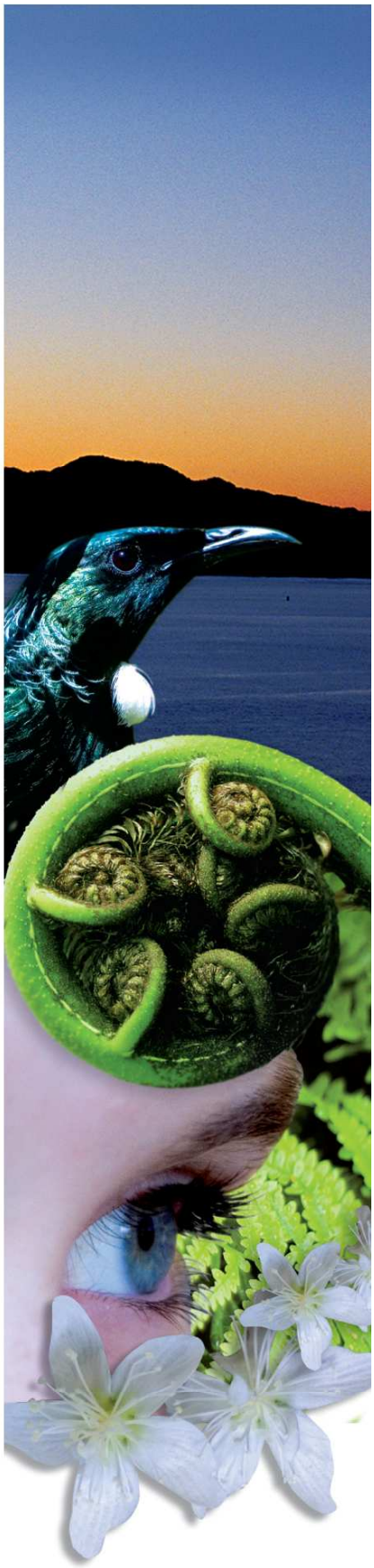
Our core values | Customer Focus 'eye' | Integrity 'sunrise' | Compassion 'bird' | Respect 'koru' | Openness 'flower'

# 2011/12 Statement of Intent

## 30 June 2011



Waitemata
District Health Board
Te Wai Awhina

This Statement of Intent has been prepared by Waitemata District Health Board (DHB) to meet the requirements of section 139 (1) of the Crown Entities Act 2004.

This document is intended to outline for Parliament and the general public the performance that will be delivered during 2011/12 by Waitemata DHB and contains non-financial and financial forecast information for the 2012/13 and 2013/14 years. The agreed performance measures are in the context of the government's strategic and service priorities for the public health and disability sector.

Signed by----------
Chair of Waitemata DHB
Dr Lester Levy

Signed by----------
Deputy Chair of Waitemata DHB
Max Abbott

Signed by----------
Waitemata DHB Board Member
Wendy Lai

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

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# MODULE 1:INTRODUCTION

## Executive summary

### Foreword from Chair and Chief Executive

Waitemata DHB is an organisation in transition. 2011/12 will see the organisation take further steps to realise its full potential to become a national leader among DHBs. We have made significant progress in the last few years towards achieving the national health targets, increasing access to services and providing high quality healthcare to our community. We will increase this momentum by nurturing a culture of patient responsiveness coupled with clinical excellence. We will implement exciting new models of care and all this while living within our means.

We have significant challenges; the provision of any health service is complex and relies on having excellent staff using robust systems and processes to provide high quality services. We need to continue to restore North Shore Hospital's reputation, develop new services, and manage volume growth and financial constraints. Therefore we need to ensure that our system is high performing and well tuned if we are to cope better with the ongoing challenges that we face.

Specifically, we are intent on building a culture where high standards of quality, professionalism and humanity for our patients are at the forefront of the services we provide. We are committed to speeding up access for our patients through reduced waiting times in our emergency departments and for elective surgery, and developing innovative models of patient care both within our own services, focusing on fast stream elective surgery and unplanned admissions, and with our providers through Whanau Ora and integrated family health centres. This requires strong clinical leadership at all levels of the organisation, increased collaboration with the primary care sector and other northern region DHBs (particularly Auckland), and proactive management of emerging issues, while ensuring value for money in all that we do.

We also have a substantial facilities modernisation programme underway to modernise outdated and inadequate facilities to provide high quality and productive health services to our community. Opening in 2011/12 are Lakeview, a state of the art emergency department on the ground floor with a cardiology unit above, a new renal unit, a car parking building and phased theatre refurbishment at North Shore Hospital. At Waitakere Hospital a new theatre and additional medical beds will become operational, the car parking areas will be extended and a newly enhanced Health Campus Zone will encompass a lecture theatre. In the community we will continue the development of the new oral community health clinics.

2011/12 will be a time for aspirational and collaborative working. Results for our population depends on pooling our collective experience, energy, ideas, courage along with a real commitment to national, regional and local priorities. We have high hopes for what our DHB can achieve alongside primary care and our neighbouring DHBs.

Finally, we recognise the dedication of our frontline staff, our many health service providers and other groups, agencies, societies and advocates, all of whom support our drive towards better health and wellbeing. Your combined efforts help to keep the Waitemata community healthy and ensure that quality health services and supports are available when they are required.

## About Waitemata DHB

### Who we are

Waitemata District Health Board (DHB) was established over 10 years ago and is one of the largest DHBs in New Zealand with responsibility for the health and wellbeing of over 550,000 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 114,000 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 restore the reputation of North Shore Hospital, 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 nurture a culture of patient responsiveness throughout the DHB and wider health sector while ensuring value for money in all that we do.

### What we do

Waitemata District Health Board (DHB) has three main functions:

- Governance and funding administration – the support for the Board and Board committees, and the clinical and management support for the planning and funding and corporate responsibilities
- Funding (purchasing) of health services from other provider organisations – the contracts we have with third party organisations such as non-government organisations, primary healthcare organisations, residential care providers, pharmacies etc.
- Provision of health and disability services – the services we directly provide through our hospitals and community services.

**Snapshot of Waitemata DHB**

- Largest and second fastest growing population of all districts - over 550,000 people, with the population expected to grow by an additional 114,000 people – 20.7% - over the next 15 years
- Around 18% of the Waitemata population is Asian, 10% Maori and 7% Pacific
- About 12% of the population is over 65 years, with around 2% over 85 years old
- 5,194 accrued Full Time Equivalent (FTE) staff as at February 2011
- $1.4 billion budget for 2011/12
- Provides a range of medical, surgical, obstetric, assessment, treatment and rehabilitation (for older people), mental health, community and disability services.
- Waitemata DHB also provides a range of Auckland regional services including child disability, forensic psychiatry, school dental and alcohol and drug services.

## Our population

The Waitemata district encompasses the historical boundaries of the Rodney district, North Shore city and Waitakere city councils. The district is shown in yellow on the map. The DHB's immediate neighbours are Northland DHB to the north and Auckland to the south. The district has areas of high population density and also has a significant rural population.


## Key facts about our population

Although it is not the wealthiest district in the country, Waitemata has the highest proportion of least deprived (deciles 1 and 2) people and the second lowest proportion of highly deprived (decile 10) people of any DHB. People in Waitemata have a higher life expectancy than their national counterparts and this is particularly so for Māori who have the highest life expectancy in the North Island. However there are quite large differences in life expectancy between different population groups. Within Waitemata, women tend to live an average of 4 years longer than men. Māori and Pacific people tend to live an average of 6 years less than others.

## Our population is generally healthier than other DHBs

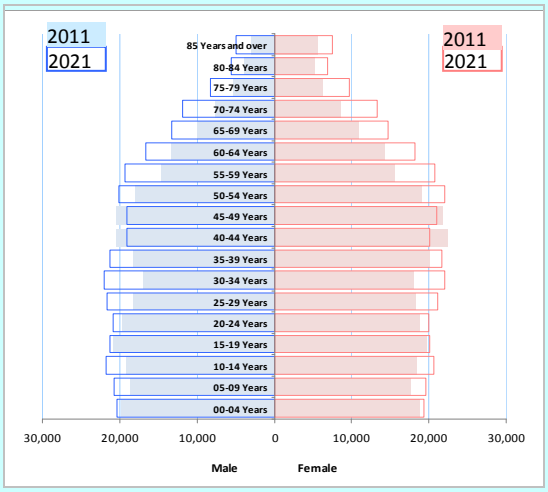
People in Waitemata have a higher life expectancy than people in New Zealand as a whole. Māori in particular live longer than all NZ Māori (3.6 years longer for men and 5.9 years longer for women).
Cardiovascular and cancer mortality are both lower in Waitemata than all New Zealand.
Diabetes prevalence in Waitemata is the lowest in the northern region.
The prevalence of smoking amongst our population is 14% - considerably lower than the national prevalence of 19%. This translates to over 60,000 people in Waitemata being regular smokers in 2006, nearly 10,000 of these being Māori.
Adults in Waitemata are less likely to be obese than in New Zealand (19.7% versus 25.4%). This is seen amongst all ethnic groups.

## Our population is growing

All age groups are growing (except the 40-49 year age band) and this impacts on our services and facilities.

- About 11% of our population visited a Waitemata DHB hospital emergency department in the last year, compared to 9% in 2005.
- Our public hospitals provided over 290,000 occupied bed days of service in 2010, compared to around 250,000 in 2005.
- Acute medical discharges are growing at around 4% on average per year.
- Surgical elective discharges growing at about 8% on average per year.

*Figure 1: Population projection and age profile 2011 to 2021*




## Our population is aging

We have by far the largest population over the age of 65 and over the age of 85 in the northern region,

- Nationally we're only second to Canterbury in the size of these groups.
- Our growth in numbers in the over 65 and in the over 85 year old age groups from 2011/12 to 2025/26 is forecast to be the highest of all DHBs.
- In 2010 the 65+ years population was only 11.8% of Waitemata's total population but accounted for more than 27% of emergency department presentations, 27% of acute surgical admissions, nearly 39% of elective surgical admissions and nearly 60% of acute medical admissions.

The growing elderly population will place increasing demands on our services. Increasingly, secondary care services will become a place which deals with the more complex end of the needs of elderly people. Correspondingly, the DHB's share of funding increases in line with the more complex needs of this growing population. The DHB must ensure that this money is directed towards services that meet these needs. It will become even more important to operate effective points of entry to the hospital system, ensuring elderly patients are seen quickly and then are able to access the services they require.

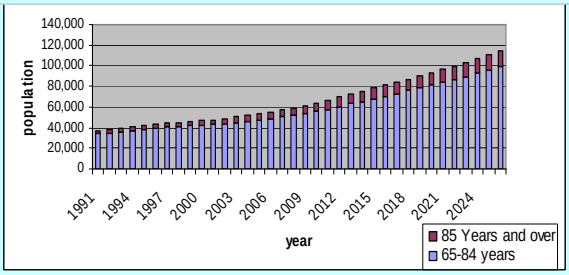



*Figure 2: Elderly Population projection*

To balance this, we need to ensure that our elderly are not admitted to hospital for conditions that can be managed in the community. A great deal of work is being focused on ensuring services are more accessible, with community health settings becoming better enabled to deal with the health needs of the elderly, close to their homes and with good support from secondary care where required.

## Our population is ethnically diverse

Waitemata has the third largest Asian (96,000) and Pacific (39,000) populations in the country, as well as a significant Māori (54,000) population.

Compared to other population groups within Waitemata, Māori and Pacific populations are more likely than others to suffer and die from cancer, heart disease, diabetes and respiratory disease.

Cardiovascular disease mortality is 69% more common in Māori as others, and more than twice as common in Pacific people as others. Among Asian people aged 15-74 years in Waitemata, during 2002-2005, Indian men had a higher cardiovascular disease avoidable mortality rate (3 times that for Chinese men who had the lowest rate), followed by Other Asian men.

Māori are twice as likely as others to get diabetes, being even higher for Pacific people and South Asians.

Māori and Pacific people have cancer mortality that is almost 50% higher than others, whilst Asian people have the lowest rates.

Whilst the prevalence of asthma for Māori and Pacific people is similar to others their hospitalisation rates are about three times that of others.

Appropriate breast and cervical screening of women is a particular area of focus for the DHB. While 75% of eligible women have had a cervical smear in the last 3 years and 65% a breast screen, coverage rates are slightly less for Māori and above the average for Pacific 66%.

## Determinants for a healthy population

Nationally and in our district, tobacco smoking is declining with a corresponding positive impact on health and life expectancy. Tobacco smoking is one of the main contributors to poor health, so the more we can do to accelerate this decline, the better the health of our population. Smoking particularly impacts on rates of cancer, cardiovascular disease (CVD), diabetes and respiratory disease and this impact is preventable. It has a particular effect on the health inequalities experienced by Māori and Pacific populations.

Obesity has a considerable impact on CVD and diabetes, both nationally and for our district. Poor diet and lack of physical activity lead to overweight and obesity. 51% of women and 61% of men in Waitemata are overweight or obese. Our obesity rates are less than the national average -one in five of our population is obese compared to one in four of the national population. However, obesity is much more common in our Māori (31%) and Pacific (48%) populations and much less common in our Asian population (8%).

There has been a gradual decline (internationally, as well as in New Zealand) in ischaemic heart disease mortality rates. This is due in part to a genuinely lower incidence and also better treatment options. While the incidence of cancer is also declining, it is not doing so at as greater rate, which means that as our population ages, the relative burden of cancer will increase.

## Our Māori and Pacific population is young

Our Pacific and Māori populations are considerably younger on average, than other ethnic groups within our population. Over 53% of our Māori and Pacific population are under the age of 25. Immunisation rates for our children have risen considerably in the last few years, reaching 89% in quarter 2 of 2010/11. However, rates for Māori are only 85%.

Māori and Pacific children have markedly poorer oral health than others. In 2009, the percentage of caries free children at 5 years old was 61% overall, but only 45% for Māori and 39% for Pacific children. Mean decayed, missing or filled teeth rates were 1.55 overall for this age group, but 2.42 for Māori and 3.00 for Pacific children – this being nearly double the overall result.

There are over 100 admissions to hospital each year for every 1,000 children in Waitemata. The most common acute admissions are for injury, gastroenteritis, asthma, viral infections, respiratory infections and skin infections. There are more than 80 admissions to hospital for every 1,000 young people in Waitemata. The most common acute admissions are for injury, abdominal or pelvic pain, and skin infections.

Further information about our population demographics, health needs and health status can be found on the Waitemata DHB website.

## Operating Environment

Waitemata DHB is wholly owned by the Crown and took over the assets and liabilities of the former Waitemata Health Limited in 2001 when it was established along with 20 other DHBs. Waitemata DHB 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 through the Crown Funding Agreement and Annual Plan negotiated annually with the Minister of Health, and the Statement of Intent, which is tabled in parliament by the Minister.

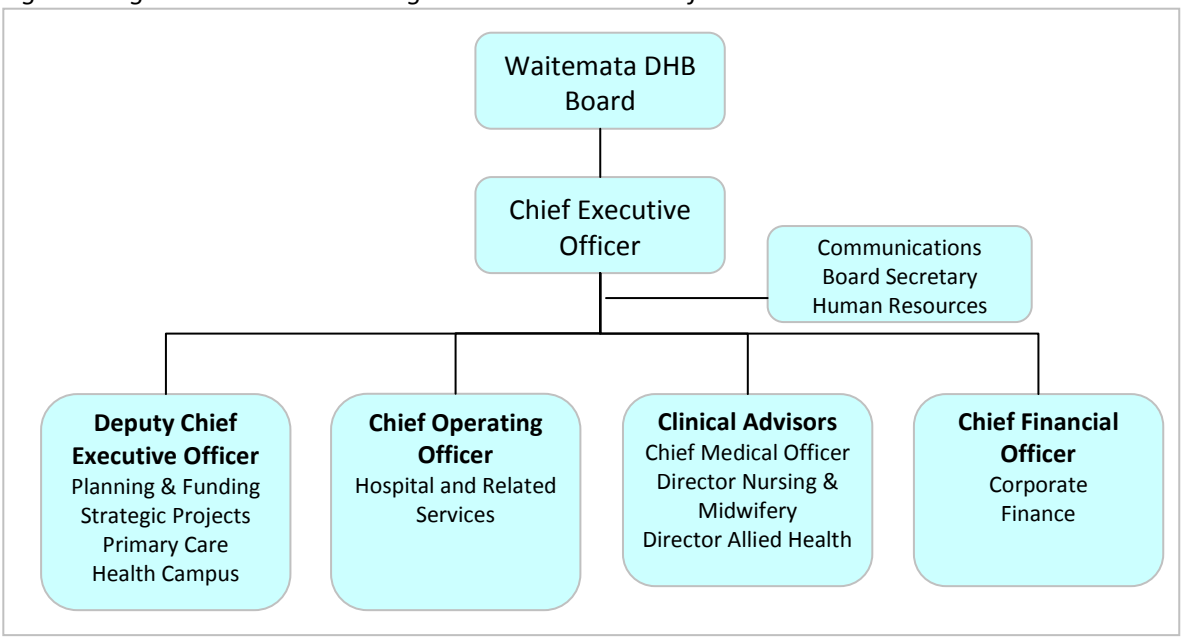
Our strategic priorities are described in this statement of intent (refer module 2). These were informed by a comprehensive health needs assessment and the development of the northern region health plan and the national priorities.

We have an established governance and organisational structure, based on the requirements of the New Zealand Public Health and Disability Act, through which the DHB functions.

Governance for Waitemata DHB is provided by a Board of eleven, seven of whom are elected and four 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 its current priorities. Three statutory advisory committees assist the Board meet its responsibilities, and the meetings of these committees 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 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.
- *The Disability Support Advisory Committee (DiSAC)* – advises on disability issues and those concerning older people.

*Figure 3 High-level summarised organisational structure of Waitemata DHB*



The Chief Executive reports to the Board and is responsible for the organisation's performance. Reporting to the Chief Executive are the Deputy Chief Executive Officer, Chief Operating Officer and the Chief Financial Officer as per the figure above.

### How our health services are funded

District Health Boards are empowered by the New Zealand Public Health and Disability Act to plan, fund and contract for the provision of health and disability support services for their eligible population (our population is projected to be 551,985 for 2011/12). We are responsible, during 2011/12, for funding most personal health services (including primary care and public hospital services), mental health services and disability services for older people. Public health, disability services (other than age related disability), and some Māori health services are still funded by the Ministry of Health.

Our district health board is one of the fastest growing because of population growth and the progressive transfer of services provided for our local catchment population from other Auckland public hospitals to North Shore Hospital and Waitakere Hospital.

During 2011/12 we will be responsible for the funding of services purchased from non-DHB providers to a total value of some $358 million. In addition, we fund services for Waitemata residents provided by other DHBs (mainly Auckland DHB) to a total value of some $315 million, and from our own DHB to a total value of $605 million.

### The services we provide

We deliver our services at North Shore and Waitakere hospitals and approximately 30 sites throughout the district (and region for our regional services). We predominantly provide secondary care health services including a range of medical, surgical, obstetric, assessment, treatment and rehabilitation (for older people), mental health, community and disability services. We also provide a range of services to the metro-Auckland community including child disability, forensic psychiatric services, school dental services and alcohol and drug services.

As of February 2011, Waitemata DHB had 5,194 accrued Full Time Equivalent (FTE) staff. The budget for our provider arm activities in 2011/12 is approximately $682 million, including direct revenue from the Ministry, Accident Compensation Corporation, patients and other revenue.

## The Treaty of Waitangi – Ngati Whatua

The DHB recognises and respects the Treaty of Waitangi as the founding document of New Zealand. The Treaty of 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 the Treaty of Waitangi in this document derive from and should therefore be understood in this context.

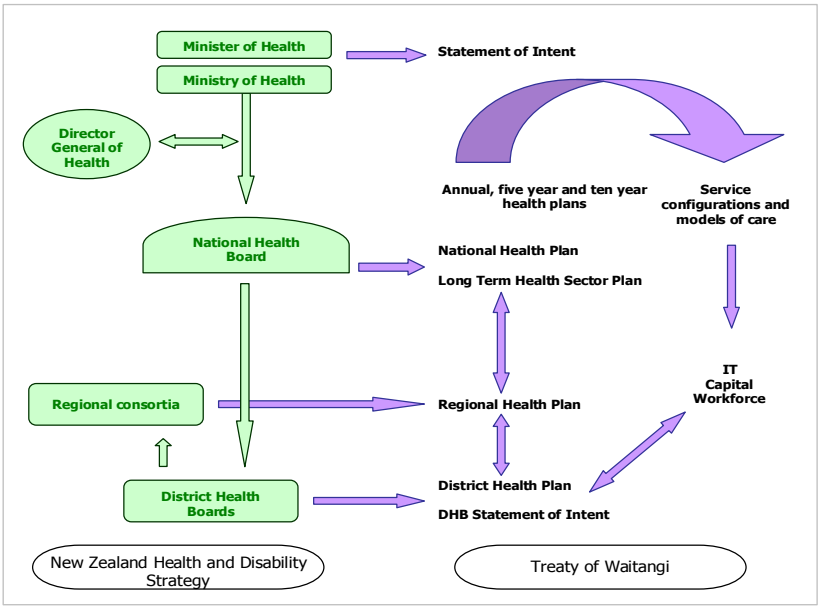
As a Crown Agent, the DHB will demonstrate how Treaty responsibilities are implemented through innovative strategies that apply the principles of Partnership, Participation and Protection. These principles are promoted by the Ministry of Health to provide direction to the health sector. Our commitment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

## The Value of Co-operative Rangatiratanga and Kawanatanga

The DHB and Te Runanga O Ngati Whatua share a Memorandum of Understanding. The Memorandum outlines key principles, processes and protocols for working together at both governance and operational levels. In order to achieve rapid progress towards equitable Maori health outcomes, both parties recognise the value of co-operative rangatiratanga and kawanatanga as the means to achieve equitable Maori health outcomes.

## Health sector planning context

We are part of a complex health sector that influences its planning and decision-making processes. The diagram provides a simplified perspective of the key stakeholders / organisations (to the left) and how they align with the planning documents (to the right). Of immediate impact on the annual plan for the 2011/12 year is the Regional Health Plan which sets the longer term priorities for DHBs in the northern region. From 2011/12 onwards, we will align our annual priorities to the wider regional goals. This serves to make redundant any previous strategic planning at the district level. These changes are brought about by changes under the New Zealand Public Health and Disability Amendment Act, 2010.




This statement of intent sets out the DHB's objectives and priorities and describes to Parliament and to the general public what the DHB intends to achieve in 2011/12 in terms of improving the health and well being of its community. Modules 4 and 5 of the plan contain non-financial and financial forecast information for the subsequent two out-years 2012/13 and 2013/14. 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.

## Factors affecting our performance

The Northern Region Health Plan identifies five drivers for change, these are the need to improve population health outcomes and reduce disparities, manage growth, respond to financial pressures, deliver better, sooner, more convenient services, and improve quality and patient safety. These drivers and the need to respond proactively to them are the key factors affecting our performance in 2011/12.

