on the template quarterly. Baseline performance should be identified as part of the establishment of the target. The goal for 2011/12 will be one of the following: For DHBs whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended For DHBs whose overall utilisation is 85% or better, a target that is a small improvement over current performance is recommended	85%	85%	Quarterly
OS6 Elective and arranged day surgery Data sourced from National Minimum Dataset. *Exception report* The standardised day surgery rate is the ratio of the 'actual' to 'expected' day surgery rate, multiplied by the nationwide day surgery rate, expressed as a percentage. The DHBs 'actual' day surgery rate, and the nationwide day surgery rate, are both defined as the number of day surgery discharges for the 12 months to the end of the quarter (for elective and arranged surgical patients), divided by the total number of surgical discharges in the 12 months to the end of the quarter (for elective and arranged surgical patients). The 'expected' day surgery rate is derived by taking the nationwide day surgery rate for discharges in each DRG, multiplying this by the proportion of total discharges the DRG represents for the DHB, and summing the result across all DRGs.	59.6%	59.6% Standardised	Quarterly

Ownership Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
OS7 Elective and arranged day of surgery admissions The number of DOSA discharges, for elective and arranged surgical patients (excluding day surgical cases) during the 12 months to the end of the quarter, divided by the total number of discharges for elective and arranged surgical patients (excluding day surgical cases) for the 12 months to the end of the quarter, to give the DOSA rate as a percentage. Data sourced from National Minimum Dataset. *Exception report* Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements.	92%	For DHBs with a 2011/12 Quarter 3 result that is below 90 percent, their suggested target is 90 percent. For DHBs with a 2011/12 Quarter 3 result that is between 90 and 95 percent, their suggested target is 95 percent. For DHBs with a 2011/12 Quarter 3 result that is above 95 percent, their suggested target will be to maintain current levels.	Quarterly
OS8 Acute readmissions to hospital The standardised acute readmission rate is the ratio of the 'actual' to 'expected' acute readmission rate, multiplied by the nationwide acute readmission rate, expressed as a percentage. The DHB's 'actual' acute readmission rate, and the nationwide acute readmission rate, are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The 'expected' acute readmission rate is derived using regression methods from the DRG cluster and patient population characteristics of the DHB. Readmissions are aggregated by DHB of service. Where an acute readmission occurs within a different DHB to that of the previous inpatient discharge (ie, the first admission), and the previous discharge DHB of Service is consistent with the previous discharge Agency Code, the readmission will be allocated against the DHB of the initial inpatient discharge. Data sourced from National Minimum Dataset. *Exception report* Where the DHB is not achieving in line with target, the DHB should provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements.	TBC by 31 July 2012 with the Ministry of Health	DHBs are to state their year-end target. The Ministry will assume that 25 percent of the improvement towards target can be made each quarter, unless the DHB specifies otherwise.	Quarterly

Ownership Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
OS10 Improving the quality of data provided to national collection systems			
Measure 1: National Health Index (NHI) duplications Numerator: Number of NHI duplicates that require merging by Data Management per DHB per quarter. The Numerator excludes pre-allocated NHIs and NHIs allocated to newborns and is cumulative across the quarter. Denominator: Total number of NHI records created per DHB per quarter (excluding pre-allocated NHIs and newborns)	Greater than 3.00% and less than or equal to 6.00%	Greater than 3.00% and less than or equal to 6.00%	Quarterly
Measure 2: Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI Numerator: Total number of NHI records created with ethnicity of 'Not Stated' or 'Response Unidentifiable' per DHB per quarter Denominator: Total number of NHI records created per DHB per quarter	Greater than 0.50% and less than or equal to 2%	Greater than 0.50% and less than or equal to 2%	
Measure 3: Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS) Numerator: Number of versions of text descriptor for specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB Denominator: Total number of specific diagnosis codes (M00-M99, S00-T98, U50 to Y98) per DHB	Greater than or equal to 55.00% and less than 65.00%	Greater than or equal to 55.00% and less than 65.00%	
Measure 4: Timeliness of NMDS data Numerator: Total number of publicly funded NMDS events loaded into the NMDS more than 21 days post month of discharge. Denominator: Total number of publicly funded NMDS events in the NMDS per DHB per quarter.	Greater than 2.00% and less than or equal to 5.00% late	Greater than 2.00% and less than or equal to 5.00% late	
Measure 5: NNPAC Emergency Department admitted events have a matched NMDS event Numerator: Total number of NNPAC Emergency Department admitted events that have a matching NMDS event Denominator: Total number of NNPAC Emergency Department admitted events	Greater than or equal to 97.00% and less than 99.50%	Greater than or equal to 97.00% and less than 99.50%	
Measure 6: PRIMHD File Success Rate Numerator: Number of PRIMHD records successfully submitted by the DHB in the quarter Denominator: Total number of PRIMHD records submitted by the DHB in the quarter	Greater than or equal to 98.0% and less than 99.5%	Greater than or equal to 98.0% and less than 99.5%	
OP1 Output Delivery Against Plan			
Part A: Hospital production Each DHB is required to submit completed Production Plans as part of the Annual Plan round. From these Production Plans, the Ministry will calculate planned outputs for the following groups of personal health services. 1. Casemix included medical services 2. Casemix included surgical services 3. Casemix included maternity services 4. Non-casemix medical services 5. Non-casemix surgical services 6. ED non-admitted events	Within 3%	Output delivery within three percent of plan	Quarterly

Ownership Dimension

Performance Measure and description	2012/13 Target	National Target	Frequency
OP1 Output Delivery Against Plan (continued…)			
Part B: Monitoring the delivery of personal health services and mental health services For Mental Health Services provided by the DHB's provider arm, the DHB must complete the Mental Health Volumes Reporting template. This will be provided by the Ministry, and included with the main quarterly reporting template.	Within 5%	Volume delivery is within five percent of plan	Quarterly

Developmental – Establishment of baseline (no target/performance expectation is set)

Performance Measure and description	National Target	Frequency
DV1: Faster cancer treatment Detailed information will be provided in the Ministry of Health's data definitions for the Faster cancer treatment indicators. Please refer to this document for information on the definitions, data collection and exceptions. This information will be available on the NSFL by March 2012.	Data is provided to establish baseline	Quarterly
DV2: Improving waiting times for diagnostic services • Elective coronary angiogram to be reported to the National Booking Reporting System (NBRS) in accordance with NBRS data dictionary reporting requirements. • CT, MRI and colonoscopy reporting templates to be submitted to the National Health Board within 20 days of the end of the previous month. The reporting template will be located on the NSFL website with other Performance Measure documents.	Data is provided to establish baseline	Quarterly

Statement of accounting policies for the year ending 30 June 2013

Reporting entity

Waitemata DHB is a health board established by the New Zealand Public Health and Disability Act 2000. Waitemata DHB is a crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Waitemata DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

Waitemata DHB is a public benefit entity, as defined under NZIAS 1.

The consolidated financial statements of Waitemata DHB comprise Waitemata DHB and its subsidiaries (together referred to as "Group") and Waitemata DHB's interest in associates and jointly controlled entities.

Waitemata DHB's activities involve funding and delivering health and disability services and mental health services in a variety of ways to the community.

Waitemata DHB's corporate address:

Level 1, 15 Shea Terrace

Takapuna

NORTH SHORE CITY 1332

Statement of compliance

The financial statements (NZGAAP) comply with New Zealand equivalents to International Financial Reporting Standards (NZIFRS), and other applicable financial reporting standards, as appropriate for public benefit entities.

Basis of preparation

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand. The financial statements are prepared on an historical cost basis except that the following assets and liabilities which are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified at fair value through profit and loss and land and buildings.

The going concern concept is assumed when preparing these financial statements. Current and expected performance obligations and funding from bodies such as the government are expected to ensure the continued operation of the entity.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value less costs to sell.

Basis of consolidation

Subsidiaries

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

Associates

Waitemata DHB holds share holdings in associate companies. The interests in these associates are not accounted for as they are not material to Waitemata DHB.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates are eliminated to the extent of Waitemata DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the income statement. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

The budget figures are per Waitemata DHB's 2010/11 District Annual Plan and are prepared on a basis consistent with the accounting policies adopted by Waitemata DHB.

Financial instruments

Non-derivative financial instruments

Non-derivative financial instruments comprise investments in equity securities, trade and other receivables, cash and cash equivalents, interest bearing loans and borrowings, and trade and other payables.

Non-derivative financial instruments are recognised initially at fair value plus, for instruments not at fair value through profit or loss, any directly attributable transaction costs. Subsequent to initial recognition non-derivative financial instruments are measured as described below.

A financial instrument is recognised if the DHB becomes a party to the contractual provisions of the instrument. Financial assets are derecognised if the DHB's contractual rights to the cash flows from the financial assets expire or if the DHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of the asset. Regular way purchases and sales of financial assets are accounted for at trade date, ie, the date that the DHB commits itself to purchase or sell the asset. Financial liabilities are derecognised if the DHB's obligations specified in the contract expire or are discharged or cancelled.

Cash and cash equivalents comprise cash balances and call deposits with maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of the DHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Accounting for finance income and expense is explained in a separate note.

Instruments at fair value through profit or loss

The Group's investments in debt and equity securities are classified as at fair value through profit and loss. An instrument is classified as at fair value through profit or loss if it is held for trading or is designated as such upon initial recognition. Financial instruments are designated at fair value through profit or loss if the Group manages such investments and makes purchase and sale decisions based on their fair value and they are managed in accordance with a documented investment strategy. Upon initial recognition, attributable

transaction costs are recognised in profit or loss when incurred. Subsequent to initial recognition, financial instruments at fair value through profit or loss are measured at fair value, and changes therein are recognised in profit or loss.