The effects of the global economic downturn, Christchurch and Japan earthquakes, will continue to impact on health spending well into the future. We are therefore working within a tightening fiscal environment where health spending will 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. This is a key driver for reviewing services across the spectrum of care to ensure productivity and value for money. Looking ahead, 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. This is particularly significant for Waitemata with such a large and growing elderly population. In partnership with the other northern region DHBs, 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

We have a common interest in getting best health outcomes value from available resources.

The strategic direction in Module 2, particularly the underlying framework and drive to build an organisation and health sector that is responsive to patients and delivers quality care while being sustainable in the long term, is key to our management of these impacts on performance.

# MODULE 2: STRATEGIC DIRECTION

## Our strategic direction

The Waitemata DHB Board is committed to:

- ensuring the six national health targets (refer later in this section) are met or exceeded as soon as possible (but no later than December 2011)
- clinical excellence coupled with patient service
- regional collaboration and integration
- clinical leadership
- proactive management of emerging issues
- innovative models of care
- ensuring value for money in all we do
- addressing the needs of priority populations (Māori, Pacific, Asian, disabled, older people and children)
- financial discipline

The Waitemata DHB Board is committed to building a culture of patient responsiveness, speeding up access for our patients through reduced waiting times, ensuring value for money in all we do and developing innovative models of patient care. The Waitemata DHB Board has identified ten priorities for clinical and executive management's attention over the 2011/12 year.

The Board's ten priorities, refer following page, do not focus attention away from the six national health targets and their drive to deliver quality health care – the Board is totally committed to ensuring the six national health targets are met or exceeded. The Board's priorities act in harmony with the six national targets and together form the compelling sense of priority for the organisation. A high level summary of how the national, regional and local Board priorities align is provided later in this section.

The underlying framework for the Board's priorities and everything we will do as an organisation in 2011/12 will create:

- greater focus and determination to achieve our goals
- authentic leadership and highly disciplined management
- strengthen collaboration within and outside of the organisation (particularly with Auckland District Health Board and primary care)
- enhanced accountability at all levels in the organisation
- high standards of quality, professionalism and humanity for our patients
- a sustainable organisation that lives within its means – ensuring our financial health is vital
- more action and 'less talk' about improving the health status of key population groups (particularly Māori, Pacific and Asian populations)

Our strategic priorities can be categorised as such:

- Our ten priorities
- National priorities and health targets
- Regional priorities
    - Northern region mission and triple aim.

## Our ten priorities

- **Culture**
  - intensification of the culture change to one of clinical excellence coupled with patient service (consistent considerate, thoughtful, kind and empathetic care for every patient)
  - urgently improve communication with patients and their families
- **Emergency Care**
  - 95 per cent of patients being admitted, discharged or transferred from the emergency department within six hours (as soon as possible but no later than December 2011)
  - 24/7 opening hours for adults and children at the Waitakere Hospital emergency department (on a sustainable basis)
  - complete Lakeview development and be fully operational by December 2011
- **New Models of Care**
  - develop and implement new models of care for:
    - fast-stream elective surgery
    - readmission prevention (focused on chronic diseases)
    - community based intervention
    - promoting good health
    - whanau ora
    - primary care
- **Clinical Leadership**
  - authentic clinical engagement and clinical leadership at all levels of the organisation from the bedside to the boardroom
  - clinicians involved in all critical strategic and operational decisions (including all major business cases)
  - leadership and management development for clinicians
  - development, management and monitoring of clinical networks
- **Regionalisation through collaboration**
  - collaboration at a regional level is an overriding principle
  - regionalisation is undertaken with studious and serious intent
  - collaboration, interaction and integration (where relevant and appropriate) with Auckland District Health Board is a critical priority
- **Health of Older People**
  - integrate and streamline services
  - "one point of entry" to all specialist services
  - effective outreach programmes
  - specialised inpatient area for stroke, and approach to dementia and delirium
  - co-ordinated approach to discharge planning.
- **Elective surgery**
  - Achieve 14,771 elective surgical discharges
- **Chronic disease management**
  - provide more systematic assessment of cardiovascular risk
  - enhanced treatment for heart disease and diabetes
- **Living within our means**
  - financial deficits are not acceptable under any circumstances
- **Bowel Screening**
  - plan and commence the bowel screening programme

## National priorities

At the highest level we are guided by the New Zealand Health and Disability strategies. These strategies are supported by numerous national strategies such as the He Korowai Oranga, Palliative Care Strategy, Cancer Control Strategy and Action Plan and the Ministry's Long Term Health Sector Plan. The statement of intent 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.

The Minister of Health each year in his letter of expectations provides guidance as to the key areas of focus from a government perspective. For 2011/12 these are summarised:

- Improving service and reducing waiting times, particularly the six health targets
- Strengthening clinical leadership from bedside to boardroom
- Providing services closer to home focused on reducing unplanned admissions, integrated family health centres and Whanau Ora
- Providing safe and efficient services for older people
- Increasing regional collaboration including regional plans, shared 'back-office' functions, regional information technology platforms and support, and workforce development
- Supporting the National Health Board, Health Benefits Ltd, Health Quality and Safety Commission
- Achieving financial break even – living within allocation.

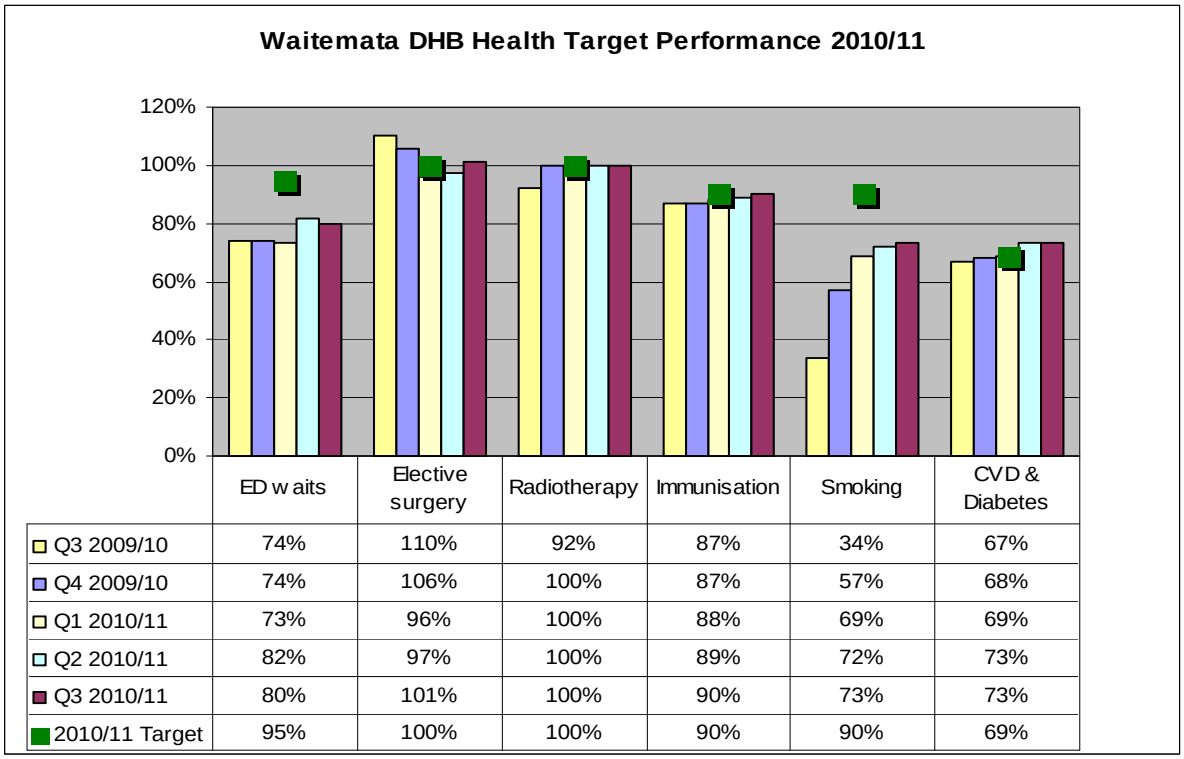
These key areas are important to the Waitemata DHB Board and have been incorporated in our top ten priorities for 2011/12.

### National Health Targets

The National Health Targets for 2011/12 are:

- shorter stays in Emergency Departments (95 percent of patients admitted, treated or discharged within 6 hours)
- improved access to elective surgery (14,771 total surgical discharges)
- shorter waits for cancer treatment radiotherapy (everyone needing radiation treatment will have this within four weeks)
- increased immunisation (95 percent of two year olds will be fully immunised by July 2012, note the target was 90 percent in 2010/11)
- better help for smokers to quit (95 percent of hospitalised smokers will be provided with advice and help to quit by July 2012 and 90 percent of primary care enrolled patients who smoke and attend clinic will be provided with advice and help to quit by July 2012)
- better diabetes and cardiovascular services (CVD risk assessment, diabetes management and diabetes annual get checked, note the intention is to move towards a national goal and public reporting of the CVD risk assessment indicator only.)

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 2011/12. We see the priorities we have developed for 2011/12 working together with the focus on health targets to deliver quality health care to our community.




| | ED waits | Elective surgery | Radiotherapy | Immunisation | Smoking | CVD & Diabetes |
|---|---|---|---|---|---|---|
| Q3 2009/10 | 74% | 110% | 92% | 87% | 34% | 67% |
| Q4 2009/10 | 74% | 106% | 100% | 87% | 57% | 68% |
| Q1 2010/11 | 73% | 96% | 100% | 88% | 69% | 69% |
| Q2 2010/11 | 82% | 97% | 100% | 89% | 72% | 73% |
| Q3 2010/11 | 80% | 101% | 100% | 90% | 73% | 73% |
| 2010/11 Target | 95% | 100% | 100% | 90% | 90% | 69% |

## Regional priorities

At a regional level we are guided by a regional services plan. The clinical and managerial leaders of the four northern region district health boards along with the three Better, Sooner, More Convenient business cases have worked together to develop the first Northern Region Health Plan. The change signalled in the Northern Region Health Plan requires a whole of system approach which recognises and leverages the diversity of DHBs and their Better, Sooner, More Convenient business case partners.

The agreed direction for our region is set out in the Northern Region's Charter. Our mission, together with the Triple Aim helps us to identify priority areas of focus. The Triple Aim drives us to improve the health of our region's population in a way that makes best use of our limited resources and enhances our patients' experience of care. Our initial Northern Region Health Plan priorities will focus on the following areas:

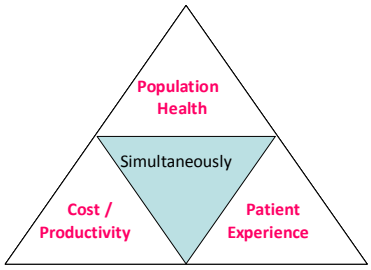
- First, do no harm focused on patient safety and improving quality.
- Life and Years (achieve longer, healthier more independent lives for the people in our region) focused on diabetes, cardiovascular disease, health of older people and cancer for the first year of the plan.
- Informed patient focused on ensuring patients get care, information and support aligned to their individual context, particularly whanau ora assessment and advanced care planning.

In addition to these three goals we have also placed emphasis on regional achievement of the national health targets, affordability and the alignment of capacity to demand.

There is also an emphasis on strengthening regional collaboration particularly for the three enablers information technology / services, workforce and facilities.

## 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 | | |
| IT/IS | Workforce | Facilities |

Further detail about the Northern Region Health Plan and deliverables for the 2011-12 year is contained in this link: http://nshint02.healthcare.huarahi.health.govt.nz/nrhp/

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 'Big Dot' Campaigns, Regional Clinical Leaders' Forum, Regional Chairs / Chief Executives Forum and Northern Region Health Plan Steering Group. We will also contribute through the achievement of specific actions within the plan such as successful implementation of the national bowel screening pilot, implementation of the global trigger tool and establishment of an integrated health centre.

## Outcomes and impacts

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. We have used the three high level regional goals, which also encompass the national and local priorities, to provide our outcomes framework, these are:

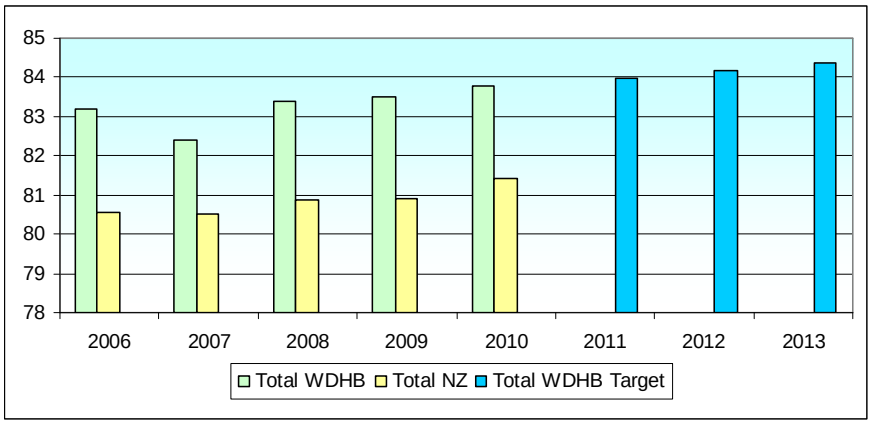
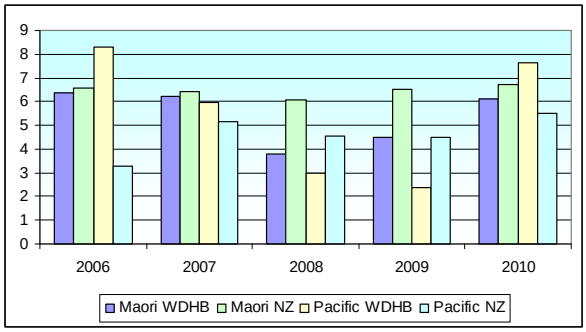
- improved population health - adding to and increasing the productive life of people in the northern region and reducing health inequalities
- improved patient experience - aiming for zero patient harm and performance improvement
- reduced cost and improved productivity - the region's health resources are efficiently and sustainably managed to meet present and future health needs.

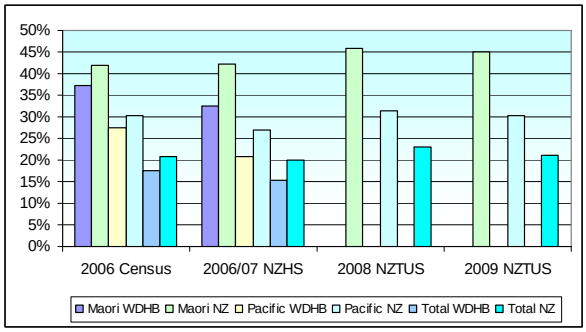
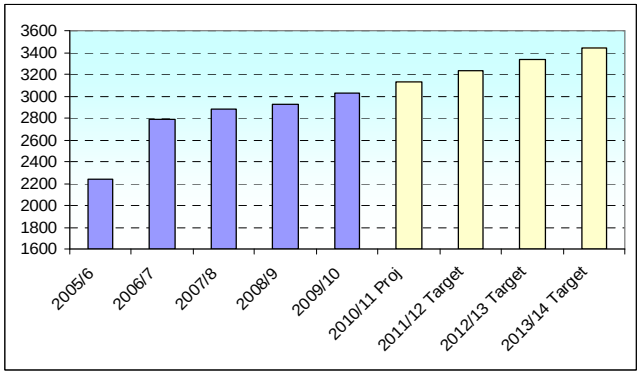
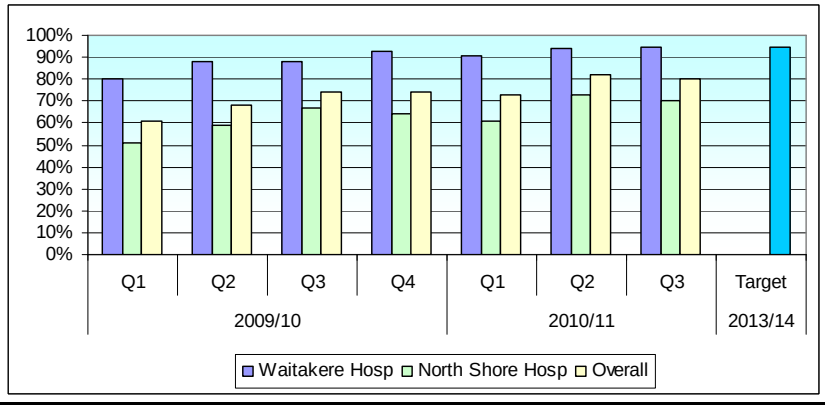
These three goals, which we are also using as outcomes, align with the World Health Organisation policy guidance for health system performance measurement and improvement[1]. Three goals are defined in the World Health Organisation framework: improving health, enhancing responsiveness to the legitimate non-health expectations of the population, and assuring fairness in financial contribution. For the latter goal we have focused on delivering efficient health services, which is where as a DHB we have the greatest

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

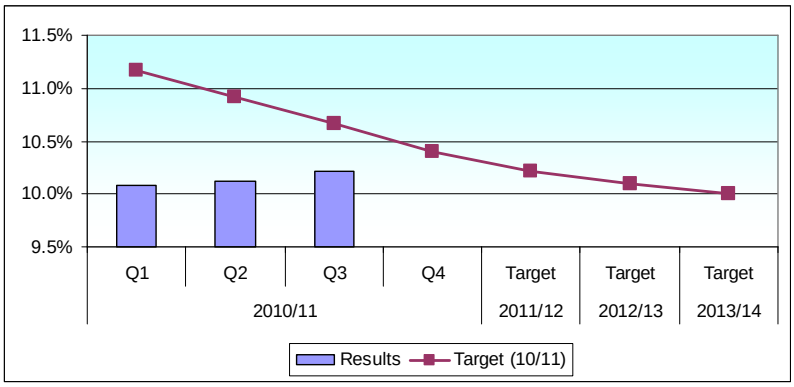
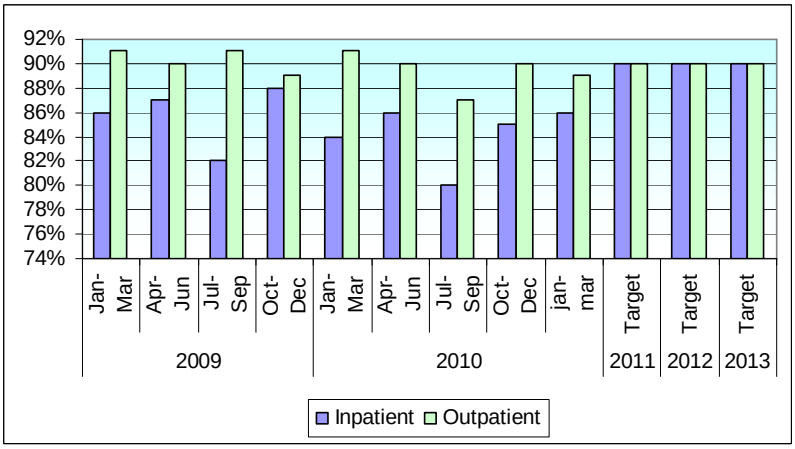
scope to ensure that our community is not required to pay excessively or unfairly for its health care. In this sense, we view high efficiency as a positive outcome in its own right because it helps to lower costs for everyone and frees up resources for other uses, be they within or outside the health 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.

| Outcome area | Key measures | Why are these measures our focus? What's the current status? |
|---|---|---|
| Improved population health | Increased life expectancy | Internationally recognised as a measure of population health status. While the health contribution to life expectancy is less than ten percent we would expect to see the continued increase of around 2 years each decade.   |
| | Reduced inequalities (measured by the life expectancy gap) | While we have good life expectancy rates, there are significant differences between the ethnic groups in our community (life expectancy gap) which we want to reduce to zero in the long term.   |

| Outcome area | Key measures | Why are these measures our focus? What's the current status? |
|---|---|---|
| | Reduced smoking levels | Smoking and tobacco contribute to a significant proportion of our mortality and morbidity rates, particularly for our Māori and Pacific community. We want to maintain our smoking levels at below the national average, ie. below 21% based on 2009 NZTUS (note: this average is expected to reduce in the medium term)<br>  |
| | Improved quality of life due to surgical interventions<br><br>(Total quality adjusted life years QALYs gained from the five Ministry of Health selected procedures) | Elective surgical procedures produce gains in health-related quality of life. We are monitoring the number of Quality Adjusted Life Years (QALYs) gained from five key elective surgical procedures: Coronary artery bypass grafts, angioplasty, hip and knee replacements, and cataract removals. We want to increase the number of QALYS years gained each year by our community from providing these five procedures[2].<br>  |
| | 95 per cent of patients being admitted, discharged or transferred from the emergency department within six hours | Ongoing achievement of this measure is essential for ensuring patients have timely access to services and treatment when they need it.<br>  |

[2] 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

<table>
<tr><th>Outcome area</th><th>Key measures</th><th>Why are these measures our focus?<br>What's the current status?</th></tr>
<tr><td rowspan="2">Improved patient experience</td><td>Reduced readmission rate</td><td>Recognised as a measure of how well discharge planning is undertaken and how the primary and secondary care system is interacting. Our aim is to reduce the readmission rate below 10%.<br> 
</td></tr>
<tr><td>Improved patient satisfaction</td><td>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.<br> 
</td></tr>
<tr><td>Reduced cost and improved productivity</td><td>Achieving a break-even position each year</td><td>Resources are finite and demand for health services is increasing at a greater rate than funding levels allow. We need to be a sustainable organisation which manages its resources efficiently and achieves a break-even position each year. 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.<br><br>
<table>
<tr><th>2009/10<br>Audited $000</th><th>2010/11<br>Forecast $000</th><th>2011/12<br>Plan $000</th><th>2012/13<br>Plan $000</th><th>2013/14<br>Plan $000</th></tr>
<tr><td>(20,891)</td><td>1,636</td><td>0</td><td>0</td><td>0</td></tr>
</table></td></tr>
</table>

This is a transition year from one accountability framework to another, therefore the connection between the statement of forecast service performance (Module 4) and the outcomes sought in the priority areas at a national, regional and local level does not always perfectly align, particularly as there is a many to many relationship between the activities provided by the DHB and the impacts expected and outcomes sought.

The following table outlines how the specific actions within our Top 10 priorities for 2011/12 mutually complement the regional and national priorities and the impacts we expect to see once the actions are implemented. We have also identified the relevant output classes for each priority area. Note that although impacts and outcomes may relate to more than one output class, information tends to appear where there is best alignment with a particular output class. This table is followed on the subsequent page by a comprehensive diagram where we have endeavoured to show the overall framework. The key performance measures in this diagram are described in more detail in the statement of forecast service performance in Module 4 by output class.