Other

Subsequent to initial recognition, other non-derivative financial instruments are measured at amortised cost using the effective interest method, less any impairment losses.

Investments in equity securities

Investments in equity securities held by Waitemata DHB are classified as designated at fair value through profit and loss, except for investments in equity securities of subsidiaries, associates and joint ventures which are measured at cost.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at their amortised cost less impairment losses. Bad debts are written off during the period in which they are identified.

Interest-bearing loans and borrowings

Interest-bearing loans and borrowings are classified as other non-derivative financial instruments and are recorded at amortised cost using the effective interest rate method.

Trade and other payables

Trade and other payables are stated at amortised cost.

Derivative financial instruments

Waitemata DHB uses interest swap contracts to economically hedge its exposure to interest rate risks arising from operational, financing and investment activities.

Derivatives that do not qualify for hedge accounting are accounted for as held for trading financial instruments.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are stated at fair value. The gain or loss on re-measurement to fair value is recognised immediately in the income statement.

The fair value of interest rate swaps is the estimated amount that Waitemata DHB would receive or pay to terminate the swap at the balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparties.

Property, plant and equipment

Classes of property, plant and equipment

Owned assets

Except for land and buildings, items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses. The cost of self-constructed assets includes the cost of materials, direct labour, the initial estimate, where relevant, the costs of dismantling and removing the items and restoring the site on which they are located, and an appropriate proportion of direct overheads.

Land and buildings are re-valued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value for the same asset recognised in profit and loss. Any decreases in value relating to a class of land and buildings are debited directly to the asset revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the income statement .

Additions to property, plant and equipment between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Disposal of property, plant and equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the income statement is calculated as the difference between the net sales price and the carrying amount of the asset.

Leased assets

Leases where Waitemata DHB assumes substantially all the risks and rewards of ownership are classified as leasehold assets. The assets acquired are stated at an amount equal to the lower of their fair value and the present value of the minimum lease payments at inception of the lease, less accumulated depreciation and impairment losses.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Waitemata DHB. All other costs are recognised in the income statement as an expense as incurred.

Depreciation

Depreciation is charged to the income statement using the straight line method. Land is not depreciated.

Depreciation is set at rates that will write off the cost or fair value of the assets, less their estimated residual values, over their useful lives. These rates are reviewed annually. The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of asset	***Estimated life***	***Depreciation rate***
• Buildings	6-60 years	1.67% – 15%
• Leasehold Improvements	3-12 years	8.33% – 33.33%
• Plant, equipment and vehicles	5 to 15 years	10-20%
• IT Equipment	3 to 5 years	4-33%

The residual value of assets is reassessed annually. Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Software
Software that is acquired by Waitemata DHB is stated at cost less accumulated amortisation and impairment losses.

Amortisation
Amortisation is charged to the income statement on a straight-line basis over the estimated useful lives of intangible assets, unless such lives are indefinite. The estimated useful lives are as follows:

Type of asset	***Estimated life***	***Amortisation rate***
• Software	3 to 5 years	20-33%

Inventories held for distribution

Inventories held for distribution are stated at the lower of cost and current replacement cost. Valuation is determined on a first in first out basis.

Impairment

The carrying amounts of Waitemata DHB's assets other than inventories are reviewed at each balance sheet date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the income statement.

All overdue receivables are assessed for impairment on an ongoing basis and appropriate provisions applied to individual invoices; taking into account age of the debt and payment histories of the debtor. Individual debts that are known to be uncollectible are written off when identified. An impairment provision equal to the receivable carrying amount is recognised when there is evidence that Waitemata DHB has exhausted all reasonable prospects of collecting the receivable.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any asset revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the asset revaluation reserve for the same class of asset.

Calculation of recoverable amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Value in use is calculated differently depending on whether an asset generates cash or not. For an asset that does not generate largely independent cash inflows, the recoverable amount is determined for the cash-generating unit to which the asset belongs.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

Reversals of impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through profit or loss.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Interest-bearing borrowings

Interest-bearing borrowings are recognised initially at fair value, less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortised cost with any difference between amortised cost and redemption value being recognised in the income statement over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the income statement as incurred.

Long service leave, sabbatical leave and retirement gratuities

Waitemata DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the balance sheet date.

Annual leave, conference leave, sick leave and medical education leave

Annual leave, conference leave, accumulating sick leave and medical education leave are short-term obligations and are calculated on an actual basis at the amount Waitemata DHB expects to pay. The obligation recognised is in respect of employees' services up to the balance sheet date.

Provisions

A provision is recognised when Waitemata DHB has a present legal or constructive obligation as a result of a past event, and it is probable that an outflow of economic benefits will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

Restructuring

A provision for restructuring is recognised when Waitemata DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

Revenue relating to service contracts

Waitemata DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Waitemata DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability.

Income tax

Waitemata DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Dividends

Dividend income is recognised in the income statement when the shareholder's right to receive payment is established.

Revenue

Crown funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

Goods sold and services rendered

Revenue from goods sold is recognised when Waitemata DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Waitemata DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Revenue from services is recognised when it is probable that the payment associated with the transaction will flow to Waitemata DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Waitemata DHB.

Interest

Interest received and receivable on funds invested is recognised as interest accrues using the effective interest method, allocating the interest income over the relevant period.

Expenses

Operating lease payments

Payments made under operating leases are recognised in the income statement on a straight-line basis over the term of the lease. Lease incentives received are recognised in the income statement over the lease term as an integral part of the total lease expense.

Financing costs

Net financing costs comprising of interest paid and payable on borrowings are calculated using the effective interest rate method accrued on a daily basis and allocated to the relevant period.

New accounting standards and interpretations not yet adopted

Certain new standards, amendments and interpretations to existing standards have been published that are not yet effective and have not been adopted by the Group for the year ended 30 June 2009.

- NZIAS 1 (revised), Presentation of Financial Statements - (effective from annual periods beginning on or after 1 January 2009)
- NZIAS 23 (revised), Borrowing costs - (effective date delayed indefinitely for Public Benefit Entities)
- NZIAS 27, Consolidated and Separate financial statements (amended 2008) – (effective from annual periods beginning on or after 1 July 2009)
- NZIFRS 3 (revised), Business Combinations – (effective for annual periods beginning on or after 1 July 2009)

Statement of Service Performance

Cost of Service

The cost of service statements, as reported in the statement of service performance, report the net cost of services for the outputs of Waitemata DHB and are represented by the cost of providing the output less all the revenue that can be allocated to these activities.

Cost Allocation

Waitemata DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

Cost Allocation Policy

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.

Criteria for Direct and Indirect Costs

Direct costs are those costs directly attributable to an output class.

Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Cost Drivers for Allocation of Indirect Costs

The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

Output Measures – Statement of Forecast Service Performance

Note: these tables refer to Auckland and Waitemata DHBs' forecast performance. Not all measures are applicable to both DHBs, this is clearly identified in the tables, where this is the case.

Key
Ω Output is demand driven, therefore targets cannot be forecast
◈ This data is for all three metro Auckland DHBs

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline◈	Target 2012/13◈	Baseline Info
Prevention Services	Health Protection	Outbreaks investigated	Outbreak investigation is an important component of the work of ARPHS and plays a major role in communicable disease control (CDC). It is an indicator of the volume of output in this output class. If one assumes that the investigations are conducted effectively, then this should also provide a measure of impact of this service with lower numbers of outbreaks reflecting better disease control generally.	Yes	1,484 (figure is high due to measles outbreak)	Ω	March 2011 – March 2012
		Number of contacts traced in relation to CDC cases	Contact tracing is a substantial component of the work in outbreak investigation. It is therefore a good indicator of the volume of output in this output class.	Yes	1166	Ω	March 2011 – March 2012
		Communicable disease protocols up-to-date	Communicable disease protocols govern the procedures used for outbreak investigation. Up to date protocols are an indicator of quality.	No	100%	100%	March 2011 – March 2012
		Communicable disease protocols adhered to	If protocols are up to date and adhered to then it is reasonable to conclude that the quality of work is high.	No	100%	100%	March 2011 – March 2012
		Number of investigations in relation to built environments	The built environment can pose potential public health risks. This is an indicator of the volume of output.	Yes	42	Ω	March 2011 – March 2012

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline◈	Target 2012/13◈	Baseline Info
Prevention Services	Health Protection	Proportion of Hazardous and New Organisms (HSNO) events responded to appropriately	As with communicable disease protocols, failure to adhere to protocols would indicate problems with quality of the service	Yes	100%	100%	March 2011 – March 2012
		Proportion of Public Health Risk Management Plan (PHRMP) reports submitted to the water supplier within 20 working days	There is a clear requirement under the Health (Drinking Water) Amendment Act (2007) to complete assessments of PHRMPs within 20 working days. This is a timeliness measure.	Yes	100%	100%	March 2011 – March 2012
		Number of emergency response exercises participated in	Exercises and simulations are fundamental to emergency preparedness. This is a measure of the volume of output in this component of health protection.	No	5	Ω	March 2011 – March 2012
		Number of emergencies responded to	A demand driven indicator of a major component of health protection output.	Yes	5	Ω	March 2011 – March 2012
		Emergency Plan up-to-date	A failure to keep emergency plans up to date would indicate poor quality output in this area.	No	ARPHS Health Emergency Plan up-to-date	Yes	March 2011 – March 2012
		Proportion of reports submitted to the Ministry of Health within 24 hours of occurrence of a public health event at the border.	Prompt reporting of public health events and emergencies indicates the speed and timeliness of response.	Yes	100%	100%	March 2011 – March 2012