## Alignment of the national and regional priorities with Waitemata DHB's priorities

| Northern Region Health Plan Strategic Goals 1 – 3 year focus | Waitemata DHB Board's Priority Actions 1 year focus | National Priorities Minister of Health's expectations 1 year focus | Impacts | Output Class | | | |
|---|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 | 4 |
| ***Population Health***<br>Adding to and increasing the productive life of people in the northern region<br><br>Big Dot Interventions:<br>• Diabetes<br>• Cardiovascular<br>• Cancer<br>• Child health<br>• Radiology<br>• Elective surgery<br>• Emergency care<br>• Health of older people | • Implement actions to achieve health targets:<br>o Quit smoking<br>o Immunisation<br>o Shorter stays in ED<br>o Diabetes<br>o Cardiovascular disease<br>o Elective surgery<br>o Cancer<br>• Implement 24/7 opening hours for adults and children at Waitakere Hospital<br>• Complete Lakeview development<br>• Implement fast stream elective surgery<br>• Implement national bowel screening pilot<br>• Implement Māori health action plan<br>• Implement Pacific health action plan<br>• Implement Asian health action plan<br>• Implement child health priority actions<br>• Implement regional and local mental health plans | Improving service and reducing waiting times | Prompt diagnosis of acute and chronic conditions<br>Restoration or maintenance of functional independence<br>Minimising unnecessary use of high cost secondary care ("gate-keeping")<br>Increased life expectancy<br>Good access to effective pharmaceutical treatments<br>Effective and prompt resolution of medical and surgical emergencies and acute conditions.<br>Reduced mortality<br>Increased survival/reduced mortality from breast and bowel cancer<br>Management and cure of treatable conditions<br>Pain relief and reassurance<br>Prevention of illness<br>Reduced health inequalities<br>Improved emergency care<br>Improved quality of life due to surgical intervention<br>A national policy, regulatory and legislative framework favouring improved and more equitable health<br>Healthier children<br>Caries among children and adolescents is prevented and caries is detected early and treated before major damage to | ✓ | ✓ | ✓ | |

| Northern Region Health Plan Strategic Goals 1 – 3 year focus | Waitemata DHB Board's Priority Actions 1 year focus | National Priorities Minister of Health's expectations 1 year focus | Impacts | Output Class | | | |
|---|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 | 4 |
| | | | teeth occurs<br>Improvement in overall oral health with a reduction of inequalities among different ethnic groups<br>Prompt recovery from acute mental illness<br>Prevention of mental illness relapses<br>Social integration and improved quality of life | | | | |
| | • Increase services deliverable by more complete integration with primary care<br>• Support the development of Whanau ora<br>• Establish integrated family health centres<br>• Implement reduced unplanned admissions programme<br>• Implement new models of care for community based intervention | Services closer to home | Patients less likely to be readmitted<br>Prevention of illness<br>Reduced health inequalities<br>Higher breastfeeding rates; reduced obesity; increased physical activity; reduced rates of smoking and better nutrition<br>Maintenance of functional independence<br>Minimising unnecessary use of high cost secondary care ("gate-keeping")<br>Reduced demand on specialist outpatient appointments<br>Patient reassurance in the case of negative results.<br>Older people with complex needs are able to age in place for longer. | ✓ | ✓ | ✓ | ✓ |
| | • Implement the specialist services for older adults work plan including:<br>o integrate and streamline services<br>o "one point of entry" to all specialist services | Safe and efficient services for older people | Older people with complex needs are able to age in place for longer.<br>Better health and fewer accidents (e.g. falls) among people over 65 years.<br>Improved happiness and quality of life for older adults | | ✓ | ✓ | ✓ |

| Northern Region Health Plan Strategic Goals 1 – 3 year focus | Waitemata DHB Board's Priority Actions 1 year focus | National Priorities Minister of Health's expectations 1 year focus | Impacts | Output Class | | | |
|---|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 | 4 |
| | o effective outreach programmes<br>o specialised inpatient area for stroke, and approach to dementia and delirium<br>o co-ordinated approach to discharge planning | | Maintenance of functional independence and health-related quality of life in older adults<br>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.<br>Improved quality of life for patients with life-threatening illness (and for their families) | | | | |
| ***Patient Experience***<br>Aiming for Zero Patient Harm and Performance Improvement<br><br>Big Dot Interventions:<br>• Clinical partnerships and networks<br>• Patient safety<br>• The informed patient<br>o Advanced care planning | • Intensify the culture change to one of clinical excellence and patient service<br>• Continue to encourage and support clinicians to be directly involved in strategic and operational decision making<br>• Implement and support authentic engagement of clinicians at all levels through clinical leadership<br>• Implement health leadership programme<br>• Implement Health Campus | Strengthened clinical leadership | Improved waiting times for our services<br>Improved patient satisfaction with our services<br>Fewer adverse clinical events<br>Improved engagement of our community – including Maori, Pacific and Asian – with our health services<br>Improved engagement of clinicians and other health professionals. | | ✓ | ✓ | |
| | • Implement the regional "First do no harm" intervention<br>• Participate in clinical networks<br>• Implement local quality improvement programmes<br>• Advanced care planning<br>• Continue facilities modernisation programme to assist with provision of high quality and productive health services | Support for the Health Quality & Safety Commission | | | | | |

| Northern Region Health Plan Strategic Goals 1 – 3 year focus | Waitemata DHB Board's Priority Actions 1 year focus | National Priorities Minister of Health's expectations 1 year focus | Impacts | Output Class | | | |
|---|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 | 4 |
| ***Cost/ Productivity***<br>The region's health resources are efficiently and sustainably managed to meet present and future health needs<br><br>Regional Priorities:<br>healthAlliance establishment<br>Regional Information Systems Plan<br>Regional Asset Planning<br>Northern Region Health Plan | • Implement regionalisation with studious and serious intent<br>• Implement new models of care<br>• Collaborate, interact and integrate with Auckland DHB<br>• Share successful DHB initiatives<br>• healthAlliance establishment<br>• Regional Information Systems Plan<br>• Regional Asset Planning<br>• Northern Region Health Plan | Regional Collaboration<br><br>Support for Health Benefits Ltd | Prudent financial management<br>Reduced demand on specialist outpatient appointments<br>Minimising unnecessary use of high cost secondary care ("gate-keeping")<br>Lower per capita out of pocket and total expenditure on pharmaceuticals | | ✓ | ✓ | |
| | • No financial deficit<br>• Business transformation<br>• Improved organisational performance through leading indicators | Living within our means | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Vision** | To make a healthy difference | | | | | | |
| **National Priorities** | Services closer to home | Safe and efficient services for older people | Improving service and reducing waiting times | Strengthened clinical leadership | Support for the Health Quality and Safety Commission | Regional collaboration | Living within our Means |

| | | | |
|---|---|---|---|
| **Northern Region Health Plan Strategic Goals** | Population Health<br>*Adding to and increasing the productive life of people in the northern region* | Patient Experience<br>*Aiming for zero patient harm and performance improvement* | Cost/Productivity<br>*The region's health resources are efficiently and sustainably managed to meet present and future health needs* |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Waitemata DHB Board's Priority Actions** | **Chronic disease management** | **Bowel Screening** | **Priority populations and services** | **Elective Surgery** | **Emergency Care** | **Culture** | **Clinical Leadership** | **Regionalisation through collaboration** | **New Models of Care** | **Living within our Means** |

| | | | |
|---|---|---|---|
| **Impacts** | ☑ **Increased life expectancy**<br>☑ **Reduced health inequalities**<br>☑ Prevention of illness and fewer acute episodes<br>☑ Prompt diagnosis of acute and chronic conditions<br>☑ Maintenance of functional independence<br>☑ Good access to effective pharmaceutical treatments<br>☑ Effective and prompt resolution of medical and surgical emergencies and acute conditions.<br>☑ Increased survival/reduced mortality from breast and bowel cancer<br>☑ Management and cure of treatable conditions<br>☑ Improved oral health of children and young people<br>☑ Improved independence and quality of life of older people<br>☑ Fewer incidences of communicable diseases<br>☑ Reduced demand for secondary care services<br>☑ **Reduced rates of smoking** | ☑ Improved waiting times for our services<br>☑ **Improved patient satisfaction**<br>☑ Fewer adverse clinical events<br>☑ Improved engagement of our community – including Maori, Pacific and Asian – with our health services<br>☑ Improved engagement of clinicians and other health professionals.<br>☑ **Improved quality of life due to surgical intervention**<br>☑ **Improved emergency care**<br>☑ **Patients less likely to be readmitted** | ☑ Reduced demand on specialist outpatient appointments<br>☑ Minimising unnecessary use of high cost secondary care ("gate-keeping")<br>☑ Lower per capita out of pocket and total expenditure on pharmaceuticals\<br>☑ Prevention of illness<br>☑ More services delivered in primary care and community based settings<br>☑ **Prudent financial management** |

| | | | |
|---|---|---|---|
| **Key Performance Measures** | 🗝 % of hospitalised smokers offered advice and help to quit<br>🗝 Smoking prevalence amongst hospitalised smokers<br>🗝 % of 2 year olds fully immunised<br>🗝 Proportion of women aged 45-69 who had a breast screen in the past 12 months<br>🗝 % of eligible population screened for bowel cancer<br>🗝 Mental health services access rates<br>🗝 Proportion of babies fully and exclusively breastfed at 6 weeks, 3 month sand 6 months<br>🗝 Proportion of eligible people with diabetes receiving their 'Get Checked' assessment<br>🗝 Proportion of people with diabetes with good diabetes management at the time of their 'Get Checked' assessment<br>🗝 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.<br>🗝 Average number of decayed, missing or filled teeth in year 8 children<br>🗝 Proportion of children who are caries free at 5 years<br>🗝 Hospitals discharge rates for falls (PP15) where the fall occurred in a residential institution<br>🗝 Elective services standardised intervention rates for our population | 🗝 Patients waiting longer than six months for their first specialist assessment (FSA)<br>🗝 Patients given a commitment to treatment but not treated within six months.<br>🗝 % of patients surveyed who are 'satisfied' or 'very satisfied' with the service they received<br>🗝 Rate of adverse clinical events<br>🗝 % of patients admitted, discharged, or transferred from an Emergency Department (ED) within six hours.<br>🗝 Hospital readmission rates<br>🗝 % of Waitemata cancer patients needing radiation therapy who receive it within 4 weeks of their first specialist assessment<br>🗝 Improve the volume of elective surgical procedures undertaken<br>🗝 Total QALYs gained from the five Ministry of Health selected procedures<br>🗝 Post-operative infection rates<br>🗝 Increased number of compliments<br>🗝 Reduced number of complaints | 🗝 Achieve financial break-even result<br>🗝 Regional achievement of national health targets<br>🗝 healthAlliance savings achieved |

| Output Class | Prevention | Early Detection and Management | Intensive Assessment and Treatment | Rehabilitation and Support |
|---|---|---|---|---|
| | 🌡 Health Protection<br>🌡 Health Promotion<br>🌡 Health Policy/Legislation Advocacy and Advice<br>🌡 Population Based Screening | 🌡 Community referred Testing & Diagnostics<br>🌡 Oral Health<br>🌡 Primary Health Care<br>🌡 Pharmacy | 🌡 Acute Services<br>🌡 Maternity<br>🌡 Elective (Inpatient/Outpatient)<br>🌡 Assessment, Treatment and Rehabilitation (Inpatient)<br>🌡 Mental Health | 🌡 Home Based Support<br>🌡 Palliative Care<br>🌡 Residential Care |

## Key risks and opportunities

There are a number of key factors which increase risks and/or provide opportunities for us. Some of these have been described previously when we discussed factors which impact our performance. Here we provide more specificity around three of the areas where we need to focus.

- **Expenditure** which is budgeted to increase by $54m above the 2010/11 forecast level. This expenditure growth is driven by the impact of population growth on our own services and demand driven services (eg laboratory, radiology and pharmacy services, residential care etc) provided in the community. It is also driven by the costs for settled employment contracts, cost of capital for facilities developments and the increasing cost of supplies and services.

  Robustly planned expenditure growth and funding growth indicates a funding gap exceeding $22m which is to be managed through the Business Transformation Programme savings initiated last year. Following on the success of the Business Transformation process implemented last year, work is underway to enhance previously identified savings and to identify, review and quantify new potential savings.

- **Inter-district flows** which encompass $36 million of inflows to the DHB and $282 million of outflows to other DHBs. We will undertake a detailed review of specific services to identify opportunities for improved access, quality and cost savings. We will:
  - Prioritise inter-district flow expenditure on improving access to DHB assessment and treatment services and reducing routine follow-up
  - Audit and monitor referral management protocols at other DHBs to ensure that patients are being accepted in accordance with agreed guidelines
  - Review the cost of services for defined patient groups, identify opportunities for cost reduction and implement required changes
  - Review automatic wash up provision for non priority elective services.

- **Sector capability** to deliver the outcomes our community needs. The sector has the capacity to deliver the outcomes needed, but the current environment is characterised by confusion and unpredictability, turf wars, lack of alignment, an overall system not fit for the future, big ambitions but hope is the plan, the risk that micro-system change is not linked to a strategic plan and by wasting our collective wisdom.

  The development of the Northern Region Health Plan has provided the platform to get us to an agreed compelling regional vision with a delivery plan for a set of core priority areas that will mobilise us for the change we need to make. Coupled with the local focus on clinical leadership, patient responsiveness and developing innovative models of care we are in a good position to build a sustainable organisation and sector and to make a positive impact for our community.

# MODULE 4: 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 to ensure we provided improved service performance information in our Statement of Intent compared with prior years.

*Summary of definitions from Planning and Managing for Results*

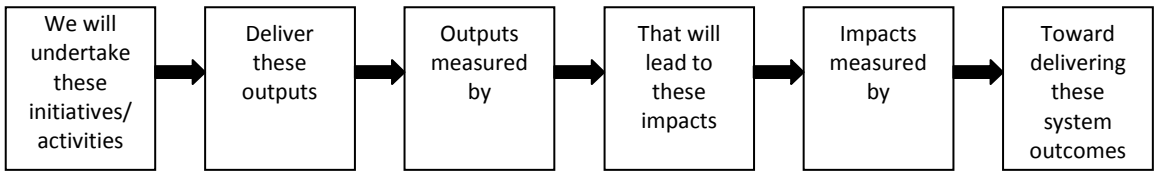
**Planning and Managing for Results – Treasury and State Services Commission**

"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.<br><br>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.<br><br>*Example: Improve the health status of the Waitemata DHB community*<br>*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.<br><br>It normally describes results that are directly attributable to the activity of an agency (DHB)<br><br>*Example: Reduce the morbidity and mortality for patients with diabetes*<br>*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)<br><br>*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. 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.

This is a transition year from one accountability framework to another, therefore the connection between the statement of forecast service performance and the outcomes sought in the priority areas at a national, regional and local level does not always perfectly align, particularly as there is a many to many relationship between the activities provided by the DHB and the impacts expected and outcomes sought. Within the output classes we have therefore focused on three high level outcomes which encompass all levels of priorities, these are:

- improved population health and reduced health inequalities
- improved patient experience
- cost/productivity.

Similarly, many of the impact measures are relatively new, and are still being developed, so that in some cases (eg. HPV immunisation) the impacts (reduced cervical cancer incidence) 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 2011/12 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 2011/12 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 diagram in Module two which links the outcomes and impacts with the national, regional and local strategic direction.

**Key to the output classes** for 2011/12

1. Prevention services
2. Early detection and management
3. Intensive assessment and treatment
4. Rehabilitation and support.

For 2011/12 the descriptions of these have changed slightly from 2010/11 to better reflect the nature of service provided. This does not create a significant change in terms of the content under each output class, as there is a close correlation between the proposed new descriptions and the logic applied when mapping purchase unit codes to each output class.

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.

**Also, please note that the output measures included in each output class table should be read in conjunction with appendix 9.6 which gives specific information on the rationale for the selection of each measure, together with baseline and target data for the measures.**

## Cost of Outputs

| New Output Class Name | Intensive Assessment & Treatment | Rehabilitation and Support | Early Detection & Management | Prevention Services | Total |
|---|---|---|---|---|---|
| | Plan | Plan | Plan | Plan | Plan |
| **Total Revenue** | **707,599,146** | **194,404,964** | **436,048,951** | **28,787,089** | **1,366,840,150** |
| **Expenditure** | | | | | - |
| Personnel | 330,615,810 | 32,289,534 | 91,525,445 | 12,786,346 | **467,217,135** |
| Outsourced Services | 25,334,737 | 4,406,034 | 7,013,497 | 979,804 | **37,734,072** |
| Clinical Supplies | 59,741,450 | 4,864,193 | 16,538,419 | 2,310,461 | **83,454,523** |
| Infrastructure & Non-Clinical Supplies | 74,071,385 | 7,555,759 | 20,505,422 | 2,864,661 | **104,997,227** |
| Payments to Providers | 217,835,764 | 145,289,444 | 300,466,168 | 9,845,817 | **673,437,193** |
| **Total Expenditure** | **707,599,146** | **194,404,964** | **436,048,951** | **28,787,089** | **1,366,840,150** |
| **Net Surplus / (Deficit)** | - | - | - | - | - |
| **New Output Class Name** | **Intensive Assessment & Treatment** | **Rehabilitation and Support** | **Early Detection & Management** | **Prevention Services** | **Total** |

**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.

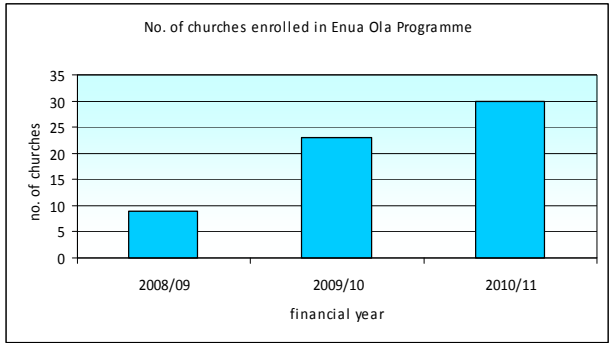
*Contribution to Outcomes*

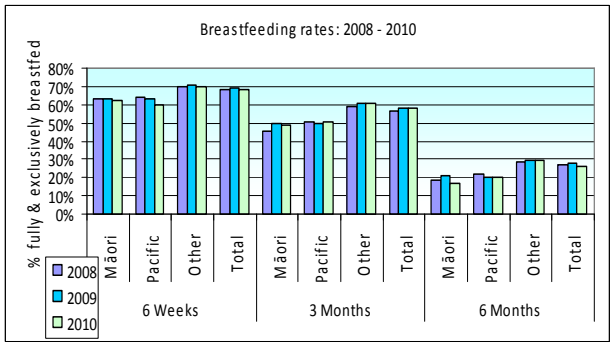
Our population's health is improved through the delivery of **prevention services** as they reduce the amount and size of disease outbreaks and reduce the harm from environmental hazards and at an individual patient level increase the survival and reduce the morbidity from breast and bowel cancer.

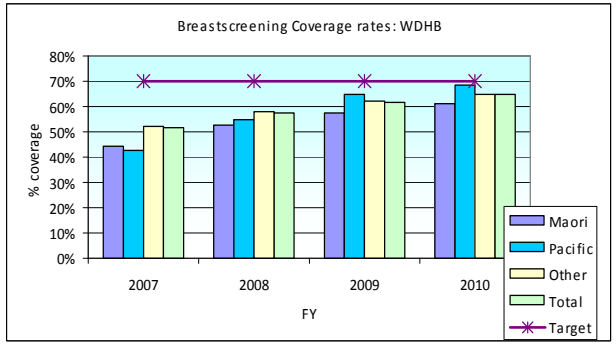
These services also contribute to reducing health inequalities as the poor and most vulnerable in society are generally those most at risk from communicable disease outbreaks and environmental hazards, and they also stand the most to gain from a regulatory environment that protects population health.

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.

*Trend graphs for key measures for these services*



**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***<br>Number of outbreaks investigated<br>Number of contacts traced<br><br>***Quality***<br>Communicable disease protocols up-to-date<br>Communicable disease protocols adhered to | Population health protected by reducing secondary cases | Number of outbreaks investigated |
| 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***<br>Number of emergency hazard investigations conducted.<br><br>***Quality***<br>Chemical and hazardous substance injury and poisoning protocol adhered to<br><br>***Timeliness***<br>Water supplier compliance/ non-compliance with duties under the Act reported to the water supplier within 20 working days | Reduction in adverse effects of environmental hazards | Number of environmental hazards detected. |

**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<br>Emergency responses | ***Quantity***<br>Number of emergency response exercises participated in<br><br>Number of emergencies responded to<br><br>***Quality***<br>Emergency Plan up-to-date<br><br>***Timeliness***<br>Reports submitted to the Environmental and Border Health Protection Team and a copy to the Public Health Operations portfolio manager immediately, or within 24 hours of occurrence of a public health event or emergency with inter-district, national or potentially international implications. | Rapid and effective emergency responses | Evaluation reports and inquiries into emergency responses |

**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***<br>Proportion of premises who submit a liquor licence application to ARPHS and all problematic premises that receive a compliance check<br><br>***Quality***<br>Liquor licensing alcohol compliance protocol for visits adhered to<br><br>***Timeliness***<br>Liquor licensing applications processed within 15 days<br>Tobacco complaints responded to within 5 days | Reduced sales of cigarettes and alcohol to youth and minors | Proportion of controlled purchase operations in which alcohol or tobacco product sales are sold to minors. |
| Fund and monitor breast feeding, nutritional improvement and physical activity programmes | Effective and well-targeted health promotion programmes | ***Quantity***<br>Number of programmes funded.<br>Number of enrolees<br>Number of session attendances<br><br>***Quality***<br>% of funding going to programmes with a logic model | Higher breast feeding rates; reduced obesity; increased physical activity; less smoking and better nutrition. | Breast feeding rates at six weeks, three months and six months |

**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***<br>Numbers of submissions made.<br><br>***Quality***<br>Submissions policy adhered to<br><br>***Timeliness***<br>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 |

**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***<br>Screening coverage rates among eligible groups<br><br>***Quality***<br>Breastscreening - Proportion of women screened who report that their privacy was respected<br><br>***Timeliness***<br>Proportion of women screened who receive their results within 10 working days | Increased survival / reduced mortality from breast cancer.<br><br>Increased survival / reduced mortality from bowel cancer. | Imputed years of life gained among Waitemata domiciled women through breast screening<br><br>Imputed QALYs gained through bowel screening of Waitemata residents. |
| Pilot a population based bowel screening programme | Eligible men and women screened for bowel cancer | ***Quantity***<br>Screening coverage rates among eligible groups<br><br>***Quality***<br>Bowel screening - Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure or any other investigations<br><br>***Timeliness***<br>Proportion of eligible individuals recalled for screening within 24 months of their previous invitation for screening | | |

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.

## 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. Waitemata DHB is in the process of consolidating from six PHOs to two PHOs. The purpose of the new configuration is to better meet the Government's Better, Sooner, More Convenient healthcare policy (aimed at providing more healthcare services in the community) and better enable Waitemata DHB to meet its priority of devolving some services to primary care.

*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.