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline◈	Target 2012/13◈	Baseline Info
Prevention Services	Health Promotion	Number of liquor license applications processed by ARPHS and all problematic premises that receive a compliance check	Compliance checks are the principal output which allows us to check that licensees are providing a controlled environment by meeting their host responsibility obligations under the Sale of Liquor Act 1989.	No	82%	100%	2011/12
		Alcohol compliance protocols are adhered to when site visits are carried out.	Failure to comply with protocols would reflect a problem with quality.	No	97%	100%	2011/12
		Proportion of liquor licensing applications processed within 15 days	Prompt processing of applications indicates a timely service	No	100%	100%	2011/12
		Proportion of tobacco complaints responded to within 5 days	Prompt response of tobacco complaints indicates a timely service	No	100%	100%	2011/12
	Health Policy / Legislation Advocacy and Advice	Numbers of submissions made.	Submissions make up a high proportion of this work. The number reflects the volume of output although some involve more work than others.	Yes	12	Ω	2011/12
		Submissions policy adhered to	Failure to comply with submission policy would indicate a problem with quality.	No	100%	100%	July 2011 – March 2012
		Submission documents submitted by deadline	An obvious indicator of timeliness.	No	100%	100%	

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Prevention Services	Population Based Screening	***Breastscreening***							
		Screening coverage rates among eligible groups: breast cancer	Coverage is a standard measure of output from screening programmes.	No	*n/a*	67.3%	*n/a*	70%	Total as at Oct 2011
		Proportion of women screened who report that their privacy was respected	Reflects the quality of the service	No	*n/a*	97.5%	*n/a*	95%	2010/11
		Proportion of women screened who receive their results within 10 working days	A timely service provides test results promptly	No	*n/a*	98.3%	*n/a*	90-95%	2010/11
		Bowel Screening							
		Proportion of eligible population sent an invitation letter each two year screening cycle	Coverage is a standard measure of output from screening programmes.	No	*n/a*	*New measure*	*n/a*	95%	
		Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure/any other investigations.	This indicates whether patients felt that they were able to make an informed decision about colonoscopy and therefore reflects the quality of the service	No	*n/a*	*New measure*	*n/a*	95%	
		Proportion of individuals referred for colonoscopy following a positive iFOBT result who receive their procedure within 50 working days	Prompt diagnostics is a timeliness indicator that ensures that screening is performed in a timely way.	No	*n/a*	*New measure*	*n/a*	95%	

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Prevention Services	Population Based Screening	***Newborn hearing screening***							
		Proportion of babies screened	Coverage is a standard measure of output from screening programmes.	No	7989 or 99.9%	*n/a*	100%	*n/a*	Dec 2010 – Nov 2011
		Referral rate to audiology <=4%.	Reflects the quality of the service	No	2%	*n/a*	<=4%.	*n/a*	Dec 2010 – Nov 2011
		Appropriate medical and audiological services initiated by 6 months of age for >=95% of infants referred through the programme.	A timely service provides prompt access	No	100%	*n/a*	>=95%	*n/a*	Dec 2010 – Nov 2011

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Early Detection and Management	Community Referred Testing & Diagnostics	Number laboratory tests by provider.	The number of laboratory tests is a direct indicator of the volume of output of community laboratory diagnostic services	No	*DML = 202,199* *LTA = 2,511,224*	*355,593* *2,825,695*	Ω Ω	Ω Ω	2010/11
		Number community referred radiological procedures.	The number of community referred radiological procedures is a direct indicator of the volume of output of community radiology diagnostic services	No	47,380	48,839.76 (extrapolated)	Ω	Ω	**PUC: CS01001 ADHB**: 2010/11 year **WDHB**: Jun-Dec 2011
		Complaints as percentage of total no. of laboratory tests ◈	A high quality community laboratory diagnostic service will receive only a small number of complaints.	No	0.00199%		↓		As at Dec 2011
		Average waiting time in minutes for a sample of patients attending Waitemata/Auckland DHB collection centres between 7am and 11am (peak collection time)	A high quality service will process patients quickly and efficiently, thereby avoiding long waiting times.	No	7.8 mins	9.15 mins	< 30 mins	< 30 mins	Nov/Dec 11
		75% of accepted community referrals for MRI or CT scans receive their scan within 6 weeks (42 days) by July 2013❖	Timely access to diagnostic testing makes an important contribution to good patient outcomes.	No	65%	57%	75%	75%	As at Jan 2012

❖ Waiting time targets apply to all MRI/CT scans, however for the purposes of this table, only the community referred ones are referred to here.

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012 & 2013		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Early Detection and Management	Oral Health	Enrolment numbers of children under five by ethnicity: Māori Pacific Other Overall	Output is directly related to the numbers of children enrolled in the service	No	 2,440 4,189 14,017 **20,646**	 4,525 3,158 20,413 **28,096**	**2012** 21,973 **2013** 22,680	**2012** 28,882 **2013** 28,882	2011 calendar year
		Utilisation rates for adolescents	This is an indication of the volume of service in relation to the target population	No	65.7%		**2012** 77% **2013** 85%	**2012** 65% **2013** 85%	2011 interim result
		Number of visits of preschool, and school children to oral health services (including adolescents)	Provides an indication of the volume of service.	No	20,195	14,170	Ω	Ω	2011 calendar year
		Number of complaints for the financial year	A high quality service will receive low numbers of complaints	No	4	10	↓	↓	2010/11
		Arrears rates by ethnicity: Māori Pacific Other Overall	A timely oral health service will have low arrears rates	No	 18.2% 19.0% 19.5% 19.2%	 16.6% 19.9% 12.2% 13.7%	**Overall** **2012:** 10% **2013:** 7%		2011 calendar year

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Early Detection and Management	Primary Care	Primary care enrolment rates	Primary care enrolment rates give an indication of access to primary care health services and differences between ethnicities reflect inequalities in access to primary care.	No	94%	94%	95%	95%	as at December 2011
		Immunisation health target achievement – proportion of 8 month olds fully immunised	Preventive health services comprise an important and high impact component of primary care. A high immunisation rate therefore gives an indication of how well our primary care services are providing preventive health care.	No	*New measure – not avail*	*New measure – not avail*	85%	85%	
		Cervical screening coverage for eligible women (25-69 years)	As with immunisation, cervical screening coverage is a good indicator of the preventive service output from primary care.	No	73.5%	73.9%	75%	75%	as at September 2011
		Percentage of B4 School Checks completed (overall coverage)	Coverage is a standard measure of output from screening programmes.		38%	31%	80%	80%	Q2 2011/12
		Proportion of practices with cornerstone accreditation	Cornerstone is an accreditation system run by the Royal New Zealand College of General Practice. To be accredited practices must accurately assess their level of performance in relation to established standards.	No	47%	54%	↑	↑	As at Feb 2012
		GMS claims from after-hours providers per 10,000 of population	The utilisation of primary care during weekends provides an indicator of the timeliness of the services available. If availability is low or costs too high then this will be reflected in the utilisation rate.	Yes	275 per 10,000	426 per 10,000	Ω	Ω	2010/11

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Early Detection and Management	Primary Care (continued…)	Proportion of patients who smoke and are seen by a health practitioner in primary care that are offered brief advice and support to quit smoking	By encouraging and supporting more smokers to make quit attempts there will be an increase in successful quit attempts, leading to a reduction in smoking rates and in the risk of the individuals contracting smoking related diseases.	No	31%	33%	90%	90%	Q3 2011/12
		Proportion of the eligible population who have had their cardiovascular risk assessed in the last five years	Ensuring long-term conditions are identified early and managed appropriately, will help improve the health and disability services people receive and aid in the promotion and protection of good health and independence.	No	45.8%	54.4%	75%	75%	Q3 2011/12
	Pharmacy	Total value of subsidy provided.	This indicates the total DHB contribution towards patients' community drug costs.	Yes	$127,405,132	$111,263,567	Ω	Ω	2010/11
		Number of prescription items subsidised.	Another indicator of overall volume of community pharmacy subsidy to our population.	Yes	6,275,146	6,158,637	Ω	Ω	2010/11
		Number of Medicine Use Reviews conducted by community pharmacy	Represents the extent to which MUR Services are being utilised to improve medicines adherence in at-risk groups	No	*n/a*	145	*n/a*	↑	2010/11
		Proportion of prescriptions with a valid NHI number.	Represents the extent to which community pharmacists are entering NHI numbers during the dispensing process; this links individuals with dispensing activity to improve data integrity in the national pharms warehouse	No	96%	97%	100%	100%	2010/11
		The proportion of the population living within 30 minutes of an extended-hours pharmacy (ie any pharmacy open at 8pm on a Sunday)	Represents the accessibility of after-hours pharmacy services to the population	No	98%	94%	95%	90%	As at Feb 2012

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Intensive Assessment and Treatment	Acute Services	Number of ED attendances.	An indicator of the volume of emergency care provided to our population.	Yes	91,224	97,770	Ω	Ω	2010/11
		Acute WIES total - provider	An indicator of the volume of acute hospital service provided to our population	Yes	92,172.6	98,750.59	↓	↓	2010/11
		Readmission rates.	While some readmissions are inevitable high standardised readmission rates compared to other DHBs is indicative of poor quality care.	Yes	10.24%	10.65%	10%	10.21%	Q2 2011/12
		Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival.	Emergency care is urgent by definition, long stays cause overcrowding, negative clinical outcomes and compromised privacy/dignity.	No	95%	92%	95%	95%	Q2 2011/12
		Compliance with national health target of 100% of patients needing radiation or chemotherapy treatment will have this within four weeks	Ensuring timely access to cancer treatment for everyone needing it will support public trust in the health and disability system; and that these services can be used with confidence.	Yes	Chemo 95% Radiation 100%	Chemo 99% Radiation 100%	100%	100%	Q3 2011/12
	Maternity	Number of births.	An indicator of volume of service provide to our population	Yes	7,523	6,621	Ω	Ω	**ADHB** 2011 year **WDHB** 2010/11
		Number of first obstetric consultations.	An indicator of volume of service provide to our population	Yes	4,410	2,757	Ω	Ω	**ADHB** 2011 year **WDHB** 2010/11
		Number of subsequent obstetric consults.	An indicator of volume of service provide to our population	Yes	4,201	2,042	Ω	Ω	**ADHB** 2011 year **WDHB** 2010/11
		Proportion of all births delivered by caesarean section.	An indicator of volume of service provide to our population	No	32.6%	26.22%	↓	↓	**ADHB** 2011 year **WDHB** 2010/11