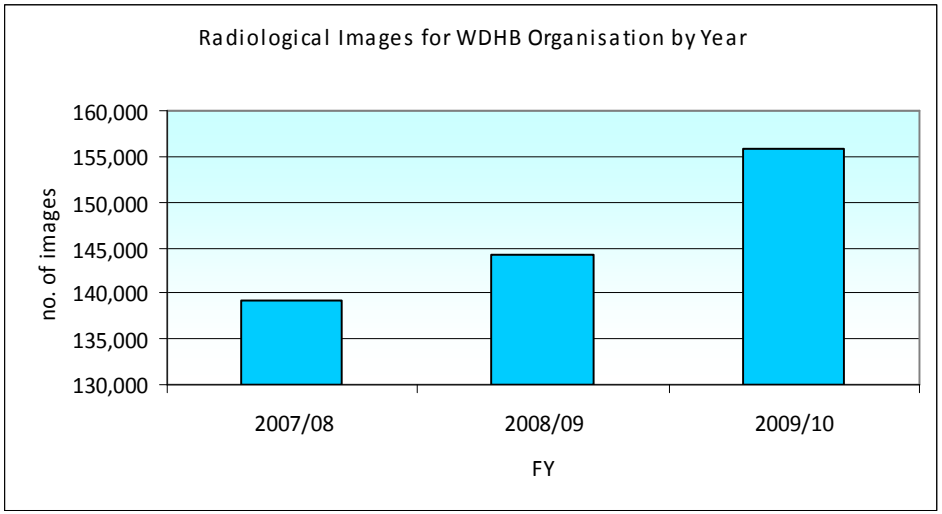
Effective early detection and management of patients reduces demand on more costly secondary and tertiary care services and can lower per capita out of pocket and total expenditure on pharmaceuticals.

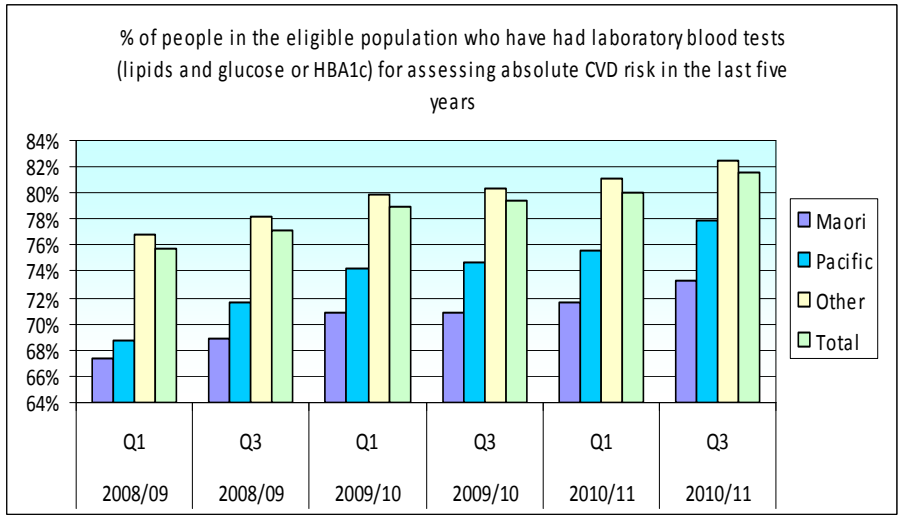
## Output: Community Referred Testing & Diagnostics

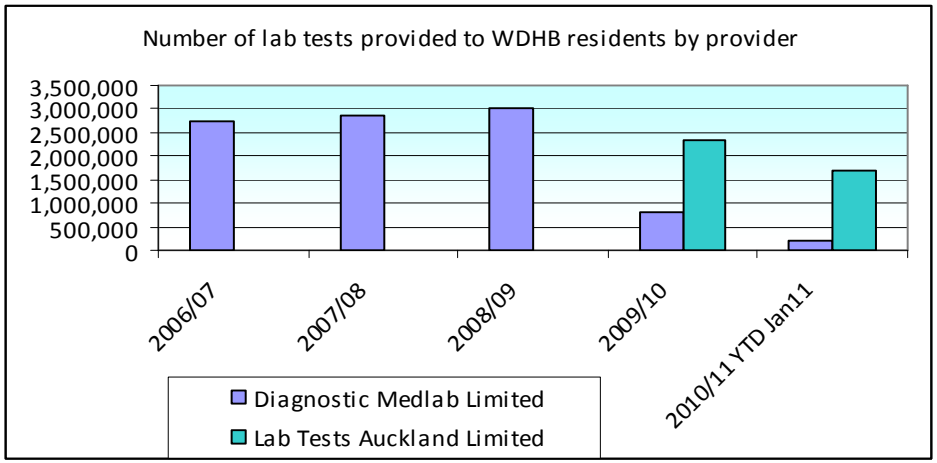
| We will undertake these activities | And deliver these outputs | Outputs measured by | That will lead to these impacts | Impacts measured by |
|---|---|---|---|---|
| Purchase and monitor community referred testing and diagnostic services including:<br>• laboratory tests<br>• radiological services for cardiology, neurology, audiology, endocrinology, respiratory<br>• pacemaker physiology tests<br>• ante-natal screening. | Community referred laboratory tests and other diagnostics services. | ***Quantity***<br>Number laboratory tests by provider.<br>Number radiological images.<br><br>***Quality***<br>Complaints as percentage of total no. of laboratory tests ◈<br><br>***Timeliness***<br>Average waiting time in minutes for a sample of patients attending Waitemata DHB collection centres between 7am and 11am (peak collection time)<br><br>Percentage of critical test results phoned through to appropriate contact person within 1 hour (a. referrer, b. patient, c. police). ◈ | Prompt diagnosis of acute and chronic conditions.<br><br>Patient reassurance in the case of negative results.<br><br>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. |

◈ Note this data is for all three metro Auckland DHBs

*Trend graphs for key measures for community referred testing & diagnostics*



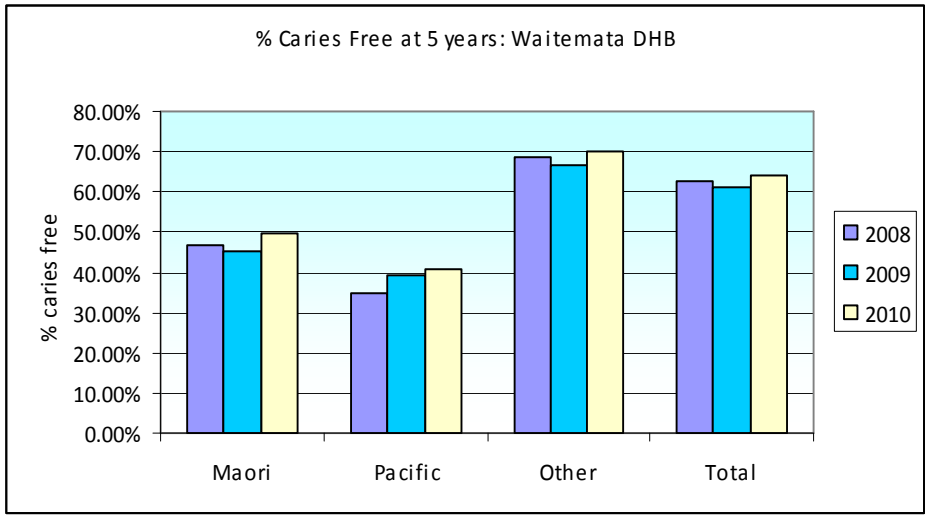



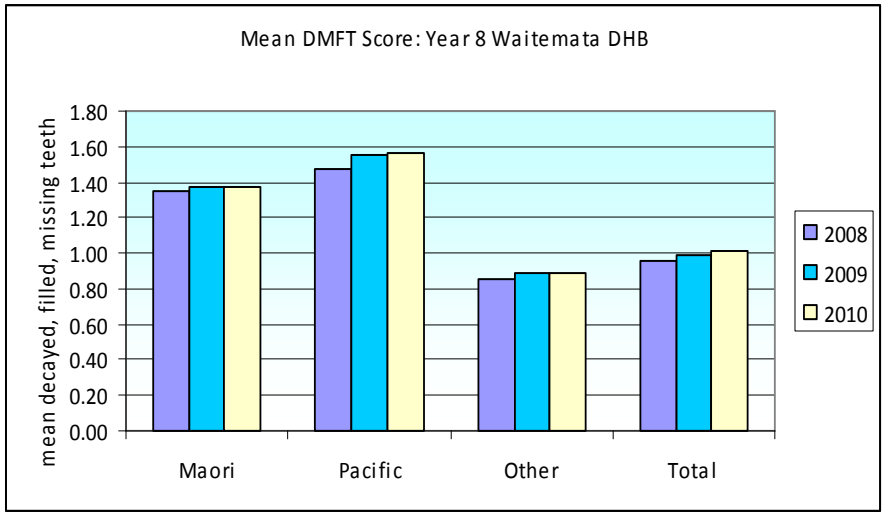



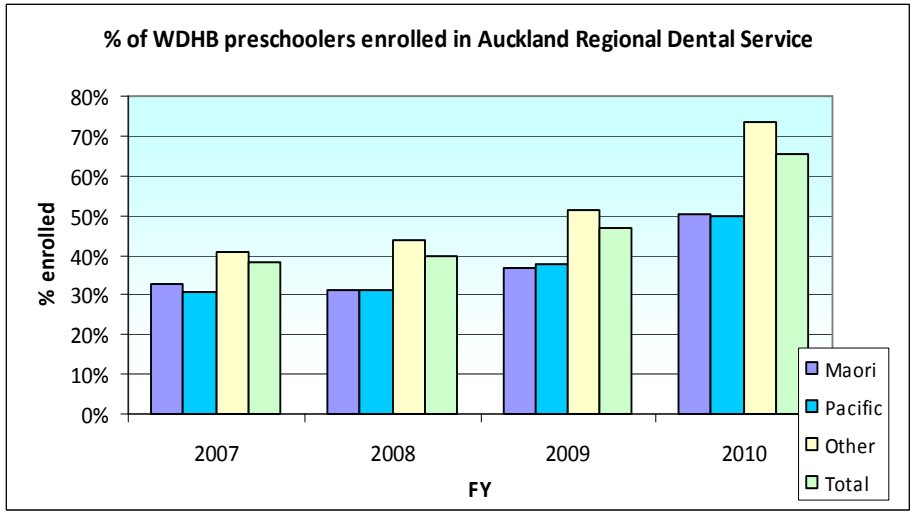
## Output: Oral Health

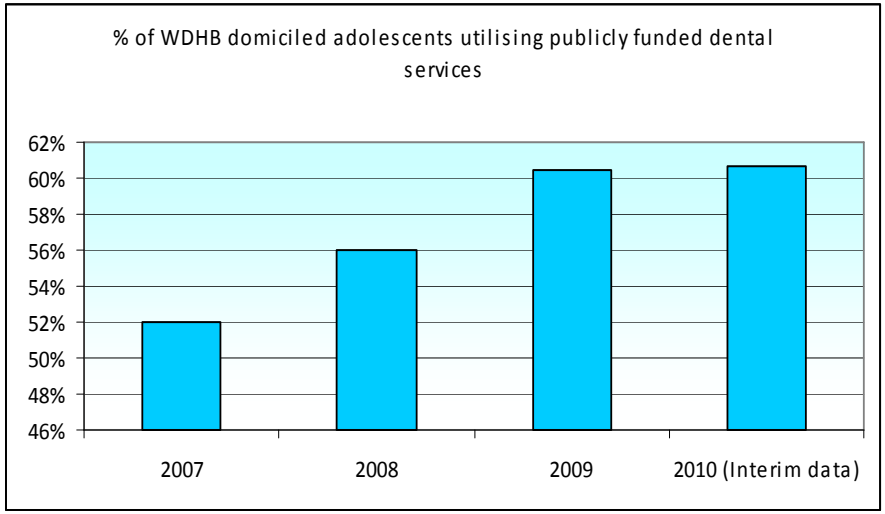
| We will undertake these activities | And deliver these outputs | Outputs measured by | That will lead to these impacts | Impacts measured by |
|---|---|---|---|---|
| Fund and/or provide a range of services for the metro Auckland region that promote, improve, maintain and restore good oral health including:<br><br>Health promotion activities targeting children and adolescents living in disadvantaged areas. Particularly Māori and Pacific peoples<br><br>Oral health examination and oral health education provided to preschool children & their parents<br><br>Oral health examination and education provided to school age children and adolescents.<br><br>Oral health examination and treatment services provided to low income adults. | Oral Health education<br><br>Oral examinations and treatment among preschool children, school children, and adolescents. | **Quantity**<br>Enrolment rates in children under five.<br><br>Utilisation rates for adolescents<br><br>Number of visits of preschool, and school children to oral health services (including adolescents)<br><br>**Quality**<br>No. of complaints in year<br><br>**Timeliness**<br>Arrears rates | Caries among children and adolescents is prevented, and caries Is detected early and treated before major damage to teeth occurs.<br><br>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 of year 8 children by ethnic group<br><br>Percentage of children caries free and average decayed , missing and filled Teeth of 5-year-old children by ethnic group |

*Trend graphs for key measures for oral health*



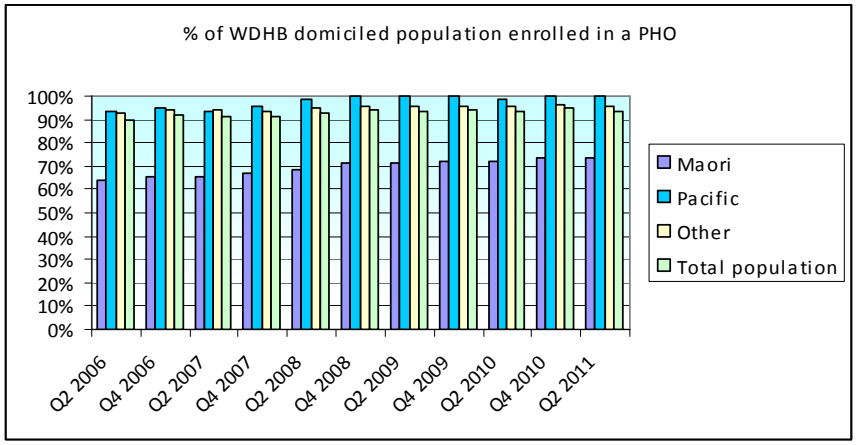



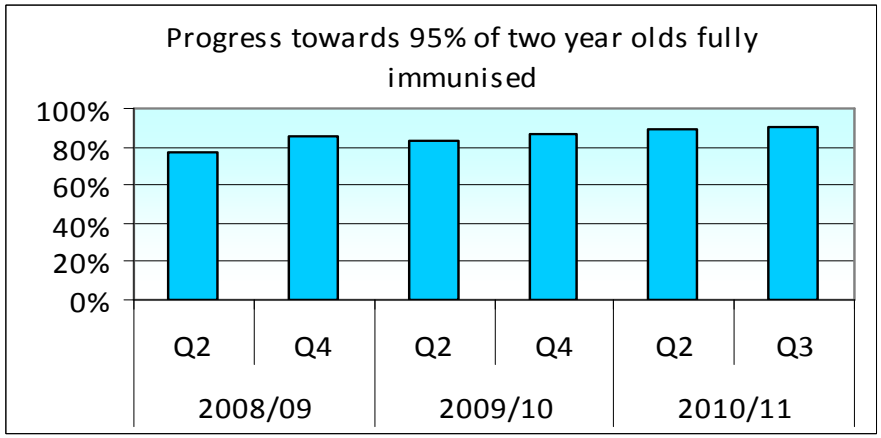



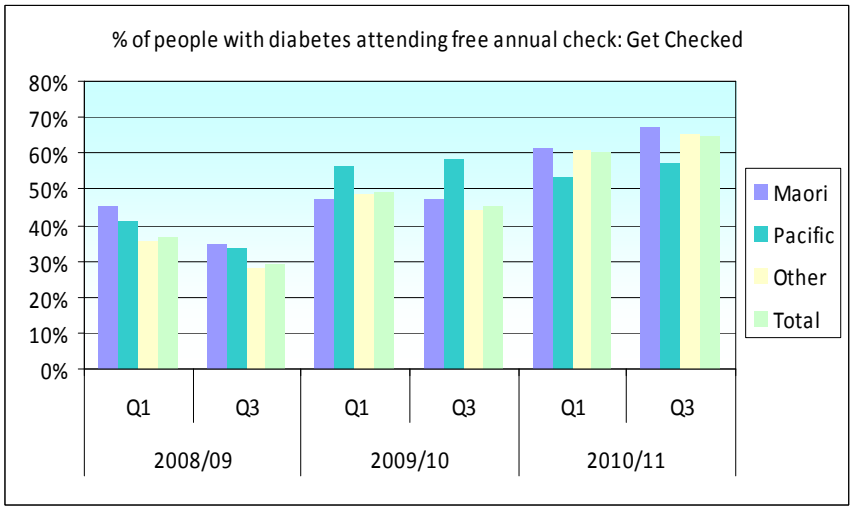
## Output: Primary Health Care

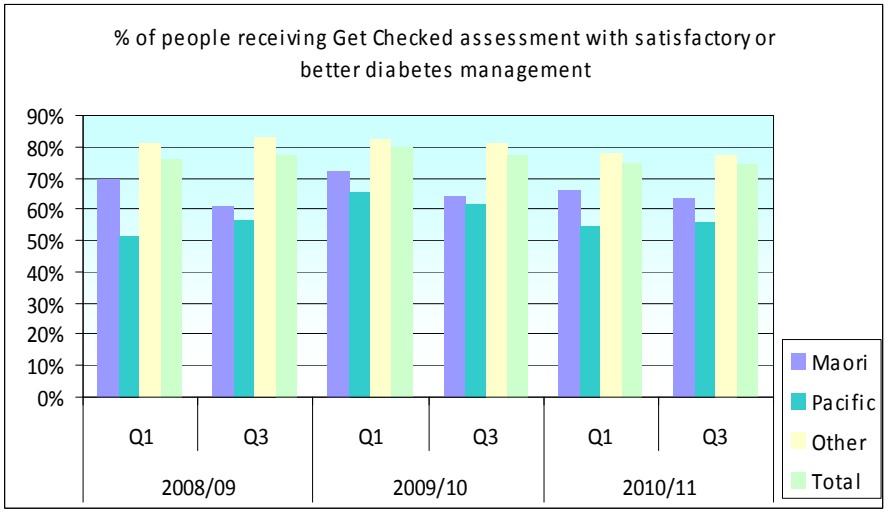
| We will undertake these activities | And deliver these outputs | Outputs measured by | That will lead to these impacts | Impacts measured by |
|---|---|---|---|---|
| Subsidise the provision of primary care services provided by GP teams, including certain specific health programmes such as Diabetes "Get Checked", CVD Risk assessment and management, "Care Plus", and Primary Options. Also immunisation and before schools checks.<br><br>Subsidise the provision of primary care services provided by Primary Health Organisations including diabetes coordination, services to improve access for high risk groups,<br><br>Subsidise Region-wide work to improve the performance of primary care through the GAIHN.<br><br>Contract cancer care coordination (navigation) services for Māori and Pacific populations | Enrolment PHO affiliated general practice teams.<br><br>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.<br><br>Preventive health care including immunisation, before schools checks, and advice and help to quit smoking.<br><br>Referral to secondary care services when appropriate.<br><br>[Community referred diagnostic and pharmaceutical outputs included in a separate output subclass] | **Quantity**<br>Ethnic-specific primary care enrolment rates<br><br>Immunisation health target achievement<br><br>Cervical screening coverage<br><br>**Quality**<br>Proportion of practices with cornerstone accreditation<br><br>**Timeliness**<br>GMS claims from after-hours providers per 10,000 of population | Management and cure of treatable conditions.<br><br>Prevention of illness.<br><br>Maintenance of functional independence.<br><br>Pain relief and reassurance.<br><br>Minimising unnecessary use of high cost secondary care ("gate-keeping") | Proportion of high grade cervical cytological abnormalities among the cohort of Waitemata women eligible for HPV immunization.<br><br>Proportion of people with diabetes who receive free annual checks<br><br>Proportion of people with diabetes who have satisfactory or better diabetes management<br><br>Standardised acute discharge rate and case-weights – trend and benchmarked against other DHBs<br><br>The percentage of two year olds are fully immunised by July 2012 |

*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**<br>Total value of subsidy provided.<br>Proportion of dispensing expenditures relative to expenditure on pharmaceuticals.<br>Number of prescriptions subsidised.<br>Number of Medicine Use Reviews conducted by community pharmacy<br><br>**Quality**<br>Proportion of prescriptions with a valid NHI number.<br><br>**Timeliness**<br>The number of extended-hours pharmacies associated with after-hours accident and medical centres | Good access to effective pharmaceutical treatments.<br><br>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. |

**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.

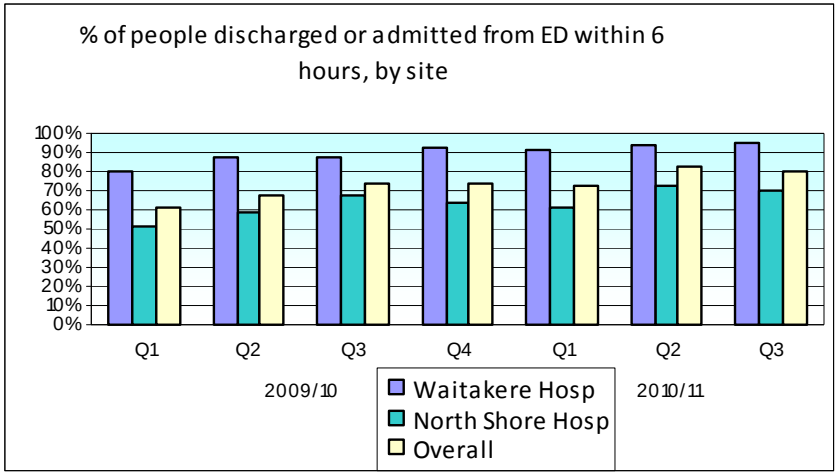
The overall patient experience, both as an outpatient and as an inpatient, is improved with prompt service delivery, caring and courteous staff and comfortable, easily accessed facilities catering for all patients needs.

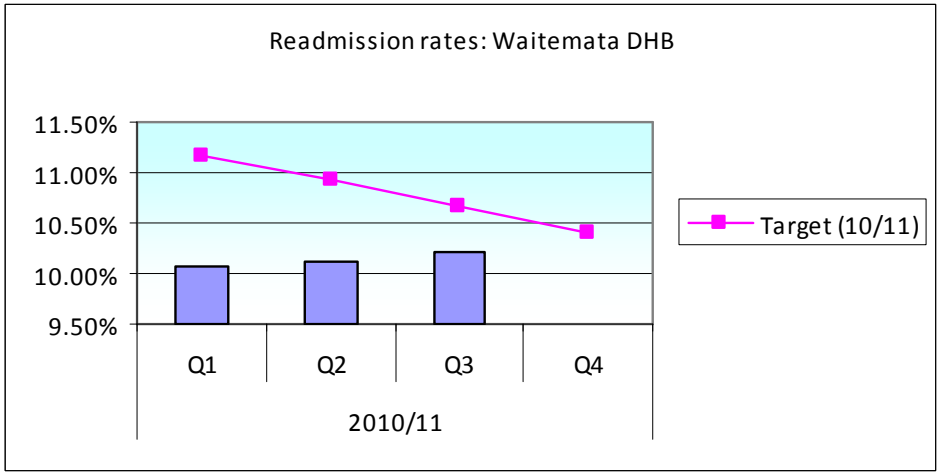
Efficient elective and acute service delivery and careful prioritisation of **intensive assessment and treatment** services maximise the cost-effectiveness of these services provided to our community.

**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:<br>• timely access to all service components (including diagnostics) and appropriate timely discharge.<br>• capacity to meet needs<br>• right treatment in the right place<br>• timely patient transfer to appropriate services from Emergency Department.<br>• good access to support services in the community or primary care level to support patient recovery. | Acute inpatient services<br><br>Emergency department services | **Quantity**<br>Number of ED attendances.<br><br>Acute service discharges.<br><br>**Quality**<br>Readmission rates.<br><br>Proportion of the population living within 30 minutes travelling time of an ED service.<br><br>**Timeliness**<br>Compliance with national health target of 95% of ED patients discharged admitted or transferred within six hours of arrival. | Effective and prompt resolution of medical and surgical emergencies and acute conditions.<br><br>Reduced mortality.<br><br>Improved patient satisfaction with our services<br><br>Improved engagement of clinicians and other health professionals<br><br>Patients less likely to be readmitted | Standardised mortality ratio (Target: be among the 4 DHBs with the lowest standardised mortality ratio). |

*Trend graphs for key measures for acute services*



**Output: Maternity**

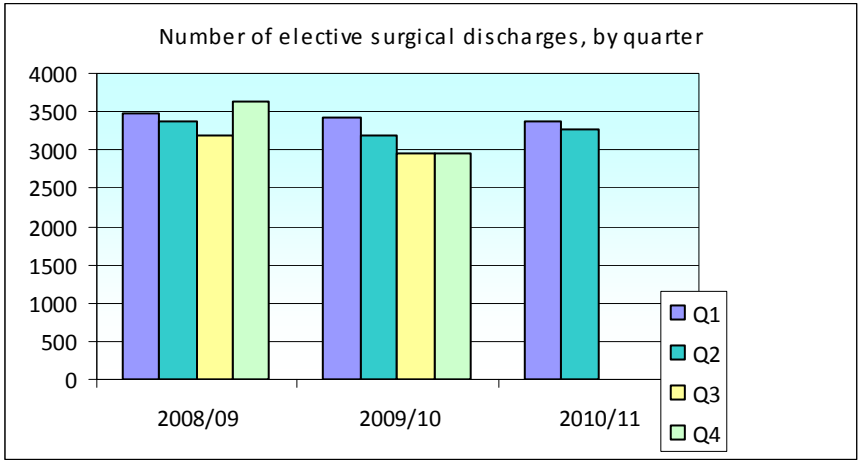
| We will undertake these activities | And deliver these outputs | Outputs measured by | That will lead to these impacts | Impacts measured by |
|---|---|---|---|---|
| Provide readily accessible maternity, obstetric and neonatal care services. | Non-specialist antenatal consultations.<br><br>Obstetric antenatal consultations.<br><br>Postnatal inpatient and outpatient care.<br><br>Delivery services.<br><br>Specialist neo-natal inpatient and outpatient care.<br><br>Amniocentesis | **Quantity**<br>Number of deliveries.<br><br>Number of first obstetric consultations.<br><br>Number of subsequent obstetric consults.<br><br>**Quality**<br>Caesarean section rate.<br><br>Established breastfeeding at discharge.<br><br>Documentation of smoking status and offer of help to quit<br><br>Proportion of women with antenatal BMI calculated<br><br>**Timeliness**<br>Gestation at first booking | Safer childbirth.<br><br>Healthier children. | Third/fourth degree tears for all first births<br><br>APGAR score <= 6 at 5 mins for live term infants<br><br>Blood loss >= 1500 ml during first 24 hours following a vaginal birth |

**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.<br><br>**NOTE:** A detailed description of activities to achieve elective surgery health target is provided in Module 3. | Elective inpatient services.<br><br>Elective outpatient services. | **Quantity**<br>Compliance with national health target for surgical discharges.<br><br>Surgical intervention rate.<br><br>Number of case-weights in relation to health target.<br><br>Number of outpatient consultations<br><br>**Quality**<br>Readmission rates.<br><br>Post-operative hospital-acquired bacteraemia rates.<br><br>**Timeliness**<br>Patients waiting longer than six months for their first specialist assessment (FSA)<br>Patients given a commitment to treatment but not treated within six months | Restoration of functional independence.<br><br>Increased life expectancy.<br><br>Improved patient satisfaction with our services<br><br>Improved waiting times for our services<br><br>Fewer adverse clinical events<br><br>Patients less likely to be readmitted | Total QALYs[3] gained from the five Ministry of Health selected procedures calculated as the number of procedures multiplied by QALYs per procedure as follows:<br>Hip replacement (primary) = 0.85<br>Hip replacement (revision) = 0.15<br>Knee replacement (primary) = 0.8<br>Cataract = 1.1<br>CABG = 1.3<br>PCI = 1.64 |

[3] 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*



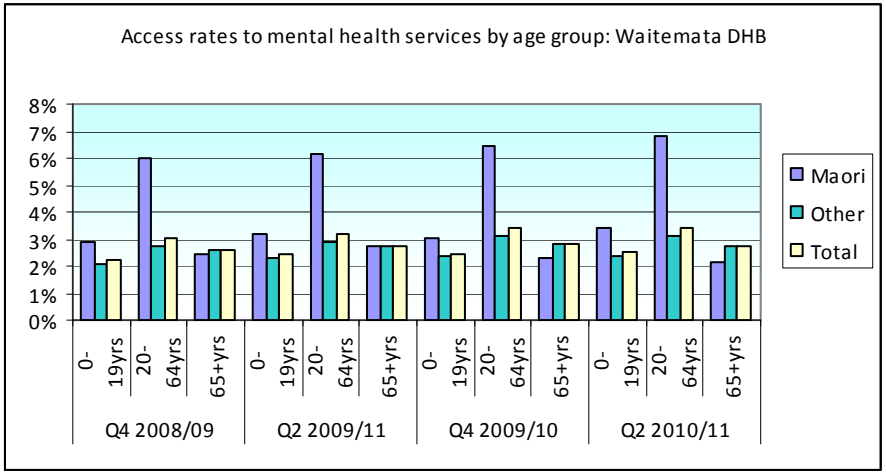
**Output: Assessment Treatment and Rehabilitation (Inpatient)**

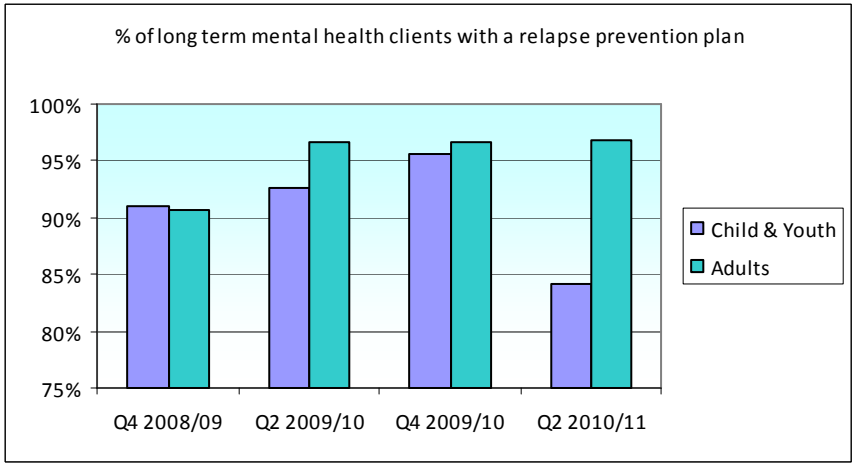
| We will undertake these activities | And deliver these outputs | Outputs measured by | That will lead to these impacts | Impacts measured by |
|---|---|---|---|---|
| Provide an inpatient specialist geriatric evaluation, management and rehabilitation service for older adults<br><br>**NOTE:** A detailed description of activities for health of older people is provided in Module 3. | Sub-acute inpatient care of older adults. | **Quantity**<br>AT&R bed days<br><br>**Quality**<br>Average no. of falls per 1,000 occupied bed days<br><br>**Timeliness**<br>AT&R average waiting time (waitlist date to transfer to AT&R) | 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 discharge as measured by the Barthel Index. |

**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.<br><br>The matrix of services comprise<br><br>- Acute & Intensive services;<br><br>- Community based clinical treatment & therapy services; and<br><br>- Services to promote resilience, recovery and connectedness | **Quantity**<br>Access Rates for total and specific population groups (defined as the proportion of the population utilising MH&A services in the last year). The population groups for which this indicator is measured are:<br>• Total / child & youth / adult / older adult population (all ethnicities)<br>• Maori (total / adult / child & youth / older adult)<br>• Pacific (total / adult / child & youth / older adult)<br><br>**Quality**<br>Proportion of long term clients with Relapse Prevention Plan (RPP) [target of 95%] in the above population groups<br><br>**Timeliness**<br>Alcohol and drug service waiting times and waiting list report (Policy Priorities 8) | Prompt recovery from acute mental illness.<br><br>Prevention of mental illness relapses.<br><br>Social integration and improved quality of life. | |

*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 on 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<br><br>Fund home based support services delivered in accordance with assessed needs. | Home based support assessments<br><br>Home based support care. | **Quantity**<br>Average number of hours per month of home based support services for:<br>• Personal care<br>• Household management<br><br>**Quality**<br>Number of complaints received regarding home based support.<br><br>**Timeliness:**<br>Percentage of NASC clients assessed within 6 weeks | Older people with complex needs are able to age in place for longer.<br><br>Better health and fewer accidents (e.g. falls) among people over 65 years.<br><br>Improved happiness and quality of life for older adults. | Proportion of people receiving HBS over 65 years.*<br><br>Proportion of people in residential care aged over 65.<br><br>Hospitals discharge rates for falls (PP15) where the fall occurred at home.*<br><br>Proportion of people assessed to have high or very high needs who reside in their own home.<br><br>InterRAI depression rating scale change since assessment Ω |

* Benchmarked against other DHBs.
Ω Can only be measured by ad-hoc audit

**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.<br>Specialist community palliative care services.<br>Home based palliative care services. | **Quantity**<br>Hospice palliative care bed day occupancy<br>Number of people who died while receiving hospice care<br>Numbers of initial hospice assessments<br>Specialist palliative care consults (hospice)<br>**Quality**<br>Overall **p**atient satisfaction with hospice services<br>**Timeliness**<br>Wait times for access to hospice beds Ω<br>Wait times for first assessment community services Ω | Improved quality of life for patients with life-threatening illness (and for their families/whanau) | Proportion of deaths from palliative conditions occurring outside of hospitals.* |

* Benchmarked against other DHBs.
Ω Can only be measured by ad-hoc audit

**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.<br><br>Ensure sufficient contracted beds are available to people assessed as requiring long term residential care. | Residential care bed days. | **Quantity:**<br>Total number of subsidised aged residential care bed days.<br><br>**Quality:**<br>Certification of residential care service providers.<br>Number of complaints received about aged residential care provider/s.<br><br>**Timeliness:**<br>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.<br><br>Hospitals discharge rates for falls (PP15) where the fall occurred in a residential institution.*<br><br>InterRAI depression rating scale change since assessment Ω |

# MODULE 5: STEWARDSHIP

## Stewardship

This section details how we manage our business effectively and efficiently to deliver on the priorities described in modules 2 and 4. It shows how our high level strategic planning translates into action in an organisational sense within the DHB and details the supportive infrastructure requirements to achieve this. As both funder and deliverer of health services, 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.

## Ownership Interests

### Value for Money

We have a strong focus organisationally on managing within budget. This principle is maintained in planning for a breakeven position for 2011/12 and beyond and is one of our top ten priorities. We accept the reality of the current economic environment and the realisation that funding is likely to continue to grow at a slower pace than has previously been encountered. This means we need to get smarter about the way we deliver health services to ensure we get the best value for money with the least waste.

The Business Transformation process was introduced last year to identify, plan for and implement initiatives across the DHB (funder, provider and corporate) that allow us to live within our means whilst enhancing service delivery to our population. A Business Transformation steering group has been established as part of the planning process. Membership includes both clinicians and managers. Together this group receives, reviews and monitors progress to ensure a break even position is attained. Each division group within the organisation has specific targets they need to work. Please refer to Module 8 for more detail.

### Organisational Performance Management

We have developed an organisational performance framework which links the high-level outcomes framework included in the Statement of Intent with day to day activity. This framework was developed in response to the Board's priority in 2010/11 for leading indicators.

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 leading indicators scorecard, Chief Operating Officer – Provider Group Hospital Advisory Committee Report and quarterly reporting against the deliverables set out in the Annual Plan.
- and in response to general business requirements, eg analysis of inter-district flow performance, monitoring of responsibility centre performance, services analysis etc.

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

All business cases and projects include rigorous risk management processes. In 2011/12 we will be establishing a comprehensive risk register that incorporates:

- Clinical/patient care related risks
- Financial risks
- Property and equipment risks
- Service coverage risks

Note, these are not mutually exclusive. For example, clinical risks may arise from financial constraints, and mitigation of clinical risks may cause financial risks.

## Funder Interests

The Waitemata DHB Funder ensures the planning and funding of health and disability support services is in line with national health and disability strategies and local population health needs.

The funding responsibilities cover the totality of services delivered for its population. This includes hospital based services and community based services. Community services are delivered by both our provider arm and indirectly through contracts with non-government organisations (NGOs). The latter includes primary care and the community care component of pharmacy services, laboratory services, maternity services, mental health services and alcohol and drug services. Māori health services and Pacific health services are also specifically provided for within the DHB and in the community.

The Waitemata Funder also contracts services from other district health board providers. These services are substantial and include both hospital based services and community based services. Hospital services delivered out of district are mostly for specialist tertiary and/or regional services provided by Auckland DHB. An example is the provision of specialist cancer treatment which is only offered at Auckland DHB for our region. Community services delivered out of district mostly result from our residents that have other co-incidental commitments outside of the district (for example, for work and study).

In total the Waitemata DHB Funder is responsible for $1.4 billion in funding of which $605 million is for the provision of services by our Provider Arm and $358 million is for the provision of services through contracts with our NGOs. A further $315 million is for the funding of services by providers or contract holders not located in the Waitemata District. This expenditure is commonly termed Inter District Flows (IDF). The remaining $9 million is to cover Governance and Funder related capability and administration.

The most significant financial risk facing the Funder results from demand utilisation growth in excess of the demographic (or population) growth funding made available each year. Within Funder NGO services this risk mostly eventuates within community pharmacy services and health of older persons services. In particular the dispensing fee component of community pharmacy and the home based support services component of older persons are most at risk with demand growth historically well in excess of demographic funding. Within hospital services this risk results from acute medical and surgical inpatient services delivered at Auckland DHB for our population. While these services are paid for in block according to an agreed budget, our ultimate liability is subject to actual utilisation and an automatic wash-up at the end of each financial year.

Waitemata DHB Funder is responsible for managing the full range of funding responsibilities for its funded functions. This encompasses the following functions:

- needs assessment including the monitoring of the population's health status and the inequalities in health status
- planning, prioritisation and strategy development
- development of service specifications
- provider selection in accordance with accepted protocol
- contract development and negotiation
- management of provider relationships
- provider payment and performance monitoring
- service evaluation
- review and re-negotiation of service agreements
- fiscal viability
- financial accountability
- value for money initiatives

Some Waitemata DHB services are funded and contracted directly by the Ministry of Health. These include for example, breast and cervical screening and disability support services for people aged less than 65 years. There are similarly some funding functions undertaken by a shared funding support agency (the Northern DHB Support Agency, or NDSA) which was established by the three Auckland DHBs in March 2001.

We 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 manger 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.

- Medicines Control, a division of the Ministry of Health audits all Pharmacies at least once within a five-year cycle.
- All personal health and capitation agreements are audited on a 3 yearly cycle, with the exclusion of small value contracts.
- Facilities providing rest home and hospital services are required to be audited to receive their certification that they comply with health and disability sector standards. This audit is carried out by designated audit agencies and then submitted for review to HealthCert of the Ministry of Health. Certification is issued for between 6 months and 3 years, depending on the audit report received and how recently the facility became a provider. Mental health providers are audited on a 3 yearly cycle.

## Provider interests

Waitemata DHB operates North Shore Hospital in Takapuna and Waitakere hospital in west Auckland. We provide 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.

*Funding and financial management*

Approximately 50 percent of all the DHB's funding is spent on provider arm services. In order to manage this effectively, the provider arm continues to operate with a strong focus on value for money, looking for best delivery of services through service reconfiguration and changes in models of care. Demand management is also a critical factor in living within our budget, necessitating improvements in productivity that will see us achieve our targets while lowering our unit costs. Closer scrutiny via the costing system of divisional budgets will help us determine the best ways to manage costs for our services.

*Performance*

We are focused on providing efficient and effective services across the primary/secondary interface, balancing services provided in secondary care with those more appropriately located in the community. There is a strong focus on customer service, addressing public confidence in and satisfaction with the health care provided. In order to do this we need to ensure we recruit and retain the right staff, address training requirements and foster a culture of clinical excellence coupled with genuine care for patients.

As discussed in the *Organisational Performance Management* section above, a balanced scorecard has been developed for the Board which incorporates provider division information. Along with this, an expanded range of service level KPIs are now reported to the Hospital Advisory Committee (HAC) and the balanced scorecard approach is well used within the Provider Arm. The organisation is very much focused on delivering on the health targets and therefore performance reporting centres on the necessary metrics that contribute to the achievement of the Health Targets eg. throughput information for ECC. Weekly updates are provided to the entire organisation detailing the current performance against each of the six Health Targets.

In 2011/12 we plan to use the multidisciplinary utilisation review groups (set up in 2010/2011 for laboratories and radiology) to assist in managing clinical support demand within the services. Evaluation of performance increasingly includes a focus on cost per purchase unit and staff productivity to output.

*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 2011 / 2012 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 and Safety Quality Commission and the Northern Region Health Services Plan (as of January 2011.)

In order to achieve the outcome of improved quality of service and safety for patients, in line with the DHB's quality and safety plan, the DHB plans to deliver on the following during 2011/2012:

- The implementation of the 'First Do No Harm' regional approach to patient safety
- The improvement, standardisation and increase of organisational capability regarding Reportable Events identification, investigation and resolution
- The improvement, standardisation and increase of organisational capability regarding Corrective Action identification, completion and implementation
- The deployment and implementation of Patient Smart Fast throughout Waitemata DHB to increase organisational capability to undertake structured problem solving

## Other Interests

### Trusts

**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 who 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 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.

### Subsidiaries

**HealthAlliance Ltd** is a shared services agency performing non-clinical support functions for its shareholding district health boards. Functions provided include procurement and supply chain, financial processing, information services and payroll processing. Until February 2011 HealthAlliance performed these functions primarily for its two shareholders: Waitemata DHB and Counties Manukau DHB. In March 2011 the role of HealthAlliance was enlarged. It began performing support functions for all four northern region DHBs: Waitemata, Counties Manukau, Auckland and Northland. All four DHBs are now shareholders in HealthAlliance. Health Benefits Limited, the national health procurement agency has also taken a shareholding.

**Northern DHB Support Agency Ltd (NDSA)** is a support services agency in which Waitemata DHB has a 33% shareholding. NDSA performs a number of funding functions on behalf of the northern region DHBs, particularly in relation to mental health contracts.

**Auckland Regional RMO Services Ltd (ARRMOS)**, in which Waitemata DHB has a 34% shareholding, arranges the allocation of registrars and house officers to the DHBs and performs a range of other functions related to the recruitment and training of junior medical staff.

**Milford Secure Properties Ltd** is a nominee company with shares held by a professional trustee. It was used during negotiations to purchase a property for Waitemata DHB. It is currently inactive.

## Organisational health

We are committed to building a performance and patient focused culture, and this culture change forms one of our ten priorities. Another of our ten priorities is clinical leadership, and we are aiming for clinicians to be leaders from the bedside to the boardroom. Clinical leadership is internationally recognised as a fundamental driver of improved patient care.

We place a strong emphasis on staff learning and development, and we recognise the importance of good workforce information, to inform workforce planning and development.

We work closely with and actively involve staff unions through established consultative processes. We are working with other DHBs nationally and regionally, and with central government agencies and educational and training institutions to address workforce issues.

We also 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 an aid to recruitment and retention of staff.

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 persons 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.

Similarly we aim to involve and engage our community in our planning and decision-making processes at the earliest possible opportunity, this has become more important as we respond to the implementation of the new service change processes. Consumer / community engagement occurs through a number of mechanisms:

- The partial funding by the DHB of Rodney and Waitakere Health Links and North Shore Community Health Voice. These groups play an increasing role in sharing of information, providing community/consumer input into service planning and design and co-opted membership of our Community and Public Health Advisory Committee.
- Developing and engaging with local government with reference to social/wellbeing outcomes i.e. Waitakere Collaboration, Community Waitakere, Social Wellbeing (Rodney), North Shore Council of Social Services, Active Communities.
- Local community network meetings eg. Glenfield, COMSUP in Helensville and Massey,
- Collaboration with other government agencies particularly Ministry of Social Development (MSD) including representation on the Community Response Forums

- Regional collaboration with other metro-Auckland DHBs to ensure consistency across the region and to benefit from one another's strengths eg Auckland DHB is looking to develop web-based engagement mechanisms.
- The Community Engagement Forum, whose membership includes the Healthlinks/Voice, provider arm general managers, and priority group (eg Māori, disability etc) representation from within the DHB.
- Awhina health campus creates increased opportunities for engagement with students, trainees, staff and community networks associated with education, research, community development and innovation
- Local boards are also providing another opportunity to develop engagement with our communities.

## Building capability

### Regional Collaboration

Regionalisation through collaboration is one of our priorities for 2011/12. We will collaborate with the other northern region DHBs to achieve the goals in the Northern Region Health Plan, simultaneously delivering population health, quality of patient experience and considering the cost dimension.

Through healthAlliance 'back-office' functions, workforce development and information technology will be regionalised. This includes common regional processes, data structures, work flows and reporting to enable clinicians to access patient information and work regionally.

***Regional Workforce and Human Resource Joint Activity and Initiatives***

In 2011/12 the four DHBs in the northern region will strengthen and build on the cooperative and collaborative activity already undertaken across a range of human resource functions over past years. This work provides an enabling platform on which to progress regional activity in line with health policy and ministerial expectation of greater collaboration and sharing of resources across support services. The establishment of the shared services Health Benefits Ltd at a national level and healthAlliance including all four northern region DHB's locally provides the organisational mechanisms for the formalisation of ongoing planning and implementation of shared strategies and projects within the greater human resources field.

A key objective is for the northern region DHBs to have common systems and organisational structures that enable them to better plan for and manage the human resources issues across the spectrum of the employment relationship of our large and diverse workforces. The northern region DHBs HRMS Strategy 2009-2013 is developed, but will be reviewed in line with any national strategic directions. The achievement of this document and agreement confirms the existence of significant regional competency and commitment.

It is critical that our talent is retained within the sector so that service delivery goals can be achieved. There is an established Regional Recruitment Managers group whose strategic objective is:" Regional collaboration resulting in industry leading talent acquisition and retention". National strategy in the area of employment relations will drive the regional employment relations activity in the coming year. Employment relations experts from within

the region will continue to contribute to national employment relations at strategic and operational levels.
The Auckland region DHBs own and operate a shared services organisation which facilitates RMO Administration across the region. The RMOs access training opportunities regionally and are allocated into appropriate training runs under the direction of professional College aligned Vocational Training Committees. Nationally the organisation's focus for 2011/12 is to work closely with Health Workforce NZ on the implementation of regional training hubs which would see close formal ties with Northland DHB developed, compulsory career plans and otherwise implementing the recommendations of the RMO Commission for a seamless training experience regardless of employer. Regionally the organisation is focused on ensuring DHB demand for RMO positions is aligned with the ability of the Universities to supply RMOs, holding vacancy rates within a range of 2.5-7.5% increasing RMO retention rates and ensuring improved RMO access to medical education and annual leave.