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Intensive Assessment and Treatment	Maternity	Established breastfeeding at discharge excluding NICU admissions	A good quality maternity service is 'baby-friendly' and will have high rates of established breastfeeding by the point of discharge.	No	81.5%	79.10%	>=80%	75%	**ADHB** 2011 year **WDHB** 2010/11
		Third/fourth degree tears for all primaparous vaginal births	Womens Hospital Australasia (WHA) core maternity indicator: 3rd/4th degree tears major complication of vaginal delivery; significant impact on quality of life		4%	2.22%	↓	↓	**ADHB** 2011 year **WDHB** 2010/11
		Percentage of term elective caesarean performed at ≥ 39 weeks	Early booking and antenatal care associated with better maternal/foetal health outcomes. If our service is timely and accessible, patients will book at early gestation.	No	47.4%	68.84%	↑	↑	**ADHB** 2011 year **WDHB** 2010/11

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Intensive Assessment and Treatment	Elective (Inpatient/ Outpatient)	Compliance with national health target for surgical discharges.	Elective surgery has a major impact on the health status of New Zealanders by reducing disability (eg cataract surgery and arthroplasty) and by reducing mortality (eg PCI).	No	11,179	13,786	12,891	15,853	2010/11
		Standardised elective surgical intervention rate.*	The need for elective surgery varies according to the population composition (eg older people require more elective surgery). By standardising our surgical output for our population composition we can assess whether our output is high or low compared to the national norm.	No Joints Cataracts Cardiac PCR Angio Overall	 12.70 35.45 4.81 13.71 30.05 282.67	 19.08 27.93 5.44 19.70 39.49 281.11	 21 27 6.2-6.5 11.9 32.3	 21 27 6.2-6.5 11.9 32.3	2010/11

* per 10,000 of population

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Intensive Assessment and Treatment	Elective (Inpatient/ Outpatient)	Number of outpatient first specialist assessment (FSA) consultations	FSA consultations are important component of our elective services output and the total number is a good indicator of the volume of our output.	Yes	83,210	38,900	Ω	Ω	2010/11
		Patient experience - Percentage of respondents who rate the care and treatment that they receive as 'very good' or 'excellent'	Reflects the quality of the service.	No	82%	*n/a*	90%	*n/a*	Feb 2012
		Elective surgical infection rates per 1,000 elective discharges	Reflects the quality of the service.	No	*n/a*	0.34	*n/a*	↓	2011
		Patients waiting longer than six months for their first specialist assessment (FSA)	Long waiting times for first specialist assessment causes people to suffer conditions longer than necessary, and therefore reflects poor timeliness of the services.	No	0.8%	1.1%	0%	0%	Jan-12
		Patients given a commitment to treatment but not treated within six months.	If a decision to treat has been made then it can be assumed that the treatment will lead to health gain. The longer a patient waits for this the less benefit s/he will get from the treatment.	No	2.4%	3.0%	0%	0%	Jan-12

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Intensive Assessment and Treatment	Assessment Treatment and Rehabilitation (Inpatient)	AT&R Bed days	Bed-days are a standard measure of the total output from this activity.	Yes	35,545	14,020	≥ baseline	≥ baseline	2010/11
		Number of AT&R inpatient events	A standard measure of the total output from this activity.	Yes	1,996	2,003	Ω	Ω	2010/11
		Average no. of falls per 1,000 occupied bed days	A high quality AT&R service will rehabilitate their patients so that they fall less, this would indicate a high quality service.	No	7.6	3.0	↓	↓	**WDHB** Jan 2012 **ADHB** Average May 11 – Apr 12
		Proportion waiting 4 days or less from waitlist date to AT&R service	This is an obvious indicator of the timeliness of our AT&R service.	No	87%	65%	≥ 87%	≥ 65%	**ADHB** Jan 2012 **WDHB** 2010/11