The Physician Assistant role was piloted at Counties Manukau DHB during 2010/11 and the objective for the 2011/12 year is to further expand the trial to other services within the region. The development of the Centre for Research and Innovation (Ko Awatea) at Counties Manukau DHB and the Health Campus at Waitemata DHB will enhance the learning opportunities provided within DHBs and across the region in technical and clinical training, leadership and management development and professional development. Work is ongoing to get recruitment, learning, education and workforce plans regionally aligned.

Health Workforce New Zealand (HWNZ) funds a number of initiatives that focus on:

- Training for post-graduate nurses
- Resident medical officer (RMO) training
- Community based health worker Hauora Maori training and associated costs

***Regional Information Systems Priorities***

The Northern Region Information Systems Implementation Plan (NRISIP) outlines the programme of work required to achieve the strategic objectives of the National IT Plan 2010 and the Regional Information Strategy 2010 -2020 for the next 3 to 5 years. Due to challenges around resourcing, complexity and governance the programme may need to be spread over a longer timeframe.

As agreed by the regional chief medical officers, the main clinical driver is to improve the continuity of care for patients in our region across the continuum of services through providing consistent and reliable access to core clinical documents and facts for all clinicians involved in a patient's care. This is fundamental to the northern region's ability to deliver on the whole of system approach to health service delivery which is being embedded throughout the northern region health plan.

A significant technical driver is the need to ensure that basic aspects of information systems development and functioning are both resilient and comparable across the four DHBs. This will provide a platform from which all can continue to develop regional information systems (IS) in a coordinated fashion. A key business driver is the need to replace Northland's legacy systems, as identified in the Readiness Assessment produced by the National Information Technology (IT) Board. It will likely be necessary to delay progress on some projects in some, if not all, DHBs during the period of catch-up required to establish a more uniform regional platform.

Two key processes will require active, strong leadership by senior management:

1. The development of regionally agreed and consistent business and clinical processes, which the regional technical information systems will underpin and enable.
2. The reprioritisation required within each DHB to match IS developments to available resources and to ensure that the order in which projects are undertaken takes account of crucial interdependencies and the need for regional consistency.

The Minister of Health's letter of expectations requires regional plans which focus on a small number of high priorities and regionalisation of IT platforms and IT support. The 16 February 2011 letter to DHB CEOs from the Chair of the DHB Information Group and from the Director of the National Health IT Board states that each DHB will need to significantly reduce the number of local health IT projects and focus on regional clinical projects. Furthermore, replacing legacy applications must be a priority so that each region has a common and standard regional IT platform. In this context the chief information officers and chief medical officers have identified a shortlist of key foundation projects which need to be planned, funded and implemented regionally.

*Other priorities*
Regional project teams will be established over the next few months to plan these programmes of work and project the necessary funding for the coming years. These programmes of work should be the key focus for regional investment and activity and should be "protected" in local DHB capital and operational expenditure prioritisation processes.

Some investment will also be possible and required in other regional projects that underpin the delivery of key clinical priorities in the short to medium term. Other regional priorities that have been identified include:

- E referrals Phase 2
- E discharges implemented to national standards
- E medicines including e medicines reconciliation, community and hospital e prescribing
- Shared Care Plan Phase 2
- E rostering
- establishment of the northern regional shared service organisation (NRSSO) including network integration, single sign-on and single service desk
- shared financial management systems
- IS support for Better Sooner More Convenient business case workstreams

## Waitemata DHB/Auckland DHB

We are working with Auckland DHB to progress opportunities for joint service planning and delivery across our two organisations. This is assisted by our shared chair and Māori board members. The recent merging of the Primary Care Planning and Funding Team across the two DHBs will see increasing consistency of relationships and primary care management across the two DHBs. This will include the participation of the Waitemata DHB PHOs in the Auckland DHB District PHO Alliance. We will look to integrate further services where service quality or costs can be improved by doing so.

## Building Capability within Waitemata DHB

***Asset Management***

We developed an Asset Management Plan (AMP) in 2005 which was updated in September 2009. 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. In addition, the AMP reflects the future strategic capital intentions of the DHB, outlining the key facility development projects required to ensure the DHB continues to meet the future demand for health services (as articulated in the Clinical Services Plan (CSP)). As such, the AMP provides a linkage and/or supports various key Waitemata DHB planning and operational work streams such as CSP, facilities and site master planning, capital budgeting and operational budgeting.

***Facilities Modernisation***

We aim to modernise outdated and inadequate facilities in line with the strategic objective of providing high quality and productive health services. Over the past twelve months we have delivered the following projects as outlined in the DAP 2010/11:

- new ward 2 at North Shore hospital for medical patients
- Waitakere hospital emergency care centre 24/7 project
- Waitakere hospital Rangitira paediatric short stay unit
- North Shore hospital ward 10 refurbishment
- North Shore hospital senior medical officer lounge
- Operating theatre refurbishment
- Oral health clinics in Henderson, Edmonton and Glenfield.

Over the next 12 month (2011/12) period we anticipate delivering the following projects:

- North Shore hospital car parking building
- Renal office suite and dialysis unit – operational by July 2011
- Stage 1 Health Campus for education, training and research
- North Shore hospital Lakeview Extension incorporating a state of the art emergency department
- North Shore hospital cardiology services including a coronary care unit, step-down unit, cardiology ward and cardiac catheterisation laboratories as part of the Lakeview build
- North Shore hospital phased theatre refurbishment – dependent on elective surgical unit establishment
- continuing the new oral community health clinics
- Rangitira ward refurbishment
- Refurbishment of ward 3 at North Shore hospital.

We are also actively pursuing the following projects as we move towards 2012/13:

- North Shore hospital elective surgical unit
- North Shore hospital new Taharoto mental health facility.

*Sustainability*

The Waitemata District Health Board is leading the way across District Health Boards in New Zealand in addressing the issue of sustainability with the appointment of a full time sustainability officer. The purpose of this 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 New Zealand government are keen to ensure that all government departments address sustainability and where possible utilise a more holistic and sustainable approach to business as demonstrated by the government initiative The Carbon Neutral Public service programme which paved the way for schemes such as The Carbon Emissions Trading Scheme.

The global impacts of climate change are already becoming evident and further changes are inevitable, this will mean that human health is and will increasingly be affected. Therefore, as conscientious health care practitioners we have a duty to ensure that our services are developed and delivered in a sustainable way.

The World Health Organisation published a paper in 2009 entitled 'Healthy hospitals Healthy Planet Healthy People', addressing climate change in health care settings, within which it was discussed that the health sector can and should play a leading role in mitigating the effects of climate change by firstly 'getting our own house in order' and secondly by creating 'a series of health economic and social co-benefits that improve the health of the population'.

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

*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 2011/12.

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 Rugby World Cup requires special emergency planning consideration in 2011/12. This event has a particular impact on Auckland DHB, but Waitemata DHB will ensure that its incident management plans are fully aligned with Auckland DHB so that we are able to participate in a co-ordinated response throughout the Rugby World Cup. Activities to be undertaken in preparation for the RWC include:

- Ensure staffing capacity to cope with demands
- Focus on liquor licensing issues
- Ensure preparedness for a potential increase in food-borne illness
- Planning for the impact increased visitors may have on primary care

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.

## Legislative Requirements

We will provide the Ministry 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.

### 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 new Awhina health campus we expect to create new MoUs with a number of partners, focusing on creating umbrella Board level agreements centred on goals and opportunities that are of mutual interest. These will 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 8: FINANCIAL PERFORMANCE

## Financial performance

Our financial goal is to improve health outcomes and reduce inequalities while living within our means. That is to deliver health services to our population in line with legislative requirements, Ministerial expectations and within the funding available to our DHB.

This will be achieved through:

- Fostering a culture of financial accountability and discipline throughout the organisation to ensure we live within our means.
- Carefully planning and implementing affordable capital developments that enable us to maintain appropriate infrastructure to meet the health service delivery requirements for our population;
- Continued focus on implementing smarter ways of delivering quality health services more efficiently, more cost effectively and reducing any waste; and
- Continued participation in and implementation of regional and national value for money initiatives including establishment of a shared services organisation for the Northern Region DHBs.

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

- We are forecasting a surplus of $1.6M for the 2010/11 year, against a planned breakeven result. This positive result reflects containment of cost growth, aided by the successful implementation of a Business Transformation Initiative that is expected to generate savings in excess of $40M by the end of 2010/11. The surplus is planned to be spent on capital expenditure in 2011/12, as such, is not a cyclical surplus to be offset by a deficit in future years. Potential risks to the forecast result include the impact of the final Inter District Flow wash-ups and the impact of a severe early winter season if this occurs in the last quarter of the year. We will proactively manage identified risks to meet the forecast financial result.

- We are also planning a breakeven result for 2011/12 and the out-years. Breakeven is planned for all of our business divisions (Provider arm, Governance & Funding Administration and Funding arm). Key assumptions for the 2011/12 financial plans are outlined later in this section. This plan was developed from a combined 'bottom-up, top down' budgeting process to ensure development of realistic financial plans that reflect the level of planned services and activities and to ensure accountability is retained from the responsibility centre through to service group level and organisational level.

Underpinning the financial plans is a comprehensive Business Transformation Programme also discussed later in this section.

## Forecast Financial Statements

The tables below provide a summary of the consolidated financial statements for the audited result for 2009/10, year end forecasts for 2010/11 and plans for 2011/12 to 2013/14.

### Statement of Comprehensive Income

| | 2009/10 Audited $000 | 2010/11 Forecast $000 | 2011/12 Plan $000 | 2012/13 Plan $000 | 2013/14 Plan $000 |
|---|---|---|---|---|---|
| Government and Crown Agency Revenue | 1,165,146 | 1,214,357 | 1,262,837 | 1,301,795 | 1,341,955 |
| Patient Sourced and Other Income | 20,395 | 20,988 | 26,272 | 27,084 | 27,919 |
| IDFs & Inter DHB Provider Income | 75,470 | 78,741 | 77,731 | 80,429 | 83,220 |
| **Total Funding** | **1,261,011** | **1,314,086** | **1,366,840** | **1,409,308** | **1,453,094** |
| Personnel Costs | 434,816 | 446,874 | 467,217 | 481,631 | 496,485 |
| Outsourced Costs | 47,967 | 45,364 | 37,734 | 38,900 | 40,098 |
| Clinical Supplies Costs | 73,678 | 74,544 | 83,455 | 86,027 | 88,681 |
| Infrastructure & Non-Clinical supplies Costs | 99,050 | 99,982 | 104,997 | 108,252 | 111,611 |
| Payments to Other Providers | 614,191 | 645,686 | 673,437 | 694,498 | 716,219 |
| **Total Expenditure** | **1,269,702** | **1,312,450** | **1,366,840** | **1,409,308** | **1,453,094** |
| **Net Surplus / (Deficit)** | **(8,691)** | **1,636** | **0** | **0** | **0** |
| **Other Comprehensive Income** | | | | | |
| **Gains/(Losses) on Property Revaluations** | (12,200) | 0 | 0 | 0 | 0 |
| **Gains/(Losses) in Foreign Currency Translation Reserve** | 0 | 0 | 0 | 0 | 0 |
| Gains/(Losses) in Cashflow Hedge Reserve | 0 | 0 | 0 | 0 | 0 |
| Gains/(Losses) in Asset for Sale Financial Assets Reserve | 0 | 0 | 0 | 0 | 0 |
| **TOTAL COMPREHENSIVE INCOME** | **(20,891)** | **1,636** | **0** | **0** | **0** |

Strong financial performance is demonstrated in the financial plans. Our financial planning continues on the premise of a non-negotiable requirement to achieve breakeven results for 2011/12 and ongoing.

While containing costs is a challenge for us given high demographic growth, the impact of the ageing population and continuing cost pressures in operational costs, we recognise that our revenue in future years is most likely to grow at a much slower rate than previously experienced. In addition we will be increasing elective volumes in line with the rest of New Zealand. This growth will need to be managed through productivity improvements, process improvements, efficiencies and savings.

The Business Transformation Initiative first implemented in 2010/11, along with the culture of increased financial responsibility, discipline, accountability and governance oversight on

financial performance will all combine to assist in delivering the planned results. Improving productivity, reducing waste, effectively utilising available resources and working smarter are all strategies that will continue to be adopted to ensure the sustainability of our health services and financial performance.

## Statement of Cashflows

| | 2009/10 Audited $000 | 2010/11 Forecast $000 | 2011/12 Plan $000 | 2012/13 Plan $000 | 2013/14 Plan $000 |
|---|---|---|---|---|---|
| Operating Receipts | 1,287,214 | 1,310,170 | 1,364,935 | 1,407,344 | 1,451,069 |
| Operating Payments (-ve) | (1,242,053) | (1,283,484) | (1,330,584) | (1,371,809) | (1,414,317) |
| **Operating Cashflow** | **45,161** | **26,686** | **34,351** | **35,535** | **36,752** |
| Capital Expenditure (-ve) | (33,455) | (77,095) | (63,916) | (20,764) | (19,820) |
| Increase in restricted funds and investments | 2,339 | 3,916 | 1,905 | 1,964 | 2,025 |
| **Investing Cashflow** | **(31,116)** | **(73,179)** | **(62,011)** | **(18,800)** | **(17,795)** |
| Equity Injections | 2,377 | 5,285 | 5,288 | 0 | 0 |
| New debt | 0 | 36,584 | 23,540 | 0 | 0 |
| Other non current liability movements | 0 | 0 | 0 | 0 | 0 |
| Interest paid | (9,843) | (10,171) | (15,611) | (16,093) | (16,589) |
| **Financing Cashflow** | **(7,466)** | **31,698** | **13,217** | **(16,093)** | **(16,589)** |
| Total Cash In | 1,291,930 | 1,355,955 | 1,395,668 | 1,409,308 | 1,453,094 |
| Total Cash Out | (1,285,351) | (1,370,750) | (1,410,111) | (1,408,666) | (1,450,726) |
| **Net cash movements** | 6,579 | (14,795) | (14,443) | 642 | 2,368 |
| plus Cash (opening) | 27,321 | 33,900 | 19,105 | 4,662 | 5,304 |
| **Cash (closing)** | **33,900** | **19,105** | **4,662** | **5,304** | **7,672** |

Cashflow forecasts reflect the impact of capital projects approved by the Minister of Health (such as the Lakeview Extension, Car Park and Oral Health Projects) and other projects approved by the Waitemata DHB Board. The deterioration in closing cash in 2011/12 is due to significant cash contributions by the DHB towards the capital projects, with the DHB meeting 50% of the $141M funding required for capital expenditure for the first two planning years from internally generated cash. Equity injections reflect Crown funding for the Oral Health project.

Waitemata DHB currently has borrowing facilities from the Crown Health Financing Agency (CHFA) of $201.376M, of which $165.796 is drawn. The undrawn facility of $35.58M is for the Lakeview Extension project and drawings against this are expected to start prior to the end of this year. The facilities with the CHFA will increase to $225.92M following an application for a new loan facility of $24.544M for the Car Park project approved by the Minister in March 2011.

## Statement of Financial Position

| | 2009/10 Audited $000 | 2010/11 Forecast $000 | 2011/12 Plan $000 | 2012/13 Plan $000 | 2013/14 Plan $000 |
|---|---|---|---|---|---|
| Current Assets | 63,853 | 56,105 | 41,662 | 41,804 | 44,172 |
| Non current assets | 421,964 | 478,585 | 524,375 | 525,401 | 523,855 |
| Less: Current Liabilities (-ve) | (141,543) | (146,003) | (147,072) | (148,340) | (148,862) |
| Working Capital | (77,690) | (89,898) | (105,410) | (106,536) | (104,690) |
| **Net funds employed** | **344,274** | **388,687** | **418,965** | **418,865** | **419,165** |
| | | | | | |
| Non current liabilities | 183,238 | 220,730 | 245,720 | 245,620 | 245,920 |
| Crown equity | 161,036 | 167,957 | 173,245 | 173,245 | 173,245 |
| **Net funds employed** | **344,274** | **388,687** | **418,965** | **418,865** | **419,165** |

The financial projections show a strong financial position, despite a reduction in the value of land of $12.2M from asset revaluations as at 30 June 2010. The increasing non-current asset base over the years reflects continued investment in DHB facilities and infrastructure to ensure the DHB has adequate and appropriate facilities to continue to meet the health needs of our population. No property disposals are planned for the period.

### 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 Maori sites of significance.

### Statement of Movement in Equity

| | 2009/10 Audited $000 | 2010/11 Forecast $000 | 2011/12 Plan $000 | 2012/13 Plan $000 | 2013/14 Plan $000 |
|---|---|---|---|---|---|
| Total equity at beginning of the period | 179,550 | 161,036 | 167,957 | 173,245 | 173,245 |
| Total Comprehensive Income - DHB Governance & Funding Administration | 1,028 | 0 | 0 | 0 | 0 |
| Total Comprehensive Income - DHB Provider | (30,385) | 1,636 | 0 | 0 | 0 |
| Total Comprehensive Income - DHB Funds | 8,466 | 0 | 0 | 0 | 0 |
| Equity Injections - Capital | 2,377 | 5,285 | 5,288 | 0 | 0 |
| Equity Injections - Deficit Support | 0 | 0 | 0 | 0 | 0 |
| Capital Repaid | 0 | 0 | 0 | 0 | 0 |
| Other Movements | 0 | 0 | 0 | 0 | 0 |
| Movement in Trust and Special Funds | 0 | 0 | 0 | 0 | 0 |
| **Total Equity at end of the period** | **161,036** | **167,957** | **173,245** | **173,245** | **173,245** |

Asset revaluations as at 30 June 2010 resulted in a $12.2M reduction in land values. This, together with a deficit generated in 2009/10 contributed to the reduction in the equity closing position in 2009/10. Equity injections for the Oral Health project and a surplus forecast for 2009/10 improve the equity position.

## Significant Assumptions

### Revenue Growth

Growth in Population Based Funding Formula (PBFF) revenue for 2011/12 is based on the National Health Board funding envelope advice, with an increase of $42.757M or 3.8 per cent over 2010/11 funding envelope. This is comprised of a 1.72 per cent increase to fund cost pressures and 2.08 per cent for demographic growth.

For the out-years, we have assumed that funding increase would be of the same nominal value as that signalled for 2011/12 as advised by the National Health Board.

Other revenue is based on contractual arrangements in place and reasonable estimates for other income.

Overall funding increase over 2010/11 forecast is $52.754M as summarised in the table below:

| | $'000s | Comment |
|---|---|---|
| Government and Crown Agency Revenue | **47,470** | Reflects PBFF Funding envelope increases, increases for direct contracts with the Ministry of Health, Funding from the Health Workforce NZ for CTA and ACC contracts. |
| Patient Sourced and Other Income | 5,284 | Patient sourced income, including Non-Residents income from ineligible patients, interest income and other income. |
| **Total Revenue Increase** | **52,754** | |

## Expenditure Growth and Other Drivers for Expenditure Growth

Expenditure is budgeted to increase by $54.390M above the 2010/11 forecast level and this expenditure growth is driven by demographic growth in current services provided by the DHB, demographic growth impacting on demand driven third party contracts, clinical staff growth to meet service growth requirements, costs for settled employment contracts (including automatic wage creep), cost of capital for facilities developments and inflationary pressure on supplies and services.

*Key assumptions used in forecasting expenditure include:*

- Planned personnel costs include the impact of all settled employment agreements, automatic step increases and impact of new FTEs. Financial plans also include risk provisions for employment contracts that have expired and have not yet been settled as well as employment agreements that will expire during the planning period.
- The clinical supplies cost growth is based on actual known inflation factors in contracts, estimation of price and exchange rate impacts on supplies with advice from procurement and adjustments for known specific information within services. Costs also reflect the impact of service growth.
- Demand driven funder expenditure is based on appropriate demographic growth analysis and historical expenditure trends, in line with available funding. Funder budgets also take into consideration the Minister of Health's expectations in regard to budgeting for pharmaceuticals, primary care and age related residential care.
- The ongoing implementation of Better Sooner More Convenient strategies and initiatives (as outlined in this Annual Plan and as approved in the Northern Region Health Plan for commencing in 2011/12) is resourced at 2010/11 spend plus growth in line with funding envelope expectations.

Apart from cost pressures from employment contract settlements and inflationary factor on consumables and infrastructure costs, the other key driver for expenditure growth for Waitemata DHB is its demographic growth and ageing population. Based on the 2006 Census, Waitemata DHB has the second fastest growing population in New Zealand, which is not expected to change for the three years of this plan. Every five years our population grows by over 50,000 people. 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 out-year expenditure assumptions include consideration of the projected demographic growth described above, existing service expansions, agreed service transfers, personnel cost growth, price increases and supply cost considerations.

**Business Transformation**

As part of the annual planning cycle, robust processes were used to estimate the financial implications of delivering services planned by the DHB and the capital and operating resources required to deliver the services. Following a thorough assessment of budgets, challenging these budgets and identification of budget improvements at responsibility centre level throughout the organisation, a funding gap of $22.348M still remained. To bridge this gap, the DHB considered savings instead of service reductions.

On the back of a successful Business Transformation Programme implemented in 2010/11 (with the DHB expecting to achieve more than $40M of the $42M planned savings), the DHB has continued to progress the identification of savings to close the new $22M funding gap for 2011/12. Improvements to the Business Transformation Programme framework have also been made to enhance the process of identifying new opportunities and enhancing existing ones. A more structured governance approach is now in place with a Steering Group overseeing the savings work streams and ongoing identification and communication processes as well as reporting to the Waitemata DHB Executive Leadership, the Board (and Committees) and the National Health Board.

The key sources for the $22.348M savings required for 2011/12 are summarised below:

- Reduced personnel costs arising from efficiencies and productivity improvements from staff skill mix reviews, multi skilling of staff, staff utilisation reviews, rationalisation of surgical house officers and reconfiguring management and administration.
- Savings from surgical services arising from improved productivity and efficiencies in delivering additional Electives for 2011/12.
- Reduced Operating Theatre Consumables and ward consumables.
- Improvements in Community Radiology Services, Outpatient services reviews, and reduction of ICU/HDU beds
- Savings from contract/ service reviews including in-house cleaning, orderly service reviews, ESBL screening reviews and laboratory service reviews
- Mental Health savings arising from optimising workforce capability and capacity (Nursing and Allied Health), utilisation of technologies to improve efficiency (e.g. use of Video Conferencing in Forensic Services) and acuity levels budget reviews.
- Contract reviews across the DHB business including vendor contracts and Funder contracts.

The Business Transformation is not just a savings programme to meet annual financial planning requirements. Rather, it is a means for reviewing the business as a whole in order to deliver long term sustainable transformation to reduce costs without compromising service delivery and caring for patients. The organisation is looking hard for sustainable opportunities that will assist the organisation as a whole in reducing waste, improving productivity, increasing efficiency and optimising the use of limited resources so that we can truly “live within our means” not only in 2011/12 but beyond.

Clinical Value Pathway reviews will be undertaken to identify sustainable savings. O date, the Business Transformation Steering Group have identified a number of loss-making services in comparison with National Pricing Program. In order to better understand the cost pressures

of these loss-making services, the Steering Group has commenced a Clinical Value Pathways review process. The main aim of this work is to improve the efficiency and productivity of services and better alignment with the National Pricing Program.
The Steering Group recognises this work will take time and therefore do not expect savings for 2011/12 and is intended to be a long-term strategy to improve efficiency and productivity across the organisation. Work has now commenced in Cardiology, Orthopaedics and Chronic obstructive pulmonary disease in the first phase of review.

**Inter-District Flows and Service Changes**

Service changes for InterDistrict Flows are per the national Health Board IDF Funding advice and any agreements with relevant DHBs. Key service changes are discussed below.

The next step in the Phase 1 Renal Service transfer from Auckland occurs in July 2011 with increased local dialysis services being provided at North Shore Hospital. The 2011/12 funding envelope includes reduced levels of inter district flow revenue at Auckland DHB associated with service transfers to Waitemata DHB that were commenced in 2010/11. These changes include renal, chronic pain and emergency department services.

Recent changes to primary care contracting arrangements in the Auckland region impact on inter-district flow arrangements currently reflected in the funding envelope. Specifically, an adjustment in inter-district flows between Waitemata DHB and Auckland DHB is needed with the transfer of specific contract management responsibilities.

The following table summarises the inter-district flow changes to the funding envelope that need to be implemented in 2011/12 associated with this change. All other inter-district flows are based on the agreed levels reflected in the 2011/12 funding envelope.

| | **Current** inter-district flows **2011/12** | **Revised** inter-district flows **2011/12** | **Change 2011/12** |
|---|---|---|---|
| Inflow (ADHB to WDHB) | $ 36,464,339 | $ 36,182,662 | ($281,677) |
| Outflow (WDHB to ADHB) | $264,451,862 | $ 281,960,162 | $17,508,300 |

We will also undertake a detailed review of specific services to identify opportunities for improved access, quality and cost savings. We will:

- Prioritise inter-district flow expenditure on improving access to DHB assessment and treatment services and reducing routine follow-up
- Audit and monitor referral management protocols at other DHBs to ensure that patients are being accepted in accordance with agreed guidelines
- Review the cost of services for defined patient groups, identify opportunities for cost reduction and implement required changes
- Review automatic wash up provision for non priority elective services
- Progress agreement to implement marginal pricing for volumes provided in addition to the contracted volume.

## Additional Information

### Provider Arm Financial Performance

| | 2009/10 Audited $000 | 2010/11 Forecast $000 | 2011/12 Plan $000 | 2012/13 Plan $000 | 2013/14 Plan $000 |
|---|---|---|---|---|---|
| **Income** | | | | | |
| MoH via Funder | 560,788 | 578,312 | 605,726 | 624,413 | 643,676 |
| MoH Direct | 37,630 | 47,303 | 38,080 | 39,254 | 40,465 |
| Other | 30,457 | 31,738 | 40,359 | 41,620 | 42,918 |
| **Total Income** | **628,875** | **657,353** | **684,165** | **705,287** | **727,059** |
| **Expenditure** | | | | | |
| Personnel | 429,882 | 440,511 | 461,847 | 476,096 | 490,780 |
| Outsourced services | 45,893 | 43,284 | 35,391 | 36,484 | 37,608 |
| Clinical supplies | 73,678 | 74,544 | 83,455 | 86,027 | 88,681 |
| Infrastructure & non clinical supplies | 97,262 | 97,378 | 103,472 | 106,680 | 109,990 |
| Allocations | 345 | 0 | 0 | 0 | 0 |
| **Total expenditure** | **647,060** | **655,717** | **684,165** | **705,287** | **727,059** |
| **Surplus / (Deficit)** | **(18,185)** | **1,636** | **0** | **0** | **0** |

The Provider arm year end forecast is a surplus of $1.6M. This is a remarkable result given the Provider arm is emerging from an era of deficits which have been mainly driven by cost growth greater than revenue growth. Key drivers for Provider arm operating and capital cost pressures include:

- Significant service changes from the transfer of services from other DHBs, mainly orthopaedics, paediatric, hands, cardiac and other services; increase in elective surgery, mental health, oral health services and acute demand growth
- High salary increases from the advent of MECAs have contributed to significant salary and wages growth mainly in the Provider arm
- Significant investment in capital to replace, refurbish and expand existing facilities and infrastructure
- Revaluation of existing assets.

The Provider financial performance improvement reflects significant savings planned and expected to be achieved for 2010/11. The Provider arm is expected to contribute $33M of the $42M savings in the 2010/11 DAP. Most of the planned savings will be generated by year end and offsetting savings have been identified where some of the planned savings are not achievable resulting in an overall forecast surplus position. The plan is to apply the surplus to capital expenditure in 2011/12 to address some of the historical legacy of deferred Capex.

Moving forward, cost pressures are expected to continue in the Provider arm as revenue growth is now slower than previously experienced, while cost growth is not abating. For 2011/12 and for the first time for Waitemata DHB, the Provider arm has a negative funding

adjuster of $6.5M from the internal funding received from the Funder. This adjuster means that the Provider arm is expected to deliver additional volumes at discounted national prices. This partly contributes to the funding gap of $22m previously discussed, for which savings and productivity improvements are required to address the gap. The DHB Production Plan provided as part of this DAP planning package illustrates all the service volumes expected and planned to be delivered by the Provider.

### Governance and Funding Administration Arm Financial Performance

| | 2009/10 Audited $000 | 2010/11 Forecast $000 | 2011/12 Plan $000 | 2012/13 Plan $000 | 2013/14 Plan $000 |
|---|---|---|---|---|---|
| Revenue | 9,479 | 11,047 | 9,238 | 9,523 | 9,816 |
| Expenditure | 8,451 | 11,047 | 9,238 | 9,523 | 9,816 |
| **Surplus/(Deficit)** | **1,028** | **0** | **0** | **0** | **0** |

The year end forecast result for the Governance and Funding Administration arm is in line with the 2010/11 DAP and breakeven is planned for the three year planning period.

The reduction in both revenue and costs from 2010/11 to 2011/12 mainly reflects transfers of staff and services to the Provider arm, mainly the following responsibility centres: Clinical library; Knowledge Centre; Clinical Research, Nursing development and Medical Education Unit which are all part of the Health Campus services.

### Funding Arm Financial Performance

| | 2009/10 Audited $000 | 2010/11 Forecast $000 | 2011/12 Plan $000 | 2012/13 Plan $000 | 2013/14 Plan $000 |
|---|---|---|---|---|---|
| Revenue | 1,192,408 | 1,234,771 | 1,288,169 | 1,328,195 | 1,369,465 |
| Expenditure | | | | | |
| Personal Health | 850,673 | 885,666 | 944,279 | 973,645 | 1,003,926 |
| Mental Health | 195,042 | 201,771 | 195,714 | 201,802 | 208,080 |
| DSS | 123,962 | 131,899 | 134,639 | 138,793 | 143,074 |
| Public Health | 3,209 | 2,616 | 2,502 | 2,579 | 2,659 |
| Maori Health | 2,093 | 2,046 | 2,029 | 2,092 | 2,156 |
| Governance | 8,963 | 10,773 | 9,006 | 9,284 | 9,570 |
| Total Expenditure | 1,183,942 | 1,234,771 | 1,288,169 | 1,328,195 | 1,369,465 |
| **Surplus/(Deficit)** | 8,466 | 0 | 0 | 0 | 0 |

The year end forecast result for the Funding Arm is in line with the 2010/11 DAP and breakeven is planned for the three year planning period.

Funder 2011/12 expenditure plan increases by 4.3 per cent over the forecast for 2010/11 after incorporating savings targets for the funder. The Production Plan for the Funding arm is included in the overall DHB 2011/12 Production Plan, showing the services purchased by the Funder from the DHB internal Provider, NGOs and IDFs.

The financial performance of the Funder in relation to NGO Third Party Providers is summarised in the table below:

## Funder Non Government Organisations

| | 2010/11 Forecast $000 | 2011/12 Plan $000 |
|---|---|---|
| Revenue | 352,632 | 358,203 |
| Expenditure | | |
| Personal Health | 216,062 | 218,982 |
| Mental Health | 30,352 | 31,212 |
| DSS | 96,825 | 104,699 |
| Public Health | 2,180 | 1,280 |
| Maori Health | 2,013 | 2,030 |
| Total Expenditure | 347,432 | 358,203 |
| **Surplus / (Deficit)** | **5,200** | **0** |

The favourable forecast within Funder NGO for 2010/11 in part reflects one off and sustainable savings resulting from the early adoption by the Funder of a formal value for money evaluation process and the focus on savings initiatives across the services for which the Funder is directly responsible. This favourable forecast is expected to be offset by an unfavourable 2010/11 year end forecast in Funder IDF. The adverse IDF position is mostly a consequence of the increase in acute medical and surgical inpatient case weighted volume (WIES) being delivered at Auckland hospitals for Waitemata domiciled patients.

Both the 2010/11 forecast and 2011/12 plan incorporate the effect of recent changes to primary care contracting arrangements within the Auckland region and the resulting shift in revenue and expenditure between Primary Care services and Inter District Flow services. Similar financial realignments are expected to continue into 2011/12 in response to ongoing membership changes between Primary Healthcare Organisations (each change in PHO membership in 2011/12 will have an IDF consequence).

The Funder NGO Plan for 2011/12 reflects the funding and pricing expectations advised in the 2011/12 Funding Envelope as well as demand related expenditure forecasts. Demand growth is modelled on current and historical utilisation trends together with expected demographic projections.

The price component of expenditure growth in the Funder 2011/12 plan has been maintained to a minimum with only Age Related Residential Care services and First Contact Patient Care services receiving a mandatory price increase. These are in line with the Minister's pricing expectations expressed in the Funding Envelope. There is also a national decision by District Health Boards for the Combined Dental Agreement to receive a price related adjustor.

The more significant cause of NGO expenditure growth relates to the additional investment in Community Pharmacy services and reflects the Governments commitment to increased spending on community pharmaceuticals as well as the resulting increase in the dispensing fee component. Similarly, budgeted NGO expenditure also includes volume growth expected from increased utilisation of services contracted under other national and local service agreements. These include Health of Older Persons services, Primary Care services and Oral Health services.

The impact of the Funder value for money process is included in the Funder 2011/12 Plan and partly funds essential demand expenditure growth. The Funder value for money process will continue throughout 2011/12 and will include the systematic review of all service agreements in order to achieve the best health outcomes possible for the funding available.

## Capital Expenditure

| | 2009/10 Audited $000 | 2010/11 Forecast $000 | 2011/12 Plan $000 | 2012/13 Plan $000 | 2013/14 Plan $000 |
|---|---|---|---|---|---|
| **Funding Sources:** | | | | | |
| Free cashflow from depreciation | 22,814 | 22,795 | 24,645 | 25,406 | 26,188 |
| External Funding | 2,377 | 41,869 | 28,828 | 0 | 0 |
| Cash reserves | 8,264 | 12,431 | 10,443 | (4,642) | (6,368) |
| **Total Funding** | 33,455 | 77,095 | 63,916 | 20,764 | 19,820 |
| **Baseline Capital Expenditure** | | | | | |
| Land | 0 | 0 | 0 | 0 | 0 |
| Buildings & Plant | 1,429 | 6,400 | 14,856 | 7,000 | 8,000 |
| Clinical Equipment | 4,878 | 4,010 | 8,400 | 6,200 | 7,000 |
| Other Equipment | 323 | 180 | 204 | 200 | 200 |
| Information Technology | 3,330 | 3,280 | 2,424 | 2,000 | 2,200 |
| Intangible Assets (Software) | (752) | 1,030 | 2,496 | 2,000 | 2,300 |
| Motor Vehicles | 3,460 | 0 | 96 | 100 | 120 |
| **Total Baseline Capital Expenditure** | **12,668** | **14,900** | **28,476** | **17,500** | **19,820** |
| **Strategic Investments** | | | | | |
| Land | 0 | 0 | 0 | 0 | 0 |
| Buildings & Plant | 19,675 | 60,651 | 29,729 | 3,141 | 0 |
| Clinical Equipment | 0 | 0 | 0 | 0 | 0 |
| Other Equipment | 0 | 0 | 5,406 | 94 | 0 |
| Information Technology | 0 | 0 | 0 | 0 | 0 |
| Intangible Assets (Software) | 1,112 | 1,544 | 305 | 29 | 0 |
| **Total Strategic Capital Expenditure** | **20,787** | **62,195** | **35,440** | **3,264** | **0** |
| **Total Capital Payments** | **33,455** | **77,095** | **63,916** | **20,764** | **19,820** |

Major projects included in the strategic capital are:

- Lakeview Extension ($45.174M Crown and DHB funded), to be completed by November 2011.
- Lakeview First Floor Cardiology Services ($8.5M funded by $7.3M DHB cash and $1.2M leasing) to be completed by January 2012.
- Car Park ($24.544M, Crown debt funded) to be completed by October 2011 to enable the Lakeview Extension to be fully commissioned.
- Oral Health ($13.787M, Crown and DHB funded) to be completed in the 2011/12 year.
- Renal Business Case ($8.085M DHB funded) to be completed in 2011/12.

In addition, two business cases have been completed for the Elective Surgery Unit ($39.4M) and the redevelopment of Taharoto Mental Health Unit ($29.975M). These are with the Ministry of Health for consideration.

## Other measures and standards necessary to assess DHB Performance

### Full Time Equivalent (FTEs) Staff Levels

Full time equivalent staff numbers will grow by 238.7 FTEs (4.4 per cent) over 2010/11 budget levels as summarised below.

| Staff Category | **2010/11 Budget** | **2011/12 Budget** | **Variance (FTE)** | **Variance (%)** |
|---|---|---|---|---|
| Medical | 802.2 | 815.2 | 13.0 | 1.6% |
| Nursing | 2,337.4 | 2,394.3 | 56.9 | 2.4% |
| Allied Health | 1,379.9 | 1,416.1 | 36.2 | 2.6% |
| Support | 131.0 | 246.6 | 115.6 | 88.3% |
| Management & Administration | 828.0 | 845.0 | 17.0 | 2.1% |
| **Total** | **5,478.5** | **5,717.3** | **238.7** | **4.4%** |

FTE changes from 2010/11 to 2011/12 budget are primarily attributed to service transfers, demographic service growth, bringing in-house cleaning and surgical services, externally funded contracts and other changes as summarised in the table below:

| **Reason for FTE movement** | **FTE Change** |
|---|---|
| Renal Service change (Transfer of Renal Services from Auckland DHB to Waitemata DHB) | 32.9 |
| Oral Health Service growth (Service growth per year two of the Oral Health Business case) | 33.8 |
| Waitakere ECC 24/7 (Expansion of Emergency Department Services at Waitakere Hospital to enable adult services to be provided 24/7) | 9.9 |
| Lakeview ED/ADU Expansion (service expansion per Lakeview business case) | 62.4 |
| Elective Services growth (Increase in elective surgical services as per MoH revenue advice, including one FTE for Elective Surgery Unit) | 12.3 |
| Lakeview Extension First Floor Cardiology Services (Lakeview Extension Business Case scope change reflecting fit-out of first floor for Cardiology services) | 9.7 |

| Reason for FTE movement | FTE Change |
|---|---|
| Externally Funded contracts (including 2nd Breast Screening Mobile Unit, New HPV Contract, increase in 2010/11 Mental Health Blue Print Funding, additional revenue and service contract for MEDHOPS - MoH Gastro, Massey University, Abbotts and InterRai Projects) | 19.6 |
| CT Scanner | 5.4 |
| Rangitira Expansion (additional paediatric medical services) | 5.4 |
| Car Park (Car park business case with 4 FTEs starting October 2011, which will be 3 FTEs in for the 2011/12 full year view) | 3.0 |
| Additional Beds (Titirangi bed expansion to support the expansion of surgical services at Waitakere Hospital) | 6.0 |
| WDHB Service Changes (In-house Cleaning, Surgical In-sourcing and IS business case) | 120.5 |
| Health of Older People Service development | 8.0 |
| Funder externally funded contracted FTEs not to be counted as part of the Management & Admin cap (per MoH advice). | 2.0 |
| Transfers from hA for electronic rostering and timesheet project. | 2.0 |
| Net reductions from budget improvements/changes and efficiencies | (94.1) |
| **Net FTE Changes** | **238.7** |

The Management and Administration cap set for Waitemata DHB and its subsidiaries by the Minister of Health is 1,009 FTEs. The DHB has managed to maintain FTEs within the cap despite significant service changes arising from service transfers from Auckland DHB, new services including externally funded contracts and demographic growth.

The table below summarises the Management and Administration FTE cap and the plan against that for 2011/12:

| | 2010/11 Cap | 2011/12 Cap | 2011/12 Plan | Variance |
|---|---|---|---|---|
| FTES Established (including vacancies) | 828 | 845 | 847 | (2) |
| + Contractors | 35 | 20 | 20 | |
| + Subsidiaries | 159 | 144 | 144 | |
| **TOTAL** | **1,009** | **1,009** | **1,011** | (2) |

The 2011/12 cap is still as set by the Minister at 1,009, although reflecting movements within categories, with a planned reduction in use of contracted FTEs, transfer of two FTEs from subsidiary and more established FTEs. However, the planned management and administration FTEs are two FTEs outside the cap for 2011/12. The Ministry of Health advised that two FTEs for an MoH funded “Change Management Programme” for Maori services (which is not an ongoing Business as Usual requirement) are not to be counted as part of the management and admin cap.

## Banking Facilities and Covenants

**Term Debt Facilities:**
Waitemata DHB has term debt facilities of $201.376M with the Crown Health Financing Agency, of which $165.796M is currently drawn and $35.58M is undrawn as shown in the table below:

| Loan Facility Schedule | Loan Reference | Principal Amount | Loan Value Date | Loan Maturity Date | Interest Rate | Interest Rate basis |
|---|---|---|---|---|---|---|
| WT001 | 58938 | $22,154,000 | 30-Jun-08 | 15-Dec-17 | 6.52% | Fixed |
| | 51307 | $72,000,000 | 29-Jun-07 | 15-Apr-15 | 6.79% | Fixed |
| | 51309 | $10,000,000 | 29-Jun-07 | 15-Apr-15 | 6.79% | Fixed |
| | 51308 | $15,000,000 | 29-Jun-07 | 30-Jun-14 | 7.04% | Fixed |
| | 75840 | $15,000,000 | 29-Jul-10 | 15-Apr-13 | 4.46% | Fixed |
| | 75841 | $9,846,000 | 29-Jul-10 | 15-Apr-13 | 4.46% | Fixed |
| WT002 | 53669 | $1,542,000 | 04-Oct-07 | 15-Apr-15 | 6.55% | Fixed |
| | 67984 | $8,100,000 | 29-Jun-09 | 15-Apr-13 | 5.04% | Fixed |
| | 72604 | $12,154,000 | 29-Jan-10 | 24-Jan-11 | 2.70% | Floating |
| Sub-total Drawn Facilities | | $165,796,000 | | | | |
| WT003 | | $35,580,000 | | | | |
| Total Facilities | | $201,376,000 | | | | |

The Minister recently approved the DHB's car park business case and a loan application for $24.544M has been submitted to the CHFA. This loan is less than the approved total project cost, reflecting savings of $1.9M realised from the construction tendering. CHFA Debt facilities will therefore increase to $229.92M on completion of the car park project.

Further strategic business cases under the Minister's consideration (e.g. the Elective Surgery Unit business case) and other business cases being developed (such as the Taharoto Mental Health redevelopment) will require external financing which will increase the debt facilities further.

**Working Capital Facilities:**

Under the current Operating Policy Framework, all DHBs are required to maintain a standby working capital facility with either private sector banks or undrawn CHFA loan facilities to cover for any future withdrawal by the Ministry of Health of the income in advance incentive currently in place.

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.

**Banking Covenants:**

Standard financial covenants are in place with all three banks we have a relationship with.

The Crown Health Financing Agency advised us that the requirement for DHBs to comply with financial covenants has been waived. DHB financial performance is monitored on a monthly basis to assess any deterioration in credit worthiness and an annual loan review is conducted to confirm continuation of loan facilities.

All covenants in place are currently being met and are planned to continue to be met throughout the planning period.