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Age	Eth	Baseline		Target 2012/13		Baseline Info
							ADHB	WDHB	ADHB	WDHB	
Intensive Assessment and Treatment	Mental Health	Access Rates for total and specific population groups (defined as the proportion of the population utilising MH&A services in the last year).	This indicator demonstrates the utilisation of our mental health services in relation to our population size. Low "Access" rates would indicate that our services may not be reaching a high proportion of those who need them.	No[3]	0-19 20-64 65+	M T M T T	4.21% 2.35% 9.55% 3.61% 3.29%	3.60% 2.62% 7.51% 3.43% 2.48%	4.08% 2.53% 8.18% 3.3%	3.60% 3.0% 7.50% 3.50%	Q2 2011/12
		Proportion of long term clients with Relapse Prevention Plan (RPP) [target of 95%] in the above population groups	There is evidence that relapse prevention programmes targeted to patients with a high risk of relapse/recurrence who have recovered after antidepressant treatment significantly improves antidepressant adherence and depressive symptom outcomes. The absence of a relapse prevention plan among mental health patients therefore indicates a failing in service quality.	No	Adult Child and Youth	M P Tot M P Tot	98.5% 100% 99% 100% 100% 100%	100% 98.61% 97% 93.10% 100% 96%	95% 95% 95% 95% 95% 95%	95% 95% 95% 95% 95% 95%	Q2 2011/12

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13❖		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Intensive Assessment and Treatment	Mental Health (continued…)	Alcohol and drug service waiting times and waiting list report (Policy Priorities 8) – waiting times should fall within target for maximum waiting time for each service: • Inpatient detoxification • Specialist prescribing • Structured counselling Seen within 3 weeks Seen within 8 weeks	Waiting times for service are an obvious indicator of timeliness.	No	61.70% 73.30%	78.43% 85.21%	80% 95%	80% 95%	Oct 2010 – Sept 2011

❖ Note: for WDHB these targets apply to the 20-64 year age group only
for ADHB these targets apply to 20-64 and 65+ year age groups only

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Rehabilitation and Support Services	Home Based Support	Average number of hours per month of home based support services for: • Personal care • Household management	A simple indicator of the average number of hours of home-based support that we provide.	Yes	n/a	52,958 23,783	n/a	Ω Ω	2010/11
		No. of InterRAI assessments	Simple indicator of output of service	Yes	130 per month	n/a	150 per month	n/a	average
		The proportion of people aged 65 and older receiving long-term home-support services (who have received HBSS over at least 3 months) who have had a comprehensive clinical assessment and a completed care plan (PP18)	Good quality, comprehensive and regular assessments will reduce numbers going into residential care and, for older people, services in their own home are much more convenient.	No	*New measure*	~6%	95%	20%❖	
		Percentage of NASC clients assessed within 6 weeks	Long waiting times indicate poor timeliness of this service.	No	96%	95%	≥ 96%	≥ 95%	**WDHB** Average 2011 year **ADHB** Average: Oct/Nov 11

❖Note: progress towards the 95% will need to be staged as Waitemata DHB was a late adopter of the InterRAI tool and training in its use will not be completed until January 2013.

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Rehabilitation and Support Services	Palliative Care	Number of contacts *WDHB Only*	Inpatient hospice care is the main component off our expenditure on palliative care. Episodes or contacts measure the total output from this activity.	Yes	*n/a*	21,232	*n/a*	↑	Extrapolated based on 6 months 2011
		Total number of completed episodes of care (death or discharge) *ADHB Only*		Yes	734	*n/a*	Ω	*n/a*	April 2011 – March 2012
		Proportion of cancer patients admitted to hospice who are Māori, Pacific or Asian versus proportion of cancer deaths who are Māori, Pacific or Asian (historical baseline) ❖ Asian calculated for ADHB only	Indicator of access equality	Yes	**Admissions** M 5% P 12% A 11% **Deaths** M 7% P 11% A 8%	**Admissions** M 9% P 7% **Deaths** M 6% P 4%	% admitted should reflect % deaths by ethnicity	% admitted should reflect % deaths by ethnicity	**Hospice** **ADHB** Apr 11 – Mar 12 **WDHB** Extrapolated based on 6 months 2011 2009 cancer death data used for both
		Proportion of patients acutely referred who had to wait >48 hours for a hospice bed	Well functioning service should provide timely access for acute patients.	Yes	11%	14%	↓	↓	**WDHB** Extrapolated based on 6 months 2011 **ADHB** 2011

Output Class	Sub-output Class	Measure	Rationale	Demand Driven?	Baseline		Target 2012/13		Baseline Info
					ADHB	WDHB	ADHB	WDHB	
Rehabilitation and Support Services	Residential Care	Total number of subsidised aged residential care bed days.	Bed days are a standard measure of the volume of aged residential care service.	No	954,667	751,082	≥ baseline	≥ baseline	**WDHB** 2010/11 **ADHB** Oct 10 – Sep 11
		Proportion of long term residents residing within facilities that have received InterRAI training who have had an InterRAI clinical assessment within the year.	Good quality, comprehensive and regular assessments will improve the quality of care received by residents.	No	*New measure*	*New measure*	20%	20%	
		Percentage of NASC clients assessed within 6 weeks	Long waiting times indicate poor timeliness of this service.	No	96%	95%	≥ 96%	≥ 95%	**WDHB** Average 2011 year **ADHB** Average: Oct/Nov 11