# MODULE 9: APPENDICES

## 9.6 Output Measures – Statement of Forecast Service Performance

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | 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. 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 | 75[2] | 75Ω | 2009/10 |
| | | Number of contacts traced | 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 | 664[2] | 650Ω | 2009/10 |
| | | 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 | no baseline available | 100% | |
| | | 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 | no baseline available | 100% | |
| | | Number of emergency hazard investigations conducted | Environmental hazard investigation is another important component of health protection. This is an indicator of the volume of output. | Yes | no baseline available | Ω | |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **Prevention Services** | Health Protection (continued…) | Chemical and hazardous substance injury and poisoning protocol adhered to | As with communicable disease protocols, failure to adhere to protocols would indicate problems with quality of the service | No | no baseline available | 100% | |
| | | Proportion of water supplier compliance/non-compliance with duties under the Act reported to the water supplier within 20 working days | There is a clear requirement under that Act to report water supplier compliance within 20 working days. This is a timeliness measure. | No | no baseline available | 100% | |
| | | 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 | 6 | 6Ω | 2010/11 |
| | | Number of emergencies responded to | A demand driven indicator of a major component of health protection output. | Yes | 3 | Ω | CIMS* structure was activated |
| | | Emergency Plan up-to-date | A failure to keep emergency plans up to date would indicate poor quality output in this area. | No | no baseline available | Yes | |
| | | Proportion of reports submitted to the Environmental and Border Health Protection team and a copy to the Public Health Operations portfolio manager immediately or within 24 hours of occurrence of a public health event or emergency with inter-district, national or potentially international implications | Prompt reporting of public health events and emergencies indicates the speed and timeliness of response. | No | no baseline available | 100% | |

* Coordinate Incident Management System - standard structure for dealing with emergencies in NZ which ensures coordination between all the key agencies and stakeholders

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **Prevention Services** | Health Promotion | Proportion of premises who submit a liquor licence application to ARPHS and all problematic premises that receive a compliance check | Compliance checks are the principal output of our efforts to reduce sales of tobacco and alcohol to minors | No | 100% | 100% | 2009/10 |
| | | Proportion of liquor licensing alcohol compliance protocol for visits adhered to | Failure to comply with protocols would reflect a problem with quality. | No | no baseline available | 100% | |
| | | Proportion of liquor licensing applications processed within 15 days | Prompt processing of applications indicates a timely service | No | no baseline available | 100% | |
| | | Proportion of tobacco complaints responded to within 5 days | Prompt response of tobacco complaints indicates a timely service | No | no baseline available | 100% | |
| | | Number of programmes/enrolees/session attendances | The number of programmes, enrolees and session attendances indicates the volume of output of those programmes directed at individuals | No | *Programmes*<br>Enua Ola – 30<br>Asian Groups – 4<br>Ethnic specific breastfeeding classes – 3<br>*Sessions*<br>Enua Ola – 1,200<br>Asian Groups – 160<br>Ethnic specific breastfeeding classes – 44<br>*Average attendance per session*<br>Enua Ola – 30<br>Asian Groups – n/a<br>Ethnic specific breastfeeding classes – n/a | *Programmes*<br>Enua Ola – 30<br>Asian Groups – 4<br>Ethnic specific breastfeeding classes – 3<br>*Sessions*<br>Enua Ola – 1,200<br>Asian Groups – 160<br>Ethnic specific breastfeeding classes – 48<br>*Average attendance per session*<br>Enua Ola – 30<br>Asian Groups – 30<br>Ethnic specific breastfeeding classes – 10 | May 2011 |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **Prevention Services** | Health Promotion (continued…) | % of funding going to programmes with a logic model | Logic models make explicit the rationale behind health promotion activities and provide a solid framework for monitoring and evaluation. Their existence is therefore an indicator of the quality of the contract. | No | 0% | 25% | 2010/11 |
| | 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 | 17 | 15Ω | |
| | | Submissions policy adhered to | Failure to comply with submission policy would indicate a problem with quality. | No | no baseline available | 100% | |
| | | Submission documents submitted by deadline | An obvious indicator of timeliness. | No | no baseline available | 100% | |
| | Population Based Screening | ***Breastscreening*** | | | | | |
| | | Screening coverage rates among eligible groups: breast cancer | Coverage is a standard measure of output from screening programmes. | No | 64.80% | 70% | Total: 2010 |
| | | Proportion of women screened who report that their privacy was respected | Reflects the quality of the service | No | 98% | 95% | |
| | | Proportion of women screened who receive their results within 10 working days | A timely service provides test results promptly | No | 98.7% | 90-95% | |
| | | ***Bowel Screening*** | | | | | |
| | | Screening coverage rates among eligible groups: bowel cancer | Coverage is a standard measure of output from screening programmes. | No | *not avail* | 15% of eligible population | |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **Prevention Services** | Population Based Screening (continued…) | Proportion of individuals attending colonoscopy pre-assessment who feel fully informed about the colonoscopy procedure or 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 | *not avail* | 90% | |
| | | Proportion of eligible individuals who are recalled for screening within 24 months of their previous invitation for screening | Prompt recall is a timeliness indicator that ensures that screening is performed at the intended frequency. | No | *not avail* | 95% | |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **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 = 823,690*<br>*LTA = 2,350,191* | 824,000Ω<br>2,350,000Ω | 2009/10 |
| | | Number radiological images. | The number of radiological images is a direct indicator of the volume of output of community radiology diagnostic services | No | 155,877 | 155,900Ω | 2009/10 |
| | | 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 | 0.02% | ↓ | 2009/10 |
| | | Average waiting time in minutes for a sample of patients attending Waitemata 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 | 9.5 mins | < 30 mins | Apr-11 |
| | | Percentage of critical test results phoned through to appropriate contact person within 1 hour (a. referrer, b. patient, c. police). (metro Auckland DHBs) | Rapid feedback of urgent test results makes an important contribution to good patient outcomes. | No | 99% | > 98% | Apr-11 |
| | Oral Health (WDHB) | Enrolment rates in children under five. | Output is directly related to the proportion of children enrolled in the service | No | 24,569 | 25,395 | 2010 calendar year |
| | | Utilisation rates for adolescents | This is an indication of the volume of service in relation to the target population | No | 60.70% | 65% | 2010 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 | 124,272 | 142,857 | 2010 calendar year |
| | | Number of complaints for the financial year | A high quality service will receive low numbers of complaints | No | 10 | ↓ | 2009/10 |
| | | Arrears rates | A timely oral health service will have low arrears rates | No | 13% | 10% | 2010 calendar year |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| Early Detection and Management | Primary Care | Ethnic-specific 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 | Asian = 76%<br>Maori = 74% | 80%<br>80% | as at March 2011 |
| | | Immunisation health target achievement | 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 | 90% | 95% | Q3 2010/11 |
| | | Cervical screening coverage | As with immunisation, cervical screening coverage is a good indicator of the preventive service output from primary care. | No | 76.10% | | at December 2010 |
| | | Proportion of practices with cornerstone accreditation | Cornerstone is an accreditation system run by the Royal New Zealand College of General Practice. In order to be accredited practices must accurately assess their level of performance in relation to established standards. | No | 50% | ↑ | As at May 2011 |
| | | 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 | 465/10,000 | 465Ω | 2009/10 |
| | Pharmacy | Total value of subsidy provided. | This indicates the total DHB contribution towards patients' community drug costs. | Yes | $107,012,646 | n/a | 12 months to 28 Feb 2011 |
| | | Proportion of dispensing expenditures relative to expenditure on pharmaceuticals. | High dispensing costs relative to pharmaceutical cost would indicate inefficiency in the operation of the subsidy. | No | 29% | n/a | 12 months to 28 Feb 2011 |
| | | Number of prescriptions subsidised. | Another indicator of overall volume of community pharmacy subsidy to our population. | Yes | 5,943,760 | n/a | 12 months to 28 Feb 2011 |
| | | 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 | unavail | ↑ | |
| | | 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 | 97% | 95% | YTD to end Feb 2011 |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **Early Detection and Management** | Pharmacy (continued…) | The number of extended-hours pharmacies associated with after-hours accident and medical centres | Represents the availability of pharmacy services in relation to accident and medical centres | No | 4 | 4 | YTD May 2011 |
| **Intensive Assessment and Treatment** | Acute Services | Number of ED attendances. | An indicator of the volume of emergency care provided to our population. | Yes | 81,388 | 81,000Ω | 2009/10 |
| | | Acute medical and surgical discharges. | An indicator of the volume of acute hospital service provided to our population | Yes | 48,101 | ↓ | |
| | | Readmission rates. | Although some readmissions are inevitable a high standardised readmission rate compared to other providers is indicative of poor quality care. | Yes | 10.21 | 10.21 | Q3 2010/11 |
| | | Proportion of the population living within 30 minutes travelling time of an ED service. | An accessible health service will have a high proportion of its population living within 30 minutes of an ED | No | 93% | 90% | As at May 2011 |
| | | 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 standards of privacy and dignity. | No | 80% | 95% | Q3 2010/11 |
| | Maternity | Number of deliveries. | An indicator of volume of service provide to our population | Yes | 6,746 | 6,746 Ω | 2010 year |
| | | Number of first obstetric consultations. | An indicator of volume of service provide to our population | Yes | 2,628 | 2,600Ω | 2009/10 |
| | | Number of subsequent obstetric consults. | An indicator of volume of service provide to our population | Yes | 1,958 | 2,000Ω | 2009/10 |
| | | Caesarean section rate. | High caesarean rates indicate some intervention when there is no likely impact on foetal or maternal health outcomes. Caesarean results in increased maternal anaesthetic & surgical risks, and has financial implications. | No | 25.9% | ↓ | 2010 |
| | | Established breastfeeding at discharge. | A good quality maternity service is 'baby-friendly' and will have high rates of established breastfeeding by the point of discharge. | No | 79.8% | 75% | 2010 |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **Intensive Assessment and Treatment** | Maternity (continued…) | Documentation of smoking status and offer of help to quit | Maternal smoking risk factor for poor foetal health outcomes. Good quality care will document this risk factor and offer the patient advice and help to quit. | No | 81% | 95% | Apr-11 |
| | | Proportion of women with antenatal BMI calculated | Maternal obesity associated with a range of maternal & foetal complications | No | new measure | 97.3% | 2010 |
| | | Gestation at first booking | 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 | new measure | 21.6% | 2010 |
| | 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 (e.g. cataract surgery and arthroplasty) and by reducing mortality (e.g. PCI). | No | 12,859 | 14,771 | 2009/10 |
| | | Standardised elective surgical intervention rate. | The need for elective surgery varies according to the population composition (e.g. 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[3] | 264.37/ 10,000 | 292/10,000 | 2010 calendar year |
| | | Number of case-weights in relation to health target. | The case weight provides an indication of the complexity of the surgery. The total therefore is an indication of the volume of output. | No | 17,479.71 | 19,287 | 2009/10 |
| | | Number of outpatient consultations | Outpatient consultations are important component of our elective services output and the total number is a good indicator of the volume of our output. | Yes | 105,830 | 106,000Ω | 2009/10 |
| | | Readmission rates. | See above. This indicator can be calculated separately for readmissions following an elective surgical discharge. | No | 10.21 | 10.21 | Q3 2010/11 |
| | | Post-operative hospital-acquired bacteraemia rates. | Hospital-acquired bacteremia is a negative event reflecting the quality of infection control systems within the hospital. | No | 0.05% | ↓ | 2010 calendar year |
| | | 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 | 1.2% | 0% | Feb-11 |
| | | 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 | 3.2% | 0% | Apr-11 |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **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 | 35,474 | ≥ | 2009/10 |
| | | 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 | 13 | ↓ | 2010 |
| | | AT&R average waiting time (waitlist date to transfer to AT&R) | This is an obvious indicator of the timeliness of our AT&R service. | No | Not avail. | ≤ 4 days | |
| | 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] | *Maori*<br>0-19 3.38%<br>20-64 6.81%<br>*Other*<br>0-19 2.40%<br>20-64 3.12%<br>*Total*<br>0-19 2.55%<br>20-64 3.43%<br>65+ 2.71% | *Maori*<br>0-19 3.48%<br>20-64<br>6.86%<br>*Other*<br>0-19 2.50%<br>20-64<br>3.15%<br>*Total*<br>0-19 2.65%<br>20-64<br>3.47%<br>65+ 2.76% | Q2 2010/11 |
| | | 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 = 98%<br>Child & Youth = 84% | 95% | Q2 2010/11 |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **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:<br>• Inpatient detoxification<br>• Specialist prescribing<br>• Structured counselling | Waiting times for service are an obvious indicator of timeliness. | No | Inpatient detox <21 days<br>Specialist prescribing <7days<br>Structured counselling 0 days | Inpatient detox <21 days<br>Specialist prescribing <7days<br>Structured counselling 0 days | Q2 2010/11 |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **Rehabilitation and Support Services** | Home Based Support | Average number of hours per month of home based support services for:<br>• Personal care<br>• Household management | A simple indicator of the average number of hours of home-based support that we provide. | Yes | <br><br><br>52,300<br>26,280 | <br><br><br>↑<br>↑ | 2009/10 |
| | | Number of complaints received regarding home based support. | Good quality home based support services will receive few complaints. | No | 0 | maintain | 2009/10 |
| | | Percentage of NASC clients assessed within 6 weeks | Long waiting times indicate poor timeliness of this service. | No | 95% | ≥ | 2009/10 |
| | Palliative Care | Hospice palliative care bed day occupancy | Inpatient hospice care is the main component off our expenditure on palliative care. Bed-days are a standard measure of the total output from this activity. | Yes | 68% | ↑ | 2010 calendar year |
| | | Number of people who died while receiving hospice care | | Yes | 896 | n/a | 2010 calendar year |
| | | Numbers of initial hospice assessments | Team assessment is the first point on the pathway to hospice placement and an important output of the palliative care service. | Yes | 889 | n/a | 2010 calendar year |
| | | Specialist palliative care consults (hospice) | | Yes | 2,742 | n/a | 2010 calendar year |
| | | Overall patient satisfaction with hospice services (community and inpatient) | Patient/family/whanau satisfaction with the hospice service provides an indicator of the quality of end of life and palliative care that we provide. | No | 95% | ↑ | 2010 |
| | 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 | 705,486 | ≥ | 2009/10 |

| Output Class | Sub-output Class | Measure | Rationale | Demand Driven? | Baseline | Target 2011/12[1] | Baseline Info |
|---|---|---|---|---|---|---|---|
| **Rehabilitation and Support Services** | Residential Care (continued…) | Rest home audit reports | Under the Health and Disability Services (Safety) Act 2001, all rest homes and other aged residential care facilities must be audited and certified to ensure they are providing safe and reasonable care and meet the standards set out in the Act. Residential care facilities are certified for set periods of time up to a maximum of five years. Rest home audits include a table showing the rest home's achievement against the Health and Disability Sector Standards using a four point scale. These offer detailed information on the quality of care. | No | 46/60 | ↑ | Between Aug 10 – May 11 |
| | | Number of complaints received about aged residential care provider/s. | A high quality services should have low rates of complaint. | No | 16 | ↓ | 2009/10 |
| | | Percentage of NASC clients assessed within 6 weeks | Long waiting times indicate poor timeliness of this service. | No | 95% | ≥ | 2009/10 |

[1] Where the indicator is demand driven this is not a target in the true sense but rather a forecast of activity.
[2] Refers to NorthWest health district
[3] Although this indicator is potentially demand driven, it is assumed that it is currently limited by supply side factors
Ω Demand driven forecast activity

## 9.7 Statement of accounting policies for the year ending 30 June 2012

**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, i.e., 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.

## 9.8 Commonly used acronyms and abbreviations

| Acronym and Jargon | Description |
|---|---|
| A&D | Alcohol and Drug |
| A&M | Accident and Medical Centre |
| ADHB | Auckland District Health Board |
| ADT | Admission, Discharge, Transfer |
| ADU | Assessment & Diagnostic Unit |
| ALOS | Average Length of Stay |
| AOD | Alcohol and Other Drug |
| AP | Annual Plan (DHB) |
| ARDS | Auckland Regional Dental Service |
| ARMHIT | Auckland Regional Mental Health Information Technology |
| ARO | Auckland Radiation Oncology |
| ARPHS | Auckland Regional Public Health Service |
| ARPHS SSDP | ARPHS Services Service Delivery Plan |
| ARRMOS | Auckland Regional Resident Medical Officers Services Ltd (replaces NCTN) |
| ARSS | Auckland Regional Settlement Strategy |
| ASH | Ambulatory Sensitive Hospitalisations |
| ASMS | Association of Salaried Medical Specialists |
| AT&R | Assessment, Treatment and Rehabilitation |
| ATM | All in one triage and smoking cessation support form |
| AUT | Auckland University of Technology |
| | |
| BFH | Baby Friendly Hospital |
| BSA | BreastScreen Aotearoa |
| BSI | Blood Stream Infections |
| BSMC | Better Sooner More Convenient (Government Health Policy) |
| | |
| C&F | Child & Family |
| CADS | Community Alcohol and Drug Service |
| Care Plus Programme | A primary health care initiative targeting people with high health need due to chronic conditions, acute medical or mental health needs, or terminal illness. |
| CATT | Community Assessment and Treatment Team |
| CCU | Coronary Care Unit |
| CDS | Child Development Service |
| CE | Crown Entity |
| CEA | Collective Employment Agreement |
| CEC | Collective Employment Contract |
| CFA | Crown Funding Agreement |
| CFO | Chief Financial Officer |
| CHFA | Crown Health Financing Agency |
| CIO | Chief Information Officer |
| CMDHB | Counties Manukau District Health Board |
| CME | Continuing Medical Education |
| CMHC | Community Mental Health Centre |
| CN | Charge Nurse |
| CNS | Clinical Nurse Specialist |
| COO | Chief Operating Officer |
| COPD | Chronic Obstructive Pulmonary Disease |
| CPI | Critical Performance Indicators |
| CPHAC | Community & Public Health Advisory Committee (committee of the WDHB Board) |
| CTA | Clinical Training Agency |
| CVD | Cardiovascular Disease |

| Acronym and Jargon | Description |
|---|---|
| CVDRAM | Cardiovascular Disease Risk Assessment and Management |
| CW&F | Child, Women and Family services (WDHB provider group) |
| CWD | Case Weighted Discharges |
| | |
| Detox | Detoxification Service |
| DHB | District Health Board |
| DHBNZ | District Health Board NZ an association representing DHBs |
| DiSAC | Disability Support Advisory Committee (committee of the WDHB Board) |
| DMFT | Decayed/Missing/Filled Teeth |
| DMHS | District Mental Health Service |
| DN | District Nurse |
| DNA | Did not attend |
| DRGs | Diagnostic Related Groups |
| DSS | Disability Support Services |
| | |
| ECC | Emergency Care Centre |
| ED | Emergency Department |
| eMR | Electronic Medicines Reconciliation |
| EN | Enrolled Nurse |
| ENT | Ear Nose and Throat |
| EOI | Expression of Interest |
| eReferrals | Electronic Referrals |
| ESPIs | Elective Services Performance Indicators for DHBs (monitored by MoH) |
| ESUs | Elective Surgical Units |
| | |
| FFT | Future funding track |
| FSA | First Specialist Assessment (Hospital Out-patient visit) |
| FTE | Full-time equivalent (staff) |
| FU | Follow-up (hospital outpatient visit) |
| | |
| GAIHN | Greater Auckland Integrated Health Network |
| Get Checked | The free annual diabetes check from a GP / Practice Nurse for people with diabetes |
| GLH | Green Lane Hospital |
| GP | General Practitioner |
| | |
| hA | healthAlliance (Northern Region DHB joint support unit) |
| HAC | Hospital Advisory Committee (committee of the WDHB Board) |
| HBSS | Home Based Support Services |
| HCA | Health Care Assistant |
| HCC | Health Care Community (electronic patient management system) |
| HDC | Health and Disability Commissioner |
| HDU | High Dependency Unit |
| HOP | Health of Older People |
| HQSC | Health Quality and Safety Commission |
| HR | Human Resources |
| HRC | Health Research Council |
| HRIS | Human Resource Information System |
| HWIP | Health Workforce Information Programme |
| HWNZ | Health Workforce New Zealand |
| | |
| ICU | Intensive Care Unit |
| IDF | Inter District Flows (services provided by one DHB for residents of another DHB) |

| Acronym and Jargon | Description |
|---|---|
| IEA | Individual Employment Agreement |
| IFHC | Integrated Family Health Centres |
| IMMS | Immunisation |
| Imprest System | A storage cupboard in the ward which is pre-filled with an agreed selection and quantity of medicines |
| IT | Information Technology |
| InterRai | Older Persons Health Assessment System |
| IP | In Patient (hospital) |
| IS | Information Systems |
| ISSP | Information Systems Strategic Plan |
| | |
| KPIs | Key Performance Indicators |
| KYMS | Know Your Midwife Service |
| | |
| LDT | Local Diabetes Team |
| Linac | Linear Accelerator |
| LMC | Lead Maternity Carer |
| LOS | Length of Stay |
| LSCS | Late Stage Caesarean Section |
| LTCCP | Long Term Council Community Plan |
| | |
| M&M | Morbidity & Mortality |
| MaPO | Māori Co-Purchasing Organisation |
| MaGAC | Māori Health Gain Advisory Committee (committee of the WDHB Board) |
| MECA | Multi Employer Collective Agreement |
| MH&A | Mental Health & Addictions |
| MHINC | Mental Health Information National Collection |
| MHPs | Māori Health Plans |
| MHSG | Mental Health Service Group |
| MIT | Mobile Intensive Team |
| MoH | Ministry of Health |
| MOKO | Māori mental health service |
| MoU | Memorandum of Understanding |
| MOSS | Medical Officer of Special Scale |
| MR | Medicines Reconciliation |
| MRI | Magnetic Resonance Imaging |
| MRSA | Methicillin Resistant Staphylococcus Aureus |
| | |
| NASC | Needs Assessment and Service Coordination |
| NCC | National Capital Committee |
| NCN | Northern Cancer Network |
| NCSP | National Cervical Screening Programme |
| NDSA | Northern DHB Support Agency |
| NGO | Non-Government Organisation |
| NHB | National Health Board |
| NHI | National Health Index (unique health identifier for every individual) |
| NHPPD | Nursing Hours Per Patient Day |
| NICU | Neonatal Intensive Care Unit |
| NITS | National Information Technology Strategy (Ministry of Health) |
| NMDS | National Minimum Data Set (national collection of hospital discharge data) |
| NNC | Network North Coalition (Mental Health stakeholder group). |
| NRDHBs | Northern Regional DHBs |
| NRN | Northern Regional Network |

| Acronym and Jargon | Description |
|---|---|
| NRT | Nicotine Replacement Therapy |
| NSH | North Shore Hospital |
| NSU | National Screening Unit |
| NZCCSAP | New Zealand Cancer Control Strategy and Action Plan |
| NZHS | New Zealand Health Strategy |
| NZDS | New Zealand Disability Strategy |
| NZHIS | New Zealand Health Information Service |
| NZIFRS | New Zealand equivalent of International Financial Reporting Standards |
| NZNO | New Zealand Nurses Association |
| NZQF | New Zealand Quality Foundation |
| | |
| OAG | Office of the Auditor General |
| OP | Out Patient |
| OPF | Operating Policy Framework - part of the Crown Funding Agreement (for DHBs) |
| ORL | Otorhinolaryngology (Ear, Nose and Throat) |
| | |
| PACS | Picture Archiving and Communications System (computerised radiology images) |
| PAMP | Pictorial Asthma Medication Plan |
| PBFF | Population Based Funding Formula |
| PC | Practicing Certificate. |
| PDRP | Professional Development and Recognition Programme (for nurses) |
| PHC | Primary Health Care |
| PHCS | Primary Health Care Services |
| PHO | Primary Healthcare Organisation |
| P&L | Profit and Loss |
| PHN | Public Health Nurse |
| POAC | Primary Options for Acute Care |
| PSA | Public Service Association |
| PT | Physiotherapist |
| | |
| Q[*2*] | Quarter [2] – generally financial year quarter eg. Q2 = October - December |
| QUM | Quality Use of Medicines |
| | |
| RC | Responsibility Centre |
| RCS | Regional Coordination Service (Mental Health) |
| RDA | Resident Doctors Association |
| RESN | Regional Elective Services Network |
| RFS | Regional Forensic Service |
| RIS10-20 | Regional Information Strategy 2010 - 2020 |
| RMHFT | Regional Mental Health Funding Team |
| RMO | Resident Medical Officer |
| RN | Registered Nurse |
| ROOG | Regional Oncology Operational Group |
| RSP | Regional Service Plan |
| RT | Radiotherapy/therapist |
| RWRS | Regional Work Rehabilitation Service |
| | |
| *SafeRx*® | Safe Use of Medicines |
| SCBU | Special Care Baby Unit |
| SCS | Service Coverage Schedule - part of the Crown Funding Agreement (for DHBs) |
| SFWU | Service and Food Workers Union |
| SIRP | Serious Incident Review Panel |
| SLA | Service Level Agreement |

| Acronym and Jargon | Description |
|---|---|
| SLT | Speech Language Therapist |
| SMO | Senior Medical Officer |
| SMT | Senior Management Team |
| SoI | Statement of Intent (DHB Accountability Document) |
| SSOA | Specialised Services for Older Adults |
| SSSG | Shared Services Support Group |
| | |
| TA | Territorial Authority (local authority) |
| | |
| WDHB | Waitemata District Health Board |
| WDHBCCG | WDHB Cancer Control Group |
| WIES | System for comparing the relative costs of Medical and Surgical admissions (Weighted In-lier Equivalent Separations) |
| WIMS | Waitakere IPCS Maternity Scheme Team |
| WSN | Waitemata Stakeholder Network (Mental Health) |
| WTH | Waitakere Hospital |
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| YTD | Year to date